The Myriad myRisk® Hereditary Cancer Panel
Analyzes Several Genes Associated with Hereditary Colorectal Cancer:

Myriad myRisk® provides actionable information and clear direction for patients with colorectal cancer.

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Booth #233 or www.MyriadPro.com

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PROVIDER SUPPORT

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Welcome
to the
AMERICAN SOCIETY OF COLON AND RECTAL SURGEONS
ANNUAL SCIENTIFIC MEETING
LOS ANGELES, CALIFORNIA
APRIL 30–MAY 4, 2016
Los Angeles Convention Center
The American Society of Colon and Rectal Surgeons recognizes the indispensable role that health care companies play in helping the Society maintain its focus on colorectal surgery and enhance the care its members provide to patients. ASCRS thanks the following companies for their generous support of this year’s Annual Scientific Meeting.

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASCRS Executive Council</td>
<td>6</td>
</tr>
<tr>
<td>Program Committee</td>
<td>6</td>
</tr>
<tr>
<td>Education Information</td>
<td>7</td>
</tr>
<tr>
<td>Online Evaluation</td>
<td>8</td>
</tr>
<tr>
<td>Maintenance of Certification</td>
<td>9</td>
</tr>
<tr>
<td>General Information</td>
<td>10</td>
</tr>
<tr>
<td>Annual Named Lectures</td>
<td>13</td>
</tr>
<tr>
<td>Masters in Colorectal Surgery</td>
<td>14</td>
</tr>
<tr>
<td>Awards</td>
<td>15</td>
</tr>
<tr>
<td>Non-CME Corporate Forums</td>
<td>16</td>
</tr>
<tr>
<td>Thanks to Our Corporate Supporters</td>
<td>17</td>
</tr>
<tr>
<td>Research Foundation of the ASCRS</td>
<td>19</td>
</tr>
<tr>
<td>On-Going Video Display</td>
<td>20</td>
</tr>
<tr>
<td>Daily Schedule</td>
<td>22</td>
</tr>
<tr>
<td>Schedule-at-a-Glance</td>
<td>28</td>
</tr>
<tr>
<td>Committee Meetings</td>
<td>32</td>
</tr>
<tr>
<td>Past Presidents</td>
<td>33</td>
</tr>
<tr>
<td>Saturday Program</td>
<td></td>
</tr>
<tr>
<td><em>Workshop: Transanal Endoscopic Surgery</em></td>
<td>34</td>
</tr>
<tr>
<td><em>Symposium and Workshop: Laparoscopic Colectomy</em></td>
<td>36</td>
</tr>
<tr>
<td><em>Symposium and Workshop: Emerging Therapies in Fecal Incontinence</em></td>
<td>38</td>
</tr>
<tr>
<td><em>Workshop: Robotic Colon and Rectal Surgery: Tips, Tricks, and Simulation for the Novice Surgeon</em></td>
<td>38</td>
</tr>
<tr>
<td><em>Symposium and Workshop: Ventral Rectopexy: An International Perspective</em></td>
<td>42</td>
</tr>
<tr>
<td><em>Workshop: AIN and HRA: What the Colorectal Surgeon Needs to Know</em></td>
<td>45</td>
</tr>
<tr>
<td>*Workshop: Young Surgeons Mock Orals: “Your Turn in the Hot Seat”</td>
<td>47</td>
</tr>
<tr>
<td><em>Symposium: Research</em></td>
<td>48</td>
</tr>
<tr>
<td><em>Symposium: Question Writing: The Perfect Written Exam Question; Do You Know How to Write One?</em></td>
<td>49</td>
</tr>
<tr>
<td><em>Workshop: Robotic Colon and Rectal Surgery: Tips, Tricks, with Simulation for the Experienced Surgeon</em></td>
<td>50</td>
</tr>
<tr>
<td><em>Symposium: Managing Complications</em></td>
<td>51</td>
</tr>
<tr>
<td><em>Symposium: Health Care Policy/Reform 2016 and Beyond: A Round Table Discussion</em></td>
<td>52</td>
</tr>
<tr>
<td><em>Symposium: Translational Medicine: How Genetics Drive Patient Care in Your Colorectal Practice</em></td>
<td>53</td>
</tr>
<tr>
<td><em>Symposium: Advanced Endoscopy and Endoluminal Surgery</em></td>
<td>54</td>
</tr>
<tr>
<td><em>Symposium: Transanal Total Mesorectal Excision (taTME)</em></td>
<td>55</td>
</tr>
<tr>
<td>Sunday Program</td>
<td></td>
</tr>
<tr>
<td><em>Symposium: Robotic Colon and Rectal Surgery: Tips, Tricks, and Simulation</em></td>
<td>57</td>
</tr>
<tr>
<td>Core Subject Update</td>
<td>58</td>
</tr>
<tr>
<td><em>Workshop: Transanal Total Mesorectal Excision (taTME) Hands-on Course</em></td>
<td>59</td>
</tr>
<tr>
<td><em>Symposium: Stomas and Complex Abdominal Wall Problems for the Colorectal Surgeon</em></td>
<td>61</td>
</tr>
<tr>
<td><em>Symposium: Laparoscopic Nuts and Bolts and Robotic Rivets</em></td>
<td>62</td>
</tr>
<tr>
<td><em>Symposium: Anal Cancer</em></td>
<td>63</td>
</tr>
<tr>
<td><em>Luncheon Symposium: Effective Quality Improvement in Diverse Settings</em></td>
<td>64</td>
</tr>
<tr>
<td>Luncheon Symposium: Social Media: Basics and Beyond – What’s in It for Me?</td>
<td>65</td>
</tr>
<tr>
<td>Welcome and Opening Announcements: How ASCRS Helps You.</td>
<td>66</td>
</tr>
<tr>
<td>Norman D. Nigro, MD, Research Lectureship</td>
<td>66</td>
</tr>
<tr>
<td>Abstract Session: Perioperative Outcomes.</td>
<td>67</td>
</tr>
<tr>
<td>Symposium: Colon and Rectal Surgery Training and Beyond: Education for Colorectal Residents and Colorectal Surgeons.</td>
<td>69</td>
</tr>
<tr>
<td>Symposium: Comprehensive Management of Colon Cancer: An Interactive Forum.</td>
<td>70</td>
</tr>
<tr>
<td>Abstract Session: Benign Anorectal/Pelvic Floor I</td>
<td>71</td>
</tr>
<tr>
<td>Symposium: Crohn’s Disease</td>
<td>73</td>
</tr>
<tr>
<td>Symposium: International Colorectal Surgery: Perspectives from Latin America.</td>
<td>74</td>
</tr>
<tr>
<td>After Hours Debate.</td>
<td>75</td>
</tr>
<tr>
<td>Welcome Reception</td>
<td>75</td>
</tr>
</tbody>
</table>

**Monday Program**

Meet the Professor Breakfasts | 76
Residents’ Breakfast | 76
Symposium: Beyond the OR. | 77
Symposium: Current Management of Diverticulitis. | 79
Abstract Session: Basic Science. | 80
Memorial Lectureship Honoring Victor W. Fazio, MD. | 81
Presidential Address. | 81
Symposium: Rectal Cancer One: The Trials of Rectal Cancer. | 82
Abstract Session: Benign Colon. | 83
Abstract Session: Neoplasia I | 84
Symposium: Familial Feud: Generation X vs. Generation Z. | 86
Harry E. Bacon, MD, Lectureship. | 87
Symposium: New Technologies. | 88
Residents’ Reception. | 89

**Tuesday Program**

Meet the Professor Breakfasts | 90
Symposium: Building a Successful Research Program | 91
ASCRS/SSAT Symposium: Update on Inflammatory Bowel Disease/Ulcerative Colitis | 92
Symposium: Fecal Incontinence | 93
Abstract Session: Neoplasia II. | 94
Abstract Session: General Surgery Forum | 96
Masters in Colorectal Surgery Lectureship Honoring Robert Beart, Jr., MD. | 97
Women in Colorectal Surgery Luncheon | 97
Symposium: Young Surgeons Symposium: Board Certification and Beyond | 98
Abstract Session: Inflammatory Bowel Disease | 99
Symposium: The American College of Surgeons Commission on Cancer National Accreditation Program for Rectal Cancer: Why, How and When. | 101
Symposium: Stage IV Colorectal Cancer | 102
The presentations, slides, and handouts provided in this program are the property of The American Society of Colon and Rectal Surgeons. Attendees may not photograph, videotape, audiotape or otherwise record or reproduce any of the presentations without express written permission from ASCRS. Any attendee believed to be violating this restriction will be removed from the session and may be prohibited from participating in further ASCRS events.
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PROGRAM COMMITTEE

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Program Chair

Joshua Bleier, MD
Program Vice-Chair

Scott Steele, MD
Program Vice-Chair

Thomas Read, MD
Council Representative

Disclosures of Executive Council and Program Committee are listed on pages 161-167
Annual Scientific Meeting Goals, Purpose and Learning Objectives

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

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

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

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

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

Target Audience

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

Accreditation

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

Continuing Medical Education Credit

The American Society of Colon and Rectal Surgeons (ASCRS) designates this live activity for a maximum of 48 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Attendees can earn 1 CME Credit hour for every 60 minutes of educational time.

Successful Completion: Participants must be registered for the conference and attend the session(s). Each participant will receive a username and password for completion of the evaluations for the ASCRS 2016 Annual Scientific Meeting; participants must complete an online evaluation form for each session they attend to receive credit hours. There are no prerequisites unless otherwise indicated. ASCRS requests that attendees complete the online evaluations by July 31, 2016.

Self-Assessment (MOC) Credit

Many of the sessions offered will be designated as self-assessment MOC credit, applicable to Part 2 of the ABCRS MOC program. In order to claim self-assessment credit, attendees must participate in a post-test. Information/instructions will be sent to all meeting registrants prior to the Annual Scientific Meeting.

ASCRS Mission

The American Society of Colon and Rectal Surgeons is an association of over 3,000 surgeons and other health care professionals dedicated to assuring high quality patient care by advancing the science through research and education for prevention and management of disorders of the colon, rectum and anus.

Disclaimer

The primary purpose of the ASCRS Annual Meeting is educational. Information, as well as technologies, products and/or services discussed, are intended to inform participants about the knowledge, techniques and experiences of specialists who are willing to share such information with colleagues. A diversity of professional opinions exist in the specialty and the views of the American Society of Colon and Rectal Surgeons disclaims any and all liability for damages to any individual attending this conference and for all claims which may result from the use of information, technologies, products and/or services discussed at the conference.
Disclosures and Conflict of Interest
In compliance with the standards of the Accreditation Council for Continuing Medical Education and the ASCRS, faculty has been requested to complete a Disclosure of Financial Relationships. Disclosures will be made from the podium at the time of presentation, as well as included in the Program Book and mobile app. All perceived conflicts of interest will be resolved prior to presentation; and, if not resolved, the presentation will be denied.

Educational Grant Commercial Supporters
This activity is supported by independent educational grants from:
- Acelity (KCI, LifeCell, Systagenix)
- Applied Medical
- Cook Medical
- Ethicon US, LLC
- Intuitive Surgical, Inc.
- KARL STORZ Endoscopy-America, Inc.
- Mallinckrodt Pharmaceuticals
- Medtronic
- Merck & Co., Inc.
- Myriad Genetics
- Olympus America Inc.
- Richard Wolf Medical Instruments Corporation
- Stryker Endoscopy
- Torax Medical, Inc.

This activity is also supported by the following companies through an independent educational grant consisting of loaned durable equipment and disposable supplies.
- Applied Medical
- CONMED
- Cook Medical
- CooperSurgical
- Ethicon US, LLC
- Intuitive Surgical, Inc.
- KARL STORZ Endoscopy-America, Inc.
- Medtronic
- Olympus America Inc.
- Redfield Corporation
- Richard Wolf Medical Instruments Corporation
- Seiler Instrument & Manufacturing Co, Inc.
- Stryker Endoscopy
- Zinnanti Surgical Design Group Inc.

Online Evaluation
ASCRS will again use a convenient online evaluation for the 2016 Annual Meeting. This system will allow you to complete evaluations online for all the certified CME sessions you attend.

Online access: http://www.pswebsurvey.com/ASCRS
You will be asked to enter your Last Name and ID Number in order to complete the evaluations. Your ID Number is located on your Registration Card and Badge.
Online evaluations are requested to be completed by July 31, 2016 and must be completed by December 31, 2016

SELF-ASSESSMENT (MOC) CREDIT
Maintenance of Certification (MOC) Self-Assessment
This year, portions of the Annual Meeting will be available for MOC/Self-Assessment Credit.
These selected sessions are identified in this Program as “SELF-ASSESSMENT (MOC) CREDIT”.
Following the session, attendees will be able to take an online post-session test that must be completed and passed with a minimum score of 75% in order to receive Self-Assessment (MOC) Credit. If for some reason you do not pass the test, you will receive the regular CME credit for the sessions you attend.
Tests must be taken by July 31, 2016.
The 2016 scientific offerings assist the physician with the six core competencies first adopted by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties. Attendees are encouraged to select areas of interest from the program which will enhance their knowledge and improve the quality of patient care.

1. **Patient Care and Procedural Skills** – Provide care that is compassionate, appropriate and effective treatment for health problems and to promote health.

2. **Medical Knowledge** – Demonstrate knowledge about established and evolving biomedical, clinical and cognate sciences and their application in patient care.

3. **Interpersonal and Communication Skills** – Demonstrate skills that result in effective information exchange and teaming with patients, their families and professional associates (e.g. fostering a therapeutic relationship that is ethically sound, uses effective listening skills with non-verbal and verbal communication; working as both a team member and at times as a leader).

4. **Professionalism** – Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to diverse patient populations.

5. **Systems-based Practice** – Demonstrate awareness of and responsibility to larger context and systems of healthcare. Be able to call on system resources to provide optimal care (e.g. coordinating care across sites or serving as the primary case manager when care involves multiple specialties, professions or sites).

6. **Practice-based Learning and Improvement** – Able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence and improve their practice of medicine.

The ASCRS assists the American Board of Colon and Rectal Surgery with a 4-part process for continuous learning:

**Part I – Professional Standing (Every 3 years)**
- A valid, full and unrestricted medical license.
- Hospital privileges in the specialty, if clinically active.
- Chief of Staff Evaluation – contact information for the chief of surgery and chair of credentials at the institution where most work is performed.

**Part II – Lifelong Learning and Self-Assessment (Every 3 years)**
- Continuing medical education (CME) – completion of at least 90 hours of Category I CME relevant to the physician’s practice over a three-year cycle.
- Completion of Self-assessment: Over a 3-year cycle, 50 of the 90 Category I CME must include a self-assessment activity – a written or electronic question-and-answer exercise that assesses the physician’s understanding of the material presented in the CME program.
- CARSEP or SESAP are suggested; however, any approved CME credit that provides self-assessment greater that 75% or passing score (including CME components for MOC) will be accepted for Part II.

**Part III – Cognitive Expertise (Every 10 years)**
- Successful completion of a secure recertification examination, which may be taken three years prior to certificate expiration. A full exam application is required. All MOC requirements must be fulfilled up to this point to apply.

**Part IV – Evaluation of Performance in Practice (Every 3 years)**
- Communications and interpersonal skills
- Ongoing participation in a national, regional or local outcomes registry or quality assessment program (such as SCIP, ACS NSQIP®, SQIP or the ACS case log system).
Abstracts

All abstract presentations are numbered and the complete abstracts are available on the ASCRS website, www.fascrs.org.

Annual Meeting Mobile App

Download the FREE mobile app to maximize your time at the Annual Meeting. Easily view the schedule, exhibitors, speakers, and more! This mobile app is available for all smartphones and tablet platforms – iPhone, Blackberry and Android.

Download the free ASCRS Mobile App by scanning one of the two QR Codes below:

iPhone or iPad
http://ativ.me.970

Android, or Blackberry
http://ativ.me.971

Badge Designations

Blue ................ Member/Fellow Physicians
Purple ............. Non-Member Physicians
Green .............. Nurses/Allied Health
Lime .............. Residents/CR Fellows
Orange ............ Non-Physicians
Red ............... Technical Exhibitors
Teal .............. Spouse/Companions
Rust ............... Press
Fuchsia .......... Staff
Gray ............. Meeting Technicians/Workers

Replacement badges – $10.00 each

Los Angeles Visitors Desk

A Los Angeles visitors desk will be available to all attendees to make restaurant reservations, assist with city information and provide maps and brochures. This booth is located in the West Lobby of the Los Angeles Convention Center and will be available during the following hours:

Saturday ............... 9:00 am – 5:00 pm
Sunday .................. 9:00 am – 5:00 pm
Monday .................. 9:00 am – 5:00 pm
Tuesday .................. 9:00 am – 5:00 pm
Wednesday .......... 9:00 am – 5:00 pm

Capturing of NPI Numbers

As part of the healthcare reform legislation, the Physician Payment Sunshine Act requires medical device, biologic, and drug companies to publicly disclose gifts and payments made to physicians, as of August 1, 2013.

To help our exhibitors and industry partners in fulfilling the mandatory reporting provisions of the Sunshine Act, ASCRS has requested U.S. healthcare provider attendees to supply their 10-digit NPI (National Provider Identifier) number when registering for the 2016 Annual Scientific Meeting. The NPI will be imbedded in the bar code data on the attendee’s badge. Exhibitors can download the NPI information by scanning the badge through a lead retrieval system so that they can record and track any reportable transactions. For more information on the capturing of the NPI number; please visit the ASCRS website.

Child Care Services

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

Dinner Dance Tickets

Full-paying members and fellows who requested a ticket for the Tuesday evening Dinner Dance will receive a voucher as part of their packet. This voucher must be exchanged for assigned table seating by noon, Monday.

Non-members and others who wish to purchase tickets may do so at the ASCRS Registration Desk. The cost is $125 per ticket. Please do so as early as possible in order to meet the ticket exchange deadline.

ePoster Displays

ePoster viewing stations are located in the Exhibit Hall and open during exhibit hours. All ePosters and ePosters of Distinction will be presented during scheduled breaks. See pages 121-152.

Authors of ePosters have been assigned a specific time frame to be at a designated monitor and available for questions.
Exhibit Hall
More than 70 technical and scientific exhibitors will display their products and services in West Hall A throughout the convention.

ASCRS appreciates the support of its exhibitors and urges all registrants to visit the displays.

Exhibit hours:
- Sunday .......................... 3:00 pm – 5:00 pm
- Monday .......................... 9:00 am – 4:30 pm
- Tuesday .......................... 9:00 am – 2:00 pm

First Aid Station
A first aid office is located by West Hall A and is available during the following hours:
- Saturday ....................... 6:00 am – 7:30 pm
- Sunday .......................... 6:00 am – 7:15 pm
- Monday .......................... 6:00 am – 6:30 pm
- Tuesday .......................... 6:00 am – 6:00 pm
- Wednesday .................... 6:00 am – 5:30 pm

Index of Participants
The names of all program speakers, with page numbers to indicate their scheduled appearances, are listed on pages 168-169.

Networking Goes Viral with #ASCRS16
Be a part of the Annual Meeting conversation! Use hashtag #ASCRS16 in your meeting-related tweets. Follow twitter.com/fascrs_updates or facebook.com/fascrs. Share Facebook posts about the meeting from facebook.com/fascrs.

New Members
New members of the ASCRS will be identified by a special ribbon affixed to their name badge. We encourage you to introduce yourself and make our new members welcome.

Photography/Video Recordings
By registering for this meeting, attendees acknowledge and agree that ASCRS or its agents may take photographs during events and may freely use those photographs in any media for ASCRS purposes, including but not limited to news and promotional purposes.

The presentations, slides, and handouts provided in this program are the property of ASCRS or used by permission. Meeting participants may not photograph, videotape, audiotape or otherwise record or reproduce any of the presentations without express written permission from ASCRS. Any attendee believed to be violating this restriction will be removed from the session and may be prohibited from participating in future ASCRS meetings.

Registration Desk Hours
The ASCRS Registration Desk will be located in the West Hall A Registration Area of the Los Angeles Convention Center.
- Saturday ....................... 6:30 am – 6:00 pm
- Sunday .......................... 6:30 am – 6:00 pm
- Monday .......................... 6:15 am – 4:30 pm
- Tuesday .......................... 6:15 am – 4:00 pm
- Wednesday .................... 6:15 am – 4:00 pm

Social Events
The ASCRS and the Research Foundation invite you to attend the Welcome Reception on Sunday from 7:30 – 9:00 pm in the Platinum Ballroom at the JW Marriott Hotel. This event is complimentary to all registered attendees. Enjoy hors d’oeuvres, refreshments and networking.

The Annual Dinner Dance is scheduled for Tuesday with the reception beginning at 7:00 pm and the dinner at 8:00 pm in the Platinum Ballroom at the JW Marriott Hotel. There is no additional cost for a ticket for full-paying Members and Fellows. The cost for others is $125 per ticket. Please remember to exchange your Dinner Dance voucher for a seat assignment no later than noon, Monday. This year’s event will feature a stand-up comedy routine from Full House star and comedian Dave Coulier, and an appearance from Big Bang Theory director Mark Cendrowski.
GENERAL INFORMATION

Speaker Ready Room
All presentations MUST be made using submitted PowerPoint or Keynote files. Please bring your presentation to the Speaker Ready Room at least EIGHT hours (preferably 24 hours) prior to the start of the session in which you are speaking. Presentations from laptops and iPads will NOT be permitted.

The Speaker Ready Room is located in Room 510 and is available to all program participants. Speakers are requested to take advantage of this opportunity prior to their presentation to review their slides.

Friday ...................... 3:00 pm – 6:00 pm
Saturday ...................... 6:00 am – 6:30 pm
Sunday ...................... 6:30 am – 6:30 pm
Monday ...................... 6:30 am – 6:30 pm
Tuesday ...................... 6:30 am – 6:00 pm
Wednesday .................. 6:30 am – 4:00 pm

Spouse/Companion Registration Options
If your spouse/companion is not yet registered for the meeting, we encourage them to register to be able to participate in the following events.

The spouse/companion pass does not allow for access into sessions.

Package #1 ($150) Includes:
  Welcome Reception, 7:30 – 9:00 pm, Sunday
  Annual Reception, 7:00 – 8:00 pm, Tuesday
  Annual Dinner Dance, 8:00 – 10:00 pm, Tuesday
  Admission to the exhibit floor

Package #2 ($75) Includes:
  Welcome Reception, 7:30 – 9:00 pm, Sunday
  Admission to the exhibit floor

Complimentary Wi-Fi Available
Free Wi-Fi is provided to all ASCRS attendees at the Los Angeles Convention Center. To access the free Wi-Fi simply:

• Open your wireless network connections
• Connect to the “ASCRS” wireless network
ANNUAL NAMED LECTURES

Norman D. Nigro, MD, Research Lectureship
Sunday, May 1, 1:30 – 2:15 pm
Room: West Hall B

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

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

Harry E. Bacon, MD, Lectureship
Monday, May 2, 4:15 – 5:00 pm
Room: West Hall B

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

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

Parviz Kamangar
Humanities in Surgery Lectureship
Tuesday, May 3, 3:45 – 4:30 pm
Room: West Hall B

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

Ernestine Hambrick, MD, Lectureship
Wednesday, May 4, 10:45 – 11:30 am
Room: West Hall B

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

Dr. Hambrick founded the STOP Foundation to promote screening and prevention of colon and rectal cancer. In addition, she has volunteered many hours working for the ASCRS including serving as Vice President.

Take Your Meeting Mobile
Target what you want to attend, learn and do at the ASCRS Annual Meeting with the ASCRS mobile app – the app is free and the options are endless!

View all the annual meeting info right at your fingertips:
- Schedule of events
- Exhibitor list and details
- Speakers, sponsors and more

Download the free app today and maximize your time at the meeting.
- To download a mobile version, scan one of the QR Codes on the right.
- For all other devices, go to http://ativ.me/972.
This lectureship has been established to honor a different senior surgeon each year who has made a considerable contribution to the specialty and the Society.

This year’s Masters in Colorectal Surgery lecture will take place on Tuesday, May 3, from 10:45 – 11:30 am, in West Hall B and will be presented by Heidi Nelson, MD.

This year Dr. Robert W. Beart, Jr., will be honored. Below are past honorees.

2016
Robert W. Beart, Jr., MD

2015
David J. Schoetz, Jr., MD

2014
Eugene P. Salvati, MD

2013
Victor W. Fazio, MD

2012
Herand Abcarian, MD

2011
Philip H. Gordon, MD

2010
Stanley M. Goldberg, MD
Colorectal Society Regional Awards

The following awards will be chosen at the 2016 Annual Meeting and announced at the Wednesday Business Meeting.

Each recipient will be given a plaque and a $500 cash award from the regional society sponsoring the award. Awards are given for the best basic science or clinical paper presented from the podium or as a poster.

- The Canadian Society of Colon & Rectal Surgeons Award (Surgical Resident)
- The Chicago Society of Colon & Rectal Surgeons Durand Smith, MD, Award (Basic Science/Podium)
- The Midwest Society of Colon and Rectal Surgeons William C. Bernstein, MD, Award (Basic Science/Poster)
- The New England Society of Colon and Rectal Surgeons Award (Clinical/Podium)
- The Northern California Society of Colon and Rectal Surgeons Award (Clinical/Podium)
- The Ohio Valley Society of Colon and Rectal Surgeons Award (Clinical/Podium)
- The Pennsylvania Society of Colon & Rectal Surgeons Award (Clinical/Poster)

ASCRS Award

- Best Paper Award
  The recipient of this award will attend the Annual Meeting of the European Society of Coloproctology in Milan, Italy, September 28-30, 2016.
- The ASCRS Barton Hoexter, MD Best Video Award

Call for Abstracts 2017 ASCRS Annual Meeting

Tripartite Meeting
June 10-14, 2017
Washington State Convention Center
Sheraton Seattle Hotel
Seattle, Washington

Online Submission Site Opens
July, 2016

Program Chair: Rocco Ricciardi, MD
Program Vice-Chair: Anjali Kumar, MD
Following the close of Saturday and Monday's scientific session, all registrants are invited to attend the special Corporate Forums at the JW Marriott Hotel.

Corporate Forums are non-CME promotional offerings organized by industry and designed to enhance your educational experience.

### Saturday, April 30

7:00 – 8:30 pm  
Platinum Ballroom Salon E (2nd Floor)  
JW Marriott Los Angeles L.A. LIVE  

*Supported by Olympus America Inc.*

**Managing Complex Colorectal Procedures Using 4K and 3D Advanced Imaging with Advanced Energy Technology**

**Presented by:**  
**Jeffrey Cohen, MD**  
Clinical Professor of Surgery; Hartford Hospital, Hartford, CT  
**Eric M. Haas, MD**  
Chief, Division of Colon and Rectal Surgery; Houston Methodist Hospital, Houston, TX  
**Patricia Sylla, MD**  
Assistant Professor Surgery, Colorectal Surgery; Mount Sinai Hospital, New York, NY

During this Non-CME Corporate Forum, attendees will gain insight on surgical approaches from experienced clinicians who will discuss the application of advanced Olympus technologies during complex colorectal procedures. Faculty will discuss how these advanced systems can enhance minimally invasive surgery, while giving participants the opportunity to ask questions about the latest surgical platforms.

Also, visit Olympus America Inc. at Booth #311.

### Monday, May 2

6:30 – 8:00 pm  
Platinum Ballroom Salon E (2nd Floor)  
JW Marriott Los Angeles L.A. LIVE  

*Supported by Mallinckrodt Pharmaceuticals*

**Is Your Perioperative Analgesia Protocol Up to Date?**

**Presented by:**  
**Mark Gilder, MD**  
Saint Barnabas Medical Center, West Orange, NJ

Discussion topics will include:  
- Enhanced Recovery After Surgery (ERAS)  
- Unmet needs in Acute Pain Management  
- Non-Opioids as a Foundation of Multimodal Analgesia

Also, visit Mallinckrodt Pharmaceuticals at Booth #432.
THANKS TO OUR CORPORATE SUPPORTERS

ASCRS is grateful to the following companies and organizations for their generous support of the following projects and programs this year:

**Acelity (KCI, LifeCell, Systagenix)**
Supporter of the Sunday Symposium on Stomas and Complex Abdominal Wall Problems for the Colorectal Surgeon… Smartphone Charging Stations**… and promotional e-Blasts**.

**Ambry Genetics**
Supporter of signage in the convention center**.

**Applied Medical**
Co-supporter of Saturday’s Workshop on Transanal Endoscopic Surgery*… the Saturday Workshop on Laparoscopic Colectomy*… the Sunday Transanal Total Mesorectal Excision (taTME) Hands-on Course*… partial support of Sunday’s Symposium on Laparoscopic Nuts and Bolts and Robotic Rivets… the Sunday Symposium on Colon and Rectal Surgery Training and Beyond: Education for Colorectal Residents and Colorectal Surgeons… the Tuesday Symposium on The American College of Surgeons Commission on Cancer National Accreditation Program for Rectal Cancer: Why, How and When… and in-kind support of Saturday’s Workshop on Ventral Rectopexy: An International Perspective*.

**CONMED**
In-kind support of Saturday’s Workshop on AIN and HRA: What the Colorectal Surgeon Needs to Know*.

**Cook Medical**
Co-supporter of Saturday’s Workshop on Ventral Rectopexy: An International Perspective*.

**CooperSurgical**
In-kind support of the Saturday Workshop on AIN and HRA: What the Colorectal Surgeon Needs to Know*… and Sunday's Transanal Total Mesorectal Excision (taTME) Hands-on Course*.

**Ethicon US, LLC**
Supporter of Tuesday’s Women in Colorectal Surgery Luncheon… co-supporter of Saturday’s Workshop on Laparoscopic Colectomy*… Saturday’s Workshop on Ventral Rectopexy: An International Perspective*… and promotional e-Blasts**.

**Intuitive Surgical, Inc.**
Supporter of Saturday’s Workshop on Robotic Colon and Rectal Surgery: Tips, Tricks, and Simulation for the Novice Surgeon*… Saturday's Workshop on Robotic Colon and Rectal Surgery: Tips, Tricks, and Simulation for the Experienced Surgeon*… Sunday’s Symposium on Robotic Colon and Rectal Surgery: Tips, Tricks, and Simulation… and co-supporter of Monday’s Symposium on New Technologies**.

**KARL STORZ Endoscopy-America, Inc.**
Co-supporter of Saturday’s Workshop on Transanal Endoscopic Surgery*… and Sunday’s Transanal Total Mesorectal Excision (taTME) Hands-on Course*.

**Mallinckrodt Pharmaceuticals**
Supporter of the Wednesday Symposium on ERAS Update… Pocket Program Guide**… promotional e-Blasts**… Non-CME Corporate Forum**… and an advertisement in the Convention Program Guide**.

**Medtronic**
Supporter of the Badge Lanyards**… Hotel Key Card**… co-supporter of Saturday’s Workshop on Transanal Endoscopic Surgery*… the Saturday Workshop on Laparoscopic Colectomy*… the Sunday Transanal Total Mesorectal Excision (taTME) Hands-on Course*… partial support of Saturday’s Symposium and Workshop on Emerging Therapies in Fecal Incontinence*… the Tuesday Symposium on Fecal Incontinence… and in-kind support of Saturday’s Workshop on Ventral Rectopexy: An International Perspective*.

**Merck & Co., Inc.**
Supporter of a Product Theater**… and partial support of the Meet the Professor Sessions.

**Myriad Genetics**
Supporter of the Saturday Symposium on Translational Medicine: How Genetics Drive Patient Care in Your Colorectal Practice… and an advertisement in the Convention Program Guide**.

*In-kind support
**Promotional support
THANKS TO OUR CORPORATE SUPPORTERS

ASCRS is grateful to the following companies and organizations for their generous support of the following projects and programs this year:

**NOVADAQ**
Supporter of a Product Theater**.

**Olympus America Inc.**
Supporter of a Non-CME Corporate Forum**… the Tuesday ASCRS Fellowship Reception… co-supporter of Saturday’s Workshop on Laparoscopic Colectomy*… the Sunday Transanal Total Mesorectal Excision (taTME) Hands-on Course*… and in-kind support of Saturday’s Workshop on Ventral Rectopexy: An International Perspective*.

**Redfield Corporation**
In-kind support of Saturday’s Workshop on AIN and HRA: What the Colorectal Surgeon Needs to Know*.

**Richard Wolf Medical Instruments Corporation**
Co-supporter of Saturday’s Workshop on Transanal Endoscopic Surgery*… the Sunday Transanal Total Mesorectal Excision (taTME) Hands-on Course*… and in-kind support of Saturday’s Workshop on Laparoscopic Colectomy*.

**Seiler Instrument & Manufacturing Co, Inc.**
In-kind support of Saturday’s Workshop on AIN and HRA: What the Colorectal Surgeon Needs to Know*.

**Shire**
General contribution in support of the Annual Scientific Meeting.

**Stryker Endoscopy**
Co-supporter of the Sunday Transanal Total Mesorectal Excision (taTME) Hands-on Course*… the Monday Symposium on New Technologies**… and in-kind support of Saturday’s Workshop on Transanal Endoscopic Surgery*.

**The Medicines Company**
Co-supporter of the Monday Symposium on New Technologies**.

**TransEnterix**
Co-supporter of the Monday Symposium on New Technologies**.

**Torax Medical, Inc.**
Supporter of a banner in the Convention Center**… and partial support of Saturday’s Symposium and Workshop on Emerging Therapies in Fecal Incontinence.

**Zinnanti Surgical Design Group Inc.**
In-kind support of Saturday’s Workshop on AIN and HRA: What the Colorectal Surgeon Needs to Know*.

*In-kind support
**Promotional support
The Research Foundation of the ASCRS appreciates the generous support of the following corporate and regional society partners who have contributed to the

2016 Meet the Challenge Fundraiser

GOLD SUPPORTER
Medtronic

SILVER SUPPORTER
Edwards Lifesciences

OUR REGIONAL SOCIETY SUPPORT
Canadian Society of Colon and Rectal Surgeons
Chesapeake Colorectal Society
Chicago Society of Colon and Rectal Surgeons
Midwest Society of Colon and Rectal Surgeons
New Jersey Society of Colon and Rectal Surgeons
Northern California Society of Colon and Rectal Surgeons
New York Society of Colon and Rectal Surgeons
Piedmont Society of Colon and Rectal Surgeons
Pennsylvania Society of Colon and Rectal Surgeons
Southern California Society of Colon and Rectal Surgeons

Our Meet the Challenge campaign provides grants and awards in support of research and training in the colorectal field. These Research Foundation of the ASCRS grants have realized improvements in our understanding and ability to diagnose and treat diseases and disorders such as colorectal cancer, polyps, inflammatory bowel disease and functional disorders. By funding these initiatives these partners are participating in the future of colon and rectal surgery and the advancement of the specialty.

Our supporters challenge you to Meet the Challenge by donating today!

Become a part of the future and advancement of the colon and rectal specialty!

Research Foundation Mentor Award 2016-2017

Thomas Read, MD
Established in 1992 by the Research Foundation of the ASCRS, the Mentor Award is conferred biannually in a joint decision by the Young Researcher’s Committee of the Research Foundation and by the Research Foundation Board of Trustees. This honor recognizes a member of the ASCRS who has made exceptional contributions to the education and career development of trainees and other colleagues through their commitment to both clinical and scholarly pursuits. This award recognizes that member of the ASCRS who has provided an example of success in his own career while also giving of his own time in furthering the career of younger colleagues.
ON-GOING VIDEO DISPLAY

The following videos will be available for viewing in Room S15B (Convention Center), Sunday through Wednesday.

STATION 1

Repair of Traumatic Cloaca
S. J. Marecik, M. Rossi, K. Kocher, J. J. Park, L. M. Prasad, Park Ridge, IL

Robotic Ventral Rectopexy
S. A. Vogler, Minneapolis, MN

Robotic Parastomal Hernia Repair with Overlay Biologic Mesh
M. B. Hopkins, Chapel Hill, NC

Robotic Complete Mesocolic Excision for Left Colon Cancer
B. Baca, A. Aghayeva, D. Atasoy, O. Bayraktar, V. Ozben, I. Erguner, I. Hamzaoglu, T. Karahasanoğlu, Istanbul, Turkey

Fluorescent Imaging in Anorectal Advancement Flaps
J. Turner, C. Clark, A. Chase, Atlanta, GA

Laparoscopic Ventral Mesh Rectopexy (Lap VMR)
J. S. Khan, F. Sagias, Portsmouth, Hampshire, United Kingdom

STATION 2

ASCRS Barton Hoexter, MD Best Video Award
Perineal Anatomy for Colorectal Surgeons
M. A. Kuzu, H. I. Acar, A. Comert, M. A. Guner, Ankara, Turkey

A Novel Single Stage Sphincter Saving Intersphincteric Approach for Management of Deep Postanal Abscess bb
C. B. Tsang, Singapore, Singapore

Transanal Mucosectomy Revisited
J. P. Kaminski, K. Zaghiyan, P. Fleshner, Los Angeles, CA

Transanal Completion Proctectomy after Total Colectomy and Ileal Pouch-anal Anastomosis for Ulcerative Colitis: A Modified Single Stapled Technique
A. de Buck van Overstraeten, A. M. Wolthuis, A. D’Hoore, Leuven, Belgium

Autonomic Nerve Structures during Laparoscopic TME in Obese

The Anatomical Landmarks for Radical Pelvic Surgery
H. I. Acar, E. Ismail, S. Celik, M. A. Guner, M. A. Kuzu, Ankara, Turkey, Istanbul, Turkey, Ankara, Turkey

STATION 3

Repair of Postprostatectomy Retro-Urethral Fistula with Gracilis Interposition Flap

Low Anterior Resection with Splenic Flexure Mobilisation: A Comparison of the da Vinci® Si and Xi Robotic Systems
E. S. Yeo, B. Min, Seoul, Korea

Rectal Eversion Technique: A Method to Achieve Very Low Rectal Transection and Anastomosis with Particular Value in Laparoscopic Cases
V. Poylin, D. Nagle, P. Mowschenson, T. E. Cataldo, Boston, MA

Abdomino-perineal Resection en bloc with Internal Obturator Muscle, Seminal Vesicle and Pelvic Plexus

Novel Method for Management of Complicated Small Bowel Leaks: Usage of Endoluminal Wound Vac Therapy
C. D. Lyons, S. G. Leeds, Dallas, TX

Robotic Complete Mesocolic Excision for Right Colon Cancer
B. Baca, A. Aghayeva, O. Bayraktar, V. Ozben, D. Atasoy, I. Erguner, I. Hamzaoglu, T. Karahasanoğlu, Istanbul, Turkey

Laparoscopic taTME: A Magnifying Glass to Preserve Pelvic Nerves
The following videos will be available for viewing in Room 515B (Convention Center), Sunday through Wednesday.

**STATION 4**

Laparoscopic Inferior Mesenteric Vein Dissection for Splenic Flexure Take-down  
K. Butler, M. H. Whiteford, Portland, OR  
Robotic TAH/BSO and Low Anterior Resection with Intracorporeal Colonic J-Pouch and Transvaginal Extraction - A Multidisciplinary Approach  
E. H. Lawson, V. Wright, T. D. Francone, Burlington, MA  
IPAA with Transanal Endoscopic Mucosectomy: A Novel Approach in FAP  
A. Feigel, R. Steinhagen, P. Sylla, New York, NY  
Modification of ELAPE Technique: Intraabdominal Levator Transection  
Reduced-Port Robotic Complete Mesocolic Excision and Central Vascular Ligation for Right-Sided Colon Cancer  
S. Bae, W. Jeong, O. Bae, S. Baek, Daegu, Korea  
Robotic Ileocolic Resection for Recurrent Ileocolic Crohn’s Disease  
B. Murray, C. Johnson, Tulsa, OK  
Sacral Nerve Stimulator for Fecal Incontinence: Use of Curved Stylet Enhances Motor Response  
B. Y. Lan, M. Zutshi, H. Tracy, B. Gurland, Cleveland, OH

**STATION 5**

A Novel Approach for Robotic Mobilization of the Splenic Flexure  
O. Isik, C. Benlice, E. Gorgun, Cleveland, Ohio  
Robotic Cecopexy for Cecal Bascule  
M. B. Hopkins, Chapel Hill, NC  
Emergent Laparoscopic Hartmann’s Procedure for Hinchey III Diverticulitis in a Young Patient  
J. Koury, Hummelstown, PA  
Abdomino-Perineal Resection with Sacrectomy  
Cecal Bascule: Robotic Single Site Right Hemicolectomy  
B. Biteman, V. Obias, Washington, DC  
Robotic Surgery for Rectal Cancer and Lateral Lymph Node Dissection  
T. Watanabe, S. Ishihara, K. Kawai, H. Nozawa, K. Hata, T. Kiyomatsu, E. Sunami, Tokyo, Japan  
Laparoscopic Perineal Hernia Repair  
A. Bhakta, J. Brady, S. L. Stein, Cleveland, OH  
Laparoscopic De-Torsion of an Ileal Pouch and Pouch Pexy  
J. Brady, S. Steele, Cleveland, OH
### Saturday, April 30

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:00 am – 6:30 pm</td>
<td>Speaker Ready Room</td>
<td>510</td>
</tr>
<tr>
<td>6:30 am – 6:00 pm</td>
<td>Registration for ASCRS Annual Meeting</td>
<td>West Hall A Registration Area</td>
</tr>
<tr>
<td>7:30 – 9:30 am</td>
<td>Transanal Endoscopic Surgery Workshop</td>
<td>511</td>
</tr>
<tr>
<td>7:30 – 10:00 am</td>
<td>AIN and HRA: What the Colorectal Surgeon Needs to Know Workshop</td>
<td>409A</td>
</tr>
<tr>
<td>7:30 – 11:30 am</td>
<td>Robotic Colon and Rectal Surgery: Tips, Tricks with Simulation for the Novice Surgeon Workshop</td>
<td>408B</td>
</tr>
<tr>
<td>7:30 am – noon</td>
<td>Transanal Endoscopic Surgery Hands-on Lab / Group A</td>
<td>515A &amp; 515B</td>
</tr>
<tr>
<td>7:30 am – noon</td>
<td>Transanal Endoscopic Surgery Workshop / Group B</td>
<td>511</td>
</tr>
<tr>
<td>7:30 am – noon</td>
<td>AIN and HRA: Group 1</td>
<td>409A</td>
</tr>
<tr>
<td>7:30 am – noon</td>
<td>AIN and HRA: Group 2</td>
<td>410</td>
</tr>
<tr>
<td>7:30 am – noon</td>
<td>AIN and HRA: Group 3</td>
<td>409B</td>
</tr>
<tr>
<td>10:30 am – noon</td>
<td>Transanl Endoscopic Surgery Luncheon (lab registrants only)</td>
<td>507</td>
</tr>
<tr>
<td>Noon – 1:00 pm</td>
<td>AIN and HRA Lunch with Panel Discussion &amp; Questions</td>
<td>409A</td>
</tr>
<tr>
<td>Noon – 1:00 pm</td>
<td>Young Surgeons Mock Orals: “Your Turn in the Hot Seat” Workshop</td>
<td>406B</td>
</tr>
<tr>
<td>12:30 – 1:00 pm</td>
<td>Emerging Therapies in Fecal Incontinence Refreshment Break</td>
<td>152-153 Foyer</td>
</tr>
<tr>
<td>12:30 – 1:00 pm</td>
<td>Transanal Endoscopic Surgery Lunch (lab registrants only)</td>
<td>511</td>
</tr>
<tr>
<td>12:30 – 3:00 pm</td>
<td>Symposium: Research</td>
<td>151</td>
</tr>
<tr>
<td>12:30 – 3:30 pm</td>
<td>Symposium: Question Writing: The Perfect Written Exam Question; Do You Know How to Write One?</td>
<td>503</td>
</tr>
<tr>
<td>12:30 – 4:30 pm</td>
<td>Robotic Colon and Rectal Surgery: Tips, Tricks with Simulation for the Experienced Surgeon Workshop</td>
<td>408B</td>
</tr>
<tr>
<td>1:00 – 2:30 pm</td>
<td>AIN and HRA: Group 1</td>
<td>409A</td>
</tr>
<tr>
<td>1:00 – 2:30 pm</td>
<td>AIN and HRA: Group 2</td>
<td>410</td>
</tr>
<tr>
<td>1:00 – 2:30 pm</td>
<td>AIN and HRA: Group 3</td>
<td>409B</td>
</tr>
<tr>
<td>1:00 – 3:00 pm</td>
<td>Symposium: Managing Complications</td>
<td>Petree Hall</td>
</tr>
<tr>
<td>1:00 – 3:00 pm</td>
<td>Symposium: Health Care Policy/Reform 2016 and Beyond: A Round Table Discussion</td>
<td>152-153</td>
</tr>
<tr>
<td>1:00 – 4:30 pm</td>
<td>Laparoscopic Colectomy Hands-on Session for Lab Registrants</td>
<td>502A</td>
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<tr>
<td>1:00 – 4:30 pm</td>
<td>Emerging Therapies in Fecal Incontinence Hands-on Session for Lab Registrants</td>
<td>502B</td>
</tr>
<tr>
<td>1:00 – 4:30 pm</td>
<td>Emerging Therapies in Fecal Incontinence Case Presentations</td>
<td>501BC</td>
</tr>
<tr>
<td>1:00 – 4:30 pm</td>
<td>Ventral Rectopyex Hands-on Session for Lab Registrants</td>
<td>408A</td>
</tr>
<tr>
<td>1:30 – 4:30 pm</td>
<td>Transanal Endoscopic Surgery Workshop / Group A</td>
<td>511</td>
</tr>
<tr>
<td>1:30 – 4:30 pm</td>
<td>Transanal Endoscopic Surgery Hands-on Lab / Group B</td>
<td>515A &amp; 515B</td>
</tr>
<tr>
<td>2:00 – 2:10 pm</td>
<td>Research Symposium Refreshment Break</td>
<td>151 Foyer</td>
</tr>
</tbody>
</table>
Saturday, April 30 (continued)

2:00 – 5:00 pm Research Foundation Research Committee ....................................................... 512
2:05 – 2:15 pm Question Writing Refreshment Break ....................................................... 503 Foyer
3:00 – 5:00 pm Symposium: Translational Medicine: How Genetics Drive Patient Care in Your Colorectal Practice ............................................................ 152-153
3:00 – 5:00 pm Symposium: Advanced Endoscopy and Endoluminal Surgery Petree Hall
5:00 – 7:00 pm Symposium: Transanal Total Mesorectal Excision (taTME) Petree Hall
7:00 – 8:30 pm Non-CME Corporate Forum: Olympus America Inc. Platinum Ballroom Salon E (2nd Floor – JW Marriott)

Sunday, May 1

6:30 am – 6:00 pm Registration ............................................................ West Hall A Registration Area
6:30 am – 6:30 pm Speaker Ready Room ....................................................... 510
6:30 am – 6:30 pm On-Going Video Display ............................................................................ 515B
7:00 – 9:00 am Research Foundation Board of Trustees Meeting ......................................... Plaza II & III (3rd Floor – JW Marriott)
7:00 – 9:00 am Symposium: Robotic Colon and Rectal Surgery: Tips, Tricks, and Simulation Petree Hall
7:00 – 9:30 am Core Subject Update .................................................................................... West Hall B
7:30 – 9:15 am Transanal Total Mesorectal Excision (taTME) Hands-on Course .................. 503
9:00 – 10:00 am Young Surgeons Committee ................................................................. 511C
9:15 am – 1:15 pm Transanal Total Mesorectal Excision (taTME) Hands-on Course .......... 502A
9:30 – 11:30 am ACS Advisory Council ................................................................. Atrium II (3rd Floor – JW Marriott)
9:45 – 11:45 am Symposium: Stomas and Complex Abdominal Wall Problems for the Colorectal Surgeon Petree Hall
9:45 – 11:45 am Symposium: Laparoscopic Nuts and Bolts and Robotic Rivets. West Hall B
9:45 – 11:45 am Symposium: Anal Cancer ........................................................................ Concourse Hall (150-153)
10:00 – 11:00 am Self-Assessment Committee ................................................................. 511B
10:00 – 11:00 am Social Media Committee ................................................................. 505
11:00 am – noon Continuing Education Committee ............................................................ 511A
11:00 am – 12:30 pm DC&R Editorial Board Meeting .................................................... 501BC
11:30 am – noon Rectal Cancer Coordinating Committee .................................................. 512
11:30 am – 12:30 pm New Technologies Committee ..................................................... 511C
11:30 am – 12:30 pm Regional Society Committee ......................................................... 506
11:30 am – 1:00 pm ISUCRS Luncheon Meeting ............................................................... Atrium III (3rd Floor – JW Marriott)
11:45 am – 12:45 pm Awards Committee ............................................................... 513
11:45 am – 12:45 pm Luncheon Symposium: Effective Quality Improvement in Diverse Settings Concourse Hall (150-153)
11:45 am – 12:45 pm Luncheon Symposium: Social Media: Basics and Beyond – What's in it for Me? Petree Hall
11:45 am – 12:45 pm Alliance / American College of Surgeons Investigators Meeting Plaza I (3rd Floor – JW Marriott)

Continued next page
# DAILY SCHEDULE

*All programs are held in the Los Angeles Convention Center unless otherwise noted.*

<table>
<thead>
<tr>
<th>HOURS</th>
<th>ROOM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday, May 1 (continued)</td>
<td></td>
</tr>
<tr>
<td>12:45 – 1:30 pm</td>
<td>Welcome and Opening Announcements: How ASCRS Helps You. West Hall B</td>
</tr>
<tr>
<td>1:15 – 2:00 pm</td>
<td>Transanal Total Mesorectal Excision (taTME) Hands-on Course. 503</td>
</tr>
<tr>
<td>1:30 – 2:15 pm</td>
<td>Norman D. Nigro, MD, Research Lectureship. West Hall B</td>
</tr>
<tr>
<td>2:15 – 3:45 pm</td>
<td>Abstract Session: Perioperative Outcomes. 515A</td>
</tr>
<tr>
<td>2:15 – 3:45 pm</td>
<td>Symposium: Colon and Rectal Surgery Training and Beyond: Education for Colorectal Residents and Colorectal Surgeons. Petree Hall</td>
</tr>
<tr>
<td>2:15 – 3:45 pm</td>
<td>Symposium: Comprehensive Management of Colon Cancer: An Interactive Forum. West Hall B</td>
</tr>
<tr>
<td>3:00 – 5:00 pm</td>
<td>Exhibit Hours. West Hall A</td>
</tr>
<tr>
<td>3:45 – 4:15 pm</td>
<td>Refreshment Break in Exhibit Hall. West Hall A</td>
</tr>
<tr>
<td>3:45 – 4:15 pm</td>
<td>ePoster Presentations. West Hall A</td>
</tr>
<tr>
<td>4:15 – 5:45 pm</td>
<td>Abstract Session: Anorectal/Pelvic Floor I. 515A</td>
</tr>
<tr>
<td>4:15 – 5:45 pm</td>
<td>Symposium: Crohn's Disease. West Hall B</td>
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<tr>
<td>5:45 – 6:45 pm</td>
<td>After Hours Debate. West Hall B</td>
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<tr>
<td>6:15 – 7:15 pm</td>
<td>International Council of Coloproctology Meeting. 515A</td>
</tr>
<tr>
<td>6:45 – 7:45 pm</td>
<td>OSTRiCh Consortium General Assembly. 503</td>
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<tr>
<td>7:30 – 9:00 pm</td>
<td>Welcome Reception. Platinum Ballroom (2nd Floor – JW Marriott)</td>
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<tr>
<td>9:00 – 11:00 pm</td>
<td>Young Surgeons Reception. Off-Site (Wolfgang Puck Bar &amp; Grill)</td>
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<tr>
<td>9:00 pm – midnight</td>
<td>E.P. Salvati Society Meeting. Plaza I &amp; II (3rd Floor – JW Marriott)</td>
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## Monday, May 2

<table>
<thead>
<tr>
<th>HOURS</th>
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<tbody>
<tr>
<td>6:15 am – 4:30 pm</td>
<td>Registration. West Hall A Registration Area</td>
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<tr>
<td>6:30 – 7:30 am</td>
<td>“Meet the Professor” Breakfasts</td>
</tr>
<tr>
<td>M-1</td>
<td>ERAS. 501A</td>
</tr>
<tr>
<td>M-2</td>
<td>Private Practice: Is There A Future? 501B</td>
</tr>
<tr>
<td>M-3</td>
<td>Anorectal and Pelvic Pain. 501C</td>
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<tr>
<td>M-4</td>
<td>Future of Minimally Invasive Surgery. 511A</td>
</tr>
<tr>
<td>M-5</td>
<td>Colorectal Trauma. 511B</td>
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<tr>
<td>M-6</td>
<td>Bring Your Research Idea. 511C</td>
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<tr>
<td>6:30 – 7:30 am</td>
<td>Residents' Breakfast. Platinum Ballroom Salons F-J (2nd Floor – JW Marriott)</td>
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<tr>
<td>6:30 – 7:30 am</td>
<td>CREST Committee. 506</td>
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<tr>
<td>6:30 – 7:30 am</td>
<td>International Committee. 512</td>
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<tr>
<td>6:30 am – 6:30 pm</td>
<td>Speaker Ready Room. 510</td>
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<td>6:30 am – 6:30 pm</td>
<td>On-Going Video Display. 515B</td>
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<tr>
<td>7:30 – 9:00 am</td>
<td>Abstract Session: Basic Science. 515A</td>
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<tr>
<td>7:30 – 9:30 am</td>
<td>Symposium: Beyond the OR. Petree Hall</td>
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<tr>
<td>7:30 – 9:30 am</td>
<td>Symposium: Current Management of Diverticulitis. West Hall B</td>
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<tr>
<td>8:00 – 9:00 am</td>
<td>History of ASCRS Committee. 512</td>
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<tr>
<td>9:00 am – 4:30 pm</td>
<td>Exhibit Hours. West Hall A</td>
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<tr>
<td>9:30 – 10:00 am</td>
<td>Refreshment Break in Exhibit Hall. West Hall A</td>
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<tr>
<td>HOURS</td>
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<tr>
<td>9:30 – 10:00 am</td>
<td>ePoster Presentations</td>
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<tr>
<td>10:00 – 10:45 am</td>
<td>Memorial Lectureship Honoring Victor W. Fazio, MD</td>
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<tr>
<td>10:45 – 11:30 am</td>
<td>Presidential Address</td>
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<tr>
<td>11:30 am – noon</td>
<td>Past Presidents’ and Spouses of Past Presidents’ Reception</td>
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<tr>
<td>11:30 am – 12:30 pm</td>
<td>Healthcare Economics Committee</td>
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<tr>
<td>11:30 am – 12:30 pm</td>
<td>Quality Assessment and Safety Committee</td>
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<td>11:30 am – 12:30 pm</td>
<td>Residents Committee</td>
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<tr>
<td>11:30 am – 12:45 pm</td>
<td>Complimentary Box Lunch in Exhibit Hall</td>
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<tr>
<td>11:30 am – 12:45 pm</td>
<td>ePoster Presentations</td>
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<tr>
<td>11:30 am – 12:45 pm</td>
<td>Awards Committee</td>
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<tr>
<td>11:30 am – 12:45 pm</td>
<td>Research Foundation Young Researchers Committee</td>
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<tr>
<td>11:30 am – 12:45 pm</td>
<td>Past Vice Presidents’ Luncheon</td>
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<tr>
<td>11:35 am – 12:45 pm</td>
<td>Product Theater: Merck &amp; Co., Inc.</td>
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<tr>
<td>Noon – 12:45 pm</td>
<td>Past Presidents’ Luncheon</td>
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<tr>
<td>Noon – 12:45 pm</td>
<td>Spouses of Past Presidents’ Luncheon</td>
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<tr>
<td>12:30 – 1:30 pm</td>
<td>Public Relations Committee</td>
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<tr>
<td>12:45 – 2:15 pm</td>
<td>Symposium: Rectal Cancer One: The Trials of Rectal Cancer</td>
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<tr>
<td>12:45 – 2:15 pm</td>
<td>Abstract Session: Benign Colon</td>
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<td>2:15 – 3:45 pm</td>
<td>Abstract Session: Neoplasia I</td>
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<tr>
<td>2:15 – 3:45 pm</td>
<td>Symposium: Familial Feud: Generation X vs. Generation Z</td>
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<tr>
<td>2:15 – 4:15 pm</td>
<td>Fundamentals of Rectal Cancer Surgery Committee</td>
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<tr>
<td>3:45 – 4:15 pm</td>
<td>Ice Cream and Refreshment Break in Exhibit Hall</td>
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<tr>
<td>3:45 – 4:15 pm</td>
<td>ePoster Presentations</td>
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<tr>
<td>4:00 – 5:00 pm</td>
<td>Awards Committee</td>
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<tr>
<td>4:15 – 5:00 pm</td>
<td>Harry E. Bacon, MD, Lectureship</td>
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<tr>
<td>5:00 – 6:00 pm</td>
<td>Symposium: New Technologies</td>
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<td>6:00 – 7:00 pm</td>
<td>Operative Competency Evaluation Committee</td>
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<tr>
<td>6:30 – 8:00 pm</td>
<td>Residents’ Reception</td>
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<tr>
<td>6:30 – 8:00 pm</td>
<td>Non-CME Corporate Forum: Mallinckrodt Pharmaceuticals</td>
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<tr>
<td>6:30 – 8:30 pm</td>
<td>Baylor University Medical Center Alumni Reception</td>
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<tr>
<td>6:30 – 8:30 pm</td>
<td>Mayo Clinic Colon and Rectal Surgery Alumni Reception</td>
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<tr>
<td>6:30 – 9:30 pm</td>
<td>Cleveland Clinic Annual Alumni Reception</td>
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<tr>
<td>7:00 pm</td>
<td>Chicago Society of Colon &amp; Rectal Surgeons Dinner</td>
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<tr>
<td>7:00 – 8:00 pm</td>
<td>Stony Brook University Alumni Reception</td>
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<tr>
<td>7:00 – 8:30 pm</td>
<td>Ferguson Surgical Society Cocktail Hour</td>
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<tr>
<td>7:00 – 8:30 pm</td>
<td>Lehigh Valley Health Network Alumni Reception</td>
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</tbody>
</table>
All programs are held in the Los Angeles Convention Center unless otherwise noted.

