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Program Leadership

Kirsten Wilkins, MD  
Program Chair

Joshua Bleier, MD  
Program Vice-Chair

Scott Steele, MD  
Program Vice-Chair

Annual Scientific Meeting Mission, Goal, 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.

This activity is supported by educational grants from commercial interests. Complete information will be provided to participants prior to the activity.

Target Audience

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

Accreditation

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

Continuing Medical Education Credit

The American Society of Colon and Rectal Surgeons (ASCRS) designates this live activity for a maximum of 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.

Method of Participation

Participants must be registered for the conference and attend the session(s). Each participant will receive a username and password for completion of the evaluation form for the meeting; participants must complete an online evaluation form for each session they attend to receive contact hours. There are no prerequisites unless otherwise indicated.

Self-Assessment Credit

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

Please Note: Times and speakers are subject to change.

ASCRS Mission

The American Society of Colon and Rectal Surgeons is an association of surgeons and other professionals dedicated to ensuring 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 Scientific 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 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 the Disclosure of Financial Relationships. Disclosures will be made at the time of presentation, as well as included in the Program Book. All perceived conflicts of interest will be resolved prior to presentation; and, if not resolved, the presentation will be denied.

Social Events
The Welcome Reception will be held Sunday, May 1 from 7:30 – 9:00 pm (complimentary to all registered attendees) and will feature hors d’oeuvres, cocktails and entertainment. The Welcome Reception will be held at the JW Marriott Los Angeles L.A. LIVE Hotel. The Research Foundation will join forces with ASCRS to welcome all at this reception.

The Annual Dinner Dance is scheduled for Tuesday, May 3, with the reception beginning at 7:00 pm and the dinner at 8:00 pm. There is no additional cost for a ticket for full-paying Members and Fellows. Members/Fellows must indicate whether they want to attend the dinner dance either online or on the registration form, and then obtain their seating ticket onsite prior to the dinner dance. The cost for others is $125 per ticket.

Complimentary WiFi Available
There is complimentary WiFi in the Los Angeles Convention Center.

Special Needs
In compliance with the Americans with Disabilities Act, ASCRS requests that participants in need of special accommodations submit a written request to ASCRS well in advance.

Accommodations
The meeting will be held at the Los Angeles Convention Center and JW Marriott Los Angeles L.A. LIVE hotel in Los Angeles, CA.

The Los Angeles Convention Center and hotels are approximately 30 minutes from Los Angeles International Airport.

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

JW Marriott Los Angeles L.A. LIVE
(Headquarters – 1 block from the Convention Center)
$279 Single / Double (877) 622 3056

Courtyard Los Angeles L.A. LIVE
(1.5 blocks from the Convention Center)
$231 Single / $251 Double (800) 228-9290

Residence Inn Los Angeles L.A. LIVE
(1.5 blocks from the Convention Center)
$251 Single / $271 Double (800) 228-9290

Luxe City Center
(1 block from the Convention Center)
$257 Single / Double (213) 748-1291

Hotel reservations/rate availability are not guaranteed after the room block is full or after March 25, 2016. Please register early – only a limited number of rooms are available.

The deadline for hotel reservations is Friday, March 25, 2016.

Official ASCRS Travel Agency
To book your airline reservation, call ASCRS’s official travel agency, Uniglobe Preferred Travel, at (800) 626-0359 and after the prompt dial “0” (M-F 8:30 am – 5:30 pm CST).

If you prefer, you may book your travel online at www.uniglobepreferred.com. Click on the “down arrow” under the Business Travel tab and then click on Rapid-Rez link. When the booking page comes up, click on “Create New User”. Enter personal information, click “done”; the next page is for more detailed personal information – here you must enter a credit card number and billing address to make a reservation. Scroll down and click “Save”. Click on the “Travel Planner” tab to make a reservation and select ASCRS for the “Trip Reason”. Please record your User ID and your Password for future use. Booking on this site will have a reduced agency service fee of $15.
ANNUAL SCIENTIFIC MEETING INFORMATION

Exhibit Hours
Sunday, May 1, 3:00 – 5:00 pm
Afternoon refreshment break
Monday, May 2, 9:00 am – 4:30 pm
Morning and afternoon refreshment breaks
Complimentary box lunch
Tuesday, May 3, 9:00 am – 2:00 pm
Morning refreshment break
Complimentary box lunch

Spouse/Companion Program
Please review the following and indicate your choices online or on the registration form.

Package #1 ($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 only

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

Temperature
The average temperature in May ranges from a low of 54° to a high of 72°F.

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.

Registration Fees
Please see registration information online.

Cancellation Policy
If you need to cancel your meeting registration, the Society will refund your General Registration fee, minus the $75 cancellation fee, upon written request. No refunds will be issued for requests received after April 4, 2016.

The Society will refund workshop fees if your cancellation request is received in writing before April 4, 2016.

Cancellations must be received in writing. Send requests to the ASCRS Registration Department at:
Email: meetings@fascrs.org
Fax: (847) 290-9203
Mail: American Society of Colon and Rectal Surgeons
Meeting Registration Dept.
85 W. Algonquin Rd., Ste. 550
Arlington Heights, IL  60005

Not a member? Join now to save on registration!
Members save $320 off the price of 2016 Annual Scientific Meeting registration. If you plan to attend the meeting, your membership will pay for itself, plus offer you:

• Print and electronic subscription to Diseases of the Colon and Rectum
• Complimentary access to CREST, our robust online education portal
• Listing in the patient-directed Find a Surgeon search engine
• Discounted pricing on products
• Access to an extensive members-only resource library
• Ability to post job openings and your resume on our job board
• Access to our case study listserv for members
• …and much more.

The ASCRS is the professional home of more than 3,300 healthcare professionals who work in the field of colon and rectal surgery. We’re dedicated to advancing and promoting the science and treatment of patients with diseases affecting the colon, rectum, and anus through education, advocacy, and fellowship. Join us.
**Workshop**

**Transanal Endoscopic Surgery**

7:30 am – 4:30 pm

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

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 1980’s 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.

