

## Steven D. Wexner: Presidential Address

Steven D. Wexner, M.D., F.R.C.S., F.R.C.S.(Edinb)

Cleveland Clinic Florida, Weston, Florida

**T**hank you very much, Lester, for that very kind introduction; don't worry, I have a few embarrassing photos of myself in my talk. You do not have a monopoly on that subject. I thank you, Lester, for the beautiful introduction, and thanks, ladies and gentlemen, for the singular honor you have given me this past year of being President of our Society.

We have heard many presidents stand up at this and at other societies, and tell us that the most difficult part of the year was not the business of the society. As you will hear during my talk, I had a fantastic team, including physicians and nonphysicians, helping me run the Society. The team included staff in the Chicago office of the American Society of Colon and Rectal Surgeons (ASCRS), the Executive Council, and people at home. The hardest part of the President's job is selecting a theme for the presidential address and subsequently creating the talk. I am not going to misrepresent that this task was easy for me. I went through a variety of topics, and Lester was way ahead of me saying, "I need the pictures for the intro." My reply was, "Lester, I don't even know what I'm talking about yet."

However, ultimately, it went off like a light bulb when I realized that what has been important in my career is the global collaboration we enjoy in this small specialty—and we are small. In the American College of Surgeons, we are, next to the pediatric surgeons—no pun intended—the second smallest specialty group. We are a small group, which provides something very, very unique: a global collaboration that enhances the mission of this Society and ultimately the care of our patients.

So once I arrived at a theme, I had a lot of fun preparing this talk; hopefully, you will have fun listening to it. I will begin by expressing my gratitude to the many people who have made this past year both possible and enjoyable. I am grateful to the entire membership for hav-

**Financial Disclosure:** The author has no relevant financial disclosures.

**Correspondence:** Steven D. Wexner, M.D., Cleveland Clinic Florida, 2950 Cleveland Clinic Blvd, Weston, FL 33331. E-mail: wexners@ccf.org; greenel5@ccf.org

Dis Colon Rectum 2012; 55: 1101–1110  
DOI: 10.1097/DCR.0b013e31826a4f08  
© The ASCRS 2012

DISEASES OF THE COLON & RECTUM VOLUME 55: 11 (2012)



Steven D. Wexner, M.D.

ing bestowed this honor upon me. Yes, I have derived significant amounts of pleasure in this role. I have learned a huge amount from my many respected friends and colleagues from around the world. You will see some of them featured in my address. I am thankful to each and every one of them, and to others not mentioned here, for their teachings, their time, and their friendship. I have gained a significant amount of wisdom from them, as well as from my colleagues at home and elsewhere, and from my residents—I am always learning from my residents—and alumni.

This talk was conceived and created by me, but with significant and critical technological expertise from Marylise Boutros, another member of our department at home, who put in all of the impressive bells and whistles that you will see. However, the talk is based upon the contributions of all of you, because I have benefited in some way from everyone in the Society and, indeed, I have been enriched by each of you.

Now an apology: I have intentionally omitted the many renowned North American surgeons, such as the 7 gentlemen you saw on the panel earlier this morning, in terms of describing their numerous advances and contributions to innovation in our specialty made during my professional lifetime; that omission was intentional only to allow, within the limited time of this address, highlights of the international collaboration that I think has driven our specialty forward. My standard disclosures are in the program book, or perhaps they form volume 2 of the program book.

Now, you have heard about my colleagues at home. Accordingly, my first thanks within this talk goes to them, because without their assistance, my job as President would have been considerably more difficult. First, to Juan Noguera, who has been nominated by the nominating committee for consideration of the fellows during the business meeting Wednesday for election as Vice President of the Society; next, to Eric Weiss, the Residents' Review Committee Chair for colorectal surgery over the last several years, as well as Chair of the Residency Review Committee for Colorectal Surgery for the Accreditation Council for Graduate Medical Education. Thank you, again, to Dana Sands and to David Maron for putting on a marvelous program here today and for your help throughout the year. Thank you to our past president, Lester Rosen, who gave that beautiful introduction; to Fabio Potenti, who also has considerable expertise as a chef; to Giovanna da Silva, to Marylise Boutros, and to the entire department at home, thanks to all of you. Giovanna, unfortunately, cannot be here because she is really being home alone while the rest of us are here in San Antonio. My appreciation goes to everyone for making the year possible, as well as to my colleagues in Naples, who are faculty in our residency program; Tony Vernava, one of my coresidents, and Susan Cera, one of our alumni and former clinical associates. You both do a great job helping us with our residents. Thank you to all of you for making this past year feasible by your fantastic expertise and assistance at home.