<table>
<thead>
<tr>
<th>HOURS</th>
<th>ROOM</th>
<th>DETAILS</th>
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</thead>
<tbody>
<tr>
<td>7:00 – 9:00 pm</td>
<td>Icahn School of Medicine at Mount Sinai Alumni Reception.</td>
<td>Ford’s Filling Station (Lobby – JW Marriott)</td>
</tr>
<tr>
<td>7:00 – 9:00 pm</td>
<td>Washington University Colon &amp; Rectal Surgery Fellowship Alumni Reception.</td>
<td>Atrium III (3rd Floor – JW Marriott)</td>
</tr>
<tr>
<td>7:00 – 10:00 pm</td>
<td>Colon &amp; Rectal Clinic of Orlando Alumni Dinner.</td>
<td>Atrium I (3rd Floor – JW Marriott)</td>
</tr>
<tr>
<td>7:15 pm</td>
<td>Minnesota Alumni Dinner.</td>
<td>Atrium I (3rd Floor – JW Marriott)</td>
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**Monday, May 2 (continued)**

<table>
<thead>
<tr>
<th>ROOM</th>
<th>DETAILS</th>
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</thead>
<tbody>
<tr>
<td>6:30 – 7:30 am T-1 How to Bail</td>
<td>501A</td>
</tr>
<tr>
<td>6:30 – 7:30 am T-2 Leaks</td>
<td>501B</td>
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<tr>
<td>6:30 – 7:30 am T-3 Modern Management of Fecal Incontinence</td>
<td>501C</td>
</tr>
<tr>
<td>6:30 – 7:30 am T-4 Pouch Problems and Solutions</td>
<td>511A</td>
</tr>
<tr>
<td>6:30 – 7:30 am T-5 Rectal Cancer: Difficult Cases and Controversies</td>
<td>511B</td>
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<tr>
<td>6:30 – 7:30 am T-6 Coding and Reimbursement</td>
<td>511C</td>
</tr>
<tr>
<td>7:30 – 9:00 am Symposium: Building a Successful Research Program.</td>
<td>Petree Hall</td>
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<tr>
<td>8:00 – 9:00 am Exhibitor’s Advisory Committee.</td>
<td>505</td>
</tr>
<tr>
<td>9:00 am – 2:00 pm Exhibit Hours.</td>
<td>West Hall A</td>
</tr>
<tr>
<td>9:00 – 9:30 am Refreshment Break in Exhibit Hall.</td>
<td>West Hall A</td>
</tr>
<tr>
<td>9:30 – 10:45 am Symposium: Fecal Incontinence</td>
<td>West Hall B</td>
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<tr>
<td>9:30 – 10:45 am Abstract Session: Neoplasia II</td>
<td>Petree Hall</td>
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<tr>
<td>9:45 – 10:45 am Product Theater: NOVADAQ.</td>
<td>West Hall A</td>
</tr>
<tr>
<td>11:30 am – 12:30 pm Women in Colorectal Surgery Luncheon.</td>
<td>West Hall A</td>
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<tr>
<td>11:30 am – 12:30 pm Awards Committee</td>
<td>513</td>
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<tr>
<td>11:30 am – 12:30 pm Research Foundation Fundraising Assistance Committee.</td>
<td>512</td>
</tr>
<tr>
<td>11:30 am – 12:30 pm Website Committee</td>
<td>504</td>
</tr>
<tr>
<td>12:30 – 2:00 pm Symposium: Young Surgeons Symposium: Board Certification and Beyond.</td>
<td>Petree Hall</td>
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<tr>
<td>12:30 – 2:00 pm Symposium: The American College of Surgeons Commission on Cancer National Accreditation Program for Rectal Cancer: Why, How and When.</td>
<td>West Hall B</td>
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</tbody>
</table>
Tuesday, May 3 (continued)

12:30 – 2:00 pm  Abstract Session: Inflammatory Bowel Disease ................................................... 515A
2:00 – 3:30 pm  Symposium: Stage IV Colorectal Cancer ................................................... West Hall B
2:00 – 3:30 pm  Abstract Session: Research Forum ................................................... 515A
2:00 – 3:30 pm  Abstract Session: Benign Anorectal/Pelvic Floor II ................................................... Petree Hall
3:45 – 4:30 pm  Parviz Kamangar Humanities in Surgery Lectureship ................................................... West Hall B
4:00 – 5:00 pm  Awards Committee .............................................................................. 513
4:30 – 5:30 pm  After Hours Debate .......................................................................................... West Hall B
5:30 – 6:30 pm  Membership Committee .............................................................................. 504
5:30 – 6:30 pm  ASCRS Fellowship Reception ................................................... Plaza I – III (3rd Floor – JW Marriott)
7:00 – 8:00 pm  ASCRS Annual Reception .............................................................................. 515B
8:00 – 10:30 pm  ASCRS Annual Dinner Dance ................................................... 515B

Wednesday, May 4

6:15 am – 4:00 pm  Registration .......................................................................................... West Hall A Registration Area
6:30 – 7:30 am  “Meet the Professor” Breakfasts
W-1  Academic Development .................................................................................. 501A
W-2  Quality Metrics ................................................................................................. 501B
W-3  Fistula in Ano ............................................................................................... 501C
W-4  Complicated Crohn’s Disease ........................................................................ 511A
W-5  Bring Your Worst ......................................................................................... 511B
W-6  Rectovaginal Fistula ...................................................................................... 511C
6:30 am – 4:00 pm  Speaker Ready Room .............................................................................. 510
6:30 am – 5:00 pm  On-Going Video Display .............................................................................. 515B
7:30 – 9:00 am  Symposium: Benign Anorectal ................................................... West Hall B
7:30 – 9:00 am  Symposium: ERAS Update .............................................................................. Petree Hall
9:30 – 10:45 am  Symposium: Rectal Cancer II ................................................... West Hall B
9:30 – 10:45 am  Abstract Session: Video Session ................................................... Petree Hall
10:45 – 11:30 am  Ernestine Hambrick, MD, Lectureship ................................................... West Hall B
11:30 am – 12:30 pm  Lunch Break ........................................................................... On Your Own
11:30 am – 12:30 pm  Awards Committee .............................................................................. 513
12:30 – 2:00 pm  Symposium: Pelvic Floor Disorders ................................................... Petree Hall
12:30 – 2:00 pm  Symposium: Take Me to Your OR ................................................... West Hall B
2:00 – 3:30 pm  Symposium: Colorectal Potpourri ................................................... Petree Hall
2:00 – 3:30 pm  Afternoon Debate .............................................................................. West Hall B
4:00 – 5:00 pm  ASCRS Annual Business Meeting and State of the Society Address ................................................... 515A

All programs are held in the Los Angeles Convention Center unless otherwise noted.
<table>
<thead>
<tr>
<th>Time</th>
<th>Laparoscopic Colectomy Symposium (Didactic) 7:30 am – noon</th>
<th>Emerging Therapies in Fecal Incontinence Symposium (Didactic) 7:30 am – 12:30 pm</th>
<th>Robotic Colon and Rectal Surgery: Tips, Tricks, and Simulation Workshop for the Novice Surgeon Hands-on-Lab 7:30 – 11:30 am</th>
<th>Robotic Colon and Rectal Surgery: Tips, Tricks, and Simulation Workshop for the Experienced Surgeon (Cadaver) Hands-on-Lab 12:30 – 4:30 pm</th>
<th>Ventral Rectopexy Symposium (Didactic) 7:30 am – noon</th>
<th>AIN and HRA: What the Colorectal Surgeon Needs to Know Workshop 7:30 am – 2:30 pm</th>
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**SCHEDULE-AT-A-GLANCE**

**Sunday, May 1**

- 9:30 – 9:45 am: Refreshment Break in Foyer

**Monday, May 2**

- 9:30 – 10:00 am: Meet the Professor Breakfasts
  - 6:30 – 7:30 am: Residents’ Breakfast

**Abstract Session:**

- 7:30 – 9:30 am: Current Management of Diverticulitis
  - 10:00 – 10:45 am: Presidential Address

**Symposium:**

- 11:45 am – 12:45 pm: Rectal Cancer One: The Trials of Rectal Cancer
  - 12:45 – 2:15 pm: Benign Colon

**Abstract Session:**

- 3:45 – 4:15 pm: International Colorectal Surgery Perspectives from Latin America
  - 3:45 – 4:15 pm: Benign Anorectal/Pelvic Floor I
  - 3:45 – 4:15 pm: Crohn’s Disease

**Symposium:**

- 7:30 – 9:00 pm: Welcome Reception
## Schedule at a Glance

### Tuesday, May 3

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### Wednesday, May 4

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<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>6:00 am</td>
<td>Meet the Professor Breaks</td>
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<td>6:15 am</td>
<td>refreshment Break in Foyer</td>
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<tr>
<td>6:30 am</td>
<td>SYMPOSIUM: Symposium: SympOsium: Benign Anorectal</td>
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<tr>
<td>6:45 am</td>
<td>SYMPOSIUM: Symposium: General Surgery Forum</td>
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<td>7:00 am</td>
<td>SYMPOSIUM: Rectal Cancer II</td>
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<tr>
<td>7:15 am</td>
<td>SYMPOSIUM: Abstract Session: Video Session</td>
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<td>SYMPOSIUM: Abstract Session: General Surgery Forum</td>
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**Dinner Dance**

8:00 pm – 10:30 pm

**Annual Business Meeting and State of the Society Address**

4:00 pm – 5:00 pm
<table>
<thead>
<tr>
<th>HOURS</th>
<th>ROOM</th>
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<tbody>
<tr>
<td><strong>Saturday</strong></td>
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<tr>
<td>8:00 am – noon</td>
<td>Executive Council Meeting . Plaza II &amp; III (3rd Floor, JW Marriott)</td>
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<tr>
<td>2:00 – 5:00 pm</td>
<td>Research Foundation Research Committee</td>
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<tr>
<td><strong>Sunday</strong></td>
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<tr>
<td>7:00 – 9:00 am</td>
<td>Research Foundation Board of Trustees Plaza II &amp; III (3rd Floor, JW Marriott)</td>
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<tr>
<td>9:00 – 10:00 am</td>
<td>Young Surgeons Committee 511C</td>
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<tr>
<td>10:00 – 11:00 am</td>
<td>Self-Assessment Committee 511B</td>
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<tr>
<td>10:00 – 11:00 am</td>
<td>Social Media Committee 505</td>
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<tr>
<td>11:00 am – noon</td>
<td>Continuing Education Committee 511A</td>
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<tr>
<td>11:30 am – noon</td>
<td>Rectal Cancer Coordinating Committee 512</td>
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<tr>
<td>11:30 am – 12:30 pm</td>
<td>New Technologies Committee 511C</td>
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<tr>
<td>11:30 am – 12:30 pm</td>
<td>Regional Society Committee 506</td>
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<tr>
<td>11:45 am – 12:45 pm</td>
<td>Awards Committee 513</td>
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<tr>
<td><strong>Monday</strong></td>
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<tr>
<td>6:30 – 7:30 am</td>
<td>CREST Committee 506</td>
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<td>6:30 – 7:30 am</td>
<td>International Committee 512</td>
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<tr>
<td>8:00 – 9:00 am</td>
<td>History of ASCRS Committee 512</td>
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<tr>
<td>11:30 am – 12:30 pm</td>
<td>Healthcare Economics Committee 511C</td>
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<tr>
<td>11:30 am – 12:30 pm</td>
<td>Quality Assessment and Safety Committee 511B</td>
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<tr>
<td>11:30 am – 12:30 pm</td>
<td>Residents Committee 511A</td>
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<tr>
<td>11:30 am – 12:45 pm</td>
<td>Awards Committee 513</td>
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<td>Research Foundation Young Researchers Committee 512</td>
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<tr>
<td>12:30 – 1:30 pm</td>
<td>Public Relations Committee 501A</td>
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<td>2:15 – 4:15 pm</td>
<td>Fundamentals of Rectal Cancer Surgery Committee 511A</td>
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<td>4:00 – 5:00 pm</td>
<td>Awards Committee 513</td>
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<tr>
<td>6:00 – 7:00 pm</td>
<td>Operative Competency Evaluation Committee 512</td>
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<tr>
<td><strong>Tuesday</strong></td>
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<tr>
<td>6:30 – 7:30 am</td>
<td>Professional Outreach Committee 512</td>
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<td>8:00 – 9:00 am</td>
<td>Exhibitor’s Advisory Committee 505</td>
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<tr>
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<td>Awards Committee 513</td>
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<tr>
<td>11:30 am – 12:30 pm</td>
<td>Clinical Practice Guidelines Committee 513</td>
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<td>11:30 am – 12:30 pm</td>
<td>Research Foundation Fundraising Assistance Committee 511A</td>
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<td>Video Based Education Committee 505</td>
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<td>11:30 am – 1:00 pm</td>
<td>Website Committee 504</td>
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<td>5:30 – 6:30 pm</td>
<td>Membership Committee 504</td>
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<tr>
<td><strong>Wednesday</strong></td>
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<tr>
<td>11:30 am – 12:30 pm</td>
<td>Awards Committee 513</td>
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*1899-1900 Joseph M. Mathews
*1900-1901 James P. Tuttle
*1901-1902 Thomas C. Martin
*1902-1903 Samuel T. Earle
*1903-1904 William M. Beach
*1904-1905 J. Rawson Pennington
*1905-1906 Lewis H. Adler, Jr.
*1906-1907 Samuel G. Gant
*1907-1908 A. Bennett Cooke
*1908-1909 George B. Evans
*1909-1910 Dwight H. Murray
*1910-1911 George J. Cooke
*1911-1912 John L. Jelks
*1912-1913 Louis J. Hirschman
*1913-1914 Joseph M. Mathews
*1914-1915 Louis J. Krause
*1915-1916 T. Chittenden Hill
*1916-1917 Alfred J. Zobel
*1917-1919 Jerome M. Lynch
*1919-1920 Collier F. Martin
*1920-1921 Alois B. Graham
*1921-1922 Granville S. Hanes
*1922-1923 Emmett H. Terrell
*1923-1924 Ralph W. Jackson
*1924-1925 Frank C. Yeomans
*1925-1926 Descum C. McKenney
*1926-1927 William H. Kiger
*1927-1928 Louis A. Buie
*1928-1929 Edward G. Martin
*1929-1930 Walter A. Fansler
*1930-1931 Dudley Smith
*1931-1932 W. Oakley Hermance
*1932-1933 Curtice Rosser
*1933-1934 Curtis C. Mechling
*1934-1935 Louis A. Buie
*1935-1936 Frank G. Runyoon
*1936-1937 Marion C. Pruitt
*1937-1938 Harry Z. Hibshman
*1938-1939 Dudley Smith
*1939-1940 Martin S. Kleckner
*1940-1941 Clement J. Debere
*1941-1942 Frederick B. Campbell
*1942-1944 Homer I. Silvers
*1944-1946 William H. Daniel
*1946-1947 Joseph W. Ricketts
*1947-1948 George H. Thiele
*1948-1949 Harry E. Bacon
*1949-1950 Louis E. Moon
*1950-1951 Hoyt R. Allen
*1951-1952 Robert A. Scarborough
*1952-1953 Newton D. Smith
*1953-1954 W. Wendell Green
*1954-1955 A.W. Martin Marino, Sr.
*1955-1956 Stuart T. Ross
*1956-1957 Rufus C. Alley
*1957-1958 Julius E. Linn
*1958-1959 Karl Zimmerman
*1959-1960 Hyrum R. Reichman
*1960-1961 Walter A. Fansler
*1961-1962 Merrill O. Hines
*1962-1963 Robert J. Rowe
*1963-1964 Robert A. Scarborough
*1964-1965 Garnet W. Ault
*1965-1966 Norman D. Nigro
*1967-1968 Raymond J. Jackman
*1968-1969 Neil W. Swinton
*1969-1970 James A. Ferguson
*1970-1971 Walter Birnbaum
*1971-1972 Andrew Jack McAdams
*1972-1973 John E. Ray
*1973-1974 John H. Remington
*1974-1975 Rupert B. Turnbull
*1975-1976 Patrick H. Hanley
*1976-1977 John R. Hill
*1977-1978 Alejandro F. Castro
*1978-1979 Donald M. Gallagher
1979-1980 Stuart H.Q. Quan
*1980-1981 Malcolm C. Veenendenheimer
1981-1982 Bertram A. Portin
*1982-1983 Eugene S. Sullivan
1983-1984 Stanley M. Goldberg
*1984-1985 A.W. Martin Marino, Jr.
1985-1986 Eugene P. Salvati
1987-1988 Frank J. Theuerkauf
1988-1989 Herand Abcarien
1990-1991 Peter A. Volpe
1992-1993 W. Patrick Mazier
1993-1994 Samuel B. Labow
1994-1995 Philip H. Gordon
1996-1997 David A. Rothenberger
1997-1998 Ira J. Kodner
1998-1999 Lee E. Smith
1999-2000 H. Randolph Bailey
*2000-2001 John M. MacKeigan
2001-2002 Robert D. Fry
2002-2003 Richard P. Billingham
2004-2005 Bruce G. Wolff
2005-2006 Ann C. Lowry
2006-2007 Lester Rosen
*2007-2008 W. Douglas Wong
2008-2009 Anthony J. Senagore
2009-2010 James W. Fleshman
2010-2011 David E. Beck
2011-2012 Steven D. Wexner
2012-2013 Alan G. Thorson
2013-2014 Michael J. Stamos
2014-2015 Terry C. Hicks

*Deceased
Workshop

Transanal Endoscopic Surgery

7:30 am – 4:30 pm
Rooms: 511, 515A & 515B

Registration Required (includes Didactic and Hands-on Workshop) • Member Fee: $595 • Non-Member Fee: $695
Limit: 48 participants • Lunch Included

Supported by independent educational grants and loaned durable equipment from:
Applied Medical
KARL STORZ Endoscopy-America, Inc.
Medtronic
Richard Wolf Medical Instruments Corporation
Stryker Endoscopy

Transanal excision of tumors of the rectum has been limited by the technical difficulties of operating in a confined space with inadequate instrumentation. Access to lesions higher than 6 cm from the anal verge is not feasible with standard transanal techniques. Transanal endoscopic microsurgery (TEM) was designed to overcome these limitations and has proven to be an invaluable endoscopic tool in treating rectal lesions which might otherwise require proctectomy. Over the last several years, the armamentarium of transanal approaches has increased, with the development of 2 new platforms, Transanal Endoscopic Operations (TEO) and Transanal Minimally Invasive Surgery (TAMIS). These platforms offer other options for advanced transanal surgery.

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

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

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

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

**Director:** Peter Cataldo, MD, Burlington, VT; **Assistant Director:** Mark Whiteford, MD, Portland, OR

Room: S11

7:30 am  **Welcome and Introductions**  
Peter Cataldo, MD, Burlington, VT

7:40 am  **Indications and Preoperative Evaluation**  
Jorge Marcet, MD, Tampa, FL

7:55 am  **TES for Benign Disease**  
Brian Valerian, MD, Albany, NY

8:10 am  **TES for Malignant Disease**  
Peter Cataldo, MD, Burlington, VT

8:25 am  **Avoiding and Managing Complications**  
Scott Steele, MD, Cleveland, OH

8:40 am  **Transanal TME**  
Patricia Sylla, MD, New York, NY

8:55 am  **Getting Started**  
Dana Sands, MD, Weston, FL

9:10 am  **Teaching TEM, TEO, TAMIS, SILS Videos**  
Eric Haas, MD, Houston, TX; Rodrigo Perez, MD, PhD, Sao Paulo, Brazil; Scott Steele, MD, Cleveland, OH; Mark Whiteford, MD, Portland, OR

9:25 am  **Lab Introduction**  
Mark Whiteford, MD, Portland, OR

**Group B – TES Panel Discussion**

9:30 am – 12:30 pm  
Room: S11

**Peter Cataldo, MD, Burlington, VT, Workshop Director**

Panel:  
Steven Hunt, MD, St. Louis, MO; Rodrigo Perez, MD, PhD, Sao Paulo, Brazil; Scott Steele, MD, Cleveland, OH; Brian Valerian, MD, Albany, NY

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

12:30 pm  **Lunch** (Room: S11)

**Group A – TES Panel Discussion**

1:30 – 4:30 pm  
Room: S11

**Joshua Bleier, MD, Philadelphia, PA, Workshop Director**

Panel:  
Elisabeth McLemore, MD, Los Angeles, CA; Dana Sands, MD, Weston, FL; Patricia Sylla, MD, New York, NY; Mark Whiteford, MD, Portland, OR

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

4:30 pm  **Adjourn**

**Group B – Hands-on Lab**

1:30 – 4:30 pm  
Room: 515A & 515B

**TEO** (Room: 515A)  
Skandan Shanmugan, MD, Philadelphia, PA; Patricia Sylla, MD, New York, NY

**TEM** (Room: 515A)  
Traci Hedrick, MD, Charlottesville, VA; Dana Sands, MD, Weston, FL

**SILS** (Room: 515B)  
Eric Haas, MD, Houston, TX; Jorge Marcet, MD, Tampa, FL; Jaime Sanchez, MD, Tampa, FL

**TAMIS** (Room: 515B)  
Sam Atallah, MD, Winter Park, FL; Sergio Larach, MD, Orlando, FL; Elisabeth McLemore, MD, Los Angeles, CA; Theodoros Voloyiannis, MD, Houston, TX

12:30 pm  **Lunch** (Room: S11)

4:30 pm  **Adjourn**
Symposium and Workshop

Laparoscopic Colectomy

7:30 am – 4:30 pm
Room: Petree Hall

Registration Required (includes Didactic and Hands-on Workshop) • Member Fee: $525 • Non-Member Fee: $625
Limit: 24 participants • Lunch Included
Didactic Session Only: $25 (7:30 am – noon)

Supported by independent educational grants and loaned durable equipment from:
Applied Medical
Ethicon US, LLC
Medtronic
Olympus America Inc.
Richard Wolf Medical Instruments Corporation

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

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

Review of Laparoscopic and Anatomic Principles
Port Placement Philosophy

Procedural Reviews
• Right colectomy
• Left colectomy
• Proctectomy
• Rectopexy
• Hartmann reversal
• Peristomal hernia repair

Technical Descriptions
• Medial to lateral approach
• Lateral to medial approach
• Stapling
• Safe energy utilization
• Hand assist colectomy

New Technologies
• Single site
• Fluorescence imaging

New Techniques

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

Existing Gaps

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

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

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

Continued next page
Laparoscopic Colectomy Symposium and Workshop (continued)

Co-Director: Amir Bastawrous, MD, Seattle, WA
Co-Director: Eric Johnson, MD, Tacoma, WA

7:30 am – noon
Room: Petree Hall

Didactic Session

7:30 am  Welcome and Introductions
Amir Bastawrous, MD, Seattle, WA
Eric Johnson, MD, Tacoma, WA

7:40 am  Right Colectomy, Literature Review and Overview of Techniques
Steven Mills, MD, Orange, CA

7:55 am  Video Presentation: Inferior to Superior Right Colectomy
Amanda Hayman, MD, Portland, OR

8:10 am  Video Presentation: Medial to Lateral Right Colectomy
Melinda Hawkins, MD, Seattle, WA

8:25 am  HALS. When, Why, How?
Jennifer Beaty, MD, Omaha, NE

8:40 am  Panel Discussion

8:55 am  Video Presentation: Laparoscopic Left Colectomy, Literature Review and Overview of Techniques
Kevin Kasten, MD, Greenville, NC

9:10 am  Video Presentation: Medial to Lateral Left Colectomy
Jennifer Blumetti, MD, Chicago, IL

9:25 am  Video Presentation: Splenic Flexure Approaches
Carrie Peterson, MD, Milwaukee, WI

9:40 am  Anastomotic Options (Intracorporeal, Extracorporeal, Hand-Sewn, Side to Side, Etc.)
Mukta Krane, MD, Seattle, WA

9:55 am  Panel Discussion

10:10 am  Laparoscopic Proctectomy and TME, Literature Review and Overview of Technique
Konstantin Umanskiy, MD, Chicago, IL

10:25 am  Video Presentation: TME
Sean Langenfeld, MD, Omaha, NE

10:40 am  Video Presentation: Tips for the Difficult Pelvis
Karim Alavi, MD, Worcester, MA

10:55 am  Panel Discussion

11:20 am  Expert Complications and Challenges
Bradley Champagne, MD, Cleveland, OH

11:40 am  Discussion

Noon  Adjourn

Noon  Lunch Provided for Hands-on Lab Participants
(Room: 507)

1:00 – 4:30 pm
Room: 502A

Hands-on Session

Demonstrate the knowledge you acquired during the morning symposium to strengthen your skills. Each participant will be assigned to a station and will work with one other participant and faculty throughout the hands-on lab.

1:00 pm  Introduction and Description of Procedures

1:10 pm  Laparoscopic Low Anterior Resection, Medial to Lateral Approach

3:00 pm  Break

3:10 pm  Laparoscopic Right Colectomy, Medial to Lateral Approach

4:30 pm  Adjourn

Faculty for hands-on session includes:
Karim Alavi, MD, Worcester, MA; Jennifer Beaty, MD, Omaha, NE; Jennifer Blumetti, MD, Chicago, IL; Bradley Champagne, MD, Cleveland, OH; Kevin Kasten, MD, Greenville, NC; Mukta Krane, MD, Seattle, WA; Amanda Hayman, MD, Portland, OR; Melinda Hawkins, MD, Seattle, WA; Sean Langenfeld, MD, Omaha, NE; Steven Mills, MD, Orange, CA; Carrie Peterson, MD, Milwaukee, WI; Konstantin Umanskiy, MD, Chicago, IL
Symposium and Workshop

Emerging Therapies in Fecal Incontinence

7:30 am – 4:30 pm
Rooms: 152-153

Registration Required (includes Didactic and Hands-on Workshop) • Member Fee: $525 • Non-Member Fee: $625
Limit: 80 participants • Lunch Included
Didactic Session Only: $25 (7:30 am – 12:30 pm)

Supported by independent educational grants and loaned durable equipment from:
Medtronic
Torax Medical, Inc.

Fecal incontinence is a socially difficult condition for the affected patient and its true prevalence is frequently underestimated because of patients’ hesitation to discuss symptoms with their physicians. Recently, new treatment options have been introduced and there are additional modalities that are currently under evaluation.

Traditional surgical alternatives have limitations. Surgical sphincter repair has satisfactory short-term results, but continence tends to deteriorate over time. The placement of an artificial bowel sphincter has significant morbidity and revision rates, while a diverting colostomy is generally a last resort.

Both sacral nerve stimulation (SNS) and the injection of bulking agents have been used for many years in the urologic field. These treatment modalities have recently become recognized in the field of colorectal surgery for the treatment of fecal incontinence. In addition to these new procedures, there are additional procedures being investigated such as the pelvic sling and magnetic anal sphincter.

The hands-on session will be offered in two versions. For participants who have limited SNS experience, the hands-on training will consist of performing SNS on a cadaveric and on an inanimate model under the supervision of a faculty member. We will review again the steps of the procedure for optimal lead placement and review basic programming. There will also be an advanced version aimed at physicians who have already incorporated SNS into their practice. This group will review advanced lead placement techniques and discuss trouble-shooting and advanced programming.

Existing Gaps
What Is: The initial assessment of patients with fecal incontinence can include physiology testing, ultrasound and defecography. The accuracy of these examinations depends upon the operator’s ability to perform the exam and properly interpret the results.

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

What Should Be: It is important that colorectal surgeons understand indications for physiology testing, anorectal ultrasound and defecography and how to interpret these tests in order to effectively manage patients with fecal incontinence. With a comprehensive review of all the treatment modalities available for fecal incontinence, surgeons will be able to identify the appropriate procedure for the appropriate patient. Surgeons will be able to identify indications for SNS and how to perform the procedure. With hands-on practice of SNS in an inanimate lab training session under the guidance of experts, physicians will be able to adopt this technique into their practice when clinically indicated and be able to perform it in an expert manner. For physicians that have already adopted SNS into their practice, they will be able to learn more advanced techniques for optimal lead placement and programming.

Learning Objectives: At the conclusion of this session, participants should be able to: a) Explain the initial assessment and management of patients with fecal incontinence; b) Explain the importance of and interpret endorectal ultrasound; c) Describe the interpretation of anal manometry; d) Explain and interpret defecography; e) Explain the operative set-up, identification of landmarks and steps for optimal lead placement in the performance of SNS; f) Identify the postoperative management of patients with an implant including troubleshooting difficulties; g) Describe how to inject into the anal canal; h) Describe alternatives to these procedures; i) Develop technical skills necessary to perform SNS.
Emerging Therapies in Fecal Incontinence (continued)

**Co-Director:** Anders Mellgren, MD, PhD, Chicago, IL  
**Co-Director:** Kelly Garrett, MD, New York, NY

7:30 am – 12:30 pm  
Rooms: 152-153

**Didactic Session**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30 am</td>
<td>Welcome and Introductions</td>
<td>Anders Mellgren, MD, PhD, Chicago, IL; Kelly Garrett, MD, New York, NY</td>
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<tr>
<td>7:35 am</td>
<td>Fecal Incontinence: Initial Assessment and Management</td>
<td>Johan Nordenstam, MD, PhD, Chicago, IL</td>
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<tr>
<td>7:50 am</td>
<td>Ultrasound: Technique and Interpretation</td>
<td>Liliana Bordeianou, MD, Boston, MA</td>
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<tr>
<td>8:05 am</td>
<td>The Role of Defecography and Manometry</td>
<td>Sarah Vogler, MD, Minneapolis, MN</td>
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<tr>
<td>8:20 am</td>
<td>Vaginal Insert and Other Non-Surgical Alternatives</td>
<td>Ian Paquette, MD, Cincinnati, OH</td>
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<tr>
<td>8:35 am</td>
<td>Overlapping Sphincteroplasty: How Effective Is It?</td>
<td>Massarat Zutshi, MD, Cleveland, OH</td>
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<tr>
<td>8:50 am</td>
<td>Discussion</td>
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<tr>
<td>9:05 am</td>
<td>Refreshment Break in Foyer</td>
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<tr>
<td>9:15 am</td>
<td>SNS: Method of Action and Clinical Results</td>
<td>Klaus Matzel, MD, Erlangen, Germany</td>
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<tr>
<td>9:30 am</td>
<td>SNS: Who Is a Good Candidate?</td>
<td>Joshua Bleier, MD, Philadelphia, PA</td>
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<tr>
<td>9:45 am</td>
<td>SNS: Best Practices for Optimal Lead Placement</td>
<td>Sandip Vasavada, MD, Cleveland, OH</td>
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<tr>
<td>10:00 am</td>
<td>SNS: Complications and Troubleshooting</td>
<td>Karen Noblett, MD, Riverside, CA</td>
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<tr>
<td>10:15 am</td>
<td>Tibial Nerve Stimulation: A Viable Alternative?</td>
<td>Amy Thorsen, MD, Minneapolis, MN</td>
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<tr>
<td>10:30 am</td>
<td>Discussion</td>
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<tr>
<td>10:50 am</td>
<td>Refreshment Break in Foyer</td>
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<tr>
<td>11:00 am</td>
<td>Injectables: Clinical Results</td>
<td>Andreas Kaiser, MD, Los Angeles, CA</td>
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<tr>
<td>11:15 am</td>
<td>When to Consider Ventral Rectopexy and Clinical Outcomes</td>
<td>Ian Lindsey, MD, Oxford, United Kingdom</td>
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<tr>
<td>11:30 am</td>
<td>Ventral Rectopexy: How I Do It</td>
<td>Andrew Stevenson MD, Chermside, QLD, Australia</td>
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<tr>
<td>11:45 am</td>
<td>Pelvic Sling Procedures and Preliminary Results</td>
<td>Massarat Zutshi, MD, Cleveland, OH</td>
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<tr>
<td>Noon</td>
<td>When to Consider an Artificial or Magnetic Sphincter</td>
<td>Paul-Antoine Lehur, MD, PhD, Nantes, France</td>
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<tr>
<td>12:15 pm</td>
<td>Discussion</td>
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<td>12:30 pm</td>
<td>Adjourn</td>
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<tr>
<td>12:30 pm</td>
<td>Lunch Provided for Hands-on Lab Participants</td>
<td>(Rooms: 505 &amp; 506)</td>
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*Continued next page*
Emerging Therapies in Fecal Incontinence *(continued)*

1:00 – 2:30 pm  
Room: 502B

**Hands-on Session**

<table>
<thead>
<tr>
<th>Groups 1-8</th>
<th>1:00 – 1:45 pm</th>
<th>1:45 – 2:30 pm</th>
</tr>
</thead>
</table>
| **Group 1**          | SNS Lead Placement (cadaver model)  
Amy Thorsen, MD | SNS Inanimate Model and Basic Programming  
Ian Paquette, MD |
| **Group 2**          | SNS Inanimate Model and Basic Programming  
Ian Paquette, MD | SNS Lead Placement (cadaver model)  
Amy Thorsen, MD |
| **Group 3**          | SNS Lead Placement (cadaver model)  
Adam Abodeely, MD | SNS Inanimate Model and Basic Programming  
Massarat Zutshi, MD |
| **Group 4**          | SNS Inanimate Model and Basic Programming  
Massarat Zutshi, MD | SNS Lead Placement (cadaver model)  
Adam Abodeely, MD |
| **Group 5**          | SNS Advanced Lead Placement (cadaver model)  
Margarita Murphy, MD | SNS Troubleshooting and Advanced Programming  
Sandip Vasavada, MD |
| **Group 6**          | SNS Troubleshooting and Advanced Programming  
Sandip Vasavada, MD | SNS Advanced Lead Placement (cadaver model)  
Margarita Murphy, MD |
| **Group 7**          | SNS Advanced Lead Placement (cadaver model)  
Joshua Bleier, MD | SNS Troubleshooting and Advanced Programming  
Karen Noblett, MD |
| **Group 8**          | SNS Troubleshooting and Advanced Programming  
Karen Noblett, MD | SNS Advanced Lead Placement (cadaver model)  
Joshua Bleier, MD |

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<tr>
<th>Groups 9-16</th>
<th><strong>Case Discussions</strong> (Room: 501BC)</th>
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<tr>
<td></td>
<td>Drs. Kelly Garrett, Paul-Antoine Lehur, Klaus Matzel, Anders Mellgren</td>
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2:30 pm  Break

*Continued next page*
Emerging Therapies in Fecal Incontinence *(continued)*

3:00 – 4:30 pm  
Room: 502B

**Hands-on Session**

<table>
<thead>
<tr>
<th>Groups 9-16</th>
<th>3:00 – 3:45 pm</th>
<th>3:45 – 4:30 pm</th>
</tr>
</thead>
</table>
| **Group 9** | SNS Lead Placement (cadaver model)  
Amy Thorsen, MD | SNS Inanimate Model and Basic Programming  
Ian Paquette, MD |
| **Group 10** | SNS Inanimate Model and Basic Programming  
Ian Paquette, MD | SNS Lead Placement (cadaver model)  
Amy Thorsen, MD |
| **Group 11** | SNS Lead Placement (cadaver model)  
Adam Abodeely, MD | SNS Inanimate Model and Basic Programming  
Massarat Zutshi, MD |
| **Group 12** | SNS Inanimate Model and Basic Programming  
Massarat Zutshi, MD | SNS Lead Placement (cadaver model)  
Adam Abodeely, MD |
| **Group 13** | SNS Advanced Lead Placement (cadaver model)  
Margarita Murphy, MD | SNS Troubleshooting and Advanced Programming  
Sandip Vasavada, MD |
| **Group 14** | SNS Troubleshooting and Advanced Programming  
Sandip Vasavada, MD | SNS Advanced Lead Placement (cadaver model)  
Margarita Murphy, MD |
| **Group 15** | SNS Advanced Lead Placement (cadaver model)  
Joshua Bleier, MD | SNS Troubleshooting and Advanced Programming  
Karen Noblett, MD |
| **Group 16** | SNS Troubleshooting and Advanced Programming  
Karen Noblett, MD | SNS Advanced Lead Placement (cadaver model)  
Joshua Bleier, MD |

| Groups 1-8 | **Case Discussions***(Room: 501BC)***  
Drs. Kelly Garrett, Paul-Antoine Lehur, Klaus Matzel, Anders Mellgren |

4:30 pm  Adjourn
**Workshop**

**Robotic Colon and Rectal Surgery: Tips, Tricks with Simulation for the Novice Surgeon**

7:30 – 11:30 am  
Room: 408B  

**Registration Required • Member Fee: $525 • Non-Member Fee: $625 • Limit: 16 participants**

Supported by an independent educational grant and loaned durable equipment from Intuitive Surgical, Inc.

Robotic colorectal surgery is a rapidly expanding field. While interest keeps growing among practitioners all over the world, a need exists to ensure optimal procedural adoption with adherence to best practices and techniques. This course will provide an opportunity for participants to interact with highly experienced faculty and expand both the fundamentals and the advanced techniques employed in robotic colorectal procedures.

This hands-on portion of the course will consist of a dry lab session for novice robotic surgeons. The dry session will involve basic robotic procedural set-up as well as simulation and inanimate exercises. The main focus will be on proper docking techniques and port placement as well as intra-operative trouble shooting and suggestions on how to organize a robotic program.

**Existing Gaps**

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

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

**Co-Director:** Alessio Pigazzi, MD, PhD, Orange, CA  
**Co-Director:** Craig Rezac, MD, New Brunswick, NJ

**Faculty for hands-on session includes:**

- Jorge Lagares-Garcia, MD, Charleston, SC
- John Marks, MD, Wynnewood, PA
- Benyamine Mizrahi, MD, Kansas City, MO
- Deborah Nagle, MD, Boston, MA

The course will consist of four stations, each with a faculty member teaching appropriate set-up. Right hemicolectomy, left hemicolectomy, LAR, APR and transverse colectomy will be addressed.

**Learning Objectives:** At the conclusion of this session, participants should be able to: a) Describe the basic set-up and instrumentation of robotic surgery; b) Explain the different procedural approaches in robotic colorectal surgery; c) Describe how to troubleshoot and address specific robotic-related complications in colorectal surgery.
Symposium and Workshop

Ventral Rectopexy: An International Perspective

7:30 am – 4:30 pm
Rooms: 151 & 408A
Registration Required (includes Didactic and Hands-on Workshop) • Member Fee: $525 • Non-Member Fee: $625
Limit: 20 participants • Lunch Included
Didactic Session Only: $25 (7:30 am – noon)

Supported by independent educational grants and loaned durable equipment from:
- Applied Medical
- Cook Medical
- Ethicon US, LLC
- Medtronic
- Olympus America Inc.

Rectal prolapse is a debilitating condition with both functional and anatomic sequelae. There are a myriad of surgical options to repair rectal prolapse with low-quality evidence directing the best approach. Laparoscopic ventral rectopexy (LVR) is the current gold standard for treatment of rectal prolapse in European countries.

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

Ventral rectopexy has become the gold standard for rectal prolapse repair in Europe and Australia and is gaining interest in the USA. Successful functional outcomes and minimizing complications depends on appropriate surgical training for this procedure.

Existing Gaps

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

What Should Be: Surgeons should have the opportunity to learn the techniques of LVR through didactic video based learning and simulation.

Learning Objectives: At the conclusion of this session, participants should be able to: a) Explain laparoscopic ventral rectopexy, indications and long-term outcomes; b) Describe surgical steps for ventral rectopexy; c) Distinguish how to avoid and deal with surgical complication during and after LVR; d) Recall mesh and graft materials; e) Recognize when to get the urogynecologist involved and how to work together; f) Recognize technical points and troubleshooting problems during VR.

Continued next page
Ventral Rectopexy: An International Perspective (continued)

**Director:** Brooke Gurland, MD, *Cleveland, OH*

**Assistant Director:** James Ogilvie, Jr., MD, *Grand Rapids, MI*

7:30 am – noon
Room: 151

**Didactic Session**

7:30 am  Welcome and Introductions  
Brooke Gurland, MD, Cleveland, OH

7:40 am  Principles and Evolution of Mesh Procedures for Rectal Prolapse  
C. Neal Ellis, MD, Odessa, TX

7:55 am  Laparoscopic Ventral Rectopexy – Evolution of Technique and Long-Term Outcomes  
Andre D’Hoore, MD, PhD, Leuven, Belgium

8:10 am  Indications: VR for ODS and Internal Prolapse, Patient Selection, Functional Outcomes  
Ian Lindsey, MD, Oxford, United Kingdom

8:25 am  Indications: Patient Selection, Functional Outcomes VR for Full Thickness Rectal Prolapse  
Paul-Antoine Lehur, MD, PhD, Nantes, France

8:40 am  VR, Sacrocolpopexy, Combined Pelvic Floor Evaluation  
Beri Ridgeway, MD, Riverside, CA

8:55 am  Working with the Urogynecologist  
Anders Mellgren, MD, PhD, Chicago, IL

9:10 am  Open vs Lx vs Robotic VR  
Joseph Carmichael, MD, Orange, CA

9:25 am  Refreshment Break in Foyer

9:35 am  Biologics for Pelvic Floor Surgery  
James Ogilvie, Jr., MD, Grand Rapids, MI

9:50 am  Synthetic Mesh Options and Litigation  
Beri Ridgeway, MD, Riverside, CA

10:05 am  LVR Surgery Video; LVR Steps and How I Do It  
Andrew Stevenson, MD, Chermside, QLD, Australia

10:30 am  Complications and Learning Curve  
Anthony Richard Dixon, MD, Bristol, United Kingdom

10:45 am  Robotic VR Video/Procedure Steps  
Cesar Santiago, MD, Tampa, FL

11:00 am  Robotic VR – Is It Worth It?  
Brooke Gurland, MD, Cleveland, OH

11:15 am  Is there a Role for Resection?  
Liliana Bordeianou, MD, Boston, MA

11:30 am  Panel

Noon  Adjourn

Noon  Lunch Provided for Hands-on Lab Participants (Room: 406A)

1:00 – 4:30 pm
Room: 408A

**Hands-on Session**

1:00 pm  Patient Positioning/Port Placement LVR/Exposing the Pelvis  
James Ogilvie, Jr., MD, Grand Rapids, MI

1:10 pm  LVR Peritoneal Dissection/Exposing RVF Space  
Andre D’Hoore, MD, PhD, Leuven, Belgium

1:20 pm  Mesh or Graft Placement and Suturing on to the Rectum  
Andrew Stevenson, MD, Chermside, QLD, Australia

1:30 pm  Fixation at the Sacrum  
Ian Lindsey, MD, Oxford, United Kingdom

1:40 pm  Closure of the Peritoneum  
Joseph Carmichael, MD, Orange, CA

1:50 pm  Redo Rectal Prolapse Video  
Anthony Richard Dixon, MD, Bristol, United Kingdom

2:00 pm  Trainer Boxes

4:30 pm  Wrap-Up

4:30 pm  Adjourn
**Workshop**

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

7:30 am – 2:30 pm  
Room: 409A

*Registration Required • Member Fee: $525 • Non-Member Fee: $625 • Limit: 45 participants • Lunch Included*

**Supported by independent educational grants consisting of loaned durable equipment from:**
- CONMED
- CooperSurgical
- Redfield Corporation
- Seiler Instrument & Manufacturing Co, Inc.
- Zinnanti Surgical Design Group Inc.

The incidence of anal cancer is increasing due to rising rates of human papilloma virus (HPV) infection. HPV infection can lead to anal intraepithelial neoplasia (AIN) that can be identified with high-resolution anoscopy (HRA). While colon and rectal surgeons are very familiar with the evaluation and treatment of anal cancer, many do not know how to identify the anal cancer precursor, AIN, with HRA. While the efficacy of HRA with targeted ablation of HSIL to prevent anal cancer has never been proven through prospective trials, there is a growing awareness even among surgeons who do not utilize HRA that close follow-up is necessary.

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

**Existing Gaps**

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

**What Should Be:** Colon and rectal surgeons should have a thorough understanding of AIN. In addition, colon and rectal surgeons should have an understanding of how to use HRA to evaluate and treat AIN. Finally, surgeons should know all the treatment options available for patients with AIN. Even if surgeons do not believe in treatment of HSIL to prevent cancer, they need to know how to recognize progressing lesions and superficially invasive cancers.

