American Society of Colon & Rectal Surgeons

Annual Scientific Meeting

May 19-23, 2018

Nashville

Music City Center

Nashville, Tennessee

FASCRS.org
# Table of Contents

<table>
<thead>
<tr>
<th>Date</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday, May 1</strong></td>
<td>- Meet the Professor Breakfasts</td>
</tr>
<tr>
<td></td>
<td>- Coffee and Controversies: Minimally Invasive Surgery</td>
</tr>
<tr>
<td></td>
<td>- Abstract Session: Inflammatory Bowel Disease</td>
</tr>
<tr>
<td></td>
<td>- Symposium: Through the Ages: Caring for the Adult Who Was a Pediatric</td>
</tr>
<tr>
<td></td>
<td>Surgery Patient</td>
</tr>
<tr>
<td></td>
<td>- Symposium: Ethics</td>
</tr>
<tr>
<td></td>
<td>- E-poster Presentations</td>
</tr>
<tr>
<td></td>
<td>- Symposium: Ask the Expert Panel – Complex Cases</td>
</tr>
<tr>
<td></td>
<td>- Presidential Address</td>
</tr>
<tr>
<td></td>
<td>- E-poster Presentations</td>
</tr>
<tr>
<td></td>
<td>- Abstract Session: Education</td>
</tr>
</tbody>
</table>
|                 | - Symposium: Your Day Just Got Complicated:  
|                 |   Management of Intra-Operative Consults and Postoperative Complications   |
|                 | - Symposium: Controversies in the Management of Inflammatory Bowel Disease |
|                 | - Abstract Session: Outcomes                                                |
| **Monday, May 21** | - Symposium: Pathogen or Partner? The Role of the Gut Microbiome in the   |
|                 |   Colorectal Surgical Patient                                              |
|                 | - Symposium: Financial Planning for the Colorectal Surgeon:  
|                 |   Everything You Have Always Wanted to Know, But Were Afraid to Ask     |
|                 | - E-poster Presentations                                                    |
|                 | - Harry E. Bacon, MD, Lectureship                                          |
|                 | - Symposium: New Technologies (No CME)                                      |
|                 | - Residents’ Reception                                                      |
| **Tuesday, May 22** | - Meet the Professor Breakfasts                                             |
|                 | - Residents’ Breakfast                                                      |
|                 | - Parviz Kamangar Humanities in Surgery Lectures                            |
|                 | - Symposium: The Best of the Diseases of the Colon and Rectum Journal      |
|                 | - E-poster Presentations                                                    |
|                 | - Abstract Session: General Surgery Forum                                   |
|                 | - Symposium: Out of the Movies and Into Reality:  
|                 |   How Disruptive Technology May Change the Way You Practice                |
|                 | - Symposium: What the American College of Surgeons Does for Me as an ASCRS |
|                 |   Member                                                                     |
|                 | - Masters in Colorectal Surgery Lectureship                                |
|                 | - Honor Patricia L. Roberts, MD                                             |
|                 | - Women in Colorectal Surgery Luncheon                                      |
|                 | - Memorial Lectureship Honoring Dr. Bertram Portin                         |
|                 | - E-poster Presentations                                                    |
|                 | - Abstract Session: Basic Science                                           |
|                 | - Abstract Session: Research Forum                                          |
|                 | - Symposium: Hereditary Colorectal Cancer Syndromes                         |
|                 | - ASCRS Annual Business Meeting and State of the Society Address            |
|                 | - Drinks and Disputes: The After Hours Debates                             |
|                 | - ASCRS Music City Gala                                                    |
| **Wednesday, May 23** | - Meet the Professor Breakfasts                                             |
|                 | - Coffee and Controversies: Minimally Invasive Surgery                     |
|                 | - Abstract Session: Neoplasia II                                            |
|                 | - Symposium: The Future of Surgical Practice:  
|                 |   How Will Changes in the Rules Affect You?                                |
|                 | - Symposium: When the Dust Settles – Reconstruction After Leaks, Fistulas  |
|                 |   and Abdominal Wall Defects                                                |
|                 | - Abstract Session: Video Session                                           |
|                 | - Ernestine Hambrick, MD, Lectureship                                      |
|                 | - Abstract Session: Neoplasia II                                            |
|                 | - Symposium: Translating Outcomes Data Into Meaningful Practice Change     |
|                 | - Abstract Session: Pelvic Floor Disorders                                  |
|                 | - Symposium: Difficulties Surrounding the Management of Diverticulitis     |

**General Meeting Information** ........................................ 3

**Saturday, May 19**
- Workshop: Advanced Robotics for the Practicing Surgeon .......... 6
- Symposium and Workshop: Advanced Methods for the Management of Rectal Prolapse .......... 7
- Symposium and Workshop: Transanal Total Mesorectal Excision (taTME) .......... 9
- Workshop: AIN and HRA: What the Colorectal Surgeon Needs to Know .......... 12
- Symposium: Health Care Policy .......... 15
- Symposium: Critical Review of Scientific Manuscripts:  
  - A How-to Guide .......... 16
- Workshop: Young Surgeons Mock Orals & More .......... 17
- Symposium: Leadership .......... 19
- Workshop: Question Writing: Do You Know How to Write the Perfect Exam Question? .......... 20

**Sunday, May 20**
- Symposium and Workshop: Advanced Endoscopy .......... 21
- Core Subject Update .......... 23
- Symposium: Contemporary Management of Lower GI Bleeding .......... 24
- Symposium: When You Hear Hoofbeats, Think Zebras:  
  - Uncommon/Atypical Colorectal Conditions .......... 26
- Symposium: Robotic Colon and Rectal Surgery:  
  - Tips and Tricks .......... 28
- Welcome and Opening Announcements .......... 29
- Norman D. Nigro, MD, Research Lectureship .......... 29
- Abstract Session: Neoplasia I .......... 29
- Symposium: Anal and Rectovaginal Fistula Management:  
  - From Simple to Complex .......... 30
- Symposium: Complex Cases – I Need Help! Plastic Surgery for the Colorectal Surgeon .......... 31
- Abstract Session: Benign Disease .......... 32
- Symposium: Enhanced Recovery Protocols and Pathways for Colectomy and Beyond: Involving Your Allied Health and Other Health Professionals .......... 33
- Welcome Reception .......... 34

**Monday, May 21**
- Meet the Professor Breakfasts .......... 35
- Coffee and Controversies: Minimally Invasive Surgery .......... 36
- Abstract Session: Inflammatory Bowel Disease .......... 37
- Symposium: Through the Ages: Caring for the Adult Who Was a Pediatric Surgery Patient .......... 38
- Symposium: Ethics .......... 39
- E-poster Presentations .......... 40
- Symposium: Ask the Expert Panel – Complex Cases .......... 41
- Presidential Address .......... 42
- E-poster Presentations .......... 42
- Abstract Session: Education .......... 42
- Symposium: Your Day Just Got Complicated:  
  - Management of Intra-Operative Consults and Postoperative Complications .......... 43
- Symposium: Controversies in the Management of Inflammatory Bowel Disease .......... 44
- Abstract Session: Outcomes .......... 44

**Tuesday, May 22**
- Meet the Professor Breakfasts .......... 49
- Residents’ Breakfast .......... 49
- Parviz Kamangar Humanities in Surgery Lectureship .......... 49
- Symposium: The Best of the Diseases of the Colon and Rectum Journal .......... 50
- E-poster Presentations .......... 50
- Abstract Session: General Surgery Forum .......... 50
- Symposium: Out of the Movies and Into Reality:  
  - How Disruptive Technology May Change the Way You Practice .......... 51
- Symposium: What the American College of Surgeons Does for Me as an ASCRS Member .......... 53
- Masters in Colorectal Surgery Lectureship:  
  - Honoring Patricia L. Roberts, MD .......... 54
  - Women in Colorectal Surgery Luncheon .......... 54
  - Memorial Lectureship Honoring Dr. Bertram Portin .......... 54
- E-poster Presentations .......... 54
- Abstract Session: Basic Science .......... 54
- Abstract Session: Research Forum .......... 54
- Symposium: Hereditary Colorectal Cancer Syndromes .......... 55
- ASCRS Annual Business Meeting and State of the Society Address .......... 55
- Drinks and Disputes: The After Hours Debates .......... 56
- ASCRS Music City Gala .......... 57

**Wednesday, May 23**
- Meet the Professor Breakfasts .......... 58
- Coffee and Controversies: Minimally Invasive Surgery and Big Data vs. Social Media .......... 59
- Symposium: Are There Solid Options for Fecal Incontinence? .......... 62
- Symposium: The Future of Surgical Practice:  
- Symposium: When the Dust Settles – Reconstruction After Leaks, Fistulas and Abdominal Wall Defects .......... 64
- Abstract Session: Video Session .......... 65
- Ernestine Hambrick, MD, Lectureship .......... 65
- Abstract Session: Neoplasia II .......... 65
- Symposium: Translating Outcomes Data Into Meaningful Practice Change .......... 66
- Abstract Session: Pelvic Floor Disorders .......... 66
- Symposium: Difficulties Surrounding the Management of Diverticulitis .......... 67
Program Leadership

Eric Johnson, MD
Program Chair

Jamie Cannon, MD
Program Vice Chair

Jason Mizell, MD
Program Vice Chair

Annual 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 41.75 AMA PRA Category 1 Credit(s)™. Physicians should only claim 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 2018 ASCRS 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, 2018.

Self-Assessment Credit

Many of the sessions offered will be designated as self-assessment CME credit, applicable to Part 2 of the ABCRS MOC program. To claim self-assessment credit, attendees must complete 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.

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, are intended to inform participants about the knowledge, techniques and experiences of specialists who are willing to share such information with colleagues. A diversity of professional opinions exist in the specialty and the views of the ASCRS disclaim 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
As required by the Accreditation Council for Continuing Medical Education (ACCME) and in accordance with the American Society of Colon and Rectal Surgeons policy, the ASCRS must identify and resolve conflicts of interest for all individuals responsible for the development, management, presentation, or evaluation of content for a CME activity. Financial disclosures are reviewed in advance, to ensure any potential conflicts of interest are resolved. Disclosure in no way implies that the information presented is biased or of lesser quality; it is incumbent upon course participants to be aware of these factors in interpreting the program contents and evaluating recommendations.

Specific disclosure information for the 2018 Annual Meeting will be in the final program guide and mobile app.

Social Events
The Welcome Reception will be held Sunday, May 20, 7:00 – 10:00 pm (complimentary to all registered attendees) and will feature hors d’oeuvres, cocktails and entertainment. The Welcome Reception will be held at the Country Music Hall of Fame and Museum. The Research Foundation will join forces with ASCRS to welcome all at this reception.

The ASCRS Music City Gala is scheduled for Tuesday, May 22, 7:30 – 10:30 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, and then obtain their ticket on-site prior to the event. The cost for others is $150 per ticket.

Complimentary Wi-fi Available
There is complimentary Wi-fi for attendees in the Music City Center.

Accommodations
The meeting will be held at the Music City Center and Omni Nashville Hotel in Nashville, TN.

The Music City Center and hotels are approximately 20 minutes (9 miles) from the Nashville International Airport.

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

Omni Nashville Hotel
(Headquarters – Across the street from the Convention Center)
$242 Single
(800) THE-OMNI
$252 Double

The Westin Nashville
(1 block from the Convention Center)
$275 Single / Double
(866) 912-1028

Hilton Nashville Downtown
(1 block from the Convention Center)
$254 Single / Double
(615) 620-2150
(Monday-Friday, 7:00 am – 6:00 pm CST)

Hotel reservation/rate availability is not guaranteed after the room block is full or after April 16, 2018. Please register early – only a limited number of rooms are available.

The deadline for hotel reservations is Monday, April 16, 2018.

HOUSING ALERT:
ASCRS is not contracted with any housing company or travel agency to place hotel reservations on behalf of ASCRS, its exhibitors or its sponsors. These companies have not entered into agreements with the ASCRS or Nashville hotels and are not able to guarantee rates and accommodations during the conference dates. Should you be contacted by any agency, please email ASCRS at meetings@fascrs.org with the details.

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

Official ASCRS Travel Agency
To make your airline reservation, call ASCRS’ official travel agency, Uniglobe Travel Partners, at (800) 626-0359 (M-F 8:30 am – 7:00 pm CST).
Exhibit Hall Hours
Sunday, May 20, 11:30 am – 4:30 pm
Complimentary box lunch
Afternoon refreshment break
Monday, May 21, 9:00 am – 4:30 pm
Morning and afternoon refreshment breaks
Complimentary box lunch
Tuesday, May 22, 9:00 am – 2:00 pm
Morning refreshment break
Complimentary box lunch

Spouse/Companion Program
Please review the following and indicate your choices when you register.
Package #1 ($175) Includes:
Welcome Reception, 7:00 – 10:00 pm, Sunday
ASCRS Music City Gala, 7:30 – 10:30 pm, Tuesday
Admission to the exhibit floor only
Package #2 ($75) Includes:
Welcome Reception, 7:00 – 10:00 pm, Sunday
Admission to the exhibit floor only

Temperature
The average temperature in May ranges from a low of 75° to a high of 82°F.

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

Registration Fees
Please see registration information online.

Cancellation Policy
If you need to cancel your meeting registration, the Society will refund your General Registration fee, minus the $75 cancellation fee, upon written request. No refunds will be issued for requests received after April 30, 2018.
The Society will refund workshop fees if your cancellation request is received in writing before April 30, 2018.
Cancellations must be received in writing. Send requests to the ASCRS Meeting Registration Department at:
Email: meetings@fascrs.org
Fax: (847) 427-9656
Mail: American Society of Colon and Rectal Surgeons Meeting Registration Dept.
85 W. Algonquin Rd., Ste. 550
Arlington Heights, IL 60005

Not a member? Join now to save on registration!
Membership provides highly discounted 2018 Annual Scientific Meeting registration fees, so if you plan to attend the meeting, your membership will pay for itself, plus includes:
• Subscription to Diseases of the Colon and Rectum.
• Office listing in “Find a Surgeon” search engine on the ASCRS website.
• Discounted pricing on products, such as CREST®, CARSEP® and brochures.
• 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 organization of more than 3,800 physicians and health care 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.
Saturday, May 19

Workshop
Advanced Robotics for the Practicing Surgeon

7:00 am – noon

Registration Required • Member Fee: $625 • Nonmember Fee: $750 • 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, advanced maneuvers to facilitate robotic ascending colectomy, intracorporeal anastomosis and low anterior resection.

Each cadaver station will accommodate four participants. 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.

Existing Gaps
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.

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:
• Describe the set up and instrumentation of advanced robotic colorectal procedures.
• Explain different procedural approaches in robotic colorectal surgery.
• Explain how to troubleshoot and address specific robotic-related complications in colorectal surgery.

Co-Directors: Vincent Obias, MD, Washington, DC
Mark Soliman, MD, Orlando, FL

Faculty:
Ovunc Bardakcioglu, MD, Las Vegas, NV
Eric Haas, MD, Houston, TX
Bryce Murray, MD, Tulsa, OK
Elizabeth Raskin, MD, Loma Linda, CA
Craig Rezac, MD, New Brunswick, NJ
Joshua Tyler, MD, Biloxi, MS

5.0 CME
Symposium and Workshop

Advanced Methods for the Management of Rectal Prolapse

7:30 am – 4:30 pm

Registration Required (Includes Didactic and Hands-on Workshop) • Member Fee: $625 • Nonmember Fee: $750

Limit: 20 participants • Lunch Included

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

Rectal prolapse is a debilitating condition with both functional and anatomic sequelae. Recurrence rates for complete rectal prolapse have been reported as high as 10-20%. The surgical approach to treat these recurrences remains an unresolved problem. Laparoscopic Ventral Rectopexy (LVR) is the current gold standard for treatment of rectal prolapse in European countries.

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

LVR 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. Poor technique minimizes the functional benefit and increases the risk for complications. Formal training programs in Ventral Rectopexy (VR) can help to avoid complications and improve outcomes.

Existing Gaps

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, rectocoele, fecal incontinence and obstructed defecation. LVR is the gold standard for rectal prolapse repair in Europe. There are few training opportunities in the United States for LVR and 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 with other prolapse operations for patients who are not optimal candidates for VR.

Objectives: At the conclusion of this session, participants should be able to:
• Explain Laparoscopic Ventral Rectopexy, indications and long-term outcomes.
• Describe surgical steps for Ventral Rectopexy.
• Distinguish how to avoid and how to deal with surgical complications after prolapse surgery.

