

ACPGBI Conference News

THE OFFICIAL NEWSPAPER FOR THE MEETING OF THE ASSOCIATION OF COLOPROCTOLOGY OF GREAT BRITAIN AND IRELAND

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Welcome to the ACPGBI annual meeting 2009

Message from the President, *Professor Nick Carr*

The Association of Coloproctology annual meeting this year in Harrogate returns with an invigorating programme which should be of interest to all coloproctologists. Apart from our 'home grown' faculty of highly respected opinions and speakers, we have visiting lecturers from both Germany and Australia.

As usual, we have our ACME update on Monday. Whilst much of the day is devoted to various aspects of laparoscopic colorectal surgery training, by way of sponsorship from Ethicon-Endo-surgery, we also have our endoanal ultrasonic training morning, sponsored by BK medical. There are two aspects of our subject which, in my opinion, achieve great importance in our CME day. The first of these relates to the timely consideration of optimising patients for major colorectal resections and the second to the symposium with respect to anal cancer. Although this is a rare disease, its diversity of man-

agement and outcome are of considerable concern to our fraternity and patients.

Our thrust this year has been to keep away from too many parallel sessions except in the free paper sessions on Wednesday morning. These original scientific contributions are clearly important in advancing the research and scientific aspects of coloproctology, as are the BJS papers on Tuesday afternoon. Hence there will be nothing in your way to enjoy the way in which young surgeons are exploring coloproctological research. Similarly there will be an Arris and Gale lecture on Wednesday.

Much of our concerns in

recent years have related to rectal cancer. However, this year we have concentrated on data looking at local recurrence and survival after resections for colonic cancer, and we have both Paul Finan and Werner Hohenberger to relate these facts to us. Moreover, I am told that we have in store a magnificent lecture from Michael Solomon concerning the radical resection on pelvic side wall recurrence after recurrent rectal cancer.

However, the organising committee felt that benign diseases of the colorectum deserved some consideration. The first of these relates to inflammatory bowel disease (IBD); more specifical-

ly ulcerative colitis. I believe that this session on Tuesday morning will be excellent and a highlight will be the debate between Peter Sagar and Paris Tekkis versus John Macfie and Peter Goodfellow concerning where training for pouch surgery should take place.

Continuing with benign disease, Robin Phillips will chair a haemorrhoid symposium on Tuesday afternoon.

On Thursday morning important generic issues will be covered, including coping with the EWTN and laparoscopic training. Our meeting finishes with news from the highly successful Bowel Disease Research Foundation,



Professor Nick Carr

an update on NBOCAP and the use of large databases to improve quality in cancer outcomes.

Finally, I would like to thank industry for their continuing support and hope that you all have an instructive and enjoyable time; there should be something for everyone at this meeting.

Pelvic exenteration techniques for lateral pelvic wall involvement and quality of life

Professor Michael J. Solomon
Department of Colorectal Surgery & Surgical Outcome Research Centre (SOuRCe)
University of Sydney, Australia



Professor Michael Solomon

Despite its first description in 1948, pelvic exenteration for locally advanced primary or recurrent rectal cancer still remains a surgical challenge associated with a high mortality and significant morbidity. As a result, the role of pelvic exenteration still remains somewhat contentious even though promising evidence shows a marked improvement in survival amongst those who undergo such radical surgery. Our experience over the past decade with this procedure has demonstrated a 36–46% five-year survival rate for those who undergo pelvic exenteration for

recurrent rectal cancer¹. While the evidence shows a marked improvement in survival compared to those treated non-operatively, its role remains debatable for lateral pelvic side wall recurrence (LR)¹.

We have previously demonstrated that the ability to achieve a clear resection margin (R0 stage) is predictive of survival. However, for patients with local recurrence achieving an R0 stage is technically more difficult due to the proximity of the recurrence to the bony pelvis. For this reason, some believe that extensive radical resection for LR may not translate into a worthwhile survival gain, and, that the subsequent quality of life during this period will be extremely poor. However, our data combined with other encouraging survival data has prompted the development and adoption of a more radical lateral approach to lateral pelvic involvement. This paper describes the technique developed to particularly address extensive lateral pelvic side wall involvement by locally advanced or recurrent pelvic cancer, in order to achieve a clear resection margin, which should translate into improved survival in these patients. The effect on quality of life of pelvic exenterations will be discussed.

