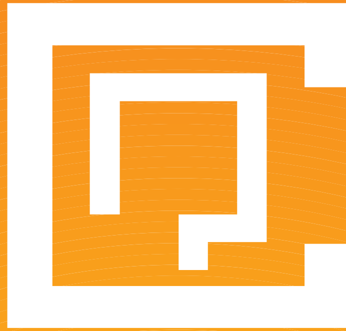

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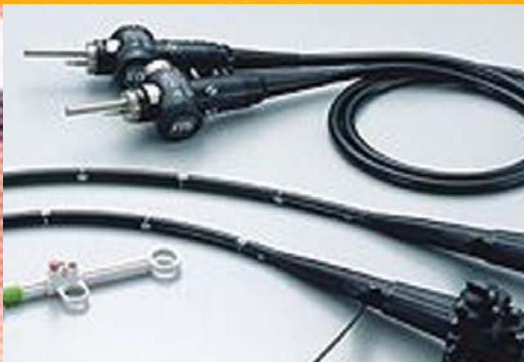

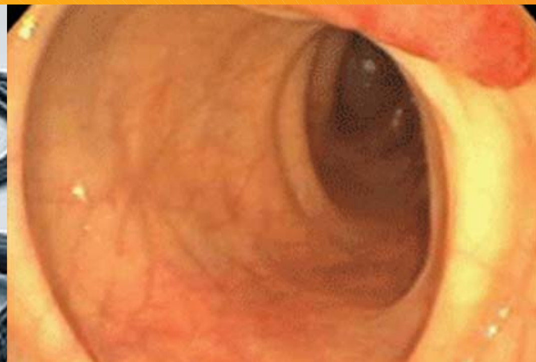

9th Annual Scientific Meeting

What's new in Coloproctology?

Programme Book

Rooms 201, 2/F, New Wing
Hong Kong Convention and Exhibition Centre
Hong Kong SAR, China

27 January 2007

CME Accreditation

CME points

Hong Kong College of Family Physicians
Hong Kong College of Physicians
The College of Surgeons of Hong Kong
MCHK CME Programme (non-specialist)

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Programme

13:00 - 13:45	**Lunch & Registration**
13:45 - 14:00	**Opening Address:** *Dr. Janet F. Y. LEE & Dr. Cliff C. C. CHUNG*
Symposium :	**What's new in Coloproctology?**
	Chairpersons: *Dr. Janet F. Y. LEE & Dr. Kevin K. K. YAU*
14:00 - 14:20	**Treatment for irritable bowel syndrome - where are we?** *Professor Justin C. Y. WU* Associate Professor Department of Medicine and Theurapeutics (Division of Gastroenterology and Hepatology) Prince of Wales Hospital The Chinese University of Hong Kong
14:20 - 14:40	**Chemotherapy for stage IV colorectal cancer** *Professor Brigette B. Y. MA* Associate Professor Department of Clinical Oncology Prince of Wales Hospital The Chinese University of Hong Kong
14:40 - 15:00	**Robotics in Colorectal Surgery** *Professor Simon S. M. NG* Associate Professor Department of Surgery (Colorectal Division) Prince of Wales Hospital The Chinese University of Hong Kong
15:00 - 15:15	**Panel Discussion**
15:15 - 15:40	**Break**

