## Table of Contents

### General Information

#### Saturday, June 1
- **Workshop:** Advanced Robotics for the Practicing Surgeon  
  18
- **Symposium and Workshop:** Advanced Methods for the Management of Rectal Prolapse  
  19
- **Symposium and Workshop:** Transanal Total Mesorectal Excision (taTME)  
  21
- **Symposium:** Practice Management  
  23
- **Workshop:** Young Surgeons Mock Orals and More  
  25
- **Symposium:** Advanced Practice Provider/Allied Health  
  27
- **U.S.-China Colorectal Surgical Symposium**  
  28
- **Workshop:** Question Writing: Do You Know How to Write the Perfect Exam Question?  
  29

#### Sunday, June 2
- **Pelvic Floor Disorders Consortium**  
  30
- **Symposium and Workshop:** Advanced Endoscopy  
  30
- **Core Subject Update**  
  32
- **Symposium:** Critical Review of Scientific Manuscripts  
  33
- **Symposium:** Latin American Symposium  
  35
- **Simpósio Latinoamericano**  
  36
- **Symposium:** Colorectal Surgery Research: Tips and Tricks from the Experts  
  37
- **Symposium:** Care of the Geriatric Colorectal Patient  
  38
- **Welcome and Opening Announcements**  
  39
- **Humanities in Surgery Lectureship**  
  39
- **Abstract Session:** Neoplasia I  
  40
- **Symposium:** Pelvic Floor: Present and Future  
  40
- **Symposium:** Decreasing Complications of Pain Management by Enhanced Recovery Strategies  
  41
- **Abstract Session:** Research Forum  
  42
- **Symposium:** What’s New in Ulcerative Colitis?  
  42
- **Symposium:** The Evolving Landscape of Colorectal Surgical Education  
  43
- **ASCRS ROCKS! Welcome Reception at the Rock and Roll Hall of Fame**  
  44
## Monday, June 3

**Meet the Professor Breakfasts**

**Symposium**: Coffee and Controversies: Leela Prasad Memorial Debates

**Abstract Session**: Lightning Talks

**Symposium**: Rectal Cancer

**Symposium**: Technical Pearls: Minimally Invasive Colectomy, Step-By-Step

Harry E. Bacon, MD, Lectureship

Presidential Address

E-poster Presentations

**Abstract Session**: Pelvic Floor

**Symposium**: Current Management of Crohn’s Disease. Joint ASCRS/SSAT Symposium

**Symposium**: When Do You Change Your Approach? A Framework for Translating Evolving Evidence into Practice Change

**Abstract Session**: Basic Science

**Abstract Session**: Video Session

**Symposium**: ASCRS/ACS Partnership to Support the Colorectal Surgeon

E-poster Presentations

**Symposium**: Best of the Diseases of the Colon & Rectum Journal

**Symposium**: New Technologies (No CME)

Residents’ Reception

## Tuesday, June 4

**Meet the Professor Breakfasts**

Norman D. Nigro, MD, Research Lectureship

**Symposium**: Harnessing Social Media to Advance #ColorectalSurgery

**Symposium**: Management of Anal Dysplasia

E-poster Presentations

**Abstract Session**: Neoplasia II

**Symposium**: Avoiding Burnout and Achieving Optimal Work-Life Balance

**Symposium**: My Microbiome Made Me Do It

Masters in Colorectal Surgery Lectureship Honoring Ian C. Lavery, MD

E-poster Presentations

Women in Colorectal Surgery Luncheon

Memorial Lectureship Honoring Philip H. Gordon, MD

Abstract Session: General Surgery Forum

**Symposium**: Advanced Endoscopy/Intraluminal Surgery: Raising the Bar for Detection and Non-Resectional Management of Advanced Polyps

**Symposium**: Enhancing the Physician Patient Relationship

ASCRS Annual Business Meeting and State of the Society Address

Drinks and Disputes: The After Hours Debates

ASCRS Blues Fest-Farewell Reception
# Wednesday, June 5

<table>
<thead>
<tr>
<th>Event</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meet the Professor Breakfasts</td>
<td>65</td>
</tr>
<tr>
<td><strong>Symposium</strong>: Coffee and Controversies</td>
<td>66</td>
</tr>
<tr>
<td><strong>Abstract Session</strong>: Outcomes</td>
<td>67</td>
</tr>
<tr>
<td><strong>Abstract Session</strong>: Education</td>
<td>67</td>
</tr>
<tr>
<td><strong>Symposium</strong>: Hereditary Cancer Syndromes: What the Colorectal Surgeon Really Needs to Know</td>
<td>68</td>
</tr>
<tr>
<td><strong>Abstract Session</strong>: Inflammatory Bowel Disease</td>
<td>69</td>
</tr>
<tr>
<td><strong>Symposium</strong>: Advances and Controversies in the Management of Diverticulitis</td>
<td>69</td>
</tr>
<tr>
<td><strong>Symposium</strong>: Healthcare Economics: Policy Implications in the Future of Medicine</td>
<td>70</td>
</tr>
<tr>
<td>Ernestine Hambrick, MD, Lectureship</td>
<td>71</td>
</tr>
<tr>
<td><strong>Abstract Session</strong>: Quality</td>
<td>72</td>
</tr>
<tr>
<td><strong>Symposium</strong>: Mission Impossible: Preparing for and Navigating the Difficult and Unexpected Operative Scenario</td>
<td>72</td>
</tr>
<tr>
<td><strong>Symposium</strong>: Benign Anorectal - Complex Problems, Advanced Techniques, and Special Populations</td>
<td>73</td>
</tr>
<tr>
<td><strong>Abstract Session</strong>: Benign Disease</td>
<td>73</td>
</tr>
<tr>
<td><strong>Symposium</strong>: Is it Really Unresectable? Management of Advanced and Recurrent Colorectal Cancer</td>
<td>74</td>
</tr>
<tr>
<td><strong>Symposium</strong>: Robotics: Practical Tips and Tricks</td>
<td>75</td>
</tr>
</tbody>
</table>
Program Leadership

Brian Kann, MD
Program Chair

Traci Hedrick, MD
Program Vice Chair

M. Benjamin Hopkins, MD
Program Vice Chair

Annual Meeting Scientific Meeting Goals, Purpose and Learning Objectives

The goals of the American Society of Colon and Rectal Surgeons Annual Scientific Meeting are 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 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, e-poster 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. ASCRS takes responsibility for the content, quality and scientific integrity of this CME 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.
Continuing Medical Education Credit
The American Society of Colon and Rectal Surgeons (ASCRS) designates this live activity for a maximum of 39.5 AMA PRA Category 1 Credit(s)™. 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 online evaluation form for the ASCRS 2019 Annual Meeting. Participants must complete an online evaluation form for each session they attend to receive credit hours. There are no prerequisites unless otherwise indicated.

ASCRS requests that attendees complete the online evaluations by August 31, 2019.

Self-Assessment Credit
Many of the sessions offered will be designated as self-assessment credit, applicable to Part 2 of the ABCRS MOC program. 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 Meeting.

Please Note: Times and speakers are subject to change.

Application for Nursing Accreditation is in process.

ASCRS Mission
The American Society of Colon and Rectal Surgeons is a community of health care professionals who are dedicated to advancing the understanding, prevention and treatment of disorders of the colon, rectum and anus.
Disclaimer
The primary purpose of the ASCRS Annual Meeting is educational. Information, as well as technologies, products and/or services discussed, is intended to inform participants about the knowledge, techniques and experiences of specialists who are willing to share such information with colleagues. A diversity of professional opinions exist in the specialty and the views of the ASCRS 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 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 mobile app and Program Book. All perceived conflicts of interest will be resolved prior to presentation; and, if not resolved, the presentation will be denied.

Code of Conduct
ASCRS is a listening organization focused on its participants. ASCRS 2019 Annual Scientific Meeting is designed to increase interaction, engagement, collaboration, connectivity and community, in a fun and safe learning environment.

We value the participation of each member of the community and endeavor to deliver an enjoyable and fulfilling experience. Meeting participants are expected to conduct themselves with integrity, courtesy and respect for others and maintain the highest level of professionalism at all meeting programs and events, whether officially sponsored by ASCRS or not. All attendees, speakers, organizers, volunteers, partners, vendors and staff at any ASCRS event are required to observe the following Code of Conduct.

ASCRS is dedicated to providing a harassment-free meeting experience for everyone, regardless of gender, sexual orientation, disability, physical appearance, body size, race or religion. We do not tolerate harassment of meeting participants in any form. All communication should be appropriate for a professional audience including people of diverse backgrounds and cultures. Sexual language and imagery is not appropriate for the conference.

Be kind to others. Do not insult or defame participants. Harassment in any form, sexist, racist, or exclusionary jokes are not condoned at ASCRS Events.

Participants violating these rules may be asked to leave the meeting at the sole discretion of ASCRS. Thank for helping to make this a welcoming event for all.
Meeting Accommodations
All meeting activities will be held at the Huntington Convention Center of Cleveland, Ohio unless otherwise noted.

Huntington Convention Center of Cleveland
300 Lakeside Ave E
Cleveland, OH 44113
Map: Click here

Complimentary Wi-Fi Available
Complimentary Wi-Fi will be provided in the Huntington Convention Center of Cleveland.

Parking
The Huntington Park Garage is located directly across from the Convention Center and has two entrances at Lakeside and West 3rd Street. It is open 24 hours, 7 days a week. Cost averages $10.00 per day.

Hotel Accommodations
ASCRS has negotiated special rates at three hotels, listed below, which are located near the Convention Center. Rooms and rates are based on availability and subject to state and local fees/taxes (which are currently 16.5% per room). Be sure to make reservations by May 9, 2019; afterward, the discounted room rates may not apply.

All reservations require a first night room deposit, or guests can guarantee reservations with a major credit card. Your credit card will not be charged prior to arrival. Make any necessary cancellations at least 72 hours before the scheduled date of arrival to avoid a cancellation charge. Hotel check-in time is 3:00 pm and check-out is Noon.

Make your reservation today! Click here to make your reservation online. Do not call the hotel directly as all hotel reservations must be made with Destination Cleveland hotel reservations services.

Beware of Unauthorized Hotel Solicitations
Note that Destination Cleveland is the only official hotel provider associated with our meeting. While other hotel resellers may contact you offering accommodations for your trip, they are not endorsed by or affiliated with the meeting. Beware that entering into financial agreements with non-endorsed companies can have costly consequences. Should you be contacted by any agency other than Destination Cleveland, please email ASCRS at ascrs@fascrs.org with the details.

Hilton Cleveland Downtown – Headquarters Hotel
100 Lakeside Ave East
Cleveland, Ohio 44114 USA
$245 (single/double occupancy), city/state taxes apply.

Parking
On-site parking is available at the Hilton Cleveland Downtown for $28 USD. Valet parking is also available at a rate of $36 USD daily.

Westin Cleveland Downtown
777 Saint Claire Ave
Cleveland, Ohio 44114 USA
$239 (single/double occupancy), city/state taxes apply.

Parking
On-site parking is available at the Westin Cleveland Downtown for $15 USD. Valet parking is also available at a rate of $34 USD daily.
General Meeting Information

Cleveland Marriott Downtown at Key Tower
1360 W Mall Dr.
Cleveland, Ohio 44114 USA
$224 (single/double occupancy), city/state taxes apply.

Parking
On-site parking is available at the Cleveland Marriott Downtown at Key Tower for $25 USD.
Valet parking is also available at a rate of $35 USD daily.

Airport Transportation Information

Cleveland Hopkins International Airport (CLE) is 12 miles from Cleveland downtown. Akron-Canton Airport (CAK) is 53 miles from downtown

Taxi Service - The estimated taxi fare from CLE to the Convention Center and hotels is $35 (one way). Pickups are made at the taxi entrance on the south end of baggage claim, adjacent to Carousel 11. You will need to arrange your taxi with the taxi pick up window and you will be given a voucher to give to your taxi driver. Taxi service is only available with a pre-arranged voucher at the south end of the baggage claim.

The estimated taxi fare from CAK to the Convention Center and hotels is $145 (one way).

Ride Share (Uber/Lyft) - Pickups are made at the Ground Transportation Center, which is located midway between the terminal and the Smart Parking Garage. Please follow the signs for ride share from the baggage claim level welcome center.

Public Transportation (RTA Rapid) - located on the lower level of the main terminal. Trains depart from CLE every 15 minutes. Visit the RTA website for maps, rates and schedules.

Super Shuttle - Reserve with SuperShuttle to and from Cleveland Hopkins International Airport (CLE) ahead of time on their website or app.

Private Car (Carey) - To book a private car, create an account on the Carey website. Once an account is created you can either make reservations through the phone number listed or online. You can also download the app on an IPhone or Android device. Once logged into your account you will need to create your reservation which will include your pick up location, date, time and passenger options. After entering your travel details, select continue. When you select continue, it will then ask if you would like to apply a promo code or account number. You will click yes and select Promo Code. Enter your code (KLATAS), select Apply & Continue to your vehicle selection. Select your vehicle option and click Review & Confirm, you will then enter payment info. Once booking is complete you can find your reservation in the My Reservations tab of your account.

Call 800-336-4646 or visit https://www.carey.com/ if you have additional questions.

Car Rental Partners
Avis is the official car rental service for the ASCRS 2019 Annual Scientific Meeting. We encourage you to enroll in either Avis®, Budget® or both. Discount codes can be found below:

An advanced reservation is recommended. First, create an Avis or Budget account. For this you’ll need your driver’s license and credit card ready. You can rent a car without an account, but you’ll lose the benefit of skipping the counter.

If you already have a profile, add the ASCRS’ discount codes, D619101 for AVIS Wizard and D958401 for Budget Fastbreak, to your account to receive the special rates and benefits.

Negotiated insurances are not included.

Weather and Meeting Attire
Cleveland, OH has an average high temperature of 79 degrees Fahrenheit/26 degrees Celsius in June, with an average low temperature of 60 degrees Fahrenheit/15 degrees Celsius. Attire for the conference is business casual. Because meeting room temperatures sometimes fluctuate, attendees may wish to bring a sweater or jacket.
ASCRS ROCKS! Welcome Reception at the Rock and Roll Hall of Fame  
Sunday, June 2, 7:00 - 10:30 pm

ASCRS ROCKS! Welcome Reception at the Rock and Roll Hall of Fame will be held Sunday, June 2, 7:00 - 10:30 pm (complimentary to all registered attendees) and will feature hors d’oeuvres, cocktails and entertainment. The Welcome Reception will be held at the Rock and Roll Hall of Fame.

The Rock and Roll Hall of Fame, located on the shore of Lake Erie in downtown Cleveland, Ohio, recognizes and archives the history of the best-known and most influential artists, producers, engineers, and other notable figures who have had some major influence on the development of rock and roll. The Rock and Roll Hall of Fame Foundation was established on April 20, 1983, by Atlantic Records founder and chairman Ahmet Ertegun. In 1986, Cleveland was chosen as the Hall of Fame’s permanent home.

The Research Foundation will join forces with ASCRS to welcome all at this reception.

Residents’ Reception  
Monday, June 3, 6:30 – 8:00 pm

Open to residents and colorectal program directors only.

Network with colon and rectal surgery program directors and members of the ASCRS Residents Committee to learn more about the specialty and the Society. Cocktails and hors d’oeuvres will be served, and a copy of the ASCRS Manual of Colon and Rectal Surgery, Second Edition, will be raffled.

Women in Colorectal Surgery Luncheon  
Tuesday, June 4, 11:30 am-1:00 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 interact with experienced colon and rectal surgeons from a variety of settings. Please mark the registration form if you plan to attend. **The cost is $30 per person.**

ASCRS Blues Fest- Farewell Reception  
Tuesday, June 4, 6:30 – 8:00 pm

ASCRS Blues Fest- Farewell Reception will feature Blues inspired Hors’ devours, drinks and some great entertainment. It is scheduled for Tuesday, June 4, 6:30 – 8:00 pm. and located at ASCRS headquarters hotel, Hilton Cleveland Downtown. There is no additional cost for a ticket for full-paying Members and Fellows. Members/Fellows must indicate whether they want to attend the event when registering for the meeting. All other registration categories must purchase a ticket. **The cost for additional tickets is $150 per person.**
General Meeting Information

Registration
Location: Grand Ballroom Foyer

Hours:
- Friday, May 31: 3:00 pm - 6:00 pm
- Saturday, June 1: 6:30 am - 5:00 pm
- Sunday, June 2: 6:30 am - 6:00 pm
- Monday, June 3: 6:30 am - 4:30 pm
- Tuesday, June 4: 6:00 am - 4:30 pm
- Wednesday, June 5: 6:30 am - 3:30 pm

Exhibit Hours
Location: Hall C
- Sunday, June 2: 11:30 am - 4:30 pm
  Lunch available for attendees
  PM refreshment break
- Monday, June 3: 9:00 am - 4:30 pm
  AM and PM refreshment break
  Lunch available for attendees
- Tuesday, June 4: 9:00 am - 2:00 pm
  AM refreshment break
  Lunch available for attendees

For questions or to secure exhibit space, sponsorship and marketing opportunities contact:
Jim Anderson, Manager, Sponsorship & Exhibits Sales
American Society of Colon and Rectal Surgeons (ASCRS)
847-686-2308

Trina Jordan, CEM, Manager, Meetings & Expositions
American Society of Colon and Rectal Surgeons (ASCRS)
678-303-3057

Sue Hoffman, Sales Coordinator
American Society of Colon and Rectal Surgeons (ASCRS)
847-686-2307

Speaker Ready Room
Location: Room 23

Hours:
- Friday, May 31: 3:00 pm - 6:00 pm
- Saturday, June 1: 6:00 am - 6:30 pm
- Sunday, June 2: 6:30 am - 6:00 pm
- Monday, June 3: 6:30 am - 6:30 pm
- Tuesday, June 4: 6:00 am - 6:00 pm
- Wednesday, June 5: 6:30 am - 3:30 pm

Child Care Services
Please contact the concierge at the hotel at which you are staying for a list of bonded independent baby sitters and babysitting agencies.
General Meeting Information

Cancellation Policy
Notification of cancellation must be submitted in writing. Cancellations received on or before May 10, 2019, will be refunded, minus a $100 USD cancellation fee. Refunds will not be granted after this date and will not be given for no-shows. Substitutions are allowed at any time, but must be submitted in writing and must be of the same member status. Send requests to ASCRS at ascrs@fascrs.org.

Foreign Visa Requirements
Visa requirements vary based on national origin, current residence, previous travel and passport eligibility.

- The U.S. Department of State is the most trusted source for up-to-date information on visa and passport issues.
- The Visa Waiver Program (VWP) enables most citizens or nationals of participating countries to travel to the United States for tourism or business for stays of 90 days or less without first obtaining a visa, when they meet certain requirements.
- The Visa Wizard is a tool to help travelers understand what type of visa they may need.

How do I apply?
We recommend that you apply for a visa as soon as possible. You will need to complete an application and provide a photograph. An interview may be required. Contact the U.S. Embassy or consulate in your country for specific application procedures and estimated wait times for interview appointments.
General Meeting Information

Not a member? Join now to save on registration!

Members save $320 off the price of 2019 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 Find a Surgeon search engine on the ASCRS website.
- Discounted pricing on products.
- Access to an extensive members-only resource library.
- Ability to post job openings and your resume on our job board.
- ...and much more.