In addition to the card-carrying, board-certified colorectal surgeons, there are 2 other individuals at home to whom I owe a debt of gratitude and appreciation for very special friendships, one of whom you have just heard mentioned in Dr Rosen's beautiful introduction, Raul Rosenthal, Chairman of our Department of General Surgery and Residency Program Director for our newly accredited general surgery residency program, and, of course, Mariana Berho, our Chair of Laboratory Medicine and Pa-

thology, who is a member of ASCRS and a regular speaker at our Society. There is a certain commonality in that they are both faculty at this meeting, both internationally acclaimed academicians, and both born in Argentina. However, my relationships with the 2 of them are, obviously, quite different. Thanks to both of you, Raul and Mariana.

To my colleagues in Ohio, it has been a fantastic year of collaboration within our department at Cleveland Clinic as well as with the Society. As you scan the list of names, starting with the department chair, Feza Remzi in Cleveland, you will see many other individuals, all of whom are active contributory members of the ASCRS, including Tracy Hull, Dave Dietz, Matt Kalady, Jim Merlino, and the rest of the staff; thank you to all of you, again, for collaboration at home, in the clinic, and here in the ASCRS.

None of us could do the jobs we do without assistance; you heard about Debbie from Lester. But it takes a big team. Work cannot be done individually. And I would be totally remiss and, again, very disingenuous to say anything happened because of me. I happen to be fortunate enough to chair the department, but it is a team of people who help us on a daily basis in the operating room as well as outside the operating room. Thank you to all of you for making our lives easier and, most importantly, making the lives of our patients better.

I mentioned that I learn from my residents, and I always do. Everyone in this room, including me, is an alumnus of one or more programs. I learn a lot from my residents; it is our residents who drive forward the business of this Society—not just our residents, obviously, the residents of all of the more than 50 training programs that we now enjoy. These are the people who constantly come forward with innovations, new ways of doing things, new ways of thinking about problems, immersed in deep thought, being able to think of research projects that they present. And, as you look through the program here, Dr Maron found some of the most insightful, interesting papers to put on this program. These contributions are not from us on faculty but are from our residents who often conceive these ideas. I owe a huge debt of gratitude to my current and my former residents, and to all the residents and programs and the recent graduates who make this Society and program what it is. Thank you to each of you.

I am an alumnus of several programs, as Lester mentioned. My first colorectal mentor was Tom Dailey. I had to find somebody slightly taller than me, whom I could look up to physically as well as intellectually. Tom was at the Roosevelt Hospital with his former partner, Rick Brabbee, both of whom got me involved in colorectal surgery when I was an intern presenting at the New York Society of Colon and Rectal Surgeons. By the time I was a PGY3, I got to go present at the ASCRS, where I met Stan Goldberg, who was president in 1984 at the New Orleans meeting. At that time I also got to meet Bill Heald. As you saw, one of my very



**FIGURE 1.** David G. Jagelman with Steven D. Wexner at Cleveland Clinic Hospital in 1988.

first lectures was in 1985 in Basingstoke when Bill was kind enough to have me speak on rectal cancer. Then I had a dilemma. Do I stay in the United States and do a colorectal residency, or should I go and be, as Bill kindly offered, a senior registrar in Basingstoke? Stan came up with an idea: “Why don’t you do your U.S. training first and then go to Basingstoke to be a senior registrar?” However, in the meantime, I got intercepted by a different Englishman, Dr David Jagelman (Fig. 1). So instead of exporting myself to the United Kingdom, I was very, very fortunate to work with a British expatriate here in Cleveland, who had the opportunity to flee the wonderful winter climate of the shores of Lake Erie and go down instead to the shores of the Atlantic in South Florida. Stan had introduced me to David Jagelman in 1987.

I spent 6 years before David’s unfortunate untimely death at the age of 53 in 1993 learning at the hands of a master. I owe a major debt of gratitude to all of my mentors. The 6 years with David were very unique and very rewarding. Yesterday, our media award was presented—eponymously, named after David—and at 2:00 today you will be hearing Dr Graham Newstead give the Jagelman Oration at this meeting.

In addition to my direct mentors, there are my indirect mentors, the gentlemen and ladies of this Society who have driven it forward, who have given us the foundation, the pillars upon which we have built and on which we stand today. It is their vision that has allowed us to be here. You have just seen some of them, and you know why they have the reputations they have.

You are well aware of their academic prowess; you are well aware of their clinical skills. You have seen them in action with their administrative capabilities, but you may not have seen them in action with some of the other talents they enjoy. I urge you to ask for an encore performance on Wednesday night at the black tie dinner.

There is no way the work of this Society gets done because of a president. It gets done because of an executive



**FIGURE 2.** Chinese lithograph: Photo taken at the museum in Nanjing University Hospital in Nanjing, China. Courtesy of Dr Ding.