Programme

Free Paper Session

15:40 - 17:00	**Chairpersons:** *Dr. LEUNG Chi Man & Dr. Patrick Y. Y. LAU*
15:40 - 15:50	Adjuvant Radiotherapy is An Independent Risk Factor for Small Bowel Obstruction After Curative Rectal Cancer Surgery *Dr. Sophie S. F. HON* *Department of Surgery, Prince of Wales Hospital*
15:50 - 16:00	Towards Painless Colonoscopy : A Double Blinded Randomized Controlled Trial on Carbon Dioxide Insufflation Colonoscopy *Dr. James C. H. WONG* *Department of Surgery, Pamela Youde Nethersole Eastern Hospital*
16:00 - 16:10	Long Term Follow-Up of The Efficacy of Multidisciplinary Approach on The Management of Chronic Constipation *Dr. Regina W. C. LEUNG* *Department of Physiotherapy, Kwong Wah Hospital*
16:10 - 16:20	Emergency Laparoscopic-Assisted Versus Open Right Hemicolectomy for Complicated Caecal Diverticulitis : A Comparative Study of Short-Term Outcomes *Dr.* Jimmy C. M. LI *Department of Surgery, Prince of Wales Hospital*
16:20 - 16:30	Laparoscopic Resection for Colorectal Cancer in Octogenarians – Result in A Decade *Dr.* LING Yeuk Hei *Department of Surgery, Pamela Youde Nethersole Eastern Hospital*
16:30 - 16:40	Prospective Series of Endo-Ultrasonography (EUS) with Miniprobe Staging for Early Colorectal Tumour *Dr.* Weida DAY *Department of Surgery, Kwong Wah Hospital*
16:40 - 16:50	Prospective Study of Quality of Life Among Hong Kong Chinese Patients with Rectal Cancer Undergoing Curative Laparoscopic Resection *Dr.* LEUNG Wing Wa *Department of Surgery, Prince of Wales Hospital*
16:50 - 17:00	**Prize Presentation and Closing :** *Dr. Janet F. Y. LEE*

TREATMENT FOR IRRITABLE BOWEL SYNDROME : WHERE ARE WE?

Professor Justin C. Y. WU
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Irritable bowel syndrome (IBS) is a chronic recurrent functional bowel disorder that is characterized by recurrent episodic attacks of abdominal pain and disturbed bowel functions. It is one of the commonest gastrointestinal disorders in Hong Kong and is associated with significant morbidity with major impairment of social functioning and quality of life of patients.

The pathophysiology of IBS is poorly understood. It is generally believed that the mechanism of IBS involves interplay of biological, psychological and social factors, which results in an abnormal state of heightened perception or processing of visceral nociceptive signals (visceral hyperalgesia). In recent years, it has been shown that abnormal serotonin (5-HT) activity plays an important role in the pathophysiology of IBS.

Owing to the lack of understanding on its mechanism, treatment of IBS has been largely empirical and far from satisfactory. Therapeutics doctor-patient relationship, dietary modification, education and reassurance are prerequisites for effective management of IBS. Early diagnosis and treatment of concomitant psychological disorder is beneficial. To date, the first line medical therapy is targeted to individual symptoms such as pain, diarrhea and constipation. Antispasmodic, peripheral-acting opioid receptor agonist and laxatives are still the drugs of choice for these symptoms, respectively. However, they may aggravate other IBS symptoms. Recent meta-analyses and systematic reviews show that there is no significant difference in efficacy among these drugs. Low dose tricyclic antidepressants (TCAs) and selective serotonin reuptake inhibitors (SSRIs) are second line treatment for pain even in patients without psychological disorders but their use are limited by side effects and intolerance, especially for TCAs.

Modulation of serotonin activities has become a popular novel medical treatment in recent years. In contrast to conventional drugs, serotonin receptor modulators have been shown to be effective for both pain relief and regulation of bowel disturbance in a number of randomized placebo controlled trials. Alosetron, a $5HT_3$ antagonist, is the first serotonin receptor modulators that has been shown to be more effective than antispasmodic for treatment of IBS with diarrhea. The enthusiasm was dampened with the anecdotal reports of ischemic colitis associated with the use of alosetron. Tegaserod, a $5HT_4$ agonist, has been shown effective for treatment of IBS with constipation. Psychological therapy is generally reserved for refractory patients with significant psychological disorders. A number of novel medical therapies, which included chloride channel activator and combined 5HT4 agonist/5HT3 antagonist, and their values in treatment IBS and other functional bowel disorders are currently under evaluation.