Co-Directors: Brooke Gurland, MD, Stanford, CA
Andrew Stevenson, MD, Chermside, Australia

Continued next page
Advanced Methods for the Management of Rectal Prolapse (continued)

Didactic Session
7:30 am – noon

7:30 am  Introduction  Brooke Gurland, MD, Stanford, CA
          Andrew Stevenson, MD, Chermside, Australia

7:40 am  Principles and Evolution of Procedures for Rectal Prolapse  
          Stanley Goldberg, MD, Minneapolis, MN

7:55 am  VR – Evolution of Technique and Long Term Outcomes  
          Andre D’Hoore, MD, Leuven, Belgium

8:10 am  Testing? What Helps Me Prior to Prolapse/VR Repair?  
          Amy Thorsen, MD, Minneapolis, MN

8:25 am  Synthetic vs. Biologic – The “Mesh” Debate  
          James Ogilvie, Jr., MD, Grand Rapids, MI

8:40 am  Patient Selection – Is Everyone a Candidate for VR?  
          Anders Mellgren, MD, Chicago, IL

8:55 am  Management and Prevention of VR Complications  
          Elizabeth Raskin, MD, Loma Linda, CA

9:10 am  LVR Surgery Video: How I Do It  
          Roel Hompes, MD, Oxford, United Kingdom

9:30 am  Questions and Answers

9:50 am  Break

10:00 am  Is VR the Panacea for Obstructed Defecation Syndrome?  
           Roel Hompes, MD, Oxford, United Kingdom

10:10 am  And it’s Back! Dealing with Recurrent Rectal Prolapse  
           Brooke Gurland, MD, Stanford, CA

10:25 am  Robotic VR Surgery Video – How I Do It  
           Joseph Carmichael, MD, Orange, CA

10:45 am  Top Ten Tips for VR – Synthetics  
           Andre D’Hoore, MD, Leuven, Belgium

10:55 am  Top Ten Tips for VR – Biologics  
           Andrew Stevenson, MD, Chermside, Australia

11:05 am  Top Ten Tips to Avoid Complications  
           Brooke Gurland, MD, Stanford, CA

11:15 am  Panel Discussion and Case Presentations  
           Liliana Bordeianou, MD, Boston, MA  
           James Ogilvie, Jr., MD, Grand Rapids, MI

11:45 am  Questions and Answers

Noon  Adjourn

Noon  Lunch (Provided for Hands-on Workshop Participants)

Hands-on Workshop
1:00 – 4:30 pm • Tickets Required

1:00 pm  Simulation Demonstration/  
            Laparoscopic and Robotic to Describe  
            Procedure Steps with Models and  
            Step-by-Step Live Demonstration  
            by the Experts  
            All Faculty

1:30 pm  Hands-on Participation Begins

4:30 pm  Adjourn
Symposium and Workshop

Transanal Total Mesorectal Excision (taTME)

7:30 am – 4:30 pm

Registration and Pre-registration Survey Required (Includes Didactic and Hands-on Workshop) • Fee: $1,100
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 the use of available transanal endoscopic platforms, rectal and mesorectal dissection can be completed endoluminally with early identification of the distal transection margin and direct in-line exposure of perirectal and mesorectal planes.

During the morning didactic session, the evolution of taTME will be reviewed, including global trends in adoption, short and long term results to date, ongoing clinical trials, as well as newer trends in transanal endoscopic proctectomy. Experts will review the current consensus on patient selection, relevant pelvic anatomy, prerequisite skills and training recommended to ensure safe implementation. Techniques will be reviewed through in-depth taTME video-based demonstrations, clinical case presentations, operative set up and key steps in transanal dissection based on tumor location. Pitfalls during dissection will be demonstrated with tips and tricks on how to overcome intraoperative difficulties and complications.

The hands-on workshop is intended to train high volume rectal cancer surgeons with expertise in minimally invasive TME and transanal endoscopic surgery (TES). Each surgical team will perform taTME on one platform with laparoscopic assistance.

Existing Gaps
What Is: A lack of clinical experience with and training in taTME operation persists, particularly in the United States.

What Should Be: This course will review the current status of taTME, indication and contraindications for taTME, recommended training, safe adoption and implementation of taTME programs, operative set-up and specific techniques, as well as pitfalls and complications. In-depth didactic lectures with videos will be provided by expert faculty.

Objectives: At the conclusion of this session, participants should be able to:
- Explain the rationale, indications, contraindications for taTME based on published evidence and review of clinical outcomes.
- Recognize the recommended prerequisite skills and training guidelines for safe adoption and implementation of taTME.
- Apply recommended taTME dissection techniques, identify anatomic landmarks and recognize correct and incorrect dissection planes.

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

Pre-registration Survey (Required for hands-on workshop)
While the ASCRS taTME didactic session (7:30 am – noon) is open to all registrants for a nominal fee, the hands-on cadaver workshop (noon – 4:30 pm) will be limited to surgeons with prerequisite skills in minimally-invasive TME and transanal endoscopic surgery (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/2018-tatme-registration-info. PLEASE NOTE: You must be registered for the Annual Meeting before your pre-registration survey will be reviewed. If you are not registered, your survey will not be reviewed.
Transanal Total Mesorectal Excision (taTME) (continued)

Didactic Session
7:30 am – noon

7:30 am  Introduction
Patricia Sylla, MD, New York, NY

taTME Evolution and Revolution
7:35 am  taTME Evolution and Rationale
Antonio Lacy, MD, Barcelona, Spain

7:45 am  Uptake of taTME: A Global Perspective
Andrew Stevenson, MD, Brisbane, Australia

7:55 am  taTME: Outcomes to Date
Marta Penna, MD, London, United Kingdom

8:05 am  Next Steps in Validation of taTME – Europe
Jurriaan Tuynman, MD, Amsterdam, The Netherlands

8:15 am  Next Steps in Validation of taTME – US/Asia
Patricia Sylla, MD, New York, NY

8:25 am  Current Trends in taTME and Applications in Evolution
Roel Hompes, MD, Oxford, United Kingdom

8:35 am  Questions and Answers

4.5 CME

Operative Techniques and Strategies (Video-Based)
10:25 am  OR Team Setup and Options in Instrumentation
Rodrigo Perez, MD, Sao Paulo, Brazil

10:35 am  taTME for Mid-Rectal Tumors: Pursestring and Circumferential Dissection
Carl Brown, MD, Vancouver, Canada

10:45 am  taTME for Low Rectal Tumors: Mucosectomy and Intersphincteric Resection
Mark Whiteford, MD, Portland, OR

10:55 am  Anastomotic Reconstruction: Techniques and Troubleshooting
Elena Vikis, MD, Vancouver, Canada

11:05 am  Intraoperative Misadventures: Getting Out of Trouble
Matthew Albert, MD, Altamonte Springs, FL

11:15 am  Questions and Answers

11:25 am  Case Presentations
All Faculty

noon  Adjourn

noon  Lunch (Provided for Hands-on Workshop Participants)

Continued next page
SATURDAY, MAY 19

Transanal Total Mesorectal Excision (taTME) (continued)

Hands-on Workshop
1:00 – 4:30 pm

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

taTME and Pursestring Stations:
Matthew Albert, MD, Altamonte Springs, FL
Sam Atallah, MD, Winter Park, FL
Joep Knol, MD, Hasselt, Belgium
Antonio Lacy, MD, Barcelona, Spain
Elena Vikis, MD, Vancouver, Canada
Andrew Stevenson, MD, Brisbane, Australia
Willem Bemelman, MD, Vinkeen, The Netherlands
Roel Hompes, MD, Oxford, United Kingdom
Scott Steele, MD, Cleveland, OH
Jurriaan Tuynman, MD, Amsterdam, The Netherlands
Karim Alavi, MD, Worcester, MA
Marylise Boutros, MD, Montreal, Canada
Elisabeth McLemore, MD, Los Angeles, CA
Todd Francone, MD, Boston, MA
Rodrigo Perez, MD, Sao Paulo, Brazil
Mark Whiteford, MD, Portland, OR
Carl Brown, MD, Vancouver, Canada
Mark Sun, MD, Minneapolis, MN

4:15 pm Debrief
4:30 pm Adjourn
The incidence of anal cancer is increasing due to rising rates of human papilloma virus (HPV) infection. HPV infection can lead to anal intraepithelial neoplasia (AIN) that can be identified with high-resolution anoscopy (HRA). While colon and rectal surgeons are very familiar with the evaluation and treatment of anal cancer, many do not know how to identify the anal cancer precursor, AIN, with HRA. While the efficacy of HRA with targeted ablation of HSIL to prevent anal cancer has never been proven through prospective trials, there is a growing awareness even among surgeons who do not utilize HRA that close follow-up is necessary.

**Existing Gaps**

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

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

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

- Explain the new AJCC anal cancer staging guidelines.
- Describe the prevalence of anal HPV infection.
- Recognize how to best diagnose AIN.
- Describe the fundamentals of how to perform high-resolution anoscopy.
- Identify treatment options available for AIN.

**Co-Directors:** Stephen Goldstone, MD, New York, NY  
Mark Welton, MD, Minneapolis, MN

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

---

**Workshop**

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

7:30 am – 4:30 pm

**Registration Required • Member Fee: $625 • Nonmember Fee: $750 • Limit: 45 participants • Lunch Included**

---

Continued next page
### AIN and HRA: What the Colorectal Surgeon Needs to Know

(continued)

**SATURDAY, MAY 19**

**11:15 am – 12:45 pm**

<table>
<thead>
<tr>
<th>Group</th>
<th>11:15 – 11:45 am</th>
<th>11:45 am – 12:15 pm</th>
<th>12:15 – 12:45 pm</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1</strong></td>
<td><strong>Lesion Identification</strong>&lt;br&gt;(Understanding Lesion Patterns to Differentiate LG from HG)&lt;br&gt;<strong>Gallery of Images</strong>&lt;br&gt;Naomi Jay, RN, NP, PhD</td>
<td><strong>Hands-on Workshop:</strong> HRA Including Use of the Colposcope and Biopsy Techniques&lt;br&gt;J. Michael Berry-Lawhorn, MD&lt;br&gt;Teresa Darragh, MD&lt;br&gt;Stephen Goldstone, MD&lt;br&gt;Mark Welton, MD</td>
<td><strong>HRA the Movie</strong>&lt;br&gt;Joel Palefsky, MD</td>
</tr>
<tr>
<td><strong>Group 2</strong></td>
<td><strong>HRA the Movie</strong>&lt;br&gt;Joel Palefsky, MD</td>
<td><strong>Lesion Identification</strong>&lt;br&gt;(Understanding Lesion Patterns to Differentiate LG from HG)&lt;br&gt;<strong>Gallery of Images</strong>&lt;br&gt;Naomi Jay, RN, NP, PhD</td>
<td><strong>Hands-on Workshop:</strong> HRA Including Use of the Colposcope and Biopsy Techniques&lt;br&gt;J. Michael Berry-Lawhorn, MD&lt;br&gt;Teresa Darragh, MD&lt;br&gt;Stephen Goldstone, MD&lt;br&gt;Mark Welton, MD</td>
</tr>
<tr>
<td><strong>Group 3</strong></td>
<td><strong>Hands-on Workshop:</strong> HRA Including Use of the Colposcope and Biopsy Techniques&lt;br&gt;J. Michael Berry-Lawhorn, MD&lt;br&gt;Teresa Darragh, MD&lt;br&gt;Stephen Goldstone, MD&lt;br&gt;Mark Welton, MD</td>
<td><strong>HRA the Movie</strong>&lt;br&gt;Joel Palefsky, MD</td>
<td><strong>Lesion Identification</strong>&lt;br&gt;(Understanding Lesion Patterns to Differentiate LG from HG)&lt;br&gt;<strong>Gallery of Images</strong>&lt;br&gt;Naomi Jay, RN, NP, PhD</td>
</tr>
</tbody>
</table>

1:00 pm **Lunch with Panel Discussion and Questions**

**2:00 – 3:30 pm**

<table>
<thead>
<tr>
<th>Group</th>
<th>2:00 – 2:30 pm</th>
<th>2:30 – 3:00 pm</th>
<th>3:00 – 3:30 pm</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1</strong></td>
<td><strong>IRC and Hyfrecator Movie</strong>&lt;br&gt;Stephen Goldstone, MD</td>
<td><strong>Hands-on Workshop:</strong> HRA Treatment Practicum&lt;br&gt;Naomi Jay, RN, NP, PhD&lt;br&gt;Joel Palefsky, MD&lt;br&gt;Mark Welton, MD</td>
<td><strong>Cases: Identifying Lesions, Determining Sites for Biopsies</strong>&lt;br&gt;J. Michael Berry-Lawhorn, MD&lt;br&gt;Teresa Darragh, MD</td>
</tr>
<tr>
<td><strong>Group 2</strong></td>
<td><strong>Cases: Identifying Lesions, Determining Sites for Biopsies</strong>&lt;br&gt;J. Michael Berry-Lawhorn, MD&lt;br&gt;Teresa Darragh, MD</td>
<td><strong>IRC and Hyfrecator Movie</strong>&lt;br&gt;Stephen Goldstone, MD</td>
<td><strong>Hands-on Workshop:</strong> HRA Treatment Practicum&lt;br&gt;Naomi Jay, RN, NP, PhD&lt;br&gt;Joel Palefsky, MD&lt;br&gt;Mark Welton, MD</td>
</tr>
<tr>
<td><strong>Group 3</strong></td>
<td><strong>Hands-on Workshop:</strong> HRA Treatment Practicum&lt;br&gt;Naomi Jay, RN, NP, PhD&lt;br&gt;Joel Palefsky, MD&lt;br&gt;Mark Welton, MD</td>
<td><strong>Cases: Identifying Lesions, Determining Sites for Biopsies</strong>&lt;br&gt;J. Michael Berry-Lawhorn, MD&lt;br&gt;Teresa Darragh, MD</td>
<td><strong>IRC and Hyfrecator Movie</strong>&lt;br&gt;Stephen Goldstone, MD</td>
</tr>
</tbody>
</table>

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

3:30 pm  Incorporating Anal Dysplasia Diagnosis and Treatment Into Your Practice
          Mark Welton, MD, Minneapolis, MN

4:00 pm  Panel Discussion of Practice Models, Judging Competency and Special Considerations
          J. Michael Berry-Lawhorn, San Francisco, CA
          Teresa Darragh, MD, San Francisco, CA
          Stephen Goldstone, MD, New York, NY
          Naomi Jay, RN, NP, PhD, San Francisco, CA
          Joel Palefsky, MD, San Francisco, CA
          Mark Welton, MD, Minneapolis, MN

4:30 pm  Adjourn
Symposium

Health Care Policy

9:30 – 11:30 am

According to the World Health Organization, at the very granular level, health care policy refers to decisions, plans and actions undertaken to achieve specific health care goals within a society. A precise health care policy with a defined vision, priorities and roles of various groups, which builds consensus and informs people, can pave the way for the future. Surgery and advocacy on the national level and state level are impacted by socioeconomic issues, legislative issues and regulatory issues. Communication between health care professionals, legislators, decision-makers and researchers is paramount. Health care policy can include policies and practices regarding access to care and health equity, delivery of care, payment models and financing of health care. Health care policy can be implemented on a global, national, state, local and individual basis.

Advocacy is a necessary and gained skill that allows for support and recommendation of particular health care policies that benefit patients, physicians and other constituents who are affected by said policies. The restructuring of the Affordable Care Act, redesign of Medicaid, implementation and coordination of Medicare with Medicaid, bundled care, MIPS and reporting structures, payer systems and access to and equality of care for patients including health maintenance and prevention are some of the issues that are of discussion at the national level and state level.

The symposium will educate attendees so that they might understand health care policy as it applies to colorectal surgical practice. Insight, perspective and an understanding of effective advocacy may promote a proactive approach to health care policy and reform among ASCRS members. A raised awareness and improved base of knowledge will allow adaptability and understanding of the many changes to health care policy that are anticipated in the coming years.

Existing Gaps

What Is: Health care policy is rapidly evolving on a state and national level. These policies directly affect the practice of colorectal surgery. It has become a challenge for our members to follow and understand health care policy as it rapidly evolves.

What Should Be: Each of our members should have a basic understanding of the changes in health care policy and be able to apply them to the practice of colorectal surgery. As a Society, we must provide the opportunity to our membership to have access and resources for ongoing education and insight regarding health care policy.

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

• Explain current issues in national and global health care policy.
• Recognize health care disparities.
• Identify areas of potential state and national advocacy.

Co-Directors: Walter Peters, Jr., MD, Dallas, TX
Kelly Tyler, MD, Springfield, MA

9:30 am Introduction
Walter Peters, Jr., MD, Dallas, TX
Kelly Tyler, MD, Springfield, MA

9:35 am Update on Current Health Care Legislation
George Blestel, MD, Greer, SC

9:50 am The Surgeon and the Opioid Epidemic
Walter Peters, Jr., MD, Dallas, TX

10:00 am Is a Single Payer System the Answer?
Kelly Tyler, MD, Springfield, MA

10:05 am Access to Care: The Future of the Health Care Insurance Market
Lawrence Van Horn, PhD, Nashville, TN

10:30 am Disparities in Care in Colorectal Surgery
Timothy Geiger, MD, Nashville, TN

10:50 am Questions and Answers

11:10 am Adjourn
Symposium


10:00 – 11:30 am
Registration Required • Limit: 70 participants

The peer review process is central to the continued advancement of surgical knowledge. It requires continuous critical review of new manuscripts to ensure that the best available evidence is disseminated within the surgical community. 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.

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 of the scientific literature. During this symposium, we will examine the most common primary methodologies, identify appropriate questions to investigate, 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.

Existing Gaps

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 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.

Objectives: At the conclusion of this session, participants should be able to:
• Recognize when observational studies can provide relatively strong evidence.
• Identify the advantages and limitations of administrative database studies.
• Recognize potential for bias and methodological issues within randomized controlled trials.
• Recall the components of a valuable comprehensive systematic review and meta-analysis.
• Apply resources to enhance your critical appraisal skills.