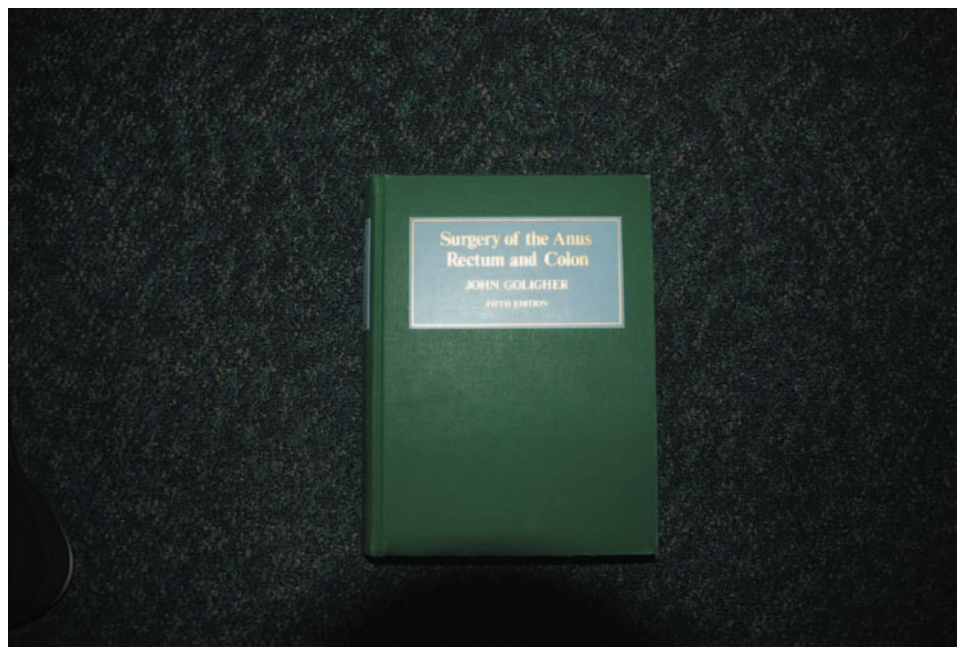
council and many others. I was blessed with a fantastic, interactive, available executive council this past year. I could call upon these ladies and gentlemen any day, any time of the night. Unfortunately for them, with my travel overseas, it often was the middle of the night. But they were always responsive. I thank each and every one of you for your wonderful counsel, your wisdom, your guidance, and your friendship this past year. This Society ticks along not because of the president and council on an exclusive basis at all, but we have a fantastic team in Chicago, their management organization with Stella, Rick, Gina, and the rest of the team. Thanks to all of you for making the Society what it is, keeping us on the course from president to president and putting on such an extraordinary scientific meeting.

All of the people on council, all of the people in the office in Chicago, and all the rest of the members and fellows have helped the Society achieve our purposes. What are those purposes? To provide a forum for presentation. That is why we are here at this meeting interacting, to improve the quality of care of our patients. That is really why we practice as physicians and why we coalesce as a Society. Toward that end, we need to publish our findings, here at this meeting and in our journal. We need to educate future generations. We need to continue to educate ourselves, we need to perpetually innovate and move forward, and we need to increase public awareness about the diseases we treat and the people who treat them.

We started to fulfill these purposes in 1899 when 15 proctologists attended a meeting in Columbus, Ohio, with 7 charter members of the Society, gradually adding others. The first president, Joseph Mathews, had gotten the idea for the ASCRS by visiting St Mark’s Hospital on City Road in London. He realized this specialty needed to be introduced in the United States.

When I first attended an ASCRS meeting, my future mentor, Stan Goldberg, was president of the Society. And





**FIGURE 3.** Surgery of the Anus, Rectum and Colon (5th Edition) by John Goligher (1984) outlined that controversy exists regarding growths with their lower margins between 5.0 and 9.5 cm from the anal verge.

I was enamored by the friendship, the camaraderie, as well as the unbelievable information being exchanged at that meeting in New Orleans; it solidified what I wanted to do. Clearly, I was not alone. There were 7 charter members when Dr Mathews was president. When Dr Goldberg was president, we had increased to 1200. Since that time, our membership has grown, almost logarithmically. A lot of people have reached the same conclusion that I reached in the mid-1980s: this is a great specialty and a wonderful, fantastic society. Including the people whom your council has recommended for election at the meeting of the fellows on Wednesday, this Society will top 3000 members this year. I would like to thank Dr Maher Abbas, our membership chair, who has helped us reach this number. Over 25% of our members are international, totaling over 700 international members and fellows. The international business, not just of this Society, but of all of colorectal surgery societies, has been greatly enhanced by the hard work of Rick Billingham, Graham Newstead, and Stan Goldberg, again, as the senior advisor to the International Council of Coloproctology (ICCP). These gentlemen, with their group, have managed to coalesce 47 societies, representing 194 countries of the world, into meaningful communication and collaboration, which helps us and ultimately helps our patients.