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

**Director:** Stephen Goldstone, MD, New York, NY  
**Assistant Director:** Naomi Jay, RN, NP, PhD, San Francisco, CA

Room: 409A

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Faculty Name, Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30 am</td>
<td>Welcome and Introductions</td>
<td>Stephen Goldstone, MD, New York, NY</td>
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<tr>
<td>7:35 am</td>
<td>Intro to HPV: Scope of the Problem</td>
<td>Joel Palefsky, MD, San Francisco, CA</td>
</tr>
</tbody>
</table>
| 7:50 am | How to Diagnose AIN: Screening and Diagnostics    | J. Michael Berry-Lawhorn, MD, San Francisco, CA  
Naomi Jay, RN, NP, PhD, San Francisco, CA |
| 8:10 am | Fundamentals of HRA                               | Naomi Jay, RN, NP, PhD, San Francisco, CA |

8:30 am | HRA Findings of AIN and Biopsy                    | Naomi Jay, RN, NP, PhD, San Francisco, CA  
J. Michael Berry-Lawhorn, MD, San Francisco, CA |

9:20 am | HRA-Guided Treatment Options                      | Stephen Goldstone, MD, New York, NY  
Joel Palefsky, MD, San Francisco, CA |

10:00 am | Panel Discussion and Questions                    | J. Michael Berry-Lawhorn, San Francisco, CA  
Stephen Goldstone, MD, New York, NY  
Naomi Jay, RN, NP, PhD, San Francisco, CA  
Joel Palefsky, MD, San Francisco, CA |

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

10:30 am – noon

**Hands-on Session**

*Director: Stephen Goldstone, MD, New York, NY*

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

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<tr>
<th>Time Slot</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
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<tbody>
<tr>
<td>10:30 – 11:00 am</td>
<td><strong>Lesion Identification</strong> (understanding lesion patterns to differentiate LG from HG) Naomi Jay, NP, PhD Room: 409A</td>
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<td><strong>Hands-on Workshop:</strong> HRA Including Use of the Colposcope and Biopsy Techniques J. Michael Berry-Lawhorn, MD Stephen Goldstone, MD Room: 409B</td>
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<td><strong>Hands-on Workshop:</strong> HRA Including Use of the Colposcope and Biopsy Techniques J. Michael Berry-Lawhorn, MD Stephen Goldstone, MD Room: 409B</td>
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<tr>
<td>11:30 am – noon</td>
<td><strong>HRA the Movie</strong> Joel Palefsky, MD Room: 410</td>
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<td><strong>HRA the Movie</strong> Joel Palefsky, MD Room: 410</td>
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**Noon** Lunch with Panel Discussion and Questions (Room: 409A)

1:00 – 2:30 pm

**Hands-on Session**

*Director: Stephen Goldstone, MD, New York, NY*

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

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<tbody>
<tr>
<td>1:00 – 1:30 pm</td>
<td><strong>IRC and Hyfrecator Movie</strong> Stephen Goldstone, MD Room: 409A</td>
<td><strong>Cases: Identifying Lesions, Determining Sites for Biopsies</strong> J. Michael Berry-Lawhorn, MD Room: 410</td>
<td><strong>Hands-on Workshop:</strong> HRA Treatment Naomi Jay, NP, PhD Joel Palefsky, MD Room: 409B</td>
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<td><strong>Hands-on Workshop:</strong> HRA Treatment Naomi Jay, NP, PhD Joel Palefsky, MD Room: 409B</td>
</tr>
<tr>
<td>2:00 – 2:30 pm</td>
<td><strong>Cases: Identifying Lesions, Determining Sites for Biopsies</strong> J. Michael Berry-Lawhorn, MD Room: 410</td>
<td><strong>IRC and Hyfrecator Movie</strong> Stephen Goldstone, MD Room: 409A</td>
<td><strong>IRC and Hyfrecator Movie</strong> Stephen Goldstone, MD Room: 409A</td>
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</tbody>
</table>

2:30 pm Adjourn
**Workshop**

**Young Surgeons Mock Orals: “Your Turn in the Hot Seat”**

**Noon – 3:00 pm**

Room: 406B

**Registration Required • Fee: $50 • Limit: 45 participants**

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

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

This course is for current colorectal residents and board-eligible colon and rectal surgeons.

**Existing Gaps**

**What Is:** No high-quality formal mock examination review courses exist to prepare recent colorectal fellowship graduates for the oral examination.

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

**Director:** Jason Mizell, MD, Little Rock, AR

**Assistant Directors:** Anjali Kumar, MD, Seattle, WA; Vitaliy Poylin, MD, Boston, MA

**Noon**

**Welcome and Introductions**

Jason Mizell, MD, Little Rock, AR

**12:30 pm**

**Small Group Oral Exam Sessions**

- **Small Group Oral Exam A**
  - Room: 404A
  - Joselin Anandam, MD, Dallas, TX
  - Satyadeep Bhattacharya, MD, Carbondale, IL
  - Karin Hardiman, MD, PhD, Ann Arbor, MI
  - Daniel Klaristenfeld, MD, San Diego, CA
  - Yosef Nasseri, MD, Los Angeles, CA
  - Vitaliy Poylin, MD, Boston, MA

- **Small Group Oral Exam B**
  - Room: 404B

- **Small Group Oral Exam C**
  - Room: 405

**2:45 pm**

**Perspectives and Pitfalls**

Joselin Anandam, MD, Dallas, TX

Satyadeep Bhattacharya, MD, Carbondale, IL

Karin Hardiman, MD, PhD, Ann Arbor, MI

Daniel Klaristenfeld, MD, San Diego, CA

Yosef Nasseri, MD, Los Angeles, CA

**3:00 pm**

**Adjourn**

**Learning Objectives:** At the conclusion of this session, participants should be able to: a) Describe the structure of the oral examination; b) Practice answering colorectal oral board style questions in a high pressure format; c) Demonstrate knowledge among colleagues and learn from previous examinees.
This symposium will assist practicing colorectal surgeons who have the desire to contribute to our understanding of the pathogenesis and management of colorectal diseases. Nuts and bolts of study design, data management and analysis, as well as common pitfalls will be reviewed, focusing on clinical, health services, quality improvement and system-based research. Key attributes of successful work submitted to the ASCRS annual meeting, Diseases of the Colon and Rectum, ASCRS Research Foundation and ACS Clinical Congress will be discussed. Breakout sessions will provide hands-on experience with study design, abstract and manuscript construction, addressing reviewer comments, and critical review of submitted work.

Only a fraction of submitted abstracts and manuscripts are ever presented or published. The most common reason for rejection is inappropriate study design and/or data interpretation. There is very little training during most surgical residencies in the areas of study design, data analysis, and critical review of submitted research.

**Existing Gaps**

**What Is:** Research proposals and completed research submitted to the ASCRS forums are frequently missing important elements that compromise the validity and applicability of the findings.

**What Should Be:** Grants, abstracts and papers submitted to colorectal venues should be valid and value added.

**Director:** Thomas Read, MD, Burlington, MA  
**Assistant Director:** Elizabeth Wick, MD, Baltimore, MD

**12:30 pm**  
**What’s a Good Fit for Me: Clinical, Basic Science, Health Services or Quality Improvement Research?**  
Elizabeth Wick, MD, Baltimore, MD

**12:45 pm**  
**Getting Support: Funding 101 and Grant Submission Strategies**  
Kelli Bullard Dunn, MD, Louisville, KY

**1:00 pm**  
**Developing and Maintaining a High-Quality Prospective Database**  
Rocco Ricciardi, MD, Burlington, MA

**1:15 pm**  
**Hypothesis Generation and Study Design 101**  
David Etzioni, MD, Phoenix, AZ

**1:30 pm**  
**Nuts and Bolts of Data Analysis: Univariate, Multivariate, Statistics…Oh My!**  
Scott Regenbogen, MD, Ann Arbor, MI

**1:45 pm**  
**Strategies for Writing Successful Abstracts and Manuscripts**  
Matthew Mutch, MD, St. Louis, MO

**2:00 pm**  
**Refreshment Break in Foyer**

**Breakout Sessions**

**2:10 – 2:40 pm**  
**Abstracts and Manuscripts: Writing and Revision** (Room: 151)  
Matthew Mutch, MD, St. Louis, MO  
Rocco Ricciardi, MD, Burlington, MA

**Grant Submission and Revision** (Room: 150A)  
Kelli Bullard Dunn, MD, Louisville, KY  
Elizabeth Wick, MD, Baltimore, MD

**Study Design** (Room: 150B)  
David Etzioni, MD, Phoenix, AZ  
Scott Regenbogen, MD, Ann Arbor, MI

**2:40 pm**  
**Perspective from the Other Side: How to Critically Review an Abstract or Manuscript**  
Thomas Read, MD, Burlington, MA

**2:55 pm**  
**Wrap-Up**

**3:00 pm**  
**Adjourn**

**Learning Objectives:** At the conclusion of this session, participants should be able to: a) Describe the basics of clinical research, health services research and quality and systems-based research; b) Identify a research question that can be answered; c) Recognize how to develop and maintain clinical databases; d) Distinguish the basics of clinical trial design for the practicing surgeon; e) Design, analyze and protect research; f) Construct successful work for presentation and peer-review publication.
**Symposium**

**Question Writing: The Perfect Written Exam Question; Do You Know How to Write One?**

**12:30 – 3:30 pm**

Room: 503

**Registration Required • Limit: 70 participants**

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

**Existing Gaps**

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

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

**Director:** Tracy Hull, MD, Cleveland, OH

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

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

12:30 – 4:30 pm
Room: 408B

Registration Required • Member Fee: $525 • Non-Member Fee: $625 • Limit: 16 participants

Supported by an independent educational grant and loaned durable equipment from Intuitive Surgical, Inc.

This session will involve cadaver-based procedural exercises aimed at demonstrating state-of-the-art techniques employed in different colorectal operations with a focus on right colectomy, left colectomy, transverse colectomy, LAR and APR.

The main focus will be on operative techniques, identification and preservation of critical anatomy and intra-operative trouble shooting. This course is intended for surgeons who are in their learning curve having done a minimum of five robotic procedures as primary surgeons and wish to increase their proficiency. Each candidate will be asked to supply a case log and show access to a robotic system in his/her practice.

Existing Gaps

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

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

Co-Director: Alessio Pigazzi, MD, PhD, Orange, CA
Co-Director: Craig Rezac, MD, New Brunswick, NJ

Faculty for hands-on session includes:
Jorge Lagares-Garcia, MD, Charleston, SC
John Marks, MD, Wynnewood, PA
Benyamine Mizrahi, MD, Kansas City, MO
Deborah Nagle, MD, Boston, MA

This cadaver course will consist of four stations, each with a faculty member teaching appropriate set-up. Right hemicolecctomy, left hemicolecctomy, LAR, APR and transverse colectomy will be addressed.

Learning Objectives: At the conclusion of this session, participants should be able to: a) Describe the basic set-up and instrumentation of robotic surgery; b) Explain the different procedural approaches in robotic colorectal surgery; c) Describe how to troubleshoot and address specific robotic-related complications in colorectal surgery.
Symposium

Managing Complications

1:00 – 3:00 pm
Room: Petree Hall

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

Existing Gaps

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

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

Director: David Margolin, MD, New Orleans, LA
Assistant Director: Bruce Orkin, MD, Chicago, IL

1:00 pm Non-Healing Perineal Wound
Jonathan Efron, MD, Baltimore, MD

1:15 pm The Intraoperative Anastomotic Leaks
Daniel Popowich, MD, New York, NY

1:30 pm Management of Pelvic Bleeding
Todd Francone, MD, Burlington, MA

1:45 pm Management of the Anticoagulated Patient
Brian Kann, MD, New Orleans, LA

2:00 pm The Microbiome
Neil Hyman, MD, Chicago, IL

2:15 pm Post-Operative Anastomotic Leak
Harry Reynolds, Jr., MD, Cleveland, OH

2:30 pm Panel Discussion

3:00 pm Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Describe strategies to avoid and treat complications of coloanal anastomoses, including stenosis, bleeding, and disruption with presacral abscess and chronic fistula; b) Discuss management strategy for dealing with pelvic bleeding; c) Manage and limit complications in the urgent operation of patients on novel anticoagulation agents, antiplatelet agents and drug eluting stents. Understand strategies to prevent and treat perioperative venous thromboembolism; d) Explain the role of the microbiome in the prevention and management of anastomotic leaks; e) Develop strategies for the treatment of non-healing perineal wounds.

*This session addresses Self-Assessment (MOC) credit requirements as explained on page 9.
Health Care Policy/Reform 2016 and Beyond: A Round Table Discussion

1:00 – 3:00 pm
Rooms: 152-153

Over the last five years health care delivery has changed dramatically, especially with more physicians becoming employed by hospitals, health care networks and academic centers including safety-net hospitals. This has caused a great deal of concern by those physicians who want to remain in the private practice setting. This also affects the decisions of young physicians who are in residency and fellowships as to “readjusting” their career goals.

Today the “health care economic market” has matured to some degree and there are more defined payment models. There is a growing body of evidence that there will be “hybrid payment models” that will exist within a network reimbursement strategy. There is still hope for private practitioners because there are “virtual” affiliation models that can be developed to remain “independent” yet financially aligned with some networks.

The role of the safety net hospital will continue to evolve and may be forced to reorganize their operations and their care delivery, and reposition themselves within the health care market. For many safety-net systems, the changes required are substantial. There is an ongoing need for discussion and consensus on the continuing role of safety-net systems under health reform; and the likely need for continuing government support to ensure that patients can continue to benefit from the extra value these systems provide. The round table will allow for a very interactive and informative discussion based on concerns of colon and rectal surgeons who are on the front lines of clinical practice.

Existing Gaps

What Is: Under the current Alternative Payment Models how will colon and rectal surgeons incorporate, affiliate or align themselves to continue to practice high quality care.

What Should Be: Colon and rectal surgeons should understand that these Alternative Payment Models are evolving away from the FFS method of reimbursement and which system will benefit them the most. Colon and rectal surgeons should also understand the impact of the ACA on safety-net hospitals and how these hospitals need to evolve and re-position themselves in the health care market to remain relevant.

Director: Glenn Ault, MD, Los Angeles, CA
Assistant Director: Anthony Senagore, MD, Galveston, TX

1:00 pm The Role of the Public Safety Net Hospital Under the ACA
Mitchell Katz, MD, Los Angeles, CA
1:20 pm Value-Based Purchasing
Patrick Bailey, MD, Washington, DC
1:40 pm Alternative Payment Models: What Works
Robert Jasak, Esq., Washington, DC

2:00 pm The Role of the Public Safety Net Hospital in Graduate Medical Education Under the ACA
Lawrence Opas, MD, Los Angeles, CA
2:20 pm Round Table Discussion
3:00 pm Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Recognize how various reimbursement models are evolving including Alternative Payment Models and Value Based Reimbursement and the effect they may have on compensation; b) Describe the importance of quality indicators for reimbursement; c) Define the evolving role of the safety-net hospital and how it fits into today’s health care market under the ACA; d) Distinguish the evolving role of the safety-net hospital and how that role is evolving to fit into today’s health care system under the Affordable Care Act.
**Symposium**

**Parallel Session 2-A**

**Translational Medicine:**

**How Genetics Drive Patient Care in Your Colorectal Practice**

**1 2 3** *

3:00 – 5:00 pm

Rooms: 152-153

*Supported by an independent educational grant from Myriad Genetics*

Advanced technologies have allowed an exponential increase in our understanding of the genetic underpinnings of colorectal diseases. As we learn more about molecular genetics at the cellular level, we are able to develop a more personalized treatment approach. Genetic variation is being increasingly incorporated into clinical practice for both malignant and benign colorectal diseases. This has traditionally been applied mainly to the diagnosis and management of inherited colorectal cancer syndromes, but now translatable genetic information about sporadic cancers and inflammatory bowel disease help guide treatment. It is essential that the colon and rectal surgeon be up-to-date regarding the genetics of colorectal diseases, and how to apply this knowledge into routine clinical practice. This symposium will provide an overview of clinical genetics, discuss updates on new genes and hereditary colorectal cancer syndromes, and how genetics may be implemented into the daily management of hereditary and sporadic colorectal cancer, and inflammatory bowel disease.

**Existing Gaps**

**What Is:** In their routine daily practice, clinicians do not often appreciate the relevance of understanding genetics as it applies to diagnosis and management of hereditary colorectal cancer syndromes, prognosis and prediction of response to therapy in sporadic cancers, and influence of outcomes on inflammatory bowel disease. As a result, their patients may not receive appropriate treatment, surveillance, and/or counseling.

**What Should Be:** Patients with hereditary cancer syndromes are readily identified and offered appropriate counseling, medical and surgical therapy. Surgical and adjuvant strategies for colorectal cancer and inflammatory bowel disease should also include understanding of the influence of genetic determinants on clinical outcome.

**Co-Director:** Matthew Kalady, MD, Cleveland, OH

**Co-Director:** Paul Wise, MD, St. Louis, MO

3:00 pm  **Genetics Overview**

Gregory Kennedy, MD, PhD, Birmingham, AL

3:20 pm  **Serrated Polyps and the Serrated Pathway to Colorectal Cancer**

James Church, MD, Cleveland, OH

3:40 pm  **Newly Recognized Genes and Concepts in Hereditary CRC and Gene Panel Testing**

Stephen Gruber, MD, PhD, Los Angeles, CA

4:00 pm  **Genetic Biomarkers to Guide Sporadic CRC Management**

Martin Weiser, MD, New York, NY

4:20 pm  **Using Genes to Stratify Risk in IBD**

Walter Koltun, MD, Hershey, PA

4:40 pm  **Panel Discussion**

5:00 pm  **Adjourn**

**Learning Objectives:** At the conclusion of this session, participants should be able to: a) Recognize the basic principles of genetics and the key genes involved in sporadic and hereditary colorectal cancer; b) Explain the underlying concepts of the serrated pathway to colorectal cancer and the management of serrated polyps and polyposis; c) Distinguish the newly described genes in hereditary colorectal cancer syndromes and be familiar with the new products available to help diagnosis genetic mutations underlying these syndromes; d) Describe the influence of particular genotypes on prognosis and outcomes for sporadic colorectal cancer and inflammatory bowel disease, including how this information may be utilized in clinical practice.

*This session addresses Self-Assessment (MOC) credit requirements as explained on page 9.*
Symposium

Advanced Endoscopy and Endoluminal Surgery

3:00 – 5:00 pm
Room: Petree Hall

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

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

Existing Gaps

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

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

Director: Sang Lee, MD, New York, NY
Assistant Director: I. Emre Gorgun, MD, Cleveland, OH

3:00 pm How to Improve Patient Comfort: Water Emersion, CO₂ Positioning, What Types of Scopes? Charles Whitlow, MD, New Orleans, LA

3:12 pm How to Achieve Cecal Intubation in Patients with Angulated and Redundant Colon Kyle Cologne, MD, Los Angeles, CA

3:24 pm Advances in Endoscopic Detection of Dysplasia in IBD Toshiaki Watanabe, MD, PhD, Tokyo, Japan

3:36 pm How to Improve Polyp Detection: Quality Measures and New Techniques and Tools for Improvement Daniel Feingold, MD, New York, NY

3:48 pm Beyond Polypectomy: EMR and ESD Richard Whelan, MD, New York, NY

4:00 pm Combined Endoscopic Laparoscopic Surgery (CELS) and Beyond Jeffrey Milsom, MD, New York, NY

4:12 pm Colonic Stenting David Margolin, MD, New Orleans, LA

4:24 pm How to Avoid Complications and Treatment of Endoscopic Complications Jacques Van Dam, MD, PhD, Los Angeles, CA

4:36 pm Future Endoscopic Tool Box: New Tools, Changing Paradigms? Jeffrey Marks, MD, Cleveland, OH

4:48 pm Panel Discussion

5:00 pm Adjourn

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

*This session addresses Self-Assessment (MOC) credit requirements as explained on page 9.
Symposium

Transanal Total Mesorectal Excision (taTME)

This is the didactic part of the taTME Hands-on Workshop on Sunday.

5:00 – 7:00 pm
Room: Petree Hall

Supported by independent educational grants from:
- Applied Medical
- KARL STORZ Endoscopy-America, Inc.
- Medtronic
- Olympus America Inc.
- Richard Wolf Medical Instruments Corporation
- Stryker Endoscopy

Registration Required · Fee: $25

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

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

Existing Gaps

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

What Should Be: This course will introduce high volume rectal cancer surgeons with expertise in laparoscopic and robotic TME and transanal endoscopic surgery to transanal TME. The course will provide a comprehensive review of rationale, indications, surgical techniques, results and limitations of taTME. The course intends to guide safe adoption of this approach as an alternative to standard radical resection when clinically indicated, and in the context of a multidisciplinary rectal cancer program.

Co-Director: Patricia Sylla, MD, New York, NY
Co-Director: Justin Maykel, MD, Worcester, MA

5:00 pm taTME: History and Rationale
Mark Whiteford, MD, Portland, OR

5:10 pm Evolution of taTME Technique
Antonio Lacy, MD, PhD, Barcelona, Spain

5:25 pm taTME: Patient Selection and Published Results to Date
Elisabeth McLemore, MD, Los Angeles, CA

5:35 pm taTME Registry: International Update
Roel Hompes, MD, Oxford, United Kingdom
John Monson, MD, Orlando, FL

5:50 pm Patient Selection, Operative Set-Up and Instrumentation
Sam Atallah, MD, Winter Park, FL

6:00 pm taTME Step-Wise Techniques
Joep Knol, MD, Hasselt, Belgium

6:15 pm taTME Pitfalls and Complications
Matthew Albert, MD, Altamonte Springs, FL

6:25 pm Initiating a taTME Program
Justin Maykel, MD, Worcester, MA

Continued next page
Transanal Total Mesorectal Excision (taTME) (continued)

6:35 pm  What's Next with taTME: International Initiatives
Roel Hompes, MD, Oxford, United Kingdom
Patricia Sylla, MD, New York, NY

6:45 pm  Discussion

7:00 pm  Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Describe the rationale, indications, contraindications, and preliminary results of taTME based on published evidence; b) Explain the operative set-up, transanal platforms and instrumentation available to perform taTME; c) Recognize the operative techniques through didactic lectures and video demonstrations; d) Recall the intraoperative complications and limitations of taTME; e) Name the recommended pathway for establishing a multidisciplinary team-based taTME program.
Symposium
Robotic Colon and Rectal Surgery: Tips, Tricks, and Simulation

7:00 – 9:00 am
Room: Petree Hall

Supported by an independent educational grant from Intuitive Surgical, Inc.

Over the past several years robotic colon and rectal surgery has gradually gained acceptance among many colorectal surgeons. This is a worldwide trend occurring not only in the US but also throughout Europe and Asia. Robotic colorectal surgery continues to evolve with the new Xi platform, specifically designed for multi-quadrant access, being released late last year. Advances in stapling devices, energy sources and advanced optics will further assist in the growth of this field.

This didactic session will feature lectures with multiple videos. Various topics will be covered. Suggestions on starting a robotic program will be addressed as well as proper port placement, robot docking and patient selection. The faculty will discuss various tips and advice on approaches to different parts of the colon and rectum for various pathologies aimed at facilitating the learning curve of the participants.

This course is aimed at three populations of surgeons:

1) Practicing colon and rectal surgeons who perform robotic surgery but are still in their learning curve. This session will give them insight on how to improve efficiency.

2) Practicing colon and rectal surgeons who do not currently do robotic surgery but wish to introduce robotic surgery into their practice.

3) Colon and rectal residents who are interested in robotics.

Existing Gaps

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

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

Director: Craig Rezac, MD, New Brunswick, NJ
Assistant Director: Alessio Pigazzi, MD, PhD, Orange, CA

7:00 am Starting Up: How to Begin Safely
Kelly Tyler, MD, Springfield, MA

7:15 am Robotic Low Anterior Resection
Joseph Martz, MD, New York, NY

7:30 am Robotic Abdominoperineal Resection
David Larson, MD, Rochester, MN

7:45 am Robotic Multiport Right Hemicolectomy with Intracorporeal Anastomosis
Craig Johnson, MD, Tulsa, OK

8:00 am Robotic Surgery for Inflammatory Bowel Disease
Jamie Cannon, MD, Birmingham, AL

8:15 am 8:30 am New Techniques and Technologies in Robotics: Single Incision, Parastomal Hernia Repair, Transanal Surgery, Firefly, Stapler, Vessel Sealer and Xi
Vincent Obias, MD, Washington, DC

8:45 am Panel Discussion

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

*This session addresses Self-Assessment (MOC) credit requirements as explained on page 9.

7:00 – 9:30 am
Room: West Hall B

The Core Subject Update was developed to assist in the education and recertification of colon and rectal surgeons. Twenty-four core subjects have been chosen and are presented in a four-year rotating cycle. Presenters are experts on their selected topics and present evidence-based reviews on the current diagnosis, treatment and controversies of these diseases. Following each presentation, a brief discussion period is moderated by the course director.

**Existing Gaps**

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

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

**Director:** Justin Maykel MD, Worcester, MA
**Assistant Director:** Karim Alavi, MD, Worcester, MA

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<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter</th>
<th>Location</th>
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<tr>
<td>7:00 am</td>
<td>Hemorrhoids/Fissures</td>
<td>Michael McGee, MD, Chicago, IL</td>
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<tr>
<td>7:20 am</td>
<td>Discussion</td>
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<td>7:25 am</td>
<td>Prolapse/Intussusception/SRUS</td>
<td>W. Conan Mustain, MD, Little Rock, AR</td>
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<td>7:45 am</td>
<td>Discussion</td>
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<td>7:50 am</td>
<td>Ulcerative Colitis</td>
<td>Charles Heise, MD, Madison, WI</td>
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<td>8:10 am</td>
<td>Discussion</td>
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<tr>
<td>8:15 am</td>
<td>Trauma/Volvulus</td>
<td>Timothy Counihan, MD, Pittsfield, MA</td>
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**Learning Objectives:** At the conclusion of this session, participants should be able to: a) Maintain an understanding of the pathophysiology of anal fissures and hemorrhoids to offer patients the spectrum of nonsurgical and surgical treatment options; b) Describe the causes and factors related to rectal prolapse and discuss the treatment options including open, laparoscopic, and robotic; c) Maintain command of the medical and surgical treatment of ulcerative colitis, in both acute and chronic settings; d) Review the literature for acute colorectal conditions including colorectal trauma and volvulus as well as the indications for surgery and fecal diversion; e) Recognize the range of benign and malignant anal tumors and the rare retrorectal tumor as well as the evaluation and management options; f) Know when to offer testing as well as the impact on clinical/surgical recommendations for hereditary colorectal cancer.
Workshop

Transanal Total Mesorectal Excision (taTME) Hands-on Course

7:30 am – 2:00 pm
Room: 503

Registration and Pre-registration Survey Required (Includes Saturday Didactic and Sunday Hands-on Workshop)
Fee: $1,000 • Limit: 16 participants • Lunch Included

Supported by independent educational grants and loaned durable equipment from:
- Applied Medical
- CooperSurgical
- KARL STORZ Endoscopy-America, Inc.
- Medtronic
- Olympus America Inc.
- Richard Wolf Medical Instruments Corporation
- Stryker Endoscopy

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

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

The taTME Hands-on Course is intended for high-volume rectal cancer surgeons with expertise in minimally invasive TME and transanal endoscopic surgery. Each surgical team will practice taTME with laparoscopic assistance on a fresh human cadaver under the proctorship of expert faculty.

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

What Should Be: This course will introduce high volume rectal cancer surgeons with expertise in laparoscopic and robotic TME and transanal endoscopic surgery to transanal TME. The course will provide a comprehensive review of rationale, indications, surgical techniques, results and limitations of taTME. The course intends to guide safe adoption of this approach as an alternative to standard radical resection when clinically indicated, and in the context of a multidisciplinary rectal cancer program.

Learning Objectives: At the conclusion of this session, participants should be able to: a) Explain the operative set up, transanal platforms and instrumentation available to perform taTME; b) Demonstrate taTME operative techniques through didactic lectures and video demonstrations; c) Develop the technical skills necessary to perform taTME in a cadaver model; d) Describe the intraoperative complications and limitations of taTME.

Continued next page
Transanal Total Mesorectal Excision (taTME) Hands-on Course (continued)

Co-Director: Patricia Sylla, MD, New York, NY
Co-Director: Justin Maykel, MD, Worcester, MA

7:30 – 9:15 am
Room: 503

7:30 am  Introduction and Objectives
Justin Maykel, MD, Worcester, MA

7:40 am  Interactive Video Session: In-depth taTME Surgical Techniques Intersphincteric Proctectomy for IBD
Elisabeth McLemore, MD, Los Angeles, CA

7:50 am  Interactive Video Session: In-depth taTME Surgical Techniques: taTME for APR
Roel Hompes, MD, Oxford, United Kingdom

8:00 am  Interactive Video Session: In-depth taTME Surgical Techniques: taTME for LAR, Mid-Rectal Cancer
Antonio Lacy, MD, PhD, Barcelona, Spain

8:10 am  Interactive Video Session: In-depth taTME Surgical Techniques: taTME for LAR for Very Low Rectal Cancer
Joep Knol, MD, Hasselt, Belgium

8:20 am  Interactive Video Session: Avoiding Complications: The Bad; Botched Pursestring, Bleeding, Wrong Plane
Matthew Albert, MD, Altamonte Springs, FL

8:30 am  Interactive Video Session: Avoiding Complications: The Ugly; Prostatic Urethral Injury
Patricia Sylla, MD, New York, NY

8:40 am  Getting Started with taTME: Practical Considerations: One vs. Two Surgeon Teams: Pros and Cons
Rodrigo Perez, MD, PhD, Sao Paulo, Brazil

8:50 am  Getting Started with taTME: Robotic Surgeons: Where Does taTME Fit into My Practice?
Sam Atallah, MD, Winter Park, FL

9:00 am  Getting Started with taTME: Practical Considerations: TAMIS taTME Toolkit
Dana Sands, MD, Weston, FL

9:05 am  Getting Started with taTME: Practical Considerations: TEO taTME Toolkit
Alessio Pigazzi, MD, PhD, Orange, CA

9:10 am  Getting Started with taTME: Practical Considerations: TEM taTME Toolkit
Mark Whiteford, MD, Portland, OR

9:15 am – 2:00 pm
Room: 502A

Hands-on Lab

9:15 am  Instructions
Patricia Sylla, MD, New York, NY

9:30 am  Break in Foyer

9:40 am  Station 1-4: TAMIS taTME
Matthew Albert, MD, Altamonte Springs, FL;
Sam Atallah, MD, Winter Park, FL;
Roel Hompes, MD, Oxford, United Kingdom;
Antonio Lacy, MD, PhD, Barcelona, Spain;
Justin Maykel, MD, Worcester, MA;
Elisabeth McLemore, MD, Los Angeles, CA

9:40 am  Station 5-6: TEO taTME
Rodrigo Perez, MD, PhD, Sao Paulo, Brazil;
Alessio Pigazzi, MD, PhD, Orange, CA;
Patricia Sylla, MD, New York, NY

1:15 pm  Lunch and Debrief (Room: 503)

2:00 pm  Adjourn
Symposium

Stomas and Complex Abdominal Wall Problems for the Colorectal Surgeon

9:45 – 11:45 am
Room: Petree Hall

Supported by an independent educational grant from Acelity (KCI, LifeCell, Systagenix)

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

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

Existing Gaps

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

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

Co-Director: David Beck, MD, New Orleans, LA
Co-Director: Eric Johnson, MD, Tacoma, WA

9:45 am Doctor, Please Help Me! This Stoma is a Problem
Samantha Hendren, MD, Ann Arbor, MI

10:00 am Prevention, Repair, Re-Siting, or Takedown… What to do with the Parastomal Hernia?
Alessio Pigazzi, MD, PhD, Orange, CA

10:15 am So Many Products, So Little Time. How to Choose the Right Mesh for Your Patient
Jamie Cannon, MD, Birmingham, AL

10:30 am Panel Discussion

10:45 am How Can I Get This Defect Closed? Plastic Surgery Consult or Do It Yourself?
James Bittner, IV, MD, Richmond, VA

11:00 am Hernia Plus Fistula…How to Manage Complex Enterocutaneous and Enteroatmospheric Fistulas
Joseph Carmichael, MD, Orange, CA

11:15 am My Complex Hernia Repair Has Failed… What Next?
Yuri Novitsky, MD, Cleveland, OH

11:30 am Panel Discussion

11:45 am Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Describe methods of dealing with complex stoma related problems; b) Describe the common advanced techniques for abdominal wall reconstruction of large ventral and parastomal hernia defects; c) Describe the pros and cons associated with use of various common mesh products available on the market; d) Describe the surgical care and optimal order of operations for those with digestive tract fistulas associated with abdominal wall hernias.

*This session addresses Self-Assessment (MOC) credit requirements as explained on page 9.
Laparoscopic Nuts and Bolts and Robotic Rivets

9:45 – 11:45 am
Room: West Hall B

Laparoscopic, robotic, and endoscopic surgical techniques are an integral part of modern colorectal surgical practice. The education of surgeons in these techniques occurs in a variety of settings including fellowship training, industry-sponsored training programs, and professional society continuing medical education programs. In this symposium, both core principles and state of the art laparoscopic, robotic, and endoscopic surgery approaches to common colorectal conditions are presented by experts in the field. The educational format will be short videos followed by panel discussion with audience participation. The aim of this symposium is to expand the knowledge base of society members and guests in the areas of laparoscopic and robotic colorectal surgery.

**Existing Gaps**

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

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

**Director:** Jon Vogel, MD, Aurora, CO
**Assistant Director:** Suraj Alva, MD, Edison, NJ

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<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>9:45 am</td>
<td>Welcome and Introductions</td>
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<td>9:50 am</td>
<td>Lap Right Colectomy: Ensuring Adequate Lymph Node Harvest</td>
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<td>Luiz Felipe de Campos Lobato, MD, Brasilia, DF, Brazil</td>
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<tr>
<td>9:55 am</td>
<td>Lap Left Colectomy: One Step at a Time: IMV, Splenic Flexure, and IMA</td>
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<td>John Byrn, MD, Ann Arbor, MI</td>
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<td>10:00 am</td>
<td>Laparoscopic TME: The Anterior Dissection Plan and Rectal Division</td>
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<td>Raul Bosio, MD, Cleveland, OH</td>
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<td>Robotic APR – Avoidance of the Waist</td>
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<td>Slawomir Marecik, MD, Chicago, IL</td>
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<td>10:10 am</td>
<td>Single Port Laparoscopic Colectomy: More with Less</td>
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<td>Eric Haas, MD, Houston, TX</td>
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<td>10:15 am</td>
<td>HAL Colectomy – For Whom and What For?</td>
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<td>Jeffrey L. Cohen, MD, Hartford, CT</td>
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<td>10:20 am</td>
<td>Panel Discussion</td>
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<td>10:35 am</td>
<td>Laparoscopic Approach to Entero- or Colovaginal/Vesicle Fistula</td>
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<td>Luca Stocchi, MD, Cleveland, OH</td>
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<td>10:40 am</td>
<td>Laparoscopic Ileocolic Resection for Crohn’s Disease</td>
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<td>Phillip Fleshner, MD, Los Angeles, CA</td>
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<td>10:50 am</td>
<td>Robotic Segmental Colectomy</td>
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<td>Vincent Obias, MD, Washington, DC</td>
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<td>10:55 am</td>
<td>Rectopecty: Dissection and Fixation</td>
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<td>Anna Serur, MD, Brooklyn, NY</td>
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<td>11:00 am</td>
<td>Panel Discussion</td>
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<td>Endoscopic Mucosal Resection</td>
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<td>I. Emre Gorgun, MD, Cleveland, OH</td>
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<td>Elisabeth McLemore, MD, Los Angeles, CA</td>
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<td>11:25 am</td>
<td>Transanal Surgical Pitfalls and Solutions</td>
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<td>Mark Whiteford, MD, Portland, OR</td>
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<td>11:30 am</td>
<td>Panel Discussion</td>
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<td>11:45 am</td>
<td>Adjourn</td>
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**Learning Objectives:** At the conclusion of this session, participants should be able to: a) Perform basic and advanced laparoscopic, robotic, and endoscopic colorectal surgical techniques; b) Avoid and manage complications of laparoscopic, robotic and endoscopic surgical techniques; c) Approach colorectal surgical conditions in novel ways; d) Explain various surgical approaches to common and extraordinary surgical problems; e) Engage in discussions with their patients on the pros and cons of laparoscopic, robotic, and endoscopic surgical techniques.

*This session addresses Self-Assessment (MOC) credit requirements as explained on page 9.
Symposium Parallel Session 3-C

Anal Cancer

9:45 – 11:45 am
Room: Concourse Hall (150-153)

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

As experts in benign and malignant diseases of the colon, rectum and anus, practicing colorectal surgeons need to be up to date on the current management recommendations for premalignant and malignant lesions of the anus and perianus. Definitions and management options have been fairly controversial over the last 15 years. New landmarks exist for defining lesions as either anal or perianal and treatment recommendations based on these categories are significantly different. Further, because of confusion surrounding categorization of premalignant lesions of the lower anogenital tract, a task force recommended standardization of terminology surrounding histologic findings. These recommendations were published in the pathology literature in 2013. In 2015, guidelines were introduced for anal cancer screening. This information needs to be widely socialized.

Existing Gaps

What Is: There is confusion regarding guidelines for anal cancer screening and treatment.

What Should Be: Recent literature has defined guidelines for anal cancer screening in women. This session will also cover current radiation therapy modalities for anal cancer and treatment options for superficially-invasive anal squamous-cell carcinoma.

Director: Mark Welton, MD, Stanford, CA
Assistant Director: Sandy Hwang Fang, MD, Baltimore, MD

9:45 am Welcome and Introductions
Mark Welton, MD, Stanford, CA

9:50 am Screening Modalities and Recommendations for Anal Cancer Screening
Ira Leeds, MD, Baltimore, MD

10:05 am High-Resolution Anoscopy: Pathological Review of Anal Intraepithelial Neoplasia
J. Michael Berry-Lawhorn, MD, San Francisco, CA

10:20 am Anal Cancer Screening in Women
Cindy Kin, MD, Stanford, CA

10:35 am An Update on Radiation Therapy for Anal Cancer: Management and Complications
Jennifer Wo, MD, Boston, MA

10:50 am Superficially Invasive Squamous-Cell Carcinoma of the Anus and the ANCHOR Study
Dana Fugelso, MD, Boston, MA

11:05 am Panel Discussion

11:45 am Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Define the current screening options for anal cancer and its associated gross and histologic pathology; b) Describe current radiotherapy treatment options for anal cancer; c) Define anal superficially invasive squamous-cell carcinoma and review its treatment options.

*This session addresses Self-Assessment (MOC) credit requirements as explained on page 9.
Luncheon Symposium

Effective Quality Improvement in Diverse Settings

11:45 am – 12:45 pm
Room: Concourse Hall (150-153)

Quality improvement is integral to clinical practice. In general, efforts to improve the quality of surgical care have had a significant positive impact on patient outcomes. However, physicians and hospitals striving for local quality improvement may face unique challenges associated with their settings and patient mix.

We will update attendees on challenges to quality of care and solutions for quality improvement from a variety of settings and for a variety of patient populations. We will discuss solutions for quality improvement in low volume or rural practice, safety net hospitals, academic settings, and mixed income community practices.

Existing Gaps

What Is: Most Americans receive colorectal surgery care in low volume or safety net hospitals. Surgeons working in such settings address the same quality improvement issues as everyone else but may face additional challenges related to resources and patient mix.

What Should Be: Surgeons in diverse practices and settings should understand ways to modify and implement quality initiatives that address their unique needs.

Director: Arden Morris, MD, Ann Arbor, MI
Assistant Director: Larissa Temple, MD, New York, NY

11:45 am An Overview of the Quality of Surgical Care in U.S. Safety Net Hospitals
Charles Mouch, MD, Ann Arbor, MI

11:55 am Quality Improvement in a Rural Academic Hospital with a Mission to the Poor: The Oregon Experience
Daniel Herzig, MD, Portland, OR

12:05 pm Quality of Care in Global Surgery: Lessons Learned
Rudolph Rustin, MD, Mt. Pleasant, SC

12:15 pm Special Challenges to Quality Improvement in a Military Setting
Ronald Gagliano, MD, Phoenix, AZ

12:25 pm Do Patient Navigators Improve Quality of Care?
Samantha Hendren, MD, Ann Arbor, MI

12:35 pm Panel Discussion

12:45 pm Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Explain how to assess current data regarding quality of surgical care and outcomes, and in safety net and rural hospitals. Identify the principals of a culture of safety and quality improvement; b) Describe the practical steps to implementing and maintaining a quality improvement project that may be modified to fit diverse settings; c) Define how to evaluate the success of a quality improvement initiative.
Luncheon Symposium

Social Media: Basics and Beyond – What’s in It for Me?

11:45 am – 12:45 pm
Room: Petree Hall

The term “social media” is often used to describe a variety of outlets, including but not limited to Facebook, Twitter, LinkedIn, Instagram, YouTube, blogs, google+, and more. The use of these outlets in medicine has skyrocketed in recent years for a variety of reasons, including education, discussion, networking, outreach, humor, and many others.

A basic understanding of the advantages and disadvantages of social media is crucial. While there are many potential uses, many of these are poorly understood by practicing physicians and engaging in social media can be time consuming. It also has a number of possible negative aspects.

The ASCRS Social Media Committee was created to assist health care providers with a specific interest in diseases of the colon, rectum and anus to achieve high-quality patient care by providing an interactive venue for discussion, information and education regarding all aspects of colorectal disease, and utilizing several multimedia platforms in various social media outlets.

Existing Gaps

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

What Should Be: Surgeons should have a basic understanding of what social media is, how it can benefit a practice or practitioner, and what some of the pitfalls associated with social media are.

Co-Director: Kyle Cologne, MD, Los Angeles, CA
Co-Director: William Harb, MD, Nashville, TN

11:45 am Welcome and Introductions
Kyle Cologne, MD, Los Angeles, CA
William Harb, MD, Nashville, TN

11:50 am What the #eck Is Social Media, and Why Should I Care?
Lilian Kao, MD, Houston, TX

Noon The Basics: From Hashtag to Handle, What Is the Lingo of Social Media?
Anjali Kumar, MD, Seattle, WA

12:10 pm What Are the Dangers of Social Media?
Sean Langenfeld, MD, Omaha, NE

12:20 pm How to Put Together a Successful Social Media Campaign for a Cause
Thomas Varghese, Jr., MD, Salt Lake City, UT

12:30 pm Use It or Lose It – How to Use Social Media Effectively without Being Consumed by It
Sharon Stein, MD, Cleveland, OH

12:40 pm Discussion Forum and Questions

Learning Objectives: At the conclusion of this session, participants should be able to: a) Describe what defines social media and how it can be used in medical practice; b) Explain how to navigate the basic features of common social media outlets; c) Describe the potential dangers of social media use and how to avoid them; d) Describe the differences in the common social media platforms.
Welcome and Opening Announcements: How ASCRS Helps You

12:45 – 1:30 pm
Room: West Hall B

Charles E. Littlejohn, Stamford, CT
President, ASCRS

Kirsten Wilkins, MD, Edison, NJ
Program Chair

Joshua Bleier, MD, Philadelphia, PA
Scott Steele, MD, Cleveland, OH
Program Vice-Chairs

Jason Hall, MD, Burlington, MA
Awards Chair

Thomas Sokol, MD, Los Angeles, CA
Local Arrangements Co-Chair

Kyle Cologne, MD, Los Angeles, CA
Social Media Chair and Local Arrangements Co-Chair

Steven Wexner, MD, PhD (Hon), Weston, FL
President, ASCRS Research Foundation

Roberta Muldoon, MD, Nashville, TN
Public Relations Chair

Norman D. Nigro, MD, Research Lectureship

1:30 – 2:15 pm
Room: West Hall B

The Legacy of Norman Nigro: Back to the Future

Angelita Habr-Gama, MD, PhD
Professor of Surgery, University of São Paulo School of Medicine; Director, Angelita and Joaquim Gama Institute, São Paulo, Brazil

Introduction: Steven Wexner, MD, PhD (Hon)

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

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

Perioperative/Outcomes

Co-Moderator: Joseph Carmichael, MD, Orange, CA
Co-Moderator: Cary Aarons, MD, Philadelphia, PA

2:15 – 3:45 pm
Room: S15A

2:20 pm
Anastomotic Leak after Colorectal Resection: A Population-Based Study of Risk Factors and Hospital Variation
Nikolian, V. C., Kamdar, N., Regenbogen, S. E., Morris, A. M., Byrn, J. C., Campbell, D. A., Hendren, S., Ann Arbor, MI

2:25 pm
Discussion

2:28 pm
Preoperative Immunonutrition and Elective Colorectal Resection Outcomes – A Propensity Score Matched Analysis

2:33 pm
Discussion

2:36 pm
Truth in Reporting: How Data Capture Methods Obfuscate Actual Surgical SSI Rates Within a Healthcare Network System
Bordeianou, L. 1, Rattner, D. 1, Hutter, M. 1, Antonelli, D. 1, Mahmood, S. 2, Rubin, M. 2, Bleday, R. 1, Berger, D. 1, Boston, MA, Salem, MA

2:41 pm
Discussion

2:44 pm
A National Database Analysis Comparing the NIS and ACS-NSQIP Datasets in Laparoscopic vs. Open Colectomies: Inherent Variance May Impact Outcomes

2:49 pm
Discussion

2:52 pm
Risk Factors for Superficial Surgical Site Infection after Elective Rectal Cancer Resection: A Multivariate Analysis of 8,800 Patients from the ACS NSQIP Database

2:57 pm
Discussion

3:00 pm
Is Non-Steroidal Anti-Inflammatory Drug Use Associated with an Increased Incidence of Anastomotic Leak in Colorectal Surgery? A Systematic Review and Meta-analysis
Smith, S. A., Roberts, D. J., Lipson, M. E., Datta, I., Heine, J. A., Buie, W. D., MacLean, A. R., Calgary, AL, Canada

3:05 pm
Discussion

3:08 pm
Thirty-day Outcomes Following Diverting Loop Ileostomy Takedown Using the Michigan Surgical Quality Collaborative Database
Bhama, A. R., Collins, S., Ferraro, J., Cleary, R. K., Ann Arbor, MI

3:13 pm
Discussion

3:16 pm
Bowel Preparation is Associated with Reduced Morbidity in Elderly Patients Undergoing Elective Colon Resection
Dolejs, S., Guzman, M., Fajardo, A., Holcomb, B., Zarzaur, B., Robb, B., Waters, J., Indianapolis, IN

3:21 pm
Discussion

The first author is the presenting author unless otherwise noted by an *.

Continued next page
Perioperative/Outcomes (continued)

3:24 pm  Liposomal Bupivacaine Use in Transversus Abdominis Plane Blocks Reduces Pain and Postoperative Intravenous Opioid Requirements after Colorectal Surgery
Stokes, A., Adhikary, S., Quintili, A., Puleo, F., Choi, C. S., Hollenbeak, C., Messaris, E., Hershey, PA

3:29 pm  Discussion

3:32 pm  Does Hospital Transfer Impact Outcomes After Colorectal Surgery?
Chow, C. J.1, Gaertner, W.1, Jensen, C.2, Sklow, B.2, Madoff, R.1, Kwaan, M.1
1Minnesota, MN, 2St. Paul, MN

3:37 pm  Discussion

3:30 pm  Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: (S1) Identify independent risk-factors associated with anastomotic leak following colorectal resections; Anastomotic leak rates vary between hospital and there are opportunities for quality improvement in select hospitals.; (S2) Recognize the potential role for immunonutrition in gastrointestinal surgery; Use propensity score matching to compare different groups of participants in an observational study.; (S3) Explain the differences between the NSQIP and NHSN databases from the standpoint of measuring SSIs; Explain the differences between standartized and non standartized data gathering methods as far as their ability to record and compare complications; Consider adverse impact of impoper measurements on healthcare; (S4) Evaluate the outcomes of laparoscopic vs. open right left and sigmoid colectomies utilizing two large national populated-based datasets; Evaluate discrepancies in demographics, co-morbidities, and outcomes in two highly utilized large national population-based datasets; (S5) Recognize the risk factors for developing superficial surgical site infections after rectal cancer resection; Develop a plan of close outpatient clinical follow up for patients who underwent rectal cancer resection; (S6) Describe the association between nonsteroidal anti-inflammatory drug use and dehiscence of lower gastrointestinal anastomoses; 2. Recognize the limitations of published studies examining the association between nonsteroidal anti-inflammatory drug use and dehiscence of lower gastrointestinal anastomoses; (S7) Analyze the risk factors for poor outcomes after takedown loop ileostomy; Develop a plan to decrease risk factors for poor outcomes after takedown loop ileostomy; (S8) Develop an evidenced based strategy for bowel preparation in elderly patients; Describe the current use of bowel preparation in elderly patients; (S9) Describe the potential benefits of using longer-acting local anesthetics during transversus abdominis plane blocks; Demonstrate the overall implications of using less narcotics perioperatively on a patient's postoperative course; (S10) Describe the impact of hospital transfer on mortality for colorectal surgery; Describe the impact of hospital transfer on major morbidity for colorectal surgery.

The first author is the presenting author unless otherwise noted by an *.
Symposium

Colon and Rectal Surgery Training and Beyond: Education for Colorectal Residents and Colorectal Surgeons

2:15 – 3:45 pm
Room: Petree Hall

Supported in part by an independent educational grant from Applied Medical

All colon and rectal surgeons are involved in surgical education, either at a personal level, in arranging for the best methods to address their own learning needs, or as teachers of colorectal or general surgery trainees. This course will address some of the topical areas in surgical education, including maintenance of competence, especially in new technologies, milestones and their assessment, and use of new education technologies.

Existing Gaps

What Is: Most surgeons are familiar with longstanding models of resident training, continuing professional development, education techniques, and evaluation. New requirements will require increased emphasis on use of simulation, and demonstration of competence in milestones, both for trainees and surgeons in practice.

What Should Be: Surgeons will have a better understanding on how simulations and simulators can be best used in colon and rectal surgery training and continuing professional development. As well, surgeons will have greater knowledge about the use of milestones and their assessment.

Director: Jesse Moore, MD, Burlington, VT
Assistant Director: Helen MacRae, MD, Toronto, ON, Canada

2:15 pm Welcome and Introductions
Jesse Moore, MD, Burlington, VT
Helen MacRae, MD, Toronto, ON, Canada

2:20 pm Milestones
Glenn Ault, MD, Los Angeles, CA

2:35 pm Simulations and Simulators
Sandra de Montbrun, MD, Toronto, ON, Canada

2:50 pm Training and Re-Training of Surgeons in Practice
Ajit Sachdeva, MD, Chicago, IL

3:05 pm MOC: Why Is the Board Making Us Do All This Stuff?
Anthony Senagore, MD, Galveston, TX

3:20 pm Panel Discussion

3:45 pm Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Describe how simulation technology can be incorporated into colon and rectal residency and continuing professional development; b) Explain what milestones are and how their attainment can be assessed; c) Distinguish the expectations for maintenance of certification and its importance; d) Recognize common barriers to continuing professional development and ways to overcome them.
Comprehensive Management of Colon Cancer: An Interactive Forum

2:15 – 3:45 pm
Room: West Hall B

The past 50 years has seen substantial progress in our understanding and in the management of colon and rectal cancer (CRC). Surveillance colonoscopy with resection of premalignant polyps has led to a decreased incidence of CRC even though compliance with the recommendations is suboptimal. Epidemiologic and genetic information allow us to identify individuals at risk for cancer and should allow us to prevent the disease in many individuals. Patients diagnosed with advanced CRC live much longer than in the past, and many are cured. This is attributed to many factors, including cross-sectional imaging that properly stages patients and identifies metastases earlier, new surgical approaches and numerous new chemotherapies. Higher resolution imaging modalities have improved the ability to properly stage patients; surgical advances include minimally invasive procedures and laparoscopic-assisted procedures and safer and more extensive lymphatic clearance. Despite these advances, there is still disagreement on the indications for surgery, optimal surgical approach, and need for additional therapy in many cases. The optimal environment to tackle these “controversies” is through case-based discussion with experts in the field and with participation from the audience.