Better imaging techniques available today, a multidisciplinary surgical approach and improved surgical technique have changed the definition of resectability. Patients previously considered unresectable due to ischium or ileum bone involvement

are now considered resectable by functional preserving composite resection of the pelvis, that is, resection of an anatomical bony component of the pelvis. Computed Tomography combined with Positron Emission Tomography (CT-PET scan) has arguably allowed better assessment of metastatic disease from what appears to be local recurrence alone. Magnetic resonance imaging (MRI) of the pelvis allows accurate and individual assessment of the tumour and planning of the surgical approach particularly with assessment of the lateral pelvic side wall and bone involvement.

Importantly this lateral dissection technique described, achieved clear margins (R0 stage) in 53% of patients who would otherwise have been considered 'unresectable'. Moreover, 71% of these patients remained disease free at the site of surgical resection with an average disease free interval of 30 months. Despite the complexity and magnitude of this technique, in our experience it is feasible and safe as indicated by a 0% peri-operative mortality rate in this patient cohort. Careful preoperative planning with extensive radiological assessment and a multidisciplinary approach is paramount prior to proceeding to surgery if one wishes to achieve a clear (R0) resection. The benefit of this technique is that it enables one to get lateral from the level of the internal iliac vessels and into a fresh tissue plane. This allows exposure and resection of involved is-

DON'T MISS!
Michael J. Solomon Plenary Lecture
Wednesday 10th June
15:15 - 15:45
Auditorium

chium and ileum, piriformis and obturator muscles, and the lumbosacral trunk and sciatic nerves in order to achieve that clear margin.

In conclusion we cannot stress enough the importance of a multidisciplinary approach and careful and thorough preoperative radiological assessment if an R0 margin of resection is to be achieved. The complexity of this procedure can involve any combination of procedures as demonstrated in this series of patients. Extensive preoperative assessment and operative planning can be predictive of the number of specialties and type of resection that may be required. Quality of life is comparable to quality of life after primary rectal cancer resections.

References:

- Heriot AG, Byrne CM, Lee P, Dobbs B, Tilney H, Solomon MJ, Mackay J, Frizelle F. Extended Radical Resection: The choice for locally recurrent rectal cancer. *Dis Colon Rectum* 51:284-291, 2008
- Austin K, Solomon MJ. Pelvic exenteration with En bloc internal iliac vasculature excision for locally advanced lateral pelvic cancer. *Dis Colon Rectum* (Dis Colon Rectum) 52:7, 2009
- Austin K, Solomon MJ, Young J. Quality of life after pelvic exenteration for recurrent and locally advanced rectal cancer. *Br J Surg* (under editorial review)

Monday's Programme

8th June

09:30 – 19:00 Registration Open

Queen's Suite B

10:00 – 14:00
Session A Colorectal Surgery for Senior TraineesTraining in Laparoscopic Colorectal Surgery
Mark ColemanIntroduction to Pelvic Floor Surgery, PPH & STARR
David JayneMy Experience of a Laparoscopic Colorectal Surgery Fellowship
John EvansThe Science of Tissue Management
Ethicon Endo-Surgery Staff10:00 – 14:00
Session B Advanced Laparoscopic Colorectal Surgery for ConsultantsTraining in Laparoscopic Colorectal Surgery
Mark ColemanLaparoscopic Colorectal Surgery (pouch construction)
Bruce JaffrayComplications in Laparoscopic Colorectal Surgery
Hugh GallagherThe Science of Tissue Management
Ethicon Endo-Surgery Staff