When I attended that meeting in 1984, I could not envision that one day we would have on our podium, sharing information, people like Petr Tsarkov from Moscow, Russia, Zoran Krivokapic from Belgrade, Serbia, the current president of the European Society of Coloproctology, and Adam Dziki from Lodz, Poland, past president of the European Society of Coloproctology. The world has changed a lot, and

people now come together from all corners of the planet, working in the same direction to help our patients and our Society. The presence of these gentlemen at our meeting today and this week really gets us back to our roots, because when this Society started, the initial by-laws stipulated 15% of total membership as international. You saw that our current membership is at 27% international.

When I began this office after the Vancouver meeting last year, there were 12 honorary fellows. Before the presidency of Tony Senagore, there were 11, all of whom were from the United Kingdom and Australia. Professor Thorolf Hager from Kronach, Germany had been elected at the recommendation of Tony Senagore and the unanimous approval of the council in 2009 (Table 1). Honorary international fellows represented less than one-half of 1% of our membership. It is with great pride and pleasure that I recommend to you and to our fellows at our business meeting 18 individuals who are going to be equally divided between this year's ballot and next year's ballot under the presidency of Alan Thorson (Table 2).

As you scan this list of names, you see individuals from around the world who have collaborated with us, with each other, and with others to improve the quality of care for our patients and who have been major contributors to this Society. Your executive council has unanimously recommended these individuals to be voted upon as honorary fellows. They help us fulfill the mission of our Society and this purpose of exchanging ideas and discussing what we do.

One of the topics discussed at the inaugural 1899 meeting was also discussed in the past president's panel this morning—anal fistulas. Fistulas have been a consis-

**TABLE 1.** Honorary fellows as of May 2011

Professor John Alexander-Williams	United Kingdom
Professor David G. Failes	Australia
Professor Thorolf Hager	Germany
Professor Peter R. Hawley	United Kingdom
Professor Miles Irving	United Kingdom
Professor Michael R. B. Keighley	United Kingdom
Professor Mark Killingback	Australia
Professor Brian Morgan	Australia
Professor Basil C. Morson	United Kingdom
Professor Ralph John Nicholls	United Kingdom
Professor Russell W. Stitz	Australia
Professor Ian P. Todd	United Kingdom

tent theme since 1899. The majority of the 13 papers on the initial program in Columbus, Ohio were on anal fistulas. This year, there were a few more submissions that Dana Sands and Dave Maron managed to cull through, including videos, 768 submissions from 39 countries around the world.

In addition to looking at all of these submitted abstracts and putting together all of these superlative sessions, they also created the meet-the-professor breakfast, the symposia, the hands-on workshops, all of the presentations and events that we're enjoying at this meeting, including videos and posters. Thankfully, they had the assistance of the most modern, updated electronic technology to work with—the board between them was the bible to get this meeting put together. Thank you again, Dana and Dave, for this stellar meeting.

Fistulas still remain a mainstay of our meeting. You have just heard fistulas discussed in several of the last cases. But it is not new. Hippocrates described the use of setons 2 and a half millennia ago. This is an interesting drawing for several reasons. It is a photo I took from a lithograph in a museum in Nanjing University Hospital in Nanjing, China, where the Ding family is now in their 10th generation as practicing colorectal surgeons at that hospital (Fig. 2). Their ancestors go back to the Ming dynasty. Dr Shuqing Ding, who has spent time with us at Cleveland Clinic Florida, is here at this meeting. If you look closely, you might think that this is one of her ancestors trying the world's first natural orifice transluminal endoscopic surgery (NOTES) procedure several generations ago. I have been told that what it actually says is that anal fistulas are a complex problem. That is why, despite it being described by Hippocrates 2 and a half millennia ago, we are still arguing about it today.

The Europeans were not ahead, but at that time there were no known scientific communications between China and Europe. John of Arderne noted in 1349 that fixing a fistula, just as we heard from our 7 past presidents, required a lot of expertise. Fortunately, some of that expertise was possessed across the channel by Charles Francois Felix, who performed a 4-stage fistulotomy successfully, we are told,

**TABLE 2.** Honorary fellows unanimously proposed by executive council for election during the 2012 and 2013 annual business meetings