ASCRS is the professional home of more than 3,900 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.
## Schedule at a Glance

### Friday, May 31, 2019

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:00 - 6:00 pm</td>
<td>Speaker Ready Room Open</td>
</tr>
<tr>
<td>3:00 - 6:00 pm</td>
<td>Registration Open</td>
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</tbody>
</table>

### Saturday, June 1, 2019

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:00 am - 6:30 pm</td>
<td>Speaker Ready Room Open</td>
</tr>
<tr>
<td>6:30 am - 5:00 pm</td>
<td>Registration Open</td>
</tr>
<tr>
<td>7:00 am - Noon</td>
<td>Advanced Robotics for the Practicing Surgeon Hands-on Lab</td>
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<tr>
<td>7:30 am - Noon</td>
<td>Transanal Total Mesorectal Excision (taTME) Symposium (Didactic)</td>
</tr>
<tr>
<td>7:30 am - Noon</td>
<td>Advanced Methods for the Management of Rectal Prolapse (Didactic)</td>
</tr>
<tr>
<td>8:00 am - Noon</td>
<td>Practice Management Course</td>
</tr>
<tr>
<td>Noon - 1:00 pm</td>
<td>Lunch for Hands-On Workshop Participants Only</td>
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<tr>
<td>12:30 - 5:30 pm</td>
<td>Young Surgeons Mock Orals &amp; More Workshop</td>
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<tr>
<td>1:00 - 4:00 pm</td>
<td>Question Writing: Do You Know How to Write the Perfect Exam Question? Workshop</td>
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<tr>
<td>1:00 - 4:30 pm</td>
<td>Transanal Total Mesorectal Excision (taTME) Hands-on Workshop</td>
</tr>
<tr>
<td>1:00 - 4:30 pm</td>
<td>Advanced Methods for the Management of Rectal Prolapse Hands-on Lab</td>
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<tr>
<td>1:00 - 5:00 pm</td>
<td>Advance Practice Provider Symposium</td>
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<tr>
<td>5:15 - 6:30 pm</td>
<td>U.S.-China Colorectal Surgical Symposium</td>
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<tr>
<td>6:00 - 9:00 pm</td>
<td>Young Surgeons Reception</td>
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<tr>
<td>6:30 - 7:30 pm</td>
<td>U.S.-China Colorectal Surgical Reception</td>
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### Sunday, June 2, 2019

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>6:30 am - 6:00 pm</td>
<td>On-Going Video Room</td>
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<tr>
<td>6:30 am - 6:00 pm</td>
<td>Speaker Ready Room Open</td>
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<tr>
<td>6:30 am - 6:00 pm</td>
<td>Registration Open</td>
</tr>
<tr>
<td>7:00 - 11:00 am</td>
<td>Pelvic Floor Disorders Consortium</td>
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<tr>
<td>7:30 - 9:30 am</td>
<td>Core Subject Update</td>
</tr>
<tr>
<td>7:30 - 11:30 am</td>
<td>Advanced Endoscopy Symposium and Workshop</td>
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<tr>
<td>8:00 - 9:30 am</td>
<td>SYMPOSIUM: Critical Review of Scientific Manuscripts</td>
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<tr>
<td>8:00 - 9:30 am</td>
<td>SYMPOSIUM: Latin American Symposium</td>
</tr>
<tr>
<td>9:30 - 9:45 am</td>
<td>Refreshment Break in Foyer</td>
</tr>
<tr>
<td>9:45 - 11:45 am</td>
<td>SYMPOSIUM: Colorectal Surgery Research: Tips &amp; Tricks from the Experts</td>
</tr>
<tr>
<td>9:45 - 11:45 am</td>
<td>SYMPOSIUM: Care of the Geriatric Colorectal Patient</td>
</tr>
<tr>
<td>11:30 am - 4:30 pm</td>
<td>Exhibit Hall Hours</td>
</tr>
<tr>
<td>11:45 am - 12:45 pm</td>
<td>Lunch in the Exhibit Hall</td>
</tr>
<tr>
<td>12:45 - 1:30 pm</td>
<td>Welcome and Opening Announcements</td>
</tr>
<tr>
<td>1:30 - 2:15 pm</td>
<td>Humanities in Surgery Lectureship</td>
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<tr>
<td>2:15 - 3:45 pm</td>
<td>Abstract Session: Neoplasia I</td>
</tr>
<tr>
<td>2:15 - 3:45 pm</td>
<td>SYMPOSIUM: Pelvic Floor: Present &amp; Future</td>
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<tr>
<td>Time</td>
<td>Event</td>
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<tr>
<td>2:15 - 3:45 pm</td>
<td>SYMPOSIUM: Decreasing Complications of Pain Management by Enhanced Recovery Strategies</td>
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<tr>
<td>3:45 - 4:15 pm</td>
<td>Refreshment Break in the Exhibit Hall</td>
</tr>
<tr>
<td>4:15 - 5:45 pm</td>
<td>Abstract Session: Research Forum</td>
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<td>4:15 - 5:45 pm</td>
<td>SYMPOSIUM: What's New in Ulcerative Colitis?</td>
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<td>4:15 - 5:45 pm</td>
<td>SYMPOSIUM: The Evolving Landscape of Colorectal Surgical Education</td>
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<td>7:00 - 10:30 pm</td>
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**Monday, June 3, 2019**

<table>
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<tbody>
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<td>Registration Open</td>
</tr>
<tr>
<td>6:30 am - 6:30 pm</td>
<td>On-Going Video Room</td>
</tr>
<tr>
<td>7:00 - 8:00 am</td>
<td>Meet the Professor Breakfasts</td>
</tr>
<tr>
<td>7:00 - 8:00 am</td>
<td>Coffee &amp; Controversies: Leela Prasad Memorial Debate</td>
</tr>
<tr>
<td>8:00 - 9:30 am</td>
<td>Abstract Session: Lightning Talks</td>
</tr>
<tr>
<td>8:00 - 9:30 am</td>
<td>SYMPOSIUM: Rectal Cancer</td>
</tr>
<tr>
<td>8:00 - 9:30 am</td>
<td>SYMPOSIUM: Technical Pearls: Minimally Invasive Colectomy, Step-By-Step</td>
</tr>
<tr>
<td>9:00 am - 4:30 pm</td>
<td>Exhibit Hall Hours</td>
</tr>
<tr>
<td>9:30 - 10:00 am</td>
<td>Refreshment Break and E-Poster Presentations in the Exhibit Hall</td>
</tr>
<tr>
<td>10:00 - 10:45 am</td>
<td>Harry E. Bacon, MD, Lectureship</td>
</tr>
<tr>
<td>10:45 - 11:30 am</td>
<td>Presidential Address</td>
</tr>
<tr>
<td>11:30 am - 12:45 pm</td>
<td>Complimentary Box Lunch and E-Poster Presentations in the Exhibit Hall</td>
</tr>
<tr>
<td>12:45 - 2:00 pm</td>
<td>Abstract Session: Pelvic Floor</td>
</tr>
<tr>
<td>12:45 - 2:00 pm</td>
<td>Current Management of Crohn’s Disease. Joint ASCRS/SSAT Symposium</td>
</tr>
<tr>
<td>12:45 - 2:00 pm</td>
<td>SYMPOSIUM: When Do You Change Your Approach? A Framework for Translating Evolving Evidence into Practice Change</td>
</tr>
<tr>
<td>2:00 - 3:30 pm</td>
<td>Abstract Session: Basic Science</td>
</tr>
<tr>
<td>2:00 - 3:30 pm</td>
<td>Abstract Session: Video Abstracts</td>
</tr>
<tr>
<td>2:00 - 3:30 pm</td>
<td>SYMPOSIUM: ASCRS/ACS Parntership to Support the Colorectal Surgeon</td>
</tr>
<tr>
<td>3:30 - 4:00 pm</td>
<td>Refreshment Break and E-Poster Presentations in the Exhibit Hall</td>
</tr>
<tr>
<td>4:00 - 4:45 pm</td>
<td>Best of the Diseases of the Colon and Rectum Journal</td>
</tr>
<tr>
<td>4:45 - 6:15 pm</td>
<td>(non-CME) New Technologies Symposium</td>
</tr>
<tr>
<td>6:30 - 8:00 pm</td>
<td>Residents’ Reception</td>
</tr>
</tbody>
</table>
### Schedule at a Glance

**Tuesday, June 4**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:00 am - 6:00 pm</td>
<td>On-Going Video Room</td>
</tr>
<tr>
<td>6:00 am - 6:00 pm</td>
<td>Speaker Ready Room Open</td>
</tr>
<tr>
<td>6:00 am - 4:30 pm</td>
<td>Registration Open</td>
</tr>
<tr>
<td>6:30 - 7:30 am</td>
<td>Meet the Professor Breakfast</td>
</tr>
<tr>
<td>7:30 - 8:15 am</td>
<td>Norman D. Nigro, MD, Research Lectureship</td>
</tr>
<tr>
<td>8:15 - 9:00 am</td>
<td>SYMPOSIUM: Harnessing Social Media to Advance #ColorectalSurgery</td>
</tr>
<tr>
<td>8:15 - 9:00 am</td>
<td>SYMPOSIUM: Management of Anal Dysplasia</td>
</tr>
<tr>
<td>9:00 - 9:30 am</td>
<td>Refreshment Break and E-Poster Presentations in the Exhibit Hall</td>
</tr>
<tr>
<td>9:00 am - 2:00 pm</td>
<td>Exhibit Hall Hours</td>
</tr>
<tr>
<td>9:30 - 10:45 am</td>
<td>Abstract Session: Neoplasia II</td>
</tr>
<tr>
<td>9:30 - 10:45 am</td>
<td>SYMPOSIUM: Avoiding Burnout and Achieving Optimal Work-Life Balance</td>
</tr>
<tr>
<td>9:30 - 10:45 am</td>
<td>SYMPOSIUM: My Microbiome Made Me Do It</td>
</tr>
<tr>
<td>10:45 - 11:30 am</td>
<td>Masters in Colorectal Surgery Lectureship</td>
</tr>
<tr>
<td>11:30 am - 1:00 pm</td>
<td>Complimentary Box Lunch and E-Poster Presentations in the Exhibit Hall</td>
</tr>
<tr>
<td>11:30 am - 1:00 pm</td>
<td>Women in Colorectal Surgery Luncheon</td>
</tr>
<tr>
<td>1:00 - 1:45 pm</td>
<td>Memorial Lecture Honoring Philip H. Gordon, MD</td>
</tr>
<tr>
<td>1:45 - 3:15 pm</td>
<td>Abstract Session: General Surgery Forum</td>
</tr>
<tr>
<td>1:45 - 3:15 pm</td>
<td>SYMPOSIUM: Advanced Endoscopy/Intraluminal Surgery: Raising the Bar for Detection and Non-Resectional Management of Advanced Polyps</td>
</tr>
<tr>
<td>1:45 - 3:15 pm</td>
<td>SYMPOSIUM: Enhancing the Physician Patient Relationship</td>
</tr>
<tr>
<td>3:15 - 3:30 pm</td>
<td>Refreshment Break in the Foyer</td>
</tr>
<tr>
<td>3:30 - 4:30 pm</td>
<td>ASCRS Annual Business Meeting and State of the Society Address</td>
</tr>
<tr>
<td>4:30 - 5:30 pm</td>
<td>Drinks and Disputes: The After Hours Debates</td>
</tr>
<tr>
<td>5:30 - 6:30 pm</td>
<td>Fellowship Reception</td>
</tr>
<tr>
<td>6:30 - 8:00 pm</td>
<td>ASCRS Blues Fest-Farewell Reception</td>
</tr>
</tbody>
</table>
## Schedule at a Glance

**Wednesday, June 5**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>6:30 am - 3:30 pm</td>
<td>On-Going Video Room</td>
</tr>
<tr>
<td>6:30 am - 3:30 pm</td>
<td>Speaker Ready Room Open</td>
</tr>
<tr>
<td>6:30 am - 3:30 pm</td>
<td>Registration Open</td>
</tr>
<tr>
<td>7:00 - 8:00 am</td>
<td>Coffee &amp; Controversies</td>
</tr>
<tr>
<td>7:00 - 8:00 am</td>
<td>Meet the Professor Breakfasts</td>
</tr>
<tr>
<td>8:00 - 9:15 am</td>
<td>Abstract Session: Outcomes</td>
</tr>
<tr>
<td>8:00 - 9:15 am</td>
<td>Abstract Session: Education</td>
</tr>
<tr>
<td>8:00 - 9:15 am</td>
<td>SYMPOSIUM: Hereditary Cancer Syndromes: What the Colorectal Surgeon Really Needs to Know</td>
</tr>
<tr>
<td>9:15 - 9:30 am</td>
<td>Refreshment Break in Foyer</td>
</tr>
<tr>
<td>9:30 - 10:45 am</td>
<td>Abstract Session: Inflammatory Bowel Disease</td>
</tr>
<tr>
<td>9:30 - 10:45 am</td>
<td>Symposium: Advances and Controversies in the Management of Diverticulitis</td>
</tr>
<tr>
<td>9:30 - 10:45 am</td>
<td>Symposium: Healthcare Economics: Policy Implications in the Future of Medicine</td>
</tr>
<tr>
<td>10:45 - 11:30 am</td>
<td>Ernestine Hambrick, MD Lectureship</td>
</tr>
<tr>
<td>11:30 am - 12:30 pm</td>
<td>Lunch on Your Own</td>
</tr>
<tr>
<td>12:30 - 2:00 pm</td>
<td>Abstract Session: Quality</td>
</tr>
<tr>
<td>12:30 - 2:00 pm</td>
<td>SYMPOSIUM: Mission Impossible: Preparing for and Navigating the Difficult and Unexpected Operative Scenario</td>
</tr>
<tr>
<td>12:30 - 2:00 pm</td>
<td>SYMPOSIUM: Benign Anorectal - Complex Problems, Advanced Techniques, and Special Populations</td>
</tr>
<tr>
<td>2:00 - 3:30 pm</td>
<td>Abstract Session: Benign Disease</td>
</tr>
<tr>
<td>2:00 - 3:30 pm</td>
<td>SYMPOSIUM: Is it Really Unresectable? Management of Advanced and Recurrent Colorectal Cancer</td>
</tr>
<tr>
<td>2:00 - 3:30 pm</td>
<td>SYMPOSIUM: Robotics: Practical Tips and Tricks</td>
</tr>
</tbody>
</table>
Saturday, June 1

Workshop
CME Credit Hours: 5

**Advanced Robotics for the Practicing Surgeon**

7:00 am – Noon

*Registration Required • Member Fee: $670 • Non-Member Fee: $800 • Limit: 20 participants*

This workshop will offer the practicing surgeon a highly customized and procedural oriented cadaver-based experience that demonstrates state-of-the-art techniques employed in a variety of colorectal operations. The focus will be on tips, tricks, and advanced maneuvers to facilitate robotic ascending colectomy, intracorporeal anastomosis and low anterior resection. We will also provide the surgeons hands on access to the newest FDA approved robotic systems on cadaveric platforms.

This session will involve cadaveric-based procedural exercises on robotic surgical platforms. Port placement, docking techniques, patient positioning and troubleshooting will be covered for each procedure. A primary focus during the workshop will be on operative techniques, methods to improve operative efficiency, identification and preservation of critical anatomy, and high value points to help negotiate the robotics learning curve.

This course is intended to assist surgeons during their learning curve to accelerate their move from robotic proficiency to mastery. And expose the surgeons to the newest robotic technology that may help their practice.

**Gap Analysis:**

**What Is:** Easily available resources to guide 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. And, access to new systems on cadavers if limited.

**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.

**Objectives:** At the conclusion of this session, participants should be able to:

1. Describe the setup and instrumentation of advanced robotic colorectal procedures.
2. Explain different procedural approaches in robotic colorectal surgery and understand strength and weaknesses of FDA approved robotic systems.
3. Explain how to troubleshoot and address specific robotic-related complications in colorectal surgery.

**Co-Directors:** Todd Francone, MD, Newton, MA
Vincent Obias, MD, Washington, DC

**Faculty:**
Lilian Chen, MD, Boston, MA
I. Emre Gorgun, MD, Cleveland, OH
Nell Maloney Patel, MD, New Brunswick, NJ
Joshua Waters, MD, Indianapolis, IN
Rectal prolapse is a relatively common debilitating condition with both functional and anatomic sequelae. Throughout the past century, more than 100 different surgical procedures have been described and there is no consensus regarding the best technique. Recurrence rates for complete rectal prolapse have been reported as high as 20-50 percent. The ideal surgical approach to treat these recurrences remains an unresolved problem.

Ventral rectopexy (VR) is the current gold standard for treatment of rectal prolapse in most countries outside of North America. Modern, minimally-invasive approaches to VR includes laparoscopic Ventral Rectopexy (LVR). VR 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 multicompartment pelvic floor defects.

VR is technically demanding and requires a complete ventral dissection of the rectovaginal septum (rectovesical in men) down to the pelvic floor and suturing skills within a confined space that further maximizes the difficulty. Formal training programs in VR can help to avoid complications and improve outcomes.

Gap Analysis:

What Is:
Laparoscopic/Robotic 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, enterocoele, rectocele, fecal incontinence, and obstructed defecation VR is considered the gold standard for rectal prolapse repair in Europe and Australia. There are few training opportunities in the USA for LVR or RVR.

What Should Be:
Surgeons should have the opportunity to learn the techniques of LVR and RVR through didactic video-based learning and simulation. Surgeons should also be familiar other prolapse operations for patients who are not optimal candidates for VR.

Objectives:
At the conclusion of this session, participants should be able to:
1. Explain ventral rectopexy, indications and long-term outcomes.
2. Describe surgical steps for Ventral Rectopexy using a minimally-invasive approach such as laparoscopy or robotics.
3. Distinguish how to avoid and how deal with surgical complication after prolapse surgery.

Co-Directors:
Brooke Gurland, MD, Stanford, CA
Andrew Stevenson, MD, Brisbane, Australia
### Saturday, June 1

**Advanced Methods for the Management of Rectal Prolapse (continued)**

**Didactic Session only - CME Credit Hours: 4.5**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>CME Credit Hours</th>
<th>Speaker and Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30 am</td>
<td>Introduction</td>
<td>10.00 am</td>
<td>Brooke Gurland, MD, Stanford, CA</td>
</tr>
<tr>
<td>7:40 am</td>
<td>Principles and Evolution of Procedures for Rectal Prolapse</td>
<td>10.10 am</td>
<td>Anders Mellgren, MD, PhD, Chicago, IL</td>
</tr>
<tr>
<td>7:55 am</td>
<td>VR - Evolution of Technique and Long-Term Outcomes</td>
<td>10.25 am</td>
<td>Oliver Jones, MD, Southhampton Hants, United Kingdom</td>
</tr>
<tr>
<td>8:10 am</td>
<td>Testing? What Helps Me Prior to Prolapse/VR Repair?</td>
<td>10.55 am</td>
<td>Amy Thorsen, MD, Minneapolis, MN</td>
</tr>
<tr>
<td>8:25 am</td>
<td>Synthetic vs. Biologic - The “Mesh” Debate</td>
<td>11.05 am</td>
<td>James Ogilvie, Jr., MD, Grand Rapids, MI</td>
</tr>
<tr>
<td>8:40 am</td>
<td>Patient Selection: Should Everyone Get a VR?</td>
<td>11.15 am</td>
<td>Liliana Bordeianou, MD, Boston, MA</td>
</tr>
<tr>
<td>8:55 am</td>
<td>Robotic VR Surgery Video: How I Do It</td>
<td>11.45 am</td>
<td>Joseph Carmichael, MD, Orange, CA</td>
</tr>
<tr>
<td>9:10 am</td>
<td>LVR Surgery Video: How I Do It</td>
<td>Noon</td>
<td>Pierpaolo Sileri, MD, PhD, Rome, Italy</td>
</tr>
<tr>
<td>9:30 am</td>
<td>Questions and Answers</td>
<td>Noon</td>
<td></td>
</tr>
<tr>
<td>10:00 am</td>
<td>Is VR the Panacea for Obstructed Defecation Syndrome</td>
<td></td>
<td>Oliver Jones, MD, Southhampton Hants, United Kingdom</td>
</tr>
<tr>
<td>10:25 am</td>
<td>Dealing with Recurrent Rectal Prolapse</td>
<td></td>
<td>Brooke Gurland, MD, Stanford, CA</td>
</tr>
<tr>
<td>10:45 am</td>
<td>Management and Prevention of VR Complications</td>
<td></td>
<td>Pierpaolo Sileri, MD, PhD, Rome, Italy</td>
</tr>
<tr>
<td>10:55 am</td>
<td>VR - Evolution of Technique and Long Term Outcomes</td>
<td></td>
<td>Oliver Jones, MD, Southhampton Hants, United Kingdom</td>
</tr>
<tr>
<td>11:05 am</td>
<td>Top Ten Tips for VR - Biologics</td>
<td></td>
<td>Andrew Stevenson, MD, Brisbane, Australia</td>
</tr>
<tr>
<td>11:15 am</td>
<td>Top Ten Tips to Avoid Complications</td>
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<td>Ian Paquette, MD, Cincinnati, OH</td>
</tr>
<tr>
<td>11:45 am</td>
<td>Panel Discussion and Case Presentations</td>
<td></td>
<td>James Ogilvie, Jr., MD, Grand Rapids, MI</td>
</tr>
<tr>
<td>Noon</td>
<td>Questions and Answers</td>
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<tr>
<td>Noon</td>
<td>Adjourn</td>
<td></td>
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<tr>
<td>Noon</td>
<td>Lunch</td>
<td></td>
<td>(Provided for Hands-on Lab Participants)</td>
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</tbody>
</table>

### Hands-on Workshop

**Hands-on session only**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>CME Credit Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00 pm</td>
<td>Simulation Demonstration/Laparoscopic and Robotic to Describe Procedure Steps with Models with Step-by-Step Live Demonstration by the Experts</td>
<td>3.5</td>
</tr>
<tr>
<td>1:30 pm</td>
<td>Hands-on Participation Begins (Robotics and Laparoscopic)</td>
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</tbody>
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**Hands-on Session only**

- Simulation Demonstration/Laparoscopic and Robotic to Describe Procedure Steps with Models with Step-by-Step Live Demonstration by the Experts
- All Faculty

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**Hands-on Participation Begins**

- (Robotics and Laparoscopic)
Saturday, June 1
Symposium and Workshop
CME Credit Hours: Up to 8 Total

**Transanal Total Mesorectal Excision (taTME)**

7:30 am – 4:30 pm

*Registration and Pre-registration Survey Required (Includes Didactic and Hands-on Workshop) • Fee: $1,175
Limit: 16 participants • Lunch Included*

Didactic Session Only: $25 (7:30 am – Noon)

The standard of care in rectal cancer treatment requires multidisciplinary team assessment and strategies with Total Mesorectal Excision (TME) at the cornerstone of curative resection. Despite the demonstrated short-term clinical benefits over traditional open TME, minimally invasive abdominal approaches have failed to overcome the formidable challenge of accessing the deep pelvis to achieve distal rectal transection with negative margins and an intact mesorectum.