Existing Gaps

What Is: Colon cancer surgery is performed by a large number of general and colorectal surgeons in the country. Even in the elective setting a large number of cases are performed through a laparotomy, with incomplete preoperative staging and limited lymphatic clearance. Furthermore the use of adjuvant chemotherapy varies extensively across specialties, practice types and patient populations. The surgical approach and appropriate operation for colon cancer differs amongst specialists. The appropriate management for flat polyps remains controversial.

What Should Be: Surgeons should understand proper surgical techniques, indications for adjuvant therapy and the need for a multidisciplinary evaluation and management of colon cancer patients. Surgeons should understand the different options for patients with flat polyps and those with obstructive lesions.

Director: Bradley Champagne, MD, Cleveland, OH
Assistant Director: Imran Hassan, MD, Cedar Rapids, IA

<table>
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<th>Time</th>
<th>Discussion</th>
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| 2:15 pm| Introduction
Bradley Champagne, MD, Cleveland, OH |
| 2:30 pm| Case 1: Best Operative Approach
Justin Maykel, MD, Worcester, MA |
| 2:45 pm| Case 2: Decision Making for Flat and/or Unresectable Polyps
Mark Whiteford, MD, Portland, OR |
| 3:00 pm| Case 3: The Obstructed Patient
Thomas Read, MD, Burlington, MA |
| 3:15 pm| Case 4: Adjuvant Chemotherapy: Who, What, Why?
Peter Cataldo, MD, Burlington, VT |
| 3:30 pm| Controversial Topics! What Would You Do?
Panel vs Audience
Neil Hyman, MD, Chicago, IL |
| 3:45 pm| Adjourn |

Learning Objectives: At the conclusion of this session, participants should be able to: a) Describe different minimally invasive approaches to right colon cancer; b) Identify when to recommend an open operation for colon cancer; c) Describe what operation is best for transverse colon cancers; d) Describe when to take the middle colic artery; e) Recognize new criteria and prognostic factors as indication for adjuvant therapy; f) Recognize patients that should be referred for chemotherapy; g) Identify the appropriate treatment for obstructive colon cancer; h) Describe indications for surgery after the “completely” resected flat polyp; i) Identify patients that may be too old for surgery; j) Realize the best “first step” in the management of metastatic colon cancer patients.

3:45 – 4:15 pm

Refreshment Break in Exhibit Hall and ePoster Presentations (See page 121 for schedule.)
Abstract Session

Benign Anorectal/Pelvic Floor I

4:15 – 5:45 pm
Room: S15A

Co-Moderator: Andrea Bafford, MD, Baltimore, MD.  
Co-Moderator: Amy Thorsen, MD, Minneapolis, MN

4:20 pm  Identifying Predictors of Success of the LIFT Procedure in the Treatment of Fistula-in-ano: Does Location Matter?  S11

4:25 pm  Discussion

4:28 pm  New-onset Benign Anorectal Disorders after Bariatric Surgery: Importance of Bowel Habit  S12
Cano-Valderrama, O.1, Sánchez-Pernaute, A.2, Rubio, M. Á., Domínguez-Serrano, I.2, Torres, A. J., 1Santa Cruz de Tenerife, Spain, 2Madrid, Spain

4:31 pm  Discussion

4:34 pm  Percutaneous Nerve Evaluation versus Staged Sacral Nerve Stimulation for Fecal Incontinence  S13
Rice, T., Ferguson, M. A., Rafferty, J., Paquette, I., Cincinnati, OH

4:39 pm  Discussion

4:42 pm  Sacral Nerve Stimulation for Treatment of Fecal Incontinence Following Proctectomy  S14
Mizrahi, I.1, Haim, N.1, Chadi, S.1, Gurland, B.2, Zutshi, M.2, Wexner, S.1, Dasilva, G.1, 1Weston, FL, 2Cleveland, OH

4:47 pm  Discussion

4:50 pm  Repair of Traumatic Cloaca  S15
Mareck, S. J., Rossi, M., Kochar, K., Park, J. J., Prasad, L. M., Park Ridge, IL

4:55 pm  Discussion

5:02 pm  Efficacy and Cost-Effectiveness of In-Office Peripheral Nerve Evaluation Versus Out-Patient Advanced Nerve Evaluation for Fecal Incontinence  S16
Saidy, M., Adewole, A., Ambroze, W., Schertzer, M., Armstrong, D. N., Atlanta, GA

5:05 pm  Discussion

5:10 pm  Magnetic Anal Sphincter Augmentation in Patients with Severe Fecal Incontinence – Results after 28 Implantations and a Follow-up of 4 Years  S17
Pakravan, F., Helmes, C., Duesseldorf, Germany

5:13 pm  Discussion

5:18 pm  Bilateral Posterior Tibial Nerve Stimulation in Treatment of Obstructed Defecation  S18
Madbouly, K., Abbas, K., Alexandria, Egypt

5:21 pm  Discussion

5:26 pm  Advantage of Stapled Transanal Rectal Resection for Treatment of Rectocele Associated with Obstructed Defecation Syndrome: A Long-Term Follow-Up  S19
Giarratano, G., Toscana, E., Shalaby, M., Sileri, P., Toscana, C., Rome, RM, Italy

5:29 pm  Discussion

5:34 pm  Robotic Ventral Rectopexy  S20
Vogler, S. A., Minneapolis, MN

5:37 pm  Discussion

5:45 pm  Adjourn

The first author is the presenting author unless otherwise noted by an *.

Continued next page
Benign Anorectal/Pelvic Floor I (continued)

**Learning Objectives:** At the conclusion of this session, participants should be able to: (S11) Discuss the role anal fistula location plays in the outcomes of the LIFT procedure; Compare outcomes of the LIFT procedure with the endorectal advancement flap in the treatment of anal fistulas; (S12) Analyze the importance of benign anorectal disorders after bariatric surgery; Discuss the importance of bowel habits in the development of new onset benign anorectal disorders; (S13) Analyze the difference in outcome of percutaneous nerve evaluation versus staged sacral nerve stimulation for management of fecal incontinence; Develop an approach to evaluate patients for sacral nerve stimulation in the setting of fecal incontinence; (S14) Assess the effectiveness of sacral nerve stimulation for the treatment of fecal incontinence following a proctectomy for benign and malignant disease; Recognize the complications of sacral nerve stimulation for the treatment of fecal incontinence following a proctectomy; (S15) Present the technique how to repair traumatic cloaca; Levatorplasty is a helpful maneuver in traumatic cloaca repair; (S16) Explain the different approaches available to evaluate neuro-sensory response of sacral nerves for fecal incontinence; Explain the cost differences of these various methods of evaluating sacral nerve stimulation for fecal incontinence; (S17) to Explain the role of surgical management for severe fecal incontinence; and the mechanism and indication for a magnetic sphincter augmentation; (S18) Explain the rational of posterior tibial nerve stimulation in improving symptoms of obstructed defecation; Analyze the outcome of posterior tibial nerve stimulation in cases of obstructed defecation; (S19) Analyze the role of a transanal technique in the treatment of rectocele; Analyze outcome of patients underwent a stapled transanal rectal resection for rectocele and ODS; (S20) Identify the key technical steps of a robotic ventral rectopexy; Explain how to place lightweight polypropylene mesh in the pelvis during a robotic ventral rectopexy to treat prolapse.
Crohn’s disease is a complex intestinal disorder whose cause and effect remain incompletely understood, but some insights into its associated immune dysfunction as well as disease distribution and behavior have been realized. We now appreciate the disease can be localized to the terminal ileum, ileocolon, or large bowel with concurrently or separately associated upper gastrointestinal or anoperineal disease. The disease typically begins as an inflammatory process that generally evolves to stricturing or penetrating behavior. A multidisciplinary approach has been adopted by many centers with surgery remaining an integral part of the management strategy despite advances in more targeted medical therapy.

Through a structured symposium focusing on surgical aspects of Crohn’s disease, we propose to assess the impact of pre-operative medications, define the role of bowel-sparing procedures, offer an approach to intra-abdominal abscesses, discuss the issues associated with neoplasia, review the treatment of anorectal fistulas, and describe means to address unhealed perineal wound healing. The symposium will thoroughly examine these disease-related issues and provide evidence-based practice guidance.

**Existing Gaps**

**What Is:** Our knowledge of the behavior of Crohn’s disease is constantly advancing and our management of the disorder is accordingly evolving.

**What Should Be:** Surgeons should appreciate the stricturing, penetrating, and neoplastic complications of Crohn’s disease affecting various intestinal locations, and they must understand the operative principles associated with a multidisciplinary approach to disease management.

**Director:** Scott Strong, MD, Chicago, IL  
**Assistant Director:** Joseph Notaro, MD, Edison, NJ

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<tr>
<th>Time</th>
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<tbody>
<tr>
<td>4:15</td>
<td>Welcome and Introductions</td>
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<tr>
<td></td>
<td>Scott Strong, MD, Chicago, IL</td>
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<tr>
<td>4:17</td>
<td>Pre-operative Medical Therapy – Impact on the Operation</td>
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<td>Phillip Fleshner, MD, Los Angeles, CA</td>
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<td>4:28</td>
<td>Upper GI Disease – Bowel-Sparing Techniques</td>
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<td>Alessandro Fichera, MD, Seattle, WA</td>
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<td>4:39</td>
<td>Intra-abdominal Abscess – Short- and Long-Term Management</td>
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<td>Stefan Holubar, MD, Lebanon, NH</td>
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<td>4:50</td>
<td>Large Bowel Disease-Neoplasia Complicating Disease</td>
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<td>P. Ravi Kiran, MBBS, New York, NY</td>
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<td>5:01</td>
<td>Diagnosis and Management of Fistula-in-Ano</td>
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<td>Willem Bemelman, MD, PhD, Amsterdam, The Netherlands</td>
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<td>5:12</td>
<td>Unhealed Perineal Wound – Prevention and Management</td>
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<td>Najjia Mahmoud, MD, Philadelphia, PA</td>
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<td>5:23</td>
<td>Discussion</td>
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<td>Adjourn</td>
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**Learning Objectives:** At the conclusion of this session, participants should be able to: a) Recognize the influence of medications on operative planning and patient counseling; b) Identify the indications and options for bowel-sparing approaches to upper GI disease; c) Explain the initial and subsequent treatment of patients with an intra-abdominal abscess; d) Explain the risk, diagnosis, and management of neoplasia complicating large bowel disease; e) Describe the diagnosis and treatment of fistulizing anoperineal disease; f) Explain the prevention and management of an unhealed perineal wound after proctectomy.

*This session addresses Self-Assessment (MOC) credit requirements as explained on page 9.*
Symposium

International Colorectal Surgery: Perspectives from Latin America

4:15 – 6:15 pm
Room: Petree Hall

Latin American colorectal surgeons will share their insights concerning the development of the specialty in their regions of the world. As disease patterns become globally more similar, their differences are also very important particularly as Hispanics become increasingly represented in North American communities. Diverticulitis, for example, is a different disease in Hispanics than in the mainstream population. The speakers will highlight the spectrum of colorectal surgery practice including how surgeons do more with less as well as the fast tracking of new technologies – in many cases as world leaders. A final goal of the program is to enhance educational dialogue and improve our understanding of surgical practice in Latin America.

Existing Gaps
What Is: An undifferentiated approach to populations with unique disease patterns as cultures “in transition.”
What Should Be: A better appreciation of the differences in colorectal afflictions as well as an enhanced insight regarding the contributions of Latin American surgeons towards the advancement of the specialty.

Co-Director: Michael Spencer, MD, PhD, St. Paul, MN
Co-Director: Adrian Ortega, MD, Los Angeles, CA

4:15 pm Overview of Colorectal Surgery in Central America
Fidel Ruiz-Healy, MD, Mexico City, DF, Mexico

4:30 pm Inflammatory Bowel Disease South of the Border; Is This the Same Disease? Incidence, Evaluation and Medical Management
Wolfgang Gaertner, MD, Minneapolis, MN

4:45 pm Evaluation and Management of Complex Pelvic Floor Disorders: Doing More with Less
Gonzalo Hagerman, MD, Hermosa, DF, Mexico

5:00 pm Complicated Diverticular Disease: Optimizing Outcomes
José Andres Cervera-Servin, MD, Cuajimalpa, DF, Mexico

5:15 pm Introducing New Technologies in Economically Challenged Health Systems
Rafael Sanchez-Morett, MD, Mexico City, DF, Mexico

5:30 pm Panel Discussion and Interesting Cases
Edwin Cañas Elias, MD, Santa Ana, Santa Ana, El Salvador; Enio Chaves Oliveira, MD, PhD, Goiânia, Goiás, Brazil; Francisco López-Kostner, PhD, Santiago, Chile; Billy Jimenez, MD, Mexico City, DF, Mexico; Carlos Vaccaro, MD, Buenos Aires, Argentina; Omar Vergara Fernández, MD, Mexico City, DF, Mexico

6:15 pm Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Explain the development of the specialty in Latin America; b) Describe the challenges of inflammatory bowel disease in countries where other forms of colitis are endemic; c) Explain how surgeons in emerging populations can do more with less technology in the evaluation of complex problems; d) Explain diverticulitis in Latino Populations; e) Recognize the role of Latin American surgeons in introducing new technologies; f) Recognize how Latin American experts view complex surgical problems from their world perspective.

International Council of Coloproctology Meeting

6:15 – 7:15 pm
Room: S15A

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

**Existing Gaps**

**What Is:** C. diff that fails antibiotic treatment is traditionally treated with colectomy with notoriously poor outcomes. Peri-op DVT prophylaxis is standard of care. Single dose of antibiotics within one hour of skin incision is accepted practice for most cases.

**What Should Be:** Stoma with irrigation may be appropriate for treatment of c. diff in lieu of colectomy; however, colectomy may still be necessary. Consideration should be given to extended post-op DVT prophylaxis in certain patients. Physicians should weigh the pros and cons of 24 hours of antibiotics vs. single pre-op antibiotics for certain operative situations (such as contamination).

**Co-Moderator:** Jennifer Irani, MD, Boston, MA  
**Co-Moderator:** David Rivadeneira, MD, Woodbury, NY

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<tr>
<td>5:45 pm</td>
<td><strong>C. diff and Subtotal Colectomy</strong></td>
<td>David Stewart, Sr., MD, Hershey, PA</td>
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<td>5:53 pm</td>
<td><strong>C. diff Irrigation and Stoma</strong></td>
<td>Husein Moloo, MD, Ottawa, ON, Canada</td>
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<td>6:01 pm</td>
<td><strong>Extended Prophylaxis DVT for High Risk (Con)</strong></td>
<td>Deborah Nagle, MD, Boston, MA</td>
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<tr>
<td>6:18 pm</td>
<td><strong>Extended Prophylaxis DVT for High Risk (Pro)</strong></td>
<td>Fergal Fleming, MD, Rochester, NY</td>
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<td>6:26 pm</td>
<td><strong>Antibiotics Single Pre-Op</strong></td>
<td>Christopher Mantyh, MD, Durham, NC</td>
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<tr>
<td>6:34 pm</td>
<td><strong>Antibiotics 24 Hours</strong></td>
<td>Howard Ross, MD, Philadelphia, PA</td>
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**Learning Objectives:** At the conclusion of this session, participants should be able to: a) Explain when colectomy versus stoma with irrigation is appropriate in patients with c. diff; b) Describe the pros and cons of extended DVT prophylaxis; c) Recognize the appropriate use and timing of peri-op antibiotics.

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**Welcome Reception**

7:30 – 9:00 pm  
Platinum Ballroom (2nd Floor)  
JW Marriott Los Angeles L.A. LIVE Hotel

The Welcome Reception will be held at the JW Marriott Los Angeles L.A. LIVE Hotel and is complimentary to all registered attendees. The event will feature hors d’oeuvres, cocktails and entertainment. The Research Foundation will join forces with ASCRS to welcome all at this reception.
Meet the Professor Breakfasts

6:30 – 7:30 am

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

Registrants are encouraged to bring problems and questions to this informal discussion.

Supported in part by an independent educational grant from Merck & Co., Inc.

M-1 ERAS
Joseph Frankhouse, MD, Portland, OR
Anthony Senagore, MD, Galveston, TX

M-2 Private Practice: Is There a Future?
Charles Littlejohn, MD, Stamford, CT
Walter Peters, Jr., MD, Dallas, TX

M-3 Anorectal and Pelvic Pain
Richard Billingham, MD, Seattle, WA
Liliana Bordeianou, MD, Boston, MA

M-4 Future of Minimally Invasive Surgery
Matthew Albert, MD, Altamonte Springs, FL
Eric Haas, MD, Houston, TX

M-5 Colorectal Trauma
James Duncan, MD, Bethesda, MD
Fia Yi, MD, Fort Sam Houston, TX

M-6 Bring Your Research Idea
Nancy Baxter, MD, Toronto, ON, Canada
Rocco Ricciardi, MD, Burlington, MA

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

Residents’ Breakfast

6:30 – 7:30 am

Platinum Ballroom Salons F-J (2nd Floor)
JW Marriott Los Angeles L.A. LIVE Hotel

The Educational Evolution of the Colon and Rectal Surgeon

Terry C. Hicks, MD
Vice Chair, Dept. of Colon and Rectal Surgery, Ochsner Clinic;
Clinical Professor of Surgery, LSU, School of Medicine, New Orleans, LA

Introduction: Craig Reickert, MD

Registration Required • Open to Residents Only
This symposium will focus on the magnitude of the problem and its etiology, pathology, impact and direct and indirect costs of burnout and its related negative sequelae. Participants in the symposium will better understand how these problems increase the risk of surgical error and harm to our patients; negatively impact our colleagues, staff, and health care institutions; and disrupt our careers and personal lives. The symposium will explore how to recognize burnout at its early stages when interventions could be highly effective. The final portion of the symposium will be devoted to the tools, skills, techniques and strategies that individual surgeons, our profession and our organizations can develop and use to mitigate these problems.

The era of the highly autonomous surgeon acting as “captain of the ship” whose decisions could not be questioned by patients, staff or colleagues is gone. Surgeons are now expected to involve the patient and often his/her family in decision-making and to function as effective team leaders who welcome and value each person's contributions to the care of the surgical patient regardless of rank or title.

The way in which we are expected to face our failures has changed. Because we now do more complex, risky and stressful operations on patients with more co-morbidities than ever before, the potential for error, major morbidity and mortality is significant. When errors have been made, we are expected to “own” our failures by honestly determining what went wrong, reporting serious adverse events to oversight committees and regulatory bodies, and working together to determine how such errors and near-misses could be avoided in the future. Professionalism demands that we honestly inform the patient and their family members of errors made and deal with them in a forthright manner despite the perceived risks to the surgeon of “inviting” a malpractice suit or harming our reputation.

Existing Gaps

What Is: Surgeons are generally left alone or given inadequate support, education and training to better manage the stress in our workplace created by the fundamental changes occurring in our society, the health care delivery system and our own profession. Stress can initiate an escalating cycle ultimately leading to burnout and associated sequelae including an increased risk of surgical error and harm to our patients; a negative impact on our colleagues, staff, and health care institutions; and a disruption or destruction of our careers and personal lives.

What Should Be: Physicians must learn how to navigate and work within complex medical care organizations while staying true to our profession’s calling and responding to the expectations of the public and the demands of our leaders to embrace fundamental and extensive changes in the U.S. health care system. Surgeons must have a clear understanding of the multiple challenges we face in a complex and risky perioperative environment and we must acquire the skills and develop the wisdom to effectively adapt and respond in a way that reduces stress and burnout, maintains our integrity and professionalism, and enables us to provide the best care for our patients.

As surgeons, we are at the center of these changes in our workplace and to be successful, we need new tools to cope with these new responsibilities. Competencies in leadership and management, teamwork and communication, problem solving and decision making, and situational awareness can be taught and can reduce surgeon stress, burnout and errors. In the language of the day, we need to acquire the emotional intelligence required to work successfully in high-risk, complex environments without suffering the negative consequences described above.

Surgeons increasingly are leading health care organizations and our professional societies to build better perioperative workplace environments built on trust, closed loop communication, and accountability. By following the principles of “Just Culture,” health care organizations can effectively and equitably manage the many issues arising from medical failures, mitigate the emotional and physical toll on physicians and health care workers, and use their influence to modify the education and residency training programs to better prepare physicians to meet the public’s demands for safety, transparency and accountability.

Continued next page
Beyond the OR (continued)

Director: David Rothenberger, MD, Minneapolis, MN
Assistant Director: Najjia Mahmoud, MD, Philadelphia, PA

7:30 am  Welcome and Introductions
David Rothenberger, MD, Minneapolis, MN

7:40 am  What’s the Problem?
Darrell Campbell, Jr., MD, Ann Arbor, MI

7:55 am  Why Should We Care?
David Schoetz, Jr., MD, Boston, MA

8:10 am  Individualized Solutions:
          Tools, Skills, Techniques and Strategies
          Najjia Mahmoud, MD, Philadelphia, PA

8:30 am  Organizational Solutions:
          Tools, Skills, Techniques and Strategies
          Julie Ann Freischlag, MD, Sacramento, CA

8:50 am  Case Presentations/Panel Discussion

9:30 am  Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Explain the current state of stress, burnout and associated negative sequelae among U.S. surgeons and its impact on patient outcomes, surgeons, our profession and our medical centers; b) Teach how each surgeon can develop personal tools to survive and thrive in today’s surgical environment: emotional intelligence, understanding adaptive versus technical work, establishing a Just Culture environment, maintaining professionalism in a world of competition, maintaining competencies, coping with accountability, and dealing with failure; c) Recognize how surgeons can support each other in our daily lives and can influence our health care organizations to confront and correct the common and highly disturbing phenomenon of burnout and its negative sequelae.
Symposium

Current Management of Diverticulitis

7:30 – 9:30 am
Room: West Hall B

Our understanding and management of diverticular disease has evolved over the past three decades. Once rigid recommendations regarding the management of both uncomplicated and complicated diverticulitis have been challenged. These concepts include the need for antibiotics in the management of simple acute diverticulitis, the optimal timing of elective intervention, and the necessity of surgical intervention following a complication of this disease. In addition, new procedures such as laparoscopic lavage have been evaluated. This session will review advances in our understanding of the pathophysiology of the disease and current controversies in management strategies.

Existing Gaps

What Is: Risk factors for developing disease, potential new targets for research, threshold for elective and emergent intervention, appropriate techniques for management of challenging surgical situations.

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

Director: Jason Hall, MD, Burlington, MA
Assistant Director: Daniel Feingold, MD, New York, NY

7:30 am Epidemiology and Risk Factors for Recurrent and Complicated Diverticular Disease
David Etzioni, MD, Phoenix, AZ

7:41 am Current Recommendations for the Management of Uncomplicated Diverticulitis
Sean Langenfeld, MD, Omaha, NE

7:52 am Is Colectomy Mandatory Following Successful Medical Management of a Diverticular Abscess?
Scott Regenbogen, MD, Ann Arbor, MI

8:03 am Surgery for Diverticulitis – Too Much or Too Little? An International Comparison
Stefan Post, MD, PhD, Mannheim, Germany

8:14 am Panel Discussion and Case Presentations

8:30 am Novel Therapeutic Techniques for the Management of Complicated Diverticulitis
Howard Ross, MD, Philadelphia, PA

8:41 am Emergent Management of Diverticulitis: Is a Hartmann Procedure Always Necessary?
Dana Hayden, MD, Maywood, IL

8:52 am Complicated Diverticulitis: Management of Difficult Fistulas and Strictures
W. Donald Buie, MD, Calgary, AB, Canada

9:03 am Hartmann Reversal: Optimizing Outcomes
Steven Lee-Kong, MD, New York, NY

9:14 am Panel Discussion and Case Presentations

9:30 am Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Recognize the current literature regarding the etiology of diverticulosis and diverticulitis and risks of recurrent disease; b) Recognize areas of knowledge deficit to encourage investigation in those areas; c) Appreciate best practices in the management of acute diverticulitis both in the hospitalized patient and in the outpatient setting; d) Review the current approaches to managing patients following an episode of complicated diverticulitis.
Abstract Session

Basic Science

7:30 – 9:00 am
Room: S15A

**Co-Moderator:** Susan Galandiuk, MD, Louisville, KY
**Co-Moderator:** Lisa Poritz, MD, Hershey, PA

7:35 am  **miR-1247 Suppresses Tumor Growth in Methylator Phenotype Colorectal Cancers**
Liang, J., Zhou, W., DeVecchio, J., Bissett, I. P., Church, J. M., Kalady, M., 1Cleveland, OH, 2Auckland, New Zealand

7:42 am  **Discussion**

7:47 am  **The Role of Pharmacologic Modulation of Autophagy on Anal Cancer Development in a HPV Mouse Model of Carcinogenesis**
Meske, L., Lawrence, M., Romero, A., Knaack, D., Hurley, E., Sleiman, H., Carchman, Madison, WI

7:54 am  **Discussion**

7:59 am  **Chemotherapeutic Action of Synthetic Curcumin Analogs in Colorectal Cancer**
Megna, B., Carney, P., Depke, M., Rosengren, R., Hawkins, B., Kennedy, G., 1Madison, WI, 2Otago, New Zealand

8:06 am  **Discussion**

8:11 am  **Simvastatin Enhances Radiation Sensitivity of Colorectal Cancer Cells by Targeting the EGFR-RAS-ERK Axis**
Karagkounis, G., Devecchio, J., Kalady, M., Cleveland, OH

8:18 am  **Discussion**

8:23 am  **Regenerating the Anal Sphincter: Cytokines, Stem Cells or Both?**
S26
Sun, L., Kuang, M., Penn, M., S., Damaser, M., Zutshi, M., 1Cleveland, OH, 2Akron, OH

8:30 am  **Discussion**

8:35 am  **Long-term Restoration of Fecal Continence after Autologous BioSphincter Implantation in a Large Animal Model of Passive Fecal Incontinence**
Bohl, J. L., Zakhem, E., Raghavan, S., Koch, K., Bittar, K. N. Winston Salem, NC

8:43 am  **Discussion**

8:48 am  **5-HT4 Receptors as a Target for Treating Colitis**
Scott, R. B., Spohn, S., Lavoie, B., Wilcox, R., Mawe, G., 1Danbury, CT, 2Burlington, VA

9:00 am  **Adjourn**

**Learning Objectives:** At the conclusion of this session, participants should be able to: (S22) A novel finding of mir-1247 as a potential tumour suppressor in methylator phenotype colorectal cancers; The tumour suppressive effect is clearly demonstrated both in-vitro and in-vivo highlighting a potential treatment option for the management of this subtype of colorectal cancers; (S23) Explain the important role of autophagy in anal cancer development; Consider the clinical implications of autophagic modulation on anal cancer prevention; (S24) Appreciate the potential for synthetic derivatives of curcumin to act as adjuncts to conventional chemotherapy as well as stand alone agents in colorectal cancer; Explain the molecular antitumor mechanisms of synthetic derivatives of curcumin, especially those related to the aryl hydrocarbon receptor; (S25) Explain the effects of simvastatin in enhancing colorectal cancer cell radiation sensitivity; Explain the effects of simvastatin in inhibiting colorectal cancer stem cell growth; (S26) Explain the pathophysiology of a chronic anal sphincter injury; Evaluate the role of cytokines in anal sphincter repair; (S27) Explain anorectal manometry measures for internal anal sphincter function; Describe a regenerative medicine treatment for passive fecal incontinence; (S28) To identify novel intestinal targets for protection against colitis; To determine the underlying mechanism for serotonin receptor agonist anti-inflammatory effects in colitis.

9:30 – 10:00 am
**Refreshment Break in Exhibit Hall and ePoster Presentations** (See page 121 for schedule.)

The first author is the presenting author unless otherwise noted by an *.
Memorial Lectureship Honoring Victor W. Fazio, MD

10:00 – 10:45 am
Room: West Hall B

Management of Recurrent Rectal Cancer

Ian C. Lavery, MD
Staff Physician, Department of Colorectal Surgery at Cleveland Clinic
Cleveland, OH

Introduction: Tracy Hull, MD

Dr. Victor W. Fazio is being honored this year with the Memorial Lectureship, presented by Dr. Ian Lavery. The American Society of Colon and Rectal Surgeons was saddened to hear of the passing of Dr. Victor W. Fazio, July 6, after a long illness. Dr. Fazio was ASCRS President (1995-1996) and former Diseases of the Colon and Rectum Editor-in-Chief. He was awarded the Premier Physician Award from the Crohn’s and Colitis Foundation in 1992, inducted into the Cleveland Medical Hall of Fame in 2002, and received the Order of Australia in 2004.

During his first message to the ASCRS membership he said, “Each of us can promote and defend the Society’s position as a leader and ‘spokesman’ for the study and treatment of colonic and rectal disease. And do so with spirit and conviction that we can provide a high quality of care that is unusual—giving satisfaction to patients and pause to our generalist colleagues.”

Presidential Address

10:45 – 11:30 am
Room: West Hall B

Charles E. Littlejohn, MD
Division Director, Division of Colon and Rectal Surgery, Stamford Hospital, Stamford, CT; Assistant Clinical Professor of Surgery, Columbia University

Introduction: Donald Colvin, MD

Dr. Charles E. Littlejohn, Stamford, CT, was elected President of the American Society of Colon and Rectal Surgeons at the Society’s 2015 Annual Meeting in Boston, MA.

Dr. Littlejohn has served on the ASCRS Executive Council as a Council Member from 1999-2003 and as Secretary from 2010-2014. He was the first chair of the ASCRS Young Surgeons Committee (YSC) and the first colorectal surgeon to chair the American College of Surgeons Committee on Young Surgeons. During his tenure, the YSC established its successful traveling fellowship, an exchange program between ASCRS and the Coloproctology Section of the Royal Society of Medicine. He participated on many committees, including Emerging Technologies, Program, Regional Society and Socioeconomic/Legislative.

11:30 am – 12:45 pm
Complimentary Box Lunch in Exhibit Hall and ePoster Presentations (See page 121 for schedule.)
Rectal Cancer One: The Trials of Rectal Cancer

12:45 – 2:15 pm
Room: Petree Hall

This symposium will focus on minimally invasive surgical options. It is somewhat unique that several high-quality trials have provided important evidence comparing open and laparoscopic surgery, and more recently comparing different laparoscopic approaches, particularly straight laparoscopy vs robotic surgery.

The purpose of this symposium is to have senior, experienced authors from each of the major trials present their results in a combined session. A balanced detailed discussion will then help practicing surgeons decide how to incorporate these approaches in their day-to-day surgical management of rectal cancer.

Existing Gaps
What Is: Multiple surgical approaches exist for performing a total mesorectal excision (TME) in the surgical management of rectal cancer. Surgeons are faced with complex decisions determining which is the optimal surgical approach for each specific patient.

What Should Be: Surgeons should have a precise understanding of the results of each of the major recent trials to help decide the most beneficial approach for them to use for specific patients.

Co-Director: Conor Delaney, MD, PhD, Cleveland, OH
Co-Director: James Fleshman, Jr., MD, Dallas, TX

12:45 pm Welcome and Introductions
Conor Delaney, MD, PhD, Cleveland, OH

12:50 pm Laparoscopic-Assisted or Open Resection for Treating Patient with Rectal Cancer (Z6051 Study)
James Fleshman, Jr., MD, Dallas, TX

1:01 pm Open Versus Laparoscopic Surgery for Mid to Low Rectal Cancer After Neoadjuvant Chemoradiotherapy (COREAN trial)
Jae Hwan Oh, MD, Goyang, South Korea

1:12 pm Australian Laparoscopic Cancer of the Rectum Trial (ALaCaRT)
Andrew Stevenson, MD, Chermside, QLD, Australia

1:23 pm Robotic-Assisted vs. Standard Laparoscopic Resection for Rectal Cancer (ROLARR study)
Alessio Pigazzi, MD, PhD, Orange, CA

1:34 pm Laparoscopic vs. Open Surgery for Rectal Cancer (COLOR II)
H. Jaap Bonjer, MD, Amsterdam, The Netherlands

1:45 pm Putting It All in Perspective
John Monson, MD, Orlando, FL

1:55 pm Discussion

2:15 pm Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Explain the results of each of the major randomized controlled trials comparing laparoscopic and open approaches for rectal cancer b) Recognize the data comparing robotic to laparoscopic surgery; c) Describe the complexities of choosing different surgical approaches to perform a total mesorectal excision.

*This session addresses Self-Assessment (MOC) credit requirements as explained on page 9.
**Abstract Session**

**Benign Colon**

12:45 – 2:15 pm
Room: S15A

**Co-Moderator:** Alan Herline, MD, Augusta, GA
**Co-Moderator:** Michael McGee, MD, Chicago, IL

**12:50 pm**

**Should Elective Colectomy Be Performed Following an Acute Diverticular Abscess?**
Aquila, C. T., Becerra, A. Z., Hensley, B. J., Iannuzzi, J. C., Xu, Z., Noyes, K., Monson, J., Fleming, F., Rochester, NY

**12:58 pm**

**Discussion**

**1:02 pm**

**Targeting Late, Rather than Early, Readmission after Colorectal Resection is the More Effective Strategy**
Al-Mazrou, A. M., Suradkar, K., Mauro, C., Kiran, R., New York, NY

**1:10 pm**

**Discussion**

**1:14 pm**

**Combined Endo-Laparoscopic Surgery is Less Costly than Traditional Surgery for the Large Benign Polyps**
Kiely, M. X.1, Sharma, S. K.2, Sedrakyan, A.3, Yoo, J.2, Lee, S.4, Milsom, J.5, 1Boston, MA, 2New York, NY, 3Los Angeles, CA

**1:22 pm**

**Discussion**

**1:26 pm**

**Robotic Parastomal Hernia Repair with Overlay Biologic Mesh**
Hopkins, M. B., Chapel Hill, NC

**Learning Objectives:** At the conclusion of this session, participants should be able to: (S29) Compare the risks and benefits of elective resection versus non-operative management following resolution of an acute diverticular abscess; Identify risk factors for diverticulitis recurrence following resolution of an acute diverticular abscess; (S31) To provide a clear explaining on the factors that require patients to be readmitted early (within 5 days following discharge) vs late (more than 6 days following discharge) after major colorectal procedure; To provide a recommendation on directing resources in order to minimize hospital readmission by targeting several perioperative factors; (S32) Evaluate the cost-savings of CELS versus traditional bowel resection for benign colon polyps that fail endoscopic removal; Explain the major short and long-term outcomes of the CELS approach compared to standard laparoscopic or open bowel resection; Evaluate the appropriateness of a patient for the CELS technique in the presence of certain preoperative factor predictive of outcomes; (S33) Video review of technique for a Sugarbaker parastomal hernia repair; New techniques in securing the biologic mesh for the hernia repair; (S34) Describe potential disparities in care patterns between two cohorts of patients with Clostridium difficile infection, and how this may affect outcomes; Recognize the possible importance of surgeon’s involvement in Clostridium difficile patients, even when surgery is not required; (S35) To analyse the correlation between endoscopic polyp size vs histological polyp size as size is one of the indicators for follow up surveillance scopes; Once this relationship is established for each endoscopist, one can adjust ones own reporting as this can potentially change the frequency of scope from 1 to 3 or 5 years.

The first author is the presenting author unless otherwise noted by an *.
Abstract Session
Neoplasia I

2:15 – 3:45 pm
Room: Petree Hall

Co-Moderator: Harry Papaconstantinou, MD, Temple, TX
Co-Moderator: Yi-Qian Nancy You, MD, Houston, TX

2:20 pm Preoperative Chemotherapy Is Associated with Improved Survival for Large Anorectal GIST: A National Assessment of 333 Cases S37
Hawkins, A. T., Wells, K., Mukkai Krishnamurty, D., Hunt, S., Glasgow, S. C., Dharmarajan, S., Wise, P., Birnbaum, E., Mutch, M., Silviera, M., St. Louis, MO

2:25 pm Discussion

2:28 pm Benefit of Post-Resection Adjuvant Chemotherapy for Stage III Colon Cancer in Octogenarians: Analysis of The National Cancer Database. S38
Bergquist, J. R.,1 Thiels, C. A.,1 Spindler, B. A.,1 Hayman, A. V.,1 Habermann, E.1, Pemberton, J. H.,1 Mathis, K. L.,1 1Rochester, MN, 2Portland, OR

2:33 pm Discussion

2:36 pm Biomarker-based Scoring System for Prediction of Tumor Response After Preoperative Chemoradiotherapy in Rectal Cancer by Reverse Transcriptase Polymerase Chain Reaction Analysis S39

2:41 pm Discussion

2:44 pm Downstaging Effects of Neoadjuvant Chemotherapy in Locally Advanced Colon Cancer S40
Verstegen, M.,1 Gooyer, J.,1 ‘t Lam-Boer, J.,1 Radema, S.,1 Elfrink, M.,3 Verhoef, C.,3 Schreinemakers, J.,1 de Wilt, J.,1 ‘Nijmegen, Netherlands, 1Utrecht, Netherlands, 3Rotterdam, Netherlands

2:49 pm Discussion

2:52 pm Robotic Surgery for Rectal Cancer and Lateral Lymph Node Dissection S41
Watanabe, T., Ishihara, S., Kawai, K., Nozawa, H., Hata, K., Kiyomatsu, T., Sunami, E., Tokyo, Japan

2:57 pm Discussion

3:00 pm Omission of Adjuvant Chemotherapy Increases Mortality in T3N0 Colon Cancer Patients with Inadequate Lymph Node Harvest S42
Wells, K., Hawkins, A. T., Mukkai Krishnamurty, D., Dharmarajan, S., Glasgow, S. C., Hunt, S., Mutch, M., Silviera, M., St. Louis, MO

3:05 pm Discussion

3:08 pm A Prospective Study of Circulating Tumor Cells In Patients With Locally Advanced Rectal Cancer S43

3:13 pm Discussion

3:16 pm AnastomoticLeaks after Left Hemicolectomy: Stoma Creation or Washout and Drainage? S44
Althumairi, A., Canner, J. K., Efron, J., Gearhart, S., Wick, E. C., Fang, S., Safar, B., Baltimore, MD

3:21 pm Discussion

3:24 pm The Value of MRI in Clinical Decision Making and Determining R0 in Patients with Locally Recurrent Rectal Cancer S45
Koh, C. E.,1 D’Souza, M., Brown, W. E.,2 Badgery-Parker, T.,2 Young, J.,2 Solomon, M.,1 1Drummoyne, New South Wales, Australia, 2Sydney, New South Wales, Australia

3:29 pm Discussion

3:32 pm Continued next page

The first author is the presenting author unless otherwise noted by an *.
Neoplasia I (continued)

ESCP Best Paper

3:32 pm Organ-Preservation for Clinical Complete Responders after Chemoradiation for Rectal Cancer - Does Timing of Selection Matter? S46
Milou Martens2, Britt Hupkens2, Luc Heijnen2, Monique Maas2, Doenja Lambregts2,1, Stephanie Breukink2, Laurens Stassen2, Jarno Melenhorst2, Christiaan Hoff3, Eric Belgers4, Ton Hoofwijk4, Jeroen Leijtens4, Regina Beets-Tan1,2, Geerard Beets1,2 1Leeuwenhoek, Amsterdam, 1Maastrichtn, Netherlands, 1Leeuwarden, Netherlands, 4Heerlen-Sittard, Netherlands, 5Roermond, Netherlands

3:30 pm Discussion

3:45 pm Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: (S37) Discuss the national management of anorectal gastrointestinal stromal tumors (GIST); Describe the role of preoperative imatinib in the treatment of large pelvic GISTs; (S38) Explain the magnitude of survival benefit due to post-surgical adjuvant chemotherapy in elderly patients with Stage III colon cancer; Develop a multi-disciplinary treatment plan for elderly patients with Stage III colon cancer; Explain how to utilize a national hospital-based dataset to study the differences in short and long-term multidisciplinary treatment outcomes in elderly patients; (S39) Evaluate the predictive value of biomarkers for prediction of tumor response after preoperative chemoradiotherapy for rectal cancer; Develop the biomarker-based scoring system for clinical use of individualized preoperative chemoradiotherapy in rectal cancer patients; (S40) Be aware neoadjuvant chemotherapy is a safe and feasible treatment strategy for locally advanced colon cancer; Consider treating their patient with a locally advanced colon tumor with preoperative chemotherapy; (S41) Analyze the short-term outcome of robotic surgery for rectal cancer; Analyze the technical aspect of lateral node dissection for rectal cancer; (S42) Explain the benefit of adjuvant chemotherapy to overall survival in T3N0 colon cancer patients with inadequate lymph node harvest; Implement adjuvant therapy in adherence with national guidelines for T3N0 colon cancer with inadequate lymph node harvest; (S43) 1. Appreciate the presence of circulating tumor cells in rectal cancer patients; 2. Explain the changes in circulating tumor cells in association with neoadjuvant therapy; (S44) Analyze the difference in the outcome of stoma creation vs. washout and drainage as treatment for left colon anastomotic leak; Develop a plan of management for left colon anastomotic leak requiring surgical intervention; (S45) MRI guides surgical decision making; MRI confirms current practice recommendations for locally recurrent rectal cancer.

The first author is the presenting author unless otherwise noted by an *.
Symposium

Familial Feud: Generation X vs. Generation Z

2

2:15 – 3:45 pm
Room: West Hall B

Colorectal surgeons are often called upon to manage complex medical and surgical conditions as well as some rarely seen disorders. In addition, suggested diagnostic and treatment algorithms change over time. All surgical specialties have certain topics/diseases for which the treatments remain controversial. Understanding the optimal treatment plan for patients often depends on a physician’s ability to see clarity in these lines of gray.

This session will highlight the strategies of both a group of senior colorectal surgeons as well as a group of physicians newer to the specialty. The session will cover both common and less common conditions, including recognition, diagnostic work up, and management of infectious, benign, and malignant conditions addressed by our specialty.

Existing Gaps
What Is: Many surgeons are comfortable with the straight-forward management of common colorectal conditions. Patients with complex cases or rare conditions may be incorrectly treated or may suffer from delay in treatment.

What Should Be: Surgeons should be familiar with the recognition, diagnostic work-up, and management options for complicated and less common colorectal diseases and the potential interventions necessary to provide satisfactory outcomes.

Director: David Maron, MD, Weston, FL
The “Golden-Age Family”, Generation X
Headed by Steven Wexner, MD, PhD (Hon), Weston, FL
Family:
Herand Abcarian, MD, Chicago, IL
James Fleshman, Jr., MD, Dallas, TX
Philip Gordon, MD, Montreal, QC, Canada
Ann Lowry, MD, St. Paul, MN
Anthony Senagore, MD, Galveston, TX

vs.

The “Blossoming Family”, Generation Z
Headed by Michelle Olson, MD, Urbana, IL
Family:
Jennifer Beaty, MD, Omaha, NE
Marc Brozovich, MD, Pittsburgh, PA
Bradley Champagne, MD, Cleveland, OH
James McCormick, DO, Pittsburgh, PA
Kirsten Wilkins, MD, Edison, NJ

Learning Objectives: At the conclusion of this session, participants should be able to: a) Recognize the management options of recurrent and complex colorectal disorders as well as rare conditions affecting the colon, rectum, and anus; b) Describe normal anatomic relations of the colon, rectum, and anus, as well as disturbances of these relations in colorectal disorders.

3:45 – 4:15 pm
Ice Cream and Refreshment Break in Exhibit Hall and ePoster Presentations (See page 121 for schedule.)
Harry Ellicott Bacon, MD (1900-1981), was Professor and Chairman of the Department of Proctology at Temple University Hospital. His stellar contribution was the establishment of the Journal, *Diseases of the Colon and Rectum*, of which he was the Chief-Editor. He is a Past President of the American Society of Colon and Rectal Surgeons and the American Board of Colon and Rectal Surgery. Dr. Bacon was the founder of the International Society of University Colon and Rectal Surgeons.

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

New Technologies

5:00 – 6:00 pm
Room: West Hall B

Supported by independent educational grants from:
Intuitive Surgical, Inc.
Stryker Endoscopy
The Medicines Company
TransEnterix

The New Technologies session is a non-CME symposium dedicated to the principle that through imagination and innovation many of the most challenging problems in the field of colon and rectal surgery can be solved. The focus of this session will be to analyze potentially impactful new innovations in the area of colorectal surgery, such as pharmacology, devices, prototypes, techniques and approaches.

New technologies and innovations in the area of colorectal practice are occurring at a rapid pace. The New Technologies symposium at the 2015 ASCRS annual meeting served as a national platform to highlight and discuss some of these early discoveries. To assist and potentiate innovation and technological development in our field, the 2016 New Technologies Session will invite early adopters, industry, start-ups, and health care providers to showcase relevant new technologies/techniques. One of the goals of the New Technologies symposium is to stimulate discussion about the application of such technologies in our patient population.

Director: Sonia Ramamoorthy, MD, La Jolla, CA
Assistant Director: Elizabeth Raskin, MD, Loma Linda, CA

5:00 pm  New Therapeutic Vaccination with MVA E2 Recombinant Vaccine in Anorectal Condyloma (Gene Therapy)
Arroyo, J. M., Larach, S. W., Ortega, A. E., Rosales, R., Veracruz, Mexico, Orlando, FL, Los Angeles, CA, Mexico, D.F., Mexico

5:06 pm  Benefit of Stryker Lighted Ureteral Stents
Lisa Parry, MD, La Jolla, CA

5:12 pm  Use of the New Integrated Table Motion for the Da Vinci Xi Surgical System in Colorectal Surgery
Morelli, L., Palmeri, M., Guadagni, S., Di Franco, G., Buccianti, P., Melfi, F., Zirafa, C., Di Candio, G., Pisa, Italy

5:18 pm  IONSYS: A Novel System for Patient-Controlled Analgesia
Mathew Albert, MD, Altamonte Springs, FL

5:24 pm  Fecal Diverting Device for the Substitution of Defunctioning Stoma. Preliminary Clinical Study
Kim, J., Jung, S., Kim, S., Daegu, Korea

5:30 pm  DaVinci XI “Loaded”: New Technology for Old Problems
John Nicholson, MD, Liverpool, NY

5:36 pm  CuraSeal AF™, A New Device for the Treatment of Complex Anal Fistulas: A Short-term Prospective Evaluation
Litta, F., Parello, A., Donisi, L., Campennì, *, Ratto, C., Rome, Italy

5:42 pm  Novel Robotic Surgery Platform with Haptics and Fully Reusable Instruments
Vincent Obias, MD, Washington, DC

5:47 pm  Role of Acellular Dermal Matrix Plug (Pressfit™) in the Treatment of Anal Fistula: A Prospective Study
Giarratano, G., Toscana, E., Shalaby, M., Sileri, P., Toscana, C., Rome, Italy

5:52 pm  Glycemic Endothelial Drink (G.E.D.) A Novel Solution to Address Postoperative Hyperglycemia
Anthony Senagore, MD, Parma, OH

6:00 pm  Adjourn
Residents’ Reception

6:30 – 8:00 pm
Platinum Ballroom F-J (2nd Floor)
JW Marriott Los Angeles L.A. LIVE Hotel

Open to general surgery residents and colorectal program directors only.

Residents are invited to this reception to network with colon and rectal surgery program directors, members of the Residents Committee, and other faculty from colon and rectal surgery training programs to learn more about the specialty and the ASCRS. Cocktails and hors d’oeuvres will be served.
Meet the Professor Breakfasts

6:30 – 7:30 am

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

Registrants are encouraged to bring problems and questions to this informal discussion.

Supported in part by an independent educational grant from Merck & Co., Inc.

T-1 How to Bail
H. Randolph Bailey, MD, Houston, TX
Daniel Herzig, MD, Portland, OR

T-2 Leaks
James Fleshman, Jr., MD, Dallas, TX
Brian Kann, MD, New Orleans, LA

T-3 Modern Management of Fecal Incontinence
Brooke Gurland, MD, Cleveland, OH
Alex Ky, MD, New York, NY

T-4 Pouch Problems and Solutions
Stephen Gorfine, MD, New York, NY
P. Ravi Kiran, MBBS, New York, NY

T-5 Rectal Cancer: Difficult Cases and Controversies
George Chang, MD, Houston, TX
Torbjörn Holm, MD, Stockholm, Sweden

T-6 Coding and Reimbursement
Guy Orangio, MD, New Orleans, LA
Stephen Sentovich, MD, Duarte, CA

Learning Objectives: At the conclusion of this session, participants should be able to: Describe the procedures and approaches discussed in these sessions.
A strong research program is critical to move an academic surgical department forward. The top surgical departments in the country are known for having multiple funded investigators with clear academic missions. However, how these programs develop is not always clear. Often good research is equated with publications. While it is obvious that the currency of research is the publication, it is evident that a strong research program is more than just publishing papers.

Much like the development of a clinical program, the growth of a research program requires support, infrastructure, time, and extreme dedication. While surgeons are very good at developing clinical programs, our ability to develop research programs is somewhat more limited. Many factors contribute to our inability to successfully build research programs including institutional pressures to produce revenue which is necessary to advance the missions of major academic medical centers. Because surgeons tend to be the engine for the institution, it is difficult to harness the resources to build research programs. This session will emphasize how to acquire the resources necessary as well as how to capitalize on these resources once you’ve been provided the opportunities.

Existing Gaps
What Is: Colon and rectal surgeons are often considered the clinical work horse of an academic surgical department making their academic productivity less impactful.

What Should Be: Colon and rectal surgery should be the premier specialty for both clinical and academic productivity.

Co-Director: Gregory Kennedy, MD, PhD, Birmingham, AL
Co-Director: James Yoo, MD, Boston, MA

7:30 am Achieving Academic Success: Perspective from the Chair
K. Craig Kent, MD, Madison, WI

7:45 am Integrating Research into Your Clinical Practice
Matthew Kalady, MD, Cleveland, OH

8:00 am Expanding Your Research Footprint: Mentorship and Collaboration
George Chang, MD, Houston, TX

8:15 am Under-Supported and Over-Productive – How to Get It Done
Rocco Ricciardi, MD, Burlington, MA

8:30 am Evidence to Change Clinical Practice – How High Is the Bar?
James Fleshman, Jr., MD, Dallas, TX

8:45 am Panel Discussion

9:00 am Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Identify a good career opportunity for building a research program; b) Explain the key components necessary to maintain a successful research program; c) Recognize how to mentor individuals both in your institution and elsewhere; d) Identify the key collaborative opportunities.
ASCRS/SSAT Symposium

Update on Inflammatory Bowel Disease/Ulcerative Colitis

7:30 – 9:00 am
Room: West Hall B

Although the recommendations for surgical treatment of ulcerative colitis are generally well established, there are certain clinical scenarios in which the most appropriate treatment is more ambiguous. It is these case scenarios in which competent surgeons disagree on best practice and expert guidance is most necessary. Some of these scenarios include optimal surgical treatment in the setting of acute disease exacerbation, delayed treatment for patients on biologics, and total proctocolectomy versus endoscopic resection for patients with adenoma lesions in the setting of ulcerative colitis.

This symposium will be in the format of a debate, in which six established experts each representing their argument for or against a particular scenario. The experts will present the most current data to support their argument for or against a specific treatment. At the end of each session, the audience will have the opportunity to ask more specific questions and then vote to support one side of the argument.

Existing Gaps
What Is: Surgeons face difficult real-life case scenarios and need to decide what is the best management. Data is sparse and sometimes contradictory.

What Should Be: Expert opinion should be available to better understand the issues at hand and controversies. Surgeons should have sufficient knowledge of the risks and benefits of each surgical treatment in order to offer best care for these patients.

