

American Society of Colon & Rectal Surgeons

ANNUAL SCIENTIFIC MEETING

JUNE 10-14, 2017

Washington State Convention Center
and Sheraton Seattle Hotel



TRIPARTITE MEETING

The Association of Coloproctology of Great Britain and Ireland
The Section of Coloproctology Royal Society of Medicine
Royal Australasian College of Surgeons Colon and Rectal Surgery Section
Colorectal Surgical Society of Australia and New Zealand
The European Society of Coloproctology

SEATTLE
WASHINGTON

www.fascrs.org

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EDUCATION INFORMATION

Program Leadership



Rocco Ricciardi, MD
Program Chair



Anjali Kumar, MD
Program Vice-Chair



Sonia Ramamoorthy, MD
Program Vice-Chair



James Keck, MD
International Liaison

Annual Scientific Meeting Goals, Purpose and Learning Objectives

The goals of the American Society of Colon and Rectal Surgeons' Annual Scientific Meeting are 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 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 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 44 *AMA PRA Category 1 Credit(s)*[™]. **Physicians should only claim 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.

Method of Participation

Participants must be registered for the conference and attend the session(s). Each participant will receive a username and password for completion of the online evaluation form for the ASCRS 2017 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 ABCRS MOC program. In order to claim self-assessment credit, attendees must participate in a post-test. Information/instructions will be sent to all meeting registrants prior to the Annual Meeting.

Please Note: Times and speakers are subject to change.

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.

ANNUAL SCIENTIFIC MEETING INFORMATION

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 have been requested to complete the *Disclosure of Financial Relationships*. Disclosures will be made at the time of presentation, as well as included in the Program Book. 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 on Sunday, June 11, from 7:30 – 10:00 pm (complimentary to all registered attendees) and will feature hors d'oeuvres, cocktails and entertainment. The Welcome Reception will be held at the Museum of Pop Culture (MoPOP). The Research Foundation will join forces with ASCRS to welcome all at this reception.

The **Tripartite Gala** will be held on Tuesday, June 13, beginning at 7:30 pm. There is no additional cost for a ticket for full-paying ASCRS Members/Fellows or Tripartite Members. Members/Fellows/Tripartite Members must indicate whether they want to attend the Tripartite Gala when registering for the meeting, and then obtain their dinner ticket on-site prior to the gala. The cost for others is \$150 per ticket.

Complimentary WiFi Available

Complimentary WiFi will be provided in the Washington State Convention Center.

Accommodations

The meeting will be held at the Washington State Convention Center and Sheraton Seattle Hotel in Seattle, WA.

The Washington State Convention Center and meeting hotels are approximately 30 minutes from the Seattle-Tacoma International Airport.

Hotels and Room Rates

If making a reservation by phone, call the following phone numbers and ask for the ASCRS room block. For best availability, make your reservations online.

Sheraton Seattle Hotel

(Headquarters – 1 block from the Convention Center)

\$265 Single / Double – Traditional Room (888) 627-7056

\$285 Single / Double – Deluxe Room

Grand Hyatt Seattle

(1 block from the Convention Center)

\$275 Single / Double (402) 935-5352

Hyatt Olive 8

(1 block from the Convention Center)

\$275 Single / Double (402) 593-6314

Hotel reservations/rates availability are not guaranteed after the room block is full or after May 8, 2017. Please register early – only a limited number of rooms are available.

The deadline for hotel reservations is Monday, May 8, 2017.

Note: Requests for sleeping rooms should be made directly with the hotels listed above. ASCRS has not contracted with, nor authorized, any housing provider or travel agency to make hotel reservations on behalf of the ASCRS, its exhibitors or its sponsors. Should you be contacted by any agency soliciting housing or travel-related services, please inform the ASCRS executive office.

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 make your airline reservation, call ASCRS' official travel agency, Uniglobe Travel Partners, at (800) 626-0359 (M-F 8:30 am – 7:00 pm CST).

ANNUAL SCIENTIFIC MEETING INFORMATION

Fun Run

Sunday, June 11, 6:00 – 7:00 am

Attendees are encouraged to register for the 5K “Fun Run” which will take place at Myrtle Edwards Park. Proceeds from the event will be donated to the Ostomy Supply Closet, a local charity that provides ostomy supplies for those that cannot afford them.

The bus leaves the Sheraton Seattle Hotel at 5:30 am.
Registration Fee: \$10

Exhibit Hall Hours

Sunday, June 11, 11:30 am – 4:30 pm

Complimentary box lunch
Afternoon refreshment break

Monday, June 12, 9:00 am – 4:30 pm

Morning and afternoon refreshment breaks
Complimentary box lunch

Tuesday, June 13, 9:00 am – 2:00 pm

Morning refreshment break
Complimentary box lunch

Spouse/Companion Program

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

Package #1 (\$175) Includes:

Welcome Reception, 7:30 – 10:00 pm, Sunday
Tripartite Gala, 7:30 – 10:30 pm, Tuesday
Admission to the exhibit hall only

Package #2 (\$75) Includes:

Welcome Reception, 7:30 – 10:00 pm, Sunday
Admission to the exhibit hall only

Temperature

The average temperature in June ranges from a low of 53° to a high of 71°F.

Child Care Services

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

Registration Fees

Please see registration information online.

Cancellation Policy

If you need to cancel your **meeting registration**, the Society will refund your General Registration fee, minus the \$75 cancellation fee, upon written request. No refunds will be issued for requests received after May 22, 2017.

The Society will refund **workshop** fee(s) if your cancellation request is received in writing before May 22, 2017.

Cancellations must be received in writing. Send requests to the ASCRS Registration Department at:

Email: meetings@fascrs.org

Fax: (847) 427-9656

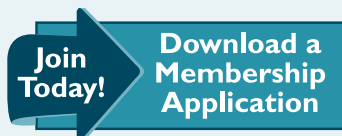
Mail: American Society of Colon and Rectal Surgeons
Meeting Registration Dept.
85 W. Algonquin Rd., Ste. 550
Arlington Heights, IL 60005



Not a member? Join now to save on registration!

Members save \$320 off of the price of 2017 Annual Scientific Meeting registration. If you plan to attend the meeting, your membership will pay for itself, plus offer you:

- Subscription to *Diseases of the Colon and Rectum*
- Complimentary access to CREST, our robust online education portal
- Listing in the patient-directed Find a Surgeon search engine
- Discounted pricing on patient brochures, textbooks and manuals
- Access to an extensive Members-Only Resource Library
- Ability to post job openings and your resume in our Career Center
- Test your knowledge with the CARSEP® Self-Assessment Exam
- ...and much more.



The ASCRS is the professional home of more than 3,500 health care professionals who work in the field of colon and rectal surgery. We're dedicated to advancing and promoting the science and treatment of patients with diseases affecting the colon, rectum and anus through education, advocacy and fellowship. **Join us.**

Workshop

Advanced Robotic Colon and Rectal Surgery: Tips, Tricks and Simulation for the Experienced Surgeon



7:00 am – noon

Registration Required • Member Fee: \$525 • Nonmember Fee: \$650 • Limit: 16 participants

This session will involve cadaver-based procedural exercises aimed at demonstrating state-of-the-art techniques employed in different colorectal operations with a focus on robotic right colectomy and LAR. Port placement for each procedure and docking techniques will be reviewed. The main focus will be on operative techniques, identification and preservation of critical anatomy and intra-operative trouble shooting. This course is intended for surgeons who have done a minimum of five robotic procedures as a primary surgeon and wish to improve their skills. Each registrant will be required to submit a case log and show access to a Robotic system in their practice. The applicants will be reviewed by the course directors.

Existing Gaps

What Is: Easily available resources to guide surgeons wishing to adopt robotic surgery are limited, especially hands-on sessions. Standardization of procedures according to best practices is also lacking in robotic surgery.

What Should Be: Ample opportunity should exist to provide practical operative experience to both novice and more experienced surgeons and interactions with highly experienced faculty.

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

Co-Director: Craig Rezac, MD, New Brunswick, NJ

Workshop Faculty:

Craig Johnson, MD, Tulsa, OK

Vincent Obias, MD, Washington, DC

Mark Soliman, MD, Orlando, FL

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

- Describe the set-up and instrumentation of advanced robotic colorectal procedures.
- Explain different procedural approaches in robotic colorectal surgery.
- Explain how to troubleshoot and address specific robotic-related complications in colorectal surgery.

Symposium and Workshop

Transanal Total Mesorectal Excision (taTME)



7:30 am – 4:30 pm

Registration and Pre-registration Survey Required (Includes Didactic and Hands-on Workshop) • Fee: \$1,000

Limit: 16 participants • Lunch Included

Didactic Session Only: \$30 (7:30 am – noon)

Standard of care treatment of rectal cancer demands a systematic, multi-disciplinary team approach where radical rectal resection with Total Mesorectal Excision (TME) remains the cornerstone of treatment. An evolving shift towards minimally invasive surgical approaches for rectal cancer continues to be hampered by the challenges of reliable pelvic exposure and adequate instrumentation for rectal and mesorectal dissection, distal rectal transection and low pelvic anastomosis.

Transanal Total Mesorectal Excision (taTME) has recently been described as a strategy to facilitate completion of minimally invasive TME, particularly for mid and low rectal cancers. Using commercially available transanal platforms, transanal endoscopic access enables early identification of the distal transection margin, visualization and dissection of the mesorectal plane, completion of the TME using laparoscopic transabdominal assistance for vascular ligation and mobilization of the left colon and splenic flexure. A growing number of case studies have described the preliminary procedural and oncologic safety of taTME, with exceedingly low conversion rates. taTME with laparoscopic assistance is an innovative minimally invasive alternative for radical rectal cancer resection.

Existing Gaps

What Is: There is currently a lack of clinical experience with and training in transanal TME operation, particularly in the United States.

What Should Be: This course will review the current status of taTME, indication and contraindications for taTME, recommended training, implementation of taTME programs, operative set-up and specific techniques, as well as pitfalls and complications. In-depth didactic lectures with videos will be provided by expert faculty.

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

- Describe the rationale, indications, contraindications and preliminary results of taTME based on published evidence.
- Explain the operative set-up, transanal platforms and instrumentation available to perform taTME.
- Recognize the operative techniques through didactic lectures and video demonstrations.
- Recall the intraoperative complications and limitations of taTME.
- Define the recommended pathway for establishing a multidisciplinary team-based taTME program.

Co-Director: Patricia Sylla, MD, New York, NY

Co-Director: Sam Atallah, MD, Winter Park, FL

Pre-registration Survey (Required)

While the ASCRS taTME didactic session (7:30 am – noon) is open to all registrants for a nominal fee, the hands-on cadaver lab (noon – 4:30 pm) will be limited to surgeons with prerequisite skills in minimally-invasive TME and transanal endoscopic surgery (TEM, TEO or TAMIS). Please click on the link to complete the survey by going to the registration information page on our website, www.fascrs.org/tatme-workshop.

Continued next page

Transanal Total Mesorectal Excision (taTME) *(continued)*

Didactic Session

7:30 am – noon

7:30 am **Introduction**
Patricia Sylla, MD, New York, NY



taTME Uptake, Results and New Trends

7:35 am **Transanal Notes: Are We There Yet?**
Mark Whiteford, MD, Portland, OR

7:45 am **taTME 8 Years Later: Lessons Learned**
Antonio Lacy, MD, PhD, Barcelona, Spain

8:00 am **taTME International Registry: Uptake, Results and Debrief**
Roel Hompes, MD, Oxford, United Kingdom

8:15 am **taTME vs. lap TME: Best Evidence and Trial Updates**
John Monson, MD, Orlando, FL

8:30 am **ta-APR, ta-IPAA, ta-Hartman's Reversal, ta-CP, and Transanal Repeat Pelvic Surgery and Other New Trends**
Albert Wolthuis, MD, Leuven, Belgium

8:45 am **Round Table Debates**

taTME Training and Implementation

9:00 am **taTME Training, Proctoring and Monitoring: International Consensus**
Roel Hompes, MD, Oxford, United Kingdom

9:15 am **Patient Selection, Preoperative Preparation and Considerations**
Todd Francone, MD, Burlington, MA

9:30 am **Implementing a taTME Program**
Dana Sands, MD, Weston, FL

9:45 am **taTME Essentials: Mastery of Transanal Anatomy**
Sam Atallah, MD, Winter Park, FL

10:00 am **Standardization of taTME Technique: Educational Initiatives**
Joep Knol, MD, Hasselt, Belgium

10:15 am **Preventing Urethral Injury During taTME: What Have We Learned?**
Patricia Sylla, MD, New York, NY

10:30 am **Round Table Debates**

In-depth taTME Techniques: Video-Based Session

10:45 am **taTME Techniques for Mid-rectal Cancer: From the Perfect Pursestring to Finding the Correct Planes**
Justin Maykel, MD, Worcester, MA

10:55 am **taTME Techniques for Very Low Rectal Tumors: From Mucosectomy to Intersphincteric Resection**
John H. Marks, MD, Wynnewood, PA

11:05 am **OR and Team Set-Up, Instrumentation**
Carl Brown, MD, Vancouver, BC, Canada

11:15 am **Anastomotic Techniques in taTME**
Elena Vikis, MD, Vancouver, BC, Canada

11:25 am **Pitfalls During taTME: Pursestring, Bleeding, Wrong Planes**
Matthew Albert, MD, Altamonte Springs, FL

11:35 am **Major Complications During taTME: Getting Out of Trouble**
Elisabeth McLemore, MD, Los Angeles, CA

11:45 am **Round Table Debates**

Noon **Adjourn**

Noon **Lunch** *(Provided for Hands-on Lab Participants)*

Continued next page

Transanal Total Mesorectal Excision (taTME) *(continued)*

Hands-on Session

1:00 – 4:30 pm



1:00 pm **Instructions to the Lab**

Sam Atallah, MD, Winter Park, FL
Patricia Sylla, MD, New York, NY

Station 1-4: TAMIS taTME

Matthew Albert, MD, Altamonte Springs, FL
Sam Atallah MD, Winter Park, FL
Roel Hompes, MD, Oxford, United Kingdom
Joep Knol, MD, Hasselt, Belgium
Antonio Lacy, MD, PhD, Barcelona, Spain
Justin Maykel, MD, Worcester, MA
Elisabeth McLemore, MD, Los Angeles, CA
Elena Vikis, MD, Vancouver, BC, Canada
Albert Wolthuis, MD, Leuven, Belgium

Station 5-6: TEO taTME

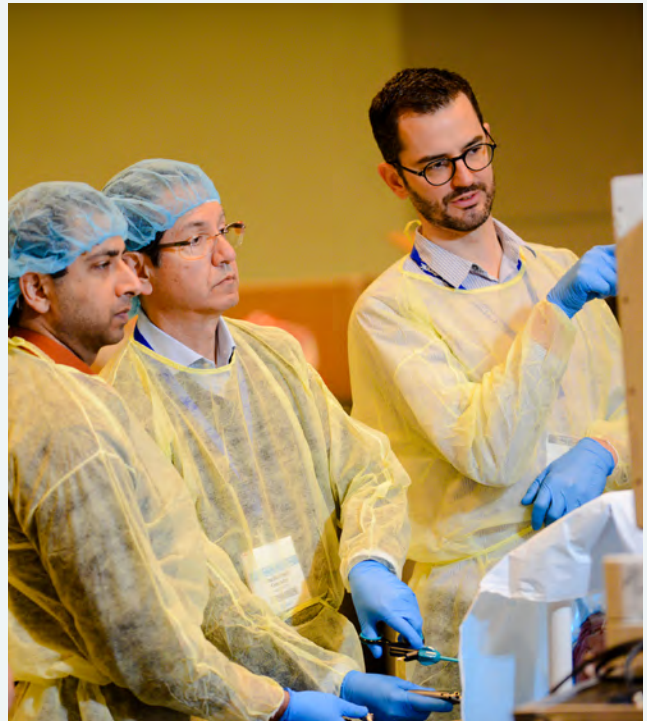
Marylise Boutros, MD, Montreal, QC, Canada
Leigh Nadler MD, Pittsburgh, PA
Alessio Pigazzi MD, PhD, Orange, CA
Patricia Sylla, MD, New York, NY

Station 7-8: TEM taTME

Carl Brown, MD, Vancouver, BC, Canada
Todd Francone, MD, Burlington, MA
Dana Sands, MD, Weston, FL
Mark Whiteford, MD, Portland, OR

4:15 pm **Debrief**

4:30 pm **Adjourn**



Symposium and Workshop

Rectal Prolapse Advanced Methods



7:30 am – 4:30 pm

Registration Required (Includes Didactic and Hands-on Workshop) • Member Fee: \$525 • Nonmember Fee: \$650

Limit: 20 participants • Lunch Included

Didactic Session Only: \$30 (7:30 am – noon)

Rectal prolapse is a debilitating condition with both functional and anatomic sequelae. Recurrence rates for complete rectal prolapse have been reported as high as 10-20%. The surgical approach to treat these recurrences remains an unresolved problem. Laparoscopic Ventral Rectopexy (LVR) is the current gold standard for treatment of rectal prolapse in European countries.