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

10:00 am Introduction
W. Donald Buie, MD, Toronto, Canada

10:05 am Observational Studies: How and When are They Valuable?
David B. Stewart, MD, Tucson, AZ

10:20 am Administrative Database Studies: A Plethora of Numbers, a Paucity of Detail
Rocco Ricciardi, MD, Boston, MA

10:35 am Randomized Controlled Trials: It’s All in the Methods
Christine Jensen, MD, Coon Rapids, MN

10:50 am Systematic Reviews & Meta-Analyses: Reproducibility, Reliability and Validity
Fergal Fleming, MD, Rochester, NY

11:05 am Resources, Reviews & Publishers: Raising Your Game
Susan Galandiuk, MD, Louisville, KY

11:15 am Panel Discussion

11:30 am Adjourn
Workshop

Young Surgeons Mock Orals & More

12:30 – 5:30 pm

Registration Required • Candidate Member Fee: $50 • Member Fee: $150 • Nonmember Fee: $200

Limit: 120 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 a practice. The workshop aims to address these critical needs of current fellows and young faculty.

During this workshop, participants will have an introduction and overview of the structure of the mock oral examination, followed by small group hypothetical practice mock oral exam scenarios, administered by different examiners, with critique of the examinees’ performances. The format replicates the actual ABCRS Oral Examination. Additionally, participants will observe their colleagues’ answers and receive critique on scenarios. Scenarios covered will be those which 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, there will be a dedicated 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, Track 1: residents/fellows-in-training or Track 2: physicians in practice applying for board certification.

Existing Gaps

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

What Should Be: Recent graduates from fellowships should be well prepared for this examination which is essential for board certification. In addition, early career advice and support is key to improving success of young surgeons.

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

• Describe the structure of the oral examination.
• Practice answering colorectal oral board-style questions in a simulated, high pressure format.
• Demonstrate knowledge among colleagues and learn from previous examinees.
• Explain career level relevant topics.

Co-Directors: Jennifer Davids, MD, Worcester, MA
  Jason Mizell, MD, Little Rock, AR
SUNDAY, MAY 19

Young Surgeons Mock Orals & More (continued)

12:30 – 5:00 pm
Track 1 (Residents/Fellows-in-Training):
12:30 pm Small Group Mock Oral Exam
Benjamin Abbadessa, MD, New York, NY; Jennifer Agnew, MD, Garden City, NY; Ellen Bailey, MD, Columbus, OH; Jeffrey Barton, MD, New Orleans, LA; Anuradha Bhama, MD, Cleveland, OH; Brian Bello, MD, Washington, DC; Lisa Cannon, MD, Chicago, IL; Jasna Coralic, MD, Milwaukee, WI; Michelle Cowan, MD, Aurora, CO; Samuel Eisenstein, MD, La Jolla, CA; Leandro Feo, MD, Manchester, NH; Leander Grimm, MD, Mobile, AL; Michael Guzman, MD, Indianapolis, IN; Deborah Keller, MD, Dallas, TX; Pamela Lee, MD, San Diego, CA; Kellie Mathis, MD, Rochester, MN; Nelya Melnitchouk, MD, Boston, MA; Conan Mustain, MD, Little Rock, AR; Carrie Peterson, MD, Milwaukee, WI; Tal Raphaeli, MD, Humble, TX; Jennifer Rea, MD, Lexington, KY; David Row, MD, Phoenix, AZ; Steven Scarcliff, MD, Birmingham, AL; Shafik Sidani, MD, Abu Dhabi, United Arab Emirates; Gabriela Vargas, MD, Salt Lake City, UT; Heather Yeo, MD, New York, NY; Karen Zaghiyan, MD, Los Angeles, CA

3:00 pm Break

3:10 pm Mock Oral Wrap-up, Questions & Surveys
Jennifer Davids, MD, Worcester, MA

3:30 pm Mini-symposium for Young Fellows
What Can ASCRS Do for You and How to Get Involved
Jennifer Holder-Murray, MD, Pittsburgh, PA

How to Prepare for the Written Exam
Jennifer Davids, MD, Worcester, MA

How to Build an Efficient Clinical Schedule
Vitaliy Poylin, MD, Boston, MA

General Surgery Call: The Good, the Bad, the Ugly
Farrell Adkins, MD, Roanoke, VA

How to Teach Residents When You Are Learning
Conan Mustain, MD, Little Rock, AR

Things I Wish I Could Have Known About the First Year in Practice: A Panel Discussion
Panel Discussion

5:00 pm Adjourn

1:00 – 5:30 pm
Track 2 (Physicians in Practice Applying for Board Certification):
1:00 pm Promoting Your Practice Smartly: Use of Social Media, Websites and Doctor Grading
Sean Langenfeld, MD, Omaha, NE

Billing and Coding: Tips and Tricks
Nelya Melnitchouk, MD, Boston, MA

Avoiding Pitfalls of the Mock Oral Exam
Teresa DeBeche-Adams, MD, Orlando, FL

Finding and Defining Your Niche
Steve Lee-Kong, MD, New York, NY

Coping with Poor Outcomes
Matt Philp, MD, Philadelphia, PA

Finances 101
Jason Mizell, MD, Little Rock, AR

2:30 pm Mock Oral Overview
Jason Mizell, MD, Little Rock, AR

3:00 pm Break

3:10 pm Small Group Mock Oral Exam
Benjamin Abbadessa, MD, New York, NY; Jennifer Agnew, MD, Garden City, NY; Ellen Bailey, MD, Columbus, OH; Jeffrey Barton, MD, New Orleans, LA; Anuradha Bhama, MD, Cleveland, OH; Brian Bello, MD, Washington, DC; Lisa Cannon, MD, Chicago, IL; Jasna Coralic, MD, Milwaukee, WI; Michelle Cowan, MD, Aurora, CO; Samuel Eisenstein, MD, La Jolla, CA; Leandro Feo, MD, Manchester, NH; Leander Grimm, MD, Mobile, AL; Michael Guzman, MD, Indianapolis, IN; Deborah Keller, MD, Dallas, TX; Pamela Lee, MD, San Diego, CA; Kellie Mathis, MD, Rochester, MN; Nelya Melnitchouk, MD, Boston, MA; Conan Mustain, MD, Little Rock, AR; Carrie Peterson, MD, Milwaukee, WI; Tal Raphaeli, MD, Humble, TX; Jennifer Rea, MD, Lexington, KY; David Row, MD, Phoenix, AZ; Steven Scarcliff, MD, Birmingham, AL; Shafik Sidani, MD, Abu Dhabi, United Arab Emirates; Gabriela Vargas, MD, Salt Lake City, UT; Heather Yeo, MD, New York, NY; Karen Zaghiyan, MD, Los Angeles, CA

5:15 pm Mock Oral Wrap-up, Questions & Surveys
Jennifer Davids, MD, Worcester, MA

5:30 pm Adjourn
Symposium
Leadership
1:00 – 3:00 pm

Leadership in the health care setting is both challenging and complex. Most leadership models were developed for the business setting rather than the health care setting and typically approach the subject from an administrative standpoint. This symposium addresses surgical leadership within the health care setting. It will draw from the cumulative wisdom and experience of surgeon leaders who have summited in their particular surgical fields and institutions to become thought leaders, department chairs, role models, mentors and even icons of surgery. The symposium will draw from this deep well of wisdom to address recent challenges to health care facilities and institutions of higher learning, including addressing leadership in the new millennium and the so-called ‘generation gap.’

Existing Gaps
What Is: Over the span of a career, many surgeons naturally ascend to take positions of added responsibility including leadership positions in hospitals or institutions of higher learning. Surgeons typically do not have any foundation or formal instruction in the methodology of leadership.

What Should Be: As surgeons take on increased responsibility, including leadership positions, they should have a foundation for the management of personnel and personalities to help guide them in decision making within the hierarchy of their particular health care institution or department of surgery.

Objectives: At the end of the session, participating surgeons should be able to:
- Define leadership within the context of a health care institution and/or department of surgery.
- Recognize generational differences that may impact leadership style.
- Recognize positive and negative characteristics of leadership.

Co-Directors: William C. Cirocco, MD, Columbus, OH
Rocco Ricciardi, MD, Boston, MA

1:00 pm  Introduction
William C. Cirocco, MD, Columbus, OH
Rocco Ricciardi, MD, Boston, MA

1:05 pm  Leadership – Defined
David A. Rothenberger, MD, Minneapolis, MN

1:15 pm  Staying Put – Spending an Entire Career at a Single Institution
H. Randolph Bailey, MD, Houston, TX

1:25 pm  Changing the Culture of an Institution or Department of Surgery – The Impossible Dream?
Robert Fry, MD, Philadelphia, PA

1:35 pm  Dealing With Difficult Faculty
Herand Abcarian, MD, Chicago, IL

1:45 pm  Overcoming Negative Leadership
Alexa Canady-Davis, MD, Pensacola, FL

1:55 pm  Managing a Department of Surgery in Changing Times
Hiram C. Polk, Jr., MD, Louisville, KY

2:05 pm  Leadership in the New Millennium – Dealing With the ‘Generation Gap’
Anna Ledgerwood, MD, Detroit, MI

2:15 pm  Panel Discussion

3:00 pm  Adjourn
Workshop

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

1:00 – 4:00 pm  
Registration Required • Limit: 70 participants

There are multiple areas of examination in the realm of colon and rectal surgery that require written questions to assess knowledge. These include the certifying written exam, the recertification exam, 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 as this is a skill that can be learned and improved with practice. In recent years, emphasis has been placed on how to write an acceptable exam question and guidelines have been published by organizations such as the National Board of Medical Examiners.

Existing Gaps

What Is: Most professionals such as colon and rectal surgeons feel that it is easy to write high quality questions. However, most 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 can write high quality questions that can be used with minimal to no revisions.

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

• Identify fundamental problems with the construction of written questions.
• Explain the sequential thought process used to write an acceptable question and understand key concepts.
• Demonstrate how to write a stem for a question.
• Prepare a two-step question combining diagnosis and management and format the answers in an acceptable form.
• Recall what happens to a question after it is submitted and before it is used in a test.

Co-Directors: Glenn Ault, MD, Los Angeles, CA  
Charles Friel, MD, Charlottesville, VA

1:00 pm  Introduction  
Glenn Ault, MD, Los Angeles, CA  
Charles Friel, MD, Charlottesville, VA

1:15 pm  Key Concept – It is the Key to a Good Question  
Charles Friel, MD, Charlottesville, VA

1:35 pm  The Stem – The Makings of a Good Question  
Shane McNevin, MD, Spokane, WA

1:55 pm  The Answers – They Can Ruin a Great Stem  
Tracy Hull, MD, Cleveland, OH

2:15 pm  Finalizing Questions – Rescue and Salvage  
Glenn Ault, MD, Los Angeles, CA

2:35 pm  Critiques: Painful But Very Important  
Kirsten Wilkins, MD, Edison, NJ

2:50 pm  Break

3:00 pm  Let’s Write Questions  
All Faculty

3:30 pm  Questions and Review  
All Faculty

4:00 pm  Adjourn
Symposium and Workshop

Advanced Endoscopy

7:30 – 11:30 am

Registration and Pre-registration Survey Required
(Includes Didactic and Hands-on Workshop) Member Fee: $625 • Nonmember Fee $750 • 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.

The adoption of new technology and techniques for surgeons in practice is challenging. There is often insufficient opportunity for the practicing surgeon to be exposed to the most state-of-the-art methods. In addition, it can be difficult for physicians to incorporate these techniques into their practice. In order to surmount these obstacles, it is necessary for the surgeon to acquire an in depth understanding of the available technology, the indications for its use and the potential benefits to the intended patient population.

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 the 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.

Existing Gaps

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

**What Should Be:** Surgeons need to have a comprehensive understanding of the newer visualization techniques as well as the indications and uses for endoscopic submucosal resection, 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 end of the session, participating surgeons should be able to:

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

Co-Directors:

I. Emre Gorgun, MD, Cleveland, OH

Sang Lee, MD, Los Angeles, CA

Pre-registration Survey *(Required for hands-on workshop)*

While the ASCRS Advanced Endoscopy didactic session (7:30 – 9:15 am) is open to all registrants for a nominal fee, the hands-on workshop (9:30 – 11:30 am) will be limited to colorectal surgeons with the necessary prerequisite skills. Please click on the link to complete the survey by going to the registration information page on our [https://www.fascrs.org/2018-advanced-endoscopy-registration-info](https://www.fascrs.org/2018-advanced-endoscopy-registration-info). **PLEASE NOTE:** You must be registered for the Annual Meeting before your pre-registration survey will be reviewed. If you are not registered, your survey will not be reviewed.
### Advanced Endoscopy (continued)

#### Didactic Session

**7:30 – 9:15 am**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30 am</td>
<td><strong>Introduction</strong></td>
<td>I. Emre Gorgun, MD, Cleveland, OH&lt;br&gt;Sang Lee, MD, Los Angeles, CA</td>
</tr>
<tr>
<td>7:40 am</td>
<td><strong>How to Classify and Categorize Premalignant and Malignant Polyps</strong></td>
<td>James Buxbaum, MD, Los Angeles, CA</td>
</tr>
<tr>
<td>7:55 am</td>
<td><strong>From EMR to ESD: Learning Curve and How Do I Get There?</strong></td>
<td>Jennifer Hrabe, MD, Iowa City, IA</td>
</tr>
<tr>
<td>8:10 am</td>
<td><strong>Endoluminal Resection, Suturing, Clips and New Techniques for Hemostasis</strong></td>
<td>Peter Marcello, MD, Boston, MA</td>
</tr>
<tr>
<td>8:25 am</td>
<td><strong>Endoluminal Stenting</strong></td>
<td>Andreas Kaiser, MD, Los Angeles, CA</td>
</tr>
<tr>
<td>8:40 am</td>
<td><strong>New Endoluminal Platforms</strong></td>
<td>Sang Lee, MD, Los Angeles, CA</td>
</tr>
<tr>
<td>8:55 am</td>
<td><strong>Panel Discussion and Questions</strong></td>
<td></td>
</tr>
<tr>
<td>9:15 am</td>
<td><strong>Adjourn</strong></td>
<td></td>
</tr>
</tbody>
</table>

#### Hands-on Workshop

**9:30 – 11:30 am • Tickets Required**

**Faculty:**
M. 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; Mark Zebley, MD, Abington, PA; Matthew Zelhart, MD, New Orleans, LA
Core Subject Update

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.

Existing Gaps

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

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

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

• Describe the issues related to stomas including indications, complications and management options.

• Maintain an understanding of the pathophysiology of benign anorectal conditions including pruritis ani, pilonidal disease and hidradenitis, offering patients the spectrum of nonsurgical and surgical treatment options.

• Discuss the causes and treatment options for rectovaginal and rectourethral fistulas.

• Review the literature outlining the current medical treatment options for inflammatory bowel disease.

• Review the causes and treatment options/algorithms for patients presenting with lower GI bleeding.

Director: Justin Maykel, MD, Worcester, MA

7:30 am       Ostomies and Stomal Therapy
               Wolfgang Gaertner, MD, Minneapolis, MN

7:45 am       Discussion

7:50 am       Benign Anorectal: Pruritis, Pilonidal, Hidradenitis
               Stefan Holubar, MD, Cleveland, OH

8:05 am       Discussion

8:10 am       Rectovaginal and Rectourethral Fistulas
               Pasithorn Amy Suwanabol, MD, Ann Arbor, MI

8:25 am       Discussion

8:30 am       Medical Management of Inflammatory Bowel Disease
               Antonio Spinelli, MD, Milan, Italy

8:45 am       Discussion

8:50 am       Lower Gastrointestinal Bleeding
               Joseph Carmichael, MD, Orange, CA

9:05 am       Discussion

9:10 am       Rectal Cancer: Neoadjuvant and Adjuvant Therapy
               Daniel Herzig, MD, Portland, OR

9:25 am       Discussion

9:30 am       Adjourn
Lower gastrointestinal bleeding (LGIB) presents a challenging clinical condition to both patients and their physicians and surgeons. Patients and families experience tremendous stress and fear at the sight of blood from the rectum. A variety of potential causes of LGIB exist, potentially occurring anywhere along the length of the GI tract. This is classically distal to the ligament of Treitz, though as high as 15% of all LGIB results from an upper source. The task remains inherently frustrating for physicians and surgeons given difficulties localizing the bleeding site and determining the cause. Operative intervention is rarely necessary, while at the same time, surgeons must remain vigilant and prepared for the occasion where bleeding is profuse and truly life threatening.

While upper gastrointestinal bleeding (UGI) appears to be decreasing in incidence, LGIB is unfortunately stable if not increasing and may be due to multiple factors. Undoubtedly, the aging population plays a significant role given the many diseases afflicting the elderly such as colorectal neoplasms, diverticulosis coli, angiodysplasia and colonic ischemia, which are common causes of LGIB. This population is also more likely to be prescribed antiplatelet and anticoagulation medications, potentially predisposing to bleeding and even adding to the severity of such episodes. Lastly, the elderly is more apt to suffer from cardiopulmonary comorbid conditions contributing further to the complexity of management. Nonetheless, even more challenging is the often intermittent nature of the bleeding episodes, making precise localization difficult and definitive diagnosis elusive.

Surgeons therefore find themselves in a daunting position as we are asked to care for patients experiencing a potentially life-threatening problem. We do so cognizant of limitations of the available diagnostic studies applied to an intermittent and elusive disease. One must resist frustration and instead pursue a methodical and rational approach to find and address treatable causes.

**Existing Gaps**

**What Is:** Comorbid patients in an aging population combined with a rising incidence of LGIB may place surgeons in a quandary.

**What Should Be:** More formalized multidisciplinary algorithm to managing LGIB utilizing validated scoring systems which stratify severity of bleeding and need for hospitalization and acute care services; rapid and accurate localization techniques to direct less invasive methods for cessation of bleeding and, when necessary, direct surgeons for more specific function preserving operative intervention; recognition of rare causes of LGIB specific to the anorectum that are more appropriately managed by the colorectal surgeon.