Transanal Total Mesorectal Excision (taTME) has recently emerged as a promising novel minimally invasive alternative in the surgical treatment of rectal cancer. This technique was developed to facilitate completion of TME for low and mid-rectal tumors by using transanal rather than transabdominal access. Through transanal endoscopic platforms, rectal and mesorectal dissection, this can be completed endoluminally with early identification of the distal transection margin and direct in-line exposure of perirectal and mesorectal planes.

During the didactic session, the most recent outcomes from large studies and from registries will be reviewed, as well as current controversies and recent trends in transanal endoscopic proctectomy. Current consensus on best strategies for implementation and training will be reviewed as well as emerging data regarding the learning curve. Finally, tips and tricks with video demonstrations will delineate the recommended operative set-up, anatomic landmarks and key steps in transanal dissection. Pitfalls during transanal dissection and anastomotic reconstruction will be reviewed with tips and tricks on how to overcome intraoperative difficulties and complications.

The hands-on course is intended to train high volume rectal cancer surgeons with expertise in minimally invasive TME and transanal endoscopic surgery. Each surgical team will perform taTME with laparoscopic assistance with a proctor.

**Gap Analysis:**

*What Is:* A lack of clinical experience with and training in transanal TME operation persists, particularly in the United States.

*What Should Be:* Opportunities for surgeons to experience and training in Transanal TME operations.

**Objectives:** At the conclusion of this session, participants should be able to:

1. Explain the contraindications and best practices for taTME based on the best published evidence.
2. Recognize the recommended prerequisite skills and training guidelines for safe adoption and implementation of taTME.
3. Apply recommended taTME dissection techniques, understand differences in anatomic landmarks between low and mid-rectal dissection, and be prepared to manage procedural complications.
4. Recognize the limitations of available comparative data and the goals and endpoints of ongoing clinical trials.

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

Pre-registration Survey (Required)

While the ASCRS taTME didactic session (7:30 am – noon) is open to all registrants for a nominal fee, the hands-on cadaver lab (Noon – 4:30 pm) 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. PLEASE NOTE: You must be registered for the Annual Meeting before your pre-survey will be reviewed. If you are not registered, your survey will not be reviewed.
Saturday, June 1

Transanal Total Mesorectal Excision (taTME) (continued)

Didactic session only - CME Credit Hours: 4.5

7:30 am
Introduction
Justin Maykel, MD, Worcester, MA
Patricia Sylla, MD, New York, NY

7:45 am
taTME – From Novice to Experts: Tips and Tricks and Video Review
Setting-up Your Team for Success: Do’s and Don’ts in taTME In taTME (set-up, patient selection, common mistakes)
Dana Sands, MD, Weston, FL

7:50 am
From Mid-rectal to Low Rectal Tumors: Finding Landmarks and The Correct Plane
Masaaki Ito, MD, PhD, Kashiwa, Japan

9:05 am
The Anastomosis – The (Updated) Truth About Leaks and Mastering Anastomotic Techniques
Mark Whiteford, MD, Portland, OR

9:20 am
Intraoperative Mishaps and Get Out Trouble Strategies
Matthew Albert, MD, Altamonte Springs, FL

9:35 am
Questions and Answers

9:45 am
taTME – Updates

9:45 am
taTME International Registry-Updates on Global Outcomes, Complications and Functional Data
Marta Penna, London, United Kingdom

10:00 am
taTME Training and Learning Curve: Consensus and Controversies
Danilo Miskovic, MD, PhD, London, United Kingdom

10:15 am
taTME Trial Updates- What Endpoints Matter?
Karen Zaghiyan, MD, Los Angeles, CA

10:20 am
Questions and Answers

10:45 am
taTME – Recent Trends, Techniques, and Controversies

10:45 am
taTME for IBD-Rationale and Outcomes
Sherief Shawki, MD, Cleveland, OH

11:00 am
New Trends in Transanal Reoperative Proctectomy
Willem Bemelman, MD, PhD, Vinkeveen, The Netherlands

11:15 am
Robotic taTME-Where Do We Stand?
Simon Ng, MD, Hong Kong, Hong Kong

11:30 am
Lap, Robotic or Transanal TME-Which Way to Go and For Which Patient?
Eric Rullier, MD, Bordeaux, France

11:45 am
Questions and Answers

Noon
Adjourn

Noon
Lunch
(Provided for Hands-on Lab Participants)

Hands-on Session

1:00 – 4:30 pm
Hands-on session only
CME Credit Hours: 3.5

1:00 pm
Instructions to the Lab
Justin Maykel, MD, Worcester, MA

taTME Stations:
Matthew Albert, MD, Altamonte Springs, FL; Willem Bemelman, MD, PhD, Vinkeveen, The Netherlands; Marta Penna, London, United Kingdom; Mark Whiteford, MD, Portland, OR; Masaaki Ito, MD, PhD, Kashiwa, Japan; Simon Ng, MD, Hong Kong, Hong Kong; Eric Rullier, MD, Bordeaux, France; Dana Sands, MD, Weston, FL; Sherief Shawki, MD, Cleveland, OH; Karen Zaghiyan, MD, Los Angeles, CA

Pursestring Stations: Rotating Faculty

4:15 pm
Debrief

4:30 pm
Adjourn
Most physicians entering practice following completion of their clinical training are poorly prepared for the non-clinical aspects of the practice of medicine. Whether joining a small single specialty practice or becoming part of a large healthcare system, physicians have had little formal education and training in what is broadly described as the “business of medicine.”

In recent years, the American Society of Colon & Rectal Surgery has attempted to educate our young surgeons in at least the basics of starting a practice and understanding the financial underpinnings of practice management. It has become clear through these sporadic symposia that there is a thirst for more in-depth information on the subjects being covered. Interestingly, it isn’t just those that are early in practice, but members of the Society across the generations that are requesting a more formal approach to the broad topic of practice management. As our membership struggles to maintain healthy and successful practices in spite of tremendous disruptive forces of the healthcare system, a practical, high-yield symposium has been designed, targeting optimization of practice management and intending to cycle though a series of topics every three years.

The intent of a multiyear practice management course is to meet the needs of our membership in teaching the basic principles of the business of clinical practice development and maintenance, while also providing a “toolbox” for dealing with change management, organizational relationships, communication skills and strategic thinking. While primarily focused on colorectal surgeons in the first decade of their career, the topics presented will be relevant to the entire membership, in particular those that are contemplating transitions in their careers. The expectation is that at the completion of the course cycle, the colorectal surgeon will be well equipped to participate in the day-to-day management of their practice, be able to critically assess the opportunities for improvement in their practice and possess the tools necessary to negotiate contracts as well as understand the forces of change that surround us on a daily basis.

Gap Analysis:

**What Is:** Upon completion of training, many physicians lack the knowledge and skills necessary to understand the “business of medicine.” Both recent fellowship graduates and those who are seeking a change in career setting/location may lack the understanding and training to determine the type of practice that is best suited to them. Additionally, the disruptive forces affecting the current climate of medical practice are continuously shifting, further adding to the frustration of managing a successful practice.

**What Should Be:** Physicians should have a better understanding of the “business of medicine,” particularly as it applies to successful practice management. Physicians should be better prepared to choose a practice best suited to their needs and understand specifics of practice management, such as financial and legal considerations, practice organization and culture, contracting, and practice growth and development.

**Objectives:** At the conclusion of this symposium, participants should be able to:
1. Describe the various clinical practice structures and the organizational structure differences.
2. Describe the key elements in an employment contract, including the legal aspects of fair market value, termination and non-compete provisions, and incentive models.
3. Describe the common negotiation techniques, focusing on the concept of “getting to yes.”
4. Recognize the basic medical practice finances, including profit & loss statements, revenue cycle metrics, business plan development and practice staffing models.
5. Describe practice growth techniques, various marketing tools and understand decision making regarding scope of practice decisions and practice expansion considerations.

**Co-Directors:** Jeffrey Cohen, MD, Hartford, CT
                Jennifer Rea, MD, Lexington, KY
Saturday, June 1

**Practice Management** (continued)

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<tr>
<th>Time</th>
<th>Session</th>
<th>Location</th>
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<tbody>
<tr>
<td>8:00 am</td>
<td><strong>Introduction</strong></td>
<td>Jeffrey Cohen, MD, Hartford, CT&lt;br&gt;Jennifer Rea, MD, Lexington, KY</td>
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<tr>
<td>8:05 am</td>
<td><strong>Practice Organization &amp; Culture</strong></td>
<td>Jeffrey Cohen, MD, Hartford, CT&lt;br&gt;Daniel Herzig, MD, Portland, OR</td>
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<tr>
<td>8:45 am</td>
<td><strong>Contracting – Financial Structure</strong></td>
<td>Jason Mizell, MD, Little Rock, AK</td>
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<tr>
<td>9:05 am</td>
<td><strong>Contracting – Legal Considerations</strong></td>
<td>David Mack, JD, MPH, Hartford, CT</td>
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<td>9:25 am</td>
<td><strong>Break</strong></td>
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<tr>
<td>9:40 am</td>
<td><strong>Practice Management – Understanding Practice Finances</strong></td>
<td>Charles Papp, MD, Lexington, KY</td>
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Saturday, June 1

Workshop
CME Credit Hours: up to 5

**Young Surgeons Mock Orals and More**

Track One: 12:30 – 5:00 pm
Track Two: 12:30 – 5:30 pm

Registration is Required • Candidate Member Fee: $50 • Member Fee: $160 • Non-Member Fee: $215 • Limit: 90 participants

To achieve certification by The American Board of Colon and Rectal Surgery (ABCRS), 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 candidates’ 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. Additionally, despite years of intensive surgical training, most fellows and faculty receive very little instruction on how to navigate through the obstacles faced while starting practice. The workshop aims to prepare candidates for these examinations and address critical needs of current fellows and recent graduates.

Each session will consist of an introduction and overview of the structure of the mock oral examination, followed by multiple small group practice mock oral exam scenarios. The oral examinations are administered by different examiners, with critique of the examinees’ performances. The format replicates the actual ABCRS Oral Examination. Additionally, participants will observe their colleagues answer and receive critique on scenarios. Scenarios covered will be those that are heavily tested on 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 of these various disease processes.

In addition, a mini-symposium with topics related to board review, transition to practice, academic success, and transition of careers. This mini-symposium will be tailored to the participating tracks, i.e. current ACGME fellows or those physicians in practice applying for board certification.

**Gap Analysis:**

**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. In addition, early career advice and support is key to improving success of young colorectal surgeons.

**Objectives:** At the conclusion of this session, participants should be able to:

1. Describe the structure of the oral examination.
2. Demonstrate the ability to answering colorectal oral board style questions in a simulated, high stakes format.
3. Demonstrate knowledge among colleagues and learn from other examinees.
4. Explain career level relevant topics to his or her own career.

**Co-Directors:** Jennifer Davids, MD, Worcester, MA
Jason Mizell, MD, Little Rock, AR
Saturday, June 1

Young Surgeons Mock Orals and More (continued)

Track 1
(Residents/Fellows-in-Training):

12:30 pm  Mock Oral Overview
            Jason Mizell, MD, Little Rock, AR

1:00 pm  Small Group Mock Oral Exam
            Benjamin Abbadessa, MD, San Diego, CA
            Jennifer Agnew, MD, New York, NY
            Joselin Anandam, MD, Dallas, TX
            Ellen Bailey, MD, Columbus, OH
            Jeffrey Barton, MD, New Orleans, LA
            Anuradha Bhama, MD, Cleveland, OH
            Michelle Cowan, MD, Aurora, CO
            Ray Daugherty, Jr., MD, Baton Rouge, LA
            Marjun Philip Duldulao, MD, Los Angeles, CA
            Samuel Eisenstein, MD, La Jolla, CA
            Leandro Feo, MD, Manchester, NH
            John Gahagan, MD, New York, NY
            Lindsey Goldstein, MD, Gainesville, FL
            Leander Grimm, Jr., MD, Mobile, AL
            Michael Guzman, MD, Indianapolis, IN
            Mehran Jafari, MD, Irvine, CA
            Deborah Keller, MD, New York, NY
            David Kleiman, MD, Burlington, MA
            Ziad Kronfol, MD, El Paso, TX
            Nelya Melnitchouk, MD, Boston, MA
            Conan Mustain, MD, Little Rock, AR
            Carrie Peterson, MD, Milwaukee, WI
            Tal Raphaeli, MD, Humble, TX
            Timothy Ridolfi, MD, Milwaukee, WI
            Joselin Anandam, MD, Dallas, TX
            Steven Scarcliff, MD, Birmingham, AL
            Karen Sherman, MD, Raleigh, NC
            Gabriela Vargas, MD, Salt Lake City, UT

3:00 pm  Break

3:15 pm  Mini-symposium for Young Fellows
            How to Prepare for the Written Exam
            Russell Farmer, MD, Louisville, KY
            Finances 101
            Jason Mizell, MD, Little Rock, AR
            Things I Wish I Knew in My First Year of Practice
            Lisa Cannon, MD, Chicago, IL
            What Can ASCRS Do for You and
            What Can You Do for ASCRS?
            Jennifer Davids, MD, Worcester, MA

Panel Discussion

5:00 pm  Adjourn

Track 2
(Physicians in Practice Applying for Board Certification):

12:30 pm  Mock Oral Overview
            Jason Mizell, MD, Little Rock, AR

1:00 pm  Mini-symposium for Physicians
            Must Know Topics for the Oral Examination
            Carrie Peterson, MD, Milwaukee, WI
            Avoiding Pitfalls of the Mock Oral Exam
            Sean Langenfeld, MD, Omaha, NE
            Building Your Practice and Defining Your Niche
            Timothy Ridolfi, MD, Milwaukee, WI
            How to Make the Most out of Your First
            5 Years of Practice
            Joselin Anandam, MD, Dallas, TX
            Teaching and Mentoring While You are
            Just Getting Your Own Feet Wet
            Muneera Kapadia, MD, Iowa City, IA

Panel Discussion

3:00 pm  Break

3:15 pm  Small Group Mock Oral Exam
            Benjamin Abbadessa, MD, San Diego, CA
            Jennifer Agnew, MD, New York, NY
            Joselin Anandam, MD, Dallas, TX
            Ellen Bailey, MD, Columbus, OH
            Jeffrey Barton, MD, New Orleans, LA
            Anuradha Bhama, MD, Cleveland, OH
            Michelle Cowan, MD, Aurora, CO
            Ray Daugherty, Jr., MD, Baton Rouge, LA
            Marjun Philip Duldulao, MD, Los Angeles, CA
            Samuel Eisenstein, MD, La Jolla, CA
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            Carrie Peterson, MD, Milwaukee, WI
            Tal Raphaeli, MD, Humble, TX
            Timothy Ridolfi, MD, Milwaukee, WI
            Steven Scarcliff, MD, Birmingham, AL
            Karen Sherman, MD, Raleigh, NC
            Gabriela Vargas, MD, Salt Lake City, UT

5:30 pm  Adjourn
Saturday, June 1

Symposium

CME Credit Hours: 4

Advanced Practice Provider

1:00 – 5:00 pm

No charge

Advanced practice providers (APP’s) and other allied health members have become a crucial part of health care teams and are providing front-line care to colorectal surgery patients. The annual meeting of the American Society of Colon and Rectal Surgeons (ASCRS) provides a time for all members of the surgical team to come together for an integrative presentation of different topics relevant to their daily practice. This symposium will allow protected time for APP’s to come together with their surgeon partners and other allied health members to further their knowledge on timely topics, as colorectal surgical teams become more diverse and utilize APP’s in increasingly complex roles.

Gap Analysis:

**What is:** As the role of APP’s and other allied health professionals expands in the field of colorectal surgery, there may be a lack of awareness of the collaborative relationships that exist between APP’s and physicians. The role that each maintains in the care of increasingly complex colorectal surgery patients continues to be redefined, and issues of common meaning between APP’s and physicians continue to expand. As part of the surgical care team, APPs and other allied health members require specific education and insight to improve the care that they provide on a daily basis. The professional growth of colorectal APP’s currently is not supported to the extent that it should be by the ASCRS, and means to better foster collaborative relationships between APP’s and physicians should be better understood.

**What should be:** Physicians should have a better understanding of how to best integrate APP’s into everyday practice in a collaborative manner that benefits all parties, including the patient. The furthering of APP’s and physicians’ knowledge as it applies to their complimentary roles in patient care should be fostered by time at the ASCRS annual scientific meeting. As an integral part of the surgical care team, APP’s and other allied health members require specific education and insight to improve the care they provide on a daily basis. The ASCRS should provide opportunities to further the development and broad reach of the APP role in the practice of colorectal surgery. Professional growth of APP’s should be promoted, and members of the ASCRS should better understand how to foster the professional growth and education of APP’s.

**Objectives:** At the conclusion of this session, participants should be able to:

1. Explain the valuable roles of APP’s in colon and rectal surgery inpatient and outpatient practices.
2. Recognize the diversity of roles APP’s can maintain in colon and rectal surgery clinical practice, academia, and administration.
3. Identify successes and struggles of non-physician members of the colon and rectal surgery team.
4. Identify resources for integration and education of APP’s as they join colon and rectal surgery practices nationally.
5. Promote a national network of colon and rectal surgery APP’s with a common mission, goals, and connection to ASCRS.

**Co-Directors:** Bethany Bandi, PA-C, Cleveland, OH
Kelly Tyler, MD, Springfield, MA
**Saturday, June 1**

**Advanced Practice Provider (continued)**

**1:00 - 5:00 pm**

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<tr>
<th>Time</th>
<th>Session Title</th>
<th>Speaker(s)</th>
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<tr>
<td>1:00</td>
<td>Welcome and Introduction</td>
<td>Bethany Bandi, PA-C, Cleveland, OH</td>
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<td>Kelly Tyler, MD, Springfield, MA</td>
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<td>1:10</td>
<td>The MD/APP Relationship in Colorectal Practice: The Basics of Making it Work</td>
<td>Brittany Leano, PA-C, Chicago, IL</td>
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<td>Michael McGee, MD, Chicago, IL</td>
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<td>1:30</td>
<td>Our Model of Clinical Coordination Between APP's and MD's</td>
<td>Janet Mcdade, NP, Worcester, MA</td>
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<td>Karim Alavi, MD, Worcester, MA</td>
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<td>1:50</td>
<td>Through the Years: The Maturing Joint Practice</td>
<td>Donya Woon, CNP, Cleveland, OH</td>
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<td>Sharon Stein, MD, Cleveland, OH</td>
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<td>2:10</td>
<td>Academia and the APP: Joint Scholarly Practice Employing Evidence-Based Care</td>
<td>Lieba Savitt, NP, Boston, MA</td>
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<td>and Recovery</td>
<td>Hiroko Kunitake, MD, Boston, MA</td>
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<td>2:30</td>
<td>What is the Financial Benefit and Legalese of Having an APP? Successful</td>
<td>Priscilla Marsicovetere, JD, PA-C,</td>
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<td>Transition of an APP into Colorectal Practice</td>
<td>Lebanon, NH</td>
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<td>S. Joga Ivatury, MD, MHA, Lebanon, NH</td>
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<td>Break</td>
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<td>3:00</td>
<td>Providing Quality Care in Transition from the Inpatient to Outpatient Setting</td>
<td>Marcia A. Dinsmore, FNP, Rochester, NY</td>
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<td>Jenny Speranza, MD, Rochester, NY</td>
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<td>3:20</td>
<td>Improving Patient Experience</td>
<td>Bethany Bandi, PA-C, Cleveland, OH</td>
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<td>Sherief Shawki, MD, Cleveland, OH</td>
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<td>3:40</td>
<td>Day to Day: Case Scenarios in Joint Patient Care re</td>
<td>Jennifer Nalepinski, DNP, FNP-BC,</td>
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<td>Springfield, MA</td>
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<td>3:50</td>
<td>Expanding the APP Role Beyond Clinical Care</td>
<td>Jenna Jeganathan, PA-C, Cleveland, OH</td>
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<td>4:00</td>
<td>Panel Discussion/Closing Remarks</td>
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<td>Adjourn</td>
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<td>5:00</td>
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**The U.S. - China Colorectal Surgery Symposium**

5:15 - 6:30 pm

**No charge**

The ASCRS has had long-standing, mutually beneficial relationships with a multitude of colon and rectal surgery societies in Europe and Australasia through the Tripartite partnership. However, similar relationships with our surgical colleagues in China have been lacking. As the global reach of our specialty expands, the need to partner with our Chinese colleagues for the purpose of achieving the common goal of furthering the specialty of colon and rectal surgery becomes more evident.

**Co-Directors:**

Chuan-Gang Fu, MD, PhD, Shanghai, Peoples Republic of China
David A. Margolin, MD, New Orleans, LA
Guy R. Orangio, MD, New Orleans, LA
Hongwei Yao, MD, Beijing, Peoples Republic of China
There are multiple areas of examination in the realm of colon and rectal surgery that require written questions to assess knowledge. These include the qualifying written exam, the certifying oral exam, continuous certification questions, CARSITE, CARSEP, and CREST. 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.

Gap Analysis

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.