LVR can correct full-thickness rectal prolapse, rectoceles and internal rectal prolapse and can be combined with vaginal prolapse procedures, such as sacrocolpopexy, in patients with multi-compartment pelvic floor defects. Limiting dissection to the anterior rectum minimizes autonomic nerve damage associated with posterior dissection and division of the lateral stalks.

LVR is technically demanding and requires a complete ventral dissection of the rectovaginal septum (rectovesical in men) down to the pelvic floor and suturing skills within a confined space which further maximizes the difficulty. Poor technique minimizes the functional benefit and increases the risk for complications. Formal training programs in VR can help avoid complications and improve outcomes.

Existing Gaps

What Is: Laparoscopic Ventral Rectopexy corrects descent of the anterior and middle pelvic floor compartments and has shown to be successful for improving full thickness rectal prolapse, internal prolapse, enterocele, rectocele, fecal incontinence and obstructed defecation. LVR is the gold standard for rectal prolapse repair in Europe. There are few training opportunities in the United States for LVR or RVR.

What Should Be: Surgeons should have the opportunity to learn the techniques of LVR and RVR through didactic video based learning and simulation. Surgeons should also be familiar with other prolapse operations for patients who are not optimal candidates for VR.

Director: Brooke Gurland, MD, Cleveland, OH

Assistant Director: Andrew Stevenson, MD, Chermerside, Australia

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

- Review surgical options for primary and recurrent rectal prolapse.
- Explain laparoscopic ventral rectopexy, indications and long-term outcomes.
- Describe surgical steps for Ventral Rectopexy.
- Distinguish how to avoid and how to deal with surgical complications after prolapse surgery.

Continued next page

Rectal Prolapse Advanced Methods *(continued)*

Didactic Session

7:30 am – noon



7:30 am	Welcome and Introductions Brooke Gurland, MD, Cleveland, OH	9:10 am	LVR Surgery Video: How I Do It? Andrew Stevenson, MD, Chermside, Australia
7:40 am	Are Perineal Procedures for Rectal Prolapse Obsolete? Liliana Bordeianou, MD, Boston, MA	9:40 am	Refreshment Break in Foyer
7:55 am	Principles and Evolution of Mesh Procedures for Rectal Prolapse C. Neal Ellis, MD, Odessa, TX	9:50 am	Avoiding Complications/Minimizing the Learning Curve for VR Anthony Richard Dixon, MD, Bristol, United Kingdom
8:10 am	Testing What Helps Me Prior to Prolapse/VR Repair? Paul-Antoine Lehur, MD, PhD, Nantes, France	10:10 am	Is VR the Panacea for Obstructed Defecation Syndrome? James Ogilvie, Jr., MD, Grand Rapids, MI
8:25 am	Multidisciplinary Pelvic Floor Evaluation and Surgery: When Is It Needed? Beri Ridgeway, MD, Riverside, CA	10:25 am	And It's Back: Dealing with Recurrent Rectal Prolapse Brooke Gurland, MD, Cleveland, OH
8:40 am	Laparoscopic Ventral Rectopexy – Evolution of Technique and Long-Term Outcomes Andre D'Hoore, MD, PhD, Leuven, Belgium	11:05 am	Case Presentations – What Would You Do? Brooke Gurland, MD, Cleveland, OH James Ogilvie, Jr., MD, Grand Rapids, MI
8:55 am	Patient Selection – Is Everyone a Candidate for VR? Joseph Carmichael, MD, Orange, CA	11:45 am	Question and Answer
		Noon	Adjourn
		Noon	Lunch <i>(Provided for Hands-on Lab Participants)</i>

Hands-on Session

1:00 – 4:30 pm



1:00 pm	Patient Positioning/Port Placement LVR/Exposing the Pelvis James Ogilvie, Jr., MD, Grand Rapids, MI	1:40 pm	Fixation at the Sacrum Anthony Richard Dixon, MD, Bristol, United Kingdom
1:10 pm	RVR – Port Placement/Docking Brooke Gurland, MD, Cleveland, OH	1:50 pm	Closure of the Peritoneum Joseph Carmichael, MD, Orange, CA
1:20 pm	LVR Peritoneal Dissection/Exposing RVF Space Andre D'Hoore, MD, Leuven, Belgium	2:00 pm	Hands-on Lab
1:30 pm	Mesh or Graft Placement and Suturing on to the Rectum Andrew Stevenson, MD, Chermside, Australia	4:30 pm	Adjourn

Workshop

AIN and HRA: What the Colorectal Surgeon Needs to Know



7:30 am – 4:30 pm

Registration Required • Member Fee: \$525 • Nonmember Fee: \$650 • Limit: 45 participants • Lunch Included

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. While the efficacy of HRA with targeted ablation of HSIL to prevent anal cancer has never been proven through prospective trials, there is a growing awareness even among surgeons who do not utilize HRA that close follow-up is necessary.

Through a didactic and hands-on educational initiative, we propose a comprehensive review of anal HPV infections and the indications and use of HRA for diagnosis and treatment of AIN.

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. Even if surgeons do not believe in treatment of HSIL to prevent cancer, they need to know how to recognize progressing lesions and superficially invasive cancers.

Director: Stephen Goldstone, MD, New York, NY

Assistant Director: Tamzin Cuming, MD, London, United Kingdom

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

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

- Describe the prevalence of anal HPV infection.
- Recognize how to best diagnose AIN.
- Describe the fundamentals of how to perform high-resolution anoscopy.
- Identify treatment options available for AIN.

7:30 am	Welcome Stephen Goldstone, MD, New York, NY	9:50 am	HRA Guided Treatment Options and Management Algorithms Stephen Goldstone, MD, New York, NY Joel Palefsky, MD, San Francisco, CA
7:35 am	Introduction to HPV: Scope of the Problem Joel Palefsky, MD, San Francisco, CA	10:50 am	Panel Discussion and Questions J. Michael Berry-Lawhorn, San Francisco, CA Tamzin Cuming, MD, London, United Kingdom Teresa Darragh, MD, San Francisco, CA Stephen Goldstone, MD, New York, NY Naomi Jay, RN, NP, PhD, San Francisco, CA Joel Palefsky, MD, San Francisco, CA
7:50 am	Pathology and Cytology and the LAST Criteria Teresa Darragh, MD, San Francisco, CA		
8:10 am	How to Diagnose AIN: Screening and Diagnostics J. Michael Berry-Lawhorn, MD, San Francisco, CA Naomi Jay, RN, NP, PhD, San Francisco, CA		
8:30 am	Fundamentals of HRA Naomi Jay, RN, NP, PhD, San Francisco, CA	11:15 am	Hands-on Workshop: Lesion Identification (Understanding Lesion Patterns to Differentiate LG from HG) Naomi Jay, RN, NP, PhD, San Francisco, CA
8:50 am	HRA Findings of AIN and Biopsy Naomi Jay, RN, NP, PhD, San Francisco, CA J. Michael Berry-Lawhorn, MD, San Francisco, CA		

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AIN and HRA: What the Colorectal Surgeon Needs to Know *(continued)*

11:15 am – 12:45 pm

	11:15 – 11:45 am	11:45 am – 12:15 pm	12:15 – 12:45 pm
Group 1	Lesion Identification (Understanding Lesion Patterns to Differentiate LG from HG) Naomi Jay, RN, NP, PhD	Hands-on Workshop: HRA Including Use of the Colposcope and Biopsy Techniques J. Michael Berry-Lawhorn, MD Tamzin Cuming, MD Teresa Darragh, MD Stephen Goldstone, MD	HRA the Movie Joel Palefsky, MD
Group 2	HRA the Movie Joel Palefsky, MD	Lesion Identification (Understanding Lesion Patterns to Differentiate LG from HG) Naomi Jay, RN, NP, PhD	Hands-on Workshop: HRA Including Use of the Colposcope and Biopsy Techniques J. Michael Berry-Lawhorn, MD Tamzin Cuming, MD Teresa Darragh, MD Stephen Goldstone, MD
Group 3	Hands-on Workshop: HRA Including Use of the Colposcope and Biopsy Techniques J. Michael Berry-Lawhorn, MD Tamzin Cuming, MD Teresa Darragh, MD Stephen Goldstone, MD	HRA the Movie Joel Palefsky, MD	Lesion Identification (Understanding Lesion Patterns to Differentiate LG from HG) Naomi Jay, RN, NP, PhD

1:00 pm Lunch with Panel Discussion and Questions

2:00 – 3:30 pm

	2:00 – 2:30 pm	2:30 – 3:00 pm	3:00 – 3:30 pm
Group 1	IRC and Hyfrecator Movie Stephen Goldstone, MD	Hands-on Workshop: HRA Treatment Practicum Naomi Jay, RN, NP, PhD Tamzin Cuming, MD Joel Palefsky, MD	Cases: Identifying Lesions, Determining Sites for Biopsies J. Michael Berry-Lawhorn, MD Teresa Darragh, MD
Group 2	Cases: Identifying Lesions, Determining Sites for Biopsies J. Michael Berry-Lawhorn, MD Teresa Darragh, MD	IRC and Hyfrecator Movie Stephen Goldstone, MD	Hands-on Workshop: HRA Treatment Practicum Naomi Jay, RN, NP, PhD Tamzin Cuming, MD Joel Palefsky, MD
Group 3	Hands-on Workshop: HRA Treatment Practicum Naomi Jay, RN, NP, PhD Tamzin Cuming, MD Joel Palefsky, MD	Cases: Identifying Lesions, Determining Sites for Biopsies J. Michael Berry-Lawhorn, MD Teresa Darragh, MD	IRC and Hyfrecator Movie Stephen Goldstone, MD

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AIN and HRA: What the Colorectal Surgeon Needs to Know *(continued)*

- 3:30 pm **Anal Dysplasia Screening Outside of the US: Special Considerations**
Tamzin Cuming, MD, London, United Kingdom
- 4:00 pm **Panel Discussion of Practice Models: Judging Competency and Special Considerations**
J. Michael Berry-Lawhorn, MD, San Francisco, CA
Tamzin Cuming, MD, London, United Kingdom
Teresa Darragh, MD, San Francisco, CA
Stephen Goldstone, MD, New York, NY
Naomi Jay, RN, NP, PhD, San Francisco, CA
Joel Palefsky, MD, San Francisco, CA
- 4:30 pm **Adjourn**



Workshop

Young Surgeons Mock Orals & More



12:30 – 5:30 pm

Registration Required • Candidate Member Fee: \$50 • Member Fee: \$150 • Nonmember Fee: \$200

Limit: 90 participants

To achieve certification by The American Board of Colon and Rectal Surgery, a candidate must pass a written examination (Part I) and an oral examination (Part II). The oral examination is taken once the candidate passes the written examination. Its objective is to evaluate the candidate's clinical experience, problem-solving ability and surgical judgment and to ascertain the candidate's knowledge of the current literature on colon and rectal diseases and surgery.

During this workshop, the participants will have the opportunity to answer multiple scenarios administered by different examiner pairs. Participants will overhear their colleagues answer and receive critique on scenarios. Scenarios covered will be topics, which are required to pass the certifying oral examination and are commonly encountered in a standard colorectal practice. Additionally, this workshop will also provide feedback on performance and guidance in treatment of these various disease processes.

In addition, a mini-symposium will offer topics related to board review, transition to practice, academic success and career transition. This mini-symposium will be tailored to the participating tracks, Track 1: residents/fellows-in-training or Track 2: physicians in practice applying for board certification.

Existing Gaps

What Is: There are no high-quality formal mock examination review courses that exist to prepare recent colorectal fellowship graduates for the oral examination.

What Should Be: Recent graduates from fellowships should be well-prepared for this examination, which is essential for board certification.

Director: Jason Mizell, MD, Little Rock, AR

Assistant Director: Jennifer Holder-Murray, MD, Pittsburgh, PA

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

- Describe the structure of the oral examination.
- Practice answering colorectal oral board-style questions in a high-pressure format.
- Demonstrate knowledge among colleagues and learn from previous examinees.
- Explain career-level relevant topics.

