



Annual Meeting focuses on future of colorectal disease treatment

Six days of intense educational programming detailing the future of colorectal disease treatment await



Dr. Peter Marcello

attendees during the ASCRS 2004 Annual Meeting, May 8 - 13, in Dallas, TX.

The meeting in the Hyatt Regency Dallas will offer surgeons a comprehensive look

at advances in diagnosis and treatment while emphasizing research, patient care and teaching, according to Prog-

ram Committee Chair Dr. **Peter W. Marcello**, Burlington, MA.

“This year’s meeting devotes considerable attention to research, with a marked increase in podium and poster presentations,” he explained.

“The Program Committee has moved the Research Forum to Tuesday afternoon, where we believe more people will be able to attend. These enhancements will facilitate our members’ ability to experience the clinical and basic research that is having profound effects on how we treat patients,” Dr. Marcello added.

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Dallas Annual Meeting registration, preliminary program available online

ASCRS has introduced a convenient new option that allows members to register online for the 2004 Annual Meeting, May 8 - 13, in Dallas, TX.

Log onto www.fascrs.org to view the entire preliminary program, register for the meeting and book hotel rooms. The deadline for discounted rate is April 4.

Time-crunched surgeons will appreciate this added membership benefit, which serves as an alternative to past years, when members filled out registration forms contained in a preliminary program. **No registration packets will be mailed this year.** All information provided by registrants is protected through secure Web access.

An alternative registration method is to print out registration forms from the Website and fax them to the ASCRS Executive Offices at 847/290-9203. ✨

RESEARCH FOUNDATION REPORT

Research Foundation will increase funding, Initiate grant program to stimulate research

By James W. Fleshman, MD, President, Research Foundation of ASCRS

The ASCRS Research Foundation’s Board of Trustees has decided to make a substantial increase in its grant support to stimulate submission of more good research proposals. The Board also wishes to direct some research to specific areas that need focus. For that purpose, the Board is creating a new grant program utilizing a Request for Proposal (RFP) mechanism. These grants will be based on the need for clinical research in areas affected by colorectal surgery that would not be funded elsewhere. We would like to stimulate research in benign colorectal disease.



Dr. James Fleshman

Topics under consideration include:

- Percutaneous drainage of diverticular abscesses;

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Society uses dedication to quality care to enhance specialty worldwide

By David J. Schoetz, MD

It is difficult to believe that the year is half over. Much has been accomplished in the past six months,



Dr. David Schoetz

beginning with appointment of new committees. For approximately six weeks after the meeting in New Orleans, the process of appointing committee chairs and new committee members was my primary focus of activity. In an attempt to make this a more responsive process, we used the new strategic plan to streamline the numbers of committees and then used a list of volunteers from the membership questionnaire to populate them. Two-thirds of the chairs needed to be replaced.

It is not possible to provide a committee appointment to each individual who expresses a desire to serve; in the future, however, we will not keep individuals on committees for a defined term if they do not participate substantively in the work of the Society. Despite the increased pressures on each of our lives, the ASCRS is blessed with many volunteers who are willing to give the extra effort to support our vital organization.

Committees key to Strategic Plan

Each of the new committees will be developing strategies to help achieve our strategic plan. The Council has been assigned to the various committees and we are beginning to align the

Council representatives and committee chairs into 'Steering' Committees that will coordinate separate but related activities. One important activity will be to work with representatives from the American Board of Colon and Rectal Surgery on the development of the Maintenance of Certification process.

October saw the Clinical Congress of the American College of Surgeons. Their meeting is being substantially redesigned to try to be more responsive to the needs of the membership. Once again, the program offerings from our specialty under the direction of Dr. **Michael Stamos** were well received. Dr. **H. Randolph Bailey** was elected to the Board of Regents specifically representing colon and rectal surgery; he joins Dr. **Robin McLeod**, who already represents our specialty on the Board of Regents. Our relationship with ACS continues to flourish; we have enthusiastically supported their lobbying and educational efforts, which have greatly benefited our membership.

Our Public Relations Committee focused its efforts on the support of the successful Colossal Colon Tour, which visited a number of cities and was highlighted in Boston and Washington, D.C. This effort increased awareness of colon diseases in each city; members of the ASCRS were active participants.

More Annual Meeting participation

Dallas is the site of the annual meeting in May 2004. Program director Dr.

Peter Marcello has organized an excellent scientific meeting, using the approximately 400 submitted abstracts as the basis for the meeting. An increased number of podium presentations and posters will allow the membership to participate more fully on the latest in the field. They plan more activities for Tuesday afternoon, attempting to maximize the value of each day. The successful cadaver course for laparoscopy from last year is being repeated; in addition, a didactic seminar on laparoscopy will be presented on Sunday. Consultants' corner will for the first time in recent memory be based on cases submitted from the membership.

Beginning in January 2004, *Diseases of the Colon & Rectum* has a new publisher. The ASCRS has signed a contract with Springer-Verlag, a world leader in medical publishing with particular expertise in electronic publishing. The new logo of the Society appears on the newly designed cover. With the guidance of Dr. **Victor Fazio**, the editor-in-chief, a new video section will be developed through the online version of the journal. In the future, they will consider videos from the annual meeting and other digitized video submissions for publication in this format.

We have finalized website redesign, with substantial input from the Website Committee under the leadership of Dr. **Richard Karulf**. We are forever indebted to Dr. **John Coller** for his dedication to the creation and maintenance of the ASCRS Website. ✨

Australian government honors Dr. Victor Fazio



Dr. Victor Fazio

Dr. **Victor W. Fazio**, Cleveland, OH, Editor-in-Chief of *Diseases of the Colon & Rectum (DC&R)* and an ASCRS past president (1995-96), this year received AO (Officer of the Order) honors from the Australian Government.

The citation for Dr. Fazio, an Australian native, reads: "Dr. Victor Warren Fazio, Ohio, US, for service to Medicine as a

surgeon, researcher, administrator and educator, particularly in the area of colorectal disease."

Dr. Fazio became Editor-in-Chief of *DC&R* January 1, 1977, after serving on the Editorial Board for many years. He is Chair, Department of Colorectal Surgery, and Vice Chair, Division of Surgery, The Cleveland Clinic Foundation. He is also Professor of Surgery, Lerner College of Medicine of Case Western Reserve University. ✨

Dr. David Rothenberger appointed to Commission on Cancer

Dr. **David A. Rothenberger**, Minneapolis, MN, has been appointed to the Commission on Cancer (CoC), a consortium of multi-disciplinary professional organizations dedicated to fighting cancer.



Dr. David Rothenberger

Established in 1922 by the American College of Surgeons (ACS), the CoC sets national standards for quality multi-disciplinary care, surveys hospitals to assess compliance with those standards, and collects standardized and quality treatment data from approved institutions. This data helps make up the National Cancer Database (NCDB), a joint project between the ACS and the American Cancer Society.

“Currently, there are more than 1,400 institutions in the U.S. – roughly one in four – that meet the standards set by the CoC,” Dr. Rothenberger explained. “Interestingly, these programs treat 80% of newly-diagnosed cancer patients. The NCDB serves as an excellent research tool by offering a ‘big picture’ view of what’s happening with cancer in the United States. It allows surgeons to see whether surgeons are following standards and identify trends that may prove useful in determining preferred treatment methods,” he added.

The NCDB publishes many scientific papers based on data collected each year, mainly concerning patterns of care and resulting outcomes for a particular form of cancer. To protect patient confidentiality, names or other identifying information are removed from the data collected.

Dr. Rothenberger hopes the NCDB reports will offer solutions to some of today’s biggest controversies. For example, data may shed light on the proper role of local therapy. Reports may also show whether surgeons across the country are using neoadjuvant therapy in late-term colorectal cancer cases, as is recommended.

“Just because there are standards does not mean that everyone follows them,” he said. “I’m looking forward to learning more about how data is collected, then using that knowledge to further patient care within ASCRS and on a national level.”