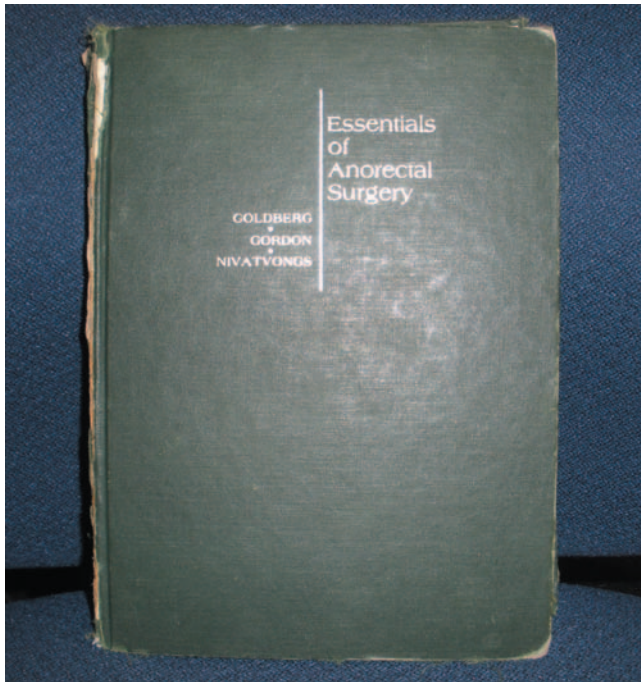
Professor Cornelius C.G.M.I. Baeten	Netherlands
Professor the Lord Darzi of Denham	United Kingdom
Professor Adam J. Dziki	Poland
Professor Najib Haboubi	United Kingdom
Professor Angelita Habr-Gama	Brazil
Professor Richard John (Bill) Heald	United Kingdom
Professor Henrik Kehlet	Denmark
Professor Zoran Krivokapic	Serbia
Professor Antonio M. Lacy	Spain
Professor Michael Ka Wah Li	Hong Kong
Professor Klaus E. Matzel	Germany
Professor Tetsuichiro Muto	Japan
Professor Graham L. Newstead	Australia
Professor Lars Pahlman	Sweden
Professor Rolland Parc	France
Professor Philip Quirke	United Kingdom
Professor Petr V. Tsarkov	Russia
Professor Norman S. Williams	United Kingdom

on Louis XIV. Although we have no MRI documentation of healing, we know that, because Charles Francois Felix kept his head, he clearly must have been successful. Interestingly, he practiced this on prisoners before trying it on the king, something our modern institutional review boards would frown upon.

Fistulas are such a vexing problem that in 1835, Frederick Salmon opened the world's first hospital for the treatment of fistulas, St Mark's Hospital on City Road, the hospital that Joseph Mathews visited that gave him the idea to form the ASCRS. Then President Hill, in his presidential address to the ASCRS in 1916, described a series of 2000 fistulas and noted that the cure rate was less than 50%. As you heard this morning, we are still discussing it and still trying to figure it out.

There are a lot of new treatments including plugs, glue, ligation of the intersphincteric fistula tract, and flaps. You have just heard about all of these things. How do we figure out which procedure to use in each patient? All of these global advances are reviewed by our practice parameters committee, under the guidance of Don Buie and Jan Rafferty. They have updated our practice parameters for the treatment of anal fistulas, documents that are well respected and well cited in the literature, the most recent iteration now in its third edition with 155 citations. I thank them and their committee for their hard work, and I also thank Lester Rosen whose vision it was to start the practice parameters program 24 years ago. Interestingly, there are now 24 practice parameters spanning the gamut that have been cited in the literature over 1300 times, showing how this Society can take that information and put it in a user-friendly context. These documents help us improve the care of our patients.

The ultimate improvement might be the avoidance of a stoma. There are perhaps 3 main groups of patients who



**FIGURE 4.** Essentials of Anorectal Surgery. Stanley M. Goldberg, Philip H. Gordon, Santhat Nivatvongs (1980).

are at high risk for a permanent stoma: patients with rectal cancer, mucosal ulcerative colitis, or fecal incontinence.

Turning first to rectal cancer, Ernest Miles at the Gordon Hospital described the now eponymously named operation, also called the abdominoperineal resection, and noted that it was probably the best way to treat rectal cancer. Even when I was in training, the textbooks of the day described the fact that if you could feel a tumor, that patient would have an abdominoperineal resection (Figs. 3 and 4). That was indeed unfortunate for my patients, given the length of my index finger. The debatable area was not what it is now, the lower third of the rectum; it was the middle third.

The debate shift was initiated through an innovation at the Moscow Proctologic Institute under the direction of Professor Alexandrov, that same hospital at which Petr Tsarkov spent 25 years as both a resident and a practicing surgeon. That innovation, of course, was the circular stapler (Fig. 5). Once it was imported to our shores, Knight and Griffen in Louisiana described double stapling. Double stapling in turn facilitated total mesorectal excision (TME). We all know the importance of this huge advance in the improvement of the quality of care of patients with rectal cancer.