CHEMOTHERAPY FOR STAGE IV COLORECTAL CANCER

Professor Brigette B. Y. MA
Associate Professor, Department of Clinical Oncology, The Chinese University of Hong Kong, Prince of Wales Hospital, Hong Kong SAR, China

The objectives of treating patients with metastatic colorectal cancer (mCRC) with palliative chemotherapy are to improve survival, improve symptoms and quality of life. Historically, patients with inoperable metastases from colorectal cancer (CRC) on supportive care alone could achieve a median survival of just 4 to 6 months. 5-Fluorouracil (5-FU) has been the cornerstone of drug treatment for metastatic CRC for the last 2 decades, and has contributed to a modest improvement of median survival to 10-12 months. Since the introduction of modern chemotherapeutic agents such as irinotecan and oxaliplatin over the last 5 to 10 years, the median survival has been increased to over 20 months in patients treated with several lines of chemotherapy. These modern agents are often used in combination with infusional 5-FU or oral 5-FU prodrugs (e.g. capecitabine), and administered in the outpatient setting. Phase III studies have confirmed the tolerability of these combined regimens, even among selected patients who are elderly, or have specific organ dysfunctions. These modern combined regimens are associated with a higher tumor shrinkage rate of 40 to 60%, a desirable effect which may allow resection of metastases isolated to the lung or liver in patients who have responded to chemotherapy and have initially inoperable metastases. However, these agents may be associated with drug resistance and some cumulative side effects, such as sensory neuropathy in oxaliplatin, which may limit their long-terms use. Therefore, recent research has focused on the safety of adding biological agents that may either augment the anti-cancer effect of chemotherapy, or overcome chemo-resistance. These include monoclonal antibodies against the epidermal growth factor receptor (EGFR), or circulating vascular endothelial growth factor (VEGF). Other studies have focused on the feasibility of intermittent breaks from chemotherapy (or 'drug holidays'), or cytoprotectants that may minimize drug toxicity. As the availability of new drugs soars, the need to search for more optimal drug combinations increases. This talk updates the most pertinent issues concerning the use of chemotherapy for mCRC, and provides some practical recommendations for the oncologists.

ROBOTICS IN COLORECTAL SURGERY

Professor Simon S. M. NG
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The minimally invasive or laparoscopic approach has revolutionised surgical care over the past 2 decades. Since the introduction of laparoscopic cholecystectomy in 1987, laparoscopic surgery has been attempted and applied to many surgical operations, including resection of benign and malignant colorectal diseases. Although the laparoscopic approach in colorectal surgery has been shown to be beneficial and oncologically safe, its use is still not yet widespread. This restriction may be due to the technical difficulties and the steep learning curve associated with these complex procedures. Conventional laparoscopic surgery has many inherent technical drawbacks, including unstable video camera platform, lack of stereoscopic or three-dimensional (3D) vision, limited motion of straight instruments, long instruments that can increase physiological hand tremor, and poor ergonomics for the surgeon. The introduction of the telerobotic systems may offer potential solutions to the above-mentioned problems.

The Intuitive Surgical® da Vinci™ surgical system was developed to facilitate laparoscopic surgery and overcome its disadvantages. This telerobotic system comprises three main components: the robotic cart with three or four mechanical arms, the console, and the endoscopic stack. The operating surgeon sits comfortably at the console, with their hands placed on master handles. Their movements are then translated via computer software to the robotic arms at the site of the operation. The system provides a magnified 3D view and intuitively transfers movements from the handle to the tip of the instrument with tremor filtering. Dexterity is enhanced via EndoWrists™ technology, returning seven degrees of freedom to the surgeon, so that precise manoeuvres like anastomosis can be accomplished easily. The system can actually facilitate less experienced surgeons to perform minimally invasive surgery in a smooth and more ergonomically manner.