*Continued next page*
**Saturday, April 30**

**Transanal Endoscopic Surgery (continued)**

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

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  
*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 (Provided)**

**Group A – TES Panel Discussion**

1:30 – 4:30 pm  
*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  
**TEO**  
Liliana Bordeianou, MD, Boston, MA; Skandan Shanmugan, MD, Philadelphia, PA; Patricia Sylla, MD, New York, NY

**TEM**  
Traci Hedrick, MD, Charlottesville, VA; Theodore Saclarides, MD, Maywood, IL; Dana Sands, MD, Weston, FL

**SILS**  
Eric Haas, MD, Houston, TX; Jaime Sanchez, MD, Tampa, FL

**TAMIS**  
Sam Atallah, MD, Winter Park, FL; Sergio Larach, MD, Orlando, FL; Elisabeth McLemore, MD, Los Angeles, CA; Theodore Voloyiannis, MD, Houston, TX

12:30 pm  **Lunch (Provided)**

**Group A – Hands-on Lab**

9:30 am – 12:30 pm  
**TEO**  
Liliana Bordeianou, MD, Boston, MA; Steven Hunt, MD, St. Louis, MO; Rodrigo Perez, MD, PhD, Sao Paulo, Brazil; Skandan Shanmugan, MD, Philadelphia, PA

**TEM**  
Traci Hedrick, MD, Charlottesville, VA; Theodore Saclarides, MD, Maywood, IL; Brian Valerian, MD, Albany, NY

**SILS**  
Eric Haas, MD, Houston, TX; Jaime Sanchez, MD, Tampa, FL; Scott Steele, Cleveland, OH

**TAMIS**  
Sam Atallah, MD, Winter Park, FL; Sergio Larach, MD, Orlando, FL; Bruce Orkin, MD, Chicago, IL; Theodore Voloyiannis, MD, Houston, TX

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

Laparoscopic Colectomy

7:30 am – 4:30 pm

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)

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
Laparascopic Colectomy Symposium and Workshop (continued)

**Director:** Amir Bastawrous, MD, *Seattle, WA*
**Assistant Director:** Bradley Davis, MD, *Cincinnati, OH*

7:30 am – noon

**Didactic Session**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Faculty</th>
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<tbody>
<tr>
<td>7:30 am</td>
<td>Welcome and Introductions</td>
<td>Amir Bastawrous, MD, Seattle, WA</td>
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<td></td>
<td></td>
<td>Bradley Davis, MD, Cincinnati, OH</td>
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<tr>
<td>7:40 am</td>
<td>Right Colectomy, Literature Review and Overview of Techniques</td>
<td>Steven Mills, MD, Orange, CA</td>
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<tr>
<td>7:55 am</td>
<td>Video Presentation: Inferior to Superior Right Colectomy</td>
<td>Amanda Hayman, MD, Portland, OR</td>
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<tr>
<td>8:10 am</td>
<td>Video Presentation: Medial to Lateral Right Colectomy</td>
<td>Melinda Hawkins, MD, Seattle, WA</td>
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<tr>
<td>8:25 am</td>
<td>HALS. When, Why, How?</td>
<td>Jennifer Beaty, MD, Omaha, NE</td>
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<tr>
<td>8:40 am</td>
<td>Panel Discussion</td>
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<tr>
<td>8:55 am</td>
<td>Laparoscopic Left Colectomy, Literature Review and Overview of Techniques</td>
<td>Kevin Kasten, MD, Greenville, NC</td>
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<tr>
<td>9:10 am</td>
<td>Video Presentation: Medial to Lateral Left Colectomy</td>
<td>Jennifer Blumetti, MD, Chicago, IL</td>
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<td>9:25 am</td>
<td>Video Presentation: Splenic Flexure Approaches</td>
<td>Carrie Peterson, MD, Milwaukee, WI</td>
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<td>9:40 am</td>
<td>Anastomotic Options (Intracorporeal, Extracorporeal, Hand-Sewn, Side to Side, Etc.)</td>
<td>Mukta Krane, MD, Seattle, WA</td>
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<tr>
<td>9:55 am</td>
<td>Panel Discussion</td>
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<tr>
<td>10:10 am</td>
<td>Laparoscopic Proctectomy and TME, Literature Review and Overview of Technique</td>
<td>Konstantin Umanskiy, MD, Chicago, IL</td>
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<td>10:25 am</td>
<td>Video Presentation: TME</td>
<td>Sean Langenfeld, MD, Omaha, NE</td>
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<td>10:40 am</td>
<td>Video Presentation: Tips for the Difficult Pelvis</td>
<td>Karim Alavi, MD, Worcester, MA</td>
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<td>10:55 am</td>
<td>Panel Discussion</td>
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<td>11:20 am</td>
<td>Expert Complications and Challenges</td>
<td>Bradley Champagne, MD, Cleveland, OH</td>
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<tr>
<td>11:40 am</td>
<td>Discussion</td>
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<td>Noon</td>
<td>Adjourn</td>
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<tr>
<td>Noon</td>
<td>Lunch <em>(Provided for Hands-on Lab Participants)</em></td>
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1:00 – 4:30 pm

**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

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)

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; g) Identify the postoperative management of patients with an Interstim implant including troubleshooting difficulties; h) Describe how to inject into the anal canal; i) Describe alternatives to these procedures; j) 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  
**Didactic Session**