Queen's Suite A

10:30 – 13:00 Endoanal Ultrasound Training Session
Organised by BK Medical

Auditorium

11:30 – 12:30 FIAT 500 - Fistula Plug Trial Launch
David Jayne

13:00 – 13:45 2009 Annual General Meeting

14:00 – 16:00 CME Update – Optimisation of Patient for Major Colonic Surgery

Surgical Risk Management & CPX
Mike GrocottPeri-operative Fluid Management
Howard WakelingEnhanced Surgical Recovery
Alan HorganThe Perioperative Physician and the PACU
Jim DownPost-operative Outcome Measures (POMS POSSUM)
Monty Mythen

Panel Discussion

16:00 – 16:30 Hall D – Tea/coffee

Auditorium

16:30 – 18:00 Oncology Symposium: Anal Cancer Management – Past, Present and Future

Overview of Past Trials
Arthur Sun MyintACT II Trial (preliminary results)
Roger JamesSurgical Aspects
Sarah O'DwyerFuture Anal Cancer Trials
Rob Glynn-Jones18:00 – 19:30 KING'S SUITE & KING'S SUITE CATERING
Welcome Drinks Reception

Colorectal surgery for senior trainees: Monday 8th June, 10:00 – 12:00, Queen's Suite B

National Training Programme in laparoscopic colorectal surgery

Mark Coleman

Laparoscopic colorectal surgery
Derriford Hospital, Plymouth, UK

The National Training Programme (NTP) in laparoscopic colorectal surgery (LCS) is expanding its base of consultant trainees across the country. It was commissioned by the Cancer Action team at the Department of Health for England, and its progress is proactively managed by the appointed Steering Group.

The programme is being led by National Clinical Lead, Mark Coleman, a consultant surgeon from Derriford Hospital, Plymouth who was appointed in September 2008 to oversee and develop the programme. Entrants to the NTP are required to be at a consultant level, and benefit from unrivalled access to an established high quality calibre of training.

The NTP website was launched earlier this year (www.lapco.nhs.uk) and is designed to form an active role for the communication and recording of training activities. It is managed and updated by the National Co-ordination Team based in Plymouth, which includes a dedicated programme manager and administrator. The NTP is intended to run for two years with the aim of training enough colorectal surgeons in LCS to a level of independence in routine colonic resections.

The aim of the programme is to implement the 2006 NICE guidelines that laparoscopic (including laparoscopic assisted) resection is recommended as an alternative to open resection for



Laparoscopic Colorectal Theatre Team

individuals with colorectal cancer in whom both laparoscopic and open surgery are considered suitable, and give access to a suitable patients with bowel cancer in England, access to a fully trained surgeon.

There are a total of ten training centres which form part of the network of NTP centres lo-

needs.

Generally, it is envisaged that around a minimum of 20 cases will be required to reach a level of competence. This may vary in either direction depending on the skill and experience of the individual. A form of assessment of competence has been incorporated into the NTP to provide sur-



Training in action with new HD TV Laparoscopic Surgical Stack Equipment

cated within England, incorporating 16 separate NHS Trusts. Each consultant trainee is assigned a trainer at their choice of training centre. The trainee is surgically assessed through the programme by their trainer which can be structured flexibly to their

geons in the programme a means of objectively determining that their training has been assessed and recorded by their NTP trainer. This information is intended for use by consultants as part of their appraisal.

There are a range of cours-

es provided through the training centres including cadaver courses, clinical immersion courses, theatre courses and master classes. There is particular emphasis on Enhanced Recovery Programmes (ERP) as data suggests that enhanced recovery programmes help to further reduce hospital stay and reduce certain complications in patients undergoing bowel resection. Overall, there is a strong emphasis placed on team working, which the NTP incorporates into its courses. In addition, access to Wet Lab courses are also available as part of the training programme.

The NTP emphasises team training as it is recognised that this hastens the ascent up the learning curve. All colorectal consultant surgeons in England who wish to take up LCS are strongly encouraged to apply to be part of the NTP. The National Training Programme Centres include:

- Newcastle
- Bradford
- Hull
- Nottingham
- Oxford
- St Marks/Colchester / Guilford
- Portsmouth
- Basingstoke/Frimley Park
- South West (Plymouth/Bristol/Yeovil)
- Imperial College London (Educational Assessment)

Information on the NTP programme including on line application can be obtained through the website www.lapco.nhs.uk. Or contact the National Training Programme Co-ordination Office on 01752 439844.