CoC membership includes more than 100 professionals from the ACS or representatives of 37 organizations affiliated with the College. Dr. Rothenberger is the newest ASCRS representative to the Commission, replacing Dr. **David J. Schoetz**, Burlington, MA. ✨

Dr. Douglas Wong first recipient of Stuart Quan Chair

Memorial Sloan-Kettering Cancer Center officials have named Executive Council Member-at-Large Dr. **W. Douglas Wong**, New York, NY, first recipient of the Stuart H.Q. Quan Chair in Colorectal Surgery after a four-year, nationwide search.



Dr. Douglas Wong

Coincidentally, the endowed Chair is named for 1979-80 Society President Dr. **Stuart Quan**. Although formally retired, Dr. Quan is Emeritus Attending Surgeon at Memorial Sloan-Kettering, and was a pioneer in improving patient treatment during his 51-year tenure.

“It is a great honor to be first recipient of a Chair named for someone so highly regarded in the world of cancer treatment,” Dr. Wong said. “I’ve had the privilege of knowing Dr. Quan for several years. He was still practicing when I arrived here six years ago.”

The Chair will support Dr. Wong’s research efforts into sphincter-preserving surgery and endorectal ultrasonography. He is also involved in experimental research on total anorectal reconstruction using an artificial bowel prosthesis.

“Prosthetics may prove an effective alternative to permanent colostomy,” Dr. Wong explained. “In addition, my team is very active in molecular profiling, attempting to develop targeted therapies suited for colorectal cancer’s early stages.”

Dr. Wong is Chief of Colorectal Surgery and Attending Surgeon at Memorial Sloan-Kettering, where he leads the Colorectal Surgical Service and the Colorectal Disease Management Team. He serves on the American College of Surgeons’ Advisory Council for Colon and Rectal Surgery and on the College’s Joint Commission on Cancer.

Dr. Quan was a pioneer in promoting pre-operative irradiation for rectal cancer in the 1950s. Today, the technique is routinely performed in cancer centers worldwide. ✨

Dr. Randolph Bailey elected ACS Regent

ASCRS Past President Dr. **H. Randolph Bailey**, Houston, TX, has been elected a Regent of the American College of Surgeons.

Dr. Bailey is former chairman of the College’s Advisory Council for Colon and Rectal Surgery (6 years) and Governor (4 years). He is also past president of the American Board of

Colon and Rectal Surgery.

Dr. Bailey is Chief of the Division of Colorectal Surgery and Program Director of the Residency Training Program at the University of Texas Medical Center, Houston. He is also Clinical Professor of Surgery at the University of Texas Medical School; consultant and Adjunct Associate

Professor, Division of Surgery, University of Texas MD Anderson Cancer Center; and Clinical Professor of Surgery at Baylor College of Medicine. ✨



Dr. Randolph Bailey

Dallas Annual Meeting focuses on future ...continued from page 1

Other improvements to the Annual Meeting's structure include a renewed focus on laparoscopic colectomy.

"We've added a laparoscopy panel discussion to the main program and a second cadaver session to Saturday's laparoscopic intestinal surgery program. The Committee created an enhanced 'pre-meeting' weekend that offers more educational programs for guests to select from," Dr. Marcello explained.

The 2004 Annual Meeting begins Saturday, May 8, with the **Hand Assisted Laparoscopic Intestinal Surgery Workshop**.

This all-day course, designed for surgeons familiar with laparoscopic techniques who wish to expand their skills to laparoscopic intestinal surgery, offers lectures, interactive video presentations and cadaver work.

The always-popular **Endorectal Ultrasound Course**, also held Saturday, will provide surgeons with education and training in the basic use of ultrasound. The program focuses specifically on applied ultrasound for colorectal disease.

A special Sunday Breakfast Symposium, **Rectocele and Obstructive Defecation**, reviews the current management of symptomatic rectoceles through a variety of surgical approaches: transanal, transvaginal, transperineal and transanal stapling.

Meanwhile, the Sunday symposium **Laparoscopic Colorectal Surgery: Where Do We Stand**, reviews the status and controversies of the procedure. Specifically, the course will focus on the results of laparoscopic colectomy for diseases such as Crohn's and ulcerative colitis.

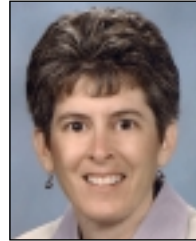
Sunday's program concludes with presentations on **Postoperative Ileus: Open vs. Laparoscopic**; the **2004 Update on Core Subjects** (see page 14 of this newsletter); and **NSAIDs, Anticoagulation, DVT Prophylaxis and the Colorectal Surgeon**.



Dr. Robert Beart



Dr. Richard Billingham



Dr. Heidi Nelson

"Colorectal surgeons are often asked to manage nonsteroidal anti-inflammatory medication (NSAID) usage for patients requiring endoscopy or major abdominal surgery. This program will review the major areas of concern for members of our specialty," Dr. Marcello explained.

The meeting's tone will encourage a spirit of fellowship and camaraderie as scientific sessions get underway Monday, May 10. The Program Committee purposely created a blend of senior and junior session moderators to offer a balance between more experienced members and those newer to the field. Monday and Tuesday topics include **colorectal cancer, laparoscopy, benign colonic disease and inflammatory bowel disease**.

Meanwhile, a total of 12 "Meet the Professor" Breakfasts provide smaller, more intimate venues for attendees to ask questions or present their own cases for review by moderators and other participants.

Wednesday's Panel Discussion, "Laparoscopic Colectomy for Cancer: Ready for Prime Time?" features the insights of Drs. **Robert W. Beart**, Los Angeles, **Richard P. Billingham**, Seattle, WA, and **Heidi Nelson**, Rochester, MN.

Other highlights include:

Poster Walk Around – Guests are welcome to enjoy wine and cheese as they review the 119 posters presented at this year's meeting (Monday, May 10);

Some Lessons Learned From the Evaluation of Seprafilm® Adhesion Barrier in Prospective Randomized

Trials – This lunch symposium offers an evaluation of Seprafilm® on adhesion formation and how clinical trials may affect colorectal practices (Tuesday, May 11);

Socioeconomic Update – Course director Dr. **David A. Margolin**, New Orleans, LA, presents a course on modifier usage. (Tuesday, May 11);

Colorectal Jeopardy – An Annual Meeting staple, this year's Colorectal Jeopardy program pits contestants against each other to match wits about colorectal disease and related topics. Beer, wine and pretzels will be served. (Wednesday, May 12);

Consultant's Corner – Expert panelists will be challenged to discuss different approaches to patient management problems derived from cases submitted by ASCRS members (Thursday, May 13). ✨

Research Foundation Special Event features fun, entertainment

Genzyme Biosurgery will again support the Research Foundation's annual Special Event. This year's event promises an evening of fun, food, refreshment, and entertainment from 7-11 p.m. Monday, May 10, in the Grand Hall Union Station of the Hyatt Regency Dallas.

"The Foundation will showcase projects that our researchers are working on and thank those who have given to the Foundation's Eagle Campaign," says Research Foundation President Dr. **James W. Fleshman**, St. Louis, MO. ✨

Distinguished speakers highlight 2004 Meeting

The Society's 2004 Annual Meeting would be incomplete without a group of distinguished speakers who will offer their thoughts on a range of perplexing issues faced by today's colorectal practitioners.