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

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

1:00 – 2:30 pm

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>
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</thead>
<tbody>
<tr>
<td><strong>Group 1</strong></td>
<td><strong>SNS Lead Placement (cadaver model)</strong> Amy Thorsen, MD</td>
<td><strong>SNS Inanimate Model and Basic Programming</strong> Ian Paquette, MD</td>
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<tr>
<td><strong>Group 2</strong></td>
<td><strong>SNS Inanimate Model and Basic Programming</strong> Ian Paquette, MD</td>
<td><strong>SNS Lead Placement (cadaver model)</strong> Amy Thorsen, MD</td>
</tr>
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<td><strong>Group 3</strong></td>
<td><strong>SNS Lead Placement (cadaver model)</strong> Adam Abodeely, MD</td>
<td><strong>SNS Inanimate Model and Basic Programming</strong> Massarat Zutshi, MD</td>
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<td><strong>Group 4</strong></td>
<td><strong>SNS Inanimate Model and Basic Programming</strong> Massarat Zutshi, MD</td>
<td><strong>SNS Lead Placement (cadaver model)</strong> Adam Abodeely, MD</td>
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<td><strong>Group 5</strong></td>
<td><strong>SNS Advanced Lead Placement (cadaver model)</strong> Margarita Murphy, MD</td>
<td><strong>SNS Troubleshooting and Advanced Programming</strong> Sandip Vasavada, MD</td>
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<td><strong>Group 6</strong></td>
<td><strong>SNS Troubleshooting and Advanced Programming</strong> Sandip Vasavada, MD</td>
<td><strong>SNS Advanced Lead Placement (cadaver model)</strong> Margarita Murphy, MD</td>
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<td><strong>Group 7</strong></td>
<td><strong>SNS Advanced Lead Placement (cadaver model)</strong> Joshua Bleier, MD</td>
<td><strong>SNS Troubleshooting and Advanced Programming</strong> Karen Noblett, MD</td>
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<td><strong>Group 8</strong></td>
<td><strong>SNS Troubleshooting and Advanced Programming</strong> Karen Noblett, MD</td>
<td><strong>SNS Advanced Lead Placement (cadaver model)</strong> Joshua Bleier, MD</td>
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<td><strong>Groups 9-16</strong></td>
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**Case Discussions**

Drs. Kelly Garrett, Paul-Antoine Lehur, Klaus Matzel, Anders Mellgren

2:30 pm  Break
Emerging Therapies in Fecal Incontinence (continued)

3:00 – 4:30 pm
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>
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<tr>
<td><strong>Group 9</strong></td>
<td>SNS Inanimate Model and Basic Programming</td>
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<td>SNS Lead Placement (cadaver model)</td>
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<td><strong>Group 10</strong></td>
<td>SNS Inanimate Model and Basic Programming</td>
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<td>SNS Lead Placement (cadaver model)</td>
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<td><strong>Group 11</strong></td>
<td>SNS Inanimate Model and Basic Programming</td>
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<td>SNS Lead Placement (cadaver model)</td>
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<td><strong>Group 12</strong></td>
<td>SNS Inanimate Model and Basic Programming</td>
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<td>SNS Advanced Lead Placement (cadaver model)</td>
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<td><strong>Group 13</strong></td>
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<td><strong>Group 14</strong></td>
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<td>SNS Advanced Lead Placement (cadaver model)</td>
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<td><strong>Group 15</strong></td>
<td>SNS Troubleshooting and Advanced Programming</td>
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<td></td>
<td>SNS Advanced Lead Placement (cadaver model)</td>
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<tr>
<td><strong>Group 16</strong></td>
<td>SNS Troubleshooting and Advanced Programming</td>
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<tr>
<td></td>
<td>SNS Advanced Lead Placement (cadaver model)</td>
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</table>

**Groups 1-8**

**Case Discussions**
Drs. Kelly Garrett, Paul-Antoine Lehur, Klaus Matzel, Anders Mellgren

4:30 pm Adjourn
SATURDAY, APRIL 30

Workshop

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

7:30 – 11:30 am
Registration Required • Member Fee: $525 • Non-Member Fee: $625 • Limit: 16 participants

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 hemicolecotomy, left hemicolecotomy, 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

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)