Colorectal surgery for senior trainees: Monday 8th June, 10:00 – 12:00, Queen's Suite B

Laparoscopic colorectal Fellowship at St Mark's, Harrow

John Evans

University Hospitals of Leicester, UK

Laparoscopic colorectal surgery is growing at an exponential rate in this country, and a number of schemes have been put in place to provide adequate training in this difficult technique. There are currently six centres in the UK that offer six-month fellowships for colorectal trainees who are usually within the last two years of their training. These fellowships are sponsored by an educational grant from Ethicon Endo Surgery that covers a full clinical salary, with on call arrangements that are locally negotiable. I was convinced at an early stage that I wanted to be able to offer laparoscopic surgery as a consultant, and I therefore applied for one of these Fellowships in 2007.

The Fellowships are awarded on the basis of Curriculum Vitae and a competitive interview. The interviews are held annually, and I was interviewed at the Royal College of Surgeons of England in October 2007. I was fortunate enough to be offered the post at St Mark's, which I eagerly accepted.

The post began on the 1st of October 2008, and I soon became very familiar with the journey up and down the M1 from Leicester. I arranged to spend weeknights in accommodation at St Mark's, with the advantage of being on site 24-hours a day. Right from the beginning of the post it became apparent what a privileged position St Mark's holds as an academic and training centre – theatre lists were planned to allow adequate time for training, which is not always possible in an acute NHS Hospital! There were a great number of educational activities and courses such as the Frontiers in Colorectal Disease, which I was encouraged to attend. Visiting clinical observers were an almost constant feature of life at St Mark's, which added to the diversity of the experience and introduced some new friends.

Of course, the most important aspect of any post is the team that one works with. Robin Kennedy was an exceptionally patient trainer, and has a wealth of experience that he was able to pass on. In addition to laparoscopic surgery, I learned a great deal about enhanced re-



John Evans

covery programmes, and participated in the ERAS symposia that were regularly held. Ian Jenkins was appointed as a second laparoscopic consultant during my Fellowship, and became a good friend as we undertook a lot of work together. The excellent theatre team, enhanced recovery facilitator, ward and administrative staff all contributed to make my time at St Mark's thoroughly enjoyable. The other Resident Surgical Officers were a source of both support and entertainment – not least of all when it was time to put on the annual St Mark's review!

I was a little sad to leave at the end of my Fellowship, although I came away feeling ful-

ly equipped to begin practice as a laparoscopic colorectal surgeon. I cannot recommend the Fellowship scheme highly enough, and would encourage trainees who are interested to seek out further details via the Dukes' Club website (www.thedukesclub.org.uk).

ACPGBI Conference News

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FIAT 500 – Fistula Plug Trial Launch: Monday 8th June, 11:30 – 12:30, Auditorium

On Monday morning in the Auditorium, Mr David Jayne, Leeds, will announce the launch of the UK FIAT500 trial (Fistula In Ano Trial:500). The trial is funded by a HTA grant and will be run under the auspices of the Research & Audit Committee of the ACPGBI. The aim of the trial is to evaluate the Biodesign (Surgisis) Fistula Plug against other recognised methods of treating complex cryptoglandular fistula-in-ano.

According to Mr Jayne, currently there is no 'gold standard' treatment for complex fistula-in-ano, with treatment dictated mainly by surgeon's preference and experience. A variety of treatment options are available and include fistulotomy, cutting and draining setons, advancement flaps, and more recently the use of biological fistula plugs. "The current evidence would suggest that no one treatment has superiority over another in terms of fistula healing," said Mr Jayne. "As well as healing the fistula, it is also important that an intervention does not result in compromise of the anal sphincters with resulting faecal incontinence. It is in this respect that the biological fistula plugs may have an advantage, as, unlike other strategies, the fistula plug does not disrupt the anal sphincter musculature. Recent reports in the literature, however, have suggested that this advantage may be offset by lower rates of fistula healing."