This year's special guest presentations include:

Harry E. Bacon Lectureship – Dr. **Leonard Zinman**, Staff Surgeon, Department of Urology, Lahey Clinic, Burlington, MA, *Rectrourethral Fistulae: A Urologist's Perspective* (Monday, May 10);

The Norman Nigro Research Lectureship – Dr. **Richard K. Reznick**, R.S. McLaughlin Professor



Dr. Leonard Zinman



Dr. Richard Reznick



Dr. Mark Seigler



Dr. Herand Abcarian



Dr. Ambaye Michael

and Chair, Department of Surgery, University of Toronto, and Vice President, Education, University Health Network, *The Anatomy of a Surgeon* (Monday, May 10);

Parvitz Kamangar Humanities in Surgery Lectureship – Dr. **Mark Seigler**, Professor of Medicine and Director, MacLean Center for Clinical Medical Ethics, University of Chicago, *Clinical Ethical Issues in Colorectal Surgery* (Tuesday, May 11);

Joseph M. Mathews Oration – Dr. **Herand Abcarian**, Turi Josefsen Professor and Chairman, Department of Surgery, University of Illinois College of Medicine at Chicago, *Why Another Oration?* (Wednesday, May 12);

The Ernestine Hambrick Lectureship, Dr. **Ambaye W. Michael**, Obstetrics & Gynecology, Addis Ababa, Ethiopia,

Obstetric Fistula, Hidden Epidemic in Developing Countries (Wednesday, May 12).

Dr. **David J. Schoetz**, Burlington MA, will present his **ASCRS Presidential Address** (Monday, May 10). ✨

Research Foundation will increase funding ...continued from page 1

- Diverticulitis after abscess drainage – operation v. no operation;
- Embolization therapy for lower GI bleeding v. surgery;
- Low anterior resection – drain or no drain;
- Seton as a means of continence preservation, versus one stage fistulotomy;
- Sphincter sparing methods of fistula repair (glue, mucosal flap or dermal flap) versus fistulotomy.

The grants set aside for each of these RFPs (\$50,000 per year for two years) will be adequate to complete an aggressive project. We hope to attract some very high quality research proposals.

Clinical research will be the major focus of RFPs, and the research may be conducted at one institution or in collaboration with other institutions or groups. The Foundation plans to award two RFPs each year, beginning in 2005.

Each RFP will be for \$50,000 per year for two years, with the second year's grant based on receipt of an interim report. The salary stipend is limited

to \$20,000 per year for the principal investigator. Indirect costs will not be funded.

We anticipate funding only those projects which meet strict criteria for funding that will guarantee completion of the project and meaningful results. We will target areas of research that currently have no other source of funding. We are excited about this effort. The Research Foundation Board is unanimous in its decision to move forward.

In addition, the Foundation plans to continue its allocation up to \$250,000 annually for Limited Project Grants (up to \$40,000 per year, renewable for a second year), two Career Development Awards of \$80,000 each for a two-year period, and an International Fellowship Award of \$20,000 per year.

We have been providing \$250,000 a year to support and promote outstanding clinical and basic research related to colorectal diseases and disorders. These plans recognize the need to increase that annual commitment in coming years, as support from government and other sources continues to decline.

Within the past year, the Research Foundation has granted two additional Limited Project Grants, two Career Development Awards, and an International Grant. We are also supporting a very interesting Quality Project led by Dr. **Neil H. Hyman**, South Burlington, VT. He and his colleagues are applying to colorectal cancer surgery a model developed by the Northern New England Cardiovascular Disease Study Groups for cardiac surgery. It led to a reduction in mortality for cardiac surgery in Northern New England from approximately 5% to 2.5%.

The Foundation's important initiatives will require increased investment or we will begin to deplete the endowment built up over 45 years of fundraising activities. To remain a viable research sponsor and become one of the largest funding groups for colorectal research, we must replace the money that is being drawn on the principal of the endowment. The future of our specialty depends on the strength of our commitment to advancing research in colorectal diseases. ✨

Research Foundation presents five grants

The ASCRS Research Foundation has presented one special project grant, two Limited Project Grants (LPGs), a Career Development Award and one International Fellowship Grant to investigators during 2003-4.

ASCRS/NECRS Quality Project

A special grant of \$45,000 supports the ASCRS/New England Colon and Rectal Surgeons (NECRS) Quality Project, directed by Dr. **Neil H. Hyman**, South Burlington, VT. The project will model an approach developed by the Northern New England Cardiovascular Disease Study Groups to measure and improve quality of care. The New England cardiac group now boasts the lowest mortality for cardiac surgery in the U.S.

A consortium of 13 medical centers in New England is collaborating in the ASCRS/NECRS program by measuring outcomes (morbidity, mortality, and possibly functional results) for patients undergoing resection for colorectal cancer. They will join in group meetings to review data and try to define practices associated with "best outcomes."

"The cardiac surgeons, some of whom participated reluctantly at first, now are enthusiastic participants and advocates for the approach," says Dr. Hyman. "This model of regional organization to improve clinical care has been very successful and really serves as a 'high road' measuring quality.

The focus is not on pitting one group of surgeons against another. Rather, it is a collaborative effort that has successfully diminished morbidity and mortality. This approach can put ASCRS in a leadership position," he adds.

Limited Project Grants

LPGs provide funding up to \$40,000 in support of one-year colorectal projects. The number of awards made each year is at the recommendation of the Research Committee and at the discretion of the Research Foundation Board of Trustees.

LPGs awarded last year are:

- *Correlation of NOD2 Gene Variants with Disease Status in Patients with Crohn's Disease*, Dr. **Eva Galka**, Pennsylvania State University, Hershey, PA.
- *Hypoxia and Rectal Cancer Response to Chemoradiation*, Dr. **Jose G. Guillem**, Sloan Kettering Cancer Center, New York, NY.
- *Characterization of IL4R-Stat6 Signaling Pathway in IBD*, Dr. **Walter A. Koltun**, Pennsylvania State University, Hershey, PA.

Career Development Awards

Career Development Awards support the efforts of young investigators launching academic careers. They provide funding of \$40,000 per year for two years and are designed as a

cooperative venture, requiring the commitment of both the institution where the research takes place and the Research Foundation.

A 2003-4 Career Development Award was presented to Dr. **Christopher R. Mantyh**, Duke University Medical Center, Durham, NC, for *The Role of VR-1 in Induced and Genetically Engineered Animal Models of Colitis*.

International Fellowship Grants

International Fellowship Grants provide research support up to \$20,000 to residents and clinical investigators from outside the U.S. or Canada to travel here or for U.S. residents and clinical investigators to travel abroad to do research.

The Research Foundation awarded a 2003-4 International Grant to Dr. **Hiroki Ohge**, Hiroshima University, Japan, for research at the University of Minnesota, Minneapolis, MN, *Measurements of Volatile Thiol Production of Ileal Pouch Contents: Potential Insights into Pathogenesis and Therapy of Pouchitis and Ulcerative Colitis*.

With an endowment of nearly \$5 million, the Research Foundation seeks to support cutting-edge research that will, in the words of President Dr. **James W. Fleshman**, St. Louis, MO, "save lives today and promote the cures of tomorrow." ✨

ASCRS colorectal surgery textbook well underway

Chapters have been submitted for the new ASCRS textbook based on the core curriculum for colorectal surgery, according to Dr. **James W. Fleshman**, St. Louis, who is directing the project, and the review process should be completed by June.

"We anticipate publication of the first edition by spring of 2005, in time for the ASCRS Annual Meeting in Philadelphia," Dr. Fleshman says. The Society plans to publish both hardcopy and online versions of the textbook, the work of five editors and five co-editors from the Society, rotating on a multi-year basis to ensure continuity and breadth of participation.

Content will be based on the core curriculum developed by the Association of Program Directors for Colon and Rectal Surgery. The Society's practice parameters will also be used, where appropriate. The Society's Self Assessment Committee will develop CME questions based on each of the textbook's chapters.

The new publisher of the Society's journal, *Diseases of the Colon & Rectum*, Springer Verlag, will publish the textbook. Springer Verlag will also develop an online version that will be updated regularly, as determined by the textbook's editorial board. The textbook will be available for use in gradu-

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European colleagues' accomplishments remarkable

By Feza R. Remzi, M.D., 2003 Traveling Fellow

It was an honor and privilege to be selected as the 2003 ASCRS Traveling Fellow. However, I had no way of knowing that my visits to different centers in the United Kingdom and Ireland, along with my attendance at the annual meeting of the Association of Coloproctology of Great Britain and Ireland would be such a remarkable experience.