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

- Explain the epidemiology of lower gastrointestinal bleeding and the range of possible causes.
- Recognize the possible investigational studies available to the clinician and suggest a rational diagnostic testing algorithm for localization of lower gastrointestinal bleeding.
- Appreciate the non-operative technologies for intervention to control lower gastrointestinal bleeding, including colonoscopic methods for bleeding control as well as interventional radiologic techniques.
- Review operative strategies, decision making and preparation for a variety of scenarios that may be faced in the operating room.

**Co-Directors:** Teresa DeBeche-Adams, MD, Orlando, FL
Seema Izfar, MD, San Antonio, TX
Contemporary Management of Lower GI Bleeding (continued)

7:30 am  Introduction  Teresa DeBeche-Adams, MD, Orlando, FL  Seema Izfar, MD, San Antonio, TX

7:40 am  Taking a Cue From Upper GI Bleed Paradigm: Can We Develop a Scoring System for Guiding Management?  Fergal Fleming, MD, Rochester, NY

7:55 am  Catching It In the Act: Best Methods for Localizing Lower GI Bleeding  Amanda Hayman, MD, Portland, OR

8:10 am  Role of Non-Operative Procedures: When Is It Okay to Wake Up the Gastroenterologist or Radiologist?  Ian Paquette, MD, Cincinnati, OH

8:25 am  The Tipping Point: When to Operate and How to Choose Which Surgery to Do  Robert Madoff, MD, Minneapolis, MN

8:40 am  Maybe It’s Not the Colon: Evaluation for Occult Small Bowel Bleeding  Eric Weiss, MD, Weston, FL

8:55 am  Rectal Zebras: Other Causes of Significant Bleeding  Kyle Cologne, MD, Los Angeles, CA

9:10 am  Panel Discussion and Case Presentations

9:30 am  Adjourn
Symposium

When You Hear Hoofbeats, Think Zebras…
Uncommon/Atypical Colorectal Conditions

9:45 – 11:45 am

There are a handful of pathologies that colorectal surgeons will encounter that will often lack any substantial clinical or evidence based recommendations for treatment. Because of their rarity, we are often left with having to do extensive research only to find very little information available that would help guide the clinician to an answer. Some of these issues to be presented are newer clinical entities related to the evolving face of medical and surgical advancement. This presentation will highlight some of the most “common” of these rarer entities.

The consequences of colorectal procedures performed on infants with congenital defects of the GI tract can often present in adulthood. These can range from bowel obstructions to defecatory dysfunction. An understanding of the surgical history, anatomy and its long-term consequences is often critical to understanding and treating the problem in the adult patient.

Although not performed in high volumes, continent pouches and their complications can often present to the colorectal surgeon in any setting. Pouch prolapse, perforation and obstruction are some of the problems that can occur. Understanding the options for salvage can benefit these patients whose only choice otherwise would be a standard ileostomy.

The advent of surgical options for transgender individuals has also expanded the potential for seeing unusual and possibly surgical problems that the colorectal surgeon may be called for. Thus, developing a basic understanding of the operative procedures involved is important, as these patients become more frequent and the centers that perform them are not readily accessible to address some of the complications.

Several other atypical issues include unusual pathology such as colorectal lymphoma, rectal varices, SRUS and miscellaneous colitides. While most of these issues are medically managed, the question will often be raised as to when a surgeon should be involved and to what degree.

Existing Gaps

What Is: There are several atypical and uncommon pathologies that surgeons will encounter and often be asked to help manage. In addition, there are new surgical techniques that are being pioneered for the transgender patient population which may affect our practice as well. Lack of updated and current information has left a dearth in this small percentage of pathologies.

What Should Be: Colorectal surgeons will often be involved in the care and assisting in the management of these patients even if a surgical treatment is not involved. This requires awareness of the current operative procedures as well as an update on uncommon pathologies.

Objectives: At the conclusion of this session, participants should be able to:
• Recall the rarer cancers of the colon, rectum and anus and propose treatment algorithms for them.
• List the procedural complications of continent ileostomies, rubber band ligation of hemorrhoids, imperforate anus reconstruction, cosmetic anorectal procedures such as anal bleaching, gender reassignment surgery and colonics.
• Describe the presentation and treatment options for rare diagnoses of the colon, rectum and anus.

Co-Directors: Anjali Kumar, MD, Seattle, WA
Carrie Peterson, MD, Milwaukee, WI
When You Hear Hoofbeats, Think Zebras…
Uncommon/Atypical Colorectal Conditions (continued)

9:45 am  Introduction
Anjali Kumar, MD, Seattle, WA

Rare and Unfortunate Cancers
9:50 am  Anal Melanoma
Linda Farkas, MD, Sacramento, CA
9:55 am  Rectal GIST
Alexander Hawkins, MD, Nashville, TN
10:00 am  Cancer in the J-Pouch
Emily Steinhagen, MD, Cleveland, OH
10:05 am  Colorectal Lymphoma
Jennifer Ayse, MD, Washington, DC
10:10 am  Rectal Squamous Cell Cancer
Mehraneh Jafari, MD, Irvine, CA
10:15 am  Cancer in the Fistula Tract
Amy Lightner, MD, Rochester, MN
10:20 am  Panel Discussion and Questions

Unusual Diagnoses
10:35 am  Cecal Diverticulitis
Amit Merchea, MD, Jacksonville, FL
10:40 am  Adult Hirschsprung’s Disease
Alessandra Gasior, DO, Columbus, OH
10:45 am  SRUS/CCP
Shafik Siddani, MD, Abu Dhabi, United Arab Emirates
10:50 am  Microscopic Colitis
Samantha Quade, MD, Everett, WA
10:55 am  Cystic Retrorectal Neoplasia
Eric Dozois, MD, Rochester, MN
11:00 am  Long Term Implications of Imperforate Anus Repair
Andreas Kaiser, MD, Los Angeles, CA
11:05 am  Panel Discussion and Questions

Unique Procedural Complications and Consequences
11:15 am  Koch Gone Bad
Jean Ashburn, MD, Cleveland, OH
11:20 am  Anorectal Considerations From Gender Reassignment Surgery
Wolfgang Gaertner, MD, Minneapolis, MN
11:25 am  Consequences of Cosmetic Anorectal/Colorectal Procedures
Zuri Murrell, MD, Los Angeles, CA
11:30 am  Post Rubber Band Ligation Sepsis
Joanne Favuzza, MD, Chicago, IL
11:35 am  Panel Discussion and Questions
11:45 am  Adjourn
Symposium

Robotic Colon and Rectal Surgery: Tips and Tricks

9:45 – 11:45 am

Over the past several years robotic colon and rectal surgery has gradually gained acceptance among many colorectal surgeons. This is a worldwide trend occurring not only in the United States but also throughout Europe and Asia. Robotic colorectal surgery continues to evolve, with more companies manufacturing surgical robots, and surgeons expanding the boundaries of what can be done via a minimally invasive approach.

A series of lectures with related videos will address the increasing options for surgeons in terms of technologies, demonstrate new techniques and the capabilities offered through robotic surgery and will educate surgeons on socioeconomic concerns with adopting robotic surgery.

This course is aimed at three populations of surgeons:
1) 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.
2) Practicing colon and rectal surgeons who do not currently do robotic surgery but wish to introduce robotic surgery into their practice.
3) Colon and rectal residents that are interested in robotics.

Existing Gaps
What Is: While robotic colorectal surgery is becoming more mainstream, not all colorectal surgeons are familiar with the capabilities of robotic surgery, and how robotics can increase what can be done via a minimally invasive approach. Many surgeons only know one robotic system and are not aware of various options that are becoming available.

What Should Be: Colorectal surgeons should be aware of what robotic systems are available and what the differences in these systems are. They should be familiar with advanced minimally invasive techniques that robotic surgery enables and understand the socioeconomic implications of starting a robotic program. 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:
• Describe what robotic systems are currently available and what their differences are.
• Explain a variety of techniques for creation of an intracorporeal anastomosis.
• Discuss the use of robotic surgery in rectal cancer patients.
• Explain the socioeconomic impact of robotics.

Co-Directors: Jamie Cannon, MD, Birmingham, AL
Todd Francone, MD, Burlington, MA

9:45 am  Introduction
Jamie Cannon, MD, Birmingham, AL
Todd Francone, MD, Burlington, MA

9:50 am  Leela M. Prasad Memorial Lecture
History of Robotics: Where We Were, Where We Are and Where Are We Going?
Slawomir Marecik, MD, Chicago, IL

10:05 am  Transanal Robotic Surgery: Local Excision to taTME
Garrett Friedman, MD, New York, NY

10:20 am  Robotic Operating Systems: What Are Our Options?
Kelly Tyler, MD, Springfield, MA

10:30 am  Techniques for Intracorporeal Anastomosis: Lefts and Rights
Mark Soliman, MD, Orlando, FL

10:45 am  Is Robotic Surgery the Answer to Minimally Invasive Rectal Cancer Surgery?
Deborah Nagle, MD, Boston, MA

11:00 am  Splenic Flexure Tips and Tricks
Ron Landmann, MD, Jacksonville, FL

11:15 am  Can Robotic Surgery Be Cost Effective? Essentials to Developing a Robotic Surgical Program
Robert Cleary, MD, Ann Arbor, MI

11:30 am  Panel Discussion

11:45 am  Adjourn

2.0 CME
Welcome and Opening Announcements

12:45 – 1:30 pm
Guy R. Orangio, MD, New Orleans, LA
President, ASCRS
Eric Johnson, MD, Tacoma, WA
Program Chair
Timothy Geiger, MD, Nashville, TN
Local Arrangements
Garrett Nash, MD, New York, NY
Awards Chair

Norman D. Nigro, MD, Research Lectureship

1:30 – 2:15 pm
Gut Microbiome, Metabolomic and Colon Cancer: The Environmental Link?
Heidi Nelson, MD
Fred C. Andersen, Professor of Surgery; Chair, Department of Surgery; Mayo Clinic; Rochester, MN
Introduction: Bruce Wolff, MD

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

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

Abstract Session*
Neoplasia I
2:15 – 3:45 pm

*Abstract titles and authors are forthcoming.
Symposium

Anal and Rectovaginal Fistula Management From Simple to Complex

2:15 – 3:45 pm

Anorectal fistulas (fistulas-in-ano) are a relatively common problem that many colorectal surgeons face during their practice, with a potential dramatic impact on the patient's quality of life. Anorectal fistulas frequently result from a previous or current anorectal abscess; up to 50% of patients with abscesses develop a fistula. These conditions are particularly challenging given the high failure rate and lack of a standard algorithm for application of the current available treatment modalities.

The surgeon's familiarity with the anatomy of the anorectal area, the pathogenesis and classification of the fistula are all necessary for adequate management. Currently, there is no medical treatment available for fistulas, except in special situations, such as Crohn's disease. Surgery is almost always necessary for a cure. Because no single technique is appropriate for the treatment of all anorectal fistulas, treatment must be dictated by the etiology and anatomy of the fistula, degree of symptoms, patient comorbidities and the surgeon's experience. The surgeon should also keep in mind the progressive tradeoff between the extent of operative sphincter division, postoperative healing rates and functional compromise. Using this information to develop a “bottom up” algorithm of which procedures to apply in which situation for the best outcome is vital.

Existing Gaps

What Is: A disorganized attempt to treat, using multiple methods in a haphazard fashion, with high recurrence rates and patient dissatisfaction.

What Should Be: An evidence-based algorithm of surgical management, considering the patient and disease-specific variables, for the best chance at healing and improving patient quality of life.

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

• Determine the anatomy and classification of the fistula.
• Develop a patient-specific bottom up algorithm to approach surgical management of anorectal fistulas.
• Describe the etiology and best approaches to treat initial and recurrent rectovaginal fistulas.

Co-Directors: Rebecca Hoedema, MD, Grand Rapids, MI
Deborah Keller, MD, Dallas, TX

2:15 pm  Introduction
Rebecca Hoedema, MD, Grand Rapids, MI
Deborah Keller, MD, Dallas, TX

2:25 pm  Surgical Anatomy of Anorectal Fistulas and Implications for Treatment
Joseph Carmichael, MD, Orange, CA

2:35 pm  Treatment of “Simple” Fistulas - When to Cut, Fill, or Flap?
Bradley Champagne, MD, Cleveland, OH

2:45 pm  Techniques for Complex Fistulas – LIFT, Bio-LIFT, Flaps
Scott Regenbogen, MD, Ann Arbor, MI

2:55 pm  Emerging Technology in Fistula Management - Stem Cells, Biologic Therapy, FiLaC, VAAFT
Phil Tozer, MD, Harrow, United Kingdom

3:05 pm  Special Consideration: Fistulizing Perianal Crohn’s Disease - Medical vs. Surgical Management
Daniel Geisler, MD, Houston, TX

3:15 pm  Rectovaginal Fistula - Etiology and Treatment Options
Elizabeth Raskin, MD, Loma Linda, CA

3:25 pm  Surgical Strategies for Complex Rectovaginal Fistula Repair
Tracy Hull, MD, Cleveland, OH

3:35 pm  Panel Discussion and Question

3:45 pm  Adjourn
Colon and rectal surgeons commonly treat patients that require flap procedures or other complex closures that are traditionally considered the purview of the plastic surgeon. As colon and rectal surgeons are involved in the creation of these wounds and are responsible for the overall management of these patients and conditions, they should have a better understanding of the principles and techniques involved in flap creation. In addition, they should have a better understanding of the need and timing of when to involve surgical colleagues from other disciplines.

They are the subject matter experts for the management of common perianal diseases such as hidradenitis suppurativa and pilonidal disease. While these conditions can often be managed with simple excision and local wound care, often these conditions recur and can lead to more complex wounds. In these cases, the management requires more advanced surgical techniques to adequately treat them.

These surgeons are experts for the management of rectourethral and rectovaginal fistulas as well as the management of complicated perineal wounds. As the incidence of anal cancer increases and the use of radiation for the management of malignancies involving the perineum also increases, it is more common for surgeons to treat complex perineal wounds, that often involve radiated tissues. These wounds require advanced techniques, often involving flap techniques in their management.

The open abdomen is becoming a more commonly encountered condition. In patients with recurrent enterocutaneous fistulae or enteroatmospheric fistulas, managing the abdominal wall in conjunction with the management of the intestines can be a very daunting proposition.

Existing Gaps

What Is: Because all of these disease conditions are managed primarily by colon and rectal surgeons, situations requiring more advanced closure are becoming more common. Reconstruction techniques can be poorly understood or not well utilized.

What Should Be: As colorectal specialists, we are involved in the management of these patients and should be comfortable with some of the more advanced closure techniques that may be required.

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

• Describe the flap techniques best utilized in the treatment of complex and recurrent pilonidal disease.
• Explain the flap techniques for treating complex perianal anal hidradenitis suppurativa and the utility of a covering colostomy.
• Recognize the techniques for harvesting muscle tissues for the management of recto-urethral and recto-vaginal fistulas.
• Describe techniques in the management of complicated open perineal wounds.
• Describe the management of the open abdominal wall at the time of enter-cutaneous fistula repair.

Co-Directors: Kurt Davis, MD, New Orleans LA
Muneera Kapadia, MD, Iowa City, IA

Continued next page
Complex Cases – I Need Help! Plastic Surgery for the Colorectal Surgeon (continued)

2:15 pm  Introduction
Kurt Davis, MD, New Orleans, LA

2:20 pm  Flaps for Pilonidal Disease, Which Flap and When?
Jeffrey Barton, MD, New Orleans, LA

2:35 pm  Perianal Hidradenitis Suppurativa, Beyond the Basics
Frank Lau, MD, New Orleans, LA

2:50 pm  Rectourethral or Rectovaginal Fistulas – The Gracilis Muscle and More
Maher Abbas, MD, Dubai, United Arab Emirates

3:05 pm  The Complicated Perineal Wound – Now What?
Jerrod Keith, MD, Iowa City, IA

3:20 pm  The Open Abdomen
Benjamin Poulose, MD, Nashville, TN

3:35 pm  Panel Discussion

3:45 pm  Adjourn

3:45 – 4:15 pm
Refreshment Break in the Exhibit Hall

Abstract Session*
Benign Disease
4:15 – 5:45 pm

*Abstract titles and authors are forthcoming.
 Symposium

Enhanced Recovery Protocols and Pathways for Colectomy and Beyond: Involving Your Allied Health and Other Health Professionals

4:15 – 5:45 pm

Enhanced Recovery Protocols (ERP) and Pathways are multimodal, perioperative strategies (e.g., standardized pre-op patient education, intra-op fluid restriction, post-op mobilization, etc.) that reduce length-of-stay (LOS), post-operative complications (POCs) and readmissions for patients after major surgery. While initially used for patients undergoing colectomy, ERPs are now used in other surgical populations including pancreaticoduodenectomy, gastrectomy and hepatectomy patients. In all specialties, a cross-disciplinary team of experts, drawn from every point of surgical care, is critical to the successful development, implementation and maintenance of ERPs.

Allied Health Professionals (AHPs) are a diverse group of health providers involved with the identification, evaluation and prevention of diseases and disorders. These individuals are distinct from health professionals in medicine such as surgeons and anesthesiologists. AHPs include dieticians, physical therapists and occupational therapists. In addition to traditional AHPs, other support services play key roles in the successful ERP including pharmacists, wound/ostomy specialists and clinical educators. The roles of these professionals in surgical recovery are equally important as the involvement of those from medicine and nursing.