Treatment protocol and endpoints

In the trial, the Biodesign Fistula Plug (Cook Medical) will be compared to alternative methods of treating complex cryptoglandular fistula-in-ano. The alternative treatment options include fistulotomy, cutting seton, and advancement flap, which for the purpose of the trial have been grouped into 'Surgeon's preference'. Mr Jayne explained that it is planned to recruit

"As well as healing the fistula, it is also important that an intervention does not result in compromise of the anal sphincters with resulting faecal incontinence. It is in this respect that the biological fistula plugs may have an advantage, as, unlike other strategies, the fistula plug does not disrupt the anal sphincter musculature."

500 patients over a three-year time period, with the patients' randomised 1:1 to either the 'fistula plug' or 'surgeon's preference'.

The primary endpoint has been chosen as symptom-specific Quality of Life (QoL) as measured by the Faecal Incontinence Quality of Life Scale, supplemented with the generic EQ-5D and visual analogue scores, said Mr Jayne. "This is preferred to fistula healing rates as it reflects the primary aim of fistula surgery; to produce symptom relief whilst maintaining anal sphincter function and preserving symptom-specific (incontinence) QoL."

The secondary endpoints include clinical fistula healing rates at 12 months, faecal incontinence rates, complication rates, re-intervention rates, health resource utilisation, and cost effectiveness. A separate sub-study will evaluate the use of MRI in the pre-operative evaluation of fistulae and the assessment of fistula healing.

Inclusion/exclusion criteria

The inclusion criteria will include patients:

- With a clinical diagnosis of high transsphincteric cryptoglandular fistula-in-ano
- Who have undergone a prior examination under anaesthesia (EUA) to characterise the nature of the fistula
- Who have a fistula tract ≥ 2 cm in length
- Who have been treated with a draining seton for a minimum period of six weeks prior to randomisation
- Who are 18 years or older and able to provide informed consent

The exclusion criteria include patients who:



David Jayne

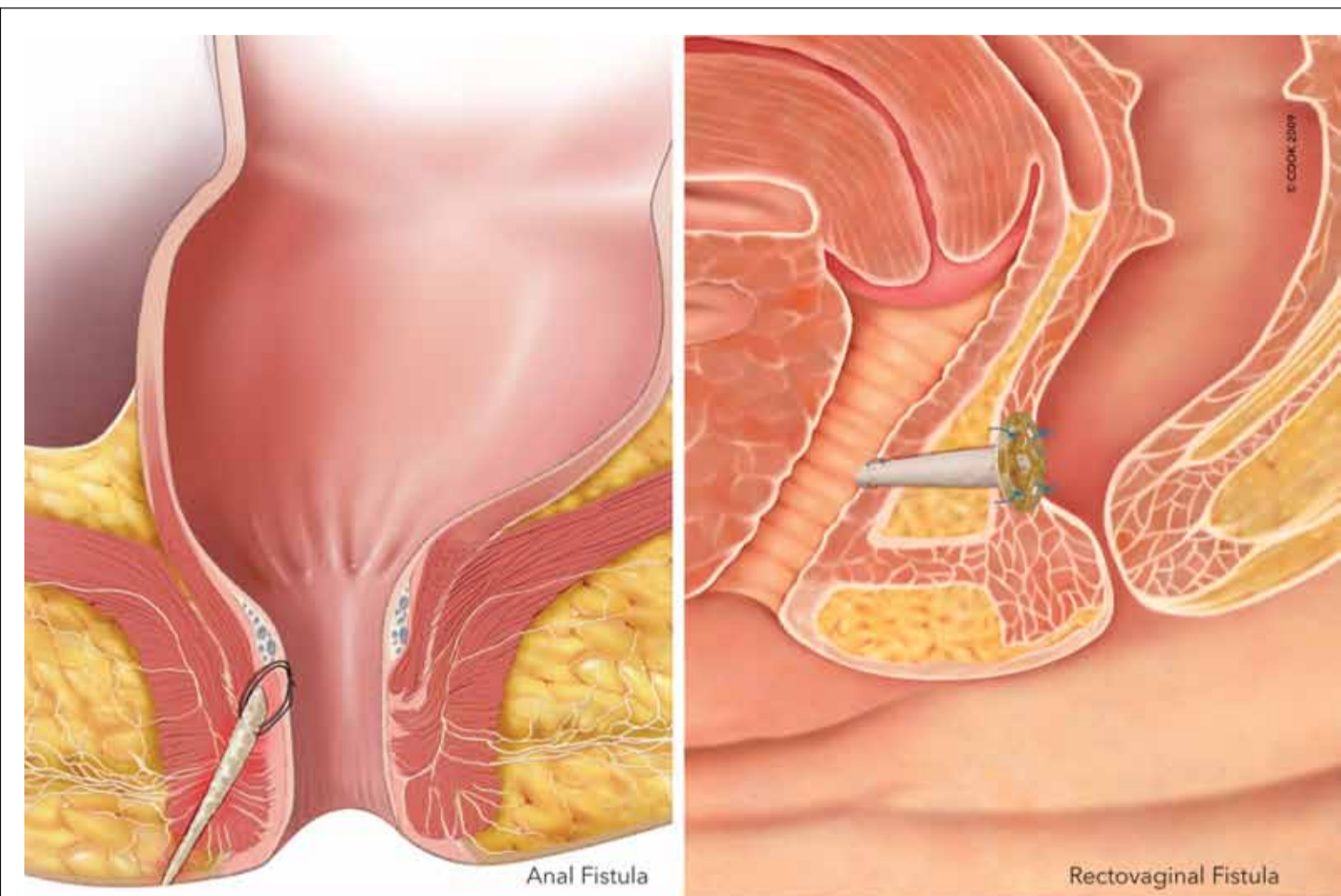
- Are unable/unwilling to provide informed consent
- Have a contraindication to general anaesthesia
- Have low transsphincteric fistulae
- Have non-cryptoglandular fistulae e.g. Crohns, obstetric, irradiation, malignant etc.
- Have other perineal fistulae e.g. rectovaginal fistulae, pouch-vaginal fistulae etc
- Have evidence of active perianal sepsis
- Have cultural or religious objection to the use of pig tissue