Objectives: At the end of this session, participants should be able to:

1. Identify fundamental problems with construction of questions developed for testing purposes.
2. Explain the sequential thinking process used to write an acceptable question and understand how a key concept drives question development.
3. Demonstrate how to write a stem for a question utilizing the key concept as a foundation.
4. Develop a second order question that combines diagnosis and management and formats the answers in an acceptable form.
5. Recognize the key differences between a written question and question sequence developed for oral examination formats.

Co-Directors: Glenn Ault, MD, MEd, Los Angeles, CA
Kirsten Wilkins, MD, Edison, NJ

1:00 pm
Introduction
Glenn Ault, MD, MEd, Los Angeles, CA
Kirsten Wilkins, MD, Edison, NJ

1:05 pm
Key Concept – The True Foundation of a Good Question
Charles Friel, MD, Charlottesville, VA

1:25 pm
The Stem – The Makings of a Good Question
Shane McNevin, MD, Spokane, WA

1:45 pm
The Answers – They Can Ruin a Great Stem
Eric Johnson, MD, Cleveland, OH

2:05 pm
Finalizing Questions – Rescue and Salvage
Glenn Ault, MD, MEd, Los Angeles, CA

2:20 pm
Critiques – Painful but Very Important
Kirsten Wilkins, MD, Edison, NJ

2:40 pm
Break

2:50 pm
The Art of Writing an Oral Examination Question
Judith Trudel, MD, Minneapolis, MN

3:10 pm
Let’s Write Questions
All Faculty

3:40 pm
Question Review
All Faculty

4:00 pm
Adjourn

Saturday, June 1

Workshop
CME Credit Hours: 3

Question Writing: Do You Know How to Write the Perfect Exam Question?

1:00 – 4:00 pm
Registration Required · Limit: 70 participants · No Charge
Sunday, June 2
7:00 - 11:00 am

Please join us for the 3rd Pelvic Floor Disorders Consortium Meeting in Cleveland.

The goal of this consortium meeting is to arrive at a consensus on the strengths and weaknesses of the three most commonly used radiological modalities used to characterize the anatomy of patients with pelvic organ prolapse (POP): echo-defecography, MRI defecography and fluoroscopic defecography. Experts from radiology, colorectal surgery, urogynecology, gastroenterology, urology and physiotherapy will converge together in a collaboration to develop consensus radiological interpretation templates. These templates could then be utilized consistently across institutions and subspecialties to facilitate the development of a “common language” and promote consistently high quality care for pelvic floor patients.

Please join us to provide your input on these templates at the in person meeting. Agenda will also include planning of future research, joint databases and education events.

RSVP is required, please RSVP by clicking here.

Sunday, June 2
Symposium and Workshop
CME Credit Hours: Up to 3.75 Total

Advanced Endoscopy
7:30 - 11:30 am
Registration Required · Member Fee: $670 · Non-Member Fee $800 · Limit: 24 participants

Didactic Session Only: $25 (7:30 – 9:15 am)

There has been significant expansion of new techniques and instrumentation for advanced endoscopic procedures. These techniques broaden our ability to perform more complex procedures in a much less invasive way. 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. Extended submucosal dissection and use of both CO2 and laparoscopic assistance have allowed surgeons to resect more complex colonic lesions without major surgery. Additionally new cutting edge endoluminal platforms have been recently developed. These new technologies can aid surgeons to remove challenging lesions intraluminally and avoid unnecessary colectomies.

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, endoscopic clipping, and endoscopic suturing. This important learning session will provide the basis for the meaningful implementation of these newer endoluminal techniques and improve their patients’ colorectal care.

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

1. Explain methods to predict neoplastic lesions of the colon and select the best endoscopic resection technique.
2. Become familiar with the available enhanced endoscopic visualization techniques.
3. Describe the indications and uses for endoscopic submucosal resection for colorectal neoplasia and the associated learning curve.
4. Explain available techniques for endoscopic closure of the bowel wall, stents and hemostatic agents.
5. Describe the new endoluminal advanced platforms.

Co-Directors: I. Emre Gorgun, MD, Cleveland, OH
Sang Lee, MD, Los Angeles, CA
Sunday, June 2

Advanced Endoscopy (continued)

Didactic session only – CME Credit Hours: 1.75 Didactic Session

7:30 – 9:15 am

7:30 am  Introduction
I. Emre Gorgun, MD, Cleveland, OH
Sang Lee, MD, Los Angeles, CA

7:40 am  How to Classify and Categorize Premalignant and Malignant Polyps
Matthew Zelhart, MD, New Orleans, LA

7:55 am  Endoluminal Resection, Suturing, Clips and New Techniques for Hemostasis
Peter Marcello, MD, Boston, MA

8:10 am  ELSI (EndoLuminal Surgical Interventions): ESD and Beyond
I. Emre Gorgun, MD, Cleveland, OH

8:25 am  How to Incorporate Advanced Endoscopic Procedures into Your Practice?
Marco Tomassi, MD, San Diego, CA

8:40 am  How to Decide Which Advanced Endoscopic Procedures to Perform?
Sang Lee, MD, Los Angeles, CA

9:15 am  Adjourn

Advanced Endoscopy

9:30 – 11:30 am  Hands-on session only – CME Credit Hours: 2

Faculty: Philip Duldulao, MD, Los Angeles, CA;
Todd Francone, MD, Boston, MA; I. Emre Gorgun, MD, Cleveland, OH; Jennifer Hrabe, MD, Iowa City, IA;
Sang Lee, MD, Los Angeles, CA; David Liska, MD, Cleveland, OH; Peter Marcello, MD, Burlington, MA;
Joongho Shin, MD, Los Angeles, CA; Toyooki Sonoda, MD, New York, NY; Richard Whelan, MD, New York, NY;
Christine Hsieh, MD, Los Angeles, CA; Matthew Zelhart, MD, New Orleans, LA; Marco Tomossi, MD, San Diego, CA
Sunday, June 2

Core Subject Update

CME Credit Hours: 2

7:30 – 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.

Gap Analysis

What Is: The evaluation and management of many colorectal conditions is rapidly evolving due to advances in technology and changing treatment paradigms making it challenging for practicing surgeons to remain up to date with the current literature.

What Should Be: Surgeons caring for patients with colorectal diseases should maintain a comprehensive and up to date understanding of these conditions to ensure that quality care is provided.

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

1. Review the anatomy and physiology of the colon, rectum, and anus and discuss common complications.
2. Describe the evaluation, management options, and complications associated with sexually transmitted diseases.
3. Maintain an understanding of the pathophysiology and treatment options for constipation and to offer patients a range of nonsurgical and surgical treatment options;
4. Review the literature for the current medical and surgical treatment of Crohn’s disease.
5. Explore advances in the management of polyps and new endoscopic approaches and procedures.
6. Recognize the surgical and non-surgical treatment strategies for advanced stage colon and rectal cancer.

Director: Mukta Krane, MD, Seattle, WA
The sheer volume of primary literature has increased the importance as there is wide variation in the quality of RCTs. Whether bias is responsible for a significant portion of the observed difference must be carefully and critically examined. Although pooling the results of multiple trials increases precision by narrowing confidence intervals, a secondary analysis of poorly designed RCTs may result in a misleading conclusion. Thus, the reviewer must be familiar with the common limitations of secondary analysis and conclusions that can be drawn.

This symposium is aimed at two groups: present and prospective reviewers for Diseases of the Colon & Rectum and the practicing surgeon who wants to increase his/her critical appraisal skills. It is designed to be hands on. Through an interactive symposium we will explore the most common study methodologies, identify appropriate questions for each, identify the advantages and disadvantages and the common mistakes in study conduct, reporting and conclusions. We will also explore essential resources for additional learning in this area.

Previously published representative papers from the four common methodologies will be identified in advance from Diseases of the Colon & Rectum. At the symposium, each participant will be assigned to a small group lead by an editorial board member from DC&R. Following an introduction of the manuscript by the faculty, the editorial board members will facilitate a working discussion and critique of each manuscript within the small groups. Board members will have access to the original editorial comments and the changes that were requested by the editors prior to publication to enhance the discussion. At the end of the discussion period, the faculty will summarize for all participants the most significant concerns from the editorial review, the changes that were made to the manuscript prior to publication and any unresolved issues that were recognized but accepted as they were not felt to have a significantly effect on outcomes.

**Gap Analysis**

**What Is:** Evidence is presented in many forms using many methodologies. Familiarity with these methodologies is necessary to evaluate the continued stream of manuscripts with respect to study design, conduct, results and conclusions. The knowledge and ability to analyze these methodologies may not be common to all surgeons in our group.

**What Should Be:** As colorectal surgeons we should be familiar with the literature not only with respect to content, but with measures of quality. The ability to recognize a quality paper is an essential skill for the journal reviewer and the practicing surgeon alike.

The RCT design is least likely to be affected by bias and is the only methodology that can identify cause and effect. Sound knowledge of study-design is needed to evaluate the many variations in structure and primary outcomes (i.e. inferiority, non-inferiority). While no study is completely void of bias it is important to determine whether bias is responsible for a significant portion of the observed effect as there is wide variation in the quality of RCTs.

The critical review process is central to the continued advancement of surgical knowledge. Continuous critical review of new manuscripts ensures that the best available evidence is disseminated within the surgical community. The volume of new material, the complexity of trial design and the increasingly nuanced conclusions require detailed and systematic critical review. While the practicing surgeon relies on the editorial process to a great extent to separate the “wheat from the chaff”, he/she also requires solid critical appraisal skills to ensure that evidence from published studies is relevant and appropriate for individual patient care. While the editor asks, “Does this manuscript add significant knowledge to the literature?”, the surgeon asks, “Does this manuscript add significant knowledge to change my practice?”

There are three generic types of surgical trials: exploratory trials to assess utility, explanatory trials to assess efficacy and pragmatic trials to assess effectiveness. Methodologies include observational studies (cohort or case control), administrative database studies, randomized controlled trials (RCT), structured reviews and meta-analyses. Each methodology has its purpose and place in the investigation of surgical care and its own strengths and weaknesses.

Traditionally, observational studies are viewed as the lowest form of evidence. Yet there are many instances where an observational study is the best and perhaps the only form of evidence that is practical and available especially if a disease entity or outcome is rare. Observational studies may provide relatively strong evidence when there is a large treatment effect, or when confounding factors would bias the results in opposition to the observed effect. They may be subject to significant bias thus the methodology and results must be carefully and critically examined.

Large non-randomized observational studies based on administrative databases have become very popular due to electronic data collection, which have the advantage of reporting on large populations and identifying trends in treatment, outcomes and rare complications. However, data collection may be incomplete or inconsistent and lack the granularity to draw conclusions as to how or why.

The RCT design is least likely to be affected by bias and is the only methodology that can identify cause and effect. Sound knowledge of study-design is needed to evaluate the many variations in structure and primary outcomes (i.e. inferiority, non-inferiority). While no study is completely void of bias it is important to determine whether bias is responsible for a significant portion of the observed effect as there is wide variation in the quality of RCTs.

Sunday, June 2

**Symposium**

**CME Credit Hours:** 1.5

**Critical Review of Scientific Manuscripts**

8:00 – 9:30 am

**Registration is Required. Limit: 100 participants - No charge**

The peer review process is central to the continued advancement of surgical knowledge. Continuous critical review of new manuscripts ensures that the best available evidence is disseminated within the surgical community. The volume of new material, the complexity of trial design and the increasingly nuanced conclusions require detailed and systematic critical review. While the practicing surgeon relies on the editorial process to a great extent to separate the “wheat from the chaff”, he/she also requires solid critical appraisal skills to ensure that evidence from published studies is relevant and appropriate for individual patient care. While the editor asks, “Does this manuscript add significant knowledge to the literature?”, the surgeon asks, “Does this manuscript add significant knowledge to change my practice?”

There are three generic types of surgical trials: exploratory trials to assess utility, explanatory trials to assess efficacy and pragmatic trials to assess effectiveness. Methodologies include observational studies (cohort or case control), administrative database studies, randomized controlled trials (RCT), structured reviews and meta-analyses. Each methodology has its purpose and place in the investigation of surgical care and its own strengths and weaknesses.

Traditionally, observational studies are viewed as the lowest form of evidence. Yet there are many instances where an observational study is the best and perhaps the only form of evidence that is practical and available especially if a disease entity or outcome is rare. Observational studies may provide relatively strong evidence when there is a large treatment effect, or when confounding factors would bias the results in opposition to the observed effect. They may be subject to significant bias thus the methodology and results must be carefully and critically examined.

Large non-randomized observational studies based on administrative databases have become very popular due to electronic data collection. They have the advantage of reporting on large populations and identifying trends in treatment, outcomes and rare complications. However, data collection may be incomplete or inconsistent and lack the granularity to draw conclusions as to how or why.

The RCT design is least likely to be affected by bias and is the only methodology that can identify cause and effect. Sound knowledge of study-design is needed to evaluate the many variations in structure and primary outcomes (i.e. inferiority, non-inferiority). While no study is completely void of bias it is important to determine whether bias is responsible for a significant portion of the observed effect as there is wide variation in the quality of RCTs.

The sheer volume of primary literature has increased the importance of secondary analysis or literature summaries. A systematic review of the literature may be combined with a meta-analysis to give a best estimate of effect. Although pooling the results of multiple trials increases precision by narrowing confidence intervals, a secondary analysis of poorly designed RCTs may result in a misleading conclusion. Thus, the reviewer must be familiar with the common limitations of secondary analysis and conclusions that can be drawn.

This symposium is aimed at two groups: present and prospective reviewers for Diseases of the Colon & Rectum and the practicing surgeon who wants to increase his/her critical appraisal skills. It is designed to be hands on. Through an interactive symposium we will explore the most common study methodologies, identify appropriate questions for each, identify the advantages and disadvantages and the common mistakes in study conduct, reporting and conclusions. We will also explore essential resources for additional learning in this area.

Previously published representative papers from the four common methodologies will be identified in advance from Diseases of the Colon & Rectum. At the symposium, each participant will be assigned to a small group lead by an editorial board member from DC&R. Following an introduction of the manuscript by the faculty, the editorial board members will facilitate a working discussion and critique of each manuscript within the small groups. Board members will have access to the original editorial comments and the changes that were requested by the editors prior to publication to enhance the discussion. At the end of the discussion period, the faculty will summarize for all participants the most significant concerns from the editorial review, the changes that were made to the manuscript prior to publication and any unresolved issues that were recognized but accepted as they were not felt to have a significantly effect on outcomes.

**Gap Analysis**

**What Is:** Evidence is presented in many forms using many methodologies. Familiarity with these methodologies is necessary to evaluate the continued stream of manuscripts with respect to study design, conduct, results and conclusions. The knowledge and ability to analyze these methodologies may not be common to all surgeons in our group.

**What Should Be:** As colorectal surgeons we should be familiar with the literature not only with respect to content, but with measures of quality. The ability to recognize a quality paper is an essential skill for the journal reviewer and the practicing surgeon alike.
Critical Review of Scientific Manuscripts (continued)

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

1. Recognize when observational studies can provide relatively strong evidence and their limitations.
2. Identify the advantages, limitations and pitfalls of administrative database studies.
3. Recognize potential for bias and methodological issues within randomized controlled trials.
4. Recall the components of a valuable comprehensive systematic review and meta-analysis.
5. Apply resources to enhance your critical appraisal skills.

Co-Directors: W. Donald Buie, MD, Calgary, AB, Canada
Susan Galandiuk, MD, Louisville, KY

8:00 am
Introduction
W. Donald Buie, MD, Calgary, AB, Canada
Susan Galandiuk, MD, Louisville, KY

8:05 am
Observational Studies:
Mary Kwaan, MD, Los Angeles, CA

8:20 am
Administrative Database Studies:
Scott Regenbogen, MD, Ann Arbor, MI

8:35 am
Randomized Controlled Trials:
Fergal Fleming, MD, Rochester, NY

8:50 am
Systematic Reviews & Meta-Analyses:
Karim Alavi, MD, Worcester, MA

9:05 am
What Happens When Reviews Disagree?
Susan Galandiuk, MD, Louisville, KY

9:15 am
Panel Discussion

9:30 am
Adjourn
Sunday, June 2
Symposium
CME Credit Hours not available
This symposium will be entirely in Spanish with an English translation.

Latin American Symposium
8:00 – 9:30 am

The ASCRS has had long-standing, mutually beneficial relationships with a multitude of colon and rectal surgery societies in Europe and Australasia through the Tripartite partnership. However, similar relationships with our surgical colleagues in Mexico, Central America, and South America have been lacking. As the global reach of our specialty expands, the need to partner with our Latin American colleagues for the purpose of achieving the common goal of furthering the specialty of colon and rectal surgery becomes more evident.

The purpose of this symposium, which will be delivered entirely in Spanish (with English translation available), is to gain a better understanding of our Latin American colleagues’ perspectives on a variety of topics spanning the specialty of colon and rectal surgery. A symposium at the ASCRS Annual Meeting conducted entirely in Spanish and featuring Latin American speakers also relays the message to our Latin American colleagues that the ASCRS welcomes their meaningful participation in our annual meeting, and hopefully will serve as a springboard for fostering future collaborative efforts.

Co-Directors: Adrian E. Ortega, MD, Los Angeles, CA Gonzalo Hagerman, MD, Mexico City, Mexico

8:00 am
STD’s and Perianal Dermatitis
Gunther Bocic, MD, Chili, South American

8:20 am
Radiofrequency Ablation of High-Grade Anal Dysplasia
Omar Vergara Fernandez, MD, Mexico City, Mexico

8:30 am
Rectal Prolapse: The State of the Art
Xavier Delgadillo, MD, Switzerland

8:40 am
Evaluation and Treatment of Obstructed Defecation Syndrome
Gonzalo Hagerman, MD, Mexico City, Mexico

8:50 am
Discussion
All Faculty

9:30 am
Adjourn
Sunday, June 2
Domingo, 2 de junio

Symposium
No recibirá créditos CME por asistir

Simposio Latinoamericano
8:00 - 9:30 am

ASCRS ha mantenido relaciones duraderas y mutuamente benéficas con una multitud de sociedades de cirugía de colon y recto en Europa y Australia a través de la asociación tripartita. Sin embargo, han faltado relaciones similares con nuestros colegas en México, América Central y América del Sur. A medida que el alcance global de nuestra especialidad se expande, la necesidad de asociarse con nuestros colegas latinoamericanos con el fin de lograr el objetivo común de promover la especialidad de cirugía de colon y recto se hace más evidente.

El propósito de este simposio, que se ofrecerá completamente en español (con traducción al inglés disponible), es lograr una mejor comprensión de las perspectivas de nuestros colegas latinoamericanos en una variedad de temas que abarcan la especialidad de la cirugía de colon y recto. Un simposio en la Reunión Anual de ASCRS realizada en español y con oradores latinoamericanos también transmite el mensaje a nuestros colegas latinoamericanos de que ASCRS agradece su participación significativa en nuestra reunión anual, y esperamos que sirva de base para fomentar futuros esfuerzos de colaboración.

This symposium will be entirely in Spanish with an English translation.

Codirectores: Adrián E. Ortega, MD, Los Ángeles, CA
Gonzalo Hagerman, MD, Ciudad de México, México

8:00 am
ETS y dermatitis perianal
Gunther Bocic, MD, Santiago, Chile

8:20 am
Ablación por radiofrecuencia de la displasia anal de alto grado
Omar Vergara Fernández, MD, Ciudad de México, México

8:30 am
Prolapso rectal: El estado del arte
Xavier Delgadillo, MD, Geneva, Switzerland

8:40 am
Evaluación y tratamiento del síndrome de defecación obstruida
Gonzalo Hagerman, MD, Ciudad de México, México

8:50 am
Mesa
Toda facultad

9:30 am
Clausura
Sunday, June 2

Symposium
CME Credit Hours: 2

Colorectal Surgery Research: Tips and Tricks from the Experts

9:45 – 11:45 am

The goal of this session is to provide an overview of different research opportunities for the practicing colorectal surgeon. There is a myriad of opportunities to contribute to new knowledge acquisition in colorectal surgery and surgeons in all practice environments and stages of their career should consider attending to learn about different paths. New initiatives including the ASCRS-CCFA surgical trials network and the Alliance OPTIsurg program will be highlighted as well as evolving areas of clinically relevant research including implementation science, health informatics and the learning health system. Information and lessons learned will also be shared about the Research Foundation of the ASCRS.

Gap Analysis

**What Is:** Disparate research ideas, not practical, not playing to our strengths.

**What Should Be:** Meaningful contributions from colorectal surgeons, playing to our strengths and advancing our field.

**Objectives:** At the conclusion of this session, participants should be able to:

1. Identify new opportunities to participate in collaborative research.
2. Describe the new CCFA-ASCRS research alliance and opportunities to participate.
3. Describe the Alliance and opportunities to participate.
4. Explain the process for a health informatics and how it can be applied to colorectal surgery practice to drive new knowledge.
5. Outline what works and doesn’t work when applying for Research Foundation of the ASCRS Grants.