Bill Heald's original article has been cited more times than all 24 of our ASCRS practice parameters combined (Fig. 6). So many people want to learn how to do TME that it has become a mainstay, whether by open surgery, laparoscopy, hand-assisted surgery, single port, or robotic operations. So many people want to learn how to do TME



**FIGURE 5.** Original Russian SPTU stapler. Courtesy of Dr Badma Bashankaev.

that applications to the institutions at which it is taught are, I am told, oversubscribed (Fig. 7). I can let you know where to get the applications and location of the college later on.

Surgeons around the world have reproduced these results attesting to the critical importance of this advance in the treatment of rectal cancer. However, TME was part of an overall picture that evolved at the same time, because, also in 1983, Professor John Nicholls at the St Mark's Hospital started to challenge the 5-cm rule and suggested that it was a rule meant to be broken.

In that same year, and in close geographic proximity, Norman Williams independently had the same idea that maybe 2 cm were adequate. Maybe we could save more sphincters by taking less distal rectal margin. The emphasis shifted from distal margin to circumferential margin. In the same time period, Professor Norman Williams and Professor Phil Quirke, working together, looked at this issue of circumferential margin, which evolved into the quality of the mesorectum, a question just posed by our past president, Jim Fleshman, on the last panel. People often ask Phil, "How did you get the idea that you needed to have something surrounded by quality, these circumferential margins?" I think it is because Phil likes to surround himself with quality all of the time.

In addition to the extirpative surgical techniques, there were adjuvants that came online around the same time. Lars Pahlman, in Sweden, led the effort for the Swedish rectal cancer trial and noted improvements in outcome by adding neoadjuvant therapy. I apologize to others who did the same thing, but I am focusing on our international colleagues. The Swedish data have shown that we can further improve local recurrence after using radiotherapy. The Dutch TME trial, with both 2-year and 10-year follow-up, has subsequently corroborated those findings.

What about the patients with mucosal ulcerative colitis? Well, initially, the Brooke ileostomy was the standard, as





**FIGURE 6.** Richard John (Bill) Heald with Steven D. Wexner in Moscow, Russia in 2011.

described by Bryan Brooke from the United Kingdom. But Nils Koch from Gothenburg, Sweden, in 1969 suggested that a pouch could be formed and obviate the need for a Brooke ileostomy. That concept evolved further in less than 10 years, when Sir Alan Parks and John Nicholls at the St Mark's Hospital took a pouch, put it in the pelvis, and anastomosed it. The fundamental component of the operation was not just the pouch, it was the mucosal stripping to eradicate all potentially neoplastic, potentially colitic, potentially dysplastic areas of mucosa.

Within 2 years, Joji Utsunomiya in Hyogo, Japan, described a stapled 2-limb J-pouch simpler to construct than a 3-limb handsewn S-pouch, but still with mucosectomy. As you can see, our alumnus, Marc Sher, is here describing the perfect level for an anastomosis to Professor Joji. However, the common denominator remained a mucosectomy. Unfortunately, mucosectomy was associated with nocturnal seepage, sepsis, stricture formation, and a myriad of other problems. In 1989, some further advances came along, and our former research fellow, the late Wit Kmiot, working with his mentor Mike Keighley in Birmingham, had described the double staple, taking this technique from Knight and Griffen for rectal cancer and applying it to mucosal ulcerative colitis. In that same year, David Jagelman and I also independently described the double-stapled J-pouch. For many years, mucosectomy was hotly debated on these panels at the ASCRS and elsewhere, but double stapling ultimately prevailed. Many other debates arose over the years relative to pouch surgery. We have pretty much answered most of the questions, one of the most vexing being indeterminate colitis, and some of the most important information has emanated from Najib Haboubi in Manchester in the United Kingdom, shedding light on indeterminate colitis and the impact on patients in whom pouches are considered.



**FIGURE 7.** Heald College on Howard Street, San Francisco, CA.

Pouches were then reimported, if you will, to rectal cancer by a few people in France in 1986, including Roland Parc, who described the colonic J-pouch for patients with rectal cancer, a now globally accepted standard operation. Ultimately, as we heard yesterday at this meeting, how about just eliminating the use of surgery altogether with watchful waiting? Angelita Habr-Gama from Sao Paulo has spent more than 14 years showing us that, in appropriately treated patients, and followed patients, we can avoid surgery, something that, as we heard yesterday, everybody is beginning to accept (Fig. 8).

Another means to avoid transabdominal surgery is endoscopic therapy. In the 1950s and 1960s, the only way you could detect a polyp was air contrast barium enema, and the only way you could remove it was colotomy and polypectomy. But because of the advance in 1973 from Wolff and Shinya, fiberoptic colonoscopy as a diagnostic tool and therapeutic polypectomy as a therapeutic tool came online. The full impact was not realized until 2 years later when Tetsuichiro Muto from Tokyo, working with Basil Morson at the St Mark's Hospital, described the adenoma carcinoma sequence, a sequence so important that I am told they begin to teach it to elementary school students in Japan.