It is hoped to involve up to 50 centres throughout the UK in the trial, although it is recognised that larger centres are likely to contribute the most patients. A series of workshops to standardise the method of fistula plug treat-

ment is scheduled for September 2009. After this, patient recruitment will begin. Recruitment will run for a period of three years with a one-year follow-up period and it is anticipated that the final results will be available in five years

"The trial is funded through a £1.2 million grant from the Health Technologies Assessment (HTA) unit of NIHR. It is also supported by Cook Medical who has kindly agreed to supply the fistula plugs free of charge to all patients recruited in the trial and to support the surgical workshops. Data from the trial will be under the ownership of the ACPGBI and its participating members, and independent of Cook Medical.

"Investigators wishing to participate should register their interest at the FIAT500 symposium during the ACPGBI meeting," said Mr Jayne.



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- ENDOSCOPY
- INTERVENTIONAL RADIOLOGY
- PERIPHERAL INTERVENTION
- SURGERY
- UROLOGY
- WOMEN'S HEALTH

Induction of new President: Thursday 11th June, 10:55 – 11:00, Auditorium

Message from the incoming President, Professor Najib Haboubi

For many decades the educational aspect of coloproctology sat heavily on the shoulders of the Section of Coloproctology of the Royal Society of Medicine (RSM), affectionately known as the Section. In the late 80s it was felt, by an eminent group of colorectal surgeons that there was a need for a political arm to promote the interests of the discipline and to set standards in service and training. The Association of Coloproctology of Great Britain and Ireland (ACPGBI) was formed from the RSM Council section thus announcing the arrival of the new subspecialty. In order to maintain total harmony between the Section and the Association, the first two years both bodies shared the same Councils, honorary secretaries and Presidents. The hard work of many people made the society what it is now. I would like to mention two past officers who have worked tirelessly to dig the foundation and raise the arcade of this glorious body; these are Adam Lewis and James Thomson who had a great deal to do with writing the bylaws and promoting the entire concept.