**Co-Directors:** Rocco Ricciardi, MD, Boston, MA
Elizabeth Wick, MD, San Francisco, CA

**Time**

9:45 am
Looking Forward: How Surgeons Can Contribute to the National Research Agenda
Rocco Ricciardi, MD, Boston, MA

10:00 am
Overview of CCFA-ASCRS Surgical Research Alliance
Neil Hyman, MD, Chicago, IL

10:20 am
Example of CCFA-ASCRS Project: Early Closure of Ostomy After IPAA
Jon Vogel, MD, Denver, CO

10:35 am
Overview of Alliance and Example of Program: OPTIsurg
George Chang, MD, Houston, TX

10:50 am
Disseminating Research Findings Through Traditional as well Alternative Channel
Deborah Keller, MD, New York, NY

11:05 am
Conflicts of Interest
W. Donald Buie, MD, Calgary, AB, Canada

11:15 am
Wait, I Don’t Work at University of Michigan: How Do I Do This?
Samuel Oommen, MD, Walnut Creek, CA

11:25 am
There is No Such Thing as a Free Lunch: Funding Your Next Big Thing with the ASCRS Research Foundation
Elizabeth Wick, MD, San Francisco, CA

11:45 am
Panel
Adjourn
Sunday, June 2
Symposium
CME Credit Hours:  2

Care of the Geriatric Colorectal Patient
9:45 – 11:45 am

The management of colorectal cancer is multidisciplinary: numerous advancements have been recently proposed but few of them have been validated for older patients. Despite the evidence that cancer is a disease of the elderly, very little level 1 evidence on its treatment is available since patients older than 70 are frequently excluded from clinical randomized trials.

Worse oncologic outcomes in the elderly population are mostly related to heterogeneous treatment strategies, which are neither consistently evidence-based, nor clinical-pathway driven. The chain of events is likely to start from the health care providers who initially assess these patients. Health care specialists assess the patient’s chronological age as the main element when considering oncologic referral for patients with cancer. At the same time, we need to acknowledge that ‘standard of care’ does not always translate into ‘the best tailored treatment’ when dealing with elderly cancer patients. The balance between ‘standard of care’, ‘conservative treatment’ and ‘under-treatment’ is difficult to establish: a tight co-operation between professionals of different fields is needed to prioritize the patients’ needs and demand, rather than conform to the physicians’ skills.

We will highlight what surgeons, patients, and hospital administrations want and need to know about care of colorectal cancer in the elderly. From all angles, it is clear that elderly patients are unique and their colorectal cancer care should be individualized and approached in a multidisciplinary fashion.

Gap Analysis
What Is: Data show an unfavorable cancer-related survival rate among the oldest patients. This group of cancer patients is likely to receive suboptimal treatment, either under-treatment as well as over-treatment. Lack of understanding of the proper assessment, preoperative optimization and personalized treatment plan are the main reasons for this.

What Should Be: Modern colorectal surgeons should be able to screen for frailty, even in a busy clinical practice, and seek multidimensional assessment collaborating with geriatricians in order to identify specific frailty areas. Additionally, we should broaden our knowledge on the role of prehabilitation strategies and of the multiple options to deliver personalized care to these patients. The role of functional recovery as crucial endpoint should be analyzed and pursued.

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

1. Describe the main instruments to assess frailty in the everyday practice.
2. Describe effective preoperative strategies to improve patients’ performances before surgery.
3. Identify the benefit of minimally invasive surgery and of enhanced recovery protocols in the elderly population.
4. Describe the value of measuring postoperative functional outcomes, the importance of regaining independence and how this should be pursued to improve patients’ outcomes.
5. Identify the role of adjuvant and neoadjuvant therapy and their role in elderly patients while balancing over- and under-treatment.
6. Identify the true value of care along the treatment paradigm offered to our patients and which areas should be implemented based on a cost-effective approach.

Co-Directors: Bradley Davis, MD, Charlotte, NC
Nicole Saur, MD, Philadelphia, PA

9:45 am
Introduction and Clinical Questions
Bradley Davis, MD, Charlotte, NC
Nicole Saur, MD, Philadelphia, PA

9:55 am
Can Frailty Assessment be Routinely Performed in a Busy Practice?
Armin Shahrokni, MD, MPH, New York, NY

10:10 am
The Role of Prehabilitation and Optimization for Surgery. Is it Worth the Wait?
Francesco Carli, MD, Montreal, PQ, Canada

10:25 am
Minimally Invasive Surgery and Enhanced Recovery Programs Can be Safely Utilized to Improve Outcomes in Elderly Patients
Hiroko Kunitake, MD, Boston, MA

10:40 am
Functional Outcomes are at Least as Important as Oncologic Outcomes in Elderly Cancer Patients. Preliminary Results of the GOSAFE International, Prospective Study
Isacco Montroni, MD, PhD, Faenza, Italy

10:55 am
When Should Neoadjuvant Therapies be Utilized in the Elderly?
Chandana Kakani, MD, Philadelphia, PA

11:00 am
How Do You Reconcile the Cost and Value of Care in the Elderly?
Fabio Potenti, MD, Weston, FL

11:10 am
Panel Discussion

11:45 am
Adjourn
Sunday, June 2

11:45 am – 12:45 pm

Complimentary Box Lunch in the Exhibit Hall

Welcome and Opening Announcements

12:45 – 1:30 pm

David A. Margolin, MD, New Orleans, LA
President, ASCRS

Brian Kann, MD, New Orleans, LA
Program Chair

Traci Hedrick, MD, Charlottesville, VA
Program Vice Chair

M. Benjamin Hopkins, MD, Nashville, TN
Program Vice Chair

Garrett Nash, MD, New York, NY
Awards Chair

Scott Strong, MD, Chicago, IL
President, Research Foundation of the ASCRS

Sharon Stein, MD, Cleveland, OH
Public Relations Chair

Sean Langenfeld, MD, Omaha, NE
Social Media Chair

Humanities in Surgery Lectureship

CME Credit Hours: .75

1:30-2:15 pm

Surgical Ethics and the Future of Surgery

Peter Angelos, MD
Linda Kohler Anderson Professor of Surgery and Surgical Ethics,
Associate Director
MacLean Center for Clinical Medical Ethics
University of Chicago
Chicago, IL

Introduction: Ira Kodner, MD
Sunday, June 2

Abstract Session*
CME Credit Hours: 1.5

Neoplasia I
2:15 – 3:45 pm

Sunday, June 2

Symposium
CME Credit Hours: 1.5

Pelvic Floor: Present and Future
2:15 – 3:45 pm

Evaluation and treatment of pelvic floor disorders continues to evolve. New technology, surgical options and treatment approaches continue to yield better options and outcomes for patients. Multidisciplinary treatment teams are now collaborating to better identify and treat pelvic floor disorders more comprehensively. This seminar will provide an overview of a multidisciplinary approach to treating pelvic floor disorders and the newest surgical options.

Gap Analysis
What Is: Colorectal surgeons, and other pelvic floor specialists, have traditionally treated patients in isolation (within their specific subspecialty). This results in suboptimal long-term surgical results, recurrence or the need for additional surgery.

What Should Be: Pelvic floor disorders should be evaluated and treated with a multidisciplinary approach in order to optimize patient care and surgical outcomes.

Objectives: At the conclusion of this session, participants should be able to:
1. Discuss the components and importance of a multi-disciplinary approach to treating pelvic floor disorders.
2. Recognize the indications for ventral rectopexy, combined prolapse repair and sacral nerve stimulation.
3. Explain the risks, benefits and indications for using mesh to repair pelvic organ prolapse.

Co-Directors: Liliana Bordeianou, MD, Boston, MA
Sarah Vogler, MD, St. Paul, MN

Introduction 2:15 pm
Liliana Bordeianou, MD, Boston, MA
Sarah Vogler, MD, St. Paul, MN

Is Multidisciplinary Evaluation and Treatment of Patients with Pelvic Floor Disorders Worth the Bother? 2:20 pm
Madhulika Varma, MD, San Francisco, CA

Urogynecologic Physical Exam 101: You Too Can POP-Q, Do You Want To? 2:30 pm
Charles Rardin, MD, Providence, RI

Ventral Rectopexy Versus Colposuspension: What, Exactly, Is the Difference and Do We Need a Lawyer? 2:40 pm
Joseph Carmichael, MD, Orange, CA
Beri Ridgeway, MD, Cleveland, OH

Sacral Nerve Stimulation for All? Limitations and Misgivings 2:50 pm
Ian Paquette, MD, Cincinnati, OH

Obstructive Defecation Syndrome – Do Colorectal Surgeons Really Have Anything to Offer? 3:00 pm
Konstantin Umanskiy, MD, Chicago, IL

Case Presentations: And You Thought You Knew It All! 3:10 pm
Liliana Bordeianou, MD, Boston, MA
Sarah Vogler, MD, St. Paul, MN

Adjourn 3:45 pm
Sunday, June 2

Symposium
CME Credit Hours: 1.5

Decreasing Complications of Pain Management by Enhanced Recovery Strategies
2:15 - 3:45 pm

The rising use and misuse of opioids in the United States has led to an epidemic contributing to drug overdose deaths with the majority being opioid related in 2016. The United States has one of the highest rates of opioid consumption per capita in the world which poses a dilemma for the surgical community.

To counteract the undesirable side effects (particularly the intestinal side effects) of perioperative opioid use, Enhanced Recovery Protocols (ERP) and Pathways have included pain management strategies since first reports.

This symposium examines the role of perioperative providers and institutions in decreasing opioid use. We will detail the impact of opioids and other strategies on the perioperative management of patients undergoing colon and rectal procedures. A review of current best practices and recent improvements in ERPs will be presented relative to the opioid dependence concerns. Coverage of worldwide practices across several specialties will provide perspective of the global issue, and the US colorectal surgeon's role.

Gap Analysis

What Is: There is level 1 evidence that Enhanced Recovery principles improve costs and patient outcomes by reducing length of stay and return of bowel function. Intentional avoidance of excess opioids by use of multimodal analgesia is an integral component of Enhanced Recovery care paradigms. However, with the growing opioid epidemic and the introduction of new pain management modalities, the management of perioperative pain within ERPs should be revisited.

What Should Be: As colon and rectal specialists, we should implement continuous improvement of our Enhanced Recovery pain management strategies to: 1. educate our patients of the dangers of opioid overuse; 2. better prepare our patients who have a pre-existing opioid dependency for intra-operative care; 3. reduce postoperative complications secondary to overuse of opioids in the post-operative period; and 4. reduce the number of opioid naive patients that may develop a chronic opioid dependency after surgery. This requires a review of the problem and new pain management modalities as well a review of current best practices.

Objectives: At the conclusion of this session, participants should be able to:
1. Recognize the impact perioperative exposure has on the opioid epidemic.
2. Describe preventive measures that reduce the chance post-operative opioid dependency.
3. Describe best Enhanced Recovery, multimodal pain management practices to minimize perioperative opioid use and opioid complications, in opioid naïve and chronic opioid users.

Co-Directors: Julie Thacker, MD, Durham, NC
Jacquelyn Turner, MD, Atlanta, GA

2:15 pm
Julie Thacker, MD, Durham, NC
Jacquelyn Turner, MD, Atlanta, GA

2:20 pm
Opioid Epidemic and the Surgical Patient, A Global Perspective
Mattias Soop, MD, PhD, Altrincham, United Kingdom

2:35 pm
Perioperative Pain Management: An Update of Multi-modal Strategies
Traci Hedrick, MD, Charlottesville, VA

2:50 pm
Decreasing Postoperative Complications in the Opioid Dependent
Ian Bissett, MD, Auckland, New Zealand

3:05 pm
Order Sets Do Fix Everything; Understanding Why Some Patients Need More or Different Pain Management Plans
Anthony Senagore, MD, Kalamazoo, MI

3:20 pm
Opioid-free Operations, Possible? An Anesthesiologist’s Perspective
Michael Manning, MD, PhD, Durham, NC

3:35 pm
Panel Discussion

3:45 pm
Adjourn

Refreshment Break in Exhibit Hall
3:45 – 4:15 pm
Sunday, June 2

**Abstract Session*  
CME Credit Hours:  1.5

**Research Forum**  
4:15 – 5:45 pm

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### Sunday, June 2

**Symposium**  
CME Credit Hours:  1.5

**What’s New in Ulcerative Colitis?**  
4:15 – 5:45 pm

Colorectal surgeons are often involved in the care of patients with ulcerative colitis. The medical, endoscopic, and surgical treatment of ulcerative colitis is evolving rapidly. The education of surgeons in these disciplines occurs in a variety of settings including fellowship training, and continuing medical education programs, to name a few. In this symposium, both core principles and state of the art medical, endoscopic, and surgical approaches to ulcerative colitis will be presented by experts in the field.

#### Gap Analysis

**What is:** Self-learning via clinical practice guidelines, journal articles, educational conferences, and courses.

**What should be:** Periodic, structured educational programs that allow practicing surgeons to remain up to date and well-informed about ulcerative colitis.

#### Objectives:

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

1. Develop a treatment strategy for patients with ulcerative colitis and mucosal dysplasia.
2. Evaluate the efficacy of modern medical therapy for ulcerative colitis.
3. Recognize the role of robotic techniques for ulcerative colitis surgery.
4. List the strengths and weaknesses of the “modified 2-stage” approach for ileal pouch surgery.
5. Manage patients with complications after ileal pouch surgery.

**Co-Directors:**  
Jon Vogel, MD, Denver, CO  
Stefan Holubar, MD, MS, Cleveland, OH

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Speaker(s)</th>
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| 4:15 pm | **Introduction**                                                            | Stefan Holubar, MD, MS, Cleveland, OH  
Jon Vogel, MD, Denver, CO                                                                 |
| 4:20 pm | **Medical Therapy for Ulcerative Colitis: Anti-TNF and Beyond**               | Paulo Kotze, MD, Curitiba, Brazil                                                                 |
| 4:27 pm | **Dysplasia in UC: Chromo-endoscopy or Colectomy?**                          | Susan Gearhart, MD, Baltimore, MD                                                                       |
| 4:34 pm | **Modified 2-Stage IPAA: Is the Benefit Worth the Risk?**                   | Timothy Sadiq, MD, Chapel Hill, NC                                                                      |
| 4:43 pm | **Minimally Invasive IPAA – Laparoscopy or Robot?**                         | Tonia Young-Fadok, MD, Phoenix, AZ  
Tony Bemelman, MD, PhD, Vinkeveen, The Netherlands                                                                 |
| 4:48 pm | **Panel #1 Questions and Answers**                                          | Stefan Holubar MD, MS, Cleveland, OH  
Willem Bemelman, MD, PhD, Vinkeveen, The Netherlands  
Jean Ashburn, MD, Winston-Salem, NC  
David Deitz, MD, Cleveland, OH                                                                                        |
| 5:03 pm | **Transanal-IPAA: Really?**                                                 | Bo Shen, MD, Cleveland, OH  
Jean Ashburn, MD, Winston-Salem, NC  
Jean Ashburn, MD, Winston-Salem, NC  
David Deitz, MD, Cleveland, OH                                                                                        |
| 5:10 pm | **Ileal Pouch Failure: Interventional Endoscopy**                           | Bo Shen, MD, Cleveland, OH  
Jean Ashburn, MD, Winston-Salem, NC  
David Deitz, MD, Cleveland, OH                                                                                        |
| 5:24 pm | **Ileal Pouch Failure: J- to Redo J- or S-Pouch – Tricks of the Trade**    | Jean Ashburn, MD, Winston-Salem, NC  
David Deitz, MD, Cleveland, OH                                                                                        |
| 5:33 pm | **Panel #2 Questions and Answers**                                          | Stefan Holubar MD, MS, Cleveland, OH  
Willem Bemelman, MD, PhD, Vinkeveen, The Netherlands  
Jean Ashburn, MD, Winston-Salem, NC  
David Deitz, MD, Cleveland, OH                                                                                        |
| 5:45 pm | **Adjourn**                                                                 |                                                                                                         |
**Sunday, June 2**

**Symposium**

CME Credit Hours: 1.5

### The Evolving Landscape of Colorectal Surgical Education

**4:15 – 5:45 pm**

Advanced technologies and minimally invasive surgical techniques contribute to rapid changes in Colon and Rectal Surgery education. This seminar will provide an overview of the current status of Colon and Rectal Surgery Fellowship, as well as possible future directions for colorectal training. In addition, it is essential to stay up-to-date in the field of colon and rectal surgery beyond fellowship. This seminar will also discuss updates to the Maintenance of Certification (MOC) process and review available lifelong learning tools specific to our field.

**Gap Analysis**

**What is:** Trainees, practicing physicians, and training programs may fail to use all available tools to support education, maintain skills and embrace new information as it becomes available.

**What should be:** Trainees, practicing physicians, and training programs adopt and use all available tools to support education, maintain skills and embrace new information as it becomes available.

**Objectives:** At the conclusion of this session, participants should be able to:

1. Describe the current state of colorectal fellowship training and application process.
2. Discuss the colorectal surgery Maintenance of Certification Process.
3. Discuss how CREST can be used during fellowship and throughout practice.

**Co-Directors:** Jennifer Beaty, MD, Omaha, NE  
                Craig Reickert, MD, Detroit, MI

**Welcome and Introduction**

Jennifer Beaty, MD, Omaha, NE  
Craig Reickert, MD, Detroit, MI

**Fellowship Program Application Process and the Standard Letter**

Robert Cleary, MD, Ann Arbor, MI

**Surgical Cases in Colorectal Fellowship... The Numbers**

Gerald Isenberg, MD, Philadelphia, PA

**Robotics Curriculum**

Amir Bastawrous, MD, Seattle, WA

**CREST Update**

Eric Johnson, MD, Cleveland, OH

**4 Years of General +2 Years Colorectal Surgery Yes, No, Maybe So?**

Glenn Ault, MD, Los Angeles, CA

**MOC Process and CertLink**

Jan Rakinic, MD, Springfield, IL

**Panel Discussion/Q&A**

**Adjourn**
ASCRS ROCKS! Welcome Reception at the Rock and Roll Hall of Fame

Sunday, June 4
7:00 – 10:30 pm

ASCRS ROCKS! Welcome Reception at the Rock and Roll Hall of Fame will be held Sunday, June 4, 7:00 - 10:30 pm (complimentary to all registered attendees) and will feature hors d’oeuvres, cocktails and entertainment. The Welcome Reception will be held at the Rock and Roll Hall of Fame.

The Rock and Roll Hall of Fame, located on the shore of Lake Erie in downtown Cleveland, Ohio, recognizes and archives the history of the best-known and most influential artists, producers, engineers, and other notable figures who have had some major influence on the development of rock and roll. The Rock and Roll Hall of Fame Foundation was established on April 20, 1983, by Atlantic Records founder and chairman Ahmet Ertegun. In 1986, Cleveland was chosen as the Hall of Fame’s permanent home.

The Research Foundation will join forces with ASCRS to welcome all at this reception.
Monday, June 3

Meet the Professor Breakfasts

CME Credit Hours: 1
7:00 – 8:00 am

Limit: 32 per breakfast • Fee $50 • Tickets Required • Continental Breakfast Included

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

M-1 HIPEC for Colorectal Carcinomatosis - What is the Current Status?
Jose Guillen, MD, New York, NY
Scott Steele, MD, MBA, Cleveland, OH

M-2 From Instructor to Chair - Academic Development and Promotion
Jonathan Efron, MD, Baltimore, MD
Evangelos Messaris, MD, Hershey, PA

M-3 Treatment of Rectourethral/Rectovaginal Fistula in a Radiated Field
Suzanne Gillern, MD, Honolulu, HI
John Migaly, MD, Durham, NC

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

1. Describe the procedures and approaches discussed in this session.
Monday, June 3
Symposium
CME Credit Hours: 1

Coffee and Controversies: Leela Prasad Memorial Debates
7:00 – 8:00 am

Debate #1:
The Surgical Robot: Expensive Beast or Cost Saver?
7:00 – 7:30 am

Debate #2:
Intra-corporeal Anastomosis: Happy Patient or a Bridge Too Far?
7:30 – 8:00 am

Interest in robotic assisted surgery has exploded over the last 15 years. What began with robotic assisted prostatectomy by urologists, has slowly crept into the colorectal surgical marketplace. There is keen interest from both patient and surgeon in this technology. Often patients will present requesting a robotic approach to their problem. Debate continues over where and how this technology is best applied to the care of our patients. Because of the potential additional expense associated with obtaining and utilizing the robotic platform, it is essential to show a benefit to the use of this technology.

Since larger scale adoption of the robotic approach in colorectal surgery has been seen, there has been an explosion in new techniques designed around reducing abdominal incision size and number. The thought is that this will lead to better patient outcomes and satisfaction, though this has not been proven.

Gap Analysis
What Is: Robotic technology utilization has exploded in the colorectal surgical workspace without definitive data supporting its use. New techniques have been introduced at a pace that is difficult to keep.

What Should Be: Surgeons utilizing robotic technology, or considering its use, should be well informed as to the risks and benefits of employing this technology, as well as the risks and benefits of utilizing different techniques with the technology.

Objectives: At the conclusion of this session, participants should be able to:
1. Describe the impact that robotic technology has on healthcare costs.
2. List different approaches to right and left sided anastomoses using the robot.
3. Cite data supporting various approaches in the robotic setting.