Co-Director: Alessandro Fichera, MD, Seattle, WA
Co-Director: Sharon Stein, MD, Cleveland, OH

Debate I: Patient Scenario Presentation:
Patients with Acute Exacerbation of Ulcerative Colitis Do Not Need to Have Three Stage (Pro vs Con)
7:30 am Pro
Randolph Steinhagen, MD, New York, NY
7:40 am Con
Neil Hyman, MD, Chicago, IL
7:50 am Rebuttal and Audience Questions

Debate II: Patient Scenario Presentation:
Patients with Ulcerative Colitis on Biologics May Have Surgery Immediately without Delay to Decrease Serum Levels (Pro vs Con)
8:00 am Pro
Scott Strong, MD, Chicago, IL
8:10 am Con
Walter Koltun, MD, Hershey, PA

8:20 am Rebuttal and Audience Questions

Debate III: Patient Scenario Presentation:
Patients with Isolated Adenoma Should Have Endoscopic Mucosal Resections, Rather than Total Proctocolectomy (Pro vs Con)
8:30 am Pro
Christina Ha, MD, Los Angeles, CA
8:40 am Con
Matthew Mutch, MD, St. Louis, MO
8:50 am Rebuttal and Audience Questions
9:00 am Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Explain the risks and benefits of a total proctocolectomy with ileal pouch anal anastomosis in the setting of acute disease exacerbation; b) Discuss the risks, medical and financial costs of a three stage procedure for ulcerative colitis; c) Explain the risks and benefits of proceeding with surgery in the setting of recent use of biologic agents; d) Evaluate different options for surgical treatment in the setting of recent biologic use; e) Discuss risks of synchronous disease in the setting of adenoma lesions in ulcerative colitis; f) Discuss the risks of localized resection in the setting of adenoma disease; g) Discuss characteristics of a localized adenoma in the setting of ulcerative colitis.

9:00 – 9:30 am
Refreshment Break in Exhibit Hall and ePoster Presentations (See page 121 for schedule.)
Fecal incontinence is a disease which is under-reported by patients and causes great psychologic strain on patients. In addition, it can be lifestyle limiting. The evaluation of patients with fecal incontinence varies greatly among clinicians and the usefulness of routine complete physiology is questionable. Traditional treatments with antimotility agents, bulking agents, biofeedback, and sphincteroplasty (in appropriate cases) leave many patients with unresolved complaints. The last 5 years have seen a paradigm shift in the success of FI management with the introduction of SNS and its profound short and long-term success. In addition, injectables are being used with increasing frequency. When these modalities fail, there still exist other more advanced or experimental therapies such as injectables tibial nerve stimulation, as well as the magnetic bowel sphincter and graciloplasty. These modalities may have success in select patients, but are rarely used.

Through an integrated educational initiative we will address the evaluation and management of patients with fecal incontinence. The symposium will span the gamut of treatments, from conservative management to more advanced modalities.

Existing Gaps
What Is: Many treatments are available for fecal incontinence. Not all patients require surgery. As newer technologies appear and are validated, surgeon awareness of the surgical options and appropriate workup is incomplete.

What Should Be: Surgeons should have a thorough understanding of the appropriate diagnosis and treatment options for fecal incontinence.

Co-Director: Joshua Bleier, MD, Philadelphia, PA
Co-Director: Dana Sands, MD, Weston, FL

9:30 am  Best Conservative Management for FI – Diet, Meds and Biofeedback
          Hiroko Kunitake, MD, Boston, MA

9:42 am  Minimally Invasive Surgical Options – Injectables, TNS and RFA
          Massarat Zutshi, MD, Cleveland, OH

9:54 am  Sphincteroplasty – Is There Still a Role?
          Giovanna da Silva, MD, Weston, FL

10:06 am  Sacral Nerve Stimulation – Best Practices
          Tracy Hull, MD, Cleveland, OH

10:18 am  Emerging and Advanced Options – What if Everything Else Fails?
          Anders Mellgren, MD, PhD, Chicago, IL

10:30 am  Panel Discussion

10:45 am  Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Explain the role and options of conservative management for FI; b) State the true efficacy, data, and indication for injectables, RFA and tibial nerve stimulation for FI; c) Describe the selection of patients who are good candidates for sphincteroplasty; d) Describe the technique and efficacy and indications for sacral nerve stimulation; e) Identify and understand the roles of emerging and advanced treatment options for FI.

*This session addresses Self-Assessment (MOC) credit requirements as explained on page 9.
TUESDAY, MAY 3

Abstract Session

Neoplasia II

9:30 – 10:45 am
Room: Petree Hall

Co-Moderator: Todd Francone, MD, Burlington, MA
Co-Moderator: JorgeMarcet, MD, Tampa, FL.

9:35 am
Predictive Factors for Postoperative Morality in Stage IV Colorectal Cancer: A Multicenter Retrospective Case-Control Study
S47
't Lam-Boer, J., Rooks, J., de Wilt, J., Utrecht, Netherlands

9:40 am
Discussion

9:43 am
Tailored Strategy for Locally Advanced Rectal Carcinoma: A Preliminary Results of a Phase II Multicenter Trial (GRECCAR 4) S48
Rouanet, P.1, Rullier, E.2, Lelong, B.3, Maingon, P.4, Tuech, J.5, Pezet, D.6, Rivoire, M.7, Meunier, B.8, Nougaret, S.9, Castan, F.10, Lemanski, C.11, Gourgou, S.11, Ychou, M.11, 1Montpellier, France, 2Bordeaux, France, 3Marseille, France, 4Dijon, France, 5Rouen, France, 6Clermont-Ferrand, France, 7Lyon, France, 8Rennes, France

9:48 am
Discussion

9:53 am
Hospital Variability in Use of Adjuvant Chemotherapy for Patients with Stage 2 and 3 Colon Cancer S49
Daly, M. C., Hanseman, D. J., Abbott, D. E., Shah, S. A., 9Paquette, I. M., Cincinnati, OH

9:58 am
Discussion

10:01 am
Assessing the Quality of Rectal Cancer Surgery in the National Surgical Adjuvant Breast and Bowel Project Protocol R-04: A Comparison by Surgeon Specialty S50
MacQueen, I.1, Yothers, G.2, Ganz, P.3, O’Connell, M.4, Beart, R. W.5, Chen, F.6, Ko, C. Y.7, Russell, M.1, 1Los Angeles, CA, 2Philadelphia, PA

10:06 am
Discussion

10:09 am
Robotic Complete Mesocolic Excision for Left Colon Cancer S51
Baca, B., Aghayeva, A., Atasoy, D., Bayraktar, O., Ozben, V., Erguner, I., Hamzaoglu, I., Karahasanoğlu, T., Istanbul, Turkey

10:14 am
Discussion

10:17 am
Insurance Status is Linked with Variation in Survival and Metastatic Site Resection in Patients with Advanced Colorectal Cancer S52
Healy, M., Pradarelli, J., Krell, R., Regenbogen, S. E., Suwanabol, P. A., Ann Arbor, MI

10:22 am
Discussion

10:25 am
Patient, Surgeon, Pathologist, and Hospital-Level Variation in Suboptimal Lymph Node Yield after Colectomy: Compartmentalizing Quality Improvement Strategies S53

10:30 am
Discussion

10:33 am
Transanal versus Robotic Total Mesorectal Excision for Rectal Carcinoma: A Comparative Analysis S54
Wilson, M. R., Burke, J. P., Dubose, A. C., Nassif, G., deBeche-Adams, T., Larach, S. W., Atallah, S., Albert, M. R., Orlando, FL

10:38 am
Discussion

10:45 am
Adjourn

The first author is the presenting author unless otherwise noted by an *.  
Continued next page
Neoplasia II (continued)

Learning Objectives: At the conclusion of this session, participants should be able to: (S47) Upon completion of this presentation, participant should be able to identify predictors of postoperative (30-day) mortality in patients undergoing surgical resection of a stage IV colorectal tumour; Upon completion of this presentation, participant should be able to preoperatively make an evidence-based risk assessment of postoperative mortality for patients undergoing surgical resection of a stage IV colorectal tumour; (S48) Locally-advanced rectal carcinomas raise the issue of an effective oncologic management with a low morbidity rate; A tailored strategy seems feasible according to the early tumoral response after induction chemotherapy; (S49) Evaluate hospital adherence to NCCN stage-specific guidelines for the use of adjuvant chemotherapy in stage 2 and 3 colon cancer patients; Analyze hospital factors associated with lower adherence rates among outlier hospitals; (S50) Identify technical measures of quality for rectal cancer surgery; Explain the differences in adherence to technical measures of rectal cancer surgery by surgeon specialty; (S51) Analyze the role of robot in colon cancer; It was shown that robotic colon cancer surgery provides ontologically enough surgery; (S52) 1. Explain the impact of insurance status on likelihood of undergoing metastectomy; 2. Identify national statistics for survival for patients with resection of lung and liver metastases; (S53) Describe the proportional effect of patient, surgeon, pathologist, and hospital level factors associated with suboptimal lymph node yield; Evaluate the effect of suboptimal lymph node yield on 5 year disease specific and overall survival; (S54) Analyze the quality of Total Mesorectal Excision for robotic and transanal proctectomy; Evaluate local and distant recurrence rates of rectal carcinoma given method of TME.
Abstract Session
General Surgery Forum

9:30 – 10:45 am
Room: 515A

Co-Moderator: Alexis Grucela, MD, New York, NY
Co-Moderator: Cristina Sardinha, MD, New Hyde Park, NY

9:35 am Should We “Eat” the Cost of Doughnuts? No Clinical Benefit from Routine Histologic Examination of Doughnuts at Low Anterior Resection for Rectal Cancer GS1
Sugrue, J.1, Dagbert, F.1, Blumetti, J.1, Chaudhry, V.1, Emmadi, R.2, Marecik, S.2, Mellgren, A.1, Nordenstam, J.1N 1Chicago, IL, 2Park Ridge, IL

9:40 am Discussant
Mithun Shenoi, MD, Durham, NC

9:42 am Q&A

9:44 am Perineal Wounds, Perhaps Less is More: A Nationwide Analysis of Perineal Reconstruction in Abdominoperineal Resections GS2
Lopez, N., Johnson, A., Strassle, P., Calvo, B., Chapel Hill, NC

9:49 am Discussant
Ira Leeds, MD, Baltimore, MD

9:51 am Q&A

9:53 am Condyloma Acuminatum, AIN and Anal Cancer in the Setting of HIV: Do We Really Understand the Risk? GS3
Fazendin, E. A., Gill, H., Crean, A., Poggio, J., Stein, D., Philadelphia, PA

9:58 am Discussant
Chady Atallah, MD, Baltimore, MD

10:00 am Q&A

10:02 am Sacral Nerve Stimulation Is an Effective Treatment for Low Anterior Resection Syndrome GS4
Eftaiha, S. M.1, Balachandran, B.1, Mellgren, A.1, Nordenstam, J.1, Sheikh, M.1, Marecik, S.2, Prasad, L. M.1, Park, J. J.1, 1Chicago, IL, 2Park Ridge, IL

10:07 am Discussant
Teresa Rice, MD, Cincinnati, OH

10:09 am Q&A

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10:11 am Success of Enhanced Recovery Protocol Implementation in Colorectal Surgery at Monmouth Medical Center GS5
Lavy, D. S.1, Otero, J.1, Windos, K.1, Ahmed, Y.1, Heleotis, T.1, Hirko, M.1, Arvanitis, M.1, Dressner, R.1, Klein, M.2 1West Long Branch, NJ, 2Long Branch, NJ

10:16 am Discussant
Nicholas Berger, MD, Milwaukee, WI

10:18 am Q&A

10:20 am Optimal Timing of the First Surveillance Colonoscopy Following Curative Resection for Colorectal Carcinoma GS6
Alhassan, N., Lie, J., Trabulsi, N., Farsi, A., Morin, N., Vasilevsky, C., Gordon, P., Boutros, M., Montreal, QB, Canada

10:25 am Discussant
De’smond Henry, MD, Atlanta, GA

10:27 am Q&A

10:29 am Adjuvant Chemotherapy after Preoperative Chemoradiation Improves Survival in Patients with Locally Advanced Rectal Cancer GS7
Sun, Z., Adam, M. A., Kim, J., Shenoi, M. M., Hsu, S. D., Migaly, J., Mantyh, C., Durham, NC

10:34 am Discussant
John Bergquist, MD, Rochester, MN

10:36 am Q&A

10:38 am Mortality Predictors on Octogenarians after Emergency Hartmann’s Procedure: A NSQIP Study GS8
Bostock, I. C., Hill, M. V., Holubar, S., Ivatury, S. J., Lebanon, NH

10:42 am Discussant
Maria Michailidou, MD, Tucson, AZ

10:44 am Q&A

10:45 am Adjourn

Continued next page
**Masters in Colorectal Surgery Lectureship Honoring Robert W. Beart, Jr., MD**

10:45 – 11:30 am
Room: West Hall B

*On the Shoulders of Giants: The Story of Robert W. Beart*

Heidi Nelson, MD  
**Fred C. Anderson Professor, Mayo Clinic**  
**Vice Chair for Research, Department of Surgery, Mayo Clinic**  
**Rochester, MN**

*Introduction: John Pemberton, MD*

The Masters in Colorectal Surgery Lectureship honors a different senior surgeon each year who has made a considerable contribution to the specialty and the Society. The 2016 lecture honors Robert Beart, Jr., MD, who has authored or coauthored more than 300 articles and nearly 100 book chapters and has continually pursued research activities in the field of colon and rectal surgery. During his esteemed career he served on the ASCRS Executive Council and on the editorial boards of the *Journal of Gastrointestinal Surgery*, the *Journal of the American College of Surgery*, the *Journal of Laparoendoscopic Surgery* and the *Annals of Surgical Oncology*. He also served as Editor-in-Chief of the *Diseases of the Colon & Rectum*.

11:30 am – 12:30 pm
Complimentary Box Lunch in Exhibit Hall and ePoster Presentations (See page 121 for schedule.)

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**Women in Colorectal Surgery Luncheon**

*Registration Required • Complimentary*

11:30 am – 12:30 pm
Room: 502

*Supported by Ethicon US, LLC*

The Women’s Luncheon offers an opportunity for women to renew friendships and make new contacts. Female surgeons, residents and medical students are welcome. Trainees are particularly encouraged to attend as the Women’s Luncheon provides an opportunity to meet experienced colon and rectal surgeons from a variety of settings.
Young Surgeons Symposium: Board Certification and Beyond

12:30 – 2:00 pm
Room: Petree Hall

Young surgeons face several challenges early in their careers. The leap from fellowship to practice often requires surgeons, fresh from training, to teach trainees. Changing sides of the table can be daunting when it coincides with a time when one is learning his/her own practice basics and preparing for board certification. Emerging successfully from the certification process requires a fundamental understanding of the differences between general surgery board and colorectal board examinations, the deadlines, requirements and resources available. Failure in the board certification process can be psychologically paralyzing. Finally, deciding to leave your first job, searching for a new position, and ultimately transitioning is a path that must be navigated delicately.

This symposium will provide surgeons with a chronologic overview of many of the “rites of passages” of early career development in colon and rectal surgery: board certification, preparation, setting up for success, maintenance of certification, tracking case logs, and the potential of transitioning between various professional settings (hospital-based practice, private practice, academic surgery).

Existing Gaps
What Is: Surgeons may be unprepared for the rigors of board certification, the professional and psychological ramifications of failure in this process, the transition from trainee to trainer, and requirements of licensing, marketing and growing their practice. Surgeons may need guidance on the process of transferring between institutions and practice setting types.

What Should Be: Recent graduates from fellowships should be well prepared for this examination which is essential for board certification. Surgeons need to have an understanding of the resources available to help with various career transitions.

Co-Director: Anjali Kumar, MD, Seattle, WA
Co-Director: Jason Mizell, MD, Little Rock, AR

12:30 pm ABCRS Certification: Beyond the Basics
Jan Rakinic, MD, Springfield, IL

12:40 pm Mock Oral Exam: Your Turn in the Hot Seat
Overview of Young Surgeons Mock Oral Symposium
Jason Mizell, MD, Little Rock, AR

Demonstration of Mock Oral Exam
Vitaliy Poylin, MD, Boston, MA
Shafik Sidani, MD, McLean, VA
Senior Evaluator: Elizabeth Raskin, MD, Loma Linda, CA

12:55 pm Perspectives from Recent Examinees: Exam Prep Tips and Resources
Heather Yeo, MD, New York, NY

1:10 pm Recovery from Failure
Anjali Kumar, MD, Seattle, WA

1:20 pm Launching your Career in CRS: Key Concepts in Early Career Planning for the CRS – Surgeon-Specific Registry and Maintenance of Certification
Daniel Rossi, MD, Anchorage, AK

1:35 pm Navigating Early Career Transitions
Gavin Sigle, MD, Littleton, CO

1:45 pm Panel Question and Answer

2:00 pm Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Recognize the structure of the board examination process, including the oral exam; b) Recall perspectives from recent examinees, including those who failed; c) Prepare for transition from trainee to trainer; d) Explain challenges of changing institutions early or mid-career.
Abstract Session

Inflammatory Bowel Disease

12:30 – 2:00 pm
Room: 515A

Co-Moderator: Mukta Krane, MD, Seattle, WA
Co-Moderator: Maher Abbas, MD, Abu Dhabi, United Arab Emirates

12:35 pm Indeterminate Colitis Precision into Crohn's Colitis and Ulcerative Colitis Using Molecular Biometrics


12:41 pm Discussion

12:44 pm Diverted versus Undiverted Restorative Proctocolectomy: An Analysis of Long-term Outcomes after Leak


12:50 pm Discussion

12:53 pm Impact of Body Mass Index on Ability to Successfully Create an Ileal Pouch Anal Anastomosis


12:59 pm Discussion

1:02 pm Laparoscopic De-Torsion of an Ileal Pouch and Pouch Pexy

Brady, J., Steele, S., Cleveland, OH

1:08 pm Discussion

1:11 pm Post-operative Venous Thromboembolism in Patients Undergoing Abdominal Surgery for Inflammatory Bowel Disease (IBD): A Common but Rarely Addressed Problem


1:17 pm Discussion

1:20 pm A Nationwide Analysis of Postoperative Venous Thromboembolism in Chronic Ulcerative Colitis Patients: Is it the Disease or the Operation?


1:26 pm Discussion

1:29 pm Patients on Vedolizumab Have a High Rate of Postoperative Complications

Stringfield, S., Parry, L., Sandborn, W., Ramamoorthy, S., Eisenstein, S., San Diego, CA

1:35 pm Discussion

1:38 pm Safety and Efficacy of the Perioperative Use of Vedolizumab in Medically Refractory IBD patients. Does “Gut-Specificity” Impact Surgical Morbidity?

Koh, S., Zaghayian, K., Flesher, P., Los Angeles, CA

1:44 pm Discussion

1:47 pm Long-Term Outcomes Following Continent Ileostomy Creation in Patients with Crohn's Disease

Aytac, E., Dietz, D., Ashburn, J., Remzi, F., Cleveland, OH

2:00 pm Adjourn

Discussion

The first author is the presenting author unless otherwise noted by an *.
Inflammatory Bowel Disease (continued)

Learning Objectives: At the conclusion of this session, participants should be able to: (S55) Explain the precision of Indeterminate colitis into Crohn’s colitis and ulcerative colitis; Ascertain Crohn’s colitis patients that were mistakenly operated for definitive ulcerative colitis; (S56) Explain the long-term outcomes of IPAA leaks in diverted and undiverted pouches; Analyze the safety of undiverted IPAA; (S57) Determine how BMI affects the ability to successfully perform ileal pouch anal anastomosis; Define the rates of unsuccessful ileal pouch anal anastomosis based on body mass index; (S58) Identify that ileal pouch torsion is a rare complication of ileal pouch anal anastomosis; Develop a surgical plan for long term repair of ileal pouch torsion; (S59) Explain the variability of VTE rates among IBD patients following surgery; Consider post-discharge VTE prophylaxis for IBD patients undergoing surgery; (S60) Assess post operative VTE rate in CUC patients undergoing the different surgical stages; Assess other risk factor for post operative VTE rate with a focus on operation; (S61) Identify rate and types of postoperative complications observed in patients with IBD on vedolizumab; Identify factors associated with developing postoperative complications following vedolizumab therapy; (S62) Introduction to the role of gut selective biologics specifically Vedolizumab in the field of colorectal surgery; Appreciate the safety and efficacy of new biological treatment even in the peri-operative period; (S63) Outcomes of CI in patients with CD are poor, regardless of the timing of CD diagnosis; While highly-selected CD patients may be offered IPAA, CI creation in these patients is contraindicated.
The American College of Surgeons Commission on Cancer National Accreditation Program for Rectal Cancer: Why, How and When

12:30 – 2:00 pm
Room: West Hall B

Supported in part by an independent educational grant from Applied Medical

The outcomes of rectal cancer surgery have traditionally been highly variable. Tremendous differences have been reported relative to the creation of permanent stomas, operative morbidity, post-operative mortality, local tumor recurrence, and survival. Many, if not all, of these variables can be quantified by surrogate means such as training, volume, centralization of services, accreditation of individuals and of programs, data audit, and quality control with quality control audit. The concept of improving these outcomes has been repeatedly proven in multiple European countries in which rectal cancer centers of excellence and rectal cancer accreditation programs have been established. The OSTRiCh (optimizing the surgical treatment of rectal cancer) consortium has during the last several years developed a template program for introducing the concept on a national level to the United States. The support of the American College of Surgeons and the Commission on Cancer have ensured the implementation of this program. This session will describe the importance of these centers, the variability of the outcomes in the United States, the pivotal roles of the radiologists and pathologists in helping us improve surgical care, the critical nature of the multidisciplinary team initiative, and the new standards for accreditation in the perioperative management of rectal cancer.

Existing Gaps

What Is: Surgeons do not routinely participate in the multi-disciplinary team approach to rectal carcinoma, although surgeons in Europe and the United Kingdom have shown that outcomes can be improved with this model. It has not been routinely employed in the United States.

What Should Be: Surgeons should routinely engage in discussion of all rectal cancer cases in a multi-disciplinary team approach including colorectal cancer pathologists, radiologists, medical oncologists, and radiation oncologists. Surgeons should strive to provide for their patients the best possible rectal cancer care by participating in the multi-disciplinary team approach within Commission on Cancer accredited programs. If surgeons are not interested in such participation, then they should be aware of the existence of programs to send their patients to these institutions for rectal cancer care.

Director: Steven Wexner, MD, PhD (Hon), Weston, FL
Assistant Director: Feza Remzi, MD, Cleveland, OH

Learning Objectives: At the conclusion of this session, participants should be able to: a) Evaluate the variability in rectal cancer surgery outcomes; b) Assess the improvements in the outcomes during and following surgery for rectal cancer achieved in Europe during the last several decades; c) Describe the new American College of Surgeons Commission on Cancer national rectal cancer accreditation program (NRCAP).
Symposium Parallel Session 13-A

Stage IV Colorectal Cancer

2:00 – 3:30 pm

Room: West Hall B

Approximately 15-20% of patients presenting with colorectal cancer will present with synchronous metastases. Great progress has been made in both the surgical management of metastases and the development of effective systemic chemotherapy options. Surgery remains the primary curative intent approach in this population but is not always indicated. Several controversies have emerged regarding the treatment of patients with stage IV disease including when to approach the patient with curative intent versus chronic chemotherapy management versus palliation. The decision is influenced by the extent of the disease, the urgency of the circumstances (such as bowel obstruction), the extent to which the disease is resectable, and the responsiveness to chemotherapy.

Attendees will learn how a multi-disciplinary approach to managing stage IV colorectal cancer patients would improve patient care and outcomes in their hospitals and clinics. Emphasis will be placed on decision-making and management options.

Existing Gaps

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

What Should Be: Colorectal surgeons should have a detailed understanding of the options available for those patients who are potentially curable, those who require emergent or urgent surgery, and those who require intervention in a staged or palliative fashion later in their course. There should be an understanding that multidisciplinary management of Stage IV colorectal cancer is the cornerstone of their care.

Co-Director: Heidi Nelson, MD, Rochester, MN
Co-Director: Najjia Mahmoud, MD, Philadelphia, PA

Learning Objectives: At the conclusion of this session, participants should be able to: a) Describe optimal timing of metastatectomy for synchronous liver mets; b) Define selection criteria for first line therapy of Stage IV disease: surgery or chemotherapy; c) Identify the proper role and timing of palliative care; d) Explain options for balancing treatment of cancer versus obstruction.
Abstract Session

Research Forum

2:00 – 3:30 pm
Room: 515A

Co-Moderator: Kyle Cologne, MD, Los Angeles, CA
Co-Moderator: Konstantin Umanskiy, MD, Chicago, IL

2:05 pm  Reprocessed Bipolar Energy for Laparoscopic Colectomy: Is It Worth It?  RF1
Brady, J.1, Bhakta, A.1, Steele, S.1, Trunzo, J. A.2, Senagore, A. J.1, Holmgren, K.2, Schiller, A.2, Champagne, B. J.2, 1Cleveland, OH , 2Westlake, OH , 3Parma, OH

2:10 pm  Discussion
2:12 pm  Q&A
2:14 pm  Use of an ACE Inhibitor or Angiotensin Receptor Blocker is a Major Risk Factor for Dehydration Requiring Readmission in the Setting of a New Ileostomy  RF2

2:19 PM  Discussion
2:21 pm  Q&A
2:23 pm  Identification of Prognostic Biomarkers for Colorectal Cancer Disease Recurrence  RF3
Hite, N., Beck, D., Hicks, T., Kann, B., Vargas, D., Whitlow, C., Margolin, D., New Orleans, LA

2:28 pm  Discussion
2:30 pm  Q&A
2:32 pm  Genetic Predictors for Neoplasia in Inflammatory Bowel Disease -- The Beginning or End of Screening for Colitis-related Neoplasia?  RF4
Adam, N.E, Asefi, G., Albert, S., Liu, C., Chopp, W., Puff, M., Ogilvie, J., Luchtefeld, M., Grand Rapids, MI

2:37 pm  Discussion
2:39 pm  Q&A

2:41 pm  Comparing Orthotopic Colorectal Cancer Mouse Models for Primary Tumor Growth and Subsequent Metastasis  RF5
Hite, N., Beck, D., Hicks, T., Kann, B., Vargas, D., Whitlow, C., Margolin, D., New Orleans, LA

2:46 pm  Discussion
2:48 pm  Q&A
2:50 pm  Does AHR Mediated Notch Signaling Contribute to Colorectal Carcinogenesis?  RF6
Carney, P., Nukaya, M., Kennedy, G., Madison, WI

2:55 pm  Discussion
2:57 pm  Q&A
2:59 pm  Another Look at Incidental Findings after Hemorrhoidectomy: Should We Send All Hemorrhoid Specimens for Routine Histologic Examination?  RF7
Larson, L. M., Helmer, S. D., Porter, M. G., Wichita, KS

3:04 pm  Discussion
3:06 pm  Q&A
3:08 pm  Intratumoral Heterogeneity in Rectal Cancer May Limit the Ability for the Molecular Prediction of Response to Neoadjuvant Chemoradiation Therapy  RF8

3:13 pm  Discussion
3:15 pm  Q&A
3:30 pm  Adjourn

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Continued next page
Reprint Objectives: At the conclusion of this session, participants should be able to:

(RF1) Explain the safety and effectiveness of reprocessed bipolar energy for laparoscopic colectomy; Identify the influence that reprocessed devices have on Operating Room Cost, Direct and Total Margin; (RF2) Use a patient’s medication history to help predict likelihood of readmission following a new ileostomy; Develop an institutional plan for managing diuretics post-operatively following diverting ileostomy; (RF3) Identify biomarkers for colorectal cancer recurrence; Quantify biomarkers which have already been identified as markers of colorectal cancer recurrence; (RF4) Identify if a certain genetic profile was associated with neoplastic development in inflammatory Bowel Disease; Establish genetic comprehensive cancer panel for screening of colitis related neoplasia in Inflammatory Bowel Disease; (RF5) Analyze the different methods of preparing an orthotopic mouse model to study colon cancer growth and metastases; Develop and refine the most reproducible and effective mouse model to study colon cancer growth and metastases; (RF6) Explain the potential role of the Notch signaling in colorectal carcinogenesis; Recognize the therapeutic potential of Notch signaling inhibition as a treatment for colorectal cancer; (RF7) Determine whether grossly normal hemorrhoid specimens should be sent for routine histologic examination; Describe the incidence of LSIL, HSIL, squamous cell carcinoma and adenocarcinoma in grossly normal hemorrhoid specimens; (RF8) Recognize the presence of significant intratumoral heterogeneity in rectal cancer; Explain the potential consequences of intratumoral heterogeneity on prediction of response tools based on single pre-treatment biopsies samples.
Abstract Session

Benign Anorectal/Pelvic Floor II

2:00 – 3:30 pm
Room: Petree Hall

Co-Moderator: Marcus Burnstein, MD, Toronto, ON, Canada
Co-Moderator: Rebecca Hoedema, MD, Grand Rapids, MI

2:05 pm  Transanal Hemorrhoidal Dearterialization (THD) for Hemorrhoidal Disease: 1000 Consecutive Cases  S62a
Campennì, P., Parello, A., Papeo, F., Donisi, L., Litta, F., Ratto, C., Rome, Italy

2:09 pm  Discussion

2:12 pm  Phenol Injection versus Laying Open in Pilonidal Disease: A Prospective Randomized Trial  S63a
Calikoglu, I.1, Gulpinar, K.1, Oztuna, D.1, Dogru, O.2, Akyol, C.1, Erkek, B.1, Kuzu, M. A.1, 1Ankara, Turkey, 2Konya, Turkey

2:16 pm  Discussion

2:19 pm  Long-term Experience of Magnetic Anal Sphincter Augmentation in Patients with Fecal Incontinence  S64
Sugrue, J.1, Lehur, P.2, Madoff, R.3, McNevin, S.4, Buntzen, S.5, Laurberg, S.6, Mellgren, A.1, 1Chicago, IL, 2Nantes, France, 3Minneapolis, MN, 4Spokane, WA, 5Aarhus, Denmark

2:23 pm  Discussion

2:26 pm  Laparoscopic Ventral Rectopexy Versus Laparoscopic Wells Rectopexy for Complete Rectal Prolapse in the Elderly: Long-term Results  S65
Madbouly, K., Alexandria, Egypt

2:30 pm  Discussion

2:33 pm  Fluorescent Imaging in Anorectal Advancement Flaps  S66
Turner, J., Clark, C., Chase, A., Atlanta, GA

2:37 pm  Discussion

2:40 pm  Bio-Thiersch as an Adjunct to Perineal Proctectomy Reduces the Rate of Recurrent Rectal Prolapse  S67
Eftaiha, S. M.1, Calata, J. F.2, Sugrue, J.1, Marecik, S.2, Prasad, L. M.2, Mellgren, A.1, Nordenstam, J.1, Park, J. J.2, 1Chicago, IL, 2Park Ridge, IL

2:44 pm  Discussion

2:47 pm  Effects of Hysterectomy on Pelvic Floor Disorders: A Longitudinal Study  S68

2:51 pm  Discussion

2:54 pm  The Correlation Between Perineal Descent and the Anatomic and Functional Abnormalities of the Pelvic Floor Assessed by Dynamic Three-dimensional Endovaginal Ultrasonography  S69

2:58 pm  Discussion

3:01 pm  Medium Term Outcomes of Biologic Mesh Rectopexy  S70
Kipling, M., Spoerer, E., Mercer-Jones, M., Sunderland, United Kingdom

3:05 pm  Discussion

3:08 pm  Laparoscopic Ventral Mesh Rectopexy (Lap VMR)  S71
Khan, J. S., Sagias, F., Hampshire, United Kingdom

3:12 pm  Discussion

3:30 pm  Adjourn

The first author is the presenting author unless otherwise noted by an *.
Benign Anorectal/Pelvic Floor II (continued)

Learning Objectives: At the conclusion of this session, participants should be able to: (S62a) Evaluate the effectiveness of minimally invasive technique (THD) to treat Hemorrhoids in the long-term period; State advanced cases and/or re-treatment of Hemorrhoids; (S63a) Compare phenol injection vs a laying open technique in a prospective randomized trial; Explain how phenol injection is minimally invasive with small risks for the patient; (S64) Analyze the long-term functional outcomes of magnetic anal sphincter augmentation; Assess the long-term safety of magnetic anal sphincter augmentation; (S65) Explain advantage and disadvantages of laparoscopic ventral rectopexy and Wells’ rectopexy in patients above 70 years; Develop an individualized plan for laparoscopic management of elderly patients with complete rectal prolapse; (S66) Describe steps used to perform fluorescent angiography in colorectal surgery; Describe steps used for anorectal advancement flaps in complex or recurrent fistula in ano; (S67) Recognize the recurrence rate for perineal proctectomy is variable and can be high; Identify adjunct procedures with perineal proctectomy to reduce the rate of recurrence of rectal prolapse; (S68) Evaluate the influence of hysterectomy on pelvic floor disorders; Analyze the effects of hysterectomy on pelvic floor symptoms such urinary, anal incontinence, obstructed defecation and constipation; (S69) Explain a new technique for assessment of perineal descent using 3-D dynamic endovaginal ultrasonography technique, comparing it with dynamic 3D anorectal ultrasonography; Correlate Excessive Perineal descent with the anatomic and functional abnormalities of the pelvic floor; Quantify the perineal descent assessed by dynamic three-dimensional endovaginal ultrasonography and determine values using this technique; (S71) Recognize a safe technique for laparoscopic ventral mesh rectopexy which can be used for patients with obstructed defecation; Explain pitfalls and tips and trick shared for performing Lap VMR.

Parviz Kamangar Humanities in Surgery Lectureship

3:45 – 4:30 pm
Room: West Hall B

“Doctor, Do Everything”:
Life and Death in the ICU

Steven Pantilat, MD
Professor of Medicine, Dept. of Medicine,
University of California, San Francisco;
Kates-Burnard and Hellman Distinguished
Professor in Palliative Care; Founding
Director of the UCSF Palliative Care
Program, San Francisco, CA

Introduction: Yanek Chiu, MD

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

4:30 – 5:30 pm
Room: West Hall B

All surgical specialties have certain topics/diseases that contain controversy. Understanding the optimal treatment plan for patients often depends on a physician’s ability to see clarity in these lines of gray. Debates are excellent tools to show differences in perspective and opinion regarding these topics. They effectively challenge and break down surgical dogma and open people to new points of view. They often help audience members crystallize their own values and beliefs.

Speakers with passionate views about opposing treatment, with clear guidelines for the debate, can create an effective and novel learning environment. Furthermore, an assertive and experienced moderator can challenge the speakers and engage the audience to both optimize critical thinking and illustrate what treatment plan may be best for different scenarios.

Existing Gaps
What Is: Pelvic floor testing has expanded although the indications for testing and interpretation of tests can be confusing.

The “difficult” patient can be disruptive to a surgical practice but many surgeons do not understand what their obligations and rights are.

What Should Be: Pelvic floor testing should be approached systematically and tailored to the patient’s symptoms. Managing the “difficult” patient should be done in a medical, legal and ethical manner.

Director: Elisa Birnbaum, MD, St. Louis, MO

4:30 pm  Pelvic Floor Testing (Yes, It Is Still Useful)  Janice Rafferty, MD, Cincinnati, OH
4:45 pm  Pelvic Floor Testing (No, It Is Not Useful)  Tracy Hull, MD, Cleveland, OH

5:00 pm  Problem Patient (Fire)  Richard Whelan, MD, New York, NY
5:15 pm  Problem Patient (Stick It Out)  Jan Rakinic, MD, Springfield, IL
5:30 pm  Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Develop a sensible approach to the use of pelvic floor tests; b) Develop strategies for the management of the “difficult” patient.
ASCRS Fellowship Reception

5:30 – 6:30 pm
Plaza I-III (3rd Floor)
JW Marriott Los Angeles L.A. LIVE Hotel

Supported by Olympus America Inc.

Open to graduating fellows and colorectal program directors only.

Millennials Entering Surgical Practice: Managing Your Inner Tech Junky

Patricia Sylla, MD
Assistant Professor Surgery, Colorectal Surgery
Mount Sinai Hospital, New York, NY

Introduction: Glenn Ault, MD

ASCRS Annual Reception and Dinner Dance

7:00 – 8:00 pm  Reception
Platinum Ballroom Foyer
JW Marriott Los Angeles L.A. LIVE Hotel

8:00 – 10:30 pm  Dinner Dance
Platinum Ballroom Salon D-J (2nd Floor)
JW Marriott Los Angeles L.A. LIVE Hotel

Tickets Required

Relax and catch up with your friends and colleagues during the Annual Reception and Dinner Dance. This year’s event will feature a stand-up comedy routine from Full House star and comedian Dave Coulier, and an appearance from Big Bang Theory director Mark Cendrowski. A complimentary ticket is included in each member’s meeting registration; non-member or spouse/companion tickets may be purchased at the registration desk for $125 fee per ticket.
Meet the Professor Breakfasts

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| 1 | 6:30 – 7:30 am | **Meet the Professor Breakfasts**<br>**Registration Required** • Fee: $40 • Limit: 30 participants per breakfast • Continental Breakfast Included<br>Registrants are encouraged to bring problems and questions to this informal discussion.**<br>Supported in part by an independent educational grant from Merck & Co., Inc.**

<table>
<thead>
<tr>
<th>W-1</th>
<th>Room: 501A</th>
<th>Academic Development&lt;br&gt;Karim Alavi, MD, Worcester, MA&lt;br&gt;Kelly Tyler, MD, Springfield, MA</th>
</tr>
</thead>
<tbody>
<tr>
<td>W-2</td>
<td>Room: 501B</td>
<td>Quality Metrics&lt;br&gt;Clifford Ko, MD, Los Angeles, CA&lt;br&gt;Arden Morris, MD, Ann Arbor, MI</td>
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<tr>
<td>W-3</td>
<td>Room: 501C</td>
<td>Fistula in Ano&lt;br&gt;José Cintron, MD, Chicago, IL&lt;br&gt;Sean Langenfeld, MD, Omaha, NE</td>
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<td>W-4</td>
<td>Room: 511A</td>
<td>Complicated Crohn’s Disease&lt;br&gt;Robert Cima, MD, Rochester, MN&lt;br&gt;Charles Friel, MD, Charlottesville, VA</td>
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<td>W-5</td>
<td>Room: 511B</td>
<td>Bring Your Worst&lt;br&gt;Robert Fry, MD, Philadelphia, PA&lt;br&gt;David Schoetz, Jr., MD, Burlington, MA</td>
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<tr>
<td>W-6</td>
<td>Room: 511C</td>
<td>Rectovaginal Fistula&lt;br&gt;Jamie Cannon, MD, Birmingham, AL&lt;br&gt;Patricia Roberts, MD, Burlington, MA</td>
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**Learning Objectives:** At the conclusion of this session, participants should be able to: Describe the procedures and approaches discussed in these sessions.
Symposium

Benign Anorectal

7:30 – 9:00 am
Room: West Hall B

Benign anorectal conditions are common problems that affect thousands of patients. New procedures and techniques are constantly being developed to treat these conditions. This symposium provides a review and update on common benign anorectal disorders, including the latest treatment modalities and procedures.

Hemorrhoids are one of the most common reasons patients are referred to a colon and rectal surgeon and are often the generic presenting complaint of many patients with other anorectal conditions. The management of hemorrhoids, including the evaluation of patients and the medical and surgical options for treatment, are constantly evolving. Currently available and emerging technologies will be discussed in detail.

Evaluation and surgical treatment for patients with fistulas-in-ano are as old as human civilization, yet the perfect solution has not been found. A variety of surgical procedures to treat anal fistulas are discussed, including less invasive techniques such as anal fistula plug and LIFT procedure.

Anal fissures are one of the more common benign anorectal conditions treated by surgeons as well as medical physicians. The trend toward less invasive approaches has resulted in decreased numbers of sphincterotomies. We will discuss the various conservative therapies as well as surgical options to treat this painful disorder.

Pruritus ani is an embarrassing condition which may cause a great deal of suffering to the patients. Many etiological factors and conditions can lead to pruritus, making this condition notoriously difficult to treat. This symposium will address common cases of treatment of anal itching and review current therapeutic options.

Proctalgia fugax and coccydynia are variants of levator syndrome resulting in anorectal pain that cannot be explained by a structural or other specified pathology. The lack of specific anatomic and structural abnormalities make the diagnosis and treatment of levator ani syndrome quite challenging. This session will address the challenges when dealing with the patient suffering from levator ani syndrome.

Existing Gaps

What Is: New therapies for benign anorectal conditions are continually evolving.

What Should Be: Colon and rectal surgeons need to adapt modern treatment and patient education tools in the treatment of benign anorectal conditions.

Co-Director: W. Donald Buie, MD, Calgary, AB, Canada
Co-Director: Konstantin Umanskiy, MD, Chicago, IL

7:30 am Novel Treatments of Hemorrhoids – Does New Always Mean Better?
Jan Rakinic, MD, Springfield, IL

7:45 am Treatment of Fistula-in-ano – Solving an Age Old Puzzle
Bradford Sklow, MD, Minneapolis, MN

8:00 am Fissure – Patience in the Virtue
Bruce Robb, MD, Indianapolis, IN

8:15 am Pruritus Ani – How to Break the Vicious Cycle
Brian Bello, MD, Washington, DC

8:30 am Proctalgia Fugax and Levator Ani Syndrome – It’s More than Just a Pain in the Butt
Marc Singer, MD, Chicago, IL

8:45 am Discussion

9:00 am Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) List current and emerging modalities for treatment of hemorrhoids; b) Recognize indication for conservative versus surgical treatment of anal fissure; c) Describe patient selection and therapeutic options for patients with fistula-in-ano; d) Recognize etiologic factors contributing to pruritus ani; e) Describe diagnostic and treatment modalities available for patients with anal pain due to levator ani syndrome.

*This session addresses Self-Assessment (MOC) credit requirements as explained on page 9.
The concept of “Enhanced Recovery” has been increasingly recognized as a set of processes of care which are designed to improve the outcome for colorectal surgical patients. The components of care are designed to recognize and correct preoperative physiology and reduce the incidence of potentially preventable postoperative complications. The continued refinement of the protocol based upon the growing body of peer review literature has provided a straightforward set of care processes, which should be able to be implemented easily.

Accurate assessment of the patient’s preoperative risk has traditionally focused on cardiovascular and respiratory function. The recognition of the impact of the preoperative inflammatory state, myasthenia, and anemia has created new opportunities for interventions aimed at correcting these negative factors. The role of preoperative glucose loading for the purpose of improved insulin sensitivity is increasingly advocated as a means of preserving the perioperative metabolism and reducing surgical site infection. Similarly, the role of a mechanical bowel preparation in conjunction with oral antibiotics has become a revisited method of further reducing surgical site infection.

Avoidance of postoperative ileus is a key component of enhanced recovery as ileus frequently leads to prolonged length of stay and impaired nutrition postoperatively. A multimodal narcotic sparing analgesia program further improves the reduction in ileus risk while also allowing for improved ambulation and patient satisfaction.

Effective implementation of an enhanced recovery program involves both knowledge of the components of care but also expertise in change management. It is important to build a concept of team around improved outcome metrics for optimal adoption of an enhanced recovery program.

**Existing Gaps**

**What Is:** Our current understanding of clinical outcomes with traditional care pathways and the need for improved outcomes and cost efficiency.

**What Should Be:** The implementation of a flexible enhanced recovery program which effectively incorporates proven processes of care within an adaptive system capable of assessing outcomes and identifying ongoing opportunities for improvement.

**Director:** Anthony Senagore, MD, Galveston, TX  
**Assistant Director:** Julie Thacker, MD, Durham, NC

**7:30 am** Welcome and Introductions  
Anthony Senagore, MD, Galveston, TX  
Julie Thacker, MD, Durham, NC

**7:35 am** The Essentials of Preoperative Assessment of Physiologic Function in the Colorectal Surgical Patient – What We Know, What Might Help?  
Skandan Shanmugan, MD, Philadelphia, PA

**7:47 am** Reducing SSIs – What Is in the Bundle?  
Robert Cima, MD, Rochester, MN

**7:59 am** The Key Components of Enhanced Recovery – What Really Matters  
Theodore Asgeirsson, MD, Wyoming, MI

**8:12 am** Implementation of the Protocol – Why Won't They Just Do What I Want?  
Deborah Nagle, MD, Boston, MA

**8:25 am** Documenting Results – What Does My Chairperson Want to Know and Why?  
Harry Papaconstantinou, MD, Temple, TX

**8:37 am** Panel Discussion and Questions

**9:00 am** Adjourn

**Learning Objectives:** At the conclusion of this session, participants should be able to: a) List the optimal methods for preoperative risk assessment; b) Recognize the methodology for preoperative improvement in physiologic function; c) Identify the key components of an enhanced recovery program; d) Describe the strategies for effective change management; e) Recognize the metrics and methodology for assessment of outcomes.

**9:00 – 9:30 am**  
Refreshment Break in Foyer
The current treatment of rectal cancer has evolved over the last few decades as a result of advances in imaging, radiation therapy, chemotherapy, surgical technique and pathology. Most patients with locally advanced rectal cancer are now treated according to a multidisciplinary approach that includes radiation, surgery, and chemotherapy. While this multidisciplinary approach has contributed to reduced recurrence and improved survival, it has been associated with significant morbidity and long-term functional sequel that impair patient quality of life permanently. Evidence is starting to mount indicating that not every patient may benefit from each component of this intense multidisciplinary approach. If any of the components of the multidisciplinary treatment could be safely eliminated, patient quality of life will improve significantly. In this symposium we will review the current evidence that may help tailor the multidisciplinary approach to the individual patient with rectal cancer.

**Existing Gaps**

**What Is:** Current treatment guidelines indicate that patients with locally advanced rectal cancer should be treated according to a multidisciplinary plan that includes radiation, surgery and chemotherapy.

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

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

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

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<tr>
<th>Time</th>
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<tr>
<td>9:30 am</td>
<td>MRI in Staging and Re-Staging in Rectal Cancer</td>
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<tr>
<td></td>
<td>Regina Beets-Tan, MD, PhD, Amsterdam, The Netherlands</td>
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<tr>
<td>9:42 am</td>
<td>Does Every Locally Advanced Rectal Cancer Need Radiation?</td>
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<td></td>
<td>Alessandro Fichera, MD, Seattle, WA</td>
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<td>9:53 am</td>
<td>Systemic Chemotherapy in Rectal Cancer: Before or After Surgery?</td>
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<td>Andrea Cercek, MD, New York, NY</td>
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<td>10:04 am</td>
<td>Is Local Excision an Available Alternative After CRT?</td>
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<td>Rodrigo Perez, MD, PhD, Sao Paulo, Brazil</td>
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<td>10:16 am</td>
<td>Watch and Wait: Selection Criteria and Surveillance Protocol</td>
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<td>Geerard Beets, MD, PhD, Amsterdam, The Netherlands</td>
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<td>10:28 am</td>
<td>Case Presentations</td>
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<td>10:45 am</td>
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**Learning Objectives:** At the conclusion of this session, participants should be able to: a) Recognize that the accuracy of MRI is assessing rectal cancer stage; b) List the side effects associated with the use of radiation in rectal cancer patients; c) Review the potential advantages of delivering systemic chemotherapy before surgery in rectal cancer patients; d) Review the alternatives to TME in patients with rectal cancer treated with neoadjuvant combined modality therapy.
WeDne SD ay

WEDNESDAY, MAY 4

Abstract Session

Video Session

1 2 3

9:30 – 10:45 am
Room: Petree Hall

Co-Moderator: Jose Cintron, MD, Chicago, IL
Co-Moderator: Mukta Krane, MD, Seattle, WA

9:30 am Presentation of ASCRS Barton Hoexter, MD Best Video Award
9:35 am ASCRS Barton Hoexter, MD Best Video Award Perineal Anatomy for Colorectal Surgeons
Kuzu, M. A., Acar, H. I., Comert, A., Guner, M. A., Ankara, Turkey

9:40 am Discussion

9:43 am A Novel Single Stage Sphincter Saving Intersphincteric Approach for Management of Deep Postanal Abscess
Tsang, C. B., Singapore, Singapore

9:48 am Discussion

9:51 am Transanal Mucosectomy Revisited
Kaminski, J. P., Zaghiyan, K., Fleshner, P., Los Angeles, CA

9:56 am Discussion

9:59 am Transanal Completion Proctectomy after Total Colectomy and Ileal Pouch-anal Anastomosis for Ulcerative Colitis: A Modified Single Stapled Technique
de Buck van Overstraeten, A., Wolthuis, A. M., D’Hoore, A., Leuven, Belgium

10:04 am Discussion

10:07 am Autonomic Nerve Structures during Laparoscopic TME in Obese
Marecik, S. J., Zawadzki, M., Melich, G.,
Vercillo, K., Park, J. J., Prasad, L. M.,
1Park Ridge, IL, 2Wroclaw, Poland

10:12 am Discussion

10:15 am The Anatomical Landmarks for Radical Pelvic Surgery
Acar, H. I., Ismail, E., Celik, S., Guner, M. A.,
Kuzu, M. A., 1Ankara, Turkey, 2Istanbul, Turkey

10:20 am Discussion

10:23 am Robotic Complete Mesocolic Excision for Right Colon Cancer
Baca, B., Aghayeva, A., Bayraktar, O1,
Ozben, V., Atasoy , D., Erguner, I., Hamzaoglu, I.,
Karahanoglu, T., Istanbul, Turkey

10:28 am Discussion

10:31 am Laparoscopic taTME: A Magnifying Glass to Preserve Pelvic Nerves
Montroni, I., David, G., Wolthuis, A. M.,
de Buck van Overstraeten, A., Spinelli, A.,
D’Hoore, A., 1Milano, Italy, 2Leuven, Belgium

10:36 am Discussion

10:40 am Question and Answer

10:45 am Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: (WV1) Demonstrate the anatomical landmarks during sphincteroplasty and levatoroplasty; Explain sphincter preservation in patients with low rectal cancer during intersphincteric resection; (WV2) Recognize a new and novel sphincter saving approach to managing deep postanal abscess; (WV3) Describe the detailed technique of transanal mucosectomy, including three pearls for an easier dissection; Describe indications for transanal mucosectomy; (WV4) Recognize how to perform a transanal completion proctectomy, facilitated by single port access through the ileostomy site; Explain how to facilitate docking of the circular stapler after transanal close rectal dissection; (WV5) Identify the nerve structures during laparoscopic TME; Demonstrate laparoscopic TME in the obese; (WV6) Demonstrate the essential anatomical landmarks during radical pelvic surgery; Explain the correct surgical planes to achieve better oncological outcomes for radical pelvic surgery; (WV7) Analyze the role of robotic surgery in right colon cancer; Recognize that robotic surgery can provide enough oncologic dissection in right colon cancer; (WV8) Recognize the seven stations while performing Low Anterior Resection of the Rectum where nerve injuries are most likely to occur; Show how laparoscopic taTME can help identify and preserve pelvic nerve anatomy in order to prevent iatrogenic injuries.

The first author is the presenting author unless otherwise noted by an *.
Ernestine Hambrick, MD, Lectureship

10:45 – 11:30 am
Room: West Hall B

Recognition and Remediation of Deficiency in Operative Performance

Hilary Sanfey, MB, BCh, MHPE, FACS
Professor of Surgery and Vice Chair for Education, Southern Illinois University School of Medicine, Dept. of Surgery, Springfield, IL

Introduction: Sharon Stein, MD

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

Dr. Hambrick founded the STOP Foundation to promote screening and prevention of colon and rectal cancer. In addition, she has volunteered many hours working for the ASCRS including serving as Vice President.