Continued next page

Young Surgeons Mock Orals & More *(continued)*

12:30 – 5:30 pm

Track 1 (Residents/Fellows-in-Training)

- 12:30 pm **Mock Oral Overview, Perspective & Pitfalls**
Jason Mizell, MD, Little Rock, AR
- 1:00 pm **Small Group Oral Exam Session**
Joselin Anandam, MD, Irving, TX; Brian Bello, MD, Washington, DC; Satyadeep Bhattacharya, MD, Carbondale, IL; Lisa Cannon, MD, Chicago, IL; Jennifer Davids, MD, Worcester, MA; Russell Farmer, MD, Louisville, KY; Leander Grimm, MD, Mobile, AL; Karin Hardiman, MD, PhD, Ann Arbor, MI; Terah Isaacson, MD, Houston, TX; Steven Lee-Kong, MD, New York, NY; Kellie Mathis, MD, Rochester, MN; Jesse Moore, MD, Burlington, VT; Yosef Nasser, MD, Los Angeles, CA; Jennifer Rea, MD, Lexington, KY; Timothy Ridolfi, MD, Milwaukee, WI; David Row, MD, Phoenix, AZ; Josef Shehebar, MD, Brooklyn, NY; Steven Scarcliff, MD, Birmingham, AL; Shafik Sidani, MD, Abu Dhabi, United Arab Emirates; Brian Teng, MD, Rochester, MN; Heather Yeo, MD, New York, NY
- 3:00 pm **Refreshment Break in Foyer**
- 3:10 pm **Mock Oral Wrap-Up & Questions**
Jennifer Holder-Murray, MD, Pittsburgh, PA
- 3:30 pm **Mini-Symposium for Young Fellows:**
What Can ASCRS Do for You and How to Get Involved?
Yosef Nasser, MD, Los Angeles, CA
- How to Prepare for the Written Exam?**
Jennifer Davids, MD, Worcester, MA
- How to Start Your First Job on the Right Foot: From Clinic to APPs to Organization**
Teresa DeBeche-Adams, MD, Orlando, FL
- How to Build a Practice – Hemorrhoids to Pouches and Endoscopy**
Daniel Herzig, MD, Portland, OR
- How to Teach Residents When You are Learning**
Mukta Krane, MD, Seattle, WA
- Contract Negotiations**
Guy Orangio, MD, New Orleans, LA
- 5:30 pm **Adjourn**

1:00 – 5:30 pm

Track 2 (Physicians in Practice Applying for Board Certification)

- 1:00 pm **Mini-Symposium for Young Faculty**
Building a Research Program: Clinical Outcomes, Basic Science and Education
Heather Yeo, MD, New York, NY
- Promoting your Practice Smartly: Use of Social Media, Websites and Doctor Grading**
Sean Langenfeld, MD, Omaha, NE
- Academic Practice – Promotion, Tenure and Advancement**
Heidi Nelson, MD, Rochester, MN
- How To Find/Effectively Utilize Other Sources of Money (Surgical Centers, Doctor Owned Hospital, Consultant)**
Eric Haas, MD, Houston, TX
- Where to Find (and How to Keep) a Mentor?**
Bradley Champagne, MD, Cleveland, OH
- How to Know if You Should Stay or Go?**
Jennifer Rea, MD, Lexington, KY
- 2:30 pm **Mock Oral Overview, Perspective & Pitfalls**
Jason Mizell, MD, Little Rock, AR
- 3:00 pm **Refreshment Break in Foyer**
- 3:10 pm **Small Group Mock Oral Exam**
Joselin Anandam, MD, Irving, TX; Brian Bello, MD, Washington, DC; Satyadeep Bhattacharya, MD, Carbondale, IL; Lisa Cannon, MD, Chicago, IL; Jennifer Davids, MD, Worcester, MA; Russell Farmer, MD, Louisville, KY; Leander Grimm, MD, Mobile, AL; Karin Hardiman, MD, Ann Arbor, MI; Terah Isaacson, MD, Houston, TX; Steven Lee-Kong, MD, New York, NY; Kellie Mathis, MD, Rochester, MN; Jesse Moore, MD, Burlington, VT; Yosef Nasser, MD, Los Angeles, CA; Jennifer Rea, MD, Lexington, KY; Timothy Ridolfi, MD, Milwaukee, WI; David Row, MD, Phoenix, AZ; Josef Shehebar, MD, Brooklyn, NY; Steven Scarcliff, MD, Birmingham, AL; Shafik Sidani, MD, Abu Dhabi, United Arab Emirates; Brian Teng, MD, Rochester, MN; Heather Yeo, MD, New York, NY
- 5:15 pm **Mock Oral Wrap-Up & Questions**
Jennifer Holder-Murray, MD, Pittsburgh, PA
- 5:30 pm **Adjourn**

Workshop

Question Writing: Do You Know How to Write the Perfect Exam Question?



1:00 – 4:00 pm

Registration Required • Member Fee: \$25 • Nonmember Fee: \$75 • Limit 70 participants

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, CARSEP and CREST. 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 improved 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 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 who are able to write high-quality questions that can be used with minimal to no revisions.

Co-Director: Charles Friel, MD, Charlottesville, VA

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

1:00 pm	Introduction Matthew Mutch, MD, St. Louis, MO	2:35 pm	Critiques: Painful But Very Important Kirsten Wilkins, MD, Edison, NJ
1:15 pm	Key Concept – It is the Key to a Good Question Charles Friel, MD, Charlottesville, VA	2:50 pm	Refreshment Break in Foyer
1:35 pm	The Stem – The Makings of a Good Question Shane McNevin, MD, Spokane, WA	3:00 pm	Let's Write Questions
1:55 pm	The Answers – They Can Ruin a Great Stem Tracy Hull, MD, Cleveland, OH	3:30 pm	Question Review
2:15 pm	Finalizing Questions – Rescue and Salvage Glenn Ault, MD, Los Angeles, CA	4:00 pm	Adjourn

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

- Identify fundamental problems with the construction of written questions.
- Explain the sequential thought process used to write an acceptable question and understand key concepts.
- Demonstrate how to write a stem for a question.
- Prepare a two-step question combining diagnosis and management and format the answers in an acceptable form.
- Recall what happens to a question after it is submitted by a writer and before it is used in a test.

Core Subject Update



7:30 – 9:30 am

The Core Subject Update 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 presentation, a brief discussion period is moderated by the course director.

Existing Gaps

What Is: It can be challenging for practicing surgeons to stay up-to-date on the most current and cutting-edge evaluation and management of colorectal diseases, particularly when rare or not seen routinely.

What Should Be: Practicing surgeons should maintain a current and comprehensive understanding of colorectal conditions and use their knowledge to provide their patients with optimal care.

Director: Justin Maykel, MD, Worcester, MA

7:30 am	Colon Cancer David Etzioni, MD, Phoenix, AZ	8:45 am	Discussion
7:45 am	Discussion	8:50 am	Anal Abscess/Fistula Ian Paquette, MD, Cincinnati, OH
7:50 am	Diverticulitis Jason Hall, MD, MPH, Boston, MA	9:05 am	Discussion
8:05 am	Discussion	9:10 am	Perioperative Jennifer Davids, MD, Worcester, MA
8:10 am	Other Colidities Michael Valente, DO, Cleveland, OH	9:25 am	Discussion
8:25 am	Discussion	9:30 am	Adjourn
8:30 am	Fecal Incontinence Roel Hompes, MD, Oxford, United Kingdom		

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

- Explain the pathophysiology of anal fistula and abscess to offer patients the spectrum of nonsurgical and surgical treatment options.
- Explain the pathophysiology and factors related to diverticulitis, differentiate uncomplicated and complicated disease and discuss the treatment options including open and laparoscopic.
- Maintain command of the incidence, risk factors, presentation, work-up and surgical treatment of colon cancer.
- Review the literature for the general topic of colidities including presentation, work-up and evaluation, medical treatments and indications for surgery.
- Recognize the appropriate evaluation and optimization of colorectal patients throughout their perioperative care.
- Know when to offer testing, as well as the impact on clinical/surgical recommendations, for patients with fecal incontinence.

Symposium

Magnum Opus: Surgical Tips & Techniques Around The World



7:30 – 9:30 am

Surgical techniques vary for numerous procedures across the world with likely substantial differences in outcome and impact to quality of life. The 2017 ASCRS tripartite meeting will include surgeons with varying techniques and experiences. The differences in technologies, approach and technique will be identified and reviewed in this session.

This session will include audience participation to identify best worldwide video in production, technique and most impactful tip.

Existing Gaps

What Is: Although most surgeons prefer one technique for the conduct of an operation, there are numerous appropriate approaches for almost all procedures and particularly in the treatment of rectal cancer and rectal prolapse.

What Should Be: The videos and course moderators will attempt to bridge current practice with videos demonstrating technological advances, tips and tricks from around the world.

USA Co-Director: Alessandro Fichera, MD, Seattle WA

Australian Co-Director: James Keck, MD, Fitzroy, Australia

European Co-Director: Graham MacKay, MD, Glasgow, United Kingdom

7:30 am	Introduction Alessandro Fichera, MD, Seattle, WA James Keck, MD, Fitzroy, Australia Graham MacKay, MD, Glasgow, United Kingdom	8:30 am	Worldwide Differences in Rectal Prolapse (Lecture) Andrew Williams, MD, London, United Kingdom
7:40 am	Worldwide Differences in Rectal Cancer Care (Lecture) Scott Regenbogen, MD, Ann Arbor, MI	8:40 am	European Experience: Transanal Approaches to Rectal Prolapse (Video) Asha Senapati, MD, Portsmouth, United Kingdom
7:50 am	European Experience: Abdominal/Pelvic Phase of Proctectomy (Video) Ian Jenkins, MD, Harrow, United Kingdom	8:50 am	Australian Experience: Ventral Rectopexy Approach for Prolapse (Video) Rowan Collinson, MD, Auckland, New Zealand
8:00 am	Australia Experience: Transanal Phase of Proctectomy (Video) Stephen Bell, MD, Malvern, Australia	9:00 am	American Experience: Posterior Rectopexy for Rectal Prolapse (Video) Tracy Hull, MD, Cleveland, OH
8:10 am	American Experience: Anastomotic Techniques after Proctectomy (Video) Martin Weiser, MD, New York, NY	9:10 am	Voting for Best Video Alessandro Fichera, MD, Seattle, WA James Keck, MD, Fitzroy, Australia
8:20 am	Voting for Best Video Alessandro Fichera, MD, Seattle, WA James Keck, MD, Fitzroy, Australia	9:20 am	Question and Answer
		9:30 am	Adjourn

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

- Describe several techniques to the abdominal, transanal and anastomotic approach for rectal cancer.
- Describe several techniques to the transanal, ventral and posterior approach for rectal prolapse.
- Explain the differences in steps necessary to perform these procedures and identify best practices.

Symposium and Workshop

Advanced Endoscopy Symposium and Workshop of the International Committee of ASCRS



7:30 – 11:30 am

Registration and Pre-registration Survey Required • Member Fee: \$525 • Nonmember Fee \$650 • Limit: 24 participants

Didactic Session Only: \$30 (7:30 – 9:00 am)

The adoption of new technology and techniques for surgeons in practice is challenging. There is often insufficient opportunity for the practicing surgeon to be exposed to the most state-of-the-art methods. In addition, it can be difficult for physicians to incorporate these techniques into their practice. In order to surmount these obstacles, it is necessary for the surgeon to acquire an in-depth understanding of the available technology, the indications for its use and the potential benefits to the intended patient population.

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. 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, endoscopic clipping and endoscopic suturing. This important learning session will provide the basis for the meaningful implementation of these newer endoluminal techniques and improve their patients' colorectal care.

Director: Peter Marcello, MD, Burlington, MA

Assistant Director: I. Emre Gorgun, MD, Cleveland, OH

Pre-registration Survey (Required)

Although the ASCRS Advanced Endoscopy Symposium didactic session is open to all registrants for a nominal fee, the hands-on workshop will be limited to colorectal surgeons with the necessary prerequisite skills. Please click on the link to complete the survey by going to the registration information page on our website, www.fascrs.org/advanced-endoscopy.

7:30 – 9:00 am

Didactic Session



7:30 am	Advanced Endoscopic Imaging: Polyps and Dysplasia Detection Dae Kyung Sohn, MD, PhD, Goyang, Korea	8:15 am	Full Thickness Laparendoscopic Excision of the Colon (FLEX) Robin Kennedy, MD, Middlesex, United Kingdom
7:45 am	From EMR to ESD: How Do I Get There? Christopher Young, MD, Newton, Australia	8:30 am	Endoscopic Management of Early Colon Cancer Yusuke Saito, MD, Hokkaido, Japan
8:00 am	Endoluminal Resection and Suturing: Ready for Prime Time? Sergey Kantsevov, MD, Baltimore, MD	8:45 am	Panel Discussion/Questions
		9:00 am	Adjourn

Continued next page

Advanced Endoscopy Symposium and Workshop of the International Committee of ASCRS *(continued)*

9:30 – 11:30 am

Hands-on Session



Faculty: Todd Francone, MD, Burlington, MA; I. Emre Gorgun, MD, Cleveland, OH; Sergey Kantsevov, MD, Baltimore, MD; Sang Lee, MD, Los Angeles, CA; Peter Marcello, MD, Burlington, MA; Matthew Mutch, MD, St. Louis, MO; Toyooki Sonoda, MD, New York, NY; Richard L. Whelan, MD, New York, NY; Christopher Young, MD, Newton, Australia; Mark Zebley, MD, Meadowbrook, PA

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

- Explain methods to improve cecal intubation rates and lesion detection.
- Become familiar with the available enhanced endoscopic visualization techniques.
- Recognize the indications and uses for endoscopic submucosal resection for colorectal neoplasia.
- Describe the indications and technical aspects of combined laparoscopic and endoscopic resection of colorectal neoplasia.
- Become familiar with available techniques for endoscopic closure of bowel wall.



Symposium

Preventing Colorectal Cancer Through Screening: What the Surgeon Should Know



9:45 – 11:45 am

High-quality colonoscopy is not only for colorectal cancer screening, but also cancer prevention through endoscopic removal of neoplastic polyps. The procedure has become better and safer in recent years, advances in patient preparation, procedure performance, outcomes monitoring and instrument processing. This session will provide a state-of-the-art review of the major topics related to colonoscopy in practice.

Existing Gaps

What Is: Colonoscopy is commonly performed, but endoscopy education opportunities are limited.

What Should Be: Practicing surgeons should be able to stay up-to-date with the most current and best practices for performing colonoscopy with an annual update.

Director: Daniel Herzig, MD, Portland, OR

Assistant Director: M. Brian Fennerty, MD, Portland, OR

9:45 am	The Evidence Base for Screening Colonoscopy James Moore, MD, Glenuga, Australia	11:00 am	I Found a Big One: Tips for Endoscopic Removal and EMR Gene Bakis, MD, Portland, OR
10:00 am	Quality Indicators in Screening Colonoscopy John Inadami, MD, Seattle, WA	11:15 am	Running a Successful Endoscopy Unit: Materials, Endoscope Processing and Providing Value Karin Hardiman, MD, PhD, Ann Arbor, MI
10:15 am	The Worst Part is the Prep: State-of-the-Art Bowel Preps for Screening Colonoscopy Amy Halverson, MD, Chicago, IL	11:30 am	Billing and Coding Update and Sedation Issues Jennifer Rea, MD, Lexington, KY
10:30 am	How Did I Miss That? Detection and Removal of Flat Polyps Anjali Kumar, MD, Seattle, WA	11:45 am	Adjourn
10:45 am	Dysplasia Screening in IBD: Chromoendoscopy and SCENIC Guidelines in Theory and in Practice Rebecca Matro, MD, Portland, OR		

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

- Describe recent changes in colonoscopy practice including split dose bowel preparations, use of chromoendoscopy, detection of flat polyps and utility of EMR.
- Explain quality metrics for colonoscopy and safety issues surrounding endoscope processing.
- Recognize current billing and coding issues.

Symposium

Robotic Colon and Rectal Surgery: Tips, Tricks and Simulation



9:45 – 11:45 am

Over the past several years, robotic colon and rectal surgery has gradually gained acceptance among many colorectal surgeons. This is a worldwide trend occurring not only in the US but also throughout Europe and Asia. Robotic colorectal surgery continues to evolve with new platforms, specifically designed for multi-quadrant access.

This didactic session will feature lectures with instructional videos. Topics covered will include technical considerations of the common colorectal operations, training and economics. Various tips and advice on approaches to different parts of the colon and rectum for various pathologies aimed at facilitating the learning curve of the participants will be discussed.

This course is aimed at three populations of surgeons:

- 1) Practicing colon and rectal surgeons who perform robotic surgery but are still early in their learning curve. This session will give them insight on how to improve efficiency.
- 2) Practicing colon and rectal surgeons who do not currently do robotic surgery but wish to introduce robotic surgery into their practice.
- 3) Colon and rectal residents that are interested in robotics.

Existing Gaps

What Is: Although robotic colorectal surgery has been shown to potentially present advantages particularly for pelvic surgery, its acceptance amongst many colorectal surgeons remains limited.

What Should Be: The speakers will attempt to bridge the knowledge gap associated with the implementation, use and outcomes of robotic surgery to educate colon and rectal surgeons on how best to use and adopt robotics into their practice.

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

Co-Director: Craig Rezac, MD, New Brunswick, NJ

9:45 am	Introduction Amir Bastawrous, MD, Seattle, WA Craig Rezac, MD, New Brunswick, NJ	10:30 am	Robotic Low Anterior Resection Antonio Lacy, MD, Barcelona, Spain
9:50 am	Challenges and Advice for Starting the Robotic Learning Curve and a Robotic Program Joseph Carmichael, MD, Orange, CA	10:45 am	Robotic Surgery for Inflammatory Bowel Disease Elizabeth Raskin, MD, Loma Linda, CA
10:00 am	Robotic Right Hemicolectomy with Intracorporeal Anastomosis Henri Lujan, MD, Miami, FL	11:00 am	Robotic Training and Skill Assessment Thomas S. Lendvay, MD, Seattle, WA
10:15 am	Robotic Abdominoperineal Resection Paolo Pietro Bianchi, MD, Milan, Italy	11:15 am	Panel Discussion
		11:45 am	Adjourn

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

- Describe the basic techniques of robotic port placement and docking.
- Define the anatomy of the colon, its vasculature and retroperitoneum from a robotic perspective.
- Explain the sequence of steps necessary to perform robotic procedures safely.
- Identify the socioeconomic costs and benefits with Robotic Colorectal Surgery.