Dr. Feza Remzi

My trip started with a visit to Basingstoke. My time at Pelican Center, North Hampshire Hospital, was short but intense. I was greeted with great hospitality by Mr. **Brendan J. Moran** and his wife.

During my visit, I was impressed with Mr. Moran and his colleague, Mr. **Tom Cecil**. They had such great organization and a unique multi-disciplinary approach to pseudomyxoma peritonei management. I was also impressed with their use of MRI in evaluating patients with rectal cancer and their ongoing M.E.R.C.U.R.Y. trial under the leadership of Professor **Bill Heald**. (In the United Kingdom, surgeons use MRI instead of endorectal ultrasound to assess tumor relationship to the fascia propria of the rectum and determine whether or not to use neo-adjuvant therapy). I believe this is a concept we in the United States should explore further.

Next, I spent two great days with Mr. **Paul J. Finan**, Mr. **Peter M. Sagar** and Mr. **Dermot Burke** at the Leed's General Infirmary. I was fascinated by their experience with multi-disciplinary approaches to rectal cancer and the fact that Leeds also serves as a referral center for the management of recurrent rectal cancer. Their approach to rectal cancer patients is an example of how dedication can generate a wealth of clinical information that often leads to seminal contributions.

During my second fellowship week, I attended the Annual Meeting of the Association of Coloproctology of Great Britain and Ireland in Edinburgh. The scientific program included excellent presentations on the latest advances in our field: topics included the genotype/phenotype correlations in Crohn's disease, new advances in laparoscopy and recent breakthroughs in familial adenomatous polyposis-related issues.

The symposium, "Abdominoperineal excision of the rectum and anus—badly done and not always necessary," was one of the highlights of the meeting. Meanwhile, the Zachary Cope lecture, "Reconstruction in colorectal surgery—a brave new world," given by Professor **Norman Williams**, was also very interesting and thought-provoking.

After the Annual Meeting, I spent a day at the Western General Hospital in Edinburgh with Professor **Malcolm G. Dunlop**. His continuing work on hereditary colorectal cancer, familial adenomatous polyposis and the genetics of colorectal disease is truly amazing. I firmly believe we will be reading and hearing a lot about Prof. Dunlop's work and research in the future.

After Edinburgh, I visited Professor **P. Ronan O'Connell** at the Mater Misericordiae Hospital in Dublin. I had a very productive two-day visit in his unit. I attended clinic sessions, went on rounds and spent time in the operating room. Prof. O'Connell's clinical expertise – not to mention the amount of basic science research activity being conducted under his leadership – was impressive.

While in Dublin, I also had a very informative visit with Mr. **John M. Hyland**, who will be the next President of ACPGIBI at St. Vincent's University Hospital.

My journey then brought me to the John Radcliffe Hospital in Oxford, where Mr. **Ian Lindsey** was a perfect host (in Professor **Neil Mortensen**'s absence). Besides spending a day in the operating room, I had an opportunity to visit the anorectal physiology laboratory. There, I learned about the organization and its multi-disciplinary approaches to pelvic floor disorders.

In conclusion, I had a great time during my three-week visit in the United Kingdom and Ireland. Despite a relative lack of resources compared to surgeons in the United States, the accomplishments of our British and Irish colleagues in patient care, research and teaching are quite remarkable.

In addition to sharing experiences with some of the most prominent British and Irish colleagues in our field and enjoying their considerable hospitality, the fellowship has allowed me to apply my experiences to my own practice. I would like to relay my appreciation to the ASCRS for this rewarding privilege. ✨

Colorectal textbook ...continued from page 6

ate programs in colorectal surgery, maintenance of certification (MOC) programs and elsewhere.

"Authorship has been solicited from senior and junior authors to provide expert commentary on all subjects and complete coverage of each area," Dr. Fleshman said.

"This effort affords a unique opportunity to define the specialty of colorectal surgery and establish ASCRS as the

organization of authoritative experts qualified to write the text for training graduate fellows and assisting the ABCRS in its Maintenance of Certification program," he said.

All proceeds from sale of the textbook will be donated to ASCRS for use as the Executive Council determines. Authors and editors will receive a free copy of the book but no honoraria for their contributions. ✨

Revised 2004 Medicare Fee Schedule released; colon and rectal surgery increase estimated at 2%

By David A. Margolin MD, ASCRS Socioeconomic Chair

Under the revised 2004 Medicare Fee Schedule released by CMS January 7, colon and rectal surgeons will experience an average fee increase of 2% this year. This increase takes the place of the 4% reduction that had been anticipated prior to action by Congress mandating that the conversion factor rise from \$36.7856 to \$37.3374 (or 1.5%).



Dr. David Margolin

The accompanying list shows MFS payment changes for selected top colon and rectal surgery codes, including the most frequently reported E&M codes.

The Socioeconomic Committee will continue to work through the established framework of the American Medical Association's (AMA) Relative Value Update Committee (RUC) and Practice Expense Advisory Committee (PEAC) to develop appropriate practice expense values for colorectal surgery codes.

We are currently working on obtaining a code for the PPH. The committee is also evaluating the producers that were sent in by the membership for possible presentation and inclusion in CPT 2006. To receive a CPT code, a procedure must be done throughout the country by a reasonable number of specialists. It also must have peer-reviewed literature supporting its efficacy. The Committee plans to con-

tinue interaction with other surgical specialties, most notably the American College of Surgeons, to help develop fair and equitable reimbursement.

In response to membership input, the socioeconomic update course at this year's ASCRS Annual Meeting will focus specifically on modifier usage. We will again enlist the aid of **Mary LeGrand**, RN, MA, of Karen Zupko & Associates, and will concentrate on specific examples germane to colon and rectal surgery.

These will be modifiers used both in the office and in the operating room. Unlike last year, there will be a longer

question and answer session. There will also be a "Meet the Professor" breakfast dealing specifically with coding and other reimbursement questions. In that vein, please send any coding questions to the ACSRS office at stellazedalis@fascrs.org, so that they may be discussed at the meeting. The Socioeconomic Committee is looking forward to two informative and stimulating courses.

The Socioeconomic Committee will put forth any new codes nominated by a member. To nominate a new code, contact Dr. David Margolin, damargolin@ochsner.org; Dr. Guy Orangio, gorangio@bellsouth.net; or Dr. Eric Weiss, weisse@ccf.org. Remember: any changes or additions to CPT codes require survey data for appropriate valuation. Therefore, be generous with your time and complete a survey if contacted by a Socioeconomic Committee member. Contact the American College of Surgeons Coding Hotline (1-800-227-7911) for answers to any specific coding questions. ✨

| PAYMENT CHANGES | | |
|--------------------------|------------------------------|-------------------|
| CPT | Description | 03/04 MFS Change* |
| Conversion Factor Change | | 1.5% |
| 44140 | Partial removal of colon | 2.3% |
| 44145 | Partial removal of colon | 2.1% |
| 44204 | Lap, partial colectomy | 2.2% |
| 45110 | Removal of rectum | 2.5% |
| 45170 | Excision of rectal lesion | 1.7% |
| 45300 | Proctosigmoidoscopy dx | 15.3% |
| 45330 | Diagnostic sigmoidoscopy | 2.2% |
| 45378 | Diagnostic colonoscopy | -0.5% |
| 45380 | Colonoscopy and biopsy | -1.4% |
| 45385 | Lesion removal colonoscopy | -0.8% |
| 46221 | Ligation of hemorrhoid(s) | 3.7% |
| 46500 | Injection into hemorrhoid(s) | 4.6% |
| 46600 | Diagnostic anoscopy | 36.8% |
| 46934 | Destruction of hemorrhoids | -10.1% |
| 99213 | Office/outpatient visit, est | 2.6% |
| 99243 | Office consultation | 1.9% |

*Change in payment for performing a procedure in a facility setting.
 Note: For 2004, CMS implemented a final *across-the-board* change to the practice expense component for all codes with a 90-day global period that had not been reviewed in 2002-2003. For some codes (e.g., 46934) this resulted in a significant decrease.