The Food and Drug Administration of the United States of America approved the da Vinci™ system for clinical use in all abdominal operations in July 2000. The first reported robotic-assisted laparoscopic colorectal procedure was performed in March 2001. Since then, there have been a small number of published reports in the literature demonstrating the feasibility and safety of robotic-assisted colorectal procedures, ranging from partial colectomies to total mesorectal excisions. The first robotic-assisted abdominoperineal resection in Hong Kong was done in November 2006. Personally I feel that the robotic system may be more useful in rectal cancer surgery because the robotic arms can allow for very accurate dissection in the confined pelvic space, and the 3D vision can give an excellent view of the pelvic anatomy.

Although most of the published studies on robotic-assisted colorectal surgery have shown comparable results when compared to conventional laparoscopic surgery, none have yet demonstrated a clear advantage to using robotic system in colorectal surgery. Other limitations of applying this technology to the field of colorectal surgery include high cost, long set-up time, lack of tactile feedback, limited instrumentation, and need for repositioning to facilitate dissection in different quadrants of the abdomen during surgery. Besides, precise manoeuvres like anastomosis are seldom required in colorectal surgery. Nevertheless, with continued refinement in technologies and techniques, many of the above-mentioned limitations can be overcome. Undoubtedly, the robotic system can benefit the surgeons by providing excellent dexterity, vision, and ergonomics, but whether this can be translated into better patient outcomes still needs further evaluation.

ADJUVANT RADIOTHERAPY IS AN INDEPENDENT RISK FACTOR FOR SMALL BOWEL OBSTRUCTION AFTER CURATIVE RECTAL CANCER SURGERY

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Aim :
Small bowel obstruction (SBO) as a complication is not uncommon after curative rectal cancer surgery; adjuvant radiotherapy (RT) may have a contributory role. This study aimed to determine the prevalence and risk factors for this complication.

Methods :
The medical records of 260 consecutive patients with rectal cancer (excluding rectosigmoid cancer) who underwent curative surgery at our institution between January 1995 and December 2000 were retrospectively reviewed to determine the prevalence of SBO requiring hospitalization and intervention. Possible risk factors for SBO were recorded and analysed using univariate and multivariate analysis.

Results :
The median duration of follow-up was 76.1 months (range, 3.3–141.8 months). Forty-four patients (16.9%) developed SBO and 19 of them required surgical intervention. Three patients (6.8%) died as a consequence of SBO. Seventy-eight patients (30%) received adjuvant RT with a median dose of 50 Gy (range 30–64 Gy). Patients receiving RT were more likely to develop SBO (25.6% vs. 13.2%, P=0.014). The median duration between adjuvant RT and the first episode of SBO was 23.5 months (range, 5.7–99.4 months). Multivariate analysis showed that adjuvant RT was the only independent risk factor for SBO (OR=2.27, 95% CI=1.17-4.42, P=0.016). Gender, operative approach (open vs. laparoscopic), abdominoperineal resection, perioperative blood transfusion, postoperative intraabdominal sepsis, tumour stage, and disease recurrence were not associated with the development of SBO.

Conclusion :
Adjuvant RT is the only independent risk factor for SBO after curative surgery for rectal cancer. Patients should be well-informed of this potential complication when they are offered adjuvant RT.

TOWARDS PAINLESS COLONOSCOPY : A DOUBLE BLINDED RANDOMIZED CONTROLLED TRIAL ON CARBON DIOXIDE INSUFFLATION COLONOSCOPY

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Background :
Colonoscopy is a useful screening and diagnostic tool. Yet many patients fear about it because of pain. Carbon dioxide (CO2) insufflation during examination was reported to result in reduced pain. However, data on CO2 insufflation colonoscopy are still limited.

Objective :
The current study is a randomized controlled trial aiming to assess the safety and potential benefits of CO2 insufflating colonoscopy.

Method :
From January to April 2006, adult patients undergoing elective colonoscopy were recruited and randomized into CO2 insufflation (CO2i) or air insufflation (AIRi) groups. All examinations were performed by either one of the two designated endoscopists. Pain scores during examination and 30 mins, one hour and two hours after were recorded using a visual analogue scale (VAS). Other outcomes measured included the caecal inturbation rate, complication and caecal inturbation time, defined as the time required to reach the caecum. By means of questionnaire, patient's satisfaction and acceptance towards the endoscopic examination were assessed after the procedure.