11:45 am – 12:45 pm

Complimentary Box Lunch in the Exhibit Hall

Welcome and Opening Announcements

12:45 – 1:30 pm

Patricia L. Roberts, MD, Burlington, MA
President, ASCRS

Rocco Ricciardi, MD, Burlington, MA
Program Chair

Anjali Kumar, MD, Seattle, WA
Local Arrangements

Garrett Nash, MD, New York, NY
Awards Chair

Michael Stamos, MD, Orange, CA
President, ASCRS Research Foundation

Roberta Muldoon, MD, Nashville, TN
Public Relations Chair

Kyle Cologne, MD, Los Angeles, CA
Social Media Chair

Norman D. Nigro, MD, Research Lectureship

1:30 – 2:15 pm



Transanal TME: From Inception to Implementation

Roel Hompes, MD
*Consultant Colorectal Surgeon;
Department of Colorectal Surgery; Oxford
University Hospitals NHS Foundation Trust;
Oxford, United Kingdom*

Introduction: Michael Stamos, MD

Dr. Norman Nigro is recognized for his many contributions to the care of patients with diseases of the colon and rectum, for his significant research in the prevention of large bowel cancer and treatment of squamous cell carcinoma of the anus and for his leadership role in his chosen specialty and allied medical organizations.

Dr. Nigro generously contributed many years of dedication and service to the specialty through his activities in the American Society of Colon and Rectal Surgeons (ASCRS) and the American Board of Colon and Rectal Surgery (ABCRS).



Abstract Session*

Neoplasia I

2:15 – 3:45 pm

*Abstract titles and authors are forthcoming.



Symposium

The ACS and NSQIP at ASCRS



2:15 – 3:45 pm

This symposium will serve as a forum for participants to learn new techniques, protocols and best practices in quality patient care to reduce morbidities and mortalities. Participants will learn best practices they can implement at their hospital to promote use of surgical checklists, residency training, and communication and teamwork in the operating room. Participants will also learn best practices to reduce Surgical Site Infections (SSIs), Urinary Tract Infections (UTIs) and other Hospital-Acquired Conditions (HACs) complications and readmissions.

Existing Gaps

What Is: Many medical errors occur secondary to failures in communications and Surgical Site Infections (SSIs) continue to be a problem in the postoperative period. There is a considerable variation in prevention and treatment of Hospital-Acquired Conditions (HACs).

What Should Be: Evidence suggests that instituting a checklist and de-briefing activities, as well as improving teamwork and communications, can improve patient safety. Not all institutions have a team-oriented culture and not all institutions follow the most up-to-date evidence-based surgical practices. There is no concise listing of prevention and treatment. Substantial evidence exists on how to prevent and treat Hospital-Acquired Conditions (HACs).

Director: Clifford Ko, MD, Los Angeles, CA

2:15 pm	Introduction to Good Data Clifford Ko, MD, Los Angeles, CA	3:15 pm	Using Data for Research Julia Berian, MD, Chicago, IL
2:25 pm	Using Data for Quality Improvement Julie Thacker, MD, Durham, NC	3:40 pm	Closing Comments Clifford Ko, MD, Los Angeles, CA
2:50 pm	Using Data for Current Policy Regulations Frank Opelka, MD, New Orleans, LA	3:45 pm	Adjourn

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

- Discuss the latest quality improvement techniques in lean, six sigma and change management.
- Discuss the most recent knowledge pertaining to national and local quality initiatives in the field of surgery.
- Explain statistical methods to analyze the NSQIP data and demonstrate practical ways to use the data for quality improvement.

3:45 – 4:15 pm

Refreshment Break in the Exhibit Hall

Abstract Session*

Benign Disease

4:15 – 5:45 pm



*Abstract titles and authors are forthcoming.

Symposium**Beyond the OR: Transitions of a Surgeon's Career****4:15 – 5:45 pm**

The needs of the surgical workforce are changing and surgeons are staying in practice for longer periods of time for a variety of reasons. The challenges of a lengthy career are being recognized and evaluated in ways they were not in the past. Although the fact of career change and transmigration has always been with us, the choices available have not been as varied or expansive. The skills training and professional development required to negotiate these choices have not kept pace with the availability of options, and many surgeons feel that they are ill-prepared to make the leap to non-clinical duties or careers that may be fulfilling but are not traditional patient care roles.

The lengthy period of time spent in training and the intensity of surgical practice rarely leave time for the kind of personal and professional development that aid career transition. Along with this, there is a real perception that a lack of institutional support for non-clinical or patient care related endeavors or that this exists as an afterthought. This aspect of continuous professional development is possibly the most neglected and often occurs at or near the end of a career and is least associated with traditional learning techniques. It can be linked with roles that may be perceived to conflict or compete with those primary to the institution or practice financial, clinical or educational goals and priorities. Furthermore, the concept of "centrality of professional identity" can play a large role in altruistic professions like medicine. The singularity of purpose and time devoted to developing, mastering and passing on a complex skill set can preclude not only personal development but professional skill mastery in related but non-clinical areas. A strong desire for specific purpose from lifelong identification as a surgeon can create hesitation and doubt when moving away from the "comfort zone" and can undermine efforts to change. Simultaneously, desire for ongoing intellectual and professional community with the difficulties and distractions of a full patient care schedule can represent a real conflict of a different variety.

Existing Gaps

What Is: Surgeons have more options for non-clinical career transitions and opportunities than ever before. Continuous professional development contemplates career changes, such as these but institutions and practice models lag behind in providing a programmatic approach to aiding those who desire a different career path. In addition, financial, psychological and practical problems can plague planning for a career transition even with well-known and structured career options.

What Should Be: Surgeons should be aware of the possibilities for transition and understand how they can contribute based upon their interests and skills. They need to start thinking and planning for transitions early in their careers, anticipating the financial and psychological problems that may complicate their choices. Ideally, aspects of professional development specifically dealing with career change and transition should be introduced into a professional curriculum in a programmatic fashion (as we do CME, maintenance of certification and professional society meeting programming) thus giving individuals a chance to think about strategy at different times in their career and decide what is right for them. Institutional support for this aspect of professional development, which often comes near the end of a productive career needs to be better defined and supported as we have opportunities that occur at the beginning of a career (e.g. grant writing courses, teaching curricula, career development awards, etc.).

Co-Director: Najjia Mahmoud, MD, Philadelphia, PA

Co-Director: Michael Stamos, MD, Orange, CA

Continued next page

Beyond the OR: Transitions of a Surgeon's Career *(continued)*

4:15 pm	Welcome and Introduction Najjia Mahmoud, MD, Philadelphia, PA Michael Stamos, MD, Orange, CA	4:50 pm	Personal Strategies for Success Ira Kodner, MD, St. Louis, MO
4:20 pm	Transition Choices—How Do You Get There? Frank Opelka, MD, New Orleans, LA	5:05 pm	Putting it all Together—How I Did It Conor Delaney, MD, PhD, Cleveland, OH
4:35 pm	Challenges and Barriers to Career Change Heidi Nelson, MD, Rochester, MN	5:20 pm	Panel Discussion
		5:45 pm	Adjourn

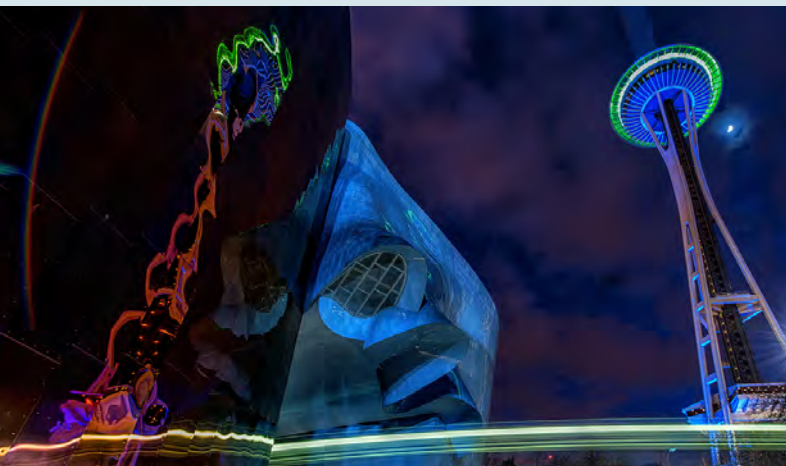
Objectives: At the conclusion of this session, participants should be able to:

- Recognize the range of opportunities to consider when considering a career change.
- Explain challenges specific to non-clinical career transitions should be anticipated and explained.
- Recognize that coping strategies for career transitions can range from those provided by the institution to personal strategies developed over time.
- Recognize that for many, transition can be the “reward” at the end of a long, productive surgical career and is vital.

Welcome Reception

7:30 – 10:00 pm

The **Welcome Reception** is complimentary to all registered attendees. The event will be held at the world famous **Museum of Pop Culture (MoPOP)** which features a music collection of approximately 140,000 artifacts and an oral history archive of more than 1,000 curator interviews with musicians and filmmakers who have influenced contemporary culture. The museum is dedicated to the ideas and risk-taking that fuel contemporary popular culture and includes mesmerizing exhibits, interactive installations and detailed histories. A fusion of textures and myriad colors, MoPOP conveys all the energy and fluidity of music. The building truly evokes the rock ‘n’ roll experience. The event will feature hors d’oeuvres, cocktails and entertainment. The Research Foundation will join forces with ASCRS to welcome all at this reception.



Symposium

Health Care Economics Update: What Every Colorectal Surgeon Needs to Know



6:30 – 8:00 am

This session will consist of presentations by invited speakers who will update attendees on the requirements of MACRA, future payment models under development, the importance of MACRA to all colorectal surgeons whether employed by large groups or in small practices, and essential elements of employment contracts for those surgeons contemplating seeking an employed position.

Existing Gaps

What Is: Many physicians are unaware of the MACRA reporting requirements and what they need to do. It is also important to recognize that MACRA is important even if you are a physician currently employed by large organizations.

What Should Be: Physicians need to know how MACRA affects them, whether they are currently employed or in private practice. Understanding the reporting requirements within MACRA and how they will impact reimbursement in the future.

Co-Moderator: Walter Peters, Jr., MD, Dallas, TX

Co-Moderator: Guy Orangio, MD, New Orleans, LA

6:30 am	What is MACRA? David Hoyt, MD, Chicago, IL	7:30 am	Employment Models: What to Look for in a Contract Jeffrey Cohen, MD, Wethersfield, CT
6:45 am	MACRA for the Small Practice Donald Colvin, MD, Fairfax, VA	7:45 am	Panel Discussion/Questions Guy Orangio, MD, New Orleans, LA
7:00 am	MACRA for the Employed Physician Walter Peters, Jr., MD, Dallas, TX	8:00 am	Adjourn
7:15 am	Episodes of Care and the Future of Bundled Payments Frank Opelka, MD, New Orleans, LA		

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

- Describe the essential components of the MACRA score.
- Determine the economic impact of MACRA adjustments on their practice.
- Verify the quality data being reported on their behalf by their employer.



Meet the Professor Breakfasts

7:00 – 8:00 am

Registration Required • Fee \$40 • Limit: 30 per breakfast • Continental Breakfast Included

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

M-1 Anorectal and Pelvic Pain
Angela Kuhnen, MD, Boston, MA
David Lubowski, MD, Hurtsville, Australia

M-2 Difficult Rectal Cancer Patients
Andreas Kaiser, MD, Los Angeles, CA
Gregory Makin, MD, Doubleview, Australia

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

Residents' Breakfast

7:00 – 8:00 am

Registration Required • Open to Residents Only



Charles Littlejohn, MD
Stamford, CT

Introduction: Ryan Bendl, DO



Photo courtesy of Seattle CVB © Tim Thompson

Symposium

Coffee and Controversies: Inflammatory Bowel Disease



7:00 – 8:00 am

Debate #1: **Decision Making in the Management of Chronic Ulcerative Colitis: Biologics, Biologics and More Biologics vs. Surgery – Why Postpone a Cure?**

7:00 – 7:30 am

Debate #2: **Low Grade Dysplasia in Well-Controlled UC: Take it All (Including Mucosectomy) vs. Don't Be So Radical! (Surveillance, Endoscopic Resection and Segmental Resection)**

7:30 – 8:00 am

Chronic Ulcerative Colitis (CUC) is a complex intestinal disorder for which the optimal management is hotly debated worldwide. As medical therapy has evolved over the decades, with the advent of new pharmaceuticals better equipped to fight the disease and prevent resistance, many patients still fail to respond to medical therapy. Operative intervention is often warranted, but by the time the patient gets an opportunity to discuss the details of surgical decision making, they may have significantly compromised their immunologic reserve with medical treatment.

In the patients for whom medical therapy has been successful in managing inflammatory bowel disease and have thus far avoided the need for operative intervention altogether, some develop neoplastic changes of the colon or rectum. Many patients with neoplasia complicating their underlying large bowel inflammation have been referred for radical operative management, but opinions have been recently argued that a more conservative approach is warranted.

Through a lively debate format, we will pit world leaders on these subjects against each other for the purpose of providing participants with the evidence-based rationale they need to propose and defend their recommendations for management of their patients with Chronic Ulcerative Colitis.

Existing Gaps

What Is: Our understanding of the behavior and complications of inflammatory bowel disease is continuously progressing. Our management of Chronic Ulcerative Colitis is evolving to best assure quality outcomes.

What Should Be: Surgeons should be equipped with evidence-based principles to provide patients who suffer from Chronic Ulcerative Colitis through this difficult decision making process about surgery versus not; total versus less radical intervention.

Director: Jeffrey Milsom, MD, New York, NY

7:00 – 7:30 am

Debate #1: **Decision Making in the Management of Chronic Ulcerative Colitis: Biologics, Biologics and More Biologics vs. Surgery – Why Postpone a Cure?**

7:00 am **Crystallizing the Controversy; Clinical Scenarios to Consider**

Jeffrey Milsom, MD, New York, NY

7:23 am **Rebuttal**

David Larson, MD, Rochester, MN

7:05 am **PRO: Biologics, Biologics, More Biologics**

William Sandborn, MD, La Jolla, CA

7:26 am

Concluding Remarks

David Larson, MD, Rochester, MN

Jeffrey Milsom, MD, New York, NY

William Sandborn, MD, La Jolla, CA

7:12 am **CON: Surgery – Why Postpone a Cure?**

David Larson, MD, Rochester, MN

7:19 am **Rebuttal**

William Sandborn, MD, La Jolla, CA

Continued next page

Coffee and Controversies: Inflammatory Bowel Disease *(continued)*

7:30 – 8:00 am

Debate #2: **Low Grade Dysplasia in Well-Controlled UC: Take it All (Including Mucosectomy) vs. Don't Be So Radical! (Surveillance, Endoscopic Resection and Segmental Resection)**

7:30 am	Crystallizing the Controversy; Clinical Scenarios to Consider Jeffrey Milsom, MD, New York, NY	7:49 am	Rebuttal Phillip Fleshner, MD, Los Angeles, CA
7:35 am	PRO: Take it All (including mucosectomy) Phillip Fleshner, MD, Los Angeles, CA	7:53 am	Rebuttal Luca Stocchi, MD, Cleveland, OH
7:42 am	CON: Don't Be So Radical! Is There a Role for Surveillance, Endoscopic Resection and Segmental Resection? Luca Stocchi, MD, Cleveland, OH	7:56 am	Concluding Remarks Phillip Fleshner, MD, Los Angeles, CA Jeffrey Milsom, MD, New York, NY Luca Stocchi, MD, Cleveland, OH
		8:00 am	Adjourn

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

- Explain the process for determining when medical therapy for treatment of CUC has run its course.
- Detail the pros and cons of long-term medical therapy for CUC, as well as surgery for CUC.
- Describe the oncologic impact of dysplasia in the setting of well-controlled CUC.
- Explore the pros and cons of surveillance, endoscopic resection and segmental resection in the setting of dysplasia in a well-controlled CUC patient.