Society welcomes allied health professional membership applications

The Society's Membership Committee extends a warm welcome to registered nurses and/or physicians' assistants with an interest in colon and rectal surgery; nurses working in biofeedback, wound and ostomy; continence nurses; and

other allied health professionals interested in becoming members.

"Physicians and allied health professionals can learn from each other, and together we can expand knowledge of the specialty of colon and rectal surgery," says Dr. **Susan Galandiuk**,

Louisville, KY, Co-Chair of the Membership Committee.

Allied health professionals must be sponsored by an active member or fellow of ASCRS. Membership applications are available at the Society's Website, www.fascrs.org. ✨

New Medicare law halts physician pay cuts; includes many changes with impact on colorectal surgery

Compiled by The Advocacy and Health Policy Division of the American College of Surgeons

The new Medicare Prescription Drug, Improvement, and Modernization Act (DIMA) averted a 4.5 percent cut in physician payment reimbursement, as Dr. **David A. Margolin** notes in his report on page 8.

Other important DIMA changes affecting surgery include:

- **Rural providers** – Medicare will pay a 5 percent bonus to physicians serving in health care scarcity areas from 2005 through 2007. In addition, geographic adjustment factors in the fee schedule have been changed for 2004 through 2006. Medicare payments in areas with relatively low costs of living were increased by raising the minimum geographic adjustment of the physician work component of the fee schedule to the nationwide average of 1.00.
- **Graduate medical education** – The indirect medical education (IME) adjustment factor is increased from 5.5 percent to 6.0 percent for the last half of fiscal year (FY) 2004, and will be set at 5.8 percent in FY 2005, 5.55 percent in FY 2006, 5.35 in FY 2007 and 5.5 percent for FY 2008 and thereafter. In addition, the Department of Health and Human Services (HHS) now has the authority to redistribute unused residency slots.
- **Specialty hospitals** – The “whole hospital” exception to physician self-referral restrictions was amended to exclude for 18 months facilities with physician owners that are devoted primarily to cardiac, orthopedic, surgical, or other designated specialties. This provision does not affect specialty hospitals in operation or under development as of the date of enactment. During the moratorium, MedPAC will conduct a study to assess the impact of physician-owned specialty hospitals on patient referrals.

- **Ambulatory surgery centers (ASCs)** – The bill alters the payment rate for services provided in ASCs such that they will be updated by the percentage increase in the Consumer Price Index-Urban less 3 percent next year, and frozen starting in the fourth quarter of 2005. In addition, the General Accounting Office (GAO) will conduct a study of ASC payments.



- **Average wholesale price (AWP) reform** – The bill decreases the reimbursement rate for drugs administered in a physician’s office to 85 percent of the AWP in 2004 and to the Average Sale Price plus 6 percent in 2005, and initiates competitive bidding as a physician choice beginning in 2006. The bill also increases practice expense reimbursements under the fee schedule for drug administration.
- **Quality initiatives** – The bill establishes a five-year demonstration program to examine health care delivery factors that improve patient care, including the provision of incentives to improve the quality and safety of care and the appropriate use of best practice guidelines. In addition, the bill mandates that the Institute of Medicine (IOM) issue a report on leading health care performance measures in the public and private sectors and outline options to implement policies aligning performance with payment in the Medicare program.
- **Systemic interoperability** – The bill provides for an 11-member Commission on Systemic Interoperability to develop a comprehensive strategy for the adoption and implementation of health care information

technology standards, including a time line.

- **Electronic prescribing** – The bill directs the HHS Secretary to develop and adopt standards for transactions and data elements to enable the electronic transmission of medical information, including prescriptions. This was a hard-fought defensive victory. Earlier versions of the bill mandated electronic prescribing for all physicians within the next three years.
- **Regulatory reform** – The bill provides regulatory relief for physicians in the following areas: extrapolation, consent settlement, evaluation and management service documentation guidelines, the Emergency Medical Treatment and Labor Act (EMTALA), written advice from contractors, and advance beneficiary notices.
- **Coding standards** – In another defensive victory, physician groups successfully lobbied to exclude language that could have replaced the *Current Procedural Terminology* (CPT) codes used in the Medicare fee schedule with ICD-10 codes. Based on strenuous objections and action by the National Committee on Vital Health Statistics, they dropped the language from the final version of the bill.

General Accounting Office issues controversial report on assistants

In January, the GAO issued a report mandated by Congress on the appropriateness of expanding Medicare fee schedule payments to certified registered nurse first assistants who provide assistant at surgery services. As has happened before when other agencies

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Where would we be without the AMA?

By Dr. Frank G. Opelka

Having just completed my tour-of-duty as the ASCRS Delegate to the American Medical Association House of Delegates, I reflect upon the AMA's struggles and wonder what our professional life would be like without the AMA. It has been a great personal privilege to serve as your delegate and represent our members to the entire house of organized medicine. As I leave my delegate position, Dr. **Clifford L. Simmang**, Dallas, TX, will assume the responsibility.



Dr. Frank Opelka

Will the AMA survive and remain effective enough to merit support from all the various state medical organizations, specialty societies and individual physicians? Since serving as a delegate to the AMA, I have watched the membership of the organization decline. Once a robust organization, its membership exceeded more than one half of practicing physicians. Now, it barely creeps to the level of 25% of practicing clinicians, residents, medical students and retirees. Each year, AMA membership dwindles further. Has interest waned in today's climate of decreasing reimbursement? The AMA may have been mistakenly removed from many physician office budgets to reduce expenses.

Tried to reinvent itself

The AMA has spent countless hours trying to recapture physician interest. The organization has tried to reinvent itself through various initiatives. I took part in a major effort to redesign the AMA into a new federation that would more favorably serve specialty societies and diffuse the power of the state medical societies. I represented surgical organizations on a committee to restructure the AMA Board of Trustees. I have participated in the AMA deliberations to design a more universal organization. Each of these redesign efforts ultimately failed. The various stake holders could not sacrifice their own ambitions for the benefit of the whole organization.

Where does this leave us? Will the AMA continue to survive? For the short term, surely it will. The more important consideration is what to do to assure that the AMA does more than survive. It must flourish, and it will not do so without your personal support.

Why should you join the AMA? What has it done for you lately? Just this past year, the AMA's accomplishments are enormous. Let me highlight a few of these accomplishments and think about what it would be like if we had no AMA.

The AMA's most prominent program focuses on professional liability. The AMA represents the best interests of physicians in the news media, on television debating Ralph Nader, before Congress and with the White House and the Executive Branch of the federal government. The AMA, in

lock-step with the American College of Surgeons (ACS), regularly trades punches with the trial lawyers on your behalf.

Goal: protect clinical care

The AMA's goal is to protect clinical care. It has helped writing legislation to protect obstetric care and trauma care in states facing a professional liability crisis. Not even the ACS has the resources AMA deploys when battling for your interests. The AMA steps up to the plate to write "amicus briefs" (friends of the court) whenever one of its members squares off with the laws in their states. Even today, the AMA seeks to help more physicians battle the various legislative and legal conflicts that threaten the very right to deliver care.

And what about CPT? Is it perfect? Certainly not. But if you did not have the AMA sponsoring CPT, the government would consider alternatives to CPT that would be less sensitive to physician interests. Hospitals and insurers are stake holders in the coding world. However, it is the AMA that keeps these codes as **physician** codes. The AMA allows us to bring forward new codes that best describe the care we deliver. Those codes undergo the RUC process to value them for our services.

Without the AMA, we would struggle to find a voice during new code development and valuation. Recently, the American Hospital Association and others strongly urged the Congress to abolish CPT and ICD 9 and replace them with a new system, ICD 10. The new system proposed would take us from over 7,000 CPT codes to more than 170,000 codes. Can you imagine the confusion and lost revenue over such a dramatic shift in our coding system? The AMA led the charge to preserve CPT. That effort alone spared each surgeon thousands of dollars in lost revenue.