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; e) 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  
**Didactic Session**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Speaker and Location</th>
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</thead>
<tbody>
<tr>
<td>7:30 am</td>
<td>Welcome and Introductions</td>
<td>Brooke Gurland, MD, Cleveland, OH</td>
</tr>
<tr>
<td>7:40 am</td>
<td>Principles and Evolution of Mesh Procedures for Rectal Prolapse</td>
<td>C. Neal Ellis, MD, Odessa, TX</td>
</tr>
<tr>
<td>7:55 am</td>
<td>Laparoscopic Ventral Rectopexy – Evolution of Technique and Long-Term Outcomes</td>
<td>Andre D’Hoore, MD, PhD, Leuven, Belgium</td>
</tr>
<tr>
<td>8:10 am</td>
<td>Indications: VR for ODS and Internal Prolapse, Patient Selection, Functional Outcomes</td>
<td>Ian Lindsey, MD, Oxford, United Kingdom</td>
</tr>
<tr>
<td>8:25 am</td>
<td>Indications: Patient Selection, Functional Outcomes VR for Full Thickness Rectal Prolapse</td>
<td>Paul-Antoine Lehur, MD, PhD, Nantes, France</td>
</tr>
<tr>
<td>8:40 am</td>
<td>VR, Sacrocolpopexy, Combined Pelvic Floor Evaluation</td>
<td>Beri Ridgeway, MD, Riverside, CA</td>
</tr>
<tr>
<td>8:55 am</td>
<td>Working with the Urogynecologist</td>
<td>Anders Mellgren, MD, PhD, Chicago, IL</td>
</tr>
<tr>
<td>9:00 am</td>
<td>Open vs Lx vs Robotic VR</td>
<td>Joseph Carmichael, MD, Orange, CA</td>
</tr>
<tr>
<td>9:25 am</td>
<td>Break</td>
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<tr>
<td>9:35 am</td>
<td>Biologics for Pelvic Floor Surgery</td>
<td>Jamie Ogilvie, Jr., MD, Grand Rapids, MI</td>
</tr>
<tr>
<td>9:50 am</td>
<td>Synthetic Mesh Options and Litigation</td>
<td>Beri Ridgeway, MD, Riverside, CA</td>
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<tr>
<td>10:05 am</td>
<td>Complications and Learning Curve</td>
<td>Anthony Richard Dixon, MD, Bristol, United Kingdom</td>
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<tr>
<td>10:20 am</td>
<td>LVR Surgery Video</td>
<td>Andrew Stevenson, MD, Chermside, QLD, Australia</td>
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<tr>
<td>11:00 am</td>
<td>Robotic VR Video</td>
<td>Brooke Gurland, MD, Cleveland, OH</td>
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<tr>
<td>11:30 am</td>
<td>Questions and Wrap-Up</td>
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<tr>
<td>Noon</td>
<td>Adjourn</td>
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<tr>
<td>Noon</td>
<td>Lunch (Provided for Hands-on Lab Participants)</td>
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1:00 – 4:30 pm  
**Hands-on Session**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Speaker and Location</th>
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<tbody>
<tr>
<td>1:00 pm</td>
<td>Patient Positioning/Port Placement LVR/Exposing the Pelvis</td>
<td>Jamie Ogilvie, Jr., MD, Grand Rapids, MI</td>
</tr>
<tr>
<td>1:15 pm</td>
<td>LVR Peritoneal Dissection/Exposing RVF Space</td>
<td>Andre D’Hoore, MD, PhD, Leuven, Belgium</td>
</tr>
<tr>
<td>1:30 pm</td>
<td>Mesh or Graft Placement and Suturing on to the Rectum</td>
<td>Andrew Stevenson, MD, Chermside, QLD, Australia</td>
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<tr>
<td>1:45 pm</td>
<td>Fixation at the Sacrum</td>
<td>Ian Lindsey, MD, Oxford, United Kingdom</td>
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<tr>
<td>2:00 pm</td>
<td>Closure of the Peritoneum</td>
<td>Joseph Carmichael, MD, Orange, CA</td>
</tr>
<tr>
<td>2:15 pm</td>
<td>Robotic VR Video/Procedure Steps</td>
<td>Cesar Santiago, MD, Tampa, FL</td>
</tr>
<tr>
<td>2:30 pm</td>
<td>Redo Rectal Prolapse Video</td>
<td>Anthony Richard Dixon, MD, Bristol, United Kingdom</td>
</tr>
<tr>
<td>2:45 pm</td>
<td>Is There a Role for Resection?</td>
<td>Liliana Bordeianou, MD, Boston, MA</td>
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<tr>
<td>3:00 pm</td>
<td>Trainer Boxes</td>
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<tr>
<td>4:00 pm</td>
<td>Wrap-Up</td>
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<td>4:30 pm</td>
<td>Adjourn</td>
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</table>
Workshop

AIN and HRA: What the Colorectal Surgeon Needs to Know

7:30 am – 2:30 pm

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

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

Through a didactic and hands-on educational initiative, we 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

7:30 am Welcome and Introductions
Stephen Goldstone, MD, New York, NY

7:35 am Intro to HPV: Scope of the Problem
Joel Palefsky, MD, San Francisco, CA

7:50 am How to Diagnose AIN: Screening and Diagnostics
J. Michael Berry-Lawhorn, MD, 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*

<table>
<thead>
<tr>
<th>Group</th>
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<th>11:00 – 11:30 am</th>
<th>11:30 am – noon</th>
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<tbody>
<tr>
<td>Group 1</td>
<td>Lesion Identification (understanding lesion patterns to differentiate LG from HG) - Naomi Jay, NP, PhD</td>
<td>Hands-on Workshop: HRA Including Use of the Colposcope and Biopsy Techniques - J. Michael Berry-Lawhorn, MD; Stephen Goldstone, MD</td>
<td>HRA the Movie - Joel Palefsky, MD</td>
</tr>
<tr>
<td>Group 2</td>
<td>HRA the Movie - Joel Palefsky, MD</td>
<td>Lesion Identification (understanding lesion patterns to differentiate LG from HG) - Naomi Jay, NP, PhD</td>
<td>Hands-on Workshop: HRA Including Use of the Colposcope and Biopsy Techniques - J. Michael Berry-Lawhorn, MD; Stephen Goldstone, MD</td>
</tr>
<tr>
<td>Group 3</td>
<td>Hands-on Workshop: HRA Including Use of the Colposcope and Biopsy Techniques - J. Michael Berry-Lawhorn, MD; Stephen Goldstone, MD</td>
<td>HRA the Movie - Joel Palefsky, MD</td>
<td>Lesion Identification (understanding lesion patterns to differentiate LG from HG) - Naomi Jay, NP, PhD</td>
</tr>
</tbody>
</table>

Noon  
**Lunch with Panel Discussion and Questions**

### 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*

<table>
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<tr>
<th>Group</th>
<th>1:00 – 1:30 pm</th>
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<tr>
<td>Group 1</td>
<td>IRC and Hyfrecator Movie - Stephen Goldstone, MD</td>
<td>Hands-on Workshop: HRA Treatment - Naomi Jay, NP, PhD; Joel Palefsky, MD</td>
<td>Cases: Identifying Lesions, Determining Sites for Biopsies - J. Michael Berry-Lawhorn, MD</td>
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2:30 pm  
**Adjourn**
Workshop