Abstract Session*

Inflammatory Bowel Disease

8:00 – 9:30 am

*Abstract titles and authors are forthcoming.



Symposium

Improving the Quality of Rectal Cancer Care



8:00 – 9:30 am

There are considerable quality of life implications for patients with cancer of the rectum. Despite numerous advances in imaging, radiation therapy, chemotherapy, surgical technique and pathology, rectal cancer continues to pose tremendous physical, cognitive and emotional burden on patients. Patients with locally advanced rectal cancer are now treated according to a multidisciplinary approach that includes radiation, surgery and chemotherapy. While this multidisciplinary approach has contributed to reduced recurrence and improved survival, it has been associated with significant morbidity and long-term functional sequel that impair patient quality of life permanently. Evidence is starting to mount indicating that not every patient may benefit from the bundled multidisciplinary approach. If any of the components of the multidisciplinary treatment could be safely eliminated without substantial increase in disease recurrence or persistence, it is likely that quality of life will improve significantly.

In this symposium, we will review the current evidence that may help tailor the multidisciplinary approach to the individual patient with rectal cancer in order to improve overall quality of life.

Existing Gaps

What Is: Current treatment guidelines for patients with rectal cancer include approaches with substantial quality of life concerns. In addition, decision making in rectal cancer care is challenging with considerable patient decision making difficulty.

What Should Be: The treatment of the rectal cancer should be individualized according to the risk of local and distant relapse with the aim of optimizing the oncologic outcomes while preserving quality of life.

Co-Moderator: David Dietz, MD, Cleveland, OH

Co-Moderator: James Fleshman, MD, Dallas, TX

8:00 am	Introduction David Dietz, MD, Cleveland, OH James Fleshman, MD, Dallas, TX	8:50 am	Methods to Preserve the Sphincter in Low Rectal Cancer Andre D'Hoore, MD, Leuven, Belgium
8:05 am	The Role of Transanal Resection Techniques in Rectal Cancer Christine Jensen, MD, Coon Rapids, MN	9:05 am	Watch and Wait: An Evidence-Based Approach Julio Garcia-Aguilar, MD, PhD, New York, NY
8:20 am	Do All Patients with Locally Advanced Rectal Cancer Need Neoadjuvant Therapy? Deborah Schrag, MD, Boston, MA	9:20 am	Question and Answer
8:35 am	Use of Decision Aids in Shared Decision Making for Patients with Rectal Cancer Robin Boushey, MD, Ottawa, ON, Canada	9:30 am	Adjourn

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

- Recognize the role of local transanal procedures.
- List the side effects associated with the use of radiation in rectal cancer patients.
- Review the potential advantages of delivering systemic chemotherapy before surgery in rectal cancer patients.
- Review the alternatives to TME in patients with rectal cancer treated with neoadjuvant combined modality therapy.
- Identify the alternatives to surgical resection in complete clinical responders.

9:30 – 10:00 am

Refreshment Break in the Exhibit Hall

Symposium

Public Reporting of Surgical Outcomes



8:00 – 9:30 am

An estimated 27% of all inpatient hospital care involves surgical treatment. Patients, payers and providers are aligned in their desire for meaningful reports regarding provider-specific surgical quality. As a result of emerging trends in the regulatory environment, these reports are increasingly available to the public.

These reports stand to have a significant impact on providers at every level. This symposium will outline the mechanics, impact and potential benefits/harms that are associated with the public reporting of surgical outcomes.

Existing Gaps

What Is: Among ASCRS membership, the level of familiarity with trends in public reporting is unknown and likely highly variable.

What Should Be: Surgeons who are members of ASCRS should clearly understand the ways in which public reports are generated and how these reports can directly and indirectly impact their practice.

Co-Director: David Etzioni, MD, Phoenix, AZ

Co-Director: Larissa Temple, MD, Rochester, NY

8:00 am	Introduction Larissa Temple, MD, Rochester, NY	8:35 am	The Patient's Perspective Arden Morris, MD, Stanford, CA
8:05 am	Understanding the Mechanics Behind Reporting Systems Ian Paquette, MD, Cincinnati, OH	8:45 am	Managing the Online Reputation of an Organization and Its Physicians Lisa Allen, PhD, Baltimore, MD
8:15 am	Public Reporting as a Driver of Quality Improvement Peter Dawson, MD, Isleworth, United Kingdom	8:55 am	Closing Thoughts Larissa Temple, MD, Rochester, NY
8:25 am	Potential Negative Unintended Consequences of Public Reporting David Etzioni, MD, Phoenix, AZ	9:00 am	Panel Discussion
		9:30 am	Adjourn

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

- Become familiar with the mechanics of how public reports of surgical outcomes are generated.
- Describe the concepts behind the potential use of surgical outcomes reports as a driver of quality improvement.
- Define the potential unintended negative consequences associated with public reporting of surgical outcomes.
- Recognize the tools available to “manage” public image.

9:30 – 10:00 am

Refreshment Break in the Exhibit Hall

Lars Pahlman Lectureship

10:00 – 10:45 am



What to Do with a T2 Rectal Cancer?

Emmanuel Tiret, MD

*Centre de Chirurgie Digestive Hospital
Saint-Antoine, Paris, France*

Introduction:

Steven Wexner, MD, PhD (Hon)

The Lars Pahlman Tripartite lecture was inaugurated at the last Tripartite meeting in response to an ESCP proposal to recognize Dr. Pahlman's contribution to Coloproctology in Europe and beyond. Dr. Pahlman delivered the first Pahlman lecture in 2014 in Birmingham and sadly passed away in 2015.



Presidential Address

10:45 – 11:30 am



The Joys of a Surgical Career

Patricia L. Roberts, MD

*Chair of the Division of Surgery at Lahey
Hospital and Medical Center in Burlington,
Massachusetts and a senior staff surgeon
in the Department of Colon and Rectal
Surgery. She also is a professor of surgery
at Tufts School of Medicine.*

Introduction: David Schoetz, Jr., MD

Dr. Patricia Roberts, Burlington, MA, was elected President of the American Society of Colon and Rectal Surgeons (ASCRS) at the Society's 2016 Annual Meeting in Los Angeles, CA.

Dr. Roberts first served on the ASCRS Executive Council as treasurer from 2013 to 2014 and as president-elect in 2015. During her tenure as a Fellow of the ASCRS, she has chaired several committees including the Awards Committee, the Program Committee, the Self-Assessment Committee, the Local Arrangements Committee and the Operative Competency Evaluation Committee.



11:30 am – 12:45 pm

Complimentary Box Lunch & E-poster Presentations in the Exhibit Hall

Abstract Session*

Outcomes

12:45 – 2:15 pm

*Abstract titles and authors are forthcoming.



Symposium

Leveraging Technology to Enhance Clinical Practice and Patient Care



12:45 – 2:15 pm

The use of various technologies (including social media, mobile smartphone applications, electronic health records and other health information technology, websites and more) have skyrocketed in recent years for a variety of reasons. They can be used for education, discussion, networking, outreach, humor and a number of other applications including patient engagement.

A basic understanding of the advantages and disadvantages of these technologies along with their relative maturity is crucial to success in today's modern clinical practice environment. While there are many potential uses, many of these are poorly understood by practicing physicians, and the sheer number of options can be overwhelming.

This symposium will discuss some of the specifics of these technologies and tools including the basic elements, potential uses and advantages including use cases for clinical care, future development, dangers and how to effectively incorporate these tools into a practice. It also will provide some guidance as to the most high yield technologies particularly for colorectal surgeons.

Existing Gaps

What Is: The amount of digital information has rapidly expanded and is constantly evolving. Now more than ever, this information is in common use by health systems, patients and some practitioners affecting care in many ways.

What Should Be: Surgeons should have a basic understanding of what technological tools exist, how they can benefit a practice or practitioner and what some of the pitfalls associated with use of these technologies involves. Colorectal surgeons should understand the advantages and disadvantages of the commonly used technologies and how they are applicable to their practices.

Co-Director: Kyle Cologne, MD, Los Angeles, CA

Co-Director: Genevieve Melton-Meaux, MD, PhD, Minneapolis, MN

12:45 pm	I'm New to this Digital Game, Where Should I Start & What are the Rules of the Game? Heather Evans, MD, Seattle, WA	1:40 pm	Education Materials & Patient Information Websites/Videos – How Do I Not Reinvent the Wheel? Joep Knol, MD, Hasselt, Belgium
1:00 pm	SoMe in Surgery – Where are We Now? Thomas Varghese, MD, Salt Lake City, UT	1:50 pm	Online Doctor Searches and Consumer-Driven Specialty Referrals – How Can I Ensure my Reputation Reflects my "Quality"? Sean Langenfeld, MD, Omaha, NE
1:10 pm	Smart Phone Applications – Which Ones, Why and How? Heather Yeo, MD, New York, NY	2:00 pm	Quality – How Does Individual Surgeon Data Work in the Big-Data and Publically Reported – Outcome World? David Etzioni, MD, Phoenix, AZ
1:20 pm	Scientific Advancement – What Do the Journals Think of Social & Electronic Media? Des Winter, MD, Dublin, Ireland	2:10 pm	Question and Answer
1:30 pm	There's Too Much Data – How Do I Strike a Balance Without Being Overwhelmed? Richard Brady, MD, Edinburgh, United Kingdom	2:15 pm	Adjourn

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

- Describe common digital tools that can be used to enhance clinical practice.
- Explain the goals and limitations of digital tools that are commonly used.
- Recognize where to find available resources to help enhance an individual's clinical practice.

Symposium

The ACS/CoC National Accreditation Program for Rectal Cancer: How it Works and an ASCRS Guide on How to Prepare for the Site Survey



12:45 – 3:45 pm

This session will discuss important information required to meet the standards for application and site visit by the American College of Surgeons Commission on Cancer National Rectal Cancer Accreditation Program.

Existing Gaps

What Is: Numerous studies have shown significant variability in the evaluation and management of rectal cancer.

What Should Be: MDT rectal cancer management and results of such management in the USA should achieve the standards and levels reached in Europe.

Co-Director: Steven Wexner, MD, PhD (Hon), Weston, FL

Co-Director: David Winchester, MD, Chicago, IL

12:45 pm	Introduction Steven Wexner, MD, PhD (Hon), Weston, FL David Winchester, MD, Chicago, IL	2:35 pm	The Role of the Multi-Disciplinary Treatment Conference Role in Improving Outcomes for Rectal Cancer Patients James Fleshman, MD, Dallas, TX
12:55 pm	The Role of the CoC in Cancer Management Frederick Greene, MD, Charlotte, NC	2:50 pm	Tailoring MDT Presentations for Success Based Upon Institutional Structure John Monson, MD, Orlando, FL
1:05 pm	The Role of Pelvic MRI in Staging and Assessing Treatment Response in Rectal Cancer Mark Gollub, MD, New York, NY	3:05 pm	Live Multidisciplinary Team Conference and Panel <i>Moderator:</i> David Dietz, MD, Cleveland, OH <i>Panelists:</i> Sudha Amarnath, MD, Cleveland, OH, Mariana Berho, MD, Weston, FL, Conor Delaney, MD, Cleveland, OH, Mark Gollub, MD, New York, NY, Neil Hyman, MD, Chicago, IL, John Monson, MD, Orlando, FL, Arun Nagarajan, MD, Weston, FL, Feza Remzi, New York, NY
1:20 pm	Education and Skills Assessment and Verification in Rectal Cancer Surgery Conor Delaney, MD, Cleveland, OH	3:05 pm	Case Presentations Julio Garcia-Aguilar, MD, New York, NY
1:35 pm	Pathological Assessment of the Resected Rectal Cancer Specimen: What Does it Tell Us About the Quality of Surgery Mariana Berho, MD, Weston, FL	3:20 pm	Case Presentations George Chang, MD, Houston, TX
1:50 pm	NAPRC Survey Readiness: The Roles of the Rectal Cancer Program Leader and the Coordinator Samuel Oommen, MD, Walnut Creek, CA Shell Portner, RN, Walnut Creek, CA	3:35 pm	Closing Remarks Steven Wexner, MD, PhD (Hon), Weston, FL David Winchester, MD, Chicago, IL
2:05pm	NAPRC Survey Update David Winchester, MD, Chicago, IL	3:45 pm	Adjourn
2:20pm	The Current Status and Future Directions of the OSTRiCh Feza Remzi, MD, New York, NY		

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

- Discuss the role of the commission on cancer in national cancer management.
- Evaluate the essential value of rectal protocol synoptic reported MRI.
- Assess the importance of the MDT in rectal cancer management.

Abstract Session*

Pelvic Floor

2:15 – 3:45 pm

*Abstract titles and authors are forthcoming.



Symposium

Quality of Care in Inflammatory Bowel Disease



2:15 – 3:45 pm

One of the most difficult decisions faced by the surgeon managing patients with Inflammatory Bowel Disease is deciding when to intervene in both the elective and urgent settings. Inappropriate prolongation of failed medical therapy can potentially cause further complications, such as perforation or intra-abdominal abscess or compromise the patient's functional or immune status. Any of these untoward consequences may increase a patient's risk for experiencing postoperative complications. The patient is placed at further risk following surgery if the surgeon fails to optimize the patient in the preoperative setting, utilize the safest approach or technique at the time of surgery or employ appropriate measures during the postoperative period.

As medical therapy has become more successful in managing Inflammatory Bowel Disease and avoiding the need for operative intervention for inflammation of the large bowel, many patients are developing neoplastic changes of the colon or rectum. Many patients with neoplasia complicating their underlying large bowel inflammation were previously referred for operative management, but opinions have been recently argued that a more conservative approach is warranted.

Existing Gaps

What Is: Our understanding of the behavior and complications of Inflammatory Bowel Disease is continuously progressing and our management of Crohn's Disease and ulcerative colitis is accordingly evolving to best assure quality outcomes.

What Should Be: Surgeons should understand the medical management and appreciate the recognized complications of Inflammatory Bowel Disease. Moreover, they must contribute thoughtful judgment, timely intervention, evidence-based approaches and sound technique as part of a multidisciplinary approach to disease management designed to enhance patient outcomes.

Co-Director: Walter Koltun, MD, Hershey, PA

Co-Director: Scott Strong, MD, Chicago, IL

2:15 pm	Introduction Walter Koltun, MD, Hershey, PA	2:53 pm	State-of-the-Art Treatment of Large Bowel Neoplasia Complicating IBD Akira Sugita, MD, Yokohama, Japan
2:17 pm	Optimal Timing of Elective Surgery in IBD Alessandro Fichera, MD, Seattle, WA	3:05 pm	Maximizing Value in the Management of Anorectal Fistulas in Crohn's Disease Neil Mortensen, MD, Oxford, United Kingdom
2:29 pm	Best Practices for Managing Severe Colitis Samuel Eisenstein, MD, La Jolla, CA	3:17 pm	Discussion
2:41 pm	Reducing Operative Risk for Intestinal Crohn's Disease Pokala Ravi Kiran, MD, New York, NY	3:45 pm	Adjourn

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

- Explain the process for determining when elective operative intervention for Inflammatory Bowel Disease is warranted to optimize outcomes.
- Describe best practices for the evaluation and management of patients afflicted by severe colitis.
- Recognize how to influence modifiable risk factors impacting operative morbidity in patients with Crohn's Disease of the small or large intestine.
- Describe state-of-the-art methods for diagnosing and managing neoplasia complicating large bowel Inflammatory Bowel Disease.
- Describe the cost-effective evaluation and preferred treatment of fistulizing anoperineal Crohn's Disease.