Supports mainstream efforts

The AMA supports countless mainstream efforts including colorectal cancer screening, childhood vaccines and other national health initiatives. The AMA studies and reports on the medical workforce, the resident hours and the resident match program. The AMA serves as a defendant in the lawsuit that seeks to end the match program. The AMA is critically tied into continuing education programs and the specialty boards.

The AMA House of Delegates is the only national medical body that brings together all the elements of American medicine. Representation in the AMA House includes family physicians and internists, alongside surgeons and medical specialties. The House includes government officials in CMS, the hospital associations, and various aspects of the support industries such as pharmaceuticals. The major health plans, HMOs and insurers are involved. The depth and breadth of the House are awesome. All aspects of

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Advisory Council represents colorectal surgeons

By Steven D. Wexner, M.D., FACS, FRCS, FRCS (Ed), Chair, ACS Advisory Council

The American College of Surgeons, under the leadership of ASCRS Fellow Dr. **Thomas R. Russell**, Chicago, recognizes the importance of specialty and subspecialty organizations. The College encourages continuing dialogue from the ASCRS. Clearly, the representation within the College by ASCRS



Dr. Steven Wexner

Fellows has dramatically increased over these past several years with the appointment of Dr. Russell as Executive Director, and shortly there-

after, election of Drs. **Robin McLeod**, Toronto, ON, Canada, and now **H. Randolph Bailey**, Houston, TX, as ACS Regents.

The ASCRS, through the Advisory Council, continues to promote some of the most popular offerings at the Annual Clinical Congress. Under the capable direction of Dr. **Michael Stamos**, Orange, CA, the program continues to be diverse, comprehensive, and well attended.

The Advisory Council offers the opportunity to interface with other specialties and help form multi-disciplinary programs at the Annual Clinical Congress. In addition, the

Advisory Council participates in many other important College decision-making functions, including resident work hours, reimbursement issues, the liability crises and tort reform, and many other similar topics.

I welcome any comments or ideas that our members may have concerning the Advisory Council. I would like to thank the membership and leadership of the American Society of Colon and Rectal Surgeons for allowing me to continue to serve as Council Chair. I am very appreciative of your confidence and will devote my attention to continuing to address the needs of our specialty and our membership at the level of the Advisory Council Chairs. ✨

Where would we be without the AMA? ...continued from page 10

medicine assemble in an organized national debate. It is impossible always to find agreement in a group with such diverse representation.

Is it prudent to let the AMA dwindle? Can you afford to ignore its membership request? Clearly, the answer is "no." We can no longer presume to save a few dollars by not joining the AMA. We cannot rely on someone else to sustain its membership. Membership and participation begin with the individual surgeon.

The AMA has to regain its position in American medicine. We can afford nothing less. The American College of Surgeons recognizes the need for the AMA. The House of Delegates has many surgical specialty representatives. This past year, the surgeons have united within the House of Delegates in a large surgical caucus. Twenty-seven surgeons sat arm-to-arm in the House with the influence of the surgical caucus tackling one issue at a time.

In the past, the AMA was often portrayed as an organization that put its emphasis on primary care, with less interest in surgery. That is no longer true. This year, the AMA's top three positions are occupied by surgeons: President, Chairman of the Board, and the Executive Vice President (CEO).

Consider where we would be without the AMA. Ask yourself how you would attempt to solve coding problems, resident education, Medicare legislation, or professional liability reform without the AMA. I ask each of you to join the AMA and declare your affiliation with the American Society of Colon and Rectal Surgeons. By doing so, you act to protect your practice from unintended legislative consequences. In declaring the ASCRS for your membership, you let the AMA know the interest the ASCRS has in the overall care of our patients. Please join in supporting Dr. Simmang in his future efforts on your behalf. ✨

Washington update ...continued from page 9

have reviewed the issue as it pertains to other non-physician providers, GAO expanded the scope of its inquiry and developed payment policy recommendations with implications extending far beyond the issue at hand. Briefly, the GAO concluded that hospitals are already being paid to provide whatever assistant at surgery services may be required for an operation – whether by a physician or by

non-physician staff. Consequently, it is recommending that Part B payments no longer be made for these services.

Organizations representing surgical specialties and nurses had an opportunity to review and comment on a draft of this report in early December, but were unable to persuade GAO to revise its findings. American Medical Association staff has plans underway

to reconvene a coalition that has addressed this effort before. Contacts and educational efforts will be directed toward the congressional committees that received the report to preempt any plans to introduce legislation that would permit the policy changes recommended by GAO. ✨

ASCRS unveils updated Website at www.fascrs.org

An updated look, more useful features and a new “Members Only” section are just a few of the improvements members will see on the newly revamped ASCRS Website. Log onto www.fascrs.org to view the new site.

The redesigned Website improves the Society’s ability to post timely important information quickly. It reorganizes information in clear, concise fashion with three different target audiences in mind: surgeons, patients and media professionals.

Click on the “Professionals” link and access inherited colorectal cancer registries, Core Subjects, CARSEP and Practice Parameters. The **Members Only** sub-section includes contact information for ASCRS members, the ability to update membership directory profiles, the Society’s Strategic Plan, and access to **full-text** articles appearing in *Diseases of the Colon and Rectum*.



A section dedicated to the public is available through the “Patients and Consumers” link. Visitors to the Website may access online brochures detailing colorectal disease symptoms and treatments, take a test to assess one’s risk for colorectal cancer and locate a colorectal surgeon.

A new “Media” section posts authoritative information for the press about colorectal disease and treatments. This virtual press room is divided into four categories: press releases, physician spokesperson bios, patient success stories and tip sheets.

The Website also features online registration for the Dallas Annual Meeting, Webcast of the 2003 Annual Meeting in New

Orleans, past and present Annual Meeting programs, information on Research Foundation grants, a job bank, residency programs and regional societies. ✨

Society website offers materials to promote March as Colorectal Cancer Awareness Month

March 2004 will mark the fifth year of official activities for Colorectal Cancer Awareness Month. To coincide with the event, ASCRS makes available an electronic folder of media relations and promotional materials for members designed to complement national and local efforts taking place during the month.

Included are a customized press release containing timely news about colorectal cancer, a colorectal cancer fact sheet, screening guidelines, screening brochures for patients, background information, patient

success stories, and other information. These materials are available for download from the Society’s Website at www.fascrs.org.

As in years past, several members of the Society’s Public Relations Committee and other members at large have participated in the Cancer Research Foundation of America (CRFA) symposium in March.

The ASCRS Website will again feature a section dedicated to Colorectal Cancer Awareness Month. It offers information for patients, the media and member physicians.

The response to previous years’ information has been extremely positive, prompting physicians from many areas to promote the importance of early screening and treatment.

All ASCRS members are encouraged to log on and see what is available for use in their own colorectal cancer awareness efforts. Members of the Society’s Public Relations Committee are available to help members in developing their own awareness programs. ✨

International Scholar, British Traveling Fellow speak

The Society’s International Scholarship winner is Dr. **Carlos M. Parellada**, Guatemala City, Guatemala. He will speak Thursday, May 13, on the topic, “Is It Possible to Do Research in a Third Developing Country? The Guatemalan Case.”

Mr. **Dermot Burke**, Leeds, West Yorkshire, UK, will give the British Traveling Fellow Presentation, “Radiologically Guided Multidisciplinary Management of Rectal Cancer.” ✨

How to do a Cochrane Review

By Dr. Richard L. Nelson, U.S. Editor, The Cochrane Colorectal Cancer Group

The process of doing a Cochrane Review has been a bit of an intimidating mystery to many ASCRS members. My purpose in this article is to unravel some of the mystery. A Cochrane Review is somewhat different from either chart reviews or lab work members may have done in the past.



Dr. Richard Nelson

There is a rigid protocol that at first seems tedious, but its usefulness quickly becomes apparent.