Transanal endoscopic microsurgery was the next evolution in another means of minimal access surgery. The late Professor Gerhard Buess, from Tuebingen, Germany, first discussed this technique, but it did not really catch on much until surgeons became facile with laparoscopic colectomy. Now, transanal endoscopic surgery is widely accepted. The hands-on course run by Pat Sylla here at the ASCRS meeting this week was oversubscribed, attesting to the global acceptance of this method. Laparoscopic colectomy, of course, was first performed in 1990 and 1991. Then-ASCRS-president Bob Beart described that we needed a registry. We needed to look critically at laparoscopic colectomy and let the members of our Society

and others know where this technology belonged in our armamentarium of treatment of colorectal problems. Because of the collaboration in this Society, within 2 years, Adrian Ortega and Bob Beart, working with surgeons from ASCRS and from the Society of Surgical Oncology and elsewhere, presented almost 1100 cases from more than 100 surgeons. If you look at the coauthors, you will also see David Winchester, the current medical director of the Commission on Cancer, and Rick Greene, who spoke with us yesterday, past chairman of the Commission on Cancer and chair of the American Joint Committee on Cancer, attesting to the collaboration this Society has and the importance in treating colorectal diseases.

The use of laparoscopy to treat benign diseases became accepted. What about treatment of cancer? I think the first inkling we had that there was going to be a green light—perhaps a yellow light—was Antonio Lacy from Barcelona in the now famous Barcelona trial in which it was shown that laparoscopy was fine. You are all familiar with that trial, but I wonder how many of you are familiar with this other trial performed by Antonio Lacy in which he assessed patients' opinions as to the good looks of surgeons, internists, and actors. I will let you ask Antonio after the meeting who was viewed as more handsome, him or George Clooney.

The collaboration in this Society continued when, in 2004, Heidi Nelson presented the now famous Clinical Outcomes of Surgical Therapy (COST) trial, which changed the yellow light of Lacy to the green light that we could do colon cancer with a laparoscope, and it became the standard. Our past president, Jim Fleshman, has been leading the COST II ACOSOG Z6051 trial. We hope soon to hear about the data from Jim and to know whether or not rectal cancer should be laparoscopically treated.

All of these technologies—colonoscopy, transanal endoscopic surgery, laparoscopy—were melded together in the setting of a single integrated operating room, not an endoscopy suite, not a specific operating room, not a laparoscopic setting, but an integrated operating room, by Michael Li at the Pamela Youde Nethersole Eastern Hospital in Hong Kong in 1995. Michael, then adding the robot into that setting, had the first environment in which all of these things worked together in concert. The robot has taken center stage in many discussions, some of the most profound being by Ara Darzi, who, to my knowledge, is the only colorectal surgeon who has ever been given the role of a health minister and has produced some excellent information on the use of the robot.

Once we have used all of these minimally invasive techniques in our patients, we would like to expedite discharge. Henrik Kehlet from Hvidovre, Denmark, showed us that we could use an enhanced-recovery pathway, adopted in this country by our past president Tony Senagore, our council member-at-large, Conor Delaney, and others, as fast-track protocols that we now all know and use.



**FIGURE 8.** Dr Mariana Berho and Dr Angelita Habr-Gama in Mendoza, Argentina in 2011.

The third group of patients at risk for a permanent stoma are the patients with fecal incontinence. There have been a plethora of international innovations for treating these patients. Norman Williams, again, as well as Cor Baeten from Maastricht in the Netherlands, described the stimulated graciloplasty. Although that operation worked, it had a very high complication profile. However, the device itself was the antecedent device to that described by Klaus Matzel from Erlangen, Germany for sacral nerve stimulation, which, of course, got US Food and Drug Administration approval here in this country and is now used throughout the world to treat fecal incontinence. Dr Tracy Hull is presenting the 5-year follow-up data of our North American sacral nerve stimulation trial here this week and ran a standing room-only course on SNS earlier in the week.

There are a lot of new ways of trying to avoid stomas in these patients. There are a host of new treatments for fecal incontinence. How do we know which of them to use in our patients? Through one of the other purposes of the Society, by publishing in our journal. Under the direction of Rob Madoff, with coeditors Tom Read and Don Buie, and through the hard work of past editor-in-chiefs, Bob Beart and Vic Fazio, both past presidents of the Society, the impact factor of our journal is at an all-time high, over





**FIGURE 9.** Steven D. Wexner with late father Justice Ira, his mother Arlene, his sons Wesley and Trevor, and his sister Sandy and brother-in-law Ron at Dr Wexner's parents' 50th wedding anniversary in 2003.

2.8. Last year, there were almost 600 submissions, 70% of which were from outside the United States, attesting to international collaboration driving forward the purpose of the Society and improving patient care.