11:30 am – 12:30 pm

Lunch (on your own)
Symposium

Pelvic Floor Disorders

12:30 – 2:00 pm
Room: Petree Hall

Pelvic floor disorders encompass functional and anatomic abnormalities of the pelvis that are associated with defecation dysfunction. The evaluation of patients with these disorders and their treatment options will be presented.

This symposium will discuss the indications and results of these options in order to impart an understanding of the treatment modalities available.

Existing Gaps

What Is: Many surgeons are unfamiliar with the spectrum of pelvic floor disorders and how to differentiate functional and anatomic abnormalities that may be contributing to the problem. Surgeons frequently are not familiar with the physiologic testing available for the evaluation of constipation, defecation disorders and their significance and impact on treatment options.

What Should Be: Surgeons should be comfortable with surgical techniques to treat rectal prolapse, intussusception and rectoceles while understanding the importance of patient selection and the role of functional disorders that can affect the outcomes. They should have an understanding of the different repairs available and their utility in treating different patient populations. Surgeons should be familiar with the physiologic evaluation tools available for constipated patients and have a strategy for surgical and non-surgical management.

Co-Director: Madhulika Varma, MD, San Francisco, CA
Co-Director: Ian Paquette, MD, Cincinnati, OH

12:30 pm  Physiology Testing for Pelvic Floor Disorders
           Ian Paquette, MD, Cincinnati, OH

12:45 pm  Functional Treatment of Dyssynergia, Intussusception and Rectocele
          Liliana Bordeianou, MD, Boston, MA

1:00 pm    Surgical Treatment of Intussusception and Rectocele
          Shane McNevin, MD, Spokane, WA

1:15 pm    Rectal Prolapse Abdominal, Perineal, Combined Repairs
           Andre D’Hoore, MD, PhD, Leuven, Belgium

1:30 pm    Case Presentations and Discussion Panel

2:00 pm    Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Explain the important contributions of functional and anatomic abnormalities to defecation dysfunction; b) Differentiate different surgical techniques for prolapse, intussusception and rectoceles; c) Plan a treatment algorithm for the management of pelvic floor disorders in different clinical settings.
Symposium

Take Me to Your OR

12:30 – 2:00 pm
Room: West Hall B

The technical nuances of surgery can be difficult to teach in a one-day course or by watching a video. Furthermore, certain colorectal procedures demand a detailed understanding of patient selection, setting up the OR, obtaining exposure, and a meticulous step-by-step approach. Descriptions of operations in textbooks or at meetings typically lack the finer points and specifics including: suture material, exposure, trouble shooting, traction, and every phase of the operation.

This session will show deconstructed videos and stills of procedures. The speakers will treat the audience as if it is their fellow/resident with 10 minutes to master the procedure. Rather than just rolling an edited video, speakers will prepare the “clips” in an effort to effectively teach all of the details of procedure. This is as close to live surgery as we can get!

Existing Gaps

What Is: Several text-books and courses fail to describe the intricate details of complex operative procedures.

What Should Be: Surgeons should understand the intricate details and pearls for specific operative procedures that are difficult, new, or performed less frequently than in the past.

Co-Director: Neil Hyman, MD, Chicago, IL
Co-Director: Tonia Young-Fadok, MD, Phoenix, AZ

12:30 pm Welcome and Introductions
Neil Hyman, MD, Chicago, IL
Tonia Young-Fadok, MD, Phoenix, AZ

12:35 pm Coccygectomy/Paracoccygeal Incision for Low Presacral Masses
Yi-Qian Nancy You, MD, Houston, TX

12:45 pm Pouch-Lengthening Procedures
Barry Salky, MD, New York, NY

12:55 pm Sacral Nerve Stimulation
Brooke Gurland, MD, Cleveland, OH

1:05 pm Gracilis Flap Interposition (Including for Rectovaginal Fistulas)
Giovan da Silva, MD, Weston, FL

1:15 pm Laparoscopic Ventral Rectopexy with Mesh
Jamie Murphy, BChir, PhD, FRCS, London, United Kingdom

1:25 pm Robotic APR with Muscle Flap
Konstantin Umanskiy, MD, Chicago, IL

1:35 pm Ultrasound-Guided/Laparoscopic/Blind TAP Blocks
Piyush Aggarwal, MD, Phoenix, AZ

1:45 pm Panel Discussion

2:00 pm Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Explain the set-up, exposure and pertinent details to complex colorectal procedures; b) Develop an understanding of how to avoid complications for these procedures.
Symposium

Colorectal Potpourri

2:00 – 3:30 pm
Room: Petree Hall

Potpourri refers to a “mixture or assortment” and in this case clinical scenarios which fall outside the more typical categories for symposia. This session will attempt to capture such topics that may be rare or unusual or otherwise uncovered in other sections of the annual meeting, but nonetheless remain relevant to our patients and prove challenging and compelling for the surgeon.

Lower gastrointestinal bleeding is a common diagnosis for which a colon and rectal surgeon is consulted, usually in conjunction with our colleagues in gastroenterology. The clinical management attempts to localize bleeding, and therapeutic interventions involve numerous choices between tests and interventions with multiple branch points on the decision tree. The evaluation and management of lower GI bleeding, along with new techniques and technology in its management, will be discussed.

The symptoms and diagnosis of endometriosis can be a frustrating exercise for both patients and surgeons. Many instances of pelvic pain are dismissed when in fact endometriosis exists. There has been long-standing controversy over the risks and benefits of medical management versus surgical extirpation. The diagnosis and management of endometriosis as it pertains to the colon and rectal surgeon will be reviewed, and particular attention will be given to the role of aggressive surgical treatment of this condition.

Radiation treatment for prostate cancer, cervical cancer, rectal cancer, and other malignancies of the pelvis has undergone a rapid evolution. From external beam radiation, to IMRT, and now to stereotactic guided radiation (Cyberknife), the pattern of short term and long term side effects of radiation on the bowel and recto-anal canal have also evolved. This session will review the emerging pattern of radiation injury associated with modern radiation treatment, and will look ahead to the future changes in this pattern inherent in expanded use of targeted therapy.

The importance of preservation of length of the small intestine when operating for Crohn’s disease has long been evident. However, in some cases, multiple resections of severe disease leave patients at risk for short gut syndrome. Modern parenteral nutrition has salvaged some of these unfortunate patients, and the era of small bowel transplant has given additional short gut patients new hope. This session will discuss the operative techniques the colon and rectal surgeon can employ when operating on a Crohn’s patient to preserve bowel length, and it will talk about new dietary approaches and other interventions that can help in the management of short gut syndrome patients.

Existing Gaps

What Is: There are specific topics within the daily experience of colon rectal surgical practice which fall outside the common themes covered in other meeting sessions. While these topics don’t always fit neatly under other subject categories, they affect a large number of our patients. These “outlying topics” might otherwise not be covered in other symposia.

What Should Be: Colon and rectal surgeons should endeavor to stay current with the treatment and management of all the problems that affect their patients. Participation in the Potpourri session will add substantially to the annual meeting’s knowledge base.
Colorectal Potpourri (continued)

**Director:** H. David Vargas, MD, *New Orleans, LA*

**Assistant Director:** Jason Penzer, MD, *New York, NY*

2:00 pm  **The Conundrum of Lower Gastrointestinal Bleeding: What's New in the Evaluation and Treatment of the Patient with Hemorrhage and Is There Light at the End of the Tunnel?**
Melissa Times, MD, Cleveland, OH

2:10 pm  **Discussion**

2:15 pm  **Endometriosis and the Large Intestine: Diagnosis, Medical Management and Indications for Surgical Resection**
Parswa Ansari, MD, New York, NY

2:25 pm  **Discussion**

2:30 pm  **Not Always our “Friend” – The Acute and Chronic Deleterious Consequences of Radiation. Evaluation, Management and When to Intervene**
Cindy Kin, MD, Stanford, CA

2:40 pm  **Discussion**

2:45 pm  **So You Like to Operate on Crohn's Disease? How to Prevent, Diagnose and Manage Short Bowel Syndrome**
Scott Strong, MD, Chicago, IL

2:55 pm  **Discussion**

3:00 pm  **Reducing Wound Infection and Anastomotic Leaks: Resurrection of Bowel Preps, Antibiotics and Other Old Warriors to Fight the War – New Information on an Age-Old Battle**
William Peche, Jr., MD, Salt Lake City, UT

3:10 pm  **Discussion**

3:15 pm  **Anticoagulation/Antiplatelet Therapy and Colonoscopy and Surgery: Should an Aspirin or Warfarin a Day Keep the Colorectal Surgeon Away?**
David Rivadeneira, MD, Woodbury, NY

3:25 pm  **Discussion**

3:30 pm  **Adjourn**

**Learning Objectives:** At the conclusion of this session, participants should be able to: a) Review the current evaluation and management of lower gastrointestinal bleeding; b) Identify indications for medical and surgical treatment of endometriosis; c) Discuss the potential colorectal complications of pelvic radiotherapy; d) Examine the risk of multiple small bowel resection and challenge of managing the patient with short bowel syndrome; e) Identify measures to reduce anastomotic leak and septic complications following colon and rectal resection; f) Discuss the balance of the risk of thrombosis and bleeding complications when performing procedures on patients on anticoagulants and antiplatelet medications.
Afternoon Debate

2:00 – 3:30 pm
Room: West Hall B

This session highlights two controversial topics in colon and rectal surgery (treatment of pilonidal disease and intersphincteric resection for distal rectal cancer), with invited experts taking PRO and CON opinions on each. A lively discussion is anticipated, with each speaker presented with the opportunity to present data, figures, and short videos to illustrate their point.

There is controversy in the management of pilonidal cyst and abscess, and how initial treatment may be tailored to minimize risk of recurrence and further morbidity.

Similarly, use of intersphincteric resection in distal rectal cancer, where part of the anal sphincter may be sacrificed, could compromise cancer cure and anal continence, but avoids a permanent colostomy.

The advantages of differing approaches to these topics will be debated by experts.

Existing Gaps

What Is: Pilonidal disease treatment, particularly in the acute setting, is controversial, and associated with a high recurrence rate. Distal rectal cancer surgical therapy has not been standardized, and the factors determining optimal outcomes remain complex with major morbidities.

What Should Be: A clear cut approach to the treatment of pilonidal disease is needed, both in the acute and more chronic setting. Parameters for when an intersphincteric resection (ISR) is indicated and NOT indicated are needed. Also the value of a well-functioning colostomy with abdominal perineal resection should be measured against an anastomosis after distal rectal cancer surgery.

Moderator: Jeffrey Milsom, MD, New York, NY

2:00 pm Welcome and Introductions
Jeffrey Milsom, MD, New York, NY

2:15 pm For Pilonidal (Upfront Flap vs. Not)
Ronald Gagliano, MD, Phoenix, AZ

2:27 pm Against Pilonidal (Upfront Flap vs. Not)
Herand Abcarian, MD, Chicago, IL

2:49 pm For ISR vs APR for Distal Rectal Cancer
John Marks, MD, Wynnewood, PA vs.

3:03 pm Against ISR vs APR for Distal Rectal Cancer
David Dietz, MD, Cleveland, OH

3:30 pm Adjourn

Learning Objectives: At the conclusion of this session, participants should be able to: a) Discover various approaches to and optimize pilonidal disease therapy, especially in the acute setting; b) Explain the advantages and risks of intersphincteric resection (ISR) in treating distal rectal cancer; c) Describe the outcomes including quality of life following abdominal perineal resection surgery for rectal cancer.
ASCRS Annual Business Meeting and State of the Society Address

4:00 – 5:00 pm
Room: 515A

Agenda

I. Call to Order – Dr. Charles E. Littlejohn

II. Approval of 2015 Business Meeting Minutes – Dr. Charles E. Littlejohn

III. Memorials – Dr. Tracy Hull

IV. Treasurer’s Report – Dr. Neil Hyman

V. Scientific Program Report – Drs. Kirsten Wilkins, Scott Steele and Joshua Bleier

VI. DC&R Editor-in-Chief Report – Dr. Robert Madoff

VII. Awards Committee Report – Dr. Jason Hall

VIII. Barton Hoexter Best Video Award – Dr. Charles E. Littlejohn

IX. Research Foundation Report – Dr. Michael Stamos

X. Research Foundation Mentor Award – Dr. Patricia Roberts

XI. American Board of Colon and Rectal Surgery Report – Dr. David Schoetz

XII. Recognition of Question Writers – Dr. Tracy Hull

XIII. Election and Elevations of Members – Dr. Charles E. Littlejohn

XIV. State of the Society Address – Dr. Charles E. Littlejohn

XV. Nominating Committee Report – Dr. Michael Stamos

XVI. New Business – Dr. Charles E. Littlejohn

XVII. Introduction of New President

XVIII. Next Meeting – June 10-14, 2017, Washington State Convention Center and Sheraton Seattle Hotel, Seattle, WA

XIX. Adjournment
ePosters of Distinction: The following ePosters have been designated as “ePosters of Distinction” and will be presented from the ePoster Theater in the Exhibit Hall at the dates and times indicated. They can also be accessed from any of the ePoster viewing monitors in the exhibit hall.

Sunday, May 1

3:50 – 4:05 pm
ePoster Theater in the Exhibit Hall

Co-Moderator: Gentry Caton, MD, Asheville, NC
Co-Moderator: Jennifer Davids, MD, Worcester, MA

3:50 pm  Anorectal Manometry and Endoanal Ultrasound in the Evaluation of Fecal Incontinence: Useful Adjuncts or Unnecessary Testing?  PD1
Conley, A., Cousins-Peterson, E., Gonzalez, C., Bernier, G., Marcet, J. E., Rasheid, S. H., Sanchez, J. E., Tampa, FL

3:55 pm  Gunsight Versus Pursestring Procedure for Closing the Wound Following Ostomy Closure: A Prospective Randomized Controlled Trial  PD2
Han, J., Wang, Z., Zhai, Z., Wei, G., Yang, Y., Gao, Z., Beijing, China

4:00 pm  Increasing Experience of LIFT Procedure for Patients with Crohn's Disease: What Have We Learned?  PD3
Kaminski, J. P., Zaghiyan, K., Fleshner, P., Los Angeles, CA

4:05 pm  A Nomogram to Predict Lymph Node Positivity Following Neoadjuvant Chemoradiation in Locally Advanced Rectal Cancer  PD4
Newton, A. D., Li, J., Jeganathan, A., Mahmoud, N., Epstein, A., Paulson, E., Philadelphia, PA

Monday, May 2

9:35 – 9:55 am
ePoster Theater in the Exhibit Hall

Co-Moderator: Satyadeep Bhattacharya, MD, Carbondale, IL
Co-Moderator: Linda Farkas, MD, Sacramento, CA

9:35 am  Proximal Internal Sphincterotomy for Chronic Anal Fissure: An Old Problem, but a New Solution  PD5
Sungurtekin, U., Ozban, M., Gokakin, A., Denizli, Turkey

9:40 am  Primary Anastomosis With or Without Proximal Diversion in Emergency Surgery for Diverticular Disease: Is There A Difference In 30 Day Outcomes?  PD6
Hite, N., Beck, D., Hicks, T., Kann, B., Vargas, D., Whitlow, C., Margolin, D., New Orleans, LA

9:45 am  Vedolizumab as Rescue Therapy in Crohn's Disease: Results from a Tertiary Care Center  PD7
Crowell, K. T., Tinsley, A., Williams, E. D., Coates, M. D., Bobb, A., Koltun, W. A., Messaris, E., Hershey, PA

9:50 am  Abdominoperineal Resection: Local Recurrence Should Occur Very Rarely  PD8
Neupane, R.1, Dosokey, E. M.1, Jabir, M. A.1, Champagne, B. J.2, Reynolds, H. L.1, Steele, S. R.1, Stein, S. L.1, Delaney, C. P.1, 1Cleveland, OH 2 Westlake, OH

ePoster Presentations

Each ePoster has been assigned a specific presentation time in which the author will present their research from a dedicated presentation monitor and answer questions.

The ePoster viewing and presentation area will be located in the Exhibit Hall and open during normal exhibit hours.

Sunday, May 1
3:45 – 4:15 pm

Monday, May 2
9:30 – 10:00 am
11:30 am – 12:45 pm
3:45 – 4:15 pm

Tuesday, May 3
9:00 – 9:30 am
11:30 am – 12:30 pm

*All ePoster presenters are listed first unless otherwise noted.
Monday, May 2

11:40 am – 12:20 pm
ePoster Theater in the Exhibit Hall

Co-Moderator: Chitra Sambasivan, MD, Riverdale, GA
Co-Moderator: Joseph Shehebar, MD, Morristown, NJ

11:40 am The Impact of Bowel Prep on the Severity of Anastomotic Leak in Elective Colectomy
Keller, D. S., Langenfeld, S., Ternent, C., Thompson, J. S., Haas, E. M., Omaha, NE, Houston, TX

11:45 am Who gets a Pouch after Colectomy in New York State and Why?
Aquina, C. T., Fleming, F., Becerra, A. Z., Hensley, B. J., Iannuzzi, J. C., Noyes, K., Monson, J., Cellini, C., Rochester, NY

11:50 am Treating Wisely: Antibiotic Stewardship in Colorectal Surgery
Fabrizio, A. C., Alimi, Y. R., Gearhart, S., Safar, B., Fang, S., Wick, E. C., Greenbelt, MD

11:55 am Percutaneous Posterior Tibial Nerve Stimulation Versus Medical Therapy for the Treatment of Low Anterior Resection Syndrome: Clinical and Manometric Short-Term Outcome of a Randomized Pilot Trial
Cuicchi, D., Cipressi, C., Pinto, C., De Raffele, E., Mirarchi, M., Ardizzoni, A., Cola, B., Bologna, Italy

Noon A Comparison of Comorbidity Indices in Risk Adjustment for Postoperative Complications after Colorectal Surgery

12:15 pm Comprehensive Human Papillomavirus Genotyping and Outcomes in Anal Cancer: An NRG Oncology/RTROG 98-11 Tissue Specimen Study

Monday, May 2

3:55 – 4:10 pm
ePoster Theater in the Exhibit Hall

Co-Moderator: Mark Manwaring, MD, Greenville, NC
Co-Moderator: Heather Yeo, MD, New York, NY

3:55 pm The Yield of Significant Findings at Colonoscopy after Diveriticulitis: A Multicenter Review
Kochar, K., Eftaiha, S. M., Blumetti, J., Chaudhry, V., Nordenstam, J., Mellgren, A., Cintron, J., Harrison, J., Chicago, IL

4:00 pm Aspirin Use in Resected Stage IV Colorectal Cancer Patients: Is There Any Benefit?
Changoor, N. R., Zogg, C. K., Madenci, A., Bleday, R., Melnitchouk, N., Goldberg, J., Boston, MA

4:05 pm Presentation, Management, and Outcomes of Colorectal Adenocarcinoma Diagnosed within One Year of Pregnancy: An Institutional Case Series

Tuesday, May 3

9:05 – 9:25 am
ePoster Theater in the Exhibit Hall

Co-Moderator: Michael B. Hopkins, MD, Raleigh, NC
Co-Moderator: Emily Paulson, MD, Philadelphia, PA

9:05 am What are the Consequences of Omission of Diverting Ileostomy if Pelvic Sepsis Occurs?
Lavryk, O. A., Remzi, F., Ashburn , J., Liska, D., Duraes, L. C., Gorgun, I. E., Kessler, H., Cleveland, OH

*All ePoster presenters are listed first unless otherwise noted.
9:10 am  High Level of ASXL1 Protein is Associated with Better Disease Free Survival in Colorectal Cancer  PD21

9:15 am  Buyer Beware of Big Data: A Comparison of NIS and NSQIP Datasets in Rectourethral Fistula Repairs  PD22

9:20 am  Sarcopenia More Important than BMI? The Prevalence and Associated Surgical Outcomes of Sarcopenic Rectal Cancer Patients  PD23
Kistner, M., He, E. C., Hoscheit, M., Nowak, L., Eberhardt, J. M., Saclarides, T., Hayden, D., Maywood, IL

11:45 am – 12:15 pm  ePoster Theater in the Exhibit Hall

Co-Moderator: Michael B. Hopkins, MD, Raleigh, NC
Co-Moderator: Emily Paulson, MD, Philadelphia, PA

11:45 am  Patterns of Health Services Utilisation in Patients with Locally Advanced and Locally Recurrent Cancers of the Pelvis  PD24
Koh, C. E., Solomon, M., Young, J., Salkeld, G., New South Wales, Australia

11:50 am  Impact of Bowel Preparation on Surgical Site Infection, Ileus, Anastomotic Leak, Major Morbidity and Mortality after Elective Colorectal Surgery: An ACS-NSQIP Analysis by Coarsened Exact Matching  PD25
Abou Khalil, J., Garfinkle, R., Morin, N., Ghitulescu, G., Vasilevsky, C., Gordon, P., Demian, M., Boutros, M., Montreal, QB, Canada

11:55 am  Self-Expanding Metal Stents Do Not Adversely Affect Long Term Oncologic Outcomes in Acute Malignant Large Bowel Obstruction  PD26
Browne, I. L., Heine, J. A., Buie, W. D., MacLean, A. R., Calgary, AB, Canada

Noon  Towards the Adoption of Transanal Total Mesorectal Excision (TaTME): Assessment of a Structured Training Program and the Experience of Surgeon Trainees  PD27

12:05 pm  Open Wounds in Colorectal Surgery: Fewer Infections… But at What Cost?  PD28
Mullen, M. G., Johnston, L. E., Hawkins, R. B., Shah, P. M., Turrentine, F. E., Hedrick, T., Friel, C. M., Charlottesville, VA

12:10 pm  Racial Disparities in Post-Operative Complications for Patients Who Die After Surgery  PD29
Giglia, M., Goss, L., Hollis, R. H., Ferrara, M., Gullick, A., Morris, M. S., Chu, D. I., Birmingham, AL

*All ePoster presenters are listed first unless otherwise noted.
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Title</th>
<th>Authors</th>
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<tr>
<td>3:50 pm</td>
<td><strong>Monitor #1 – Basic Science</strong></td>
<td><strong>Hypoxia Enhances Differentiation of Adipose-Derived Stem Cells to Smooth Muscle Cells</strong></td>
<td>F. Wang, V. Zachari, P. Pennisi, T. Fink, Y. Maeda, J. Emmersen, Harrow, United Kingdom. Aalborg, Denmark</td>
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<td>3:55 pm</td>
<td><strong>Monitor #1 – Basic Science</strong></td>
<td><strong>Dimethyl Fumarate Attenuates Colonic Inflammation in Mice</strong></td>
<td>S. Li, R. Fazl Alizadeh, C. Takasu, L. Robles, N. Vaziri, Stamos, Ichii, Irvine, Orange, CA</td>
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<td>4:00 pm</td>
<td><strong>Monitor #1 – Basic Science</strong></td>
<td><strong>Clindamycin-Gentimicin Peritoneal Lavage Decreases Surgical Site Infections in Colorectal Surgery Patients</strong></td>
<td>A. Jones, N. Bikulege, E. Ewing, A. Hale, Culumovic, Greenville, SC</td>
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<td>4:05 pm</td>
<td><strong>Monitor #1 – Basic Science</strong></td>
<td><strong>Potential use of an Oral Nonglucose Amino Acid-Based Fluid for Preventing Dehydration in Patients with Ileostomy</strong></td>
<td>A. Raza, S. Tan, A. Iqbal, L. Goldstein, Vidyasagars, Yin, VAugh, Gainesville, FL</td>
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<td>4:10 pm</td>
<td><strong>Monitor #1 – Basic Science</strong></td>
<td><strong>MRI-based Morphological Study of the Adult Complex Cryptoglandular Fistulas</strong></td>
<td>D. Ren, Guangdong, China.</td>
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<td>3:55 pm</td>
<td><strong>Monitor #3 – Benign Anorectal</strong></td>
<td><strong>Quality of Life Improvements after Doppler Guided Hemorrhoid Artery Ligation</strong></td>
<td>S. S. Brandstedter, T. Fleurizard, C. Paranjape, Akron, OH.</td>
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<td>4:00 pm</td>
<td><strong>Monitor #3 – Benign Anorectal</strong></td>
<td><strong>Comparison of Wound Complications in Open vs Closed Lateral Internal Sphincterotomy for Anal Fissure</strong></td>
<td>J. S. Park, G. Baranski, A. Yushuva, Allentown, PA.</td>
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<td>4:05 pm</td>
<td><strong>Monitor #3 – Benign Anorectal</strong></td>
<td><strong>Can Three-dimensional Anorectal Ultrasonography be Included as a Diagnostic Tool for Assessment of Anal Fistula Before and After Surgical Treatment?</strong></td>
<td>S. M. Murad-Regadas, F. Regadas, L. B. Borges, A. Vilarinho, L. B. Vera, E. Holanda, M. S. Lopes, F. W. Arruda, Ceara, Brazil</td>
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<td>4:10 pm</td>
<td><strong>Monitor #3 – Benign Anorectal</strong></td>
<td><strong>Fistulotomy Around The Sphincter (FATS) Procedure: A Simple New Concept to Treat High Fistula-in-ano</strong></td>
<td>P. Garg, V. Gupta, M. Garg, P. Singh, Haryana, India.</td>
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*All ePoster presenters are listed first unless otherwise noted.*
3:55 pm  Single-incision Laparoscopic Interval Appendectomy for Periappendiceal Abscess  
P56  
S. Bae1, W. Jeong1, O. Bae1, S. Baek1, 1. Daegu, Korea (the Republic of)  

4:00 pm  Endoscopic Resection Can Be a Safe Alternative in Giant Sessile and Pedunculated Colorectal Polyps  
P57  
K. Marimuthu1, A. Kawesha1, S. Ishaq1, 1. West Midlands, United Kingdom, 2. Birmingham, United Kingdom  

4:05 pm  Quality of Life and Functional Results in Patients Undergoing Total or Subtotal Colectomy for Slow Transit Constipation  
P58  
W. Tong, Y. Tian, L. Wang, J. Ye, X. Liu, H. Yang, B. Liu, Chongqing, China  

4:10 pm  Medical versus Surgical Treatment of Diverticulitis: How the Rise of Laparoscopy May Tip the Balance  
P59  
R. L. Lassiter, Augusta, GA  

Sunday, May 1  
Monitor #5 – Inflammatory Bowel Disease  

3:50 pm  Modified J-Ileum Pouch: Equivalent Outcomes of Ileal J-Pouch Anal Anastomosis for Patients with Ulcerative Colitis or Familial Adenomatous Polyposis  
P100  
Z. Ding, C. Jiang, Y. Wu, Q. Qian, Hubei Province, China  

3:55 pm  Intraperitoneal Rectal Stump-Related Complications Following Total Abdominal Colectomy in Patients with Inflammatory Bowel Disease  
P101  
F. Ali1, K. Hu1, M. Mahmoud2, K. A. Ludwig3, M. Otterton4, T. J. Ridolfi5, 1. Milwaukee, WI, 2. Chicago, IL  

4:00 pm  Influence of Hispanic Ethnicity in Clinical Presentation of Inflammatory Bowel Disease  
P102  
F. Rodrigues, S. Chadi1, R. Akiba, C. Varzooba, N. Palekar, G. Dasilva, S. Wexner, Weston, FL  

4:05 pm  Transanal Proctectomy for Ileal Pouch-Anal Anastomosis: An Initial Comparative Experience  
P103  
J. Burke1, A. C. Dubose1, M. R. Wilson1, S. Atallah1, M. R. Albert1, 1. Orlando, FL  

4:10 pm  Impact of Preoperative Steroid Use on Short-Term Outcomes Following Colectomy in Crohn's Disease Patients  
P104  
N. Valizadeh1, A. Murray1, R. Kiran1, 1. New York, NY  

Sunday, May 1  
Monitor #6 – Neoplastic Disease  

3:50 pm  Preoperative Short Course Radiotherapy for Rectal Cancer Provides Excellent Disease Control and Toxicity Results in a US Setting  
P117  
A. Roy1, S. Hunt1, M. Mutch1, T. E. Read1, J. Fleshman1, J. R. Olsen1, R. J. Myerson1, P. J. Parikh1, 1. St. Louis, MO, 2. Burlington, MA, 4. Dallas, TX  

3:55 pm  Limited Upper Gastrointestinal Screening is Reasonable in Lynch Syndrome Patients  
P118  
J. Hrabe1, J. M. Church1, C. Burke1, D. Crowe1, L. LaGuardia1, M. O'Malley1, M. Kalady1, 1. Cleveland, OH  

4:00 pm  Repeat Transanal Endoscopic Microsurgery for Recurrent Lesions – A Matched-Pair Case-Control Study  
P119  
F. Letarte1, S. Harriman1, M. J. Raval1, A. A. Karimuddin1, T. Phang1, C. Brown1, 1. Vancouver, BC, Canada  

4:05 pm  Precarious Margins after Laparoscopic Proctectomy Combined with Transanal Total Mesorectal Excision (Tatme) for Low Rectal Cancers – A Case-Matched Comparison  
P120  
J. W. Ogilvie1, A. Riechstein1, M. Luchtefeld1, 1. Grand Rapids, MI  

4:10 pm  Lymph Node Yield is an Independent Predictor of Survival in Rectal Cancer  
P121  
Z. Xu1, M. Berho2, A. Z. Becerra1, C. T. Aquina1, B. J. Hensley1, K. Noyes1, J. Monson1, F. Fleming1, 1. Rochester, NY, 2. Weston, FL  

Sunday, May 1  
Monitor #7 – Neoplastic Disease  

3:55 pm  Prognostic and Oncologic Significances of Perineural Invasion in Sporadic Colorectal Cancer  
P123  
A. Alotaibi1, 1. Seoul, Korea (the Republic of)  

*All ePoster presenters are listed first unless otherwise noted.*
4:00 pm  Retrospective Case-Match Comparison of Short-Term Outcomes of Laparoscopic Vs. Open Pelvic Side-Wall Lymph Node Dissection for Lower Rectal Cancer.  [P124]  
T. Sasaki1, M. Ito1, Y. Nishizawa1, Y. Tsukada1, K. Koushi1, 1., Kashiwa-City, Japan

4:05 pm  Intraperitoneal-Free Cancer Cells Represent a Major Prognostic Factor in Colorectal Peritoneal Carcinomatosis  [P125]  
B. Trilling1, E. Cotte1, D. Vaudoyer1, O. Glehen1, G. Passot1, 1. Grenoble, France

4:10 pm  Redo Low Anterior Resection as a Salvage Procedure for Low Pelvic Anastomotic Complications: What can be Expected  [P126]  
J. Thayer1, C. Y. Peterson1, T. J. Ridolfi1, K. A. Ludwig1, 1. Milwaukee, WI

Sunday, May 1
Monitor #8 – Neoplastic Disease

3:50 pm  Combined Relaparoscopy and Transanal Endoluminal Repair (Hybrid Approach) in the Management of Early Postoperative Colorectal Anastomotic Leaks – Technique and Outcomes  [P127]  
S. Bansal1, T. Ke1, T. Kato1, S. Chang1, Y. Huang1, H. Wang1, A. Fingerhut1, W. Chen1, 1. Taichung, Taiwan

3:55 pm  Transanal Endoscopic Operation VS. Transanal Excision in Rectal Tumors  [P128]  
M. H. Albandar, Seoul, Korea (the Republic of)

4:00 pm  Hemicolectomy is Associated with Improved Survival for Appendiceal Adenocarcinoma Less Than 2 Cm  [P129]  
S. O. alharthi1, H. Albeshri1, M. Baldawi1, E. Batdorff1, W. Qu1, A. Baskara1, M. Nazzal1, J. Ortiz1, 1. Toledo, OH

4:05 pm  Clinical Characteristics of Patients who Developed Early Systemic Failure after Preoperative Chemoradiotherapy for Rectal Cancer  [P130]  
S. Baek1, I. Yang1, J. Kwak1, J. Kim1, S. Kim1, 1. Seoul, Korea (the Republic of)

4:10 pm  Perineal Flap Reconstruction after Abdominal Perineal Resection in a Radiated Field: Case Comparison within an Urban Colorectal Surgery Practice.  [P131]  
M. J. Wheeler1, C. Allen1, J. F. Fitzgerald1, T. Stahl1, J. Ayscue1, L. Hernandez1, M. Bayasi1, 1. Washington, DC

Sunday, May 1
Monitor #9 – Outcomes

T. Kim1, S. Koh2, Q. Li3, K. Zagliyan2, P. Fleshner2, 1. Rancho Palos Verdes, CA, 2. Los Angeles, CA

3:55 pm  The Morbidity of a Wound: A Patient Centered Assessment  [P310]  
P. M. Shah1, H. L. Evans2, A. Harrigan1, R. G. Sawyer1, C. M. Friel1, T. Hedrick1, 1. Surgery, University of Virginia, Charlottesville, VA, 2. Surgery, University of Washing, Seattle, WA

4:00 pm  Does Laparoscopy Make Colorectal Reoperation Safer?  [P311]  
M. H. Hanna1, J. Ghagahan1, R. Fazl Alizadeh1, M. Wheelon1, S. Mills1, A. Pigazzi1, M. Stamos1, J. Carmichael1, 1. Orange, CA

4:05 pm  Enhanced Recovery After Surgery (ERAS) in Saudi Arabia: King Faisal Specialist Hospital and Research Center Jeddah.  [P312]  
O. M. Alamoudi1, H. Alansari1, A. Khan1, 1. Jeddah, Saudi Arabia

4:10 pm  Unplanned Reoperation after Colorectal Resection: When And Why We Go Back  [P313]  
M. H. Hanna1, J. Ghagahan1, R. Fazl Alizadeh1, M. Wheelon1, S. Mills1, J. Carmichael1, A. Pigazzi1, M. Stamos1, 1. Orange, CA

Sunday, May 1
Monitor #10 – Outcomes

3:50 pm  The Outcome of Robotic Resection for Rectal Cancer  [P314]  
W. Law1, D. Foo1, 1. Hong Kong

3:55 pm  Analysis of Risk Factors for Postoperative Complications in Patients Who Underwent Closure of Ileostomy After Colorectal Cancer Resection.  [P315]  
D. F. Soares1, C. R. Nahas1, M. G. Camargo1, R. A. Pinto1, C. S. Marques1, U. Ribeiro Junior1, S. Nahas1, I. Cecconello1, 1. Sào Paulo, Brazil

4:00 pm  Better In than Out – Urinary Retention After Ileostomy Takedown in Men is Common and Can be Avoided by Keeping Urinary Catheter After Surgery  [P316]  
V. Poylin1, M. Alosilla1, T. Curran1, T. E. Cataldo1, D. Nagle1, 1. Boston, MA

*All ePoster presenters are listed first unless otherwise noted.
EPOSTER PRESENTATIONS

Sunday, May 1
Monitor #12 – Pelvic Floor
3:50 pm
Patient Satisfaction and Quality of Life After Sacral Nerve Stimulator Placement for Fecal Incontinence
M. Ferrara¹, H. Waldrup¹, K. Lopiano², G. B. Bishop¹, B. Guffin¹, M. A. Parker¹, 1. Birmingham, AL, 2. Durham, NC

3:55 pm
Biofeedback for Constipation: Straining to Predict Success
A. Damle¹, D. H. Ma¹, A. T. Schlussel¹, R. C. Barrett Jr¹, J. S. Davids¹, P. R. Sturrock¹, J. A. Maykel¹, K. Alavi¹, 1. Worcester, MA

Monday, May 2
Monitor #1 – Benign Anorectal
9:35 am
Transanal Open Hemorrhoidopexy – 9-Years Results
F. Pakravan¹, C. Helmes¹, 1. Duesseldorf, Germany

9:40 am
Combination of Conservative Management With Well-Defined Goals (TONÉ) and an Office Procedure (Rubber Band Ligation) Can Prevent Need for Surgery in Most Advanced Hemorrhoid Patients
P. Garg¹, V. Gupta², M. Garg³, P. Singh⁴, 1. Punjab, India, 2. Chandigarh, India, 3. Haryana, India

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*All ePoster presenters are listed first unless otherwise noted.
Outcomes After Long-Term “Loose” Seton Treatment of Anorectal Fistulas Long-Term “Loose” Seton Use in Fistula Patients is Associated With Migration of the Internal Opening Outward and May Eliminate LIFT or Advancement Flap Procedures as Definitive Treatment

Long-Term Functional Results After Open Hemorrhoidectomy: Extended Follow-up of a Randomized Trial

Analysis of 171 Consecutive Patients with Sacrococcygeal Pilonidal Disease

Infliximab as Inpatient “Salvage” Therapy for Severe Ulcerative Colitis: Effective, Dangerous or Neither?

Reduced Port Laparoscopic Surgery For Severe Acute Ulcerative Colitis - Early Experience Shows Promising Results

One Stage Restorative Proctocolectomy With a Stapled Ileal Pouch-anal Anastomosis Using Hand-assisted Laparoscopic Surgery (HALS) for Ulcerative Colitis

Total Abdominal Colectomy and Ileorectal Anastomosis (IRA) for Crohn’s Disease (CD) Since the Introduction of Biologic Therapy

An Analysis of Cumulative and Stage to Stage Outcomes of Stage-to-Stage, Modified Stage-to-Stage and 3-Stage Restorative Proctocolectomy for Active Ulcerative Colitis

Impact of Race on Anal Cancer Outcomes in the 21st Century

Does Surgical Subspecialty Influence Time to Adjuvant Chemotherapy (TTAC) in Stage III Colon Cancer? A Single Center Review

Local Recurrence After Curative Resection for Rectal Carcinoma: The Role of Surgical Resection

Early Use of Gracilis Flap for Perineal Closures in Abdominal Perineal Resection

The Anastomotic Leak Risk Score (ALRS): A Model to Predict the Risk of Anastomotic Leakage

Rectal Cancer: Do Outcomes Justify Selective Rectal Preservation?

Outcomes of Salvage Surgery after Failure of Local Excision for Rectal Cancer: A Systematic Review

*All ePoster presenters are listed first unless otherwise noted.
**National Early Rectal Cancer Treatment Revisited**
T. Stornes¹, B. Endreseth¹, A. Nesbakken², A. Wibe¹, T. Myklebust², 1. Trondheim, Norway, 2. Oslo, Norway

**Are We Ready for Extralevatory Abdominoperineal Excision? Literature Review and a Meta-analysis**
Y. Rui¹, C. Fang¹, M. Wang¹, C. Wang¹, Z. Zhou¹, 1. Sichuan, China

**Association Between Poorly Differentiated Clusters and Efficacy of 5-Fluorouracil-Based Adjuvant Chemotherapy in Stage III Colorectal Cancer**
Y. Tajima¹, Y. Shimada¹, T. Wakai¹, T. Okamura¹, R. Yagi¹, H. Kameyama¹, 1. Niigata, Japan

**Pool of Free Hemoglobin Alpha (Hb-α) Chain: a Precursor for Colitis-Associated Colorectal Cancer**
O. Y. Korolkova¹, J. N. Myers¹, M. W. Schäffer¹, D. T. Smoot¹, T. T. Geiger¹, A. E. M’Koma¹, 1. Nashville, TN

**Significantly Elevated Levels of Proangiogenic Proteins in Wound Fluids After Colorectal Cancer Resection are a Likely Source of the Persistently Elevated Plasma Levels of Proangiogenic Proteins Noted Post-surgery**
H. Shantha Kumara¹, E. Sutton¹, G. Bellini¹, Yan¹, L. Njoh¹, V. Cekic¹, K. Baxter¹, R. L. Whelan¹, 1. New York, NY

**Expression of Cystathionine-γ-Lyase in Normal Colonic Mucosa and Ulcerative Colitis**
P. Johnson¹, C. M. Phillips¹, A. A. Mrazek¹, J. R. Zatarain¹, A. Gajjar¹, I. V. Pinchuk¹, C. Chao¹, M. R. Hellmich¹, 1. Galveston, TX

**Adhesive Small Bowel Obstruction Following Laparoscopic and Open Colorectal Surgery: A Systematic Review and Meta-Analysis**
G. Ha¹, M. Lee¹, J. Kim¹, 1. Jeonbuk, Korea (the Republic of)

**Hereditary Mutations in Colorectal Cancer: More than Meets the Diagnostic Eye**
A. M. Meyer¹, E. Dalton¹, R. McFarland¹, H. LaDuca¹, 1. Ambry Genetics, Aliso Viejo, CA

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<table>
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<tr>
<th>Time</th>
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<td>9:50 am</td>
<td>Robot-assisted versus Laparoscopic Rectal Resection for Cancer in a Single Surgeon’s Experience: A Cost-Analysis, covering the initial 50 Robotic Cases</td>
<td>L. Morelli¹, L. Cobuccio¹, V. Lorenzoni¹, S. Guadagni¹, M. Palmeri¹, G. Di Franco¹, G. Turchetti¹, F. Mosca², 1. Pisa, Italy</td>
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<td>9:55 am</td>
<td>The Bimodal Association between Pathologic Complete Response and Tumor Height in Locally Advanced Rectal Cancer Patients Undergoing Neoadjuvant Therapy.</td>
<td>S. V. Patel¹, J. Smith¹, G. Nash¹, L. Temple¹, J. Guillem¹, P. Paty¹, J. Garcia-Aguilar¹, M. Weiser¹, 1. New York, NY</td>
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<td>9:35 am</td>
<td>Where Does a Colorectal Surgeon’s Revenue Come From?</td>
<td>O. Zumba¹, C. Cheng¹, D. Connelly², C. Rezac¹, 1. North Brunswick, NJ</td>
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<td>9:40 am</td>
<td>Implementation of Routine Capnography in the Immediate Postoperative Period: Trials and Tribulations</td>
<td>B. Sarosiek¹, R. H. Thiele¹, C. M. Friel¹, T. Hedrick*, 1. Charlottesville, VA</td>
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<td>9:45 am</td>
<td>Colorectal Surgery in the Elderly. Does the Extreme Age Determine the Odds Ratio of Complications?</td>
<td>M. Martínez¹, 1. Barcelona, Spain</td>
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<td>9:50 am</td>
<td>Effectiveness of Adding Transverse Abdominus Plane (TAP) Catheters to Patient-Controlled Analgesia (PCA) in Laparoscopic Colon Resections: A Retrospective Chart Review</td>
<td>D. Bakes¹, C. Littlejohn¹, V. Frenk¹, 1. Stamford, CT</td>
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<td>9:55 am</td>
<td>Exploring Patients’ and Caregivers’ Experiences with a New Stoma and Identifying Opportunities for Improvement</td>
<td>G. Ma¹, E. Kennedy¹, 1. Toronto, ON, Canada</td>
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<td>9:50 am</td>
<td>Early Experience of Full Robotic Colorectal Resections for Cancer Combined with Other Major Surgical Procedures with the New Da Vinci Xi</td>
<td>L. Morelli¹, S. Guadagni¹, M. Palmeri¹, G. Di Franco¹, G. Caprili¹, F. Melfi¹, G. Di Candio¹, F. Mosca¹, 1. Pisa, Italy</td>
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<tr>
<td>9:55 am</td>
<td>Does Emergency Surgery Affect Resectability of Colorectal Cancer?</td>
<td>J. Jorge Barreiro¹, I. Garcia Bear¹, J. Otero Diez¹, G. Pire Abaitua¹, C. Ildefonso Cienfuegos¹, V. Sanchez Turron², L. Garcia Florez¹, 1. Asturias, Spain. 2. Madrid, Spain</td>
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<td>9:50 am</td>
<td>Local Parastomal Hernia Repair with Biological Mesh – Safe but with High Recurrence Rates.</td>
<td>M. Sheikh¹, T. Hufford¹, S. Marecki¹, L. M. Prasad¹, I. Zamfirova¹, J. J. Park¹, 1. Des Plaines, IL</td>
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<td>9:50 am</td>
<td>Risk Factors for Emergency Department Visits and Readmissions After Nonemergent Colorectal Surgery for Benign and Malignant Disease</td>
<td>S. Pannell¹, A. R. Bham¹, A. Mullard², J. Ferraro¹, R. K. Cleary¹, 1. Ann Arbor, MI</td>
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<tr>
<td>9:50 am</td>
<td>BMI is Not Associated with Risk of Anastomotic Leak Following Elective Colorectal Resection</td>
<td>S. Koller¹, M. Philp¹, H. Ross¹, 1. Philadelphia, PA</td>
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</table>
9:55 am  Competency in Performing Colonoscopy: an Assessment of Colonoscopy Skills Acquired During a Colon and Rectal Surgery Residency  
M. J. Snyder1, J. Van Eps2, C. Whitlow2,  
1. Houston, Houston, TX, 2. New Orleans, LA  
P333

Monday, May 2  
Monitor #11 – Benign Anorectal

9:35 am  Outcome Audit Into The Management Of Chronic Anal Fissures.  
J. T. Black1, N. G. Farkas1, K. Solanki1,  
A. Frampton1, A. Gupta1, N. West1, 1. London , United Kingdom  
P30

9:40 am  The Incidence and Management of Perianal Diseases in the Immunocompromised Bone Marrow Transplant Patient Population: A Single-Center Experience.  
A. Adewole1, M. SAIDY1, M. E. Schertzger1,  
D. N. Armstrong1, W. L. Ambroze1, 1. Atlanta, GA  
P31

9:45 am  Traumatic Perineal Blast Injury: A Case Series of Sphincteroplasty in Wounded Warriors  
M. O'Donnell1, M. McNally1, J. Duncan1,  
J. Nelson1, K. Kelleher1, 1. Bethesda, MD  
P32

9:50 am  Treatment of Retro-rectal Tumors: A Retrospective Study of 5-year Experience in a Single Institution  
M. Ince1, N. Ersoz2, M. Ozer1, I. Ozerhan1,  
S. Demirbas1, 1. Ankara, Turkey  
P33

9:55 am  The Effect of Patient Positioning on Rubber Band Ligation of Internal Hemorrhoids  
J. M. Downs1, F. Odom1, K. Meyers1, 1. Dallas, TX  
P34

Monday, May 2  
Monitor #12 – Pelvic Floor

9:35 am  The Usefulness of Dynamic Translabial Ultrasound vs. Ecodefecography Combined with Endovaginal Approach to Assess the Pelvic Floor Dysfunctions. What's the Effectiveness of Both Techniques?  
S. M. Murad-Regadas1, S. A. Karbage1,  
F. Regadas1, L. S. Bezerra1, A. Vilarinho1,  
L. B. Borges1, F. S. Regadas Filho1, K. Lustosa1, 1. Ceara, Brazil  
P447

9:40 am  Day-case Robotic-assisted Ventral Rectopexy is More Expensive and Time Consuming Than Day-case Laparoscopic Ventral Rectopexy  
B. Trilling1, F. Reche1, S. Barbois1, E. Girard1,  
P. Waroquet1, J. Faucheron1, 1. Grenoble, France  
P448

9:45 am  Robotic vs. Laparoscopic Ventral Rectopexies: What’s the Big Difference?  
E. Hayakawa1, J. Ogilvie1, T. Shaker1, 1. Grand Rapids, MI  
P449

9:50 am  Which Patients With Obstructed Defecation Syndrome Benefit From Ventral Rectopexy?  
E. Hayakawa1, J. Ogilvie1, T. Shaker1, 1. Grand Rapids, MI  
P450

K. Shigaki1, T. Yamana1, K. Morimoto1, R. Nishio1,  
R. Sahara1, 1. Tokyo, Japan  
P451

9:59 am  Which Patients With Obstructed Defecation Syndrome Benefit From Ventral Rectopexy?  
E. Hayakawa1, J. Ogilvie1, T. Shaker1, 1. Grand Rapids, MI  
P450

11:40 am  Assessment of Safety and Efficacy of a Novel Bipolar Energy Device as a Treatment Modality for Grade I-III Hemorrhoids.  
G. K. Maharaja1, S. W. Larach1, B. Martin-Perez1,  
1. Orlando, FL  
P35

11:45 am  Addition of Bioprosthetic Mesh Reinforcement to Ligation of Intersphincteric Fistula Tract can Result in Long Healing Times but High Fistula Closure Rates  
J. L. Reguero Hernandez1, T. Reidy1, D. Maun1,  
B. Melbert1, B. Tsai1, 1. Mooresville, IN  
P36

11:50 am  Draining Setons as Definitive Management of Fistula-in-ano  
T. Daodu1, J. A. Heine1, 1. Calgary, AB, Canada  
P37

11:55 am  Hemorrhoids Treatment with Doppler Guided Dearterialization and Mucopexy  
E. Merolla1, 1. Emilia Romagna, Italy  
P38

12:05 pm  Treatment of Fecal Incontinence with New Endoanal Polyacrylonitrile (HYEXPAN) Prosthesis  
E. Merolla1, 1. Emilia Romagna, Italy  
P40

*All ePoster presenters are listed first unless otherwise noted.
EPOSTER PRESENTATIONS

12:10 pm  Retrospective Review of Limberg Flap Versus other Surgical Management of Pilonidal Diseases in Active Duty Military Personnel  
P41
B. Tulk1, S. Gillern2, 1. Kailua, HI, 2. Honolulu, HI

12:15 pm  Transanal Hemorrhoidal Dearterialization (THD) for IV Degree Hemorrhoidal Disease  
P42
A. Parello1, E. Veronese2, E. Cudazzo3, E. D’Agostino4, C. Pagano5, E. Cavazzoni6, L. Brugnano7, F. Litta1, C. Ratto1, 1. Rome, Italy. 2. Verona, Italy. 3. Reggio Emilia, Italy. 4. Rome, Italy. 5. Milan, Italy. 6. Perugia, Italy. 7. Reggio Calabria, Italy

12:20 pm  Do We Need a Targeted Resident Curriculum Promoting Compassionate Patient Care During Outpatient Anorectal Examination in Colon and Rectal Surgery?  
P43
E. Steinhagen1, K. Umanskiy1, N. Hyman1, K. Guyton1, L. Cannon1, 1. Surgery, Chicago, IL

12:25 pm  Enhanced Imaging of Anal Canal and Anal Fistulas using a Linear Array 3D Ultrasound Probe  
P44
C. B. Tsang1, 1. Singapore

12:30 pm  Trends in the Diagnosis and Management of Horseshoe Abscess and Fistula  
P45
A. Graham1, S. Qureshi1, S. Fang1, E. C. Wick1, S. Gearhart1, Baltimore, MD

12:35 pm  Transanal Hemorrhoidal Dearterialization (THD) As A Comparison To Suture Ligation Of Hemorrhoids In High-Risk Bleeding Patients  
P46
L. Rashidi1, J. Lee1, A. Bastawrous1, D. Pollock1, 1. Seattle, WA

Monday, May 2
Monitor #2 – Neoplastic Disease

11:40 am  Appendiceal Carcinoid Tumors: Is there a Survival Advantage to Colectomy over Appendectomy?  
P172
C. Guzman1, S. Chidurala1, N. Panneerselvam1, N. J. Hellenthal1, D. Monie2, J. R. Monzon1, T. Kaufman1, 1. Cooperstown, NY

11:45 am  A Comparison of Endorectal Ultrasound and Magnetic Resonance Imaging in the Preoperative Staging of Rectal Cancer: A Single-Center Experience  
P173
M. E. Parker1, S. R. Kelley1, K. L. Mathis1, 1. Rochester, MN

11:50 am  Surgical Treatment of Stage IV Low Rectal Cancer Patients with Clinical Lateral Pelvic Lymph Node Metastasis  
P174
Y. Shimada1, Y. Tajima1, T. Okamura1, H. Kameyama1, R. Yagi1, T. Wakai1, 1. Niigata, Japan