Existing Gaps

What Is: The benefits of ERPs are well established and experience has shown that a multidisciplinary team is critical to its overall success. The important role of AHPs and other health professionals, however, within ERPs is not well understood and may be overlooked.

What Should Be: As colorectal specialists who use ERPs, we should be continuously improving ERPs and integrating the experts that surround us. These include AHPs and other health professionals who deliver important care to patients. This requires an effective understanding of the techniques, tools and people available to us to optimize care for our patients.

Objectives: At the conclusion of this session, participants should be able to:
• Describe the many roles allied health and other health professionals play in surgical recovery.
• Describe the unique contribution that allied health and other professionals provide to the success of an ERP.
• Describe the barriers and facilitators to involving allied health and other health professionals.
• Describe practical ways to involve allied health and other health professionals in developing, implementing and maintaining ERPs.

Co-Directors: Daniel Chu, MD, Birmingham, AL
Traci Hedrick, MD, Charlottesville, VA

4:15 pm  Introduction
Daniel Chu, MD, Birmingham, AL
Traci Hedrick, MD, Charlottesville, VA

5:05 pm  Wound Ostomy Support in the Era of ERPs
Amy Armstrong, WOCN, Birmingham, AL

4:20 pm  On Diets and ERPs?
Elaine Goode, Charlotte, NC

5:20 pm  Multidisciplinary Collaboration: Pulling Everyone Together
Bethany Sarosiek, RN, MS, Charlottesville, VA

4:35 pm  Role of PT/OT in Prehabilitation and Recovery
Lavon Beard, PT, MBA, Birmingham, AL

5:35 pm  Panel Discussion

4:50 pm  Role of the Clinical Pharmacist in ERPs
Rachel Kreuer, Baltimore, MD

5:45 pm  Adjourn
Welcome Reception
7:00 – 10:00 pm, Sunday

COUNTRY MUSIC HALL OF FAME

Complimentary to registered attendees, the Welcome Reception has become a tradition at the Annual Scientific Meeting. To honor Nashville’s rich music history, the 2018 Welcome Reception will be held at the Country Music Hall of Fame. The Hall of Fame is one of the most popular attractions in Nashville and welcomed nearly 1 million visitors last year.

The museum explores the origins and traditions of country music with artifacts, photographs and videos. The museum, called the “Smithsonian of Country Music,” is home to nearly 200,000 sound recordings and 500,000 photographs and thousands of artifacts, including Jimmie Rodgers’ guitar and Elvis Presley’s solid gold Cadillac limo. It features a two-story wall with every gold and platinum country record produced. Current exhibits at the museum explore the lives and careers of country music legends: Loretta Lynn, Shania Twain and power couple Tim McGraw and Faith Hill. Names of Hall of Fame inductees are displayed in the world-famous Hall of Fame Rotunda.

The museum also includes the Historic RCA Studio B (located on famed Music Row), which is Nashville’s oldest surviving recording studio. Country legends such as Dolly Parton, Waylon Jennings and Roy Orbison recorded their songs there. The studio produced more than 35,000 songs in its storied history.

Bring out your inner cowgirl or cowboy! Wear your cowboy hat, boots and jeans and join your colleagues for a captivating evening of delicious hors d’oeuvres, cocktails and entertainment.
Meet the Professor Breakfasts

7:00 – 8:00 am
Limit: 30 per breakfast • Fee $50 • Tickets Required • Continental Breakfast Included
Registrants are encouraged to bring problems and questions to this informational discussion. Please register early and indicate your 1st and 2nd choice on the Registration Form.

M-1  Ileal Pouch Complications
     Jeanie Ashburn, MD, Cleveland, OH
     Ravi Kiran, MD, New York, NY

M-2  Teaching Residents/Fellows in the Modern Era
     Andrea Bafford, MD, Baltimore, MD
     Brian Kann, MD, New Orleans, LA

M-3  HPV Related Anorectal Disease Case Based Discussion
     Stephen Goldstone, MD, New York, NY
     Mark Welton, MD, Minneapolis, MN

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

Coffee and Controversies: Minimally Invasive Surgery

7:00 – 8:00 am

Debate #1: Right Colectomy: Robotics vs. Laparoscopy
7:00 – 7:30 am

Debate #2: Rectal Cancer: taTME/Laparoscopy vs. Robotics
7:30 – 8:00 am

Technology relentlessly advances. Miniaturization, computer integration, ergonomic design and enhanced optics are rapidly applied to all aspects of our lives, including the care of our patients. Careful analysis is required to determine, however, what represents a true improvement in surgical care and what represents marketing.

Laparoscopic approaches toward colon and rectal disease began in the 1990s and the colon and rectal surgical world adopted slowly. Segments of our society rightly expressed skepticism and we all struggled together to establish the role of laparoscopy in the armamentarium of the colon and rectal surgeon.

Just as laparoscopic surgery becomes understood and its benefits well defined, the disruptive technology of robotics arrives to “upset the apple cart.”

Through guided, confrontational, humorous and instructional debate, world leaders in minimally invasive surgery will instruct and argue for a robotic or laparoscopic approach to right colon resection and transanal total mesorectal excision.

Existing Gaps
What Is: Advances in technical capabilities do not always result in improved outcomes or create efficiencies.

What Should Be: Careful analysis of laparoscopic and robotic approaches to right colectomy and transanal total mesorectal excision is therefore necessary now and warranted.

Objectives: At the conclusion of this session, participants should be able to:
• Recognize the realities, costs and benefits of both laparoscopic and robotic approaches to right colectomy.
• Explain where in the armamentarium of colon and rectal surgeons’ robotic approaches may have advantage over laparoscopic techniques.
• Gain skills in how to assess new technologies with regard to consideration of adoption.

Director: Howard Ross, MD, Philadelphia, PA

7:00 – 7:30 am
Debate #1: Right Colectomy: Robotics vs. Laparoscopy

7:00 am  What Defines the Optimum Right Colon Resection? Howard Ross, MD, Philadelphia, PA
7:05 am  Laparoscopic Right Colon Resection Is a “Perfect” Operation Sang Lee, MD, Los Angeles, CA
7:13 am  Robotic Right Colon Resection Is for Winners Martin Weiser, MD, New York, NY
7:19 am  Hunger Games Debate to the Finish Sang Lee, MD, Los Angeles, CA Howard Ross, MD, Philadelphia, PA Martin Weiser, MD, New York, NY

Continued next page
Coffee and Controversies: Minimally Invasive Surgery (continued)

7:30 – 8:00 am
Debate #2: Rectal Cancer: taTME/Laparoscopy vs. Robotics

7:30 am taTME for Rectal Cancer, Are You Insane?
Howard Ross, MD, Philadelphia, PA

7:35 am Laparoscopic taTME. It Is So Good, You Will Never Go Back!
Peter Marcello, MD, Burlington, MA

7:43 am Robotic taTME. This IS What the World Is Coming To!
Matthew Albert, MD, Altamonte Springs, FL

7:49 am The Answer Arises
Matthew Albert, MD, Altamonte Springs, FL
Peter Marcello, MD, Burlington, MA
Howard Ross, MD, Philadelphia, PA

8:00 am Adjourn

Abstract Session*
Inflammatory Bowel Disease
8:00 – 9:30 am

*Abstract titles and authors are forthcoming.
Symposium

Through the Ages: Caring for the Adult Who Was a Pediatric Surgery Patient

8:00 – 9:30 am

Pediatric patients that had gastrointestinal surgery or actively struggle with colorectal issues are often seen by adult colon and rectal surgeons once the patients reach adulthood. Colon and rectal surgeons are seen as the experts at treating all problems related to the colon and rectum in adult patients, and therefore must maintain an understanding of the complex medical and surgical issues in pediatric patients as they transition into adulthood and continue care for many decades to come.

Most colon and rectal surgeons have had little exposure to and have little experience in treating patients with congenital pediatric diseases. There are diagnostic dilemmas when patients present as adults with previously undiagnosed juvenile problems. There are nuances with surgical technique and long term management of functional outcomes in pediatric colon and rectal diseases. Many patients and diagnoses require multidisciplinary management to optimize and coordinate care.

Coordinating a transition of care into adulthood requires the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centered to adult oriented health care systems. The optimal goal of transition is to provide health care that is uninterrupted, coordinated, developmentally appropriate, psychosocially sound and comprehensive. This is markedly different than the transfer of care where one service stops and another picks up. We will examine the special needs in the transition of care of the pediatric patient with IBD, prior surgery and chronic gastrointestinal conditions.

Existing Gaps

What Is: Pediatric surgeons often assume care of the pediatric patient through early young adulthood; however, eventually the care of the patient must be transitioned to adult specialists. Often adult surgeons lack the understanding of the nuances of the surgeries performed, the long-term functional outcomes of reconstructive pediatric surgery or of the medical and psychosocial implications in treating this unique and complex patient population.

What Should Be: As colorectal specialists, we assume care of the adult pediatric patients as they transition from pediatric age to adulthood. This requires an effective understanding of the techniques and surgeries performed in pediatric patients as well as the special psychosocial and medical issues in this young patient group in order to optimize their care.

Objectives: At the conclusion of this session, participants should be able to:
• Recognize pediatric colorectal operations and their implications to the adult surgeon.
• Evaluate and treat pediatric conditions with delayed onset or in need of continued adult surgical care.
• Identify the unique medical and psychosocial needs of the adult pediatric patient as they transition care into adult practice.

Co-Directors: Jennifer Holder-Murray, MD, Pittsburgh, PA
Ian Paquette, MD, Cincinnati, OH

8:00 am  Introduction
Jennifer Holder-Murray, MD, Pittsburgh, PA
Ian Paquette, MD, Cincinnati, OH

8:05 am  Hirschprung's Disease and Congenital Polyposis, What the Adult Surgeon Needs to Know
Luis de la Torre, MD, Pittsburgh, PA

8:20 am  Congenital Malformations: Technical Considerations for Surgical Repair
Andrea Bischoff, MD, Aurora, CO

8:35 am  Treatment of Functional Bowel Outcomes of Congenital Surgery: From Antegrade Enemas to Nerve Stimulation
Jason Frischer, MD, Cincinnati, OH

8:50 am  Transitioning the Pediatric IBD Patient to an Adult IBD Practice
Laurie Fishman, MD, Boston, MA

9:05 am  Putting It All Together: Transitioning Surgical Patients Out of the Pediatric Health Care System Into the Adult Medical System
Janice Rafferty, MD, Cincinnati, OH

9:20 am  Panel Discussion and Case Presentations

9:30 am  Adjourn

1.5 CME
Ethics Symposium

8:00 – 9:30 am

Ethical challenges and dilemmas are inherent to the everyday practice of surgery. While most of us do not have any special training in the field of ethics, medical schools and residencies often provide significant exposure to the definition and application of the “principles of ethics.” We become comfortable, and sometimes experts, in the areas of decisional capacity and informed consent. We often navigate with end-of-life care more frequently and with greater ease than many of our medical colleagues, especially with our care of cancer patients or those with life-threatening conditions. Despite our wealth of experience, in practice, ethical quandaries still seem to sneak up on us and become challenging dilemmas before we even recognize their significance.

What is ethics? In our practice of colon and rectal surgery, “ethics” often has broader implications than the basic principles and their application. Ethics can be as far reaching as global medicine and caring for patients from different countries with a variety of cultures, political environments and religions. It can appear in professional arenas, such as resident education versus patient safety or appropriate relationships for advancing knowledge through industry research. It shows up in urban as well as rural practices in the form of access to care, health care reform, EMRs, networking, rating and evaluation systems and the nuances of working within a system of providers.

To make this Ethics Symposium as practical as possible, a survey was sent to ASCRS members to identify their most immediate areas of concern in the field of ethics. Over 45% of respondents chose the topic “What to do with BAD Residents and Physicians” as one of their top five ethical dilemmas. This was followed by “Depression, Burnout, and Suicide” (over 35%), “Recognizing Ethical Situations in Clinical Practice,” “Conflicting Obligations of Physicians in Practice,” “Limiting Patient Preferences and Requests to Do Everything,” “Disclosure of Adverse Outcomes and Medical Error,” “Online Physician Rating Systems (the Yelp Phenomena),” and “Teaching Ethics in Educational Training Programs.” ASCRS members are clearly interested in issues of professional ethics, which are often set aside in favor of more tangible clinical issues, such as patient autonomy or end-of-life care. We agree that these issues are highly relevant to colorectal surgeons and deserve dedicated time for education and discussion.

Existing Gaps

What Is: Many physicians received “principles of ethics” education in medical school that was applied in residency and practice, but typically with a clinical focus. The professional issues of our daily life receive inadequate attention, and therefore represent areas of concern and anxiety in our colon and rectal surgery practices. Unless an effort is made by physicians to stay up to date, many become inadequately prepared to identify “new” ethical dilemmas and do not have the strategies necessary to resolve them.

What Should Be: Care of colon and rectal surgery patients will inevitably result in ethical dilemmas in our practices. Questions of professional ethics are often inadequately considered in our training, leaving colon and rectal surgeons with significant challenges and conflicts in the modern world. An effective understanding of these dilemmas and a better knowledge of strategies to resolve them is very important to our members.

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

• Recognize an ethical dilemma in the modern colon and rectal surgery practice and identify strategies to effectively resolve it.
• Determine what to do with BAD residents and physicians in the clinical practice.
• Learn to more effectively teach ethics in training programs and be able to differentiate between ethics, compassion and empathy.
• Recognize and better understand depression, burnout and risk of suicide in the physician.
• Identify social networking and online physician rating systems in the clinical practice setting.

Co-Directors: John A. Griffin, MD, Seattle, WA
Erin O. Lange, MD, Seattle, WA

Continued next page
## Ethics Symposium (continued)

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker(s)</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 am</td>
<td>Introduction</td>
<td>John Griffin, MD, Seattle, WA</td>
<td>Seattle, WA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Erin Lange, MD, Seattle, WA</td>
<td>Seattle, WA</td>
</tr>
<tr>
<td>8:05 am</td>
<td>Recognizing Ethical Situations in Clinical Practice</td>
<td>Ira Kodner, MD, St. Louis, MO</td>
<td>St. Louis, MO</td>
</tr>
<tr>
<td>8:20 am</td>
<td>What to Do With BAD Residents and Physicians</td>
<td>Michael Herkov, PhD, Jacksonville, FL</td>
<td>Jacksonville, FL</td>
</tr>
<tr>
<td>8:35 am</td>
<td>Teaching Ethics in Educational Training Programs</td>
<td>Piroska Kopar, MD, Lebanon, NH</td>
<td>Lebanon, NH</td>
</tr>
<tr>
<td>8:50 am</td>
<td>Physician Depression, Burnout, and Suicide</td>
<td>David Rothenberger, MD, Minneapolis, MN</td>
<td>Minneapolis, MN</td>
</tr>
<tr>
<td>9:05 am</td>
<td>Online Physician Rating Systems and the Social Media</td>
<td>Sean Langenfield, MD, Omaha, NE</td>
<td>Omaha, NE</td>
</tr>
<tr>
<td>9:20 am</td>
<td>Panel Discussion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:30 am</td>
<td>Adjourn</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**9:30 – 10:00 am**

**Refreshment Break and E-poster Presentations in the Exhibit Hall**
Colorectal surgeons are often called upon to manage complex medical and surgical conditions as well as some rarely seen disorders. In addition, suggested diagnostic and treatment algorithms change over time. All surgical specialists have certain topics/diseases for which the treatments remain controversial or undefined. Understanding the optimal treatment plan for patients often depends on a physician's ability to see clarity in these lines of gray. This session will highlight the strategies of a group of senior colorectal surgeons as they confront various difficult operative scenarios one might encounter in clinical practice.

**Existing Gaps**

**What Is:** Because of evolving techniques in the management of many surgical patients and longer life expectancy, we are faced with even more complex abdominal and anorectal problems. Many operative techniques and scenarios can be quite complex and are not understood well by all.

**What Should Be:** Colorectal surgeons should be well versed in the techniques, tools and decision making required to take care of the most complex and difficult operative scenarios.

**Objectives:** At the conclusion of this session, participants should be able to:
- Recognize the management options of recurrent and complex disorders as well as rare conditions affecting the colon, rectum and anus.
- Describe normal anatomic relations of the colon, rectum and anus as well as disturbances of these relations in colorectal disorders.
- Recognize difficult operative scenarios and understand how to safely get out of trouble.

**Director:** Kyle Cologne, MD, Los Angeles, CA

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00</td>
<td><strong>Introduction</strong></td>
<td>Kyle Cologne, MD, Los Angeles, CA</td>
<td></td>
</tr>
<tr>
<td>10:02</td>
<td><strong>Hemorrhoids – The Ugly, The Uglier, and The Ugliest</strong></td>
<td>Stanley Goldberg, MD, Minneapolis, MN</td>
<td></td>
</tr>
<tr>
<td>10:10</td>
<td><strong>Inflammatory Bowel Disease – Nightmare on TNF Street</strong></td>
<td>Anthony Senagore, MD, Galveston, TX</td>
<td></td>
</tr>
<tr>
<td>10:18</td>
<td><strong>Diverticulitis – What Could Possibly Go Wrong?</strong></td>
<td>Robert Madoff, MD, Minneapolis, MN</td>
<td></td>
</tr>
<tr>
<td>10:26</td>
<td>The Entero-Everywhere Fistula – Yikes!</td>
<td>Scott Steele, MD, Cleveland, OH</td>
<td></td>
</tr>
<tr>
<td>10:34</td>
<td>The Unfixable Pelvic Floor – Is This a Terminal Disease?</td>
<td>Tracy Hull, MD, Cleveland, OH</td>
<td></td>
</tr>
<tr>
<td>10:42</td>
<td>Discussion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:45</td>
<td>Adjourn</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Presidential Address

10:45 – 11:30 am

Across the Universe: “Sounds of Laughter, Shades of Life”

Guy R. Orangio, MD
Associate Professor of Clinical Surgery, Chief Section of Colon and Rectal Surgery, LSU Healthcare Network Clinic; Adjunct Associate Professor of Clinical Surgery, Tulane School of Medicine/Department of Surgery; New Orleans, LA

Introduction: Eric Johnson, MD

Dr. Guy R. Orangio, New Orleans, LA, Chief Section of CRS LSU Department of Surgery, was elected President of the American Society of Colon and Rectal Surgeons (ASCRS) at the Society’s 2017 Annual Scientific and Tripartite Meeting in Seattle, WA.