Follow this 5-step process:

1. Think of a problem in your clinical practice. Or maybe a bit of dogma that you want to question. Or a common practice, the supporting data for which you never had time to look up or analyze. Some obvious examples recently published by the Cochrane Library are:
 - Mechanical Bowel Preps,
 - Colostomy for penetrating colon trauma.Or need to be reviewed, such as
 - Colostomy and presacral drainage for rectal trauma,
 - Fistulotomy versus fistulectomy.
2. Straight away you can contact Cochrane and register the title: you only need to give your contact information and a short rationale for doing the review. I would recommend doing a little homework first and seeing if there are any good clinical trials in this field that would provide the fuel for your systematic review. For example, I don't know of any randomized trials (RCTs) of colostomy and presacral drainage for rectal trauma (compared to 6 RCTs of colostomy versus primary repair in abdominal colon trauma). There are Cochrane Reviews on topics wherein there are no RCTs, but these seem a bit pointless to me, when there are lots of other topics to choose wherein the published evidence is adequate.

Once you have the title, you own it. No one else can take it, while you keep moving. You don't have to keep looking over your shoulder to see if you are going to get scooped.

3. Next, you must submit a protocol. The Cochrane software provides the following outline for reviews:

Background Objectives
Criteria for considering studies for this review

- Types of studies
- Types of participants
- Types of interventions
- Types of outcome measures
- Search strategy for identification of studies – Boy is this important: how thorough will your look be?
- Methods of the review
- Description of studies
- Methodological quality of included studies
- Results
- Discussion
- Reviewers' conclusions
- Implications for practice
- Implications for research
- Acknowledgments
- Potential conflict of interest

It sounds tedious, but it is really very simple. It is simply the Introduction and Methods section of the paper you will write. In the Background section, you must present a beefed up rationale for doing this review. The Methods section is so similar from review to review, it surprises me that Cochrane doesn't distribute a fleshed out template. For the protocol, you go down to, but not through, "Description of Studies."

The really important part of this process – and the principal way Cochrane Reviews differ from traditional review papers – is that all your criteria for study selection and analysis are established in advance. This process minimizes bias in study selection.

4. Once the protocol is submitted, the editorial office assigns referees to your title, who are a little like the editors that review your manuscript in a professional journal, except that these referees play a much more active role in assisting you with the review, suggesting improvements even before you get to the next step. Their job is constructive rather than restrictive. You should hear back from them within a few months, when you can get on with the data abstraction and analysis of the papers in your review.

It is a very good idea to develop a data abstraction form that is as detailed as possible at this time. Your editorial office will have several from previous reviews that you may want look at. A good form will be a huge time saver as the review progresses. Once you have your referees' comments, you modify your protocol, resubmit it, and if all looks well, get on with the review.

5. In this step, you identify studies, read them carefully, re-read them, and then abstract data for analysis. You will find that the most interesting and important parts of clinical publications in this process are the Methods and Results – sections one tends to ignore in one's normal reading of papers. Introductions get repetitive and Discussions are for the most part badly written, poorly review what else has been published in the field, and frequently arrive at conclusions that differ markedly from their data analyzes. It's the data that really count, and how they were collected.

Once the data are collected and entered into Revman (Cochrane's software), and it all starts to look very complicated, just a click of one button and magically all the analyzes are done and beautiful box and whisker plots appear with the summary statistics of your systematic review. Now you have to write the remaining review sections, with

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Two new practice parameters ready for publication

The Society's Standards Committee has prepared two new practice parameters for publication. They cover Surveillance and Follow-up of Patients with Colorectal Cancer, bringing to 15 the number of approved parameters in colon and rectal surgery.

Most of the work developing the latest parameters was completed under the leadership of former Committee Chair Dr. **Clifford L. Simmang**, Dallas, TX, says current Chair Dr. **Neil H. Hyman**, South Burlington, VT. The new parameters will be published in *Diseases of the Colon & Rectum* and posted on the Society's Website, www.fascrs.org.

"As the Committee's emphasis has shifted from consensus-driven to evidence-based guidelines, we are reviewing each of the approved parameters. We plan to update all parameters every six years," Dr. Hyman says.

For the coming year, the 27-member Committee plans to update four practice parameters: Treatment of Hemorrhoids, Fistula-in-Ano, Management of Anal Fissure, and Ulcerative Colitis – Supporting Documentation.

"Some older documents are consensus-driven," Dr. Hyman said. "We are going into the scientific literature,

reviewing all relevant papers that address the topic and assessing the strength of the evidence supporting the recommended approach."

The Society develops practice parameters to give physicians a ready point of reference, documenting a rational, evidence-based approach. "They are not meant to be prescriptive, but simply guidelines for care," Dr. Hyman stresses. Many physicians consult a practice parameter as a review article. Insurance companies may also look at ASCRS practice parameters to decide whether they should cover a particular treatment. ✨

Virtual EGFR Symposium featured on ASCRS Website

A virtual symposium, "Epidermal Growth Factor Receptor: Its Implications for the Colorectal Surgeon," will be accessible on the ASCRS Website, www.fascrs.org, through March 2005.

The goal of the symposium is to raise awareness among colorectal surgeons of the importance of the epidermal growth factor receptor (EGFR). The EGFR will play an increasing role in the adjuvant treatment of patients who have colorectal cancer.

Topics covered in the EGFR symposium include:

- *Epidermal Growth Factor Receptor Inhibitors: Mechanisms and Rationale as a Clinical Target*, **Roger B. Cohen**, M.D., Fox Chase Cancer Center;

- *Implications for Cancer Treatment*, **Leonard Saltz**, M.D., Memorial Sloan-Kettering Cancer Center;
- *Epidermal Growth Factor Receptor: Implications for the Colorectal Surgeon*, **Ronald Bleday**, M.D., Brigham and Women's Hospital;
- *Need for Testing Epidermal Growth Factor Receptor (EGFR, *erb1*) Status*, **Kenneth J. Bloom**, M.D., US Laboratories.

The online EGFR symposium features streaming audio/video and includes the speakers' slide presentations.

The symposium is offered on a complimentary basis, supported by an educational grant from **ImClone Systems/Bristol-Myers Squibb**. ✨

Core Subjects Update tracks developments in six critical areas

The 2004 Update on Core Subjects will give surgeons a comprehensive overview of the latest developments in six critical areas of colorectal care, Sunday, May 9, at the ASCRS Annual Meeting in Dallas.



Dr. Elisa Birnbaum

Course Director Dr. **Elisa Birnbaum**, St. Louis, MO, said the program will help colorectal surgeons stay abreast of important treatment advances by presenting the latest in research findings.

The 2004 Core Subjects and their presenters are:

- *Colitis*, Dr. **W. Donald Buie**, Calgary, AB, Canada;
- *Endoscopy*, Dr. **David A. Margolin**, New Orleans, LA;
- *Fistula/Abcess*, Dr. **Christopher R. Mantyh**, Durham, NC;
- *Rectal Prolapse*, Dr. **Najjia N. Mahmoud**, Philadelphia, PA;
- *Gynecology for the Colorectal Surgeon*, Dr. **Susan C. Parker**, Minneapolis, MN;

- *Adjuvant Treatment of Colorectal Cancer*, Dr. **Lisa S. Poritz**, Hershey, PA.

The American Board of Colon and Rectal Surgery (ABCRS) developed the Core Subject Update with ASCRS to foster continuing education and help prepare surgeons to maintain certification. Core Subjects and the ASCRS/CARSEP program are recommended study materials for this process. Questions developed from material presented at this meeting are included in the Board's recertification data bank. ✨

DC&R attracts record number of manuscripts

By Victor W. Fazio, MD, Editor-in-Chief, Diseases of the Colon & Rectum

The Journal has had another successful year. *DC&R* received a record number of manuscripts in 2003 – an increase of almost 15% over the previous year – and the Journal's Impact Factor hit an all time high, 2.302. Impact Factor is a measure of quality based on total number of citations and articles published.

The Journal has a new “look” with a different cover and a new interior layout reflecting the transition to our new publishers, Springer-Verlag, New York. Their proposals for *DC&R* included some exciting new features, which include online publishing of articles ahead of print (Online First™), online manuscript submission and editorial review, as well as multimedia/video online publications.