Director: Eric Johnson, MD, Cleveland, OH

7:00 – 7:30 am
Debate #1:
The Surgical Robot: Expensive Beast or Cost Saver?

Introduction
Eric Johnson, MD, Cleveland, OH

Expensive Beast!
Conor Delaney, MD, PhD, Cleveland, OH

Cost Saver!
Amir Bastawrous, MD, Seattle, WA

Rebuttal
Conor Delaney, MD, PhD, Cleveland, OH

Rebuttal
Amir Bastawrous, MD, Seattle, WA

Conclusion
Eric Johnson, MD, Cleveland, OH

7:30 – 8:00 am
Debate #2:
Intra-corporeal Robotic Anastomosis: Happy Patient or a Bridge Too Far?

Introduction
Eric Johnson, MD, Cleveland, OH

Happy Patient!
Jamie Cannon, MD, Birmingham, AL

Bridge Too Far!
Joshua Bleier, MD, Philadelphia, PA

Rebuttal
Jamie Cannon, MD, Birmingham, AL

Rebuttal
Joshua Bleier, MD, Philadelphia, PA

Conclusion
Eric Johnson, MD, Cleveland, OH

Adjourn
Rectal Cancer

Monday, June 3
Abstract Session*
CME Credit Hours: 1.5

Lightning Talks
8:00 – 9:30 am

Monday, June 3
Symposium
CME Credit Hours: 1.5

The outcomes of rectal cancer surgery remain highly variable. Tremendous differences have been reported relative to sphincter-sparing versus permanent stoma operations, surgical morbidity, post-operative mortality, local tumor recurrence, and survival. Further, variations also occur in the utilization of a multidisciplinary evaluation to include tumor board discussion, radiological staging and pathological evaluation, as well as adjuvant/neoadjuvant chemoradiation therapy. Recently, there has been involvement of the American College of Surgeons and the Commission on Cancer to educate and help implement a quality assurance program.

Over the past few years, several novel approaches to treating both early-stage and locally advanced rectal cancer are challenging the traditional standard of care. While the novel treatment paradigms aim to tailor multidisciplinary management and offer options to patients based on their disease characteristics, it is critical for surgeons and physicians to understand: (1) the quality standards and benchmark outcomes associated with the standard of care; (2) the nature of novel treatment approaches as well as the extent and the strength of the evidence associated with them; (3) how to practically integrate above knowledge and apply them to make treatment recommendations and decisions in daily practice.

This session will describe the key measures of high-quality rectal cancer care including surgical and multimodality therapies, summarize the benchmark outcomes that should be expected with traditional standard of care, discuss novel treatment paradigms along with available evidence, and provide case examples illustrating practical application of existing evidence.

Objectives: At the conclusion of this session, participants should be able to:
1. Evaluate the variability in rectal cancer surgery and understand the benchmark outcomes associated with standard of care.
2. Articulate emerging treatment paradigms that address the integration of surgical resection in combination with medical and radiation oncologic treatments that may modify the current standard of care and assess the strength of the available evidence associated with these emerging paradigms.
3. Describe the outcomes associated with various surgical approaches for rectal cancer.
4. Describe the work-up, evaluation and approach for recurrent rectal cancer.

Co-Directors: Rebecca Hoedema, MD, Grand Rapids, MI
Scott Steele, MD, MBA, Cleveland, OH

8:00 am Introduction
Rebecca Hoedema, MD, Grand Rapids, MI
Scott Steele, MD, MBA, Cleveland, OH

8:05 am Total Neoadjuvant Chemotherapy
Matthew Mutch, MD, St. Louis, MO

8:17 am Beyond Organ Preservation: Selection and Failure – What Next?
Rodrigo Perez, MD, PhD, Sao Paulo, Brazil

8:29 am Update on Trials in Rectal Cancer – What Does It Mean for My Patients?
Julio Garcia-Aguilar, MD, New York, NY

8:41 am Recurrent Rectal Cancer – Multidisciplinary Approach
Matthew Kalady, MD, Cleveland, OH

8:53 am NOSES for Rectal Cancer
Chuan-Gang Fu, MD, PhD
Shanghai, Peoples Republic of China

9:05 am Case Discussion with Panel/Questions & Answers
Rebecca Hoedema, MD, Grand Rapids, MI
Scott Steele, MD, Cleveland, OH

9:30 am Adjourn
Monday, June 3
Symposium
CME Credit Hours: 1.5

Technical Pearls: Minimally Invasive Colectomy, Step-By-Step
8:00 – 9:30 am

Over the past two decades, laparoscopic assisted colectomy has slowly evolved to become a mainstay in colorectal surgery. During this evolution, multiple different laparoscopic approaches have been described including medial to lateral, lateral to medial, hand assisted, and others. Each of these approaches require a slightly different appreciation and knowledge of the colon anatomy and relationship to adjacent organs. Since each patient may present with slightly different anatomy, disease processes, and prior history of abdominal surgery, it is important for the practicing colorectal surgeon to be familiar with alternate laparoscopic approaches to allow them to vary their technique to meet the specific needs of the patient.

This session will be a video heavy series of presentations by expert laparoscopic and robotic colorectal surgeons providing their pearls of wisdom for multiple different approaches for right and left colectomy.

Gap Analysis
What Is: Colorectal surgeries are performed by a large number of general and colorectal surgeons across the country. However, opportunities for continued medical education for practicing surgeons is limited.

What Should Be: The speakers will present video vignettes demonstrating various approaches to common steps of minimally invasive colectomies to help address challenges presented by different pathologies and patient factors.

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

1. Describe the primary vascular supply to the different segments of the colon, the neighboring organs, and a stepwise approach to their safe identification
2. Describe at least two approaches to mobilize and perform oncologic mesenteric resection for each segment of the colon.
3. Discuss the steps involved for minimally invasive intracorporeal ileocolic anastomosis.
4. Discuss the use of robotics for laparoscopic colectomy

Co-Directors: Arida Siripong, MD, Grand Rapids, MN
Mark Whiteford, MD, Portland, OR

8:00 am
Introduction
Arida Siripong, MD, Grand Rapids, MN
Mark Whiteford, MD, Portland, OR

8:05 am
Getting To The Root: Critical Anatomy for Right Colectomy
Molly Ford, MD, Nashville, TN

8:09 am
The Inside Scoop: Medial to Lateral Right Colectomy for Cancer
Bradley Champagne, MD, Cleveland, OH

8:14 am
Bottoms Up: Inferior to Superior Mobilization for Ileoceleal Crohn’s
Paul Wise, MD, St. Louis, MO

8:19 am
Gimme a Hand: Hand Assisted, Top Down Right Colectomy for Cancer
Karin Hardiman, MD, PhD, Ann Arbor, MI

8:24 am
Robotic Intracorporeal Ileocele Anastomosis. Perfect Robotic Indication
Mark Soliman, MD, Orlando, FL

8:29 am
Straight Sticks Ileocele Intracorporeal Anastomosis - I’ve Got This
Sami Chadi, MD, Toronto, CANADA

8:34 am
Panel Discussion on Laparoscopic Right Colectomy

8:45 am
All About the Vessels and the Planes: The Right way to do the Left
Gregory Kennedy, MD, Birmingham, AL

8:49 am
Insider’s Perspective: Medial to Sigmoid Colon Mobilization
Kelly Garrett, MD, New York, NY

8:54 am
Familiar and Safe: Lateral to Medial Mobilization of the Sigmoid Colon
James Ogilvie, MD, Grand Rapids, MI

8:59 am
Over the Top: Hand Assisted Splenic Flexure Mobilization
David Vargas, MD, New Orleans, LA

9:04 am
True Medial to Lateral Splenic Flexure Mobilization: IMV First Approach
Mark Whiteford, MD, Portland, OR

9:09 am
Robot: Not Just for the Pelvis Anymore: Robotic Complex Diverticular Surgery
David Larson, MD, Rochester, MN

9:14 am
When You Really Need a Hand: Hand-assisted Left Colectomy for the Morbidly Obese
Jennifer Rea, MD, Lexington, KY

9:19 am
Panel Discussion on Laparoscopic Left Colectomy

9:30 am
Adjourn
Refreshment Break and E-poster Presentations in the Exhibit Hall
9:30–10:00 am

Monday, June 3

Harry E. Bacon, MD, Lectureship
CME Credit Hours: .75
10:00 – 10:45 am
“Challenges”

Mark Malangoni, MD
Associate Executive Director
American Board of Surgery
Taylor, MI
Introduction: David A. Margolin, MD

Monday, June 3

Presidential Address
CME Credit Hours: .75
10:45 – 11:30 am

David Margolin, MD, FACS, FASCRS
Professor and Director Colon and Rectal Surgical Research
The Ochsner Clinic Foundation
The University of Queensland School of Medicine,
Ochsner Clinical School
Introduction: Charles Whitlow, MD

Dr. David A. Margolin, New Orleans, LA, Director of Colorectal Research of Ochsner Clinic Foundation Hospital, was elected President of the American Society of Colon and Rectal Surgeons (ASCRS) at the Society’s 2018 Annual Scientific Meeting in Nashville, TN.

Dr. Margolin first served on the ASCRS Executive Council as a member-at-large from 2013 to 2016, as vice president 2016 – 2017 and as president-elect 2017 – 2018. During his tenure as a Fellow of the ASCRS, he has served on several committees including Professional Development (2000-04), Socioeconomic (past Chair) (member 1998 – 2012), and Website (2009-2017). He also served as Associate Editor (2007-17) and Web Editor (2009-17) of Diseases of Colon and Rectum and as ASCRS representative to the Current Procedural terminology (CPT) (2001-05, 2008) and the Relative Value Update Committee (RUC) (2002-05) of the American Medical Association.

Complimentary Box Lunch and & E-poster Presentations in the Exhibit Hall
11:30 am -12:45 pm
Monday, June 3

Abstract Session*
CME Credit Hours: 1.25

Pelvic Floor
12:45 - 2:00 pm

Monday, June 3

Symposium
CME Credit Hours: 1.25

Current Management of Crohn’s Disease. Joint ASCRS/SSAT Symposium
12:45 - 2:00 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, large bowel, or ileocolon with concurrent or separately associated upper gastrointestinal or anoperineal disease. The disease typically begins as an inflammatory process that generally evolves to stricturing or penetrating behavior, but the chronic inflammation also increases the patient’s risk of developing neoplasia in the affected bowel. A multidisciplinary approach to the management of Crohn’s disease has been adopted by many centers with surgery remaining an integral part of the treatment strategy despite advances in medical therapy.

Glucocorticoids were the historic drug of choice for moderate or severe Crohn’s disease, but associated side effects limit their long-term use. Newer medications, such as immunomodulators and biologic agents, were developed to allow for discontinuation or avoidance of glucocorticoids. Surgical intervention is warranted when medical therapy fails to safely restore an acceptable quality of life, and the choice of operation is dependent upon many disease- and patient-driven factors. Unfortunately, symptomatic disease commonly recurs following bowel resection despite elimination all visible evidence of disease at the time of the index operation.

The use of medications as a first-line approach is inappropriate in some patients such as those with intra-abdominal abscesses resulting from penetrating disease where immune suppressing drugs are initially avoided. After the infection is controlled by non-operative means, the role of subsequent medical therapy versus surgery has been debated.

Anoperineal involvement by Crohn’s disease can manifest itself in many forms, but fistulizing behavior is sometimes the most debilitating form. A multidisciplinary approach is usually advocated and many of these patients with minimal rectal inflammation can be surgically managed using a variety of operative approaches depending upon multiple variables.

Most patients with neoplasia complicating their underlying large bowel inflammation were previously referred for operative management instead of medical therapy, but recent opinions argue for a more conservative approach, and, if an operation is performed, the extent of resection remains controversial.

Through a structured symposium focusing on both the non-operative and operative treatment of Crohn’s disease, we propose to define the role of bowel-sparing procedures, offer an approach to intra-abdominal abscesses, describe the management of recurrent disease of the terminal ileum, discuss the issues associated with neoplasia, and review the treatment options for anorectal fistulas. The symposium will thoroughly examine these disease-related issues and provide evidence-based practice guidance.

Gap Analysis

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 understand the principles associated with a multidisciplinary approach to disease management.

Objectives: At the conclusion of this session, participants should be able to:
1. Identify the indications and options for bowel- and sphincter-sparing approaches to large bowel disease.
2. Explain the subsequent treatment of patients with a resolved intra-abdominal abscess.
3. Recognize the benefits and risks associated with endoscopic and surgical management of recurrent disease of the neo-terminal ileum.
4. Appreciate the management of neoplasia complicating large bowel disease.
5. Describe the treatment of fistulizing anoperineal disease.

Co-Directors: Amy L. Lightner, MD, Rochester, MN
Scott A. Strong, MD, Chicago, IL

12:45 pm

Introduction
Amy L. Lightner, MD, Rochester, MN
Scott A. Strong, MD, Chicago, IL

12:48 pm

Large Bowel Disease – Ileostomy or Sphincter-Sparing Procedure
Luca Stocchi, MD, Cleveland, OH
Monday, June 3

**Current Management of Crohn’s Disease. Joint ASCRS/SSAT Symposium** (continued)

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<tr>
<th>Time</th>
<th>Topic</th>
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<tr>
<td>12:59 pm</td>
<td>Ileocolostomy Stenosis – Medical, Endoscopic, or Operative Management</td>
<td>Anthony De Buck Van Overstraeten, MD, Toronto, ON, Canada</td>
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<td>1:00 pm</td>
<td>Simple Anorectal Fistula – Medical or Operative Management</td>
<td>Nicola Fearnhead, MD, Cambridge, United Kingdom</td>
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<td>1:10 pm</td>
<td>Resolved Intra-Abdominal Abscess – Medical or Operative Management</td>
<td>Walter Koitun, MD, Hershey, PA</td>
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<td>1:11 pm</td>
<td>Colon Neoplasia – Surveillance, Colectomy, or Proctocolectomy</td>
<td>Pokala Kiran, MD, New York, NY</td>
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<td>1:43 pm</td>
<td>Discussion</td>
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Monday, June 3

**Symposium**

CME Credit Hours: 1.25

**When Do You Change Your Approach?**

**A Framework for Translating Evolving Evidence into Practice Change**

12:45 – 2:00 pm

Surgery evolves, and no surgeon’s practice is the same as it was when they trained. Each surgeon is challenged with the task of identifying new technologies and determining whether to incorporate evolving technology/techniques into their practice.

**Gap Analysis**

What is: Among ASCRS membership there is no clear framework to guide surgeons in their decisions to incorporate new approaches (techniques, technologies) into their practice.

What should be: Surgeons should approach emerging technologies methodically, in a way that weighs current evidence and also considers a surgeon’s individual practice context.

**Objectives:** At the conclusion of this session, participants should be able to:

1. Recognize levels of evidence, and the implications of each
2. Recognize what approaches should be considered “experimental”
3. Determine which types of approaches require formal education/training before attempting
4. Consider practice-specific barriers, risks, and rewards associated with incorporating a new technology
5. Explain supply chain cost measures and comparative value analysis of implementation of new technology

**Co-Moderators:** David Etzioni, MD, Phoenix, AZ
Larissa Temple, MD, Rochester, NY

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<tr>
<td>12:45 pm</td>
<td>Introduction and Opening Comments</td>
<td>David Etzioni, MD, Phoenix, AZ</td>
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<td>Larissa Temple, MD, Rochester, NY</td>
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<td>12:50 pm</td>
<td>Weighing the Evidence</td>
<td>Marcia Russell, MD, Los Angeles, CA</td>
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<td>1:01 pm</td>
<td>Identifying New Approaches for my Practice: How Much Evidence Before I Uptake?</td>
<td>Mark Whiteford, MD, Portland, OR</td>
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<td>1:12 pm</td>
<td>Hospital as Friend or Foe: Will my Hospital Supply Chain Say Yes to A New Technology?</td>
<td>John Hundt, MBA, Baltimore, MD</td>
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<td>1:23 pm</td>
<td>How Do I Monitor the Outcomes of a New Procedure?</td>
<td>Scott Steele, MD, Cleveland, OH</td>
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<td>1:34 pm</td>
<td>Closing Comments</td>
<td>David Etzioni, MD, Phoenix, AZ</td>
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<td>Larissa Temple, MD, Rochester, NY</td>
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<td>1:38 pm</td>
<td>Panel Discussion</td>
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<td>2:00 pm</td>
<td>Adjourn</td>
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Monday, June 3
Abstract Session*
CME Credit Hours: 1.5

Basic Science
2:00 – 3:30 pm

Monday, June 3
Abstract Session
CME Credit Hours: 1.5

Video Session
2:00 – 3:30 pm

Monday, June 3
Symposium
CME Credit Hours: 1.5

ASCRS/ACS Partnership to Support the Colorectal Surgeon
2:00 – 3:30 pm

This session will highlight some of the myriad of synergies between the American Society of Colon and Rectal Surgeons (ASCRS) and the American College of Surgeons (ACS). Programs where the ACS offers direct benefit to the colorectal surgeon beyond benefits offered by the ASCRS will be discussed.

Gap Analysis
What Is: Awareness that the ACS offers an annual clinical congress.

What Should Be: The desire to participate in numerous ACS activities and programs designed to help colorectal surgeons.

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

1. Review the health policy and advocacy accomplishments of the ACS-PAC.
2. Discuss the educational offerings which benefit colorectal surgeons.
3. Describe the quality programs available to colorectal surgeons.

Co-Directors: Patricia Turner, MD, Chicago, IL
Steven Wexner, MD, PhD (Hon), Weston, FL

Introduction
Patricia Turner, MD, Chicago, IL
Steven Wexner, MD, PhD (Hon), Weston, FL

ACS Quality Programs Help Colorectal Surgeons Improve Quality Care
Clifford Ko, MD, Los Angeles, CA

ACS Educational Programs for Colorectal Surgeons
Ajit Sachdeva, MD, Chicago, IL

The Commission on Cancer Colorectal Surgery Programs
Heidi Nelson, MD, Rochester, MN

How Advocacy and Health Policy Engagement Helps Us Help Our Patients
Frank Opelka, MD, Washington, DC

Working with the ACS to Further Our Common Goals: How to Get Involved
David Hoyt, MD, Chicago, IL

Panel Discussion/Questions and Answers

Refreshment Break and E-poster Presentations in the Exhibit Hall
3:30 – 4:00 pm
Monday, June 3
Symposium
CME Credit Hours: .75

Best of the Diseases of the Colon & Rectum Journal
4:00 – 4:45 pm

This symposium is designed for the practicing colorectal surgeon who has a desire to stay up to date on the latest in the management of colon and rectal diseases. Due to increasing demands of daily practice, the ability to stay current on the highest quality and most-cited publications can be difficult. In this symposium, we will review and summarize the most highly cited papers from the Diseases of the Colon and Rectum over the last 2 years. Presentations and discussion will focus on study design and results, practical implications of the data and a critical review of submitted work.

Gap Analysis
What Is: High quality published research is frequently missed by health care providers and this may compromise further improvements in research and clinical care.

What should be: Manuscripts of high quality should be valid, well known and value-added to the practicing health care provider.

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

1. Describe the basics of the top papers published in the DC&R.
2. Distinguish the qualities of a manuscript that provides value to the practicing surgeon.
3. Identify further questions that warrant additional research.
4. Identify at least one key point from the presentations that will guide further research or change practice patterns for the care of patients with colorectal disease

Director: Susan Galandiuk, MD, Louisville, KY

4:00 pm
Introduction
Susan Galandiuk, MD
Louisville, KY

4:05 pm
Accuracy of MRI in Restaging Locally Advanced Rectal Cancer After Preoperative Chemoradiation
Joris. J. van der Broek, MD
Alkmaar, the Netherlands

4:15 pm
Baseline T Classification Predicts Early Tumor Regrowth After Nonoperative Management in Distal Rectal Cancer After Extended Neoadjuvant Chemoradiation and Initial Complete Clinical Response
Rodrigo Oliva Perez, MD, PhD.
São Paulo, Brazil

4:25 pm
Financial Impact of Colorectal Cancer and Its Consequences: Associations Between Cancer-Related Financial Stress and Strain and Health-Related Quality of Life
Linda Sharp, PhD
Newcastle upon Tyne, United Kingdom

4:35 pm
Elevated Venous Thromboembolism Risk Following Colectomy for IBD Is Equal to Those for Colorectal Cancer for Ninety Days After Surgery
Timothy J. Ridolfi, M.D.
Milwaukee, Wisconsin

4:45 pm
Adjourn
Monday, June 3
No CME Credit Awarded

New Technologies Symposium
Refreshments will be served.

4:45 - 6:15 pm

The New Technologies Symposium has become a featured annual event at the ASCRS Scientific meeting and serves as a unique opportunity to work with ASCRS members and industry to explore and present new technologies to the membership in a non-CME format.

This year we will feature a disruptive technology panel consisting of invited panelists consisting of industry leaders. This will be a lively event with attendee participation. There will also be abstract presentations.

We are looking forward to a successful program!

Co-Directors: Eric Haas, MD, Houston, TX
Patricia Sylla, MD, New York, NY

6:30 – 8:00 pm

Residents’ Reception
Open to residents and colorectal program directors only.