Dr. Orangio first served on the ASCRS Executive Council as a member-at-large from 2010 to 2013, as vice president in 2015 and as president-elect in 2016. During his tenure as a Fellow of the ASCRS, he has served on several committees including the Awards (1991-92), Healthcare Economics (past Chair) (member 1998 – current), Regional Society, Website, History, Bylaws in various capacities and Board member of the Research Committee. He also served as ASCRS advisor to the AMA Specialty Society Relative Update Committee (since 2002), past advisor to the AMA CRT Editorial Committee and ASCRS advisor to the ACS General Surgery Coding and Reimbursement Committee (since 2007).

11:30 am – 12:45 pm

Complimentary Box Lunch & E-poster Presentations in the Exhibit Hall

Abstract Session*
Education

12:45 – 2:00 pm

*Abstract titles and authors are forthcoming.
Symposium

Your Day Just Got Complicated: Management of Intra-operative Consults and Postoperative Complications

12:45 – 2:00 pm

Colorectal surgeries account for about 10% of all general surgical procedures but account for up to 35% of all complications. As a result of this, there have been multiple attempts to improve and mitigate the effects of these complications. Complications may occur during surgeries for colorectal pathology. They may also occur during abdominal surgery for other reasons such as gynecologic or urologic pathology. Regardless of the setting in which a complication may occur, it is imperative for colorectal specialists to be familiar with possible complications and how to correct them and rescue the patient from unintended harm.

Existing Gaps

What Is: Colorectal procedures account for 10% of general surgical procedures but account for 35% of complications from such procedures. Complications are common. Intra-operative colorectal complications from other specialties often occur and the appropriate management of these scenarios lacks definition.

What Should Be: All colorectal specialists should be familiar with all the available management strategies for postoperative complications. Furthermore, colorectal surgeons should comfortably be available and prepared to assist their colleagues in other specialties during an emergent intra-operative consult.

Objectives: At the conclusion of this session, participants should be able to:
• Identify the common complications that can occur during and following colorectal surgery.
• Explain the latest algorithms for management of complications and the appropriate application of new technology.
• Recognize the possible unexpected intra-operative findings for which the colorectal specialist can be called.

Co-Directors: Bradley Champagne, MD, Cleveland, OH
Jonathan Laryea, MD, Little Rock, AR

12:45 pm  Introduction
Bradley Champagne, MD, Cleveland, OH
Jonathan Laryea, MD, Little Rock, AR

12:50 pm  Case 1
Wayne Ambroze, Jr., MD, Atlanta, GA

1:05 pm  Case 2
Eric Weiss, MD, Weston, FL

1:20 pm  Case 3
Patricia Roberts, MD, Burlington, MA

1:35 pm  Case 4
Richard Whelan, MD, New York, NY

1:50 pm  Questions and Answers

2:00 pm  Adjourn
Surgery for inflammatory bowel disease requires knowledge beyond just the technical aspects of the operation. In the past two decades, new medications such as biologics, have exploded on the scene and keeping up with them can be daunting. However, it is crucial to have a firm understanding of how our patients have been treated before we operate to reduce postoperative issues and plan the safest operation.

Likewise, management of postoperative issues to prevent long term problems is crucial for anyone who performs surgery for inflammatory bowel disease – particularly a pelvic pouch. With fewer pouches constructed each year in the United States and a reduced number which our trainees are exposed to in fellowship training, ancillary education must be utilized to provide the best care for our patients.

Colectomy for high grade dysplasia is nearly always recommended. However, there is controversy as to the risk of low grade dysplasia and when surgery is recommended. Surgeons getting referrals for low grade dysplasia struggle to understand the complex literature.

**Existing Gaps**

**What Is:** Gastroenterologists and medical doctors send patients to the surgeon and due to lack of understanding, some surgeons operate based solely on the medical doctor’s recommendation.

**What Should Be:** As surgeons, we must have sufficient understanding of the treatment of inflammatory bowel disease and the comprehensive surgical care to be a partner with the medical doctors in order to perform the best surgery and care for our patients.

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

- Discuss the risk of surgery on patients who have been on a biologic medication for their inflammatory bowel disease.
- Explain the strategy and thinking regarding redo pelvic pouch surgery and how to manage post-op complications to avoid long-term problems.
- Recognize the controversy regarding when low grade dysplasia should be an indication to remove the colon.

**Co-Directors:**

- Tracy Hull, MD, Cleveland, OH
- Shane McNevin, MD, Spokane, WA

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:45 pm</td>
<td>Introduction</td>
<td>Tracy Hull, MD, Cleveland, OH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shane McNevin, MD, Spokane, WA</td>
</tr>
<tr>
<td>12:50 pm</td>
<td>Is It Safe to Operate With Biologics on Board?</td>
<td>Amy Lightner, MD, Rochester, MN</td>
</tr>
<tr>
<td>1:05 pm</td>
<td>Pelvic Pouch Dysfunction – Can This Pouch Be Saved?</td>
<td>Jean Ashburn, MD, Cleveland, OH</td>
</tr>
<tr>
<td>1:20 pm</td>
<td>Low Grade Dysplasia: We Need to Remove the Colon</td>
<td>Scott Strong, MD, Chicago, IL</td>
</tr>
<tr>
<td>1:33 pm</td>
<td>Low Grade Dysplasia: Let’s Wait and Rescope</td>
<td>Kara DeFelice, MD, New Orleans, LA</td>
</tr>
<tr>
<td>1:46 pm</td>
<td>Case Presentations</td>
<td>Panel Discussion</td>
</tr>
<tr>
<td>2:00 pm</td>
<td>Adjourn</td>
<td></td>
</tr>
</tbody>
</table>

**Abstract Session**

**Outcomes**

2:00 – 3:30 pm

*Abstract titles and authors are forthcoming.*
Symposium

Pathogen or Partner? The Role of the Gut Microbiome in the Colorectal Surgical Patient

2:00 – 3:30 pm

Over the last decade, the health impacts of the gut microbiome as it relates to a host of illnesses, both intestinal and systemic, have come to attention. As colorectal surgeons, we not only treat diseases of the intestine that are caused in part by distortions in the gut microbiome, but we also directly cause significant distortions in the gut microbiome through bowel preparations, antibiotics and surgery itself. As the understanding of the role of the gut microbiome in surgical care expands, the importance of understanding how we distort this delicate balance increases.

Inflammatory bowel disease has for some time been considered an autoimmune condition in which the host immune system inappropriately reacts to normal intestinal bacteria, but the mechanisms behind this are only just being elucidated. An understanding of this host-bacterial interaction is essential in both developing new medications for IBD and tailoring surgery to specific patients.

Perturbations in the gut microbiome have also been noted in patients with colorectal cancer, but the question of cause or effect of these differences is just starting to be investigated. With changing populations at risk for colorectal cancer in recent decades, including a sharp increase in incidence of colorectal cancer in a young population, an understanding of the host-bacterial interaction in the development of colorectal cancer may aid us in counseling our patients at risk and in finding new prevention and treatment options.

The use of fecal microbiota transplant for recurrent *C. difficile* colitis is well established, though coordination and delivery of this treatment remains confusing for many. In addition, studies addressing other potential indications for fecal transplant are ongoing and include inflammatory bowel disease, functional gastrointestinal disorders, non-alcoholic steatohepatitis, alcoholic hepatitis, hepatic encephalopathy and neuropsychiatric conditions.

In treatment of colorectal disorders, we frequently distort the gut microbiome through use of antibiotics, mechanical bowel preparations and surgery, and the gut microbiome in turn distorts our patient’s postoperative course, impacting anastomotic leaks, wound infections, antibiotic-associated diarrhea and systemic sepsis. Recent studies suggesting a benefit of preoperative bowel preparation have shifted practice for many, but questions remain about the optimal perioperative approach.

Existing Gaps

*What Is:* The interplay of the gut microbiome in disease and postoperative outcomes is a nascent field of study, and new treatment options exist which are not well understood by all.

*What Should Be:* As colorectal specialists, we need to have a thorough understanding of the impact of routine treatments on the gut microbiome, as well as an understanding of how distortions in the gut microbiome impact surgical outcomes.

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

- Describe the impact of the gut microbiome on the treatment of IBD and colorectal cancer.
- Recognize the indications for fecal microbiota transplant.
- Describe the pros and cons of mechanical and oral antibiotic bowel preparation.
- Explain how the gut microbiome influences postoperative complications.

Co-Directors: Angela Kuhnen, MD, Boston, MA
Sonia Ramamoorthy, MD, San Diego, CA

Continued next page
Pathogen or Partner? The Role of the Gut Microbiome in the Colorectal Surgical Patient (continued)

2:00 pm  **Introduction**
Angela Kuhnen, MD, Boston, MA
Sonia Ramamoorthy, MD, San Diego, CA

2:05 pm  **The Gut Microbiome in the Pathogenesis and Treatment of IBD**
Richard Hodin, MD, Boston, MA

2:20 pm  **The Gut Microbiota in the Pathogenesis and Treatment of Colorectal Cancer**
Temitope Keku, PhD, Chapel Hill, NC

2:35 pm  **Fecal Microbiota Transplantation for Recurrent C. difficile Colitis and Other Inflammatory Intestinal Conditions**
Zain Kassam, MD, MPH, Somerville, MA

2:50 pm  **Impact of Bowel Preparation on the Gut Microbiome**
John Migaly, MD, Durham, NC

3:05 pm  **The Gut Microbiome in Postoperative Complications**
John Alverdy, MD, Chicago, IL

3:20 pm  **Discussion**

3:30 pm  **Adjourn**
Symposium

Financial Planning for the Colorectal Surgeon: Everything You Have Always Wanted to Know, But Were Afraid to Ask

2:00 – 3:30 pm

While our job satisfaction is high as colorectal surgeons, retirement should ultimately be part of each of our lives. Planning early and avoiding mistakes is essential to a successful life in retirement. While there are volumes of texts and limitless online resources to consult when making these decisions, understanding the foundation of a sound financial plan is achievable in a short amount of time.

Because our careers start at a later point in life due to the length of training, surgeons have limited time to save. Additionally, physicians typically have high incomes but little knowledge on how to most effectively manage their money. As a result, physicians are often easy prey to the finance industry. It is vital to plan correctly, carefully and efficiently to avoid financial mistakes that could have significant long-term consequences.

With this symposium, we have invited experts in the field of financial planning and insurance for physicians to provide essential information for structuring personal financial success. We have highlighted the basics, but will also add information about lesser-known strategies that are available to help physicians diversify.

Existing Gaps
What Is: Financial planning is not an area of expertise of the majority of physicians. As the demands of our careers limit time for financial research, there are common traps physicians fall into when it comes to money matters.

What Should Be: As highly successful professionals, we should achieve a basic understanding of a solid financial plan with foundational knowledge. Additionally, we should broaden our knowledge of reliable alternative investment strategies, including passive income streams.

Objectives: At the conclusion of this session, participants should be able to:
- Describe the foundation of a solid financial plan.
- Describe the pros and cons of term versus whole life insurance.
- Explain the basics of a 401k, IRA and methods of investing.
- Describe the philosophy and basic strategy of F.I.R.E. (Financial Independence Retire Early).
- Highlight common doctor mistakes and how to avoid them.
- Discuss and explain alternative forms of income for physicians.

Co-Directors: Jason Mizell, MD, Little Rock, AR
Jennifer Rea, MD, Lexington, KY

2:00 pm Introduction
Jason Mizell, MD, Little Rock, AR

2:05 pm Dumb Doctor Mistakes and How to Avoid Them
Fahd Ahmad, MD, St. Louis, MO

2:20 pm Investing – The Foundation of Your Successful Financial Plan
Sarah Catherine Gutierrez, CFP, Little Rock, AR

2:40 pm Insurances: Are They Created Equal?
Jeffrey Todd, CLU, ChFC, Lexington, KY

2:55 pm When Can I Retire?
Chad Chubb, CFP, Philadelphia, PA

3:15 pm Panel Discussion

3:30 pm Adjourn

3:30 – 4:00 pm
Ice Cream & Refreshment Break and E-poster Presentations in the Exhibit Hall
**Symposium**

**New Technologies**

4:45 – 6:15 pm

The New Technologies Symposium has become an annual event at the ASCRS Annual Scientific Meeting and serves as a unique opportunity to work with ASCRS members and industry to present new technologies in a non-CME forum.

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

---

**Residents’ Reception**

6:30 – 8:00 pm

Open to residents and colorectal program directors only.

Residents are invited to 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 drawing for a copy of the *ASCRS Manual of Colon and Rectal Surgery*, Second Edition, will be held.

---

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

4:00 – 4:45 pm

**Sticky Floors and Glass Ceilings**

Caprice Greenberg, MD, MPH  
Professor of Surgery, University of Wisconsin, Madison, WI

**Introduction:** Jamie Cannon, MD

Harry Ellicott Bacon, MD (1900-1981), was Professor and Chairman of the Department of Proctology at Temple University Hospital. His stellar contribution was the establishment of the Journal, *Diseases of the Colon and Rectum*, of which he was the Editor-in-Chief. He was a Past President of the American Society of Colon and Rectal Surgeons and the American Board of Colon and Rectal Surgery. Dr. Bacon was the founder of the International Society of University Colon and Rectal Surgeons.

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

---

**Residents’ Reception**

6:30 – 8:00 pm

Open to residents and colorectal program directors only.

Residents are invited to 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 drawing for a copy of the *ASCRS Manual of Colon and Rectal Surgery*, Second Edition, will be held.

---
Meet the Professor Breakfasts

6:30 – 7:30 am
Limit: 30 per breakfast • Fee $50 • Tickets Required • Continental Breakfast Included
Registrants are encouraged to bring problems and questions to this informational discussion. Please register early and indicate your 1st and 2nd choice on the Registration Form.

T-1 Management of Anastomotic Leak
Matthew Albert, MD, Almonte Springs, FL
Neil Hyman, MD, Chicago, IL

T-2 Difficult Reoperative Cases
Daniel Feingold, MD, New York, NY
Charles Friel, MD, Charlottesville, VA

T-3 Making the Quality Improvement Process Work for You
Arden Morris, MD, Stanford, CA
Elizabeth Wick, MD, San Francisco, CA

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

Residents’ Breakfast

6:30 – 7:30 am
Registration Required • Open to Residents Only
Surviving and Thriving in Your First Year of Practice
Patricia L. Roberts, MD
Senior staff surgeon in the Division of Colon and Rectal Surgery at Lahey Hospital and Medical Center and Chair of the Department of Surgery. She is a Professor of Surgery at Tufts School of Medicine and a Past President of the American Society of Colon and Rectal Surgeons.

Introduction: T. Cristina Sardinha, MD

Colorectal surgery residents and general surgery residents are invited to attend the Residents’ Breakfast. ASCRS Past President Dr. Patricia Roberts is the breakfast’s featured speaker. Her presentation titled “Surviving and Thriving in Your First Year of Practice” will draw on her years of experience and provide essential information for beginning your surgical career. Don’t miss this opportunity to network and enjoy breakfast with colleagues.

Parviz Kamangar Humanities in Surgery Lectureship

7:30 – 8:15 am
Mr. Parviz Kamangar has funded this unique lectureship, a grateful patient, to remind physicians and surgeons to place compassionate care at the top of their priority list.

Medical Ethics and Frankenstein’s Monster
Ira Kodner, MD
Emeritus Professor of Surgery, Washington University School of Medicine in St. Louis, MO

Introduction: Yanek Chiu, MD
Symposium

The Best of The Diseases of the Colon and Rectum Journal

8:15 – 9:00 am

This symposium will target the practicing colorectal surgeon who has a desire to continue to stay up to date on the latest in the pathogenesis and management of colorectal diseases. Due to daily rigors, 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 Diseases of the Colon and Rectum. Presentations and discussion will focus on study design and results, practical implications of the data and a critical review of submitted work.