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

Noon – 3:00 pm
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

<table>
<thead>
<tr>
<th>Noon</th>
<th>Welcome and Introductions</th>
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<th>Questions from Sessions</th>
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<td></td>
<td>Jason Mizell, MD, Little Rock, AR</td>
<td>2:30 pm</td>
<td>Anjali Kumar, MD, Seattle, WA</td>
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<tr>
<td>12:30 pm</td>
<td>Large Group Oral Exam Session</td>
<td>2:45 pm</td>
<td>Perspectives and Pitfalls</td>
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<tr>
<td></td>
<td>Jason Mizell, MD, Little Rock, AR</td>
<td>2:45 pm</td>
<td>Joselin Anandam, MD, Dallas, TX</td>
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<td>Vitaliy Poylin, MD, Boston, MA</td>
<td>2:45 pm</td>
<td>Satyadeep Bhattacharya, MD, Carbondale, IL</td>
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<tr>
<td>1:00 pm</td>
<td>Small Group Oral Exam Session</td>
<td>3:00 pm</td>
<td>Karin Hardiman, MD, PhD, Ann Arbor, MI</td>
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<td>Joselin Anandam, MD, Dallas, TX</td>
<td>3:00 pm</td>
<td>Daniel Klaristenfeld, MD, San Diego, CA</td>
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<td>Satyadeep Bhattacharya, MD, Carbondale, IL</td>
<td>3:00 pm</td>
<td>Steven Lee-Kong, MD, New York, NY</td>
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<td>Karin Hardiman, MD, PhD, Ann Arbor, MI</td>
<td>3:00 pm</td>
<td>Yosef Nasser, MD, Los Angeles, CA</td>
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<td>Daniel Klaristenfeld, MD, San Diego, CA</td>
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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.
Symposium
Research
12:30 – 3:00 pm

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  Break

**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

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

12:30 pm Welcome and Introductions
Tracy Hull, MD, Cleveland, OH

12:45 pm What Is a Key Concept?
Marcus Burnstein, MD, Toronto, ON, Canada

1:05 pm Formatting the Stem: Tips
Glenn Ault, MD, Los Angeles, CA

1:25 pm Formatting the Answers: Avoiding Common Errors
Shane McNevin, MD, Spokane, WA

1:45 pm Fundamental Problems with Questions
Najjia Mahmoud, MD, Philadelphia, PA

2:05 pm Break

2:15 pm Let’s Write Questions

3:00 pm Question Review

3:30 pm Adjourn

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

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

This session will involve cadaver-based procedural exercises aimed at demonstrating state-of-the-art techniques employed in different colorectal operations with a focus on 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 hemicolecotomy, left hemicolecotomy, 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

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.
Symposium

Health Care Policy/Reform 2016 and Beyond: A Round Table Discussion

1:00 – 3:00 pm

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, Parma, OH

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 Jasek, 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**

**Translational Medicine:**
**How Genetics Drive Patient Care in Your Colorectal Practice**

3:00 – 5:00 pm

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, Madison, WI

4:00 pm  Genetic Biomarkers to Guide Sporadic CRC Management
Martin Weiser, MD, New York, NY

3:20 pm  Serrated Polyps and the Serrated Pathway to Colorectal Cancer
James Church, MD, Cleveland, OH

4:20 pm  Using Genes to Stratify Risk in IBD
Walter Koltun, MD, Hershey, PA

3:40 pm  Newly Recognized Genes and Concepts in Hereditary CRC and Gene Panel Testing
Stephen Gruber, MD, PhD, Los Angeles, CA

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.
Symposium
Advanced Endoscopy and Endoluminal Surgery

3:00 – 5:00 pm

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.
Symposium
Transanal Total Mesorectal Excision (taTME) Didactic Session

This is part of the taTME Hands-on Workshop on Sunday.
5:00 – 7:00 pm
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

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

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

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

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

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

5:35 pm  
*taTME Registry: International Update*  
Roel Hompes, MD, Oxford, United Kingdom  
John Monson, MD, Rochester, NY

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

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

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

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

8:30 am Economics of Robotic Surgery
Robert Cleary, MD, Ann Arbor, MI

8:45 am Panel Discussion

9:00 am Adjourn

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

7:00 – 9:30 am

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

Existing Gaps

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

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

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

7:00 am Hemorrhoids/Fissures
Michael McGee, MD, Chicago, IL
7:20 am Discussion

7:25 am Prolapse/Intussusception/SRUS
W. Conan Mustain, MD, Little Rock, AR
7:45 am Discussion

7:50 am Ulcerative Colitis
Charles Heise, MD, Madison, WI
8:10 am Discussion

8:15 am Trauma/Volvulus
Timothy Counihan, MD, Pittsfield, MA
8:35 am Discussion

8:40 am Benign/Malignant Anal Tumors, Retrrectal Tumors
David Stewart, Sr., MD, Hershey, PA
9:00 am Discussion

9:05 am Hereditary Colon Cancer/Genetic Testing
Matthew Kalady, MD, Cleveland, OH
9:25 am Discussion

9:30 am Adjourn

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

Registration and Pre-registration Survey Required (Includes Saturday Didactic and Sunday Hands-on Workshop)

Fee: $1,000 • Limit: 16 participants • Lunch Included

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.

Pre-registration Survey (Required)
While the ASCRS taTME didactic session is open to all registrants for a nominal fee, the inaugural hands-on cadaver lab will be limited to surgeons with prerequisite skills in minimally-invasive TME and transanal endoscopic surgery (TEM, TEO, or TAMIS).

Please click on the link to complete the survey by going to the registration information page on our website, www.fascrs.org.