I was very privileged to have been at that time, the Vice President of the Section and therefore a Council Member. We formulated

the first council of the ACPGBI and elected Jeff Oates to be the first President followed by the late Norman Addison. Since 1990–1991, I have been continuously serving in Council in a variety of positions and was very honored by the election to be President of the Association for the forthcoming year.

For a surgical pathologist to lead a surgically dominated specialty is a testimony of the basis and foundations of the Association as a multidisciplinary Society. No other sister society, to the best of my knowledge, has acquired this ethos. At our annual general meetings, which appear to be one of the best in the world, I cannot stop smiling when watching the number of participants and the quality of research and symposia growing in number and stature. I am also very pleased to see the various disciplines being represented from surgeons to nurses, trainees and non-surgical membership. What a galaxy of people and array of disciplines serving such a noble art.

My main aim in this year is to engage the membership with the Royal College of Surgeons and try to resolve the problems of the European Working Week directives, support national audit programmes, particularly bowel



Professor Najib Haboubi

cancer, support in advancing new technologies with particular reference to widening the network for laparoscopic surgery.

Presidents cannot achieve a huge amount in one year but they rely on the excellent system of having ensured continuity with the presence

of President Elect and President in waiting, thus maintaining an active three years cycle. I must stress at this point that the Executive and Council are and have always been very strong and full of enthusiasm and wisdom. I am sure I will be supported by both and would like to pay special tribute to Anne O'Mara who has helped the Association a great deal and I am sure she will be helping me too, together with the rest of the Council. I will offer special Congratulations to Mr Nigel Scott for his election for the position of President in Waiting.

As far as my research is concerned my main areas of interest are Radiation Bowel Disease where we were one of the first groups to analyse the histopathological features of the tumour and the adjacent areas. We are currently working on other facets of the same problem. My other interest is Inflammatory Bowel Disease and the role of the pathologists in the MDT. Our group in South Manchester was one of the first to advocate MDTs in this difficult field. I am also interested in Lifestyle and Colorectal Cancer and we have established a good relationship with the John Moore University of Liverpool to research and develop further.

Advanced laparoscopic colorectal surgery for consultants: Monday 8th June, 12:00 – 14:00, Queen's Suite B

Laparoscopic colorectal surgery

Bruce Jaffray
The Royal Victoria Infirmary,
Newcastle-upon-Tyne UK



Bruce Jaffray

Laparoscopic restorative proctocolectomy is accepted as the gold standard for patients who must undergo resection of the entire colon and rectum. Despite this, hospital episode statistics show that most children undergoing surgery for ulcerative colitis in England do not receive this operation, instead receiving surgery which falls short of the ideal.

In Newcastle, it has been my practice to offer all children with ulcerative colitis who fail medical management the procedure of restorative proctocolectomy, and in recent years the chance of a minimally invasive operation. However, the differences between children and adults as candidates for this ma-

major resection enforce a different set of operative considerations.

The indications for surgery in children will be a failure of medical management to bring the disease into remission, rather than disease duration or dysplasia. Because of this it is usual to have children presenting who are severely steroid compromised. We have seen children with vertebral collapse, hypertension and insulin dependent diabetes as a result of steroid therapy for colitis. Of course, earlier referral could avoid the morbidity of medical management of this curable disease. Unfortunately it is seldom possible to stop steroid use entirely since the symptoms of colitis worsen with dose reduction. Despite

this, we have not seen any significant complications related to operating upon children who are receiving steroid therapy. In addition, the irreversible compromise of growth potential of a child passing through puberty while receiving steroid therapy places a constraint on the timing of surgery which is not relevant to adult colo-rectal practice.

The operation in children requires several alterations to the standard procedure as performed in adult patients, including a need for a hand sutured pouch anal anastomosis, and close rectal rather than mesorectal dissection. The confined space of a child's abdomen also makes laparoscopic surgery more challenging.

My currently preferred technique involves a one stage laparoscopic procto-colectomy with an ileal J pouch and always utilising a covering ileostomy. Distal dissection is with a mucosal proctectomy performed trans-anally, coupled with close rectal dissection from above utilising the harmonic scalpel. Other indications for colectomy in children which have also been seen include FAP, fibrosing colonopathy and idiopathic constipation.