Existing Gaps

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:
• Describe the basics of the top papers published in DC&R.
• Distinguish the qualities of a manuscript that provides value to the practicing surgeon.
• Identify further questions that warrant additional research.
• 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: Kelli Bullard Dunn, MD, Louisville, KY

8:15 am  Introduction
Kelli Bullard Dunn, MD, Louisville, KY

8:20 am  Tailored Treatment Strategy for Locally Advanced Rectal Carcinoma Based on the Tumor Response to Induction Chemotherapy: Preliminary Results of the French Phase II Multicenter GRECCAR4 Trial
Jean-Jacques Tuech, MD, Rouen, France

8:30 am  Effects of Hysterectomy on Pelvic Floor Disorders: A Longitudinal Study
Mehmet Kuzu, MD, Ankara, Turkey

8:40 am  Validation of MRI and Surgical Decision Making to Predict a Complete Resection in Pelvic Exenteration for Recurrent Rectal Cancer
Cherry Koh, MD, New South Wales, Australia

8:50 am  Large Variation in Blood Transfusion Use After Colorectal Resection: A Call to Action
Fergal Fleming, MD, Rochester, NY

9:00 am  Adjourn

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

Abstract Session*

General Surgery Forum

9:30 – 10:45 am

*Abstract titles and authors are forthcoming.
Symposium

Out of the Movies and Into Reality: How Disruptive Technology May Change the Way You Practice

9:30 – 10:45 am

Although colorectal surgeons understand and often discuss the use of new technologies such as social media and robotics, they often have a limited understanding of the bigger concept of disruptive technology. Disruptive technologies are innovations that initially create a new market and value network, and then eventually disrupt existing markets and networks, thus displacing more established firms, products and alliances.

A popular example of disruptive technology is Uber, which has created an international transport system without owning any cars or hiring any drivers. Uber and similar virtual companies are lean, reactive and profitable in our current social and economic climate, and the taxi industry has suffered significant financial losses as a result. Other examples include Wikipedia and its impact on traditional encyclopedias and the impact of digital photography on traditional cameras and film development.

Disruptive technology has been prevalent in medicine and surgery for many years. A well-known example is the evolution of endoluminal techniques for vascular disease, which has made previously common procedures such as an open abdominal aortic aneurysm repair uncommon, and has allowed cardiologists and radiologists to play a larger therapeutic role in vascular patients, thus narrowing the surgeon’s grip on the market share.

The future of disruptive technology within medicine and surgery will likely be even more radical. It is changing the way patients interact with physicians, tools available to physicians and the way we will educate a future generation of doctors. In order to remain relevant in the future of health care, we must understand and anticipate the changes driven by new technologies.

Existing Gaps

What Is: Despite having a relatively limited understanding of the disruptive technologies, surgeons are impacted by these innovations on a daily basis. This includes the way that they learn, how they digest new literature and new surgical techniques and how they interact with their colleagues and patients.

What Should Be: Surgeons should be able to define and identify disruptive technology, and thus better understand how it can affect their lives. This will also allow them to anticipate changes in their practice and stay ahead of the curve as their profession evolves.

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

- Define disruptive technology and identify examples in health care.
- Recognize how social media and consumer-driven internet searches have altered the way surgeons and patients digest new information.
- Explain how surgical education has been impacted by disruptive technology.

Co-Directors: Sean Langenfeld, MD, Omaha, NE
Sharon Stein, MD, Cleveland, OH

Continued next page
Out of the Movies and Into Reality: How Disruptive Technology May Change the Way You Practice  

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Presenter(s)</th>
</tr>
</thead>
</table>
| 9:30 am | Introduction: Setting the Stage                                               | Sean Langenfeld, MD, Omaha, NE  
Sharon Stein, MD, Cleveland, OH |
| 9:40 am | Dissemination of Information: How Technology Has Changed the Way We Can        | Daniel Popowich, MD, New York, NY  
Interact With Our Colleagues |
| 9:50 am | Education: What Does the Future Look Like in Surgical Education? Simulation,   | Sandra de Montbrun, MD, Toronto, Canada  
Tablets, Smartphones and Online Education: Are We Better or Worse Now? |
| 10:00 am | Sharing Information: Current EMR Are Only the First Step in What Could Be a   | Emily Steinhagen, MD, Cleveland, OH  
World-Wide Information Network to Truly Improve Patient Care. How Interactive Technology Could Revolutionize Our Interaction With Patients. |
| 10:10 am | Patient Experience: How Disruptive Technology Has Empowered Patients and the  | George Nassif, MD, Altamonte Springs, FL  
Consumer-driven Market for Surgery |
| 10:20 am | The Newest Tricks and Gadgets: Are High Fidelity Surgical and Endoscopic      | Daniel Herzig, MD, Portland, OR  
Simulation Bridging the Gap? |
| 10:30 am | Questions and Answers                                                          |                                                              |
| 10:45 am | Adjourn                                                                       |                                                              |
Symposium

What the American College of Surgeons Does for Me as an ASCRS Member

9:30 – 10:45 am

The American College of Surgeons (ACS) is the largest surgery society in the world that represents specialty surgeons. The ACS has many programs which are not familiar to all ASCRS fellows and members. In order for members of ASCRS to gain the most from their membership and interaction with ACS, it is critical to have an understanding of the programs available through the College as well as what the College does on our behalf to advocate for us as surgeons and for our patients.

Existing Gaps

What Is: Lack of knowledge of ACS offerings for colorectal surgeons.

What Should Be: Understanding of how the ACS helps colorectal surgeons in daily practice.

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

• Describe how the ACS advocates for colorectal surgery.
• Evaluate ACS educational offerings for colorectal surgery.
• Assess the value of ACS Commission on Cancer program for colorectal surgery.

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

9:30 am  Introduction
Steven Wexner, MD, PhD (Hon), Weston, FL

9:35 am  Optimizing the Quality of Our Practices with ACS Programs
Clifford Ko, MD, Los Angeles, CA

9:50 am  How the Commission on Cancer Can Improve Outcomes
Frederick Greene, MD, Chapel Hill, NC

10:05 am  ACS Education Programs for Colorectal Surgeons
Ajit Sachdeva, MD, Chicago, IL

10:20 am  ACS Advocacy Helps Us Help Our Patients
David Hoyt, MD, Chicago, IL

10:45 am  Adjourn
Women in Colorectal Surgery Luncheon

Registration Required • Complimentary

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 meet experienced colon and rectal surgeons from a variety of settings.

This year, we will once again be having table topics for discussion. Please join us for:

1. Balancing Research and Clinical
2. Creating a Successful Team
3. Managing Conflicts at Work
4. Work Life Integration
5. Tips for Building a Practice
6. Setting yourself up for Colorectal Residency

Tables will be chosen on arrival to the luncheon.

11:30 am – 1:00 pm
Complimentary Box Lunch and E-poster Presentations in the Exhibit Hall

Memorial Lectureship Honoring Dr. Bertram Portin

1:00 – 1:45 pm

Born in 1927, Dr. Portin received his medical degree from State University of New York Buffalo in 1953 and completed his general surgery residency at Edwin Meyer Memorial Hospital in 1959. He received ABCRS certification 1961 and become an ASCRS Fellow in 1964. His esteemed career included Clinical Professor of Surgery and Chair, Division of Colon and Rectal Surgery at SUNY Buffalo and Chief, Colon and Rectal Surgery at Senter Hospital, Buffalo, NY. Dr. Portin is survived by wife Rhoda, children Robert, Susan and Mark, and five grandchildren.

Abstract Session*
Basic Science
1:45 – 3:15 pm
*Abstract titles and authors are forthcoming.

Abstract Session*
Research Forum
1:45 – 3:15 pm
*Abstract titles and authors are forthcoming.
Symposium

Hereditary Colorectal Cancer Syndromes

1:45 – 3:15 pm

Advanced technologies have allowed an exponential increase in our understanding of the genetic underpinnings of colorectal diseases, and in particular inherited colorectal cancer syndromes. Identification of specific genetic variations leading to hereditary colorectal cancer syndromes has allowed for more precise classifications and a more personalized risk stratification. It is essential to be up to date regarding genetics and how they relate to the diagnosis, counseling, surveillance and management of inherited colorectal cancers.

Existing Gaps

What Is: In their routine daily practice, clinicians do not often appreciate the relevance of understanding genetics as it applies to diagnosis and management of hereditary colorectal cancer syndromes. The information regarding these syndromes is growing and changing rapidly, making it difficult for clinicians to stay current. As a result, these patients may not receive appropriate treatment, surveillance and/or counseling.

What Should Be: Patients with hereditary cancer syndromes are readily identified and offered appropriate counseling and medical and surgical therapy.

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

• Discuss the classification and diagnostic approach to hereditary colorectal cancer syndromes.
• Define the indications for surgery and surgical approach to patients with familial adenomatous polyposis, MYH-associated polyposis and Lynch syndrome.
• Describe the presentation of management options for desmoid disease in familial adenomatous polyposis.

Co-Directors: Daniel Herzig, MD, Portland, OR
Matthew Kalady, MD, Cleveland, OH

1:45 pm Welcome and Introductions
Daniel Herzig, MD, Portland, OR
Matthew Kalady, MD, Cleveland, OH

1:50 pm State of the Art 2018: Classification and Genetic Testing for Hereditary Colorectal Cancer Syndromes
Molly Ford, MD, Nashville, TN

2:05 pm Managing Adenomatous Polyposes: Which Surgery and When to Operate
Robert Gryfe, MD, PhD, Toronto, Canada

2:20 pm Tackling the Surgical Challenges of Desmoid Disease
James Church, MD, Cleveland, OH

2:35 pm Colorectal Cancer in Lynch Syndrome: The Data on Extended Resection
Y. Nancy You, MD, Houston, TX

2:50 pm Case Discussions with Panel

3:15 pm Adjourn

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. Guy R. Orangio, will present a State of the Society Address and honor this year’s award recipients.
Symposium

Drinks and Disputes: The After Hours Debates

4:30 – 5:30 pm

Debate #1: Advanced Endoscopy: Colorectal Surgeon or Gastroenterologist?
4:30 – 5:00 pm

Debate #2: Fluorescence Imaging: Valuable Commodity or Waste of Money?
5:00 – 5:30 pm

Through both enhanced imaging capabilities and improved dissection techniques, advances in the existing endoscopic technology have allowed the possibility of minimally invasive management of a broader range of lesions encountered at the time of colonoscopy. The use of fluorescence imaging in surgery has recently become more widespread; however, its value has yet to be defined.

The adoption of new technology and techniques for surgeons in practice is challenging. There is often insufficient opportunity for the practicing surgeon to be exposed to the most state-of-the-art methods. In order to surmount these obstacles, it is necessary for the surgeon to acquire an in depth understanding of the available technology, the indications for its use and the potential benefits to the intended patient population.

Advanced endoscopic techniques have broadened the scope of potential therapy for patients with colorectal neoplasia. Through the use of enhanced imaging technology, there exists the potential for increased polyp detection. Extended submucosal dissection and the use of both CO2 and laparoscopic assistance has allowed physicians to resect more complex colonic lesions from an endoluminal approach. Other advanced techniques such as colonoscopic stenting and double balloon colonoscopy have also increased the ability to diagnose and manage patients in a minimally invasive fashion. These techniques have been employed by both colorectal surgeons and gastroenterologists, and there are advantages and disadvantages of who should be performing these procedures.

Fluorescence imaging has become increasingly prevalent in recent years. It has been utilized in the identification of various anatomical structures including the ureter and biliary tract, as well as in the intraoperative assessment of intestinal perfusion. It has been postulated that demonstrating adequate perfusion of an intestinal anastomotic segment may help to reduce the incidence of anastomotic leak; however, the exact benefit of this remains unclear.

Existing Gaps

What Is: There are several new imaging techniques for colonoscopy that many surgeons are unfamiliar with. A significant number of surgeons are not performing endoscopic submucosal resection of colorectal neoplasia or combined laparo-endoscopic resection. With the continued advances of technology in endoluminal therapy, surgeons will need training to incorporate these methods into their practice. The true value of fluorescence imaging in surgery has not yet been determined.

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 for colorectal neoplasia and laparo-endoscopic resection. This will allow for the meaningful implementation of these newer endoluminal techniques into their armamentarium of skills to treat disease of the colon and rectum. Surgeons must also understand the potential benefits of the use of fluorescence imaging in surgery.

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

• Explain the indications and uses for endoscopic submucosal resection for colorectal neoplasia.
• Explain the indications and technical aspects of combined laparoscopic and endoscopic resection of colorectal neoplasia.
• Recognize the indication and utility of colonic stent placement.
• Discuss the advantages and disadvantages of the use of fluorescence imaging in colorectal surgery.

Director: David Maron, MD, Weston, FL

Continued next page
Drinks and Disputes: The After Hours Debates  (continued)

4:30 – 5:00 pm
Debate #1:  Advanced Endoscopy: Colorectal Surgeon or Gastroenterologist?

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

4:35 pm  Colorectal Surgeon Position  
Peter Marcello, MD, Boston, MA

4:39 pm  Gastroenterologist Position  
Klaus Mergener, MD, Tacoma, WA

4:43 pm  Rebuttal  
Peter Marcello, MD, Boston, MA

4:46 pm  Rebuttal  
Klaus Mergener, MD, Tacoma, WA

4:50 pm  Rebuttal  
Peter Marcello, MD, Boston, MA

4:54 pm  Rebuttal  
Klaus Mergener, MD, Tacoma, WA

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

5:00 – 5:30 pm
Debate #2:  Fluorescence Imaging: Valuable Commodity or Waste of Money?

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

5:05 pm  Fluorescence – Pro  
Alessio Pigazzi, MD, Orange, CA

5:09 pm  Fluorescence – Con  
Bradley Davis, MD, Charlotte, NC

5:13 pm  Fluorescence – Pro Rebuttal  
Alessio Pigazzi, MD, Orange, CA

5:16 pm  Fluorescence – Con Rebuttal  
Bradley Davis, MD, Charlotte, NC

5:19 pm  Fluorescence – Pro Rebuttal  
Alessio Pigazzi, MD, Orange, CA

5:22 pm  Fluorescence – Con Rebuttal  
Bradley Davis, MD, Charlotte, NC

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

5:30 pm  Adjourn

ASCRS Music City Gala

7:30 – 10:30 pm, Tuesday  
Omni Nashville Hotel  
Tickets Required

The country western theme of Nashville continues with the ASCRS Music City Gala! The gala is a wonderful opportunity to relax, socialize and enjoy an evening of delicious food and dancing.

There is no additional cost for a ticket for full-paying Members and Fellows. Nonmember or spouse/companion tickets may be purchased at the registration desk for $150 per ticket.
Meet the Professor Breakfasts

7:00 – 8:00 am

Limit: 30 per breakfast • Fee $50 • Tickets Required • Continental Breakfast Included

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

### W-1 Complex Rectal Cancer Cases
- David Dietz, MD, Cleveland, OH
- Steven Wexner, MD, PhD (Hon), Weston, FL

### W-2 Parastomal Hernia Cases
- Joshua Bleier, MD, Philadelphia, PA
- C. Neal Ellis, MD, Odessa, TX

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

- Describe the procedures and approaches discussed in this session.
Symposium

Coffee and Controversies: Minimally Invasive Surgery and Big Data vs. Social Media

7:00 – 8:00 am

Debate #1: Is There Still a Role for HALS?
7:00 – 7:30 am

Debate #2: RCT’s/Big Data or Social Media – Which Is More Effective at Driving Change?
7:30 – 8:00 am

Debate #1: Is There Still a Role for HALS?

Minimally invasive surgery provides improved short-term outcomes for colorectal surgery patients. Despite this well accepted fact, 60% of colorectal operations in the United States are performed open. There are a variety of patient related factors that weigh into this number, but the biggest driver of the lack of adoption of laparoscopy is surgeon related. Different modalities claim to make minimally invasive surgery easier and to decrease the conversion rate to open; such as robotics, transanal TME and HALS. In reality, minimally invasive surgery is a skill that requires training, practice and patience.

HALS is a technique that bridges open surgery to straight laparoscopy where the operating surgeon maintains normal tactile feedback and has a hand for retraction. HALS can be quite challenging. It can be difficult to provide proper retraction while keeping the hand out of way of the camera. Since the incision must be the size of the operating surgeon’s hand, the incision is often larger than for straight laparoscopy. Some surgeons feel that this is unnecessary, and that straight laparoscopy has decreased morbidity; therefore, HALS is no longer necessary. There are also cases of conversion to open for patient-specific factors, and HALS can help with those difficult cases by allowing the surgeon to finger fracture inflamed tissues and improve retraction with tactile feedback.

Existing Gaps

What Is: Surgeons feel that the way they perform an operation is “best.”

What Should Be: An open dialogue about when HALS is beneficial over open procedures as well as a straight laparoscopy. All surgeons appreciate that HALS is a tool that we all can use for specific cases, but it requires skill and practice.

Objectives: At the conclusion of this session, participants should be able to:
• Discuss the benefits and downsides to HALS.
• Recognize that a surgeon’s comfort with a technique can be more important than data.
• Explain the continued use and benefits of HALS in certain circumstances.

Director: Meagan Costedio, MD, Cleveland, OH

7:00 am Crystallizing the Controversy; Clinical Scenarios to Consider
Meagan Costedio, MD, Cleveland, OH

7:05 am HALS – Pro
I. Emre Gorgun, MD, Cleveland, OH

7:12 am HALS – Con
Kelly Garrett, MD, New York, NY

7:19 am HALS Pro Rebuttal
I. Emre Gorgun, MD, Cleveland, OH

7:23 am HALS Con Rebuttal
Kelly Garrett, MD, New York, NY

7:27 am Concluding Remarks
Meagan Costedio, MD, Cleveland, OH

Continued next page
Coffee and Controversies: Minimally Invasive Surgery and Big Data vs. Social Media (continued)

Debate #2: RCT’s/Big Data or Social Media- Which is More Effective at Driving Change?