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

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**  
Liliana Bordeianou, MD, Boston, MA

8:50 am  **Interactive Video Session: Avoiding Complications: The Bad: Botched Pursestring, Urethral Injury**  
Matthew Albert, MD, Altamonte Springs, 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

**Hands-on Lab**

9:15 am  **Instructions to the Lab**  
Patricia Sylla, MD, New York, NY

9:30 am  **Break**

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;  
Joep Knol, MD, Hasselt, Belgium;  
Antonio Lacy, MD, PhD, Barcelona, Spain;  
Justin Maykel, MD, Worcester, MA;  
Elisabeth McLemore, MD, Los Angeles, CA

9:50 am  **Station 5-6: TEO taTME**  
Liliana Bordeianou, MD, Boston, MA;  
Alessio Pigazzi, MD, PhD, Orange, CA;  
Patricia Sylla, MD, New York, NY

1:15 pm  **Lunch and Debrief**

2:00 pm  **Adjourn**
Symposium
Stomas and Complex Abdominal Wall Problems for the Colorectal Surgeon

9:45 – 11:45 am

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, Fort Lewis, 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
Alastair Windsor, MD, London, United Kingdom

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.
**Symposium**

**Laparoscopic Nuts and Bolts and Robotic Rivets**

9:45 – 11:45 am

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

9:45 am  **Welcome and Introductions**

9:50 am  **Lap Right Colectomy: Ensuring Adequate Lymph Node Harvest**  
Luiz Felipe de Campos Lobato, MD, Brasilia, DF, Brazil

9:55 am  **Lap Left Colectomy: One Step at a Time: IMV, Splenic Flexure, and IMA**  
John Byrn, MD, Ann Arbor, MI

10:00 am  **Laparoscopic TME: The Anterior Dissection Plan and Rectal Division**  
Raul Bosio, MD, Cleveland, OH

10:05 am  **Robotic APR – Avoidance of the Waist**  
Slawomir Marecik, MD, Chicago, IL

10:10 am  **Single Port Laparoscopic Colectomy: More with Less**  
Eric Haas, MD, Houston, TX

10:15 am  **HAL Colectomy – For Whom and What For?**  
Jeffrey L. Cohen, MD, Hartford, CT

10:20 am  **Panel Discussion**

10:35 am  **Laparoscopic Approach to Entero- or Colovaginal/Vesicle Fistula**  
Luca Stocchi, MD, Cleveland, OH

10:40 am  **Laparoscopic Ileocolic Resection for Crohn’s Disease**  
Phillip Fleshner, MD, Los Angeles, CA

10:50 am  **Robotic Segmental Colectomy**  
Vincent Obias, MD, Washington, DC

10:55 am  **Rectopexy: Dissection and Fixation**  
Anna Serur, MD, Brooklyn, NY

11:00 am  **Panel Discussion**

11:15 am  **Endoscopic Mucosal Resection**  
I. Emre Gorgun, MD Cleveland, OH

11:20 am  **TAMIS**  
Elisabeth McLemore, MD, Los Angeles, CA

11:25 am  **Transanal Surgical Pitfalls and Solutions**  
Mark Whiteford, MD, Portland, OR

11:30 am  **Panel Discussion**

11:45 am  **Adjourn**

**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.
Symposium

Anal Cancer

9:45 – 11:45 am

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.
Luncheon Symposium

Effective Quality Improvement in Diverse Settings

11:45 am – 12:45 pm

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

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

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

Kyle Cologne, MD, Los Angeles, CA
Thomas Sokol, MD, Los Angeles, CA
Local Arrangements Co-Chairs
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

The Legacy of Norman Nigro: Back to the Future
Angelita Habr-Gama, MD, PhD
Professor and Director of the Department of Gastroenterology and the Colorectal Unit at the University of Sao Paulo Medical School
University of Sao Paulo
Sao Paulo, Brazil

Introduction: Steven Wexner, MD, PhD (Hon)

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

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

Abstract Session*

Perioperative Outcomes

2:15 – 3:45 pm

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

*Abstract titles and authors are forthcoming.
Symposium

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

2:15 – 3:45 pm

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
Bradley Champagne, MD, Cleveland, OH

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, Parma, OH

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.
Symposium

Comprehensive Management of Colon Cancer: An Interactive Forum

2:15 – 3:45 pm

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

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

Abstract Session*

Benign Anorectal/Pelvic Floor I

4:15 – 5:45 pm

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

*Abstract titles and authors are forthcoming.
Symposium

Crohn’s Disease

4:15 – 5:45 pm

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

4:15 pm  Welcome and Introductions
          Scott Strong, MD, Chicago, IL

4:17 pm  Pre-operative Medical Therapy – Impact on the Operation
          Phillip Fleshner, MD, Los Angeles, CA

4:28 pm  Upper GI Disease – Bowel-Sparing Techniques
          Alessandro Fichera, MD, Seattle, WA

4:39 pm  Intra-abdominal Abscess – Short- and Long-Term Management
          Stefan Holubar, MD, Lebanon, NH

4:50 pm  Large Bowel Disease-Neoplasia Complicating Disease
          P. Ravi Kiran, MBBS, New York, NY

5:01 pm  Diagnosis and Management of Fistula-in-Ano
          Willem Bemelman, MD, PhD, Amsterdam, The Netherlands

5:12 pm  Unhealed Perineal Wound – Prevention and Management
          Najjia Mahmoud, MD, Philadelphia, PA

5:23 pm  Discussion

5:45 pm  Adjourn

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.
Symposium

International Colorectal Surgery: Perspectives from Latin America

4:15 – 6:15 pm

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

5:45 pm 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.

6:15 pm Adjourn
After Hours Debate

5:45 – 6:45 pm

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

5:45 pm  C. diff and Subtotal Colectomy
David Stewart, Sr., MD, Hershey, PA

vs.

5:53 pm  C. diff Irrigation and Stoma
Husein Moloo, MD, Ottawa, ON, Canada

6:01 pm  Extended Prophylaxis DVT for High Risk (Con)
Deborah Nagle, MD, Boston, MA

vs.

6:18 pm  Extended Prophylaxis DVT for High Risk (Pro)
Michael Stamos, MD, Orange, CA

6:26 pm  Antibiotics Single Pre-Op
Christopher Mantyh, MD, Durham, NC

vs.

6:34 pm  Antibiotics 24 Hours
Howard Ross, MD, Philadelphia, PA

6:45 pm  Adjourn

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.

Welcome Reception

7:30 – 9:00 pm
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. Please register early and indicate your 1st and 2nd choice on the Registration Form.