11:55 am  The Impact of Mesorectal ADC Value on Surgical Outcome of Laparoscopic Anterior Resection for Rectal Cancer  
P175
H. Suzumura1, M. Tsuruta1, H. Hasegawa1, K. Okabayashi1, K. Shigeta1, T. Tokuda1, S. Okuda2, Y. Kitagawa1, 1. Tokyo, Japan 2. Shinjuku Shinanomachi, Japan

Noon  Incidence of Hereditary Colorectal Cancer within a Community Practice  
P176

12:05 pm  Nationwide Demographics of Appendiceal Tumors  
P177
O. Al-Natour1, S. Alharthi1, H. Albeshri1, M. Baldawi1, W. Qu1, A. Baskara1, M. Nazzal1, J. Ortiz1, 1. Perrysburg, OH

12:10 pm  Radiofrequency Ablation Treatment (RFA) of Anal High-Grade Dysplasia: A Pilot Study  
P178

12:15 pm  Lymph Node Ratio and Surgical Quality are Strong Prognostic Factor of Rectal Cancer  
P179
J. Jorge Barreiro1, I. Garcia Bear1, G. Pire Abaitua1, R. Arias Pacheco1, G. Miguez Ruiz1, A. Rodriguez Infante1, N. Gutierrez Corral1, V. Sanchez Turron1, 1. Asturias, Spain, 2. Madrid, Spain

12:20 pm  Robotic Complete Mesocolic Excision for Treatment of Colon Cancer  
P180
V. Ozben1, D. Atasoy1, A. Aghayeva1, O. Bayraktar1, T. B. Cengiz1, B. Baca1, T. Karahasanoğlu1, I. Hamzaoglu1, 1. Istanbul, Turkey

12:25 pm  Prognostic Value of FDG-PET and Inguinal Sentinel Lymph Node Biopsy in Patients with Anal Canal Cancer  
P181
P. De Nardi1, G. Guarneri1, N. Slim1, C. Canevari1, M. Lemma1, P. Passoni1, 1. Milano, Italy

*All ePoster presenters are listed first unless otherwise noted.
<table>
<thead>
<tr>
<th>Time</th>
<th>Title</th>
<th>Authors</th>
<th>Location</th>
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<tr>
<td>12:30 pm</td>
<td>Laparoscopic-Assisted Rectal Surgery for Rectal Cancer Using the Simple Rectum Catcher Device and an Intraoperative Colonoscopy: Results of Our Hospital Study in 203 Patients.</td>
<td>A. Matsumoto1, C. Chiba Prefecture, Japan</td>
<td>1202</td>
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<td>12:35 pm</td>
<td>Laparoscopic Anterior Resection using Single-Stapling Technique (SST) for Colorectal Anastomosis with Natural Orifice Specimen Extraction (NOSE)-Technique, Feasibility.</td>
<td>S. Bansal1, S. Chang1, T. Ke1, H. Chiang1, Y. Huang1, T. Kato1, H. Wang1, W. Chen1, T. Taichung, Taiwan</td>
<td>1203</td>
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<td>12:40 am</td>
<td>Oncological Outcome after Elective Surgery for Transverse Colonic Cancer: Is Open Better than Laparoscopic? A Nationwide Cohort Study.</td>
<td>A. Nordholm-Carstensen1, K. Jensen1, H. Harling1, P. Krarup1, Copenhagen NV, Denmark</td>
<td>1137</td>
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<td>12:45 am</td>
<td>The Impact of Obesity on the Short-Term Efficacy of Intersphincteric Resection for Patients with Ultralow Rectal or Anal Canal Cancer</td>
<td>X. Wang1, Z. Gan1, C. Yang1, Y. Gong1, X. Wu1, L. Li1, Sichuan, China, Chengdu, China</td>
<td>1138</td>
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<td>12:50 am</td>
<td>Chylous Ascites after Colorectal Cancer Surgery: Risk Factors and Impact on Short-term and Long-term Outcomes</td>
<td>S. Lee1, C. Kim1, Y. Kim1, H. Kim1, Jeonnam, Korea (the Republic of)</td>
<td>1139</td>
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<td>12:55 am</td>
<td>Differences in Treatment of Rectal Cancer by Age and Demographics: A National Review</td>
<td>A. Raza1, A. Iqbal1, S. Tan1, L. Goldstein1, C. Shaw1, I. Alamo1, Gainesville, FL</td>
<td>1140</td>
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<td>Noon</td>
<td>Does Tumor Location Have an Impact on Survival in Colon Cancer?</td>
<td>J. Jorge Barreiro1, I. Garcia Bear1, J. Otero Diez1, Pire Abaitua1, G. Minguex Ruiz1, A. Rodriguez Infante1, N. Gutierrez Corral1, V. Sanchez Turron1, Asturias, Spain, Madrid, Spain</td>
<td>1141</td>
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<td>12:05 pm</td>
<td>Characterization of the Clinic-pathological Features of Patients with Colorectal Cancer related to Different Family History</td>
<td>J. Chiang1, Tao-Yuan, Taiwan</td>
<td>1142</td>
</tr>
</tbody>
</table>

*All ePoster presenters are listed first unless otherwise noted.*
11:50 am  Accuracy of Radiological Imaging in the Staging of Rectal Cancer After Neoadjuvant Chemoradiation P188
O. M. Alamousi¹, A. Abduljabbar¹, L. Ashari¹, S. Alhomoud¹, H. Alhomoud¹, M. Neimatallah², N. Alsanea¹, 1. Jeddah, Saudi Arabia, 2. Riyadh, Saudi Arabia

11:55 am  Prolong Tegafur/Uracil and Leucovorin Adjuvant Chemotherapy Improving Disease-free and Over-all Survival in High-Risk Stage II Colorectal Cancer P189
Y. Yu¹, 1. KeeLung, Taiwan

Noon  Preoperative CEA as a Predictor of Response to Neoadjuvant Radiotherapy P190
J. Mino¹, F. Elagili¹, D. Dietz², 1. Cleveland, OH

12:05 pm  Validation of the Brazilian Version (Portuguese language) of the Low Anterior Resection Syndrome Score P191
K. L. Buzatti¹, T. Juul², P. Christensen², S. Laurberg², B. Deotti¹, A. Petroianu¹, R. Gomes da Silva¹, 1. Minas Gerais, Brazil, 2. Aarhus, Denmark

12:10 pm  Is Local Excision a Better Option than Radical Resection for Stage I Rectal Cancer in Octogenarians? P192
L. C. Duraes¹, F. Remzi¹, E. Gorgun¹, D. Liska¹, L. Stocchi¹, 1. Cleveland, OH

12:15 pm  Mucinous Histology Signifies Poor Oncologic Outcome in Young Colorectal Cancer Patients P193
B. G. Soliman¹, G. Karagkounis¹, M. Kalady¹, J. M. Church¹, 1. Cleveland, OH

12:20 pm  Sphincter-preserving Surgery for Rectal Cancer in the United States – An Analysis of Trends and Risk Factors for Colostomy P194
M. Whealon¹, J. Gahagan¹, S. Mills¹, A. Pigazzi¹, M. Stamos¹, J. Carmichael¹, 1. Orange, CA

12:25 pm  Impact of Anastomotic Leakage and Related Factors on Long-term Oncologic Outcome after Low Anterior Resection for Rectal Cancer P195
G. Noh¹, C. Cheong¹, J. Han¹, M. Cho¹, H. Hur¹, B. Min¹, K. Lee¹, N. Kim¹, 1. Seoul, Korea (the Republic of)

12:30 pm  A Single Institution Experience with Transanal Minimally Invasive Surgery (TAMIS) vs. Transanal Excision (TAE) for Rectal Neoplasms P196
B. M. Martin¹, V. Shaffer¹, J. Srinivasan¹, E. Lin¹, S. Rosen¹, C. Staley¹, P. Sullivan¹, 1. Atlanta, GA

12:35 pm  Standard Abdominoperineal Resection for Low Rectal Cancer. Are we Doing it Right? Results from a District General Hospital, United Kingdom. P197
M. Shaukat¹, B. Kahlid¹, N. Islam¹, S. Anwar¹, 1. West Yorkshire, United Kingdom

Monday, May 2

Monitor #5 – Outcomes

11:40 am  Patients with Restorative Proctocolectomy Experience Higher Rates of Postoperative Ileus and Readmission after Diverting Ileostomy Closure P334
A. Stokes¹, K. Mirkin¹, C. Hollenbeak², E. Messaris², 1. Harrisburg, PA, 2. Hershey, PA

11:45 am  HIV and Colon Polyps – More than Just Average Risk? P335
R. Mundy¹, T. Adegboye¹, S. Schechter¹, N. Shah¹, 1. Providence, RI

11:50 am  Management of Anastomotic Leakage After Laparoscopic Colorectal Surgery P336
Y. Lin¹, C. Yeh¹, 1. New Taipei City, Taiwan

11:55 am  Use of Laparoscopy in Colorectal Reoperative Surgery P337
M. Laporte¹, J. Alvarez Gallesio¹, M. Maya¹, A. Sanchez Ruiz¹, A. Canelas¹, C. Peccan¹, M. Bun¹, N. Rotholtz¹, 1. Buenos Aires, Argentina

Noon  Single Surgeon Experience: 300 cases of Robotic Rectal Cancer Surgery P338
Y. D. Han¹, M. H. Albandar¹, N. Kim¹, 1. Seoul, Korea (the Republic of)

12:05 pm  Creating a Predictive Model for Outcomes in Colorectal Surgery to Enhance Surgical Decision-Making and Improve Informed Consent P339
P. Devapriya¹, J. Olson¹, S. Kumara², S. Guo², J. Dove¹, M. Fluck¹, M. Hunsinger¹, J. Blansfield¹, M. Shabahang¹, 1. Danville, PA, 2. State College, PA

12:10 pm  Risk Factors Associated with Surgical Site Infection in Colorectal Surgery P340
S. Lee¹, J. Huh¹, W. Lee¹, H. Kim¹, S. Yun¹, Y. Cho¹, Y. Park¹, 1. Seoul, Korea (the Republic of)

12:15 pm  Elective Colectomy For Diverticulitis In Transplant Patients: Is It Worth The Risk? P341
J. T. Lee¹, S. Skube¹, G. Melton-Meaux¹, M. Kwaan¹, R. Madoff¹, W. Gaertner¹, 1. Minneapolis, MN

*All ePoster presenters are listed first unless otherwise noted.
12:20 pm  Location is Everything: The role for Splenic Flexure Mobilization in Diverticulitis  
A. T. Schlussel1, J. T. Wiseman1, J. F. Kelly1, 
J. S. Davids1, J. A. Maykel1, P. R. Sturrock1, 
W. B. Sweeney1, K. Alavi1, 1. Worcester, MA

12:25 pm  Metabolic Syndrome as a Risk for Anastomotic Leak Beyond Obesity Alone  
P343  
C. Papageorge1, G. Kennedy1, 1. Madison, WI

12:30 pm  Assessing The National Trends in Colon Cancer Among Native Americans: A 12-Year Database Study  
P344  
R. Thuraisingam1, V. Pandit1, M. Michailidou1, 
J. Jandova1, V. Nfonsam1, 1. Tucson, AZ

12:35 pm  Enhanced Recovery after Colorectal Surgery: The Essential Components  
P345  
J. Smolevitz2, J. Harris1, A. Tosto1, J. Poirier1, 
B. Orkin1, J. Favuzza1, 1. Chicago, IL

Monday, May 2  
Monitor #6 – Neoplastic Disease

11:40 am  Nonelective Colon Cancer Resection: A Continued Detrimental Public Health Problem  
P200  
C. T. Aquina1, A. Z. Becerra1, C. P. Probst1, 
F. P. Boscoe2, M. J. Schymura2, K. Noyes1, 
J. Monson1, F. Fleming1, 1. Rochester, NY, 2. Albany, NY

11:45 am  Variability in Radiation Therapy for Rectal Cancer Between Academic and Community Centers.  
P201  
A. Raza1, A. Iqbal1, S. Tan1, L. goldstein1, 
C. Shaw1, I. Alamo1, 1. Gainesville, FL

11:50 am  Anal Squamous-Cell Cancer: Surgical Alternatives to Chemoradiation just as effective?  
P202  
K. Suradkar1, E. Pappou1, S. Lee-Kong1, 
D. Feingold1, R. Kiran1, 1. New York, NY

11:55 am  The Impact of Timing to Initiate Postoperative Chemotherapy on Oncologic Outcome after Rectal Cancer Surgery  
P203  
G. Noh1, C. Cheong1, J. Han1, M. Cho1, H. Hur1, 
B. Min1, K. Lee1, N. Kim1, 1. Seoul, Korea (the Republic of)

Noon  Incidence of Pulmonary Embolism in Patients with Newly Diagnosed Colorectal Cancer  
P204  
E. Daniel1, A. Dean1, M. Lim1, M. Master1, 
P. Gibbs1, I. Faragher1, 1. Melbourne, VIC, Australia

12:05 pm  The Analyses of RAS and BRAF Mutations and DNA Mismatch Repair Status in Chinese Sporadic Colorectal Cancer Patients  
P205  
J. Peng1, R. Wang1, W. Sheng1, S. Cai1, 1. Shanghai, China

12:10 pm  Comparing the Effect of Obesity between Robotic and Laparoscopic Surgery for Rectal Cancer in Obese Patients  
P206  
C. Cheong1, G. Noh1, J. Han1, M. Cho1, H. Hur1, 
B. Min1, K. Lee1, N. Kim1, 1. Seoul, Korea (the Republic of)

12:15 pm  The Impact of Preoperative Chemoradiotherapy for Anastomotic Leakage in Mid and Low Rectal Cancer Surgery: A Propensity Score Matching Analysis  
P207  
E. Park1, J. Kang1, H. Hur1, B. Min1, S. Baik1, 
K. Lee1, N. Kim1, S. Sohn1, 1. Seoul, Korea (the Republic of)

12:20 pm  Outcomes of Cytoreductive Surgery Combined With Hyperthermic Intraperitoneal Chemotherapy for Synchronous or Metachronous Peritoneal Metastasis from Colorectal Cancer  
P208  
Y. Sato1, Y. Gohda1, R. Suda1, Y. Shuuno1, 
H. Yano1, 1. Tokyo, Japan

12:25 pm  Transanal Minimally Invasive Surgery, A Versatile Tool in The Colorectal Surgeon's Armamentarium – Outcomes of 122 Patients  
P209  
Y. Halwani1, G. Melich2, E. Vikis2, 1. Toronto, ON, Canada, 2. Vancouver, BC, Canada

12:30 pm  Surgical Outcomes of Resection for Colorectal Cancer in Patients with Liver Cirrhosis  
P210  
J. Lee1, C. Yu1, J. Lee1, C. Kim1, Y. Yoon1, I. Park1, 
S. Lim1, J. Kim1, 1. Seoul, Korea (the Republic of)

12:35 pm  Oncologic Outcomes in Patients Undergoing Proctectomy without Neoadjuvant Radiation for Rectal Cancer  
P211  
J. Silva Velazco1, D. Dietz1, L. Stocchi1, I. Lavery3, 
F. Remzi1, 1. Cleveland, OH

*All ePoster presenters are listed first unless otherwise noted.
Monday, May 2
Monitor #7 – Neoplastic Disease

11:40 am  Transanal Minimally Invasive Surgery Versus Transanal Endoscopic Microsurgery for Local Excision of Benign and Malignant Tumors of the Rectum: A Matched Cohort Analysis  

11:45 am  Overall Value of Laparoscopy in Colon Cancer: Benefits for Payers and Patients  
D. S. Keller2, K. Fitch1, A. Bochner1, E. M. Haas1, 1. New York, NY, 2. Houston, TX

11:50 am  Is Oncologically Safe the Short Distal Resection Margin in Low Rectal Cancer Patients who underwent Neoadjuvant Chemoradiation Therapy?  
H. Cho1, G. Kim1, R. Yoo1*, B. Kye1, H. Kim1, 1. Suwon, Korea (the Republic of)

11:55 am  The Effect of Biofeedback Therapy during Interval of Temporary Stoma on Anorectal Function: The Interim Report of Randomized Controlled Study (NCT01661829).  
H. Cho1, G. Kim1, R. Yoo1, B. Kye1, H. Kim1, 1. Suwon, Korea (the Republic of)

Noon  Total Mesorectal Excision after Transanal Endoscopic Microsurgery for Early Rectal Cancer: Can We Salvage Unexpectedly Advanced or Recurrent Disease? A Case-matched Study  
F. Letarte1, S. Harriman1, T. Phang1, A. A. Karimuddin1, M. J. Raval1, C. Brown1, 1. Vancouver, BC, Canada

12:05 pm  Neoadjuvant Chemotherapy in Unresectable Colon Cancer  
M. Versteegen1, J. Gooyer1, J. 't Lam-Boer1, S. Radema2, M. Elfrink2, C. Verhoeft3, J. Schreinemakers4, J. de Wilt5, 1. Nijmegen, Netherlands. 2. Utrecht, Netherlands. 3. Rotterdam, Netherlands

12:10 pm  Extralevator with Vertical Rectus Abdominis Myocutaneous Flap vs. Nonextralevator Abdominoperineal Excision for Rectal Cancer: The RELAPE trial  
F. Bianco1, R. Giovanni1, P. Tsarkov1, G. Stanojevic1, S. Giuratrabocchetta1, K. Shroyer2, R. Bergamaschi1, 1.Stony Brook, NY, 2. Moscow, Russian Federation. 3. Naples, Italy

12:15 pm  Resected Irradiated Rectal Cancers: Are Twelve Lymph Nodes Really Necessary in the Era of Neoadjuvant Therapy?  
M. M. Shenoi1, M. A. Adam1, Z. Sun1, J. Kim1, C. Mantyh1, J. Migaly1, 1. Durham, NC

12:20 pm  No Survival Benefits of Preoperative Radiotherapy for Rectal Cancer with Curative Resection if Insufficient Downstage Effect of Radiotherapy  
Y. Hsu1, W. Tsai1, J. Chen1, 1. Taoyuan City, (R.O.C.), Taiwan

12:25 pm  Prognostic Factors Affecting Outcomes in Multivisceral en Bloc Resection for Colorectal Cancer.  
C. R. Nahas1, S. Nahas1, C. S. Marques1, R. A. Pinto1, L. Bustamante1, G. C. Cotii1, A. Imperiale1, U. Ribiero Junior1, W. Nahas1, D. F. Soares1, P. Hoff1, I. Ceccconello1, 1. São Paulo, Brazil

12:30 pm  Robotic Transanal Minimally Invasive Surgery, A Case Series.  
B. Murray1, K. Fisher1, C. Johnson1, 1. Tulsa, OK

12:35 pm  Factors Which Predict Adequacy of Total Mesorectal Excision for Rectal Cancer: A Single Institution Study  
C. D. Lyons1, G. Ogola1, P. Prajapati1, J. Fleshman1, J. Preskitt1, 1. Dallas, TX

Monday, May 2
Monitor #8 – Outcomes

11:40 am  Money vs. Mission: Role of Academic Medical Centers in Promoting Colorectal Cancer Screening in Underserved Communities  
J. C. Chen1, K. F. Rhoads1, 1. Stanford, CA

11:45 am  Implementation of an Enhanced Recovery After Surgery (ERAS) Program for Colorectal Patients in a Community-based Hospital.  
M. Romero Arenas1, S. Cox1, D. J. Galante1, S. Svoboda1, S. Wilson1, M. Garland1, B. Bello1, 1. Baltimore, MD

11:50 am  Case-matched Comparison of Intersphincteric Proctectomy versus Proctectomy with Stapled Coloanal Anastomosis for Low Rectal Cancer  
Y. Akmal1, Z. Lackberg1, M. A. Abbas1, 1. Abu Dhabi, United Arab Emirates

11:55 am  NPO versus No NPO: Preoperative Carbohydrate Drink Until 2 Hours Before Laparoscopic Colorectal Cancer Surgery  
S. Bae1, W. Jeong1, O. Bae1, S. Baek1, 1. Daegu, Korea (the Republic of)
Noon  Serial Endoscopic Surveillance after Low Anterior Resection to Understand and Prevent Anastomotic Leak: Safety and Feasibility P352
K. Guyton¹, B. Shakhseer¹, J. Muldoon¹, K. Umanskiy¹, M. Singer¹, B. Orkin¹, N. Hyman¹, J. Alverdy¹, 1. Chicago, IL

12:05 pm  Addition of Subcutaneous Abdominal Wound Drains to a Colon Bundle in Colorectal Surgery: A Single-Center Study Assessing Superficial Surgical Site Infections P353
G. Bellini¹, E. Sutton¹, Z. Kronfol¹, B. L. Howe¹, V. Cekic¹, K. Baxter¹, L. Njoh¹, R. L. Whelan¹, 1. New York, NY

12:10 pm  Predictors for Unplanned Reoperation following Colectomy P354
A. Althumairi¹, N. Nagarajan¹, J. K. Canner¹, J. Efron¹, S. Gearhart¹, E. C. Wick¹, S. Fang¹, B. Safar¹, 1. Baltimore, MD

12:15 pm  A Step-wise Approach to Disposition at Discharge is likely best Strategy to Impact Hospital Length of Stay after Colectomy. P355
A. M. Al-Mazrou¹, C. Chiuzan¹, R. Kiran¹, 1. New York, NY

P. Rouanet¹, M. Bertrand¹, M. Jarlier¹, A. Mourregot¹, S. Carrère¹, F. Quenet¹, P. Colombo¹, 1. Montpellier, France

12:25 pm  Should Classification as an ACS-NSQIP High Outlier Be Used to Direct Hospital Quality Improvement Efforts? P357
E. H. Lawson¹, P. Roberts¹, P. Marcello¹, T. D. Francone¹, J. Hall¹, T. E. Read¹, D. Schoetz¹, R. Ricciardi¹, 1. Burlington, MA

12:30 pm  Surgical Site Infection in Elective Colorectal Surgery: Results from a Clinical Trial P358
E. Thompson¹, S. Shanmugam¹, R. Broach¹, N. Mahmoud¹, E. Paulson¹, 1. Philadelphia, PA

12:35 pm  Are We Still Too Surgically Aggressive in Anal Melanoma Cases: A Contemporary Analysis of Practice Patterns? P359
S. Dumitra¹, M. Raoof¹, L. Lai¹, 1. Duarte, CA

*All ePoster presenters are listed first unless otherwise noted.
12:30 pm  Outcomes of Nonsurgical Treatment in Patients with Clinical Complete Response after Neoadjuvant Therapy for Rectal Cancer  
G. C. Cotti¹, C. R. Nahas¹, C. S. Marques¹, A. Imperiale¹, U. Ribeiro Junior¹, S. Nahas¹, I. Cecconello¹, P. Hoff¹, 1. São Paulo, Brazil

Monday, May 2
Monitor #10 – Neoplastic Disease

11:40 am  Clinicopathologic Characteristics and Long-Term Prognosis of Young-aged Patients with Sporadic Colorectal Cancer  
P242
S. Yang¹, Y. Park¹, W. Lee¹, H. Kim¹, S. Yun¹, Y. Cho¹, J. Huh¹, 1. Seoul, Korea (the Republic of)

11:45 am  The Association between BMI and Tumor Characteristics, Choice of Treatment and postoperative Complications in Dutch Patients with Colorectal Cancer: Results of a Retrospective Cohort Study  
P244
J. Arkenbosch¹, S. Beijer², F. van Erning², J. de Wilt², 1. Nijmegen, Netherlands, 2. Eindhoven, Netherlands

11:50 am  Lymph Node Count as a Quality Metric in Rectal Cancer Surgery after Neoadjuvant Radiation  
P245
M. Raoof¹, P. Ituarte¹, S. Dumitra¹, R. Krouse ², K. Melstrom¹, 1. Duarte, CA, 2. Tucson, AZ

11:55 am  Interval Colorectal Cancers: Sometimes Preventable, Not Necessarily Methylated.  
P246
V. N. Kozak¹, M. Kalady¹, G. Karagkounis¹, J. M. Church¹, 1. Cleveland Heights, OH

Noon  Differential miR Expression Profile Predictive of Colorectal Cancer Metastasis in Node Positive Early-Onset Colorectal Cancer  
P247
K. Butler¹, N. E. Wiegard¹, K. Ellrott¹, V. L. Tsikitis¹, 1. Portland, OR

12:05 pm  Neoadjuvant Radiation Therapy Improves Survival in Locally Advanced Colon Cancer  
P249
D. Mukkai Krishnamurty¹, A. T. Hawkins¹, K. Wells¹, M. Silviera¹, M. Mutch¹, S. C. Glasgow¹, S. Hunt¹, S. Dharmarajan¹, 1. St Louis, MO

12:10 pm  Is there a Role for Para-aortic Lymphadenectomy in the Treatment of Recurrent Rectal Cancer?  
P250
S. Gonsalves¹, K. Brown¹, L. Peter¹, K. Austin¹, M. Solomon¹, 1. Sydney, NSW, Australia
Efficacy of Fibrin Glue Therapy for Abscess Associated Enteric Fistulas  
B. Chapman1, J. Merkow1, A. Paniccia1, D. M. Overbey1, M. Gipson2, L. Wilson1, G. Stiegmann1, J. Vogel1, 1. Denver, CO, 2. Aurora, CO

Evaluations of the Risk Factor for Stoma Site Incisional Hernia after Loop Ileostomy Reversal following Rectal Cancer Resection  
F. Teraishi1, 1. Kochi, Japan

Safety and Indications of Laparoscopic Surgery for Postoperative Small-bowel Obstruction: A Single-center Study in 121 Patients  
T. Nakamura1, Y. Ishii1, A. Tsutsui1, M. Kaneda2, T. Sato1, M. Watanabe1, 1. Kanagawa, Japan, 2. Tokyo, Japan

Returns to the Operating Room (ROR): A Measure of Surgical Quality?  
A. L. Lightner1, E. Habermann1, R. Cima1, A. Glasgow2, 1. Rochester, MN

Loop Ileostomy Closure: Is Next-Day Discharge Safe and Effective?  
N. G. Berger1, R. Chou1, E. Toy1, K. A. Ludwig1, T. J. Ridolfi1, C. Y. Peterson1, 1. Milwaukee, WI

Simethicone In Postoperative Ileus (SPOT), A Randomized Controlled Trial  
C. Eskicioglu1, S. ElKheir1, S. Forbes1, 1. Hamilton, ON, Canada

Right-Sided Diverticulitis Requiring Colectomy: An Evolving Demographic? A Review of Surgical Outcomes from the National Inpatient Sample Database  
A. T. Schlussel1, N. B. Cherng1, J. A. Maykel1, Q. M. Hatch1, S. R. Steele1, 1. Worcester, MA, 2. Cleveland, OH, 3. Tacoma, WA

Mortality Risk Factor Analysis in Colonic Perforation: Would Retroperitoneal Contamination Increase Mortality in Colonic Perforation?  
R. Yoo1, H. Kim1, 1. Gyeonggi-do, Korea (the Republic of)

Surgical Infection in Penetrating Colon and Rectal Injuries: Do Antibiotics and Diverting Ostomies offer Protection?  
M. Zelhart1, D. Pointer1, L. Schindelar1, J. Silinsky1, R. Nichols1, 1. New Orleans, LA

Is Colonoscopy Necessary for Patients Presenting with Hematochezia under the Age of 40?  
M. Tang1, F. Foo1, C. Ng1, 1. Singapore

Acute Diverticulitis with Microperforation. Should it be treated the same as Acute Uncomplicated Diverticulitis?  
R. Dibble1, B. Al-Mamoori1, J. L. Poggio1, 1. Philadelphia, PA

Observation after Nonoperative management of Diverticular Abscess  
T. P. Nickerson1, K. L. Mathis1, E. J. Dozois1, H. K. Chua1, R. Cima1, S. R. Kelley1, D. W. Larson1, 1. Rochester, MN

Robotic Surgery for Diverticulitis – Is it Cost Effective?  
M. F. DeLeon1, N. Maloney Patel1, C. Rezac1, 1. New Brunswick, NJ

SILS Colectomy is Associated with Significantly Reduced Length of Stay Compared to Laparoscopic Colectomy  
A. Murray1, K. Gash1, R. Kiran1, 1. New York City, NY

Is There a Selective Role for Nonoperative Management of Renal Transplant Patients with Acute Diverticulitis? A Review of Outcomes  
J. Sugrue1, J. Lee1, F. Alsabhan1, S. M. Eftaiha1, R. Garcia-Roca1, W. Mar1, A. Mellgren1, J. Nordenstam1, 1. Chicago, IL

Endoscopic Mucosal Resection for Curative Excision of Large Colon Polyps  
K. S. Venkatesh1, K. A. Venkatesh1, S. Yee1, 1. Gilbert, AZ, 2. Mesa, AZ

Operative Safety and Functional Outcome after Restorative Proctocolectomy  
G. Noh1, M. Cho1, H. Hur1, B. Min1, K. Lee1, N. Kim1, 1. Seoul, Korea (the Republic of)

*All ePoster presenters are listed first unless otherwise noted.
Monday, May 2
Monitor #1 – Basic Science

3:50 pm Comparative Gene Expression Analysis in Colorectal Adenocarcinoma: Does Age Matter? P11
V. Nfonsam, J. Jandova, Tucson, AZ

3:55 pm Prospective Analysis of the Sealing Ability of the EnSeal G2 Articulating Tissue Sealer on Human Mesenteric Vessels in Colorectal Surgery P12

4:00 pm Anti-inflammatory and Anti-oxidant Effects of Curcumin on TNBS-induced Colitis of Rats P13

Monday, May 2
Monitor #2 – Benign Anorectal

3:50 pm Long-term Results of Fissurectomy with Anoplasty for the Treatment of Chronic Anal Fissure: A Prospective Study P50
G. Giarratano, E. Toscana, M. Shalaby, P. Sileri, C. Toscana, Rome, Italy

3:55 pm Comparative Study Between Endorectal Tridimensional Ultrasound and Transvaginal Ultrasound on the Diagnosis of Deep Infiltrating Endometriosis with Rectal Envolvement P51

4:00 pm The Utility of the LIFT Procedure in Inflammatory Bowel Disease Patients with Perianal Fistulas P52

4:05 pm Transanal Hemorrhoidal Dearterialization Makes Hemorrhoidectomy Safe While on Anticoagulation P53
B. Chong, Orlando, FL

4:10 pm How Does Rectal Endometriosis Appear on Tridimensional Endorectal Ultrasound? P54
R. M. de Almeida, P. G. de Oliveira, J. de Sousa, F. S. Correa, S. M. Silva, S. M. Murad-Regadas, Brasilia, Brazil

Monday, May 2
Monitor #3 – Neoplastic Disease

3:50 pm What is the Optimum Vessel Ligation in Splenic Flexure Cancer? P257
M. H. Albandar, Seoul, Korea (the Republic of)

I. MacQueen, J. Peredo, K. Tangney, S. Ho, M. Scheuner, M. Russell, Los Angeles, CA

4:00 pm Recurrence Rates of Colonic Adenocarcinoma Following Robotic-Assisted Segmental Resection. P259
S. Luka, J. Buro, S. Agarwal, V. Obias, Washington, DC

4:05 pm Additional Flap Operation in Bladder-preserving Surgery for Locally Advanced Rectal Cancer Involving the Prostate P260
K. Noguchi, Y. Nishizawa, A. Kobayashi, M. Ito, N. Saito, Chiba, Japan

4:10 pm Different Prognostic Significance of Mucinous and Signet-Ring Cell Components in Colorectal Cancer P261
J. Gu, P. Chen, Beijing, China

Monday, May 2
Monitor #4 – Neoplastic Disease

3:50 pm Predictors of Reclassification of Variants of Unknown Significance (VUS) Among Genes Predisposing to Colorectal Cancer P262

*All ePoster presenters are listed first unless otherwise noted.
3:55 pm  The Propensity of Postoperative CEA Level according to the Recurrence Pattern after Resection of Primary Colorectal Cancer  
P263  
S. Park1, H. Hur1, B. Min1, N. Kim1, K. Lee1, K. T. Noh1*, C. Cheong1, J. Han1, 1. Seoul, Korea (the Republic of)

4:00 pm  Educational Benefit for Surgical Beginner to Train Surgical Decision using Fluorescence Imaging System with ICG during Laparoscopic Colorectal Surgery  
P264  
G. Son1, 1. Gyeongsangnam-Do, Korea (the Republic of)

4:05 pm  Effect of a Colorectal Cancer Patient Navigator on the Completeness of Surveillance after Colorectal Cancer Resection  
P265  
D. Gill1, S. Harriman1, F. Letarte1, A. A. Karimuddin1, T. Phang1, M. J. Raval1, C. Brown1, 1. Vancouver, BC, Canada

4:10 pm  A Single Institution Review of Robotic-Assisted Right Colectomy: Oncologic Results and Follow-up  
P266  
S. Agarwal1, T. Ju1, S. Luka1, V. Obias1, 1. Washington, DC

Monday, May 2  
Monitor #5 – Pelvic Floor

3:50 pm  The Effect of Vaginal Delivery on the Anatomy and Function of the Pelvic Floor and Anal Canal Muscles. Is There Any Correlation Between Such Abnormalities and Fecal Incontinence Symptoms?  
P452  
S. M. Murad-Regadas1, A. Vilarinho1, L. B. Borges1, F. Regadas1, L. V. Rodrigues1, L. B. Veras1, G. O. Fernandes1, C. R. Bezerra1, 1. Fortaleza, Ceara, Brazil

3:55 pm  Pudendal Nerve Terminal Motor Latency Testing Does Not Provide Useful Information in Guiding Therapy for Fecal Incontinence  
P453  
G. Molina1, L. R. Savitt1, H. Milch1, T. L. Mei1, S. Chin1, J. K. Kuoi1, L. B. Bordeianou1, 1. Boston, MA, 2. Waltham, MA

4:00 pm  Is Radiographic Finding of Enterocele in Patients with Obstructed Defecation Syndrome Clinically Significant?  
P454  
F. Pakravan1, C. Helmes1, M. K. Walz2, E. Karakas2, 1. Duesseldorf, Germany. 2. Essen, Germany

4:05 pm  Evaluating the Impact from Number of Vaginal Deliveries on the Degree of Fecal Incontinence and Pelvic Floor Study Outcomes  
P456  
R. Tahliraman1, A. Ferrara1, J. R. Karas1, S. DeJesus1, R. Mueller1, M. Soliman1, P. Williamson1, J. Gallagher1, 1. Orlando, FL

4:10 pm  Multi-Disciplinary Approach to Complex Pelvic Floor Disease: Indications and Approaches  
P457  
K. Donohue1, A. Tsang2, J. Hsu1, C. Rezac1, J. Hutchinson-Colas1, N. Maloney Patel1, 1. New Brunswick, NJ. 2. New York, NY

Monday, May 2  
Monitor #6 – Inflammatory Bowel Disease

3:50 pm  Impact of Immunosuppressants on Postoperative Complications following Colectomies for Crohn's Disease: Results from the ACS-NSQIP database  
P111  
M. Abou Khalil1, J. Abou Khalil1, J. Motter1, C. Vasilevsky1, N. Morin1, P. Gordon1, G. Ghiteulescu1, M. Boutros1, 1. Montreal, QC, Canada

3:55 pm  Prognosis of Adominoperineal Resection for Severe Anorectal Crohn's Disease  
P112  
K. Koganei1, A. Sugita1, K. Tatsumi1, R. Futatsuki1, H. Kuroki1, H. Kimura1, 1. Yokohama, Japan

4:00 pm  Risk Factors of a Need for Reconstruction of a Stoma in Patients with Crohn's Disease  
P113  
N. Murao1, H. Ohge1, Y. Watadani1, S. Uegami1, N. Shigemoto1, N. Shimada1, R. Yano1, N. Nakagawa1, N. Kondo1, K. Uemura1, Y. Murakami1, T. Sueda1, 1. Hirohsima, Japan

4:05 pm  Pouch Volvulus in Patients Having Undergone Restorative Proctocolectomy for Ulcerative Colitis: A Case Series  
P114  
R. Landisch1, K. A. Ludwig1, M. Otterson1, T. J. Ridolfi1, 1. Milwaukee, WI

4:10 pm  Pouch Excision: Etiology and Associated Morbidity  
P115  
A. L. Lightner1, K. L. Mathis1, V. Poola1, D. W. Larson1, E. J. Dozois1, 1. Rochester, MN

*All ePoster presenters are listed first unless otherwise noted.
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<tr>
<td>3:50 pm</td>
<td>Is Modern Medical Management Changing Ultimate Patient Outcomes in Inflammatory Bowel Disease?</td>
<td>Q. Hatch, A. Althans, M. Keating, R. Neupane, M. Nishtala, R. Ratnaparkhi, E. Johnson, S. Steele, Tacoma, WA, 2. Cleveland, OH</td>
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<td>4:00 pm</td>
<td>Prognosis of Ulcerative Colitis Associated Colorectal Cancer Compared to Sporadic Colorectal Cancer: Propensity Score Matching Analysis</td>
<td>Y. D. Han, M. H. albandar, M. Cho, H. Hur, B. Min, K. Lee, N. Kim, Seoul, Korea (the Republic of)</td>
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Monday, May 2

Monitor #7 – Inflammatory Bowel Disease

3:50 pm  | The Effect of Preoperative Narcotic Use on Outcomes of Laparoscopic Surgery for Crohn's Disease | Y. Li, L. Stocchi, D. Cherla, E. Gorgun, H. Kessler, M. M. Costedio, Cleveland, OH |
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<td>4:00 pm</td>
<td>Increase in Hospital Admissions Due to Inflammatory Bowel Disease in Chile Between 2001 And 2012</td>
<td>J. Gomez, F. Bellolio, J. Cerda, Santiago, Chile</td>
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<td>4:05 pm</td>
<td>The Risk Factor for the Development of Pouchitis After Total Proctocolectomy and Ileal Pouch-Anal Anastomosis in Patients with Ulcerative Colitis; Meta-analysis</td>
<td>K. Hata, H. Anzai, S. Ishihara, H. Nozawa, K. Kawai, T. Kiyomatsu, T. Watanabe, Tokyo, Japan</td>
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<tr>
<td>4:10 pm</td>
<td>Preoperative Anemia and Short-term Outcomes in Patients Undergoing Surgery for Inflammatory Bowel Disease.</td>
<td>M. Michailidou, V. Nfonsam, Tucson, AZ</td>
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Monitor #8 – Inflammatory Bowel Disease

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<tr>
<td>3:55 pm</td>
<td>Crohn's Colitis: What is the Preferred Management? Segmental, Subtotal or Total Colectomy: An Analysis of Outcomes and Recurrence</td>
<td>T. M. Hassan, G. Ozuner, E. Aytaç, F. Remzi, Cleveland, OH</td>
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<td>4:00 pm</td>
<td>Impact of Preoperative Tacrolimus on the Postoperative Course in Patients with Ulcerative Colitis</td>
<td>N. Shimada, H. Ohge, Y. Watadani, S. Uegami, N. Shigemoto, N. Murao, R. Yano, N. Nakagawa, N. Kondo, K. Uemura, Y. Murakami, T. Sueda, Hiroshima, Japan</td>
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Monitor #9 – Inflammatory Bowel Disease

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<tr>
<td>4:05 pm</td>
<td>Preoperative Optimization of Patients with Inflammatory Bowel Disease undergoing Gastrointestinal Surgery: Systematic Review</td>
<td>M. S. Zangenberg, A. El-Hussuna, U. Kopylov, N. Horesh, Kobenhavn N, Denmark, 2. Tel Hashomer, Israel</td>
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*All ePoster presenters are listed first unless otherwise noted.*
Monday, May 2
Monitor #10 – Outcomes

3:50 pm Outcomes of Operative Management for Colonic Volvulus: An ACS-NSQIP Data Analysis
N. A. Alselaim1, J. Abou Khalil1, D. Hamad1, M. Demian1, N. Morin1, C. Vasilevsky1, P. Gordon1, M. Boutros1, 1. Montreal, QC, Canada

4:00 pm Securing A Job In Colon And Rectal Surgery: Perspectives From Recent Fellowship Graduates
J. Gahagan1, M. H. Hanna1, M. Whealon1, S. Mills1, J. Carmichael1, M. Stamos1, A. Pigazzi1, 1. Orange, CA

4:00 pm Postoperative Outcomes of Hand-sewn versus Stapled Colorectal Anastomosis
S. Choi1, J. Huh1, Y. Park1, Y. Cho1, S. Yun1, H. Kim1, W. Lee1, 1. Seoul, Korea (the Republic of)

3:55 pm Do BMIs Influence the Outcomes of Laparoscopic Colorectal Surgery?
S. Cho1, J. Huh1, Y. Park1, Y. Cho1, S. Yun1, H. Kim1, W. Lee1, 1. Seoul, Korea (the Republic of)

4:05 pm Is There Any Difference of TME Time Related to Pelvic Difficultly Between Robot and Laparoscopic Surgery in Rectal Cancer?
Y. D. Han1, W. Kim1, S. Park1, M. Cho1, H. Hur1, B. Min1, K. Lee1, N. Kim1, 1. Seoul, Korea (the Republic of)

4:10 pm Anastomotic Leak or Organ Space Surgical Site Infection: Are Our Quality Improvement Programs Collecting Accurate Data?
B. J. Hensley1, A. Rickles1, C. T. Aquina1, Z. Xu1, A. Z. Becerra1, K. Noyes1, J. Monson1, F. Fleming1, 1. Rochester, NY

Monday, May 2
Monitor #11 – Neoplastic Disease

3:50 pm High-grade Anal Dysplasia: Skip the Clinic and Proceed Directly to the Operating Room?
C. Atallah1, A. Najafian1, I. L. Lees1, M. Pozo1, O. Nadra1, E. C. Wick1, S. Gearhart1, B. Safar1, J. Efron1, S. Fang1, 1. Baltimore, MD

3:55 pm Clinicopathological Features of Colorectal Cancer at the Extremes of Age
J. Plummer1, 1. Kingston, Jamaica

3:55 pm Prior Surgical Score: An Analysis of the Prognostic Significance of an Initial Non-Definitive Surgical Intervention in Patients with Peritoneal Carcinomatosis of a Colorectal Origin Undergoing Cytoreductive Surgery and Hyperthermic Intraperitoneal Chemotherapy
B. K. Paul1, P. Sugarbaker1, C. Ihemelandu1, 1. Bethesda, MD

4:00 pm Extended Postdischarge Venous Thromboembolism Prophylaxis Amongst Members of the American Society of Colon and Rectal Surgeons

4:05 pm Which is the Better Prognostic Factor in Rectal Cancer Patients who Received Neoadjuvant Chemoradiotherapy: cTNM stage vs. ypTNM stage?
H. Kim1, 1. Seoul, Korea (the Republic of)

4:10 pm Comparison of Therapeutic Benefit of Bupivacaine HCl Transversus Abdominis Plane (TAP) Blocks as part of an Enhanced Recovery Pathway vs. Traditional Oral and Intravenous Pain Control after Elective Minimally Invasive Colorectal Surgery
E. A. Lax1, L. Smithson1, R. D. Pearlman1, A. A. Damdi1, 1. Southfield, MI

*All ePoster presenters are listed first unless otherwise noted.
Tuesday, May 3
Monitor #1 – Inflammatory Bowel Disease

9:35 am  Utility of Long-Term Indwelling Draining Setons in Treatment of Complex Crohn\'s Fistula-in-Ano  
P95  

9:40 am  A 60-Year-Old Male with Acute Superior Mesenteric Artery Thrombosis After Restorative Proctocolectomy with Ileal Pouch-Anal Anastomosis for Chronic Ulcerative Colitis: Report of a Case  
P96  
C. Merritt, A. A. Pena, C. Richart, R. Martinez, 1. Edinburg, TX

9:45 am  C. difficile Infection in Patients Admitted for a Flare of IBD Colitis: An Opportunity for Colectomy or for Patience?  
P97  
B. A. Umapathi, S. P. Nutting, J. R. Schubart, D. Stewart, 1. Hershey, PA

9:50 am  Are the Surgical Management and Long-Term Outcomes of Colorectal Cancer associated with Ulcerative Colitis Changing?  
P98  
T. M. Hassan, J. M. Church, F. Remzi, L. Stocchi, D. Dietz, E. Gorgun, 1. Cleveland, OH

9:55 am  Outcomes of Laparoscopic vs. Open Total Abdominal Colectomy for Crohn\'s Disease: An ACS-NSQIP Analysis  
P99  
R. Adessky, J. Abou Khalil, N. Morin, C. Vasilevsky, P. Gordon, G. Ghitelescu, M. Demian, M. Boutros, 1. Montreal, QC, Canada

Tuesday, May 3
Monitor #2 – Neoplastic Disease

9:35 am  High Level of Serum CA19-9 Can Predict the Poor Oncologic Outcomes in Colorectal Cancer Patients  
P277  

9:40 am  Surgical Complications for Local Advanced Rectal Cancer – Comparison of Two different Preoperative Chemotherapies  
P278  
J. Gu, X. Zhang, 1. Beijing, China

9:45 am  Perioperative and Survival Outcomes for Patients Aged 85 and Over Undergoing Curative Resection for Colorectal Cancer  
P279  
M. Chand, K. Kemal, L. Devoto, R. Shalaan, K. Flashman, A. Parvaiz, A. Miles, J. Khan, 1. London, United Kingdom, 2. Winchester, United Kingdom, 3. Portsmouth, United Kingdom

Tuesday, May 3
Monitor #3 – Neoplastic Disease

9:35 am  Comparison of Clinicopathological Characteristics and Prognosis between ≤5 years and >5 years Recurrence after Curative Surgery for Colorectal Cancer  
P280  

*All ePoster presenters are listed first unless otherwise noted.*
9:55 am  Is Robotic Surgery Associated with Improved Short-Term Outcomes in Rectal Cancer Patients Undergoing Abdominoperineal Resections?  P281  

Tuesday, May 3  
Monitor #4 – Outcomes

9:35 am  Optimizing Implementation of Enhanced Recovery Programs: Development of an Audit Tool and Strategy  P386  

9:40 am  Modified Frailty Index Predicts Complications and Discharge Disposition in Patients Undergoing Major Colorectal Procedures  P387  
M. Michailidou, V. Pandit, V. Nfonsam, 1. Tucson, AZ

9:45 am  Oncologic Outcome of Lateral Pelvic Lymph Node Metastasis in Locally Advanced Rectal Cancer  P388  
H. Kim, 1. Suwon, Korea (the Republic of)

9:50 am  Chronic Preoperative Narcotics Increase Hospital Length of Stay in Elective Colorectal Surgery  P389  

9:55 am  A Multi-institutional Study of Long-term Patient-reported Outcomes after Proctectomy vs. Proctocolectomy for Rectal Cancer in Patients with Lynch Syndrome  P319  

Tuesday, May 3  
Monitor #5 – Outcomes

V. Ozben, O. Bayraktar, D. Atasoy, A. Aghayeva, I. Erguner, B. Baca, I. Hamzaoglu, T. Karahasanoğlu, 1. Istanbul, Turkey

9:40 am  Postoperative Pain Control After Ultrasound Guided Transversus Abdominis Plane Blocks in Laparoscopic Colectomy Patients  P392  
C. Barrat, S. Mohanty, C. Reickert, S. Nalamati, 1. Detroit, MI

9:45 am  Relationship between Preoperative Basal Energy Expenditure and Postoperative Complications in Colorectal Cancer Patients.  P393  

9:50 am  Effectiveness of Wound-edge Protector for Preventing Surgical Site Infection After Open Surgery for Colorectal Diseases: A Randomized Phase II Trial  P394  
H. Kobayashi, U. Utaka, K. Yasuno, K. Sugihara, 1. Tokyo, Japan

9:55 am  Outcomes of Intestinal Operations in Patients with Left Ventricular Assist Devices versus Heart Transplants: a Multi-institutional Review  P395  

Tuesday, May 3  
Monitor #6 – Outcomes

9:35 am  Length of Stay after Right Colectomy = Length of Stay after Left Colectomy + 2 Days!!! A Study from ACS-NSQIP Database  P396  
H. Aydinli, O. Isik, J. M. Church, L. Stocchi, J. Ashburne, E. Gorgun, 1. Cleveland, OH

9:40 am  A Comparison between the Rates of Anastomotic Leaks in Patients Undergoing Robotic and Laparoscopic Colorectal Surgery  P398  
J. K. Jayakumaran, J. L. Poggio, 1. Philadelphia, PA

*All ePoster presenters are listed first unless otherwise noted.
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<th>Time</th>
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<tbody>
<tr>
<td>9:50 am</td>
<td>Risk Factors Associated with Postoperative Morbidity in over 500 Colovesical Fistula Patients Undergoing Colorectal Surgery</td>
<td>H. Aydinli(^1), C. Benlice(^1), G. Ozuner(^1), E. Gorgun(^1), M. A. Abbas(^1), 1. Cleveland, OH</td>
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<tr>
<td>9:55 am</td>
<td>The Outcome of Different Rectal Cancer Surgical Approaches on the Total Mesorectal Excision and Circumferential Radial Margin</td>
<td>T. K. Jalouta(^1), R. Bysma(^1), M. Luchtefeld(^1), R. Hoedema(^1), R. Figg(^1), N. Dujovny(^1), S. Heather(^1), D. Kim(^1), J. Ogilvie(^1), 1. Grand Rapids, MI</td>
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<td>9:35 am</td>
<td>Early Endoscopic Treatment of the Anastomotic Hemorrhage in Colorectal Surgery</td>
<td>M. Martínez(^1), 1. Barcelona, Spain</td>
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<td>9:40 am</td>
<td>Appropriate Management of Intra-Operative Air Leak During Leak Testing For Left-Sided Colorectal Anastomoses</td>
<td>J. B. Mitchem(^1), J. Hall(^1), P. Roberts(^1), D. Schoetz(^1), P. Marcello(^1), T. E. Read(^1), T. D. Francone(^1), R. Ricciardi(^1), 1. Burlington, MA</td>
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<tr>
<td>9:45 am</td>
<td>Impact of Previous Abdominal Surgery on Perioperative Surgical Outcomes in Laparoscopic and Robotic Colorectal Surgery</td>
<td>S. Park(^1), J. Kang(^1), E. Park(^1), S. Baik(^1), K. Lee(^1), S. Sohn(^1), 1. Seoul, Korea (the Republic of)</td>
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<td>9:50 am</td>
<td>Should Entereg be Administered for Loop Ileostomy Closures to Enhance Earlier Recovery?</td>
<td>A. Agarwal(^1), S. T. McKnight(^1), J. R. Cali(^1), M. J. Snyder(^1), R. H. Bailey(^1), 1. Houston, TX</td>
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<tr>
<td>9:55 am</td>
<td>What Is The Impact of Operative Time On Adverse Events Following Colorectal Surgery</td>
<td>R. Ricciardi(^1), G. Poles(^1), P. Marcello(^1), P. Roberts(^1), D. Schoetz(^1), J. Hall(^1), T. D. Francone(^1), T. E. Read(^1), 1. Burlington, MA</td>
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**Tuesday, May 3**