The potential for viewing procedures and techniques through “streaming videos” clearly reflects the next wave of information delivery to our subscribers. Shortly, *DC&R* will offer three kinds of Multimedia Content: Original articles and reviews, where the video is the article, with abstracts and references available in HTML format for citation; Technical Notes and Brief Communications, which will be complete articles of two to three minutes duration; and Dynamic Manuscripts.

Dynamic Manuscripts become reality

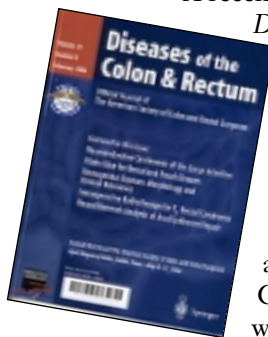
Dynamic Manuscripts are articles published in the Journal's print version, with illustrations that one can view as videos

(for example, the procedure being illustrated) via the online edition. It is anticipated that this will become reality by mid-year. It promises to add significant value to the Journal.

A recent readership survey shows the high regard in which *DC&R* is held – an overwhelming majority citing the Journal as a “must read” and the essential journal for those interested in the surgery of the large intestine and its diseases. This past year saw the third supplement published from members of the Japan Society of Coloproctology.

We have expanded our subscriber base with an agreement reached with Società Italiana Unitaria di Coloproctologia (SIUCP) where their membership will receive *DC&R*. Newly appointed Editorial Board members include Drs. **Marcus Burnstein, Leonard L. Gunderson, Kirk A. Ludwig, Robin K. S. Phillips, Thomas E. Read, Miguel A. Rodriguez-Bigas, and Michael J. Solomon.**

We are grateful to those stalwarts rotating off the Editorial Board, **Theodore J. Saclarides** and **Bruce G. Wolff**, who have given so much of their time and expertise in ensuring the Journal's success. And, of course, we cannot forget to thank continuing members of the Editorial Board for helping to make our journal what it is. Finally, we thank all of our outside reviewers and abstract reviewers for their dedication, skill and time in providing high quality reviews. ✨



How to do a Cochrane Review ...continued from page 13

a real focus on the Methodological Quality section. How were patients randomized? Were observers blinded? Did they analyze “as treated” rather than maintaining the randomization? Were there lots of drop-outs? Did they use the correct statistical test? (Many don't.) Are you worried about being left alone at this time? (Don't be.) There's lots of help, including statistical consultants, to assist you anytime. Then, send in your completed review, wait for referees' comments again, modify the manuscript, and send it in again.

Other issues

They conduct workshops frequently throughout the world to teach you much more about this process. The Cochrane Website is where to start to look for dates and places (www.cochrane.org). The American

Cochrane Center just got a great grant to conduct workshops in the U.S. over the next several years.

You can submit your review to a medical journal, too. Cochrane has dual publication agreements with over 300 journals, including *DC&R*, *JAMA*, *BMJ*, *Brit. J Surg.*

The Cochrane software, Revman, puts the review in the final format in which they will publish it in the Cochrane Library. It is a bit tedious to learn the few foibles it has about data entry and analysis. It is also a word processor. Some editorial groups let you work in Word up through the initial protocol stages, but you have to end up in Revman. It can be downloaded free from the Cochrane Website. Don't do it alone. Help exists, and you must use it.

There are many editorial groups to

which you can submit a review topic. I have worked with the Colorectal, Wounds, Injuries, Incontinence, Breast, and Inflammatory Bowel Disease Groups. They are all very welcoming and will bend over backwards to help you with your review.

Go to Cochrane meetings. They are a fun-loving, diverse group. I was initially a bit reluctant to get involved with this group. Their work seemed very derivative. Nevertheless, they have taught me a great deal, and the work I have done with them is the most satisfying research I have ever done. You may think that previously published research is perfect and complete. However, it's amazing how much you can improve others' work by reanalyzing their data and doing a combined analysis. The product, if carefully constructed, comes as close to the truth in medicine as you can get. ✨

STOP launches fire department screening drive; promotes new colorectal cancer symbol

The STOP Colon/Rectal Cancer Foundation is developing a new colorectal cancer screening initiative with



Dr. Ernestine Hambrick

the Chicago Fire Department that will parallel its successful Chicago Police Department effort and provide a national model for fire department screening, Chair

Dr. Ernestine

Hambrick, Chicago, announced.

The drive to screen Chicago's 4,600 firefighters started after Steve Aravanis, a Montgomery County, MD, paramedic, died of colorectal cancer without ever having been tested for the disease. STOP is considering a similar screening initiative for hospital employees.

Dr. Hambrick reports that more people in audiences she addresses today have been screened than ever before, but "still more than 60% are not being screened, and that has to change."

STOP is one of over 50 groups nationwide planning to use a new universal symbol to promote colorectal cancer when it is officially unveiled March 1, as part of the kickoff of National Colorectal Cancer Awareness Month. The National Colorectal Cancer Roundtable has commissioned the symbol (www.nccrt.org), whose mission is to advance colorectal cancer

awareness and control efforts by improving communication, coordination, and collaboration among health agencies, medical-professional organizations, and the public.

"Much as the red ribbon has come to signify AIDS awareness and the pink ribbon breast cancer awareness, the NCCRT hopes the new symbol will speak universally about the collective effort of the colorectal cancer community's concern about preventing the nation's number 2 cancer killer," says Dr. **Bernard Levin**, NCCRT Chair.

Supporting groups will use the symbol in Websites, printed materials, brochures, business cards, letterhead, and other communications.

"We applaud STOP for joining our efforts to signal the unity of the colorectal cancer community, our common desire to stop the nation's second-leading cause of cancer deaths for men and women, and create a symbol which reminds people to get screened and prevent colorectal cancer," says Dr. Levin.

STOP is reprinting its brochure, "The Cancer Nobody Has to Have & How to Stop It," now available in English and Portuguese. A Spanish translation of the brochure was recently completed.

STOP has distributed more than

400,000 of its brochures to physicians, individuals, organizations and corporations. They have been used in a variety of locations, events, health fairs, and meetings across the U.S., in recent meetings in Singapore and Brazil, and many other foreign countries.



"Besides regular screening tests, a healthy diet and lifestyle are very important in colon and rectal cancer prevention," Dr. Hambrick says. "After not smoking, staying lean and active provides the greatest potential for minimizing general cancer risk."

Information about STOP's interactive teaching program in colorectal cancer prevention for primary care physicians, developed with the Department of Medical Education at the University of Illinois, is available online at www.cme-online.org.

Dr. Hambrick said the Foundation still depends on individual contributions, large and small, to accomplish STOP's mission: to eradicate colorectal cancer through education directed toward preventive screening, early detection and healthy lifestyle choices.

Further information about STOP's activities may be found on its Website, www.coloncancerprevention.org. Donations may be sent to the STOP Colon/Rectal Cancer Foundation, 30 N. Michigan Ave. #1118, Chicago 60602. *

Society's National Media Awards recognize excellence in journalism

Now in its 10th year, the ASCRS National Media Awards program encourages and honors journalists who excel in communicating information about colon and rectal diseases to the public.

This year, ASCRS will present two \$1,000 cash awards and engraved plaques to winners in two major media categories: print (newspaper and general interest magazine); and broadcast (television and radio). Winners of this year's competition will receive an expense-paid trip to Dallas, TX, for an awards presentation during the Society's 2004 Annual Meeting, May 8 - 13.

Entries for the 2004 competition were due February 16. They are being judged by media professionals from Northwestern University's Medill School of Journalism and ASCRS Public Relations Committee members, who will evaluate them based on writing quality, excellence in production, research, accuracy, message impact and originality.

Key to the program's continued success is ASCRS member involvement. Surgeons who know of journalists that deserve recognition may encourage them to submit an entry for next year's competition or submit one on their behalf. Brochures detailing the program are available by calling ASCRS Public Relations at 847/934-5580. To request a form via e-mail, contact bragawpr@compuserve.com. *