In our current state of health care economics, funding for research continues to decline. As a result, randomized controlled trials are becoming more difficult to complete. Funding may come from a sponsoring company, but if the study is negative, will it get published? Large databases are a great source of a huge amount of data, allowing us to ask questions about rare diseases or outcomes. However, using large databases may lead to Type 1 error, where we find an association though one does not exist. Despite the lack of data, practitioners are learning new techniques and many of them are well publicized. Social media has catapulted this process.

Social media can provide great marketing and exposure to the provider at no cost. Physicians can use this avenue as an educational tool to alert them to new and important studies published. However, patients and physicians can be led astray. Study data still must be interpreted, and social media provides no policing of physician-driven information.

Existing Gaps
What Is: Studies are being published at a rapid rate and it can be difficult to keep with up with current standard of care. It is also difficult to interpret some of that data.

What Should Be: Use social media to help decrease the time it takes to find valuable articles to stay current with literature as well as help to improve engagement and reputation while understanding the risks of a using this public forum.

Objectives: At the conclusion of this session, participants should be able to:
• Describe the pros and cons of large database studies.
• Explain that with the current volume of data that is being published, social media helps to draw attention to important articles.
• Recognize the benefits and drawbacks of social media for both the physician and patient.

Director: Meagan Costedio, MD, Cleveland, OH

7:30 am Crystallizing the Controversy; Clinical Scenarios to Consider
Meagan Costedio, MD, Cleveland, OH

7:35 am RCT’s/Big Data – Pros
Luca Stocchi, MD, Cleveland, OH

7:42 am Social Media – Pros
Alexis Grucela, MD, New York, NY

7:49 am RCT’s/Big Data – Rebuttal
Luca Stocchi, MD, Cleveland, OH

7:53 am Social Media Rebuttal
Alexis Grucela, MD, New York, NY

7:57 am Concluding Remarks
Meagan Costedio, MD, Cleveland, OH

8:00 am Adjourn
**Symposium**

**What’s New in the Management of Rectal Cancer?**

8:00 – 9:15 am

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.

In 2017, 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: the quality standards and benchmark outcomes associated with the standard of care; the nature of novel treatment approaches as well as the extent and the strength of the evidence associated with them and how to practically integrate above knowledge and apply them to make treatment recommendations and decisions in daily practice.

**Existing Gaps**

**What Is:** Significant variability continues to impact the care and the outcomes of patients with rectal cancer. Health care providers may not routinely participate in the multidisciplinary team approach for the management of both early-stage and locally-advanced rectal carcinoma. They may not be aware of the emerging novel treatment paradigms for rectal cancer, or cannot articulate either the evidence or the strength of the evidence that support the emerging treatment paradigms, or could benefit from synthesis of evidence toward practical application in daily patient cases.

**What Should Be:** Physicians should routinely engage in discussion of all rectal cancer cases in a multidisciplinary team setting that includes colorectal cancer radiologists, pathologists, surgeons, medical oncologists and radiation oncologists. Outcomes should be more uniform to include utilization of surgical approaches following oncological principles.

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

- Evaluate the variability in rectal cancer surgery and understand the benchmark outcomes associated with standard of care.
- 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.
- Describe the outcomes associated with various surgical approaches for rectal cancer.

**Co-Directors:** Scott Steele, MD, Cleveland, OH  
Y. Nancy You, MD, Houston, TX

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 am</td>
<td>Introduction</td>
<td>Scott Steele, MD, Cleveland, OH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Y. Nancy You, MD, Houston, TX</td>
</tr>
<tr>
<td>8:05 am</td>
<td>What is the Standard of Care and Benchmark Outcomes for Early Stage and Locally Advanced Rectal Cancer?</td>
<td>George Chang, MD, Houston, TX</td>
</tr>
<tr>
<td>8:20 am</td>
<td>When Can We Preserve the Rectum Early Stage and Locally Advanced Rectal Cancer?</td>
<td>Rodrigo Perez, MD, Sao Paulo, Brazil</td>
</tr>
<tr>
<td>8:35 am</td>
<td>How Do I Selectively Use Radiation to Benefit the Rectal Cancer Patient?</td>
<td>Ibrahim Gecim, MD, Ankara, Turkey</td>
</tr>
<tr>
<td>8:50 am</td>
<td>Chemotherapy: When, Which Agents and How Long?</td>
<td>Dustin Deming, MD, Madison, WI</td>
</tr>
<tr>
<td>8:55 am</td>
<td>Case Discussion with Panel and Questions</td>
<td></td>
</tr>
<tr>
<td>9:15 am</td>
<td>Adjourn</td>
<td></td>
</tr>
</tbody>
</table>
Syposium

Are There Solid Options for Fecal Incontinence?

8:00 – 9:15 am

The prevalence of fecal incontinence (FI) is difficult to estimate, as it is frequently underreported due to embarrassment and reluctance of patients to discuss symptoms with their physicians. FI profoundly affects quality of life and causes significant social and psychological distress.

We know that the pathophysiology of FI can be complex and there may be more than one etiology that needs to be addressed. Consequently, because of multiple potential etiologies and pathophysiological risk factors, the evaluation and treatment of FI has been challenging as well as the assessment of whether treatment has been successful.

Existing Gaps

What Is: There are many treatments available for patients with FI, and it can be difficult to determine which treatment is best for a patient and a consistent and reliable method to assess outcomes.

What Should Be: Recognize which treatment options are available and how to individualize management to meet the needs and symptoms of the specific patient.

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

• Recognize the medical treatments available for fecal incontinence.
• Define the indications for overlapping sphincteroplasty or sacral nerve stimulation (SNS) for the first line treatment of FI.
• Describe the indications for magnetic sphincter use and results of treatment.
• Explain the options and novel therapies for the treatment of FI.

Co-Directors: Martha Ferguson, MD, Cincinnati, OH
Kelly Garrett, MD, New York, NY

8:00 am Introduction
Martha Ferguson, MD, Cincinnati, OH
Kelly Garrett, MD, New York, NY

8:05 am Pills, Powders and Injections: Medical Options
Sarah Vogler, MD, St. Paul, MN

8:20 am When to Tighten, When to Stimulate: SNS vs. Sphincteroplasty
Shane McNevin, MD, Spokane, WA

8:35 am Sphincter Augmentation or Replacement: Novel Treatments
Anders Mellgren, MD, Chicago, IL

8:50 am Contribution of Internal Prolapse and When to Consider Repair
Brooke Gurland, MD, Stanford, CA

9:05 am Case Presentations

9:15 am Adjourn

9:15 – 9:30 am Refreshment Break in Foyer
Symposium
The Future of Surgical Practice: How Will Changes in the Rules Affect You?

9:30 – 10:45 am

Changes in health care delivery and reimbursement are occurring rapidly and understanding those changes is necessary to put ourselves in the best possible position. Most changes are centered on reimbursement and cost containment, with the central concept to provide the highest quality of care in the most cost effective manner. Centers for Medicare & Medicaid Services (CMS) has embraced this idea by developing payment systems based on expected cost of a single episode of care and integrating with the measured outcomes of individual physicians. This is creating an environment where every decision made by a physician has direct cost and outcome influence on how we will be reimbursed going forward. Thus, the reimbursement associated with pre-operative evaluation, perioperative care and 90 day postoperative care will result in a single flat sum Alternative Payment Models (APM) or will be based on our individual and institutional scorecard for measured quality, care improvement activities, provided care information and cost Merit-based Incentive Payment System (MIPS).

To put ourselves in the best possible position, it is necessary for our members to understand these payment systems and how they impact us. Specifically, our members need to understand how surgeons will be paid as a component of health care system, what are the criteria being utilized to determine physician payment, what can individual physicians do to decrease the cost of care and how do we integrate advances in technology and care without breaking the bank.

Existing Gaps
What Is: Currently care is delivered in a very individualized manner. Each physician provides care based on their specific preferences for each individual patient. This leads to inefficiencies in the quality and cost of health care delivery.

What Should Be: The entire health care system should be able to provide the highest quality of care in the most cost effective manner. This will require a clear understanding of the rules and a realignment of priorities so that the patient, physician and system equally benefit.

Objectives: At the conclusion of this session, participants should be able to:
• Recognize the MIPS and APM payment systems.
• Explain the components of scorecards or quality metrics used to influence reimbursement.
• Distinguish strategies to provide high quality care at the lowest possible costs.

Co-Directors: Matthew Mutch, MD, St. Louis, MO
Charles Whitlow, MD, New Orleans, LA

9:30 am Introduction
Matthew Mutch, MD, St. Louis, MO
Charles Whitlow, MD, New Orleans, LA

9:35 am MACRA: What Is It and How Does It Impact Colon and Rectal Surgery?
Don Selzer, MD, Indianapolis, IN

9:50 am Physician Scorecards: How to Improve Your Score
Clifford Ko, MD, Los Angeles, CA

10:05 am Managing Patients After Discharge: Containing Costs and Improving Outcomes
Anthony Senagore, MD, Galveston, TX

10:25 am Introducing New Technology: Cost vs. Outcome
Sonia Ramamoorthy, MD, San Diego, CA

10:45 am Adjourn
**Symposium**

**When the Dust Settles – Reconstruction After Leaks, Fistulas and Abdominal Wall Defects**

9:30 – 10:45 am

During a colorectal surgeon’s career, we frequently encounter patients who have recovered from significant postoperative complications and abdominal wall catastrophes. After they have survived the initial insult, many patients are left with significant defects in the abdominal wall, massive hernias, enterocutaneous (EC) and enter-atmospheric fistulae and significant loss of domain. These issues pose a significant risk to health and quality of life and need to be addressed. These are complicated patients, often with significant co-morbidities and nutritional deficits, and the approach to successful reconstruction takes careful planning and significant expertise. Through this symposium, we aim to create a systematic way to assess all the complicated issues surrounding the planning and eventual reconstruction of the abdominal wall. By reviewing the pre-operative considerations, followed by didactic lectures aimed at reviewing the various techniques of abdominal wall reconstruction based on the compartments of the abdominal wall, and finally decisions regarding reconstructive adjuncts, we aim to try to bring clarity to a delicate and complicated situation.

**Existing Gaps**

*What Is:* As colorectal surgeons, we frequently encounter patients who have survived abdominal catastrophes, and are left with large abdominal wall defects, massive hernias and/or enterocutaneous or entero-atmospheric fistulas. These are very difficult and complex cases, and the techniques and principles necessary to optimize and prepare patients for complex abdominal wall reconstruction and the techniques and adjuncts needed to do so are not well understood by many surgeons.

*What Should Be:* In order to provide the best care for their patients, it is necessary for any colorectal surgeon that may encounter patients who have recovered from abdominal catastrophes and are left with significant abdominal wall defects, hernias or enterocutaneous fistulae, be cognizant of all of the salient issues regarding planning optimization and eventual abdominal wall reconstruction. By understanding these issues, a surgeon may be able to make an informed decision about whether or not they can safely carry out an abdominal wall reconstruction, or whether or not referral or consultation for a joint operation is required.

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

- Identify the salient issue of pre-operative nutritional assessment, imaging and EC fistula management required to prepare a patient for abdominal wall reconstruction.
- Explain the various techniques of anterior component separation needed for successful abdominal wall reconstruction and when they are appropriate to use.
- Recognize the various techniques of posterior component separation needed for successful abdominal wall reconstruction and when they are appropriate to use.
- Recall the various options of how to “bail out” of difficult abdominal wall reconstruction cases, as well as what adjunctive mesh reconstruction options are available and how to choose the appropriate one and use it safely.

**Co-Directors:** Joshua Bleier, MD, Philadelphia, PA
Joseph Carmichael, MD, Orange, CA

9:30 am  **Introduction**
Joshua Bleier, MD, Philadelphia, PA
Joseph Carmichael, MD, Orange, CA

9:35 am  **Preparing for Surgery After an Abdominal Catastrophe**
Eric Pauli, MD, Hershey, PA

9:49 am  **Anterior Component Separation: How To Do It and Why It Is The Best!**
James Bittner, IV, MD, Richmond, VA

10:03 am  **Posterior Component Separation: How To Do It and Why It Is The Best!**
Sean Orenstein, MD, Portland, OR

10:17 am  **How to Bail Out When Things Aren’t Working and Mesh Selection**
Jeffrey Blatnik, MD, Creve Coeur, MO

10:31 am  **Case Discussions with Panel**

10:45 am  **Adjourn**
Abstract Session*  
Video Session  
9:30 – 10:45 am  
*Abstract titles and authors are forthcoming.

Ernestine Hambrick, MD, Lectureship  
10:45 – 11:30 am  
Maintaining the Fire: Self-awareness, Resilience and Intentional Culture in Surgeon Wellbeing  
Taylor Riall, MD, PhD  
Professor and Acting Chair, Department of Surgery, University of Arizona, Tucson, AZ  
Introduction: Sanda Tan, MD  
This lectureship honors Dr. Ernestine Hambrick for her dedication to patients with colon and rectal disorders, surgical students and trainees and the community at large. The first woman to be board certified in colon and rectal surgery, Dr. Hambrick provided excellent care to patients and mentored numerous students, residents and young surgeons during her clinical practice.  
Dr. Hambrick founded the STOP Foundation to promote the screening and the prevention of colon and rectal cancer. In addition, she has volunteered many hours to the ASCRS, which includes having served as Vice President.

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

Abstract Session*  
Neoplasia II  
12:30 – 2:00 pm  
*Abstract titles and authors are forthcoming.
Symposium

Translating Outcomes Data into Meaningful Practice Change

12:30 – 2:00 pm

Postoperative outcomes are increasingly used to measure and report the quality of surgical care. This data has many uses, but the most important use is to drive quality improvement. With many potential sources of data that are used to represent postoperative outcomes, it is often difficult to know which data source to trust. Even more challenging is generating a valid process that uses this data to drive quality improvement. In this session, we will review the science behind quality measurement/quality improvement with the explicit purpose of empowering the surgeon as an agent of change.

Existing Gaps

What Is: ASCRS membership is potentially unfamiliar with the strengths and pitfalls of different types of data, as well as with the science behind quality improvement.

What Should Be: Surgeons should be empowered as agents of change.

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

• Explain the pros and cons of different types of data available in terms of their suitability for generating and monitoring quality improvement efforts.
• Recognize the pitfalls that can arise in a data-driven approach to quality improvement and how to avoid them.
• Develop strategies to select an appropriate quality improvement effort from within a range of possible targets.

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

12:30 pm  Introduction
Arden Morris, MD, Stanford, CA

12:35 pm  What Data Can You Trust?
David Etzioni, MD, Phoenix, AZ

12:50 pm  Patient Reported Outcomes and YOU
Larissa Temple, MD, Rochester, NY

1:05 pm  Meaningful Feedback to Surgeons
Rocco Ricciardi, MD, Boston, MA

1:20 pm  QI – It Doesn’t Always Work
Elizabeth Wick, MD, San Francisco, CA

1:35 pm  Closing Thoughts
Arden Morris, MD, Stanford, CA

1:50 pm  Questions and Answers

2:00 pm  Adjourn

Abstract Session*

Pelvic Floor Disorders

2:00 – 3:30 pm

*Abstract titles and authors are forthcoming.
Symposium

Difficulties Surrounding the Management of Diverticulitis

2:00 – 3:30 pm

The incidence of diverticular disease has increased over the past few decades. Increasingly, patients are managed with non-operative approaches. Although more patients are managed as outpatients, providers are frequently confronted with complex decision making in patients who have persistent symptoms or radiologic findings and suffer from multiple comorbid conditions.

We will review current strategies for evaluation and management of the patient with diverticular disease in both the acute and elective setting.

Existing Gaps
What Is: Risk factors for developing disease, best practice discussion of the threshold for elective and emergent intervention, and appropriate techniques for management of challenging issues in both the acute and elective clinical setting.

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

Objectives: At the conclusion of this session, participants should be able to:
- Recognize the current literature regarding etiology and impact of acute and chronic diverticulitis, and current surgical options for management in both the emergent and elective settings.
- Improve understanding and utilization of best practices for management of acute diverticulitis both in the hospitalized patient and in elective surgical planning.
- Recognize areas of treatment that need further research.

Co-Directors: Timothy Geiger, MD, Nashville, TN
              Jason Hall, MD, Boston, MA

2:00 pm Introduction
Timothy Geiger, MD, Nashville, TN
Jason Hall, MD, Boston, MA

2:05 pm Diverticulitis: Pathophysiology, Epidemiology, Genetics and Risk Factors: What Is the Best Evidence to Counsel Our Patients?
Matthew Silviera, MD, St. Louis, MO

2:15 pm Elective Management of Uncomplicated Diverticulitis
Nitin Mishra, MD, Phoenix, AZ

2:25 pm When Do We Intervene After Medical Management of a Diverticular Abscess?
Angela Kuhnen, MD, Boston, MA

2:35 pm Management of Complicated Diverticular Disease in the Face of Significant Medical Comorbidities
Ron Landmann, MD, Jacksonville, FL

2:45 pm Laparoscopic Lavage: What Do the Randomized Trials Tell Us?
Jonathan Laryea, MD, Little Rock, AR

2:55 pm Atypical Diverticulitis and Post-Diverticulitis IBS; the CT Scan is Normal But My Patient Still Has Symptoms?
Alexander Hawkins, MD, Nashville, TN

3:05 pm Panel Discussion and Case Presentations

3:30 pm Adjourn
FUTURE ASCRS MEETINGS

June 1 – 5, 2019
Cleveland Convention Center
Cleveland, OH

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

ASCRS
The American Society of Colon & Rectal Surgeons

85 West Algonquin Road, Suite 550
Arlington Heights, IL 60005-4460
Phone: (847) 290-9184
Fax: (847) 427-9656