M-1 ERAS
Joseph Frankhouse, MD, Portland, OR
Anthony Senagore, MD, Parma, OH

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: a) Describe the procedures and approaches discussed in this session.

Residents’ Breakfast

6:30 – 7:30 am

Registration Required • Open to Residents Only

The Educational Evolution of the Colon and Rectal Surgeon

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

Introduction: Craig Reickert, MD
**Symposium**

**Beyond the OR**

7:30 – 9:30 am

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

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<td>Welcome and Introductions</td>
<td>David Rothenberger, MD, MN</td>
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<td>7:40 am</td>
<td>What's the Problem?</td>
<td>Darrell Campbell, Jr., MI</td>
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<td>Why Should We Care?</td>
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<td>8:10 am</td>
<td>Individualized Solutions: Tools, Skills, and Strategies</td>
<td>Najjia Mahmoud, PA</td>
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<tr>
<td>8:30 am</td>
<td>Organizational Solutions: Tools, Skills, and Strategies</td>
<td>Julie Ann Freischlag, CA</td>
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<td>8:50 am</td>
<td>Case Presentations/Panel Discussion</td>
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**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.

Los Angeles Convention Center.
Symposium

Current Management of Diverticulitis

7:30 – 9:30 am

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

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

9:30 – 10:00 am

Refreshment Break in Exhibit Hall and ePoster Presentations

*Abstract titles and authors are forthcoming.
MONDAY, MAY 2

Memorial Lectureship Honoring Victor W. Fazio, MD

10:00 – 10:45 am
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, Monday, July 6, after a long illness at the age of 75. Dr. Fazio was an ASCRS Past 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
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 (ASCRS) at the Society’s 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
Symposium

Rectal Cancer One: The Trials of Rectal Cancer

12:45 – 2:15 pm

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, Rochester, NY

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.
Abstract Session*

Benign Colon

12:45 – 2:15 pm

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

*Abstract titles and authors are forthcoming.

Abstract Session*

Neoplasia I

2:15 – 3:45 pm

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

*Abstract titles and authors are forthcoming

Huntington Library Botanical Gardens.
Symposium
Familial Feud: Generation X vs. Generation Z

2:15 – 3:45 pm
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, Parma, OH

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
**Harry E. Bacon, MD, Lectureship**

**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 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).

**Introduction: Kirsten Wilkins, MD**

**Harry E. Bacon, MD, Lectureship**

4:15 – 5:00 pm

Is There Still a Role for Academic Surgeons?

Allan Kirk, MD, PhD
Professor of Surgery
Professor, Department of Immunology
Professor in Pediatrics
Chair, Department of Surgery
Duke Medical Center
Durham, NC

**Symposium**

**New Technologies**

5:00 – 6:00 pm

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**

**Residents’ Reception**

6:30 – 8:00 pm

Open to general surgery residents and colorectal program directors only.

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, and one copy of *The ASCRS Manual of Colon and Rectal Surgery*, second edition, will be raffled.
Meet the Professor Breakfasts

6:30 – 7:30 am

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

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

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: a) Describe the procedures and approaches discussed in this session.
Symposium

Building a Successful Research Program

7:30 – 9:00 am

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, Madison, WI
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

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
Symposium

Fecal Incontinence

9:30 – 10:45 am

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 the SECCA procedure, 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
Liliana Bordeianou, 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 such as the MAS, ABS and graciloplasty.
TUESDAY, MAY 3

Abstract Session*

Neoplasia II
9:30 – 10:45 am

Co-Moderator: Todd Francone, MD, Burlington, MA
Co-Moderator: Jorge Marcet, MD, Tampa, FL

*Abstract titles and authors are forthcoming.

Abstract Session*

General Surgery Forum
9:30 – 10:45 am

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

*Abstract titles and authors are forthcoming.

Masters in Colorectal Surgery Lectureship Honoring Robert Beart, Jr., MD

10:45 – 11:30 am

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 2015 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.

Women in Colorectal Surgery Luncheon

Registration Required • Complimentary
11:30 am – 12:30 pm

The Women’s Luncheon offers an opportunity for women to renew friendships and make new contacts. Female surgeons, residents and medical students attending the Annual Meeting 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.

11:30 am – 12:30 pm
Complimentary Box Lunch in Exhibit Hall and ePoster Presentations
Symposium

Young Surgeons Symposium: Board Certification and Beyond

12:30 – 2:00 pm

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, Washington, DC

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

Co-Moderator: Mukta Krane, MD, Seattle, WA
Co-Moderator: Maher Abbas, MD, Abu Dhabi, United Arab Emirates

*Abstract titles and authors are forthcoming.
Symposium

The American College of Surgeons Commission on Cancer National Accreditation Program for Rectal Cancer: Why, How and When

12:30 – 2:00 pm

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

12:30 pm  Why Accreditation of Rectal Cancer Centers Is Needed: Three Decades of European Evidence  
John Monson, MD, Rochester, NY

12:40 pm  Variability in the Outcomes of Surgery for Rectal Cancer in the USA  
David Dietz, MD, Cleveland, OH

12:50 pm  How the Multi-Disciplinary Team Improves Outcomes  
James Fleshman, Jr., MD, Dallas, TX

1:00 pm  How Our Radiologists Can Help Us Optimize Surgical Outcomes  
Gina Brown, MBBS, Surrey, United Kingdom

1:10 pm  How Our Pathologists Can Help Us Optimize Surgical Outcomes  
Mariana Berho, MD, Hollywood, FL

1:20 pm  The New CoC Evidence-Based Standards for Accreditation in the Perioperative Management of Rectal Cancer  
David P. Winchester, MD, Chicago, IL

1:30 pm  Panel Discussion/Questions and Answers

2:00 pm  Adjourn

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

Stage IV Colorectal Cancer

2:00 – 3:30 pm

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.