Network with colon and rectal surgery program directors and members of the ASCRS Residents Committee to learn more about the specialty and the ASCRS. Cocktails and hors d’oeuvres will be served, and a copy of the ASCRS Manual of Colon and Rectal Surgery, Second Edition, will be raffled.
Tuesday, June 4

Meet the Professor Breakfasts

CME Credit Hours: 1

6:30 – 7:30 am

Limit: 32 per breakfast • Fee $50 • Tickets Required • Continental Breakfast

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

T-1  HPV-Related Anorectal Disease - Case-Based Discussion
    Stephen Goldstone, MD, New York, NY
    Mark Welton, MD, Minneapolis, MN

T-2  Taking Your Research Idea from Concept to Reality
    Valentine Nfonsam, MD, Tucson, AZ
    Scott Strong, MD, Chicago, IL

T-3  Complex Hemorrhoidal Disease
    Timothy Ridolfi, MD, Madison, WI
    Massarat Zutshi, MD, Cleveland, OH

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

1. Describe the procedures and approaches discussed in this session.

Norman D. Nigro, MD, Research Lectureship

CME Credit Hours: .75

7:30 – 8:15 am

Colorectal Cancer in Patients Under the Age of Fifty

James Church, MD
Department of Colorectal Surgery, Digestive Disease and Surgery Institute,
Cleveland Clinic Foundation
Cleveland, OH
Introduction: Ian C. Lavery, MD
Tuesday, June 4
Symposium
CME Credit Hours: .75

Harnessing Social Media to Advance #ColorectalSurgery
8:15 - 9:00 am

The term ‘social media’ describes 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. Hashtags allow posts related to a common theme or topic to be tracked, and the #ColorectalSurgery hashtag has gained significant momentum.

While the benefits of social media continue to expand, many of these are poorly understood by practicing physicians. Furthermore, engaging in social media can be time consuming. It also has a number of possible negative consequences.

This symposium will discuss some of the specifics of how a surgeon can harness the power of social media to all aspects related to #ColorectalSurgery.

The #ColorectalResearch effort is very much in line with the ASCRS Social media committee mission statement, which is: “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 utilizing several multimedia platforms in various social media outlets.”

Gap Analysis
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: An in depth understanding of social media and colorectalsurgery is essential in today’s practice of medicine. Colorectal surgeons should understand the advantages (and disadvantages) of this and how it is applicable to daily practice.

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

1. Describe what how #ColorectalSurgery can be used to keep up on the latest research.
2. Recognize how to network with senior faculty using social media.
3. Describe the potential dangers / omissions of social media including conflict of interest disclosure.

Co-directors: Kyle Cologne, MD, Los Angeles, CA
Sharon Stein, MD, Cleveland, OH

Introduction
Kyle Cologne, MD, Los Angeles, CA
Sharon Stein, MD, Cleveland, OH

#ColorectalResearch: Using Social Media to Advance the Science
Deborah Keller, MD, New York, NY

Networking Through #SoMe: How to Make the Most of Virtual Mentors
Govind Nandakumar, MD, Bangalore, India

The European Perspective: How a Structured Approach to Social Media has Changed the World
Richard Brady, MD, Newcastle Upon Tyne, United Kingdom

Social Media and Ethics: From Conflict of Interest Disclosure to Promoting Your Own Research – What are the Rules?
Nancy Baxter, MD, PhD, Toronto, ON, Canada

Adjourn
Tuesday, June 4

Symposium
CME Credit Hours: .75

Management of Anal Dysplasia
8:15 - 9:00 am

The incidence of anal cancer is increasing due to rising rates of human papilloma virus (HPV) infection. HPV infection can lead to anal high-grade squamous intraepithelial lesions (HSIL) 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, HSIL, 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 with or without HSIL treatment.

Gap Analysis

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 HSIL and use of HRA. They are unaware or have misconceptions related to results of treatment of anal HSIL in preventing cancer.

What Should Be: Colon and rectal surgeons should have a thorough understanding of anal dysplasia. Even if surgeons do not believe in treatment of HSIL to prevent cancer they must understand the most recent data and how treatment can be accomplished utilizing multiple modalities. If the surgeon does not want to perform HRA they can utilize ancillary clinicians with proper training to fill this need.

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

1. Explain the most recent data regarding anal dysplasia treatment versus observation.
2. Identify treatment options for anal HSIL.
3. Recall the role of advanced practice clinicians in a surgical clinical practice.
4. Identify how to recognize possible atypical presentation of anal cancer and dysplasia.

Co-Directors: Stephen Goldstone, MD, New York, NY
Naomi Jay, RN, NP, PhD, San Francisco, CA

8:15 am
Introduction to the Symposium and the Most Recent Data on Treatment and Expectant Management of HSIL to Prevent Anal Cancer
Stephen Goldstone, MD, New York, NY

8:25 am
HRA Guided Ablative Therapy for Anal HSIL
Stephen Goldstone, MD, New York, NY

8:30 am
Topical Therapy for Treatment of Anal Dysplasia
Naomi Jay, RN, NP, PhD, San Francisco, CA

8:40 am
Atypical Presentation of Cancer and Anal Dysplasia
Jospeh Terlizzi, Jr., MD, New York, NY

8:45 am
Utilization of Advanced Practice Clinicians in Management of Anal Dysplasia
Naomi Jay, RN, NP, PhD, San Francisco, CA

8:50 am
Questions
All Faculty

9:00 am
Adjourn

Refreshment Break and E-poster Presentations in the Exhibit Hall
9:00 - 9:30 am
Tuesday, June 4

Abstract Session*
CME Credit Hours:  1.25

Neoplasia II
9:30 – 10:45 am

Tuesday, June 4

Symposium
CME Credit Hours:  1.25

Avoiding Burnout and Achieving Optimal Work-Life Balance
9:30 – 10:45 am

Physician burnout is a critical problem facing the healthcare system in the United States. A recent study showed an increased rate of physician burnout with 54% of physicians reporting at least one symptom of burnout in 2014 compared with 45.5% in 2011 (Shanafelt et al.). Physician burnout has been linked with higher rates of medical errors, poor patient experience, inefficiencies in care and provider attrition. A survey of nearly 7,000 U.S. physicians, published in 2016 reported that one in 50 planned to leave medicine altogether in the next two years, while one in five planned to reduce clinical hours over the next year. Hospitals, academic medical centers and health systems are increasingly engaged as the "cost" of provider burnout is significant as is the negative impact it can have on local culture. Several solutions to burnout have been suggested including establishing an environment conducive to a healthy work-life balance, reducing administrative burdens, and increasing physician engagement and leadership. This session will focus on framing the issue of physician burnout as well as identify national efforts designed to achieve ideal work-life balance.

Gap Analysis

What Is: Many physicians fail to recognize the negative impact of stress, exhaustion, and isolation on their personal well-being and professional performance. Many more feel powerless to affect changes to optimize their career satisfaction and prevent burnout.

What Should Be: Physicians should be able to recognize when barriers exist to achieving optimal performance and job satisfaction, and how these can lead to burnout. Physicians should have strategies to affect change in their personal and professional lives to prevent burnout and increase job satisfaction and performance.

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

1. Recognize the symptoms and adverse consequences of burnout among healthcare providers.
2. Describe how personal values, local work environment, and national healthcare culture contribute to the development of physician burnout.
3. Describe strategies at the personal, institutional, and national level to prevent physician burnout.

4. Explain the positive and negative implications of the term "work-life balance."
5. Describe how personal happiness and a sense of meaning affect job satisfaction.

Co-Directors: W. Conan Mustain, MD, Little Rock, AR
Sonia Ramamoorthy, MD, San Diego, CA

9:30 am
Introduction
W. Conan Mustain, MD, Little Rock, AR
Sonia Ramamoorthy, MD, San Diego, CA

9:35 am
Understanding Burnout
Robert W. Beart, Jr., MD, Crystal Bay, NV

9:55 am
It’s About More Than Resilience
James Merlino, MD, Chicago, IL

10:15 am
Creating the Life in Medicine that You Want
Nisha Mehta, MD, Charlotte, NC

10:35 am
Panel Discussion

10:45 am
Adjourn
Tuesday, June 4

Symposium
CME Credit Hours: 1.25

My Microbiome Made Me Do It
9:30 – 10:45 am

New technology has driven major advances in our understanding and delineation of the microbiome. Dysbiosis has been implicated in the pathogenesis of IBD, the development and metastatic potential of colorectal cancer and the causation of anastomotic leak. This symposium will explore these exciting and rapidly evolving areas and will help those attending separate the hype from the science.

Gap Analysis
What Is: There are major gaps in the knowledge base of colorectal surgeons regarding the role of the microbiome in health and disease.

What Should Be: Colorectal surgeons should have an understanding of evolving concepts and data.

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

1. Describe the potential role of the microbiome in the causation of anastomotic leak.

2. Recognize emerging concepts in the role of the microbiome in the development and metastatic potential of colorectal cancer.

3. Explain the potential role of dysbiosis in the pathogenesis of IBD and C difficile disease.

Co-Directors: Nancy Baxter, MD, PhD, Toronto, ON, Canada
              Neil Hyman, MD, Chicago, IL

9:30 am
Introduction
Nancy Baxter, MD, PhD,
Toronto, ON, Canada
Neil Hyman, MD, Chicago, IL

9:35 am
The Human Microbiome in Health and Disease
Heidi Nelson, MD, Rochester, MN

9:45 am
Role of the Microbiome in the Pathogenesis of Anastomotic Leak
Benjamin Shogan, MD, Chicago, IL

9:55 am
How Does the Microbiome Influence the Development and Metastatic Potential of Colorectal Cancer?
Sara Gaines, MD, Chicago, IL

10:05 am
Evolving Concepts in C difficile Colitis
David Stewart Sr., MD, Tucson, AZ

10:15 am
Panel

10:45 am
Adjourn
Tuesday, June 4

**Masters in Colorectal Surgery Lectureship Honoring Ian C. Lavery, MD**

CME Credit Hours: .75

10:45 - 11:30 am

**How to Build a Prestigious Career**

Tracy Hull, MD, FACS, FASCRS
Professor of Surgery
Cleveland Clinic Lerner College of Medicine of Case Western Reserve University
Department of Colon and Rectal Surgery
The Cleveland Clinic Foundation
Cleveland, Ohio

*Introduction: Conor Delaney, MD, PhD*

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**Complimentary Box Lunch and e-Poster Presentations in the Exhibit Hall**

11:30 am - 1:00 pm

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**Women in Colorectal Surgery Luncheon**

11:30 am – 1:00 pm • Fee: $30 • *Registration Required*

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.

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**Memorial Lectureship Honoring Philip H. Gordon, MD**

CME Credit Hours: .75

1:00 – 1:45 pm

**Colorectal Cancer Screening. Is 40 the New 50?**

Carol Ann Vasilevsky, MD
Chief Division of Colon & Rectal Surgery
Jewish General Hospital
Montreal Quebec
Canada

*Introduction: David Beck, MD*
Tuesday, June 4

Abstract Session*  
CME Credit Hours: 1.5

General Surgery Forum  
1:45 - 3:15 pm

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Tuesday, June 4

Symposium  
CME Credit Hours: 1.5

Advanced Endoscopy/Intraluminal Surgery: Raising the Bar for Detection and Non-Resectional Management of Advanced Polyps  
1:45 – 3:15 pm

Colorectal cancer is preventable in many cases if the precursor lesion is detectable and removable. Standard colonoscopic polypectomy techniques are used for the removal of the majority of polyps but are inadequate for larger polyps or those in difficult to reach locations. Several new technologies have enhanced the ability of the endoscopist to detect, evaluate and remove polyps safely, thus obviating the need for colectomy in certain instances. Included in these newer techniques are chromoendoscopy, endoscopic mucosal dissection (EMR), endoscopic submucosal dissection (ESD), over-the-scope assist devices, and endoluminal closure devices. This session is designed to introduce colorectal surgeons to current and developing techniques and technology for these procedures and guide them in the appropriate selection of neoplasms for such treatments.

Gap Analysis

**What Is:** There is a lack of familiarity and/or comfort with the alternative techniques that are available for the treatment of advanced polyps, leading to a substantial number of polyps being treated by colectomy that could potentially be amenable to removal by ESD or EMR.

**What Should Be:** Surgeons who perform colonoscopy should be adept at (or at least familiar with) alternative methods for treating difficult colonic polyps, in order to minimize both the need for colectomy as well as the risk of morbidity related to polypectomy.

**Objectives:** At the conclusion of this session, participants should be able to:

1. Select appropriate techniques for increasing polyp detection and characterization.
2. Determine which polyps are suitable for EMR or ESD.
3. Select a technique for defect closure after polypectomy if needed.
4. Describe the role for a combined laparoscopic and endoscopic approach.

**Co-Directors:**  
Kelley Garrett, MD, New York, NY  
Charles Whitlow, MD, New Orleans, LA

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1:45 pm  
Introduction  
Kelley Garrett, MD, New York, NY  
Charles Whitlow, MD, New Orleans, LA

1:50 pm  
Hide and Seek: Advanced Endoscopic Imaging for Detection of Polyps and Dysplasia  
Shamita Shah, MD, New Orleans, LA

2:00 pm  
Endoscopic Mucosal Resection – More Than Just a Snare  
Matt Zelhart, MD, New Orleans, LA

2:10 pm  
Digging In - Endoscopic Submucosal Dissection  
I.Emre Gorgun, Cleveland, OH

2:20 pm  
Endoscopic Assist Devices – Lending a Hand  
Jennifer Hrabe, Iowa City, IA

2:30 pm  
That’s a Big Hole, Now What?? Endoscopic Closure Devices  
Jeffrey Milsom, New York, NY

2:40 pm  
Considering Both Sides: Combined Endoscopic and Laparoscopic Surgery  
Sang Lee, MD, Los Angeles, CA

2:50 pm  
Panel Discussion

3:15 pm  
Adjourn
Tuesday, June 4
Symposium
CME Credit Hours: 1.5

Enhancing the Physician Patient Relationship
1:45 – 3:15 pm

The relationship between the patient and surgeon is held sacred. Patients enter the healthcare system at the most vulnerable time of their lives, and they experience a variety of emotions, including uncertainty and fear. Patients given a diagnosis with an associated ominous prognosis may develop secondary diagnoses such as clinical depression and anxiety disorders. Communication lapses may lead to significant confusion regarding diagnosis, treatment, and follow-up care. Patients rely on physicians and other providers for clarity, reassurance, and support. Physicians, surgeons in particular, have an outstanding opportunity to deliver compassion, empathy, and hope to assist patients and their families in their journey to navigate the healthcare labyrinth.

At the heart of the physician-patient relationship is effective communication. Like any other skill set in medicine, effective communication is something that can be learned, improved, and maintained. Individuals who gain admission into medical school, complete training and begin surgical practice cannot be presumed to possess good communication skills.

Good communication enhances the physician-patient relationship and includes more than just empathy and compassion. There is compelling evidence that good communication skills: improve quality and safety, enhances patient satisfaction, and may ultimately reduce physician burn-out.

Gap Analysis
What Is: The delivery of high quality, safe healthcare with empathy and compassion is the goal of every healthcare organization and physician. In today’s complex and changing world of healthcare delivery, our ability to successfully meet this goal is increasingly challenged. Physicians are required to manage more regulation, increased disease complexity, rising consumerism, and the demand for higher productivity. There is limited information to understand how to improve personal development, including communication skills, in order to enhance the physician-patient relationship.

What Should Be: Physicians should have access to information and educational materials to improve their communication skills and therefore better manage patient encounters and enhance the physician-patient relationship.

Objectives: At the conclusion of this session, participants should be able to:
1. Describe the key components of effective communication.
2. Recognize how enhanced communication skills may improve surgical teamwork as well as improve the physician-patient relationship.
3. Apply communication skills to improve specific situational experiences of the physician-patient relationship.
4. Describe how the improved patient care experience increases quality and safety.

Co-Directors: William Cirocco, MD, Columbus, OH
James Merlino, MD, Chicago, IL

1:45 pm Introduction and Patient Experience: It’s Not About Happiness
James Merlino, MD, Chicago, IL

1:55 pm Why is this Important to Physicians?
Melissa Times, MD, Cleveland, OH

2:05 pm Critical Skills for Relationship Centered Care
Laura Cooley, PhD, Lexington, KY

2:15 pm Leveraging Teamwork to Improve the Care of Patients
Kim Pyles, FACHE, New Orleans, LA

2:25 pm “Truthiness” and the Physician-Patient Relationship
William Cirocco, MD, Columbus, OH

2:35 pm Effective Conflict Resolution
Mariana Berho, MD, Hollywood, FL

2:45 pm Panel Discussion

3:15 pm Adjourn

Tuesday, June 4
3:30 – 4:30 pm
ASCRS Annual Business Meeting and State of the Society Address

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. David Margolin, will present a State of the Society Address and honor this year’s award recipients.
Tuesday, June 4

Symposium
CME Credit Hours: 1

Drinks and Disputes: The After Hours Debates
4:30 – 5:30 pm

Debate I: What is the Optimal Sphincter-Sparing Option for Fistula-in Ano?
4:30 – 5:00 pm

Debate II: Do anti-TNF Agents and Other Biologics Increase the Risk of Complication in Operations for Inflammatory Bowel Disease?
5:00 – 5:30 pm

Fistula-in-ano presents as one of the most common anorectal diseases encountered by the colorectal surgeon. Symptoms of pain and drainage lead patients to seek medical attention. Treatment failures and associated morbidities cause frustration for the patient and the surgeon. Obliteration of the internal opening has long been held as the key to resolution of a fistula caused by cryptoglandular infection. Numerous ways to accomplish this end have been described and include: 1) unroofing the entire tract and openings (fistulotomy), 2) occlusion of the tract and opening with a collagen plug, 3) occlusion of the opening alone (rectal mucosal or full-thickness flap), and 4) transection of the tract near its origin (ligation of the intersphincteric fistula tract [LIFT]). A variety of factors impact the selection of which treatment is appropriate to the individual patient. Unfortunately, our knowledge as surgeons suffers from the lack of quality research comparing one treatment modality with another.

A partial or full-thickness rectal flap can be created and used to cover the internal opening of an anal fistula. Success rates with this method range from 60 to 90% with no or minor affects on continence. Failures seem to be most associated with flap ischemia or involvement by Crohn’s disease. The LIFT procedure is a relatively recent addition to the surgeon’s options for treatment of anal fistulas. As such there is only preliminary data available which shows fistula healing rates of 60 to 80% with no adverse affects on continence.

The decision as to which of the available treatment is appropriate for the individual patient depends on patient factors, fistula anatomy and etiology, and the risk/benefit profile of the treatment. A thorough understanding of these factors is essential to high quality outcomes in the treatment of anal fistulas.

Do anti-TNF Agents and Other Biologics Increase the Risk of Complication in Operations for Inflammatory Bowel Disease?

Several studies have demonstrated worse surgical outcomes in patients being treated with these medications, while other studies have found no difference. This has led some surgeons to favor staged procedures in patients with ulcerative colitis and more judicious use of diverting stomas in patients with Crohn’s disease.

Gap Analysis
What is:
Debate I: There are various sphincter-sparing treatment options for the treatment of anal fistulas, however it is unclear which option is optimal in which clinical situation.
Debate II: Anti-TNF agents and biologics are commonly used on patients with inflammatory bowel disease who ultimately require surgical intervention, however it is not clear if they increase surgical complications or not.

What should be:
Debate I: Surgeons will understand the indications, success rates, and complications of the treatments available for anal fistulas.
Debate II: Surgeons will understand the optimal surgical treatment of patients with inflammatory bowel disease who are currently treated with anti-TNF agents and other biologics.

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

1. Describe the different treatment modalities available for anal fistula
2. Develop an algorithm for the management of different types of anal fistula
3. Explain the risks of surgical intervention in patients treated with anti-TNF and other biologic agents

Director: David Maron, MD, Weston, FL
Tuesday, June 4

Debate I: What is the Optimal Sphincter-Sparing Option for Fistula-in Ano? (continued)

4:30 – 5:00 pm

4:30 pm  Introduction  David Maron, MD, Weston, FL

4:35 pm  The LIFT Procedure is the Optimal Treatment of Anal Fistula  Peter Cataldo, MD, Burlington, VT

4:39 pm  Endorectal Advancement Flap is the Optimal Treatment of Anal Fistula  Juan Nogueras, MD, Weston, FL

4:43 pm  Rebuttal  Peter Cataldo, MD, Burlington, VT

4:46 pm  Rebuttal  Juan Nogueras, MD, Weston, FL

4:49 pm  Rebuttal  Peter Cataldo, MD, Burlington, VT

4:52 pm  Rebuttal  Juan Nogueras, MD, Weston, FL

5:00 pm  Concluding Remarks  David Maron, MD, Weston, FL

Debate II: Do anti-TNF Agents and Other Biologics Increase the Risk of Complication in Operations for Inflammatory Bowel Disease?