**Monitor #7 – Outcomes**

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<tr>
<td>9:55 am</td>
<td>Is The Variability In Surgical Resection Rates For Diverticulitis Related To The Availability of Surgeons?</td>
<td>D. Johnston(^1), D. Schoetz(^1), P. Marcello(^1), P. Roberts(^1), T. D. Francone(^1), J. Hall(^1), T. E. Read(^1), R. Ricciardi(^1), 1. Burlington, MA</td>
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<tr>
<td>9:45 am</td>
<td>Optimizing Colorectal Surgery Outcomes: What is the Contribution of Surgeon Specialty?</td>
<td>Y. R. Alimi(^1), A. Asemota(^1), B. Safar(^1), S. Fang(^1), S. Gearhart(^1), J. Efron(^1), E. C. Wick(^1), 1. Baltimore, MD</td>
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<td>9:50 am</td>
<td>Diffusion of Technology: Trends in Robotic-Assisted Colorectal Surgery</td>
<td>A. Damle(^1), R. N. Damle(^1), D. H. Ma(^1), J. Flahive(^1), J. S. Davids(^1), P. R. Sturrock(^1), J. A. Maykel(^1), K. Alavi(^1), 1. Worcester, MA</td>
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<td>9:55 am</td>
<td>Making the Case for Lighted Ureteral Stents in Laparoscopic Colorectal Surgery</td>
<td>W. P. Boyan(^1), J. Otero(^1), A. Roding(^1), D. Hanos(^1), M. Arvanitis(^1), R. Dressner(^1), 1. Shrewsbury, NJ, 2. Newark, NJ</td>
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**Tuesday, May 3**

**Monitor #9 – Outcomes**

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<th>Time</th>
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<tr>
<td>9:35 am</td>
<td>Colorectal Surgery May Be Safely Performed in Patients with Solid Organ Transplants</td>
<td>R. H. Hollis(^1), L. Graham(^1), A. Gullick(^1), M. Giglia(^1), M. Ferrara(^2), M. S. Morris(^1), D. I. Chu(^1), 1. Birmingham, AL</td>
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<td>9:40 am</td>
<td>Trends in Laparoscopic Colectomy for the State of Florida: Time to Set a National Standard</td>
<td>G. Bernier(^1), A. Conley(^1), J. E. Marcet(^1), S. H. Rasheid(^1), J. E. Sanchez(^1), 1. Tampa, FL</td>
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<td>9:45 am</td>
<td>Impact of Minimally Invasive Surgery on Outcomes following Surgery for Rectal Neoplasm within the Setting of an Enhanced Recovery Program</td>
<td>A. N. Martin(^1), P. M. Shah(^1), C. M. Friel(^1), T. Hedrick(^1), 1. Charlottesville, VA</td>
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<td>9:50 am</td>
<td>Predicting Readmission Following Colorectal Surgery</td>
<td>J. Olson(^1), M. Julien(^1), M. Senese(^1), A. Higgins(^1), J. Dove(^1), J. Blansfield(^1), K. Halm(^1), M. Shabahang(^1), 1. Danville, PA</td>
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<tr>
<td>9:55 am</td>
<td>Outcomes Following Colectomy in Octogenerians with Colon Cancer and The Need to Create More Elective Cases</td>
<td>P. E. Miller(^1), S. Levin(^1), S. Schechter(^1), T. Adegboye(^1), A. Klipfel(^1), L. Roth(^1), M. Vrees(^1), N. Shah(^1), 1. Providence, RI</td>
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*All ePoster presenters are listed first unless otherwise noted.
Tuesday, May 3
Monitor #10 – Outcomes
9:35 am  Adenoma Detection Rate in Colonoscopy: Does the Participation of a Resident Matter?  
P416
J. Turner1, D. Henry2, E. May1, M. Flood3, D. Kpodzo 2, C. Clark1, 1. Atlanta, GA

9:40 am  Assessing the Needs and Developing a Colorectal Robotics Curriculum for a General Surgery Residency  
P417
C. Barrat1, S. Nalamati1, 1. Detroit, MI

9:45 am  Gum Chewing Reduces Paralytic Ileus in Patients Managed With Enhanced Recovery Program After Laparoscopic Colorectal Resection: A Randomized Controlled Trial  
P418
N. Shum1, D. Foo1, H. Choi1, W. Law1, 1. Hong Kong

9:50 am  Factors that Influence QOL in Colorectal Cancer Elderly Patients  
P419
C. Carneiro1, R. Rocha1, R. Marinho1, C. Leichsenring1, T. Brandão1, V. Geraldes1, I. Braga1, V. Nunes1, 1. Amadora, Portugal

9:55 am  The Impact of Cancer Diagnosis on Patient-Reported Outcomes in Patients Undergoing Colorectal Surgery  
P420
A. A. Karimuddin1, G. Liu1, C. Brown1, M. J. Raval1, T. Phang1, R. Crump2, J. M. Sutherland1, 1. Vancouver, BC, Canada, 2. Milwaukee, WI

Tuesday, May 3
Monitor #11 – Outcomes & Pelvic Floor
9:35 am  Incisional Negative Pressure Wound Therapy Reduces Surgical Site Infections in Complex Colorectal Surgery Patients  
P441
O. A. Lavryk1, J. Ashburn 1, D. Liska1, L. C. Duraes1, J. Burke1, E. Gorgun1, F. Remzi1, 1. Cleveland, OH

9:40 am  Fecal Incontinence on Facebook, Google, and Twitter  
P458
A. C. Leo1, Y. Maeda1, J. Murphy2, C. Vaizey1, 1. Middlesex, United Kingdom, 2. London, United Kingdom

9:45 am  Short-term Outcome of Percutaneous Tibial Nerve Stimulation in the Treatment of Patients with Low Anterior Resection Syndrome Evaluated by the LARS and the TAPE score  
P459
D. Altomare1, A. Picciariello1, R. Digennaro1, C. Ferrara1, 1. Bari, Italy

Tuesday, May 3
Monitor #12 – Neoplastic Disease
9:35 am  The Impact of Mechanical Bowel Preparation on Colon Cancer Recurrence and Mortality following Right Hemicolectomy  
P282
A. Gosselin-Tardif1, M. Trépanier1, U. Bender1, M. Boutros1, R. Hazan1, J. Faria1, N. Morin1, G. Ghitulescu1, 1. Montreal, QC, Canada

9:40 am  The Role of Third Dimension in Rectal Cancer Assessment  
P283
M. Mohammed Ilyas1, V. Nfonsam1, 1. Tucson, AZ

9:45 am  Accuracy and Predictive Ability of Preoperative MRI for Rectal Adenocarcinoma: Room for Improvement  
P284
C. MacPherson1, D. Mihalicz1, A. R. MacLean1, H. Wang1, T. McMullen1, M. S. Brar1, I. Datta1, W. D. Buie1, 1. Calgary, AB, Canada, 2. Edmonton, AB, Canada

9:50 am  Clinical Impact of Stent in Colorectal Cancer Obstruction  
P285
D. D. Won1, S. Oh1, 1. Seoul, Korea (the Republic of)

Tuesday, May 3
Monitor #1 – Benign Colon
11:40 am  Does Conversion Adversely Impact the Clinical Outcomes for Patients with Complicated Appendicitis?  
P74
J. Kim1, J. Kang1, W. Kim1, E. Park1, S. Back1, 1. Seoul, Korea (the Republic of)

11:45 am  Safety of Laparoscopic Appendectomy in Pregnancy: Multicentre Study  
P75
K. You1, K. Park1, B. Lee1, B. Kim1, J. Kim1, G. Gyeonggi-Do, Korea (the Republic of)

11:50 am  Perioperative Colonic Motility defined by High-resolution Manometry after Intestinal Surgery  
P76
R. Vather1, A. Lin1, G. O’Grady1, P. G. Dinning2, D. Rowbotham1, I. P. Bissett1, 1. Auckland, New Zealand, 2. Bedford Park, SA, Australia

11:55 am  Predictive Factors of Optimal Outcomes for Diverticular-Associated Colovesical and Colovaginal Fistulas  
P77
A. B. Parrish1, B. W. MacLaughlin1, R. R. Kumar1, 1. Torrance, CA

*All ePoster presenters are listed first unless otherwise noted.
EPOSTER PRESENTATIONS

Noon

**Improved Outcomes for Clostridium difficile Colitis in Patients with Pre-Existing Ostomy: Bag to Differ?**

M. Lin1, J. C. Hsieh2, J. Franko1, S. Raman3, 1. Des Moines, IA, 2. Ames, IA

Noon

**Achieving a Complete Pathologic Response following Neoadjuvant Therapy in Rectal Cancer Improves Oncologic Outcomes and Mortality**

D. Mihalicz1, M. S. Brar1, W. D. Buie1, I. Datta1, A. R. MacLean1, H. Wang2, E. Kennedy4, J. A. Heine1, 1. Calgary, AB, Canada, 2. Edmonton, AB, Canada, 3. Toronto, AB, Canada

12:05 pm

**The Vancouver Outpatient Ileostomy Closure Suitability (VOIceS) score: a predictive model to facilitate outpatient closure ileostomy surgery**

F. Letarte1, M. J. Raval1, A. A. Karimuddin1, T. Phang3, C. Brown1, 1. Vancouver, BC, Canada

12:05 pm

**Oncologic Outcome after Complete Mesocolic Excision for Stage I-III Colon Cancer: A Single-center 13-year Retrospective Cohort Study of 3137 Patients**

M. Cho1, H. Hur1, B. Min1, S. Baik1, K. Lee1, N. Kim1, 1. Seoul, Korea (the Republic of)

12:10 pm

**Impact of Prior Surgery on Short-term Outcomes of Colorectal Surgery**

K. Suradkar1, A. M. Al-Mazrou1, J. Rein1, N. Valizadeh1, A. Murray1, C. Lai1, R. Kiran1, 1. New York, NY

12:10 pm

**Outcomes According to BMI in Laparoscopic Colorectal Cancer Patients**

H. Kwak1, S. Kim1, 1. Seoul, Korea (the Republic of)

12:15 pm

**Clinical Score for Predicting Postoperative Morbidity after Resection of the Primary Tumor in Patients with Stage IV Colorectal Cancer.**

J. 't Lam-Boer1, J. de Wilt1, 1. Utrecht, Netherlands

12:15 pm

**Sessile Serrated Polyposis Syndrome: A Wolfpack Dressed as Sheep**

C. Peirce1, M. Kalady1, J. M. Church1, 1. Cleveland, OH

Tuesday, May 3

Monitor #2 – Neoplastic Disease

11:40 am

**Surgical Outcome of Rectal Cancer in Hartmann Procedure: A useful way with caution**

J. Gu1, N. Chen1, 1. Beijing, China

11:40 am

**Laparoscopic Proctectomy Offers Improved Short-term Outcomes in Obese Rectal Cancer Patients Over Time: Results from ACS NSQIP**

S. Chadi1, I. Mizrahi1, H. G. Massarotti1, C. O'Rourke2, D. Maron1, G. Dasilva1, F. Potenti1, S. Wexner1, 1. Weston, FL, 2. Cleveland, OH

11:45 am

**Impact of Neoadjuvant Treatment with Imatinib in the Treatment of Rectal GIST**

C. Cheong1, M. Cho1, H. Hur1, B. Min1, N. Kim1, K. Lee1, 1. Seoul, Korea (the Republic of)

11:45 am

**Rectal Cancer Surgery in the National Surgical Adjuvant Breast and Bowel Project Protocol R-04: Why Does the Received Operation Sometimes Differ From the Intended Operation?**

A. B. Parrish1, G. Yothers2, P. Ganz1, M. O’Connell2, R. W. Beart2, F. Chen1, C. Y. Ko1, M. Russell2, 1. Los Angeles, CA, 2. Philadelphia, PA

11:50 am

**Intraoperative Decision Not To Give Intraoperative Radiation: How Does It Affect Outcomes In Colorectal Cancer?**

Q. Hatch1, C. J. Schlick2, H. L. Reynolds1, J. Brady1, Y. Wen1, R. M. Bosio1, C. P. Delaney1, S. L. Stein1, 1. Cleveland, OH, 2. Chicago, IL, 3. Tacoma, WA

11:50 am

**Trends in Treatment and Outcomes for Rectal Adenocarcinoma in the United States: A Population Based Study from 1975-2012**

E. Vo1, N. Villafane1, S. Mohammed1, S. A. Awad1, A. Artinyan1, 1. Houston, TX

11:55 am

**Short-term Results of Down-to-up TME by TAMIS following Transanal Intersphincteric Dissection for Lower Rectal Cancer Located Close to the Anus**

M. Ito1, Y. Nishizawa1, T. Sasaki1, 1. Kashiwa, Japan

11:55 am

**Rectal Cancer Surgery in the National Surgical Adjuvant Breast and Bowel Project Protocol R-04: Why Does the Received Operation Sometimes Differ From the Intended Operation?**

A. B. Parrish1, G. Yothers2, P. Ganz1, M. O’Connell2, R. W. Beart2, F. Chen1, C. Y. Ko1, M. Russell2, 1. Los Angeles, CA, 2. Philadelphia, PA

*All ePoster presenters are listed first unless otherwise noted.*
11:55 am  Adjuvant Chemotherapy in High-Risk Stage II Colon Cancer  P299
A. L. Lightner1, T. Glyn1, M. E. Parker1, C. Tse1, Z. M. Abdelsattar1, D. W. Larson1, K. L. Mathis1,
1. Rochester, MN

Noon  Functional Results after Low Anterior Resection of the Rectum for Early Rectal Cancer  P300
J. Örhalmi1, T. Dusek1, A. Ferko1, O. Sotona1,
1. Hradec Kralove, Czech Republic

12:05 pm  The Systemic Inflammatory Response in Minimally Invasive Surgery Comparing Outcomes Between Laparoscopic and Robotic Surgery  P301
D. Harji1, U. rashid1, J. vun1, M. jha1, A. Reddy1*,
1. Middlesborough, United Kingdom

12:10 pm  Reduced-Port Robotic Versus Multiport Laparoscopic Anterior Resection for Left-sided Colon Cancer  P302
S. Bae1, W. Jeong1, O. Bae1, S. Baek1, 1. Daegu, Korea (the Republic of)

12:15 pm  Oncologic Outcomes After Robotic-Assisted Resection of Rectal Adenocarcinoma.  P303
S. Luka1, J. Buro1, S. Agarwal1, V. Obias1,
1. Washington, DC

Tuesday, May 3
Monitor #4 – Neoplastic Disease & Outcomes

11:40 am  Postoperative Prognosis of Inguinal Lymph Node Metastases from Adenocarcinoma of the Rectum or Anal Canal  P304
Y. Fujimoto1, T. Akiyoshi1, T. Nagasaki1, T. Konishi1, S. Nagayama1, F. Fukunaga1, M. Ueno1, 1. Tokyo, Japan

11:45 am  Center Volume Influences Adherence to National Guidelines for Use of Neoadjuvant Chemoradiation for Rectal Cancer  P305
E. F. Midura1, M. C. Daly1, D. J. Hanseman1, B. Davis1, D. E. Abbott1, S. A. Shah1, M. Paquette1, 1. Cincinnati, OH

11:50 am  MRI Reports in Rectal Cancer Lack Key Elements Required for Treatment Planning: A Population-Based Study  P306
D. Mihalicz1, H. Wang1, C. MacPherson1, M. Taylor1, A. R. MacLean1, T. McMullen1, W. D. Buie1, 1. Calgary, AB, Canada, 2., Edmonton, AB, Canada

*All ePoster presenters are listed first unless otherwise noted.
11:55 am  Characterization of Diverticulitis Care in a Community Colorectal Surgery Group P426
J. M. Downs1, J. Corley1, F. Odom1, J. B. Hurley1, K. Meyers1, 1. Dallas, TX

Noon  Regional Database Analysis of Outcomes After Sigmoid Resection for Benign and Malignant Disease P427
S. Pannell1, A. R. Bhama1, J. Ferraro1, S. Collins1, R. K. Cleary1, 1. Ann Arbor, MI

12:05 pm  The Effect of Hypoalbuminemia on Early Patient Morbidity and Mortality following Elective Colon Resection for Colon Cancer P428
I. N. Haskins1, M. Baginsky1, R. L. Amdur1, V. Obias1, S. Agarwal1, 1. Washington, DC

12:10 pm  Are Patients with Colon Cancer Safe in Korea? The Trend of Colon Cancer Management in Korea, 2000-2012: Single Institution Retrospective Study P429
J. Han1, G. Noh1, C. Cheong1, M. Cho1, B. Min1, H. Hur1, K. Lee1, N. Kim1, 1. Seoul, Korea (the Republic of)

12:15 pm  Total Mesorectal Excision: A Comparison of Laparoscopic, Robotic, and Transanal Approaches for the Management of Cancers Involving the Distal Rectum P430
E. A. Myers1, M. Gummadi1, G. J. Marks1, J. H. Marks1, 1. Wynnewood, PA

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Tuesday, May 3
Monitor #6 – Outcomes

11:40 am  Prevalence, Risk Factors, and Trends of Peripheral Nerve Injury During Colorectal Surgery: Analysis of the National Surgical Quality Improvement Program (NSQIP) database P439
M. Al-Temimi1, M. Phelan2, M. Stamos2, A. Pigazzi2, S. Mills2, J. Carmichael2, 1. Fontana, CA, 2. Irvine, CA

11:45 am  Despite Differences in Patient Characteristics the Targeted Colectomy Module of the National Surgery Quality Improvement Project Provides Generalizable Data P440
T. Curran1, P. Soden1, V. Poylin1, T. E. Cataldo1, M. Schermerhorn1, D. Nagle1, 1. Boston, MA

11:50 am  Impact of Surgical Site Infection (SSI) Control Bundle Implementation in Reducing Infection Rate following Colorectal Surgery a Single-Center Quality Improvement Study P346
R. Hegde1, Z. Zhang1, 1. Waterbury, CT

11:55 am  Short-term Outcomes of Laparoscopic versus Open Total Colectomy with Ileorectal Anastomosis: A Case-Matched Analysis from Nationwide Database P347
A. Onder1, C. Benlice1, J. M. Church1, H. Kessler1, E. Gorgun1, 1. Cleveland, OH

*All ePoster presenters are listed first unless otherwise noted.
### Noon
**Minimal Invasive Reoperation for Anastomotic Leakage following Laparoscopic Colorectal Resection Reduces The Risk of Permanent Stoma and Death**  
J. R. Eriksen¹, 1. Roskilde, Denmark

**Hemorrhoidal Suture Ligation With or Without Mucopexy could be a Cost-Effective Alternative to Doppler-guided Procedures for Advanced Hemorrhoidal Disease.**  
K. Marimuthu¹, P. Waterland², R. Patel³, 1. Birmingham, West Midlands, United Kingdom

### 12:05 pm
**Survival after Primary Tumor Resection for Large Bowel Obstruction in Stage IV Colorectal Cancer**  
B. MacLaughlin¹, S. Dumitra², A. B. Parrish¹, R. R. Kumar¹, 1. Torrance, CA, 2. Duarte, CA

**Treatment of Nonhealing Pilonidal Disease using Topical 10% Metronidazole: A 10-Year Review**  
M. Saidy¹, A. Adewole¹, W. L. Ambroze¹, M. E. Schertzer¹, M. Al-Temimi¹, D. N. Armstrong¹, 1. Atlanta, GA

### 12:10 pm
**How Long until Reversal? An Epidemiologic Study of Outcomes following Reversal after Hartmann Colectomy for Diverticulitis**  
E. C. He¹, A. N. Kothari¹, S. Brownlee¹, P. C. Kuö¹, J. M. Eberhardt¹, D. Hayden¹, T. Saclarides¹, 1. Maywood, IL

**Multifocal Diverticulitis: A Genetically Based Disease Requiring Extended Surgical Resection**  
C. S. Choi¹, J. Chen¹, T. L. Chan¹, A. Berg¹, D. Stewart¹, W. A. Koltun¹, 1. Hershey, PA

### 12:15 pm
**Real Time Intraoperative Assessment of Colonic Perfusion in Colon and Rectal Surgery**  
B. Quartey¹, B. T. Chinn¹, K. Wilkins¹, J. R. Notaro¹, S. Alva¹, A. saleem¹, E. Rampakakis¹, P. starker², 1. New Brunswick, NJ, 2. Summit, NJ

**Using Modified Frailty Index to Predict Safe Discharge Within 48 hours of Ileostomy Closure**  
Y. Wen¹, M. A. Jabir¹, E. M. Doskey¹, D. Choi¹, A. Samy¹, C. C. Petro¹, S. R. Steele¹, C. P. Delaney¹, 1. Cleveland, OH

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**Tuesday, May 3**

### Monitor #8 – Pelvic Floor, Benign Anorectal and Benign Colon

#### 11:40 am
**Distensibility of the Anal Canal During Sacral Nerve Stimulation for Idiopathic Fecal Incontinence: A Study with the Functional Lumen Imaging Probe.**  
J. Han¹, G. Noh¹, C. Cheong¹, M. Cho¹, H. Hur¹, B. Min¹, K. Lee¹, N. Kim¹, 1. Seoul, Korea (the Republic of)

**Predictive Factors of Lymph Node Metastasis in Submucosal Invasive Colorectal Carcinoma**  
J. Han¹, G. Noh¹, C. Cheong¹, M. Cho¹, H. Hur¹, B. Min¹, K. Lee¹, N. Kim¹, 1. Seoul, Korea (the Republic of)

#### 11:45 am
**Improvement of the External Anal Sphincter Function in Female Fecal Incontinent Patients Following Gatekeeper Implantation.**  
L. Donisi¹, A. Parello¹, F. Litta¹, P. Campenni¹, C. Ratto¹*, 1. Rome, Italy

**Surgical Trends and Operative Outcomes of Rectal Prolapse in a Large New York State database**  
N. A. Al-Ali¹, J. S. Abelson¹, J. Milsom¹, H. Yeo¹, 1. New York, NY

#### 11:50 am
**Minimally Invasive Rectopexy: Experience with Titanium Fixation**  
S. M. Paim¹, D. Row¹, J. A. Griffin¹, 1. Salt Lake City, UT

**Perineal Proctectomy: The Search for Risk Factors that Predict Recurrence**  
T. K. Jalouita¹, R. Bylsm¹, J. Ogilvie¹, M. Luchtefeld¹, R. Figg¹, S. Heather¹, D. Kim¹, N. Dujovny¹, 1. Grand Rapids, MI

#### 11:55 am
**Biofeedback Therapy in Fecal Incontinence; What Predicts Response? How Long Should Treatment Be?**  
V. H. Barnica¹, M. Barnard¹, S. Vespa¹, E. D. Wietfeldt¹, J. Thiele¹, J. Rakinic¹, 1. Springfield, IL

**Impact of Clinical Diagnosis and Fecal Incontinence Symptoms on Quality of Life**  
D. Shaw¹, L. Taylor¹, J. Beatty¹, A. Thorson¹, G. Blatchford¹, N. Bertelson¹, M. Shashidharan¹, C. Ternent¹, 1. Omaha, NE

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*All ePoster presenters are listed first unless otherwise noted.*
### Noon

**Prognostic and Predictive Value of Interstitial Cajal Cell in Obstructed Defecation Syndrome**  
P461  
H. Lin1, J. Li2, D. Ren1, 1. Guangdong, China

**What is the Most Common Site of Metastasis after Curative Resection with Neoadjuvant Radiotherapy for Rectal Cancer: The Liver or the Lungs?**  
P286  
J. Gu1, H. Pan1, 1. Beijing, China

**Metachronous Neoplasia in Patients with High-Grade Dysplasia in an Adenoma: A Call for Closer Surveillance**  
P184  
M. M. Gamaleldin1, V. N. Kozak1, J. M. Church1, 1. Cleveland, OH

**A Comparison of Early Postoperative Outcomes between Fecal Immunochemical Test (FIT)-Screened and Symptomatic Patients Undergoing Surgery for Colorectal Cancer**  
P185  
S. Khorasani1, J. J. Telford1, M. Khorasani1, C. Brown1, A. A. Karimuddin1, T. Phang1, M. J. Raval1, 1. Vancouver, BC, Canada

### 12:05 pm

**Role of Staging Laparoscopy and Diversion Stoma in Locally Advanced CA Rectum With Impending Obstruction and Planned for Neoadjuvant Concomitant Chemoradiotherapy (NACTRT)**  
P213  
R. S. Bhamre1, 1. Mumbai, Maharashtra, India

**The Distinctive Diagnostic and Therapeutic Role of TES in the Management of Rectal Lesions**  
P233  
L. R. Wilson1, L. Stocchi1, M. M. Costedio1, E. Gorgun1, M. Kalady1, D. Liska1, R. Williams1, M. Valente1, 1. Cleveland, OH

**Feasibility Study to Evaluate the Safety and Utility of a Novel Circumferential Imaging Device to Visualize the Anal Canal in Patients with Anal Dysplasia**  
P122  

### 12:40 pm

**Onodera’s Prognostic Nutritional Index (OPNI) as a Prognostic factor for Post-operative Palliative Colorectal Carcinoma**  
P170  
T. Noguchi1, 1. Kumamoto, Japan

**Can We Use Albumin and Glycemia Levels for Estimating First 30-day Mortality?**  
P171  
A. Coskun1, U. Alakus1, M. Ince1, N. Ersöz1, S. Demirbas1, 1. Ankara, Turkey

**Discrepancy in EMVI Status Between MRI and Pathology in Colorectal Cancer Patients Undergoing Primary Surgery**  
P198  
M. Chand1, S. Balyaskinova2, C. Hunter3, N. West1, G. Brown2, 1. London, United Kingdom, 2. Sutton, United Kingdom 3. Leeds, United Kingdom

**Prognostic Impact of Serum CEA (Carcinoembryonic Antigen) Level from Tumor Drainage Vein in Colon Cancer**  
P199  
S. Choi1, 1. Seoul, Korea (the Republic of)

**What are the Differences on Oncologic Outcomes and Quality of Life among Right Colon, Left Colon, and Rectal Cancer?**  
P212  
L. C. Duraes1, F. Remzi1, L. Stocchi1, D. Liska1, E. Gorgun1, D. Dietz2, H. Kessler1, 1. Cleveland, OH

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*All ePoster presenters are listed first unless otherwise noted.*

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**Tuesday, May 3**

**Monitor #10 – Neoplastic Disease**

### 11:40 am

**Challenging the Myths of Introducing Robotic Colorectal Surgery – Concerns and Expectations**  
P226  
A. Reddy1, M. Jha1, D. Kamali1, U. Rashid1, J. Vun1, 1. Wynyard, United Kingdom

**Risk Factors for Colorectal Peritoneal Carcinomatosis: A Population-Based Study**  
P227  
M. Enblad1, W. Graf1, H. Birgisson1, 1. Uppsala, Sweden

**Evaluation of Intestinal Perfusion using ICG Fluorescence Imaging in Laparoscopic Colorectal Surgery with DST Anastomosis**  
P241  
K. Kawada1, S. Hasegawa1, T. Wada1, Y. Sakai1, 1. Kyoto, Japan

**Is Pathologic Near-total Regression An Appropriate Indicator of a Good Response to Preoperative Chemoradiotherapy Based on Oncologic Outcomes?**  
P255  
I. Park1, 1. Seoul, Korea (the Republic of)

### 11:55 am

**Safety and Oncologic Outcomes of Total Proctectomy and Coloanal Anastomosis With or Without Resection of Internal Sphincter for Low Rectal Cancer**  
P256  
C. Cheong1, G. Noh1, J. Han1, M. Cho1, H. Hur1, B. Min1, K. Lee1, N. Kim1, 1. Seoul, Korea (the Republic of)
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Tracy Hull
Elsevier: Royalties; Covidiem: Research Funding; Pacira: Research Funding; ABCRS: Exam Committee Chair

*Will be discussing off-label products.
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Journal of the American College of Surgeons: Salary, Social Media Editor

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Sanofi: Honorarium, Speaking

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Robert Madoff
Torax: Compensation, Consultant

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- David Stewart
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Melinda Hawkins ................ 37
Maher Abbas  .................... 99
Robert Cima  ..................... 109, 111
Dana Hayden ..................... 79
Herand Abcarian ................. 86, 119
Jose Cintron  ..................... 109, 113
Amanda Hayman ................. 37
Adam Abodeely .................. 40, 41
Robert Cleary .................... 57
Traci Hedrick .................... 35
Piyush Aggarwal ................ 116
Jeffrey Cohen ..................... 62
Charles Heise ..................... 58
Karim Alavi  ........................ 37, 58, 109
Kyle Cologne ............ 54, 65, 66, 103
Samantha Hendren .............. 61, 64
Matthew Albert .................. 55, 60, 76, 88
David Colvin  ........................ 81
Alan Herline ...................... 83
Suraj Alva  ......................... 62
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Daniel Herzig ..................... 64, 90
Joselin Anandam ................ 47
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Terry Hicks ....................... 76
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Luiz Felipe de Campos-Lobato .... 62
Rebecca Hoedema ................ 105
Theodor Asgeirsson ............. 111
Sandra de Montbrun ............. 69
Torbjorn Holm .................... 90
Sam Atallah ....................... 35, 55, 60
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Stefan Holubar .................... 73
Glenn Ault  ........................ 49, 52, 69
Andre D’Hoore  .................... 44, 115
Roel Hompes ....................... 55, 56, 60
Andrea Bafford ................... 71
David Dietz  ......................... 101, 102, 119
Tracy Hull ......................... 49, 81, 93, 107
H. Randolph Bailey .............. 90
Anthony Richard Dixon ......... 44
Steven Hunt ....................... 35
Patrick Bailey ..................... 52
Eric Dozois  ......................... 102
Neil Hyman ......................... 51, 70, 92, 116
James Bastawrous ................ 37
James Duncan  ..................... 76
Jennifer Irani ..................... 75
Nancy Baxter  ...................... 76
Jonathan Efron .................... 51
Robert Jasak ....................... 52
Jennifer Beaty ..................... 37, 86
C. Neal Ellis  ........................ 44
Naomi Jay  ........................ 45, 46
David Beck  ........................ 61
David Etzioni ....................... 48, 79
Billy Jimenez ...................... 74
Geerard L. Beets ................ 112
Sandy Fang  ........................ 63
Craig Johnson ...................... 57
Regina Beets-Tan ................. 112
Daniel Feingold ................... 54, 79
Eric Johnson  ....................... 37, 61
Brian Bello  ......................... 110
Alessandro Fichera ............... 73, 92, 112
Willem Bemelman ................. 73
Fergal Fleming .................... 75
James Berho ......................... 101
Charles Friesman ................. 82, 86, 90, 91, 101
Matthew Kalady .................... 53, 58, 91
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James Duncan ..................... 76
K. Craig Kent ....................... 91
Satyadeep Bhattacharya ........ 47
Joseph Frankhouse ............... 76
Lillian Kao  ........................ 65
Richard Billingham ............... 76
Charles Friesman ................. 109
Kevin Kasten ....................... 37
Elisa Birnbaum .................... 107
Robert Fry  ........................ 109
Mitchell Katz ....................... 52
Mariana Berho ..................... 101
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L. Michael Berry-Lawhern ........ 45, 46, 63
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Brooke Gurland ..................... 44, 90, 116
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Andrea Cercek ...................... 112
Gonzalo Hagerman ............... 74
Ian Lavery  ........................ 81
Jose Andres Cervara-Servin .... 74
Jason Hall  ........................ 66, 79
Sang Lee  ........................ 54
Bradley Champagne ............... 37, 70, 86
William Harb ....................... 65
Steven Lee-Kong ................... 79
George Chang  ...................... 90, 91, 102
Karin Hardiman ................... 47
Ira Leeds  ........................ 63
Yanek Chiu  ........................ 106
Imran Hassan ....................... 70
PROGRAM PARTICIPANTS

Ian Lindsey ........................................ 39, 44
Charles Littlejohn ............................ 66, 76, 81
Francisco López-Kostner ..................... 74
Ann Lowry ........................................ 86
Kirk Ludwig ....................................... 112
Helen MacRae .................................. 69
Najja Mahmoud .................................. 49, 73, 78, 102
Christopher Mantyh ........................... 75
Jorge Marcet ..................................... 35, 94
Slawomir Marecik ............................. 62
David Margolin .................................. 51, 54
Jeffrey Marks ..................................... 54
John H. Marks .................................... 42, 50, 60, 119
David Maron ..................................... 86
Joseph Martz ...................................... 57
Klaus Matzel ....................................... 39, 40, 41
Justin Maykel .................................... 55, 58, 60, 70
James McCormick ............................... 86
Michael McGee .................................. 58, 83
Elisabeth Mclemore ............................. 35, 55, 60, 62
Shane McNevin ................................... 49, 115
Anders Mellgren ............................... 39, 40, 41, 44, 93
Steven Mills ....................................... 37
Jeff Milsom ........................................ 54, 119
Jason Mizell ........................................ 47, 98
Ben Mizrahi ........................................ 42, 50
Husein Moloo ...................................... 75
John Monson ....................................... 55, 60, 82, 101
Jesse Moore ....................................... 69
Arden Morris ...................................... 64, 109
Charles Mouch .................................... 64
Roberta Muldoon ................................ 66
Jamie Murphy ...................................... 116
Margarita Murphy ............................... 40, 41
W. Conan Mustain ............................... 58
Matthew Mutch .................................... 48, 92
Deborah Nagle .................................... 42, 50, 75, 111
Yosef NasserI ..................................... 47
Heidi Nelson ....................................... 97, 102
John Nicholson .................................... 88
Karen Noblett ..................................... 39, 40, 41
Johan Nordenstam ................................ 39
Joseph Notaro ..................................... 73
Yuri Novitsky ...................................... 61
Vincent Obias ...................................... 57, 62, 88
James Ogilvie ..................................... 44
Jae Hwan Oh ....................................... 82
Enio Oliveira ...................................... 74
Michelle Olson .................................... 86
Lawrence Opas ..................................... 52
Guy Orangio ....................................... 90
Bruce Orkin ........................................ 35, 51
Adrian Ortega ..................................... 74
Joel Palefsky ...................................... 45, 46
Steven Pantilat ................................... 106
Harry Papasconstantinou ..................... 84, 111
Ian Paquette ..................................... 39, 40, 41, 115
Lisa Parry .......................................... 88
William Peche ..................................... 118
John Pemberton ................................... 97
Jason Penzer ....................................... 118
Rodrigo Perez ..................................... 35, 60, 112
Walter Peters ..................................... 76
Carrie Peterson .................................... 37
Alessio Pigazzi .................................... 42, 50, 57, 60, 61, 82
Daniel Popowich ................................ 51
Lisa Portz .......................................... 80
Stefan Post ......................................... 79
Vitaly Poylin ...................................... 47, 98
Janice Rafferty ................................... 107
Jan Rakinic .......................................... 98, 107, 110
Sonja Ramamoorthy ............................. 88
Elizabeth Raskin .................................. 88, 98
Thomas Read ....................................... 48, 70
Scott Regenbogen ................................ 48, 79
Craig Reickert ..................................... 76
Feza Remzi .......................................... 101
Harry Reynolds .................................... 51
Craig Rezac ......................................... 42, 50, 57
Rocco Ricciardi ................................... 48, 76, 91
Beri Ridgeway ...................................... 44
David Rivadeneira ................................ 75, 118
Bruce Robb .......................................... 110
Patricia Roberts .................................... 109
Robert Roses ....................................... 102
Howard Ross ....................................... 75, 79
Daniel Ross .......................................... 98
David Rothenberger ............................. 78
Fidel Ruiz-Healy ................................... 74
Rudolph Rustin ..................................... 64
Ajit Sachdeva ...................................... 69
Barry Salky .......................................... 116
Jaime Sanchez ...................................... 35
Rafael Sanchez-Morett ......................... 74
Dana Sands ......................................... 35, 60, 93
Hilary Sanfey ....................................... 44
Cesar Santiago ..................................... 44
T. Cristina Sardinha ............................. 96
David Schoetz ....................................... 78, 109
Anthony Senagore ................................ 52, 69, 76, 86, 88, 111
Stephen Sentovich ................................ 90
Anna Serur .......................................... 62
Skandan Shanmugan ................................ 35, 111
Shafik Sidani ....................................... 98
Gavin Sigle .......................................... 98
Marc Singer ......................................... 110
Bradford Sklow .................................... 110
Thomas Sokol ....................................... 66
Michael Spencer .................................... 74
Scott Steele .......................................... 35, 66
Sharon Stein ......................................... 65, 92, 114
Randolph Steinhausen ......................... 92
Andrew Stevenson ................................ 39, 44, 82
David Stewart ...................................... 58, 75
Luca Stocchi ........................................ 62
Scott Strong ......................................... 73, 92, 118
Patricia Sylva ...................................... 35, 55, 56, 60
Larissa Temple ..................................... 64
Julie Thacker ....................................... 111
Amy Thorsen ....................................... 39, 40, 41, 71
Melissa Times ....................................... 118
Kelly Tyler .......................................... 57, 109
Konstantin Umanskiy ......................... 37, 103, 110, 116
Carlos Vaccaro .................................... 74
Brian Valerian ..................................... 35
Jacques Van Dam .................................. 54
H. David Vargas .................................... 118
Thomas Varghese .................................. 65
Madhulika Varma .................................. 115
Sandip Vasavada .................................. 39, 40, 41
Omar Vergara Fernandez ..................... 74
Jon Vogel ............................................ 62
Sarah Vogler ....................................... 39
Theodoros VoloianniS ......................... 35
Toshiaki Watanabe ................................ 54
Martin Weiser ...................................... 53
Mark Welton ........................................ 63
Steven Wexner ..................................... 66, 86, 101
Richard L. Whelan ............................... 54, 107
Mark Whiteford ................................... 35, 55, 60, 62, 70
Charles Whitlow .................................. 54
Elizabeth Wick ...................................... 48
Kirsten Wilkins .................................... 66, 86, 87
David Winchester ................................ 101
Paul Wise ............................................ 53
Jennifer Wo ......................................... 63
Heather Yeo ......................................... 98
Fia Yi .................................................. 76
James Yoo ............................................ 91
Y. Nancy You ....................................... 84, 116
Tonia Young-Fadok .............................. 116
Massarat Zutshi ................................... 39, 40, 41, 93
These are commercial presentations conducted by exhibiting companies in a specially constructed theater on the exhibit floor. This year the Product Theater is located in West Hall A where the following sessions will be presented each day during the lunch breaks. Product Theaters are non-CME forums organized by industry and designed to enhance your learning experience.

### Monday, May 2

11:35 am – 12:45 pm  
**Supported by Merck & Co., Inc.**

**Considerations for Accelerating Gastrointestinal (GI) Recovery After Bowel Resection Surgery**

*Presented by:*
Marc Singer, MD

**Description:**
- Discuss the burden of postoperative ileus and delayed GI recovery following bowel resection surgery
- Review of data about treatment of delayed GI recovery

Visit Merck & Co., Inc. at Booth #425

### Tuesday, May 3

11:35 am – 12:30 pm  
**Supported by NOVADAQ**

**The Clinical Impact of the PINPOINT Fluorescence Imaging System in Minimally Invasive Colorectal Surgery**

*Presented by:*
Michael Stamos, MD

Dr. Stamos will present his experience using the PINPOINT Endoscopic Fluorescence Imaging system in colorectal surgery and its impact on clinical outcomes including anastomotic leak rates, discuss recently published data and provide an overview of the ongoing PILLAR III randomized controlled study.

Visit NOVADAQ at Booth #518
Exhibition Hall and Exhibitor Disclaimer

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Applied Medical is committed to advancing minimally invasive colorectal surgery by offering sophisticated training, clinical solutions and breakthrough technologies, including the GelPOINT™ path transanal access platform, Alexis® wound protector/retractor and most recently, the Voyant® intelligent energy system. Applied’s minimally invasive procedural workshops, clinical symposia, and Simse® laparoscopic trainer enable surgeons to enhance their skills and patient outcomes. To register for a workshop, visit www.appliedmedical.com.

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Website: www.medspira.com

Medspira partners with leading medical institutions to develop and market cost-effective diagnosis and treatment solutions for a variety of medical conditions. Medspira’s mcompass is a portable anorectal manometry system utilized by private offices and hospitals alike. We are happy to be able to include ultrasound and our new FDA approved biofeedback pelvic floor retraining module on the same hardware platform. The mcompass is a great solution to help in the diagnosis and now treatment of patients with fecal incontinence and chronic constipation.
As a global leader in medical technology, services and solutions, Medtronic improves the lives and health of millions of people each year. We use our deep clinical, therapeutic, and economic expertise to address the complex challenges faced by healthcare systems today. Let’s take healthcare Further, Together. Learn more at Medtronic.com.

PINPOINT Endoscopic Fluorescence Imaging System combines SPY fluorescence with the high-definition visible light capabilities of a traditional endoscopic imaging system. PINPOINT can be used as a traditional endoscopy system to obtain fluorescence images on demand or in a simultaneous imaging mode during minimally invasive surgery.

PINPOINT Imaging may assist surgeons by enabling better visualization of anatomic structures and blood flow, providing functional imaging information, resulting in reduced incidences of post-operative complications, lowering costs of care.

PINPOINT is FDA 510(k) cleared for use in minimally invasive surgical procedures for the visual assessment of blood flow in vessels and tissue perfusion.

As a global leader in molecular and companion diagnostics company dedicated to making a difference in patients’ lives through the discovery and commercialization of transformative products that answer patients’ most pressing concerns about whether they are at risk of developing disease, if they actually have a disease, how aggressive their disease is and what treatment would be most effective for them. Myriad is improving, enhancing and individualizing healthcare by providing physicians and their patients with critical information that addresses unmet medical needs across multiple specialties including oncology, preventive care, urology, dermatology, autoimmune disease and neuroscience.

OBP Medical is a leading global developer of single-use, self-contained, illuminating medical devices. Our single-use lights are among the brightest on the market, allowing for optimal visualization during procedures. Our innovative products are used in physician offices, surgery centers and more than 2,000 hospitals throughout the U.S., as well as healthcare facilities worldwide.
Olympus America Inc.  
3500 Corporate Pkwy  
Center Valley, PA 18034  
Phone: (484) 896-5000  
Website: www.medical.olympusamerica.com  

Olympus is advancing minimally invasive surgical solutions designed to help surgeons improve clinical outcomes through our innovative world’s only technologies: ENDOEYE FLEX 3D, the only articulating HD 3D video laparoscope; THUNDERBEAT, the only integration of both advanced bipolar and ultrasonic energies delivered simultaneously from a single, multi-functional instrument for laparoscopic and open procedures.

Our commitment to clinical support, professional education, flexible service and financing packages, and knowledgeable local account management make Olympus the partner of choice. Through innovative diagnostic and therapeutic solutions, Olympus is transforming the future of minimally invasive surgery. Visit our booth to discover where innovation can take you.

Pacira Pharmaceuticals, Inc.  
5 Sylvan Way  
Parsippany, NJ 07054  
Phone: (973) 254-4313  
Fax: (973) 267-0060  
Website: www.exparel.com  
Contact Name: Gigi Kisling  
Contact Email: gigik@pacira.com  

Pacira Pharmaceuticals, Inc. (NASDAQ:PCRX) is a specialty pharmaceutical company focused on the clinical and commercial development of new products that meet the needs of acute care practitioners and their patients. The company’s flagship product, EXPAREL® (bupivacaine liposome injectable suspension), indicated for single-dose infiltration into the surgical site to produce postsurgical analgesia, was commercially launched in the United States in April 2012. EXPAREL and two other products have successfully utilized DepoFoam®, a unique and proprietary product delivery technology that encapsulates drugs without altering their molecular structure, and releases them over a desired period of time. Additional information about Pacira is available at www.pacira.com.

Ovesco Endoscopy USA, Inc.  
120 Quade Dr.  
Cary, NC 27513  
Phone: (919) 651-9449  
Fax: (408) 608-2077  
Website: www.ovesco-usa.com  
Contact Email: customerservice@ovesco-usa.com  

Ovesco Endoscopy USA is a medical device company specializing in the field of flexible endoscopy and endoluminal surgery. Ovesco develops, manufactures and markets innovative products for the treatment of gastrointestinal disease. Ovesco Endoscopy USA is a subsidiary of Ovesco Endoscopy AG a company based in Tubingen, Germany.

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Infrared Coagulation has long been the leading nonsurgical treatment for internal hemorrhoids. It is also utilized to treat AIN. The IRC2100™ is easy to use, safe, and well tolerated, with clinical effectiveness proven for thirty years. Please visit us for more information as to how infrared coagulation can benefit your practice.

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Contact Email: brookscole@resical.com
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353 Corporate Woods Pkwy
Vernon Hills, IL 60061
Phone: (800) 323-wolf (9653)
Fax: (847) 913-6959
Website: www.richardwolfusa.com
Contact Email: marketing@richardwolfusa.com

We are a global business with headquarters in Germany and over a century of tradition and expertise in the field of endoscopy. We develop, manufacture and market specific system solutions for minimally invasive human medicine.

Sandhill Scientific
9150 Commerce Center Circle, #500
Highlands Ranch, CO 80129
Phone: (303) 470-7020
Fax: (303) 470-2975
Website: www.sandhillsci.com
Contact Name: Stuart Wildhorn
Contact Email: swildhorn@sandhillsci.com

Sandhill Scientific continues to be a recognized global leader in G.I. Diagnostics. The broad capabilities of our new inSIGHT Ultima ™ Manometry Platform, includes multiple configurations of High Resolution Anorectal Manometry (HRAM) using either directional or circumferential sensors as well as linear and radial air charged configurations. The BioVIEW ™ Acquisition and Analysis software program features SyncVIEW ™, a multi-dimensional wireframe representation of the anal canal. And our industry leading Sandhill University provides the most comprehensive training and education options to meet the clinical needs of users around the world.

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Italy
Phone: 39 0131 348109
Fax: 39 013 134 8383
Website: www.sapimed.com
Contact Email: info@sapimed.com

Sebela Pharmaceuticals, Inc.
645 Hembree Pkwy Ste I
Roswell, GA 30076
Phone: (678) 736-5215
Website: www.sebelapharma.com

Sebela Pharmaceuticals is a specialty pharmaceutical company located in Roswell, Georgia that markets branded prescription products in Gastroenterology which bring value to patients, physicians, and caregivers. Those products include Analpram HC® (hydrocortisone acetate 2.5% pramoxine HCL 1%) Cream 2.5%, and Lotronex® (alosetron HCL).

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St. Louis, MO 63122
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Fax: (314) 218-6144
Website: www.seilermicro.com
Contact Name: Amanda Moroney
Contact Email: amoroney@seilerinst.com

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Contact Name: Stefan Scanlan  
Contact Email: sscanlon@sontecinstruments.com

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Fax: (415) 952-9334  
Website: www.surgin.com  
Contact Name: Ryan Maaskamp  
Contact Email: rmaaskamp@surgin.com

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Website: www.thdamerica.com  
Contact Email: info@thdamerica.com

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Website: www.theprogrp.com  
Contact Name: Richard Poore  
Contact Email: dpoore@theprogrp.com

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360° Endorectal Ultrasound for Fecal Incontinence.

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Torax Medical, Inc.  
4188 Lexington Ave North  
Shoreview, MN 55126  
Phone: (651) 361-8900  
Website: www.toraxmedical.com  
Contact Email: bcar@toraxmedical.com

Torax Medical develops and markets products designed to restore human sphincter function. Our technology platform, Magnetic Sphincter Augmentation (MSA), uses attraction forces to augment weak or defective sphincter muscles to treat Fecal Incontinence (FI) and Gastroesophageal Reflux Disease (GERD).

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Phone: (651) 361-8900  
Website: www.toraxmedical.com  
Contact Email: bcar@toraxmedical.com

The Medicines Company  
8 Sylvan Way  
Parsippany, NJ 07054  
Phone: (973) 290-6000  
Fax: (973) 656-9898  
Website: www.themedicinescompany.com

The Medicines Company's purpose is to save lives, alleviate suffering, and contribute to the economics of healthcare by focusing on 3,000 leading acute/intensive care hospitals worldwide. Its vision is to be a leading provider of solutions in three areas: acute cardiovascular care, surgery and perioperative care, and serious infectious disease care. The company operates in the Americas, Europe and the Middle East, Asia Pacific regions with global centers today in Parsippany, NJ, USA and Zurich, Switzerland.
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Website: www.twistle.com  

Twistle is an automated patient engagement platform. With Twistle, you can pre-habilitate your patients for surgery, and then keep their recovery on track. Twistle is a great way to drive compliance with protocols to achieve better outcomes, higher patient satisfaction, fewer readmissions, and fewer cancelled procedures. Also, Twistle makes your care team more productive by automating many of the tedious tasks. On behalf of your care team, Twistle automatically alerts, reminds, educates, and surveys your patients to ensure the best outcomes. When necessary, Twistle notifies your care team about patients that need personalized attention. Twistle is HIPAA-compliant and meaningful use certified, and interfaces with electronic health records (EHRs).

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Website: www.vioptix.com  

ViOptix is the recognized leader in real-time measurement of tissue viability. We give clinicians a revolutionary new capability – to obtain non-invasive, objective, real-time measurement of oxygen saturation (StO2) in the soft tissues affected by many surgical procedures – to help improve patient surgical outcomes by detecting problems before symptoms are visible.

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Fax: (612) 677-3059  
Website: www.wolterskluwer.com  

Wolters Kluwer Health is a leading global provider of information and point of care solutions for the healthcare industry. Our solutions are designed to help professionals build clinical competency and improve practice so they can make important decisions on patient care. We offer evidence-based medical, nursing and allied health content and clinical decision support tools; drug information and patient surveillance; structured documentation and coding; precision medical research tools; and continuing medical education solutions. Our leading product brands include Audio-Digest, Lippincott, Ovid®, UpToDate®, and others.

United Ostomy Associations of America  
PO Box 525  
Kennebunk, ME 04043  
Phone: (800) 826-0826  
Fax: (888) 747-9655  
Website: www.ostomy.org  

United Ostomy Associations of America, Inc. (UOAA) promotes quality of life for people with ostomies and continent diversions through information, support, advocacy and collaboration. Our 300+ affiliated ostomy support groups, organized by volunteers throughout the United States, provide the opportunity for local, in-person support.

We work toward a society where people with ostomies and intestinal or urinary diversions are universally accepted and supported socially, economically, medically, and psychologically.

Please join us at our 6th National Conference, which will be held on Aug 22-26, 2017 at Hotel Irvine, Irvine CA. You may contact us at www.ostomy.org, oa@ostomy.org, or 800-826-0826.

Xodus Medical, Inc.  
702 Prominence Dr  
New Kensington, PA 15068  
Phone: (724) 337-5500  
Fax: (724) 337-0555  
Website: www.xodusmedical.com  

Xodus Medical, Inc., the leader in making surgery safer, is showcasing The Pink Pad XL - an advanced Trendelenburg positioning system. This clinically-preferred product for increasing patient safety in Trendelenburg, prevents unwanted patient movement, while protecting skin and nerves from injury and pressure-related complications. This second-generation Pink Pad offers greater surface area and features a perineal cutout for better access to the surgical site.

Extending the Trendelenburg offerings, The One-Step Arm Protectors safeguard fingers during stirrup adjustments, protect the ulnar nerve and maintain access to the IV site and pulse oximeter.

Zinnanti Surgical Design Group, Inc.  
343 Soquel Ave. Suite 409  
Santa Cruz, CA 95062  
Phone: (800) 459-1389  
Fax: (800) 459-1389  
Website: www.zinnantisurgical.com  
Contact Email: wzinnanti@zinnantisurgical.com
<table>
<thead>
<tr>
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</tr>
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<tbody>
<tr>
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</tr>
<tr>
<td>Intuitive Surgical</td>
<td>202</td>
</tr>
<tr>
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<td>311</td>
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<td>319</td>
</tr>
<tr>
<td>F&amp;B</td>
<td>102</td>
</tr>
</tbody>
</table>

**EXHIBIT HALL MAP**

**ENTRANCE**

**Product Theater**

**ePoster Theater**

**Medtronic**

**Intuitive Surgical**

**Ethicon US, LLC**

**THD USA**

**Olympus**

**Applied Medical**

**F&B**
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