Surgeons attending the symposium 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

2:00 pm  Welcome and Introductions
          Heidi Nelson, MD, Rochester, MN

2:05 pm  Staged or Simultaneous Hepatic Metastectomy?
          Robert Roses, MD, Philadelphia, PA

2:20 pm  First-Line Therapy for Stage IV Disease: Surgery or Chemotherapy?
          George Chang, MD, Houston, TX

2:35 pm  When Is It Time to Palliate?
          David Dietz, MD, Cleveland, OH

2:50 pm  Bowel Obstruction and Metastases: Now What?
          Eric Dozois, MD, Rochester, MN

3:05 pm  Panel Discussion

3:30 pm  Adjourn

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.
Parviz Kamangar Humanities in Surgery Lectureship

3:45 – 4:30 pm

"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.

Abstract Session*

Research Forum

2:00 – 3:30 pm

Co-Moderator: Kyle Cologne, MD, Los Angeles, CA
Co-Moderator: Konstantin Umanskiy, MD, Chicago, IL

*Abstract titles and authors are forthcoming.

Abstract Session*

Benign Anorectal/Pelvic Floor II

2:00 – 3:30 pm

Co-Moderator: Marcus Burnstein, MD, Toronto, ON, Canada
Co-Moderator: Rebecca Hoedema, MD, Grand Rapids, MI

*Abstract titles and authors are forthcoming.
After Hours Debate

4:30 – 5:30 pm

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 crystalize 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 Annual Reception and Dinner Dance

7:00 – 8:00 pm Reception

8:00 – 10:30 pm Dinner Dance

Tickets Required

Enjoy the company of your friends and colleagues during the Annual Reception and Dinner Dance. After dinner, unwind and cut loose with live music and dancing. A complimentary ticket is included in each member’s meeting registration; non-member or spouse/companion tickets may be purchased during registration for an additional $125 fee per ticket.
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. Please register early and indicate your 1st and 2nd choice on the Registration Form.

**W-1 Academic Development**
Karim Alavi, MD, Worcester, MA
Kelly Tyler, MD, Springfield, MA

**W-2 Quality Metrics**
Arden Morris, MD, Ann Arbor, MI
Larissa Temple, MD, New York, NY

**W-3 Fistula in Ano**
José Cintron, MD, Chicago, IL
Sean Langenfeld, MD, Omaha, NE

**W-4 Complicated Crohn’s Disease**
Robert Cima, MD, Rochester, MN
Charles Friel, MD, Charlotteville, VA

**W-5 Bring Your Worst**
Robert Fry, MD, Philadelphia, PA
David Schoetz, Jr., MD, Burlington, MA

**W-6 Rectovaginal Fistula**
Jamie Cannon, MD, Birmingham, AL
Patricia Roberts, MD, Burlington, MA

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

*Photo Credit: Los Angeles Tourism & Convention Board. California Science Center.*
Symposium

Benign Anorectal

7:30 – 9:00 am

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 educations 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 “Catch 22” 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.
Symposium

ERAS Update

7:30 – 9:00 am

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, Parma, OH
Assistant Director: Julie Thacker, MD, Durham, NC

7:30 am Welcome and Introductions
Anthony Senagore, MD, Parma, OH
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
**Symposium**

**Rectal Cancer II**

9:30 – 10:45 am

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*

9:30 am  **MRI in Staging and Re-Staging in Rectal Cancer**  Regina Beets-Tan, MD, PhD, Amsterdam, The Netherlands

9:42 am  **Does Every Locally Advanced Rectal Cancer Need Radiation?**  Alessandro Fichera, MD, Seattle, WA

9:53 am  **Systemic Chemotherapy in Rectal Cancer: Before or After Surgery?**  Andrea Cercek, MD, New York, NY

10:04 am  **Is Local Excision an Available Alternative After CRT?**  Rodrigo Perez, MD, PhD, Sao Paulo, Brazil

10:16 am  **Watch and Wait: Selection Criteria and Surveillance Protocol**  Geerard Beets, MD, PhD, Amsterdam, The Netherlands

10:28 am  **Case Presentations**

10:45 am  **Adjourn**

**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.

**Abstract Session***

**Video Session**

9:30 – 10:45 am

**Co-Moderator:** Jose Cintron, MD, *Chicago, IL*

**Co-Moderator:** Mukta Krane, MD, *Seattle, WA*

*Abstract titles and authors are forthcoming.*
Ernestine Hambrick, MD, Lectureship

10:45 – 11:30 am
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 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.

11:30 am – 12:30 pm
Lunch (on your own)
Symposium

Pelvic Floor Disorders

12:30 – 2:00 pm

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

1:15 pm Rectal Prolapse Abdominal, Perineal, Combined Repairs
Andre D’Hoore, MD, PhD, Leuven, Belgium

12:45 pm Functional Treatment of Dyssynergia, Intussusception and Rectocele
Liliana Bordeianou, MD, Boston, MA

1:30 pm Case Presentations and Discussion Panel

1:00 pm Surgical Treatment of Intussusception and Rectocele
Shane McNevin, MD, Spokane, WA

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

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)
Giovana 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

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.

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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

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

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

All registrants are invited to attend the Society’s Annual Business Meeting to hear reports on Society Initiatives and approve proposed nominees for Fellowship and Honorary Fellowship.

Outgoing ASCRS President Dr. Charles Littlejohn will present a State of the Society Address and honor this year’s Award recipients.
FUTURE ASCRS MEETINGS

June 10 – 14, 2017
Washington State Convention Center
Sheraton Seattle Hotel
Seattle, Washington

May 19 – 23, 2018
Music City Center
Omni Nashville Hotel
Nashville, Tennessee

June 1 – 5, 2019
Cleveland Convention Center
Hilton Cleveland Downtown Hotel
Cleveland, Ohio

June 6 – 10, 2020
Hynes Convention Center
Sheraton Boston Hotel
Boston, Massachusetts