3:45 – 4:15 pm

Ice Cream & Refreshment Break in the Exhibit Hall

Harry E. Bacon, MD, Lectureship

4:15 – 5:00 pm



Seeking Perfection in Health Care: Applying the Toyota Production System to Medicine

Gary Kaplan, MD
CEO of Virginia Mason Medical Center
Seattle, WA

Introduction: Rocco Ricciardi, MD



Harry Ellicott Bacon, MD (1900-1981), was Professor and Chairman of the Department of Proctology at Temple University Hospital. His stellar contribution was the establishment of the Journal, *Diseases of the Colon and Rectum*, of which he was the Editor-in-Chief. He was a Past President of the American Society of Colon and Rectal Surgeons and the American Board of Colon and Rectal Surgery. Dr. Bacon was the founder of the International Society of University Colon and Rectal Surgeons.

As a researcher and teacher of over 100 residents, he was innovative in some operations that are forerunners of sphincter saving procedures for cancer of the rectum (pull-through operation) and inflammatory bowel disease (ileoanal reservoir anastomosis).

Symposium

No CME Credit Awarded

New Technologies

5:00 – 6:30 pm

The New Technologies Symposium 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. The focus of this session will be to analyze potentially impactful new innovations in the area of colorectal surgery, such as pharmacology, devices, prototypes, techniques and approaches.

New technologies and innovations in the area of colorectal practice are occurring at a rapid pace. The New Technologies Symposium at the 2015 ASCRS Annual Meeting served as a national platform to highlight and to discuss some of these early discoveries. To assist and potentiate innovation and technological development in our field, the 2017 New Technologies Symposium will invite early adopters, industry, start-ups and health care providers to showcase relevant new technologies/techniques. One of the goals of the New Technologies Symposium is to stimulate discussion about the application of such technologies in our patient population.

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

Co-Director: Baljit Singh, MD, Leicester, United Kingdom

6:30 – 8:00 pm

Residents' Reception

Open to residents and colorectal program directors only.

Network with colon and rectal surgery program directors, members of the ASCRS Residents Committee, and other faculty from colon and rectal surgery training programs to learn more about the specialty and the ASCRS. Cocktails and hors d'oeuvres will be served, and a copy of The ASCRS Manual of Colon and Rectal Surgery, Second Edition, will be raffled.

Meet the Professor Breakfasts

6:30 – 7:30 am

Registration Required • Fee \$40 • Limit: 30 per breakfast • Continental Breakfast Included

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



T-1 Coding & Reimbursement
Guy Orangio, MD, New Orleans, LA
Stephen Sentovich, MD, Duarte, CA

T-3 Difficult Diverticulitis Cases
W. Donald Buie, MD, Calgary, AB, Canada
Kelli Bullard Dunn, MD, Louisville, KY

T-2 Rectovaginal Fistula
Elisa Birnbaum, MD, St. Louis, MO
James Keck, MD, Fitzroy, Australia

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

- Describe the procedures and approaches discussed in this session.

Symposium

Coffee and Controversies

6:30 – 7:30 am



Debate #1: **Quality Control: The Electronic Health Record: Who is Really Benefitting?**

6:30 – 7:00 am

The promise of the electronic health record (EHR) was to properly collect and collate patient data, track quality outcomes over time and improve access to and documentation of patient health information. While the EHR has proven beneficial in some aspects of health care, many argue that it has had a negative impact on health care by reducing the time spent in direct patient contact, reducing the number of patients that can be seen, and burdening the health system with high costs for upkeep and implementation. Many argue that the purpose of the EHR has been redirected away from patient care and more towards billing, coding and regulatory compliance, raising the question, “Who is really benefitting from EHR?”

Existing Gaps

What Is: The role of the EHR in practice and the pitfalls of implementation and increased utilization.

What Should Be: Surgeons should be equipped with the information and resources so they can summarize the empirical evidence concerning the current landscape regarding the advantages and disadvantages of the EHR.

Moderator: James Merlino, MD, Chicago, IL

6:30 am **Crystallizing the Controversy: Scenarios to Consider**
James Merlino, MD, Chicago, IL

6:49 am **Rebuttal**
Genevieve Melton Meaux, MD, PhD,
Minneapolis, MN

6:35 am **PRO**
Genevieve Melton Meaux, MD, PhD,
Minneapolis, MN

6:53 am **Rebuttal**
Elizabeth Wick, MD, San Francisco, CA

6:42 am **CON**
Elizabeth Wick, MD, San Francisco, CA

6:57 am **Concluding Remarks**
James Merlino, MD, Chicago, IL

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

- Detail the pros and cons of electronic health records.
- Describe the impact of EHR on patient care and patient/physician satisfaction.
- Explore the idea that EHR can enhance patient care through proper use.

Continued next page

Symposium

Coffee and Controversies *(continued)*



Debate #2: **Public Reporting: The Public has a Right to Know**

7:00 – 7:30 am

Public reporting of physician-specific outcome data may influence physicians to withhold procedures from patients at higher risk, even when physicians believe that the procedure might be beneficial. This phenomenon should be recognized in the design and administration of physician performance profiles.

Although not well studied, several concerns have been raised regarding the impact physician scorecards may have on patient care. Of primary concern, it has been suggested that physicians, knowing that their procedural mortality rates will be published, may be less inclined to offer procedures to patients at higher risk who, nevertheless, may benefit from undergoing a procedure. While most scorecards use risk-adjustment models in an attempt to account for differences in the severity of patients' illnesses, physicians remain uncertain about the ability of these models to adequately credit practitioners who perform interventions on sicker patients. Thus, while scorecards provide the public with objective information, it remains uncertain whether these reports simultaneously alter the way physicians care for patients.

One fundamental aim of such scorecards is to promote improvements in the quality of care.

Existing Gaps

What Is: Investigators have raised the concern that practitioners may refuse to perform potentially beneficial procedures on sicker patients for fear that their reported mortality statistics be adversely impacted. Others believe the most powerful way to positively influence the quality of care is through transparency of data. Surgeons' knowledge of these pros and cons are lacking.

What Should Be: Surgeons should be equipped with the information and resources so they can summarize the empirical evidence concerning public disclosure of performance data, relate the results to the potential gains and identify areas requiring further research.

Director: Kim Lu, MD, Portland, OR

7:00 am	Crystallizing the Controversy: Scenarios to Consider Kim Lu, MD, Portland, OR	7:19 am	Rebuttal Alexander Heriot, MD, Melbourne, Australia
7:05 am	PRO Alexander Heriot, MD, Melbourne, Australia	7:23 am	Rebuttal Karim Alavi, MD, Portland, OR
7:12 am	CON Karim Alavi, MD, Worcester, MA	7:26 am	Concluding Remarks Kim Lu, MD, Portland, OR
		7:30 am	Adjourn

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

- Detail the pros and cons of public reporting of surgical outcomes.
- Describe the impact of reporting on practice patterns and physician reimbursement.
- Explore the idea that outcomes reporting may improve the quality of care worldwide.

6:30 – 7:30 am

E-poster of Distinction Presentations

Parviz Kamangar Humanities in Surgery Lectureship

7:30 – 8:15 am



Trust, Patients and Doctors: Building the Perfect Arch

Carlos Pellegrini, MD, FACS
Professor and Chair, Department of Surgery; University of Washington; Seattle, WA

Introduction: Ira Kodner, MD

This unique lectureship is funded by Mr. Parviz Kamangar, a grateful patient, to remind physicians and surgeons to place compassionate care at the top of their priority list.



John Goligher, MD, Lectureship

8:15 – 9:00 am



Guidelines, Resources and Satatements – the ACPGBI Position

Peter Dawson, MD
Consultant Surgeon and ACPGBI President; Chelsea and Westminster Hospital; London, United Kingdom

Introduction: Peter Sagar, MD

The Goligher Lectureship was instituted following the death of Professor John Goligher in January 1998 to acknowledge his great contribution to coloproctology.



9:00 – 9:30 am

Refreshment Break in the Exhibit Hall

Abstract Session*

Neoplasia II

9:30 – 10:45 am

*Abstract titles and authors are forthcoming.



Symposium**Improving the Quality of Life in Patients with Fecal Incontinence****9:30 – 10:45 am**

The prevalence of fecal incontinence (FI) is difficult to estimate, as it is frequently underreported due to the embarrassment and reluctance of patients to discuss symptoms with their physicians. FI profoundly affects the quality of life and causes significant social and psychological distress.

We know that the pathophysiology of FI can be complex and there may be more than one etiology that needs to be addressed. Consequently, because of multiple potential etiologies and pathophysiological risk factors, the evaluation and treatment of FI has been challenging, as well as the assessment of whether or not treatment has been successful.

Existing Gaps

What Is: There are many treatments available for patients with FI and can be difficult to determine which treatment may be best for a given patient and a consistent and reliable method to assess outcomes.

What Should Be: The speakers will attempt to bridge the knowledge gap regarding which treatment options are available and how to individualize management to meet the needs and symptoms of the specific patient.

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

Co-Director: Madhulika Varma, MD, San Francisco, CA

9:30 am	Introduction Kelly Garrett, MD, New York, NY Madhulika Varma, MD, San Francisco, CA	10:20 am	Severity and Quality of Life: How Do Our Measures Stand-Up? Tracy Hull, MD, Cleveland, OH
9:35 am	Indications for First Line Therapy: Wrap or Zap? Anders Mellgren, MD, PhD, Chicago, IL	10:35 am	Question and Answer
9:50 am	The Pull of Magnetic Anal Sphincters Paul-Antoine Lehur, MD, PhD, Nantes, France	10:45 am	Adjourn
10:05 am	Novel Therapies In and Out of the OR: Slings, Inserts, Injections and Stimulation Ian Paquette, MD, Cincinnati, OH		

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

- Define the indications for overlapping sphincteroplasty or sacral nerve stimulation for the first line treatment of fecal incontinence.
- Describe the indications for magnetic sphincter use and results of treatment.
- Recognize the options and novel therapies for the treatment of fecal incontinence.
- Identify measures that assess treatment efficacy for both severity of disease and quality of life.

Symposium**Methods to Reduce Pain & Suffering for Patients with Anal Fistula****9:30 – 10:45 am**

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, especially simple ones. However, most surgeons are reluctant to perform this procedure in instances where substantial impairment of continence may result, recurrent fistulas or those associated with other disorders, such as Inflammatory Bowel Disease. 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. This symposium will cover the evaluation and management of patients with anal fistula.

Existing Gaps

What Is: There are many treatment options for the treatment of anal fistulas. The goals of fistula resolution of the fistula with preservation of sphincter continence. Multiple options are available in the management of chronic anal fissures. With all of these options, it is important to understand what role and expected outcomes patients will have with each procedure.

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

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

Co-Director: Ron Landmann, MD, Jacksonville, FL

9:30 am	Introduction Joshua Bleier, MD, Philadelphia, PA Ron Landmann, MD, Jacksonville, FL	10:15 am	Plug, Glue, etc. – For History Only? Kurt Davis, MD, New Orleans, LA
9:35 am	Radiological Evaluation of Fistula – When and Why? Robin Phillips, MD, Middlesex, United Kingdom	10:25 am	Quality of Life and Body Image Issues with Perianal Fistula Jean Ashburn, MD, Cleveland, OH
9:45 am	Fistulotomy – Is there Still a Role? Herand Abcarian, MD, Chicago, IL	10:35 am	The Future of Anal Fistula Treatment Maher Abbas, MD, Abu Dhabi, United Arab Emirates
9:55 am	Setons – Draining and Cutting – What is the Data? Karin Hardiman, MD, PhD, Ann Arbor, MI	10:45 am	Adjourn
10:05 am	Endorectal Advancement Flaps – Over or Under-utilized? Peter Sagar, MD, Leeds, United Kingdom		

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

- Describe the main techniques of complex fistula management.
- Explain the outcomes and potential functional consequences of the various techniques.
- Recognize the clinical issues which may indicate various approaches to complex fistula.
- Explain the impact of complex fistula management on the QOL of our patients.
- Define the anatomy of the anorectal disease and how it relates to the types of fistula in ano.

Masters in Colorectal Surgery Lectureship Honoring David Rothenberger, MD

10:45 – 11:30 am



Robert Madoff, MD
*Stanley M. Goldberg, MD,
Professor of Surgery; Chief,
Division of Colon and Rectal Surgery;
University of Minnesota; Minneapolis, MN*



Introduction: Julio Garcia-Aguilar, MD, PhD

The Masters in Colorectal Surgery Lectureship honors a different senior surgeon each year who has made a considerable contribution to the specialty and to the Society. The 2017 lectureship honors David Rothenberger, MD.

Women in Colorectal Surgery Luncheon

Registration Required • Complimentary

11:30 am – 1:00 pm

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

11:30 am – 1:00 pm

Complimentary Box Lunch & E-poster Presentations in the Exhibit Hall

Louis A. Buie, MD, Lectureship

1:00 – 1:45 pm



ERAS – What Henrik Kehlet Didn't Tell You and What Has Happened Since Then



Andrew G. Hill, MD (thesis) EdD, FACS, FRACS
Professor of Surgery, University of Auckland; Councillor, RACS Council; Head of Research, Society of Australia and New Zealand; Auckland, New Zealand

This lectureship honors Dr. Louis A. Buie, an ASCRS Past President and the first Editor-in-Chief of *Diseases of the Colon and Rectum*, the ASCRS' scientific journal.

Introduction: James Keck, MD

Abstract Session*

Basic Science

1:45 – 3:15 pm



*Abstract titles and authors are forthcoming.

Symposium**Prevention & Repair of Symptomatic Parastomal Hernia****1:45 – 3:15 pm**

Colon and rectal surgeons are viewed as subject matter experts in the creation, management and revision of stomas and stoma related problems. We currently practice in an environment that creates changing and increasing demands that relate to extremely complex stoma related problems, abdominal wall problems and digestive tract fistulas. These problems are seen with increasing frequency in this era of damage control surgery in the setting of trauma, acute care surgical emergencies and management of surgical complications. Because of our expertise, we are often called upon to manage these complex, dangerous and possibly disastrous situations.

Fistulas from bowel and parastomal hernias often co-exist with large and complex ventral hernia defects in the midline. These patients are truly the most difficult hernia patients to treat, and surgery is associated with a very high morbidity rate, as well as recurrence. Many of these large midline defects require advanced techniques to achieve reliable repair. This often necessitates component separation techniques combined with use of mesh in clean-contaminated or contaminated environments. It requires an advanced understanding of these techniques in order to determine the approach that is most appropriate for the patient.

There are numerous mesh products on the market that are available to the surgeon. These consist of biologic, synthetic and absorbable materials – all of which have innate strengths and weaknesses. The explosion of available products has led to confusion in terms of which product is best applied in a given setting. It is critical for the surgeon to have an understanding of these materials in order to make an informed and effective choice for our patients.

Through a two-hour multidisciplinary symposium, we seek to examine the above issues through lectures relating to the management of difficult stomas, complex parastomal hernia defects, parastomal hernia prevention digestive tract fistulas and complex abdominal wall reconstruction. This symposium will systematically examine these issues and provide practice guidance and recommendations for treating the most complex group of patients.