Results :
Over a 4-month period, ninety-six patients were recruited and randomized. The age and gender ratio of the groups were matched. The caecal intubation rate was 96% and 98% in the CO2i group and the AIRi group respectively. No complication occurred in the CO2i group whereas one patient from the AIRi group was developed secondary hemorrhage after polypectomy. Patients in the CO2i group had a significantly lower pain score during ($p<0.01$) and 30 minutes after ($p=0.02$) the examination. Compared to AIRi group, significantly more patients in the CO2i group reported the examination as painless (VAS 0) during the procedure (45% Vs 14%, $p<0.01$) and 30 minutes (70% Vs 51%, $p=0.05$). In both groups, high satisfaction scores were recorded. Most of the patients (93% for the CO2 group and 98% for the air group) would accept another colonoscopy if indicated. Again, most of the patients (89% for the CO2 group and 96% from the air group) would recommend others to have colonoscopy as the method for colonic evaluation.

Conclusion :
Our data suggest CO2 insufflation colonoscopy is safe. Most importantly, compared to conventional air insufflation colonoscopy, it results in significantly less pain during the examination. CO2 insufflation colonoscopy holds the potential to be a painless screening tool in the community.

Keywords :
carbon dioxide, colonoscopy

LONG TERM FOLLOW-UP OF THE EFFICACY OF MULTIDISCIPLINARY APPROACH ON THE MANAGEMENT OF CHRONIC CONSTIPATION

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Introduction :
Standard measures for the management of constipation include adequate dietary fiber and fluid intake, regular exercise, and biofeedback training. However, there is no documentation on the effect of the above in Hong Kong.

Purpose :
To evaluate the long-term efficacy of the rehabilitative program in the management of constipation in Hong Kong.

Method :
Patients diagnosed with chronic constipation using the Rome II criteria were recruited. Clinician, dietitian and physiotherapist assessed the patients. Anorectal physiology investigations and defaecation proctography were performed prior to and after the treatment program. The treatment program involved consultation by the dietitian, postural re-education, and pelvic floor re-education on proper defaecation pattern. Patients were followed up in alternate week for the first three months and monthly for another three months. Telephone follow up was followed 3 years after the program.

Results :
24 patients completed the program in the years 2002 and 2003. The mean age was 48.1 b 12.8 years. There were 5 males are 19 females, with median follow-up of 46 months (36 - 48). On completion of the program, there was significant improvement in: average straining time, median bowel frequency per week, Bristol score and fibre intake.

	Pre-treatment	Post-teatment	
Average straining time (min)	14.8+/-2.2	10.6+/-2.2	p=0.029*
Median Bowel frequency per week	2.0 (0 - 42)	6.0(0 - 42)	p=0.027*
Bristol score	2.00+/-0.5	2.9+/-0.4	p=0.006*
Fibre intake (g)	10.5+/-4.0	15.5+/-7.4	p=0.007*

	Post-treatment	Post-treatment 3-yr	
Average straining time	10.6+/-2.2	10.0+/-2.6	p=0.633
Median Bowel frequency per week	6.0 (0 - 42)	4.5 (0 – 26)	p=0.016*
Bristol score	2.9+/-0.4	3.4+/-0.8	p=1.000
Fibre intake	15.5+/-7.4	8.46+/-3.2	p=0.001*
Subjective improvement	45.2%	43.0%	p=0.615

Conclusions :
Rehabilitative program for constipation can significantly improve the symptoms of constipation including straining time, bowel frequency and Bristol score. This was a long-term effect and the decrease in average straining time was persistent at three years post-treatment. As for change of life-style, it was more difficult. Hence, there was a tendency for patients to have decrease in fibre intake again after the therapy and this contributed to the subsequent decrease in bowel frequency. Fortunately, the overall subjective improvement in constipation was persistent on long-term follow up.