5:00 – 5:30 pm

5:00 pm  Introduction  David Maron, MD, Weston, FL

5:05 pm  Anti-TNF Agents /Biologics DO Increase the Risk of Surgical Complications  Phillip Fleshner, MD, Los Angeles, CA

5:09 pm  Anti-TNF Agents/Biologics DO NOT Increase the Risk of Surgical Complications  Amy Lightner, MD, Rochester, MN

5:16 pm  Rebuttal  Amy Lightner, MD, Rochester, MN

5:19 pm  Rebuttal  Phillip Fleshner, MD, Los Angeles, CA

5:22 pm  Rebuttal  Amy Lightner, MD, Rochester, MN

5:25 pm  Concluding Remarks  David Maron, MD, Weston, FL

5:30 pm  Adjourn

ASCRS Blues Fest- Farewell Reception

Tuesday, June 4, 6:30 – 8:00 pm

ASCRS Blues Fest- Farewell Reception will feature Blues inspired Hors’ devours, drinks and some great entertainment. It is scheduled for Tuesday, June 4, 6:30 – 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 event when registering for the meeting. All other registration categories must purchase a ticket. The cost for additional tickets is $150 per ticket.
Wednesday, June 5

Meet the Professor Breakfasts

CME Credit Hours: 1

7:00 – 8:00 am
Limit: 32 per breakfast • Fee $50 • Tickets Required • Continental Breakfast

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

W-1 Managing Pouch Complications
Giovanna Da Silva, MD, Weston, FL
Skandan Shanmugan, MD, Philadelphia, PA

W-2 Coding/Billing
Steven Sentovich, MD, Duarte, CA
Guy R. Orangio, MD, New Orleans, LA

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

1. Describe the procedures and approaches discussed in this session.
Wednesday, June 5
Symposium
CME Credit Hours: 1

Coffee and Controversies
7:00 – 8:00 am

Debate #1: Long Course Chemoradiation vs. Short Course for Locally Advanced Rectal Cancer
7:00 – 7:30 am

Debate #2: Elective Colectomy for Complicated Diverticulitis
7:30 – 8:00 am

While both Europeans and American have access to the same large prospective studies, the two continents have dramatically different approaches to the delivery of neoadjuvant radiation therapy for rectal cancer. Short course radiation is the preferred treatment in the majority of European countries, while long course chemoradiation is the norm in the United States. Recent changes in the NCCN guidelines have allowed for the use of short course therapy, yet most institutions have been resistant to adoption of this modality. As bundled care looms on the horizon, the payors may drive the neoadjuvant regimen in the future.

With improved diagnostic imaging, interventional techniques and antimicrobial therapy, non-operative treatment of complicated diverticulitis has become feasible. Current recommendations still require elective sigmoid resection for patients with complicated disease. Some studies now suggest that it may be possible to manage these patients expectantly. The risks of surgery must be weighed against the quality of life and risk of catastrophic recurrent attacks.

Through instructional debate, national experts on these subjects will present the data to support their arguments and refute those of their opponent.

Gap Analysis
What Is: There is a lack of knowledge about the options for neoadjuvant radiation for rectal cancer and the non-operative options for the elective treatment of complicated diverticulitis.

What Should Be: The future will likely mandate for the best treatment that can be obtained the most economically. Data driven knowledge supporting each of these modalities will allow physicians to improve treatment for their patients with locally advanced rectal cancer and diverticulitis.

Objectives: At the conclusion of this session, participants should be able to:
1. Explain the advantages and disadvantages of short and long course neoadjuvant radiation for rectal cancer.
2. Understand how to incorporate short course neoadjuvant radiation into the algorithm for the treatment of rectal cancer.
3. Determine if observation (rather than surgery) is a viable option in the elective treatment of complicated diverticulitis.

Director: Steven Hunt, MD, St. Louis, MO
Wednesday, June 5
Abstract Session
CME Credit Hours: 1.25

**Outcomes**
8:00 – 9:15 am

Wednesday, June 5
Abstract Session
CME Credit Hours: 1.25

**Education**
8:00 – 9:15 am

**Refreshment Break in Foyer**
9:15 – 9:30 am
**Wednesday, June 5**

**Symposium**  
**CME Credit Hours:** 1.25

**Hereditary Cancer Syndromes: What the Colorectal Surgeon Really Needs to Know**

8:00 – 9:15 am

Inherited predisposition is still an underappreciated aspect of the colorectal cancer work-up and management. No matter the type of practice, every colorectal surgeon will see patients with hereditary colorectal cancer, so understanding the various facets in management is vital to delivering quality patient care. This seminar will highlight several of the more challenging areas of identification and management of hereditary colorectal cancer patients, including a better understanding of genetic test results and pathways for counseling, additional testing for extracolonic risks in patients with a “positive” result, data on chemoprevention and chemotherapy in the setting of hereditary colorectal cancer, and discussion of the growing numbers of young-onset colorectal cancer patients and how best to surveil these patients after their diagnosis.

**Gap Analysis**

**What Is:** In order for a clinician to best understand the nuances of care as it relates to hereditary colorectal cancer, they would have to sift through the literature which becomes burdensome in a busy practice. Therefore, there is a need to present this information in a concise, useable fashion to improve care for patients with hereditary colorectal cancer.

**What Should Be:** Patients with hereditary colorectal cancer should be appropriately recognized, diagnosed, counseled, and treated.

**Objectives:** At the conclusion of this session, participants should be able to:

1. Recognize and interpret genetic testing results and know how to utilize resources such as genetic counseling and a registry to improve patient outcomes.
2. Describe the indications for chemoprevention and understand the options for chemotherapy in colorectal cancer when a patient is mutation positive.
3. Discuss the incidence of young-onset colorectal cancer and better understand management and follow up of this growing group of patients.

**Co-Directors:** Molly Ford, MD, Nashville, TN  
Paul E. Wise, MD, St. Louis, MO

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**8:00 am**

**Introduction**  
Molly Ford, MD, Nashville, TN  
Paul E. Wise, MD, St. Louis, MO

**8:05 am**

**Chemoprevention and Chemotherapy – What’s New for Hereditary Colorectal Cancer Syndromes?**  
Katerina Wells, MD, Dallas, TX

**8:15 am**

**Young-Onset Colorectal Cancer – Hereditary or Not, Here It Comes!**  
Karin Hardiman, MD, PhD, Ann Arbor, MI

**8:25 am**

**Interpretation of Genetic Test Results: The Importance of Genetic Counseling and Registries**  
Heather Hampel, MS, LGC, Columbus, OH

**8:35 am**

**Patient as a Whole – What Else to Look for in Patients with Hereditary Colorectal Cancer Syndromes?**  
Emily Steinhagen, MD, Cleveland, OH

**8:45 am**

**Case Discussion with Panel and Audience Questions**

**9:15 am**

**Adjourn**

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**Refreshment Break in Foyer**  
9:15 - 9:30 am
Wednesday, June 5

**Abstract Session**
CME Credit Hours: 1.25

**Inflammatory Bowel Disease**
9:30 – 10:45 am

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Wednesday, June 5

**Symposium**
CME Credit Hours: 1.25

**Advances and Controversies in the Management of Diverticulitis**
9:30 – 10:45 am

The incidence of diverticulitis continues to increase. As our understanding of its natural history improves, identifying the best strategies for management have become increasingly challenging. Not all patients and episodes of acute diverticulitis are equal. Management of acute diverticulitis can range from observation to antibiotic therapy to surgery depending upon the individual patient. This symposium will review the indications for antibiotic therapy for acute diverticulitis, follow-up evaluation after an attack of diverticulitis, timing of surgery for recurrent diverticulitis and surgical management of acute diverticulitis.

**Gap Analysis**

**What Is:** Every patient with acute diverticulitis is treated with antibiotic therapy. Elective resection is routinely offered for recurrent diverticulitis, urgent surgery for diverticulitis often results in colostomy for these patients.

**What Should Be:** A clear approach to an individualized treatment regimen for patients with uncomplicated and recurrent diverticulitis. Minimize the risk of a colostomy for urgent surgery for diverticulitis.

**Objectives:** At the conclusion of this session, participants should be able to:

1. Appropriately prescribe the use of antibiotic therapy for acute uncomplicated diverticulitis
2. Recognize the indications for elective surgery for patients with recurrent diverticulitis
3. Describe the appropriate procedure for patient requiring urgent surgery for acute diverticulitis

**Co-Directors:** Marylise Boutros, MD, Montreal, QC, Canada
Matthew Mutch, MD, St. Louis, MO

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9:30 am

**Introduction**
Marylise Boutros, MD, Montreal, QC, Canada
Matthew Mutch, MD, St. Louis, MO

9:35 am

**Uncomplicated Diverticulitis – Are Antibiotics Necessary?**
Sean Langenfeld, MD, Omaha, NE

9:45 am

**Follow-Up After Diverticulitis – When is a Colonoscopy Appropriate?**
Kelly Garrett, MD, New York, NY

9:55 am

**Recurrent Diverticulitis – When is Elective Resection Really Indicated?**
Alexander Hawkins, MD, Nashville, TN

10:05 am

**Urgent Surgery for Acute Diverticulitis – When to Operate and What to Do**
Charles Friel, MD, Charlottesville, VA

10:15 am

**Diverticular Abscess – Acute and Long-Term Management**
Alberto Arezzo, MD, Turin, Italy

10:25 am

**Panel discussion**

10:45 am

Adjourn
Wednesday, June 5
Symposium
CME Credit Hours:  1.25

Healthcare Economics: Policy Implications in the Future of Medicine
9:30 – 10:45 am

Economics in healthcare is an important topic on many levels including hospitals, healthcare systems, patients and physicians. Surgeons are in the center of this system and must be knowledgeable about the history, current status and future possibilities of healthcare economics in order to adequately understand the business of medicine. This ensures that the surgeon is able to make informed decisions and negotiate intelligently in their own practices, with administrators, and when considering political support.

Healthcare economics is an often confusing and changing subject with many different aspects. For instance, the economics of our national healthcare system affects all people including patients, physicians, and hospitals, and it is the umbrella under which all other economic considerations are constructed and include how physicians code and bill for services and how surgical practices construct employment contracts to determine what compensation plans are appropriate for surgeons. These important issues as well as the status of our national healthcare system and its impact on Colorectal Surgery before and after the Affordable Care Act will be discussed.

Gap Analysis
What Is:  There is a lack of understanding of the Affordable Care Act, how CPT billing codes are determined, and how surgeons should be compensated for services.

What Should Be:  Surgeons must have a thorough understanding of our current healthcare system and how it has affected physicians, how surgeons are represented in RUC, and how current Colorectal Surgeons are compensated.

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

1.  Recall the history of the Affordable Care Act and how it has affected healthcare.
2.  Recognize how CPT codes are determined and how Colorectal Surgeons are represented in the Relative Value Scale Update Committee (RUC).
3.  Explain the results of the ASCRS Compensation Survey.

Co-Directors:  Jennifer Ayscue, MD, Washington, DC
Walter Peters, Jr., MD, Dallas, TX

9:30 am
Introduction
Jennifer Ayscue, MD, Washington, DC
Walter Peters, Jr., MD, Dallas, TX

9:35 am
The ACA in the Age of Trump:  What Has Changed, Where are We Going?
Srinivas Ivatury, MD, Lebanon, NH

9:50 am
Cracking the Code:  The Mysteries of the CPT and RUC
William Harb, MD, Nashville, TN

10:05 am
What is a Colorectal Surgeon Worth?  The ASCRS Compensation Survey
Walter Peters, Jr., MD, Dallas, TX

10:20 am
Panel Discussion

10:45 am
Adjourn
Wednesday, June 5

Ernestine Hambrick, MD, Lectureship

CME Credit Hours: .75
10:45 - 11:30 am

Nancy Baxter, MD, PhD
Professor of Surgery, University of Toronto
Associate Dean, University of Toronto
Head, General Surgery
St. Michael's Hospital
Toronto, ON
Canada

Introduction: Ann C. Lowry, MD

Lunch on your own
11:30 am - 12:30 pm
Wednesday, June 5
Abstract Session
CME Credit Hours: 1.5

Quality
12:30 – 2:00 pm

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Wednesday, June 5
Symposium
CME Credit Hours: 1.5

Mission Impossible: Preparing for and Navigating the Difficult and Unexpected Operative Scenario
12:30 – 2:00 pm

“The novice surgeon gains judgment and skill by confronting difficult and challenging cases after such experience results in less than optimal outcomes.” This “paraphrased” axiom reflects a painful admission summarizing the reality of every surgeon as they ascend the steep learning curve towards becoming a master of this profession and craft. No simulation can adequately prepare a young surgeon for these difficult and sometimes seemingly impossible cases and operative scenarios. This symposium strives to tackle this issue by presenting the challenging scenarios and calling upon the experienced surgeon to demonstrate how they anticipate the at-risk situation and share their view of the essentials of patient and surgeon preparation and highlight key operative maneuvers and techniques necessary to successfully navigate these trying operative scenarios.

Gap Analysis
What Is: Young surgeons gain knowledge through experience, but there are times when a surgeon may find themselves in the heat of battle needing real-time advice or tricks to get out of a sticky situation

What Should Be: Young surgeons have access to senior surgeons and/or the tools needed to identify difficult operative scenarios and the skills required to successfully overcome these challenges

Objectives: At the conclusion of this session, participants should be able to:
1. Identify potential challenging operative scenarios and mitigate those challenges through preoperative planning and preparation.
2. Utilize technical “tips & tricks” for dealing with difficult operative scenarios.
3. Improve their overall understanding and appreciation for difficult operative scenarios and gain confidence in their care of these patients.

Co-Directors: Shaun Brown, DO, Fort Bragg, NC H. David Vargas, MD, New Orleans, LA

12:30 pm
Introduction
Shaun Brown, DO, Fort Bragg, NC
H. David Vargas, MD, New Orleans, LA

12:35 pm
I Divided the IMA and the Entire Left Colon Died!
Janice Rafferty, MD, Cincinnati, OH

12:47 pm
Game time Decision - I Can’t Double Staple!
David Beck, MD, New Orleans, LA

1:00 pm
Colostomy Closure and the Case of the “Missing Rectum”
Joseph Carmichael, MD, Orange, CA

1:24 pm
Recurrent Rectovaginal Fistula “Decisions- Decisions”
Najjia Mahmoud, MD, Philadelphia, PA

1:36 pm
On Table Lavage for Large Bowel Obstruction - “Making Friends in the OR!”
Sean Glasgow, MD, St. Louis, MO

1:50 pm
“To Be or Not to Be” - The Fate of the Anastomotic Sinus
Jorge Marcet, MD, Tampa, FL

2:00 pm
Audience Questions

2:00 pm
Adjourn
**Wednesday, June 5**

**Symposium**

CME Credit Hours: 1.5

**Benign Anorectal - Complex Problems, Advanced Techniques, and Special Populations**

12:30 – 2:00 pm

Prompt diagnosis and comprehensive treatment of anorectal diseases is one of the cornerstones of colorectal expertise. While many patients are straightforward, those with special circumstances such as pregnancy, immunosuppression, anti-coagulation, or spinal cord injury may present additional challenges. Outcomes may be enhanced using newer techniques and technological advances.

**Gap Analysis**

**What Is:** Multiple treatment options exist for various complex anorectal conditions, and since these complexities do not occur in high frequency, determining best practices may prove difficult.

**What Should Be:** Recognize various treatment options that exist and how to individualize care in for special patient populations

**Objectives:** At the conclusion of this session, participants should be able to:

1. Recognize advanced surgical treatment options for various complex anorectal conditions.
2. Describe new technological advancements in the treatment of complex anorectal conditions.
3. Recognize the special patient populations that exist with anorectal diseases, such as the immunocompromised or pregnant patient.

**Co-Directors:**

W. Brian Perry, MD, San Antonio, TX
Michael Valente, MD, Cleveland, OH

12:30 pm

**Introduction**

W. Brian Perry, MD, San Antonio, TX
Michael Valente, MD, Cleveland, OH

12:33 pm

**Management of Complex Hemorrhoidal Disease**

Maria Martinez Ugarte, MD, San Antonio, TX

12:36 pm

**Anorectal Abscesses Are NOT All Created Equally**

David Liska, MD, Cleveland, OH

12:45 pm

**Fistula-in-Ano - Too Many Options?**

Joshua Tyler, MD, Biloxi, MS

12:57 pm

**“My Butt Hurts” - Management of Painful Anorectal Conditions**

James Tiernan, MD, PhD, Cleveland, OH

1:09 pm

**Pilonidal Disease and Hidradenitis Suppurtativa**

Fia Ya, MD, Fort Sam Houston, TX

1:21 pm

**Is It a Rash or an Infection? Management of Perianal Dermatologic and Infectious Conditions**

Evie Carchman, MD, Madison, WI

1:33 pm

**Panel Discussion**

2:00 pm

**Adjourn**

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**Wednesday, June 5**

**Abstract Session**

CME Credit Hours: 1.5

**Benign Disease**

2:00 – 3:30 pm
Is It Really Unresectable? Management of Advanced and Recurrent Colorectal Cancer

2:00 – 3:30 pm

New management strategies for patients with advanced and recurrent colorectal cancer have evolved in recent years. While patient selection remains the critical factor for success, refined imaging tools, effective chemotherapeutic regimens, advanced radiation techniques have enabled more effective surgical resections. Previous limits of resectability have been extended, contributing to improved survival and quality of life. It is imperative that the surgeon has a thorough understanding of when curative-intent treatment is feasible, when adjunctive multimodality treatment is beneficial, what it takes to assemble a team for multi-visceral resection, and how to judge when risks outweigh benefits of resection.

Gap Analysis

What Is: Management of advanced and recurrent colorectal cancer is challenging. Surgical treatment offers the best chance for potential cure and improved quality of life. However, some patients are not being referred for potentially curative intent surgical intervention. A thorough understanding of the boundaries of resectability, the benefits and risks of intervention and the outcomes at specialized centers is needed.

What Should Be: Every pelvis surgeon, whether working at a specialized center or not, should understand the key decision-making factors, the importance of multimodality therapy, the boundaries of resectability so that they can assist in triaging the patient to the appropriate care pathway.

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

1. Formulate a clinical algorithm for decision-making regarding advanced and recurrent colorectal cancer.
2. Identify the boundaries of resectability when tumor involves the lateral pelvic sidewall and the posterior sacral bone.
3. Describe elements contributing to a successful RO multivisceral pelvic resection

Co-Directors: David Larson, MD, Rochester, MN
Y. Nancy You, MD, Houston, TX

2:00 pm
Introduction
David Larson, MD, Rochester, MN
Y. Nancy You, MD, Houston, TX

2:03 pm
Algorithm for Pre-Operative Assessment and Selection
Per Nilsson, MD
Stockholm, Sweden

2:15 pm
Adjunct Tools: Can They Extend the Limits of Resection?
Brian Bednarski, MD, Houston, TX

2:27 pm
Multi-visceral Pelvic Surgery with RO Margin: Resection and Reconstruction
Philip Paty, MD
New York, NY

2:42 pm
Lateral and Pelvic Sidewall Involvement: Where is the Limit
Peter Sagar, MD, Leeds, United Kingdom

2:55 pm
Resection with Sacrectomy? How to Decide
David Larson, MD, Rochester, MN

3:07 pm
Illustrative Case & Q/A

3:30 pm
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Robotics: Practical Tips and Tricks
2:00 – 3:30 pm

The adoption of the robotic approach to colorectal surgery continues to increase and has resulted in a minimally invasive alternative that is decreasing the prevalence of traditional open surgery. Surgeons are expanding the boundaries of what can be done via a minimally invasive approach. It is important for colorectal surgeons to monitor the landscape of novel approaches to determine the effectiveness of these approaches and the role for minimally invasive surgery alternatives in practice.

This session will feature lectures with instructional videos. Topics covered will include the role for robotics to various colorectal operations, what technology is currently available and, on the horizon, technical tips and tricks for challenging portions of robotic surgeries, and demonstrations of how robotics can advance a minimally invasive approach.

This course is aimed at three populations of surgeons:

- Practicing colon and rectal surgeons who perform robotic surgery but are still early in their learning curve. This session will give them insight on how to improve efficiency.
- Practicing colon and rectal surgeons who do not currently do robotic surgery but wish to introduce robotic surgery into their practice.
- Colon and rectal residents that are interested in robotics

Gap Analysis
What Is: Colorectal surgeons need to be familiar with the capabilities of robotic surgery, and how robotics can increase what can be done via a minimally invasive approach. Many surgeons need awareness and/or updates on robotic approaches to various colorectal operations, and what new minimally invasive alternatives are on the horizon.

What Should Be: Colorectal surgeons should be familiar with advanced minimally invasive options for several colorectal operations and what current advances may make these operations more effective. This will allow our membership to make an educated choice as to how and when to incorporate robotics into their practice.

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

1. Describe what robotic systems are currently available and what their differences are.
2. Recognize robotic approaches to several colorectal operations and how robotics improves the conduct of these operations.
3. Discuss the use of robotic surgery in rectal cancer patients.

Co-Directors: Jamie Cannon, MD, Birmingham, AL
Robert Cleary, MD, Ann Arbor, MI
FUTURE ASCRS MEETINGS

June 6 – 10, 2020
Hynes Convention Center
Boston, MA

April 24 – 28, 2021
San Diego Convention Center
San Diego, CA

April 30 – May 4, 2022
Tampa Convention Center
Tampa, FL

June 3-7, 2023
Washington State Convention Center
Seattle, WA

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