Existing Gaps

What Is: Because of paradigm shifts in the management of our most ill surgical patients, we are faced with even more complex abdominal wall problems involving hernias, fistulas and stomas. Reconstructive techniques can be quite complex and are not understood well by all.

What Should Be: As colorectal specialists, we should be involved in the care of these patients. This requires an effective understanding of the techniques, tools and products available to us to optimize care for our patients.

Co-Director: Eric Johnson, MD, Tacoma, WA

Co-Director: Sharon Stein, MD, Cleveland, OH

1:45 pm	Elective Parastomal Hernia Repair: Useful or Futile? Mark Gudgeon, MD, Surrey, United Kingdom	2:30 pm	Mesh Related Ostomy Complications: How Can I Get Out of Trouble? Patrick O'Dwyer, MD, Glasgow, United Kingdom
2:00 pm	Can the Parastomal Hernia be Prevented? A Review of the Data David Beck, MD, New Orleans, LA	2:45 pm	Mr. Roboto...Can the Robot Help with Parastomal Hernia Repair? Igor Belyansky, MD, Annapolis, MD
2:15 pm	Biologic, Synthetic or Absorbable Mesh: Is there a Preferred Option? Angela Kuhnen, MD, Boston, MA	3:00 pm	Panel Discussion
		3:15 pm	Adjourn

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

- Describe methods of dealing with complex stoma related problems.
- Describe the common advanced techniques for abdominal wall reconstruction of large ventral and parastomal hernia defects.
- Describe the pros and cons associated with the use of various common mesh products available on the market.
- Describe the surgical care and optimal order of operations for those with digestive tract fistulas associated with abdominal wall hernias.
- Define the anatomy of the anorectal disease and how it relates to the types of fistula in ano.

Symposium**Reducing Surgical Site Infections****1:45 – 3:15 pm**

Surgical Site Infections (SSIs) are the leading surgical complication after colorectal surgery. Despite nearly a decade of investment in SSI reduction efforts, results have been mixed with some hospitals realizing meaningful improvements, but others continuing to have higher than expected rates. Surgical Site Infections continue to impart an enormous burden on patients, their families, employers and society. With increasing emphasis, as well as financial incentives, for delivering high value care SSI reduction continues to be a priority. Colon SSIs are part of most value based purchasing programs and also contribute to hospital reputational scores like the US News and World Report rankings and the Center for Medicare Services hospital star rating program.

Emerging evidence supports bundles of surgical site infection process measures as the best approach and increasingly, with adoption, hospitals are noting improvements but this approach requires significant surgeon engagement and teamwork. This session will include an overview of colorectal SSIs, measurement programs and the hospital financial and reputational risks associated with SSIs, as well as review strategies for prevention.

Existing Gaps

What Is: Despite significant literature with regards to SSI prevention, there continues to be considerable variability in the rate observed at hospitals across the country.

What Should Be: The speakers will attempt to bridge the knowledge gap associated with the translation of research into practice with respect to colorectal SSIs.

Co-Director: Christopher Mantyh, MD, Durham, NC

Co-Director: Elizabeth Wick, MD, San Francisco, CA

1:45 pm	Introduction Christopher Mantyh, MD, Durham, NC Elizabeth Wick, MD, San Francisco, CA	2:30 pm	Integrating Bundles into ERAS Julie Thacker, MD, Durham, NC
1:50 pm	Colorectal SSI: What's at Risk for You and Your Hospital? Kirsten Wilkins, MD, Edison, NJ	2:40 pm	Teamwork and Safety Culture: Should it Be in Your Bundle? Elizabeth Wick, MD, San Francisco, CA
2:00 pm	Measurement: NSQIP and NHSN and What You Need to Know About Both Clifford Ko, MD, Los Angeles, CA	2:50 pm	Surgical Coaching: Is There a Role in SSI Prevention? Jonathan Finks, MD, Ann Arbor, MI
2:10 pm	Continuous Process Improvement Robert Cima, MD, Rochester, MN	3:00 pm	Panel Discussion
2:20 pm	Colorectal SSI Bundles Christopher Mantyh, MD, Durham, NC	3:15 pm	Adjourn

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

- Explain why Surgical Site Infections matter to the surgeon and hospital system.
- Describe how Surgical Site Infections are measured, risk-stratified and reported.
- Outline a quality improvement project for Surgical Site Infections.
- Integrate a CRS SSI bundle into an ERAS platform.
- Recognize why teamwork and culture changes are critical for a successful Surgical Site Infection improvement project.
- Distinguish mentorships and coaches to assist in Surgical Site Infection prevention.

3:15 – 3:30 pm**Refreshment Break in Foyer**

ASCRS/SSAT Symposium

ERAS: Taking Your Enhanced Recovery Program (ERP) to the Next Level



3:30 – 5:00 pm

Enhanced Recovery Programs (ERPs) start in the pre-hospital phase of care with preoperative risk stratification and optimization of an individual patient's modifiable risk factors and comprehensive patient education. Preoperative carbohydrate loading is hard science-based and can help attenuate postoperative insulin resistance and optimal glucose metabolism. Intraoperatively the pathway continues with the miracle of modern pharmacotherapy, namely multimodal analgesia, also called opioid-free anesthesia and opioid-sparing analgesia, allowing avoidance of the deleterious effects of these ancient, effective but morbid opium-based medications.

Postoperatively, much of the focus of ERP is aimed at a central target: postoperative ileus, which is not only common, but also associated with increased costs and its own significant morbidity – at its extreme, (potentially lethal) aspiration events. Thus prophylaxis, recognition and treatment of POI is paramount to successful ERP implementation. From a more esoteric perspective, all elective colorectal surgery patients, even those undergoing long complex operations, can benefit from ERP. Medical professionals must learn to titrate their ERP elements to an individual patient's comorbidity profile and exclude elements, not patients.

In this joint ASCRS/SSAT symposium, world-experts will share their knowledge and expertise, to help colorectal ERP teams take their own pathways to the next level.

Existing Gaps

What Is: Traditional patterns of perioperative care after colorectal surgery may largely be based on dogma and are not necessarily based on best-available evidence, and may lead to sub-optimal postoperative patient outcomes.

What Should Be: Recognition of the advantages and limitations of an evidence-based, progressive ERP grounded in an interdisciplinary care team, continuous quality improvement and pathway approach.

Co-Director: Stefan Holubar, MD, Lebanon, NH

Co-Director: Julie Thacker, MD, Durham, NC

3:30 pm	Introduction Julie Thacker, MD, Durham, NC	4:15 pm	Putting It All Together: The McGill Experience Alexander Liberman, MD, Montreal, QB, Canada
3:35 pm	Opioid-Free Anesthesia & Opioid-Sparing Analgesia Tony Roche, MD, Seattle, WA	4:25 pm	Show Me the Money (Saved): Investing in the Value of ERP Stefan Holubar, MD, Lebanon, NH
3:45 pm	The Science of Preop Carbohydrate Loading Mattias Soop, MD, PhD, Altrincham, United Kingdom	4:30 pm	Panel Discussion/Question and Answer
3:55 pm	Ileus: The Achilles' Heel of ERP for CRS Traci Hedrick, MD, Charlottesville, VA	5:00 pm	Adjourn
4:05 pm	Sailing in a Stiff Wind: Applying ERP to Complex Cases Andrew Hill, MD, Auckland, New Zealand		

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

- Describe the physiologic principles behind preoperative carbohydrate loading.
- Discuss the medications used in multimodal analgesia (MMA).
- Apply strategies for prophylaxis of post-operative ileus (POI).
- Recognize that ERP can benefit essentially all elective colorectal surgery patients, including those undergoing complex operations.
- Explain how to implement an ERP at their own institution.
- Discuss the value equation as it applies to ERP.

Memorial Lectureship Honoring Eugene P. Salvati, MD

5:00 – 5:40 pm



Kirsten Wilkins, MD
*Clinical Assistant; Professor of
Surgery, UMDNJ; Robert Wood Johnson
University Hospital; Edison, NJ*

Introduction: Kirk Ludwig, MD

Dr. Salvati was an ASCRS Fellow since 1962, served as President of the organization from 1985-86 and regularly attended the Society's Annual Meetings. Dr. Salvati was born in Pursglove, WV in 1923. He attended the West Virginia School of Medicine and the University of Maryland and received his MD degree in 1947. He completed his internship at Muhlenberg Hospital in Plainfield, NJ, and surgical residencies in Indiana at St. Vincent's Hospital, VA Hospital, and Indiana University Medical Center. He then completed his colon and rectal surgery training in 1956 at Allentown Hospital in Allentown, PA and quickly became certified by the American Board of Surgery and the American Board of Colon and Rectal Surgery. Dr. Salvati practiced in New Jersey and served as the Program Director at UMDNJ Robert Wood Johnson. He was preceded in death by his wife Laura who passed away in 2000.



After Hours Debate

5:40 – 6:30 pm



Approximately 40,000 patients are diagnosed with rectal cancer in the United States each year. Optimal treatment of patients is dependent on the treatment choices made, surgical technique used and multimodal approaches. Ultimately, surgery is the single most important treatment modality for patients with rectal cancer, and thus, the technique is critical. At this time, there are three approaches to rectal cancer care: open TME, laparoscopic TME and robotic TME. Data demonstrating outcomes with all three of these approaches is mixed, but advocates for one approach or the other are steadfast in their resolve to recommend their approach.

This symposium will focus on surgical options for rectal cancer. The discussants will address the numerous technical considerations in rectal cancer and optimal surgical approaches. The purpose of this symposium is to identify best practices for rectal cancer and characterize the advantages of each approach while addressing the confusing literature on the topic. Through a lively point-counterpoint format, leaders on these subjects will challenge and debate each other's approach using the most up-to-date evidence-based data in their respective areas. The participants will learn about the current controversies in the management of rectal cancer and use the information provided to apply in their practice of these commonly controversial topics.

Existing Gaps

What Is: Although most surgeons prefer one technique over others for the conduct of an operation, there are numerous appropriate approaches for almost all procedures and particularly in the treatment of rectal cancer.

What Should Be: Surgeons should be equipped with latest evidence-based data to guide their oncologic resection and optimize quality of life after resection.

Rectal Cancer Debate: 65 Year Old Woman with T3N1 Rectal Cancer with Threatened Circumferential Margin and Status Post Full Course Chemoradiation.

Director: Alexander Heriot, MD, East Melbourne, Australia

5:40 pm	Crystallizing the Controversy: Clinical Scenarios to Consider Alexander Heriot, MD, East Melbourne, Australia	6:09 pm	Rebuttal Todd Francone, MD, Burlington, MA
5:45 pm	Open Standard TME David Schoetz, Jr., MD, Burlington, MA	6:15 pm	Rebuttal Peter Marcello, MD, Burlington, MA
5:51 pm	Laparoscopic TME Peter Marcello, MD, Burlington, MA	6:21 pm	Rebuttal David Schoetz, Jr., MD, Burlington, MA
5:57 pm	Robotic TME Todd Francone, MD, Burlington, MA	6:27 pm	Concluding Remarks Alexander Heriot, MD, East Melbourne, Australia
6:03 pm	Rebuttal Alexander Heriot, MD, East Melbourne, Australia	6:30 pm	Adjourn

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

- Review the world data on rectal cancer surgical approaches.
- Detail the advantages of each approach.
- Describe where each technique is best applied.
- Explain the morbidity associated with each approach.

Tripartite Gala

7:30 – 10:30 pm

Tickets Required

Relax and catch up with your friends and colleagues during the Tripartite Gala. Enjoy meeting colleagues from around the world!

A complimentary ticket is included in each member's meeting registration. Nonmember or spouse/companion tickets may be purchased at the registration desk for \$150 per ticket.



Meet the Professor Breakfasts

6:30 – 7:30 am

Registration Required • Fee \$40 • Limit: 30 per breakfast • Continental Breakfast Included

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



W-1 Complex Crohn's Cases
Alan Herline, MD, Augusta, GA
Emmanuel Tired, MD, Paris, France

W-2 Hereditary Colorectal Neoplasia
Matthew Kalady, MD, Cleveland, OH
Paul Wise, MD, St. Louis, MO

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

- Describe the procedures and approaches discussed in this session.

6:30 – 7:30 am

E-poster of Distinction Presentations



Photo courtesy of Seattle CVB; © Howard Frisk

Symposium

Coffee and Controversies



6:30 – 7:30 am

Debate #1: Lateral Pelvic Dissection: Western Approach vs. Eastern Approach

6:30 – 7:00 am

Debate #2: Early Neoplasia of the Colon: Advanced Endoscopic Methods of Resection and Surveillance vs. Oncologic Resection

7:00 – 7:30 am

Debate #1: Lateral Pelvic Dissection: Western Approach vs. Eastern Approach

Local recurrence after rectal cancer surgery is a devastating complication of the disease. The goal of every resection for locally advanced disease is to complete an R0 resection in addition to standard TME with negative margins. There are a subset of patients in whom extramesorectal lymphatic spread, such as lateral pelvic node involvement challenges our standard approaches to rectal cancer surgery. In Western countries, TME has been associated with good oncologic outcomes and low morbidity. Outside of the United States, extramesorectal metastases, such as lateral nodal involvement, are addressed with radical lymphadenectomy at the time of surgical resection. Currently, there are no guidelines on the management of lateral pelvic node metastasis.

Through a lively point-counterpoint format, world leaders on these subjects will challenge and debate each other's approach using the most up-to-date evidence-based data in their respective areas. Participants will learn about the current controversies in the management of early and late cancers and use the information provided to apply in their practice of these commonly controversial topics.

Existing Gaps

What Is: What is our understanding of the biology of lateral pelvic disease and what is the optimal management of this disease?

What Should Be: Surgeons should be equipped with latest evidence-based data to guide their oncologic resection. For those patients with locally advanced rectal cancer, surgeons should know what the indications for lateral pelvic dissection versus traditional approaches and related cancer outcomes.

Director: Jose Guillem, MD, New York, NY

6:30 am	Crystallizing the Controversy: Clinical Scenarios to Consider Jose Guillem, MD, New York, NY	6:49 am	Rebuttal George Chang, MD, Houston, TX
6:35 am	Western Approach: Standard TME George Chang, MD, Houston, TX	6:53 am	Rebuttal Hiroya Kuroyanagi, MD, Tokyo, Japan
6:42 am	Eastern Approach: TME + Radical Lymphadenectomy Hiroya Kuroyanagi, MD, Tokyo, Japan	6:57 am	Concluding Remarks

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

- Define lateral pelvic disease in rectal cancer.
- Detail the pros and cons of lymphadenectomy.
- Describe the oncologic impact of resection versus no resection.
- Recognize morbidity associated with radical lymphadenectomy versus standard surgical resection.

Continued next page

Coffee and Controversies *(continued)*

Debate #2: **Early Neoplasia of the Colon: Advanced Endoscopic Methods of Resection and Surveillance vs. Oncologic Resection**

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

Through a lively debate format, we aim to pit leaders on these subjects against each other for the purpose of providing participants with the background they need to propose and defend treatment strategies for the cecal adenoma with high grade dysplasia.

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.

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 dissection and endoscopic mucosal resection. This important learning session will provide the basis for the meaningful implementation of these newer endoluminal techniques and improve their patients' colorectal care.

Director: Toyooki Sonoda, MD, New York, NY

7:00 am	Crystallizing the Controversy: Scenarios to Consider Toyooki Sonoda, MD, New York, NY	7:23 am	Rebuttal Richard Whelan, MD, New York, NY
7:05 am	Keep the Colon: An Appeal for Advanced Endoscopic Methods (ESD, EMR, Surveillance) Sang Lee, MD, Los Angeles, CA	7:26 am	Concluding Remarks Sang Lee, MD, Los Angeles, CA Toyooki Sonoda, MD, New York, NY Richard Whelan, MD, New York, NY
7:12 am	The Patient Deserves an Oncologic Resection Richard Whelan, MD, New York, NY	7:30 am	Adjourn
7:19 am	Rebuttal Sang Lee, MD, Los Angeles, CA		

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

- Detail the pros and cons of endoscopic submucosal resection for colorectal neoplasia.
- Describe the indications for oncologic colon resection.
- Explain techniques for endoscopic closure of bowel wall and surveillance programs after resection.