EMERGENCY LAPAROSCOPIC-ASSISTED VERSUS OPEN RIGHT HEMICOLECTOMY FOR COMPLICATED CAECAL DIVERTICULITIS : A COMPARATIVE STUDY OF SHORT-TERM OUTCOMES

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Prince of Wales Hospital, Hong Kong SAR, China

Aim :
The aim of this study was to compare the operative and short-term clinical outcomes of emergency laparoscopic-assisted versus open right hemicolectomy for complicated caecal diverticulitis.

Methods :
Between September 2001 and June 2006, 18 consecutive patients with complicated caecal diverticulitis underwent emergency right hemicolectomy at out institution, 6 with the laparoscopic-assisted approach and 12 with the open approach. Clinical data were prospectively recorded and compared between the two groups.

Results :
There were no significant differences between the two groups with respect to age, gender, comorbidities, duration of symptoms, and Hinchey staging. There was no conversion in the laparoscopic-assisted group. Compared to the open group, the laparoscopic-assisted group had a slightly longer operative time (167.5 vs. 150 min, P=0.083) but significantly less blood loss (35 vs. 100 ml, P=0.041). Although the median time to first bowel motion was significantly shorter in the laparoscopic-assisted group (3 vs. 5 days, P=0.041), the time to full ambulation and the duration of hospital stay were similar between the two groups. The postoperative complication rates (50% vs. 33.3%) as well as the hospital readmission rates for complications (33% vs. 0%) were higher in the open group than the laparoscopic-assisted group, but the differences did not reach statistical significance.

Conclusion :
Emergency laparoscopic-assisted right hemicolectomy for complicated caecal diverticulitis is feasible and safe in the hands of experienced surgeons. Comparing with the open approach, the laparoscopic-assisted approach is associated with less blood loss and earlier return of gastrointestinal function.

LAPAROSCOPIC RESECTION FOR COLORECTAL CANCER IN OCTOGENARIANS - RESULT IN A DECADE

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Objectives :
To evaluate the results of laparoscopic resection for colorectal cancer in octogenarians.

Patients and Method :
Patients aged 80 years or above who had underwent elective laparoscopic resection for colorectal cancer from 1st July 1996 to 30th June 2006 were recruited with the following exceptions: (1) patients who did not give informed consent; (2) unfit for operation; (3) surgical emergencies; (4) multiple abdominal operations; or (5) locally advanced tumours. Main outcomes measures: Operating data, length of hospital stay, mortality, morbidities, recurrence and survival.

Results :
In a 10 years' period, laparoscopic colorectal cancer resection was attempted in 101 octogenarians. The median age was 83 (range: 81-85) years. The median operating time was 110 (range: 87-130) minutes, with a median blood loss of 50 (range: 20-100) ml. Conversion was required in one case with a leakage rate of 3.3%. The overall morbidity and operative mortality rate were 17% and 3% respectively. With a median follow up of 24 (range: 12-48) months, 24 patients developed recurrence. The overall 4-year survival is 51%.

Conclusions:
Laparoscopic colorectal cancer resection in selected octogenarians is safe and feasible. An aggressive attitude in treating octogenarians with colorectal cancer is justified and laparoscopic approach is the technique of choice.

PROSPECTIVE SERIES OF ENDO-ULTRASONOGRAPHY (EUS) WITH MINIPROBE STAGING FOR EARLY COLORECTAL TUMOUR

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Background :
Endo-ultrasonography (EUS) with miniprobe ultrasound provide another means of pre-operative staging of colorectal tumour. Unlike rigid transrectal ultrasonography, the miniprobe examines the tumour in their natural anatomy without direct contact and compression onto the index tumour. Secondly, it can reach lesions beyond the rectum. Furthermore, it can serve as a complementary investigation along with our usual colonoscopy.