In addition to the journal, the Society council approved a textbook being published. Within 5 years, the first edition was published under the senior editorship of past presidents Bruce Wolff and Jim Fleshman, soon thereafter followed by a manual, and last year by the second edition under the senior editorship of past president, Dave Beck, putting all this information together. We also continue to educate at this meeting and in other forums through our continuing education endeavors. I would like to thank Matt Mutch and the self-assessment committee who brought us forward with the newest versions of our Colon and Rectal Surgery Educational Program (CARSEP) syllabus, as well as Judith Trudel and the continuing education committee. The most exciting new effort, which you are going to hear much more about, is the colorectal education system template (CREST) program. Under the leadership and indefatigable work of Dr Elisa Birnbaum and the recent addition of Scott Steele, this program will give us the ability to go online and participate in training modules. We will be able to select any subject from the myriad of colorectal topics and learn about them in this one-stop shopping method, where we will have chapters from our textbook, practice parameters, all types of enduring material including Core subjects as well as photos, videos, narrated lectures, and ultimately continuing medical education and maintenance of certification (MOC) credits. I thank Elisa, Scott, and the CREST committee for all of their work.

We also need to train future generations, not just keep learning ourselves. Our first training program was at the University of Minnesota with 1 resident. We now have



**FIGURE 10.** Wesley and Trevor in Israel in 2010.

almost 90 residents training in over 50 programs. Maintenance of the highest standards of education is a lot of work. That work is done by Rick Weiss, Cristina Sardinha, and their residents' committee. I thank them for the hard work in helping us fulfill our purpose as a society.

Resident evaluation is taking a new turn, and you are going to hear more about it at this meeting through the operative competency evaluation committee under the direction of Pat Roberts and past president Ann Lowry with significant contributions from Sandra de Montbrun and Helen MacRae at the University of Toronto. The Colorectal Objective Structured Assessment of Technical Skills program is totally revolutionary. It is a giant step forward in skills assessment. Eight separate inanimate stations are used. Trainees use those stations and display their actual technical skills, or lack thereof. They are assessed by expert examiners, and in the first iteration and administration of this examination, there is a high degree of discrimination between colorectal trainees and general surgery trainees attesting to the exceptional value of this revolutionary innovative program. Dave Schoetz, past president of the Society and the Executive Director of the American Board of Colon and Rectal Surgery, is taking a serious look at this as a potential tool by which we can evaluate our trainees, putting the ASCRS at the cutting edge not only of research and education, but even skills evaluation. He and Pat are presenting the COSATS (Colorectal Objective Structured Assessment of Technical Skills) initiative here this week.

Research is also an important cornerstone of this Society. The foundation was started a year before I was born, but really had a rebirth in 1984, serendipitously by my initial mentor, Tom Dailey, and among others, past president Pat Mazier. The research foundation continues to grow. I was pleased to see we met our meet-the-challenge goal last night. The foundation has awarded 93 grants, over \$3 million. I would like to thank Jose Guillem, immediate past president, and Julio Garcia-Aguilar, the foundation president, for their hard work on behalf of all of us to help us fulfill the purpose of this Society.

Once those technologies in the conceptual research stage make it to commercialization, they need to be evaluated for general use. Chairman Peter Marcello, Cochair Sonia Ramamoorthy, and the new tech committee have taken a serious look this past year at things like single-port, sacral nerve stimulation, robotics, establishing registries, and trying to give us guidance as to where these tools fit in our practice.

In addition to educating ourselves, educating our residents, we continue to educate the public. I owe a huge debt of gratitude and express my appreciation to Harry Papaconstantinou, Scott Steele, and the public relations committee because they have really brought us into the limelight these past several years, tremendously increasing public awareness of the diseases we treat, and especially of who we are with that of name recognition.

There are many other committees that perform essential functions critical to our mission, working on behalf of this Society and on behalf of all of us. Unfortunately, time does not permit me going into each and every one of them individually, but suffice it to say a huge thank you to

every committee chair, cochair, vice chair, and committee member for helping us achieve all of the purposes of this Society. Through the hard work of everyone mentioned in this talk, this Society has become the centerpiece and the go-to society by other surgical and nonsurgical societies in this country and, in fact, throughout the world.

Two additional notes of thank you: one to the men and women in our armed forces who serve around the world keeping this country as great as it is; second, of course, to my family about whom you have heard: my late father, Justice Ira Wexner; my mom, Arlene, both of whom gave me the love, counsel, support, and guidance to be where I am today; and my sons, Wesley, who is here with us today, and Trevor, who, unfortunately, could not be here today because of the first day of his intensive summer school course (Figs. 9 and 10). I thank all of them—my dad, my mom, Wesley, and Trevor—for their love, for their guidance, and for their patience. Thank you to each of you. It has been a fantastic year. I am deeply appreciative and honored. Thank you again.