Symposium

Optimizing the Colorectal Anastomosis:
Reducing Anastomotic Leak

7:45 – 9:15 am

Anastomotic leak is perhaps the most physiologically significant and psychologically devastating complication that commonly occurs following operations for colon or rectal disease. The reported incidence of anastomotic leak following colorectal surgery has varied from 1-30% largely based on the criteria for diagnosis and the length of follow-up. Leaks account for one-third of all deaths following low anterior resection with even higher mortality rates observed with intraperitoneal leaks. Anastomotic leaks are associated with dramatically increased perioperative morbidity, prolonged length of stay, higher readmission rates, the potential need for multiple operative interventions in a hostile surgical environment and unintended permanent stomas. This results in significantly increased hospital costs and resource utilization, decreased quality of life and potentially worse oncologic outcomes.

Existing Gaps

What Is: Discussion of anastomotic leak prevention has generally centered around risk factors associated with anastomotic leak and/or mechanical means to increase anastomotic strength. Both of these areas of inquiry have contributed to only a limited understanding of the actual mechanism by which leaks occur and how best to prevent and treat them.

What Should Be: Preventive and treatment algorithms for colorectal anastomotic leaks should be evidence and consensus based to allow for management that optimizes outcomes, limits costs and improves patient satisfaction.

Director: Neil Hyman, MD, Chicago, IL

Assistant Director: Melanie Morris, MD, Birmingham, AL

7:45 am	Anastomotic Leaks: Risk Factors and Prevention Mukta Krane, MD, Seattle, WA	8:30 am	The Microbiome: The Bugs Caused My Leak John Alverdy, MD, Chicago, IL
8:00 am	Anastomotic Leaks: Technical Considerations and Treatments Karin Hardiman, MD, Ann Arbor, MI	8:45 am	Panel Discussion
8:15 am	Anastomotic Leaks in Inflammatory Bowel Disease Albert Wolthius, MD, Leuven, Belgium	9:15 am	Adjourn

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

- Describe risk factors for anastomotic leaks and prevention strategies.
- Recognize technical aspects of creating colorectal anastomoses including newer techniques.
- Describe the role of newer treatment options for anastomotic leaks, including endosponges, bear claws and wound vacs.
- Describe special considerations of anastomoses in patients with inflammatory bowel disease, including timing of surgery, medication management surrounding surgery and other factors.
- Explain the role of the microbiome in the prevention and management of anastomotic leaks.
- Develop strategies of for the treatment of non-healing perineal wounds.

9:15 – 9:30 am

Refreshment Break in Foyer

Symposium**Optimizing Pain Management in Acute & Chronic Disease****7:45 – 9:15 am**

Pain, often referred to as the fifth vital sign, is something that surgeons deal with in their daily practice. Recently with America's opioid epidemic, often blamed on how physicians and surgeons deal with pain, a greater emphasis has been placed on how to manage pain compassionately and effectively. With opioid abuse and addiction, a growing concern in the U.S. with the National Institute on Drug Abuse estimating approximately 2.1 million Americans suffer from substance use disorders related to prescription opioid pain relievers and an estimated 467,000 Americans are addicted to heroin, with increasing recognition of the strong relationship between opioid use and heroin abuse. The growth over time in opioid prescribing after surgery occurs against the backdrop of a major public health crisis of prescription opioid abuse.

This session will update participants on ways to deal with postoperative pain safely and effectively.

Existing Gaps

What Is: Although surgeons are aware of the need for adequate postoperative pain management, few have the experience and skill needed to implement their own institution.

What Should Be: Surgeons should understand more than the basics of postoperative pain management and be able to implement an effective plan for even the most difficult patients.

Co-Director: David Margolin MD, New Orleans, LA

Co-Director: Cindy Kin, MD, Stanford, CA

7:45 am	The Physiology of Pain Matthew Silveira, MD, St. Louis, MO	8:45 am	Pain Management in the Palliative Care Setting from a Surgeon's Perspective John Griffin, MD, Seattle, WA
7:57 am	Thoracic Epidurals – "Has Their Time Passed?" Joseph Carmichael, MD, Orange, CA	8:57 am	Pain Management in the Palliative Care Setting from a Medical Perspective Eric Ehrensing, MD, New Orleans, LA
8:09 am	Multimodality Pain Management – Cost vs Benefits Anthony Senagore, MD, Galveston, TX	9:09 am	Panel Discussion
8:21 am	Lidocaine: "The New Wonder Drug?" Martin Luchtefeld, MD, Grand Rapids, MI	9:15 am	Adjourn
8:33 am	Alternative Medicine and Its Role in the Post-Operative Period Emily Finlayson, MD, San Francisco, CA		

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

- Explain the principles of postoperative pain management.
- Recognize alternative, non-opioid methods that can be used to manage pain compassionately and effectively.

9:15 – 9:30 am**Refreshment Break in Foyer**

Symposium**Diverticulitis: How Can We Better Manage Disease Burden****9:30 – 10:45 am**

Diverticular change affects the sigmoid colon in adults as they age. The role of surgery in the management of diverticular disease has evolved, with significant changes in the algorithm for indication, timing and choice of surgical interventions. The option to utilize minimally invasive surgical techniques has impacted the surgeon's approach and the patient's willingness to undergo intervention for diverticular disease. Longstanding recommendations for management of both uncomplicated and complicated diverticulitis have been challenged. This session will review current strategies for the evaluation and the management of the patient with diverticular disease in both the acute and the elective clinical setting.

Existing Gaps

What Is: Describe risk factors for developing disease, potential new targets for research, threshold for elective and emergent intervention and appropriate techniques for management of challenging issues in both the acute and elective clinical setting.

What Should Be: Recognize a clear approach to both emergent and elective disease management. Important questions for future research.

Co-Director: Nancy Baxter, MD, PhD, Toronto, ON, Canada

Co-Director: Janice Rafferty, MD, Cincinnati, OH

9:30 am	Can't we all Agree? Controversy and Consensus Among International Guidelines for Diverticulitis Daniel Feingold, MD, New York, NY	10:08 am	Diverticulitis Evaluation of Patient Burden, Utilization and Trajectory David Flum, MD, Seattle, WA
9:44 am	The Role of MIS in Reducing Morbidity and Mortality in Surgery for Diverticulitis Bradley Davis, MD, Charlotte, NC	10:18 am	Does Laparoscopic Lavage Have a Role in Current Management of Acute Diverticulitis? Willem Bemelman, MD, PhD, Vinkeveen, The Netherlands
9:56 am	Elective Resection or Observation after Successful Non-operative Management of Complicated Diverticulitis – What is the Evidence? Jason Hall, MD, Burlington, MA	10:30 am	Panel Discussion and Case Presentations
		10:45 am	Adjourn

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

- Recognize the current literature regarding the impact of diverticulosis, risk for diverticulitis and current surgical options for management.
- Recognize areas of knowledge deficit to encourage investigation in those areas.
- Improve understanding and utilization of best practices for management of acute diverticulitis both in the hospitalized patient and in the outpatient setting.
- Consider the various options for surgical and non-surgical interventions in the patient with chronic diverticulitis.

Abstract Session*

Video Session

9:30 – 10:45 am

*Abstract titles and authors are forthcoming.



Ernestine Hambrick, MD, Lectureship

10:45 – 11:30 am



Physician Burnout: Prevalence, Drivers, Consequences and Mitigating Strategies

Lotte Dyrbye, MD

Professor of Medicine, Professor of Medical Education, and Consultant in the Division of Primary Care Internal Medicine at Mayo Clinic, Rochester, Minnesota. She is also Associate Chair, Faculty Development, Staff Satisfaction, Diversity for Department of Medicine, Mayo Clinic, Director of Faculty Development, Mayo Clinic School of Graduate Medical Education, and Associate Director of the Department of Medicine Program on Physician Well-being.



Introduction: Heidi Nelson, MD

This lectureship honors Dr. Ernestine Hambrick for her dedication to patients with colon and rectal disorders, surgical students and trainees and the community at large. The first woman to be board certified in colon and rectal surgery, Dr. Hambrick provided excellent care to patients and mentored numerous students, residents and young surgeons during her clinical practice.

Dr. Hambrick founded the STOP Foundation to promote the screening and the prevention of colon and rectal cancer. In addition, she has volunteered many hours to the ASCRS, which includes having served as Vice President.

11:30 am – 12:30 pm

Lunch (on your own)

11:30 am – 12:30 pm

E-poster of Distinction Presentations

Symposium

Therapeutic Options in Stage IV Colorectal Cancer



12:30 – 2:00 pm

Approximately 15-20% of patients with colorectal cancer will present with synchronous metastases. With continual progress in surgical therapy and chemotherapy, optimal therapy for each patient is individualized. Whether patients present with metastatic disease, or noted incidentally at time of the primary surgery, these present daily dilemmas that surgeons address in their practices. Frequently as patients are living with maintenance chemotherapy for unresectable metastatic disease, there are ongoing clinical trials addressing the best approach for the primary cancer.

This symposium will discuss the multidisciplinary management of Stage IV colorectal cancer. Surgeons attending the symposium will learn how a multidisciplinary approach to managing Stage IV colorectal cancer patients would improve patient care and outcomes in their hospitals and clinics. Emphasis will be placed on decision-making and management options.

Existing Gaps

What Is: Stage IV colorectal cancer patients represent a diverse and complicated cohort. The management of these patients varies extensively depending on the experience and specialty of the treating physician and the institution in which they operate. Nationally, there are large variations in approach to treatment with missed opportunities for both cure and reasonable palliation.

What Should Be: Colorectal surgeons should have a detailed understanding of the options available for those patients who are potentially curable, the synchrony of care of the metastatic and the primary disease, the synchrony of the mode of treatment (radiation, chemotherapy and surgery) and lastly how to measure success when palliation is the treatment course. There should be an understanding that multidisciplinary management of stage IV colorectal cancer is the cornerstone of their care.

Co-Director: Linda Farkas, MD, Sacramento, CA

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

12:30 pm	Introduction Linda Farkas, MD, Sacramento, CA Garrett Nash, MD, New York, NY	1:10 pm	With Unresectable Metastatic Disease is there an Advantage to Resect the Primary? Gregory Makin, MD, Doubleview, Australia
12:40 pm	Synchronous Rectal Cancer and Liver Metastases: What is Priority? Alessio Pigazzi, MD, Orange, CA	1:25 pm	How Can We Measure Quality of Care in Palliative Surgery? Cameron Platell, MD, PhD, Perth, Western Australia
12:55 pm	Unexpected Intraoperative Carcinomatosis in a Minimally Symptomatic Patient: What is the Best Treatment? Stacey Cohen, MD, Seattle, WA	1:40 pm	Case Presentations
		2:00 pm	Adjourn

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

- Describe optimal treatment of synchronous rectal and metastatic disease.
- Explain the options of treatment for patients with carcinomatosis.
- Recognize the ongoing trials and potential advantages of resection of primary disease in light of unresectable metastases.
- Describe the metrics of palliative care.

Abstract Session*

General Surgery Forum

12:30 – 2:00 pm

*Abstract titles and authors are forthcoming.



Abstract Session*

Research Forum

2:00 – 3:30 pm

*Abstract titles and authors are forthcoming.



Symposium

Clinical Trials in Rectal Cancer



2:00 – 3:30 pm

Optimal treatment of rectal cancer has become a multidisciplinary endeavor. Modern treatment involves high-quality imaging, a tumor board discussion, and in many cases, use of chemotherapy and radiation therapy followed by high-quality surgery. While guidelines exist to help clinicians manage their patients with rectal cancer, much is changing on many fronts and these changes in the sequencing of treatments, in the management of patients with good response to neo-adjuvant treatments, and the type of surgery we use for rectal cancer have been and will continue to be driven by data from well-designed and well-executed clinical trials, which are pivotal in evaluating new surgical approaches and defining new treatment paradigms. Surgeons must take an active role in clinical trials and participate in the development of both emerging and gold-standard treatments for our patients. Participation in clinical trials elevates the quality of patient care, improves outcomes and meets accreditation criterion of the American College of Surgeons' Commission on Cancer (CoC). The aim of this session, "Clinical Trials in Rectal Cancer," will be to update clinicians on trials that continue to change how rectal cancer patients are treated.

Existing Gaps

What Is: Straightforward algorithms for the stage specific treatment of rectal cancer are widely published and should be routinely followed. However, substantial changes in treatment sequencing, changes in how patients with response to neo-adjuvant treatments are managed and changes in the techniques for surgical management of rectal cancer are taking place. Many concepts are being challenged and altered.

What Should Be: The colorectal surgeon in 2017 must be familiar with the modern concepts of treatment for rectal cancer patients. If we are to remain leaders of the rectal cancer care team, we must be keenly aware of the basis for the current rectal cancer trials and the data generated by these trials. As such, we will be in a position to make changes to treatment algorithms so that the quality of care we offer to our rectal cancer patients optimizes both oncologic and quality of life outcomes.

Co-Director: Kirk Ludwig, MD, Milwaukee, WI

Co-Director: Y. Nancy You, MD, Houston, TX

2:00 pm	Neo-adjuvant Chemotherapy Alone for the Treatment of Locally Advanced Rectal Cancer? The ALLIANCE/PROSPECT Trial Martin Weiser, MD, New York, NY	2:35 pm	What Have We Learned About Laparoscopic Rectal Cancer Surgery? The Z6051, the ALaCaRT, the COREAN and the COLOR II Trials. Andrew Stevenson, MD, Chermshire, Australia
2:10 pm	Total Neo-adjuvant Therapy (TNT) Trial Y. Nancy You, MD, Houston, TX	2:50 pm	Can Surgery Be Eliminated? Watch and Wait After Neo-adjuvant Therapy: The OnCoRE Project, Sao Paulo Trials and MSKCC Trials Andrew Renehan, PhD, Manchester, United Kingdom
2:20 pm	Can We Safely Eliminate Neo-adjuvant Treatments? What the MERCURY Group Showed Brendan Moran, MD, Hampshire, United Kingdom	3:05 pm	Question and Answer
		3:30 pm	Adjourn

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

- Explain new concepts in the sequencing of neo-adjuvant treatment of locally advanced rectal cancer with a focus on eliminating the routine use of radiation therapy for properly selected patients and/or maximizing the rate of complete response to these treatments.
- Describe how innovative surgical concepts, such as minimally invasive operative techniques might alter the surgical management of rectal cancer.
- Explain when and why it might be reasonable not to operate on select patients who have had dramatic response to neo-adjuvant treatments.

4:00 – 5:00 pm

ASCRS Annual Business Meeting and State of the Society Address

All registrants are invited to attend the Society's Annual Business Meeting to hear reports on Society initiatives and approve proposed nominees for Fellowship and Honorary Fellowship. Outgoing ASCRS President, Dr. Patricia Roberts, will present a State of the Society Address and honor this year's Award recipients.

FUTURE ASCRS MEETINGS

May 19 – 23, 2018

Music City Center
Nashville, TN

June 1 – 5, 2019

Cleveland Convention Center
Cleveland, OH

June 6 – 10, 2020

Hynes Convention Center
Boston, MA

April 24 – 28, 2021

San Diego Convention Center
San Diego, CA

April 30 – May 4, 2022

Tampa Convention Center
Tampa, FL

ASCRS

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