Aim :
To examine the accuracy of Endo-ultrasonography (EUS) with miniprobe in staging of early colorectal tumour.

Method :
Patients early sessile colorectal tumour were assessed pre-operatively with EUS and miniprobe. The ultrasonographic tumour staging (uTx) of lesions was correlated with pathological staging (pTx).

Results :
Between June 2005 and November 2006, 17 patients with early sessile colorectal lesions were examined. The lesion was located in the rectum in twelve patients. The mean polyp size for uT0 lesion was 2.4 cm and the overall accuracy for uT0 staging was 92%.

Conclusions :
Endo-ultrasonography (EUS) with miniprobe is accurate in pre-operative T-staging in early sessile colorectal tumour.

PROSPECTIVE STUDY OF QUALITY OF LIFE AMONG HONG KONG CHINESE PATIENTS WITH RECTAL CANCER UNDERGOING CURATIVE LAPAROSCOPIC RESECTION

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Aim :
This study aimed to evaluate the quality of life (QoL) among Hong Kong Chinese patients with rectal cancer undergoing curative laparoscopic resection.

Methods :
Consecutive patients with rectal cancer undergoing curative laparoscopic resection were recruited into this prospective study. Their QoL was assessed using the validated Chinese version of two specific questionnaires (QLQ-C30 and QLQ-CR38) developed by the European Organisation for Research and Treatment of Cancer; these were completed before surgery and at 4, 8, and 12 months after surgery. The preoperative and postoperative QoL scores were compared, and potential factors affecting the QoL were analysed.

Results :
Forty-six patients (32 male) recruited between September 2005 and March 2006 had completed the 8th-month questionnaires. Longitudinally, there were no significant differences between the preoperative QoL and the QoL at 4 and 8 months after surgery. However, patients who underwent abdominoperineal resection had significantly worse QoL than patients who underwent sphincter-saving surgery at 4 months (P=0.012) and 8 months (P=0.032). Patients who received adjuvant therapy had worse role functioning (P=0.004) and cognitive functioning (P=0.031) than patients who had no adjuvant therapy at 4 months onward until 8 months after surgery. Young patients (age <65) had significantly better postoperative QOL (P=0.015) and emotion functioning (P=0.03) than older patients.

Conclusions :
Although there are no major differences between the overall preoperative and postoperative QoL scores among Hong Kong Chinese patients with rectal cancer undergoing curative laparoscopic resection, factors such as old age, abdominoperineal resection, and adjuvant therapy can adversely affect the postoperative QoL.

LAPAROSCOPIC REVERSAL OF HARTMANN'S PROCEDURE – A REPORT OF INITIAL EXPERIENCE

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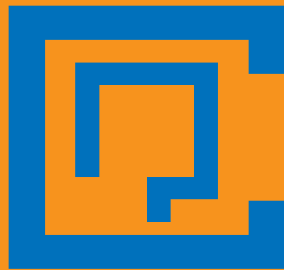
Background :
Restoration of bowel continuity after Hartmann's procedure is a major surgical undertaking which usually requires a long midline laparotomy. It carries significant morbidities including high risks of wound infection and incisional hernia. For this reason we would like to review the results of laparoscopic reversal of Hartmann's procedure performed in our department.

Methods :
During the study period we have performed 4 consecutive cases of laparoscopic reversal of Hartmann's operation. Data regarding demographic and clinical characteristics, surgical details, and postoperative course were recorded prospectively. Operative time, conversion, surgical complications and hospital stay were assessed.

Results :
The median operating time was 90 min and median blood loss was 30ml. The median time for ambulation was 4 days while that for discharge was 9 days. There was 1 case of anastomotic bleeding. No conversion and wound related complications occurred. No bowel incontinence was noticed post-operatively.

Conclusion :
Laparoscopic reversal of Hartmann's operation is technically feasible and safe. It allows patients with previous Hartmann's operation to enjoy the benefits of minimally invasive surgery.

Sponsors



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