In this presentation I discuss the operative manoeuvres which I have found to be useful in performing this procedure and illustrate the process with operative videos. I will also present some results of the surgery in children.

Oncology Symposium: Anal cancer management – past, present and future: Monday 8th June, 16:30 – 18:00, Auditorium

ACT II Trial – Preliminary results

Roger James
Maidstone Hospital, Kent, & Helen Meadows MSc Cancer
Research UK & UCL Cancer Trials Centre, London, UK



Roger James

Anal cancer is a relatively rare disease with fewer than 1,000 patients diagnosed in the UK per year. Following the closure of the ACT I trial concurrent chemoradiation is the standard of care. The outcome for patients is very good and the majority of patients have undetectable cancer after treatment and therefore avoid surgery and a permanent colostomy. Early tumours, particularly those in the anal margin, may be suitable for surgery.

The aim of the ACT II trial was to address two research questions. To compare the complete response (CR) rate at six months of CisP vs. MMC. CisP is used for other squamous cell cancers as a radiosensitiser and in combination with 5-FU is effective against relapsed anal cancer. It is less convenient to deliver and although there is less haematological toxicity than MMC it can cause neurological and renal side effects and hearing loss.

To determine if additional chemotherapy after chemoradiation, would prevent relapse by improving local and distant control. Two courses of maintenance therapy were given.

The trial was run as part of the NCRI tri-

al portfolio, was coordinated at the Cancer Research UK and UCL Cancer Trials Centre and was funded by Cancer Research UK. The trial received excellent support from almost all (53) UK radiation oncology centres and referring hospitals. The trial is the largest ever conducted in anal cancer.

Methods

Between 2001 and 2008, 940 patients were recruited to this factorial trial. Patients were randomised to receive radiotherapy and 5-FU with either MMC (n=471) or CisP (n=469) and were also randomised to receive follow-up maintenance therapy (CisP and 5-FU) after chemoradiation (n=448) or no maintenance therapy (n=446). Statistical power was $\geq 80\%$ to detect a difference in the CR rate of 5% (CisP vs. MMC), and 30% reduction in recurrence (maintenance vs. no maintenance).

Patients of any stage were selected at diagnosis and had to be fit to receive any of the treatment options. The planned radiotherapy dose was 50.4 Gy in 28 daily treatments given over 5½ weeks together with 5-FU (1,000mg/m²/day, d1-4 &

29–32) and either MMC (12mg/m², d1) or CisP (60mg/m², d1 & 29). Patients randomised to receive maintenance therapy started two cycles of CisP and 5-FU, four weeks after chemoradiation. Maintenance randomisation was not considered appropriate in 46 patients. Patients were assessed at weeks 11, & 18 and by CT, week 26, and then at regular intervals. Patients who failed to respond to treatment or who relapsed after an initial response were considered for salvage surgery.

Results

Pre-treatment characteristics were as follows: Median age 58 yrs; 62% male, 38% female; tumour site – canal (81%), margin (15%); stage T1-T2 (50%), T3-T4 (43%); node negative (62%), positive (30%).

After a median follow-up of three years, the investigators found that although both CisP during chemoradiation and maintenance chemotherapy are feasible to deliver, neither approach leads to an improved, significant difference, in outcome for patients.

The complete response rate at six months was

Continued on page 5

Optimisation of patient for major colonic surgery: Monday 8th June, 14:00 – 16:00, Auditorium

Peri-operative fluid management

Dr Howard G Wakeling

Consultant Anaesthetist

Western Sussex Hospitals NHS Trust, Worthing Hospital,
Worthing, West Sussex, UK



OBJECTIVES

As a result of attending this lecture the participant will:

1. have reviewed the evidence and probable mechanism for Oesophageal Doppler Haemodynamic Monitoring improving perioperative outcomes.
2. have discussed the limitations of physical assessment and blood pressure measurement.
3. have discussed the issue of whether non-invasive measures of cardiac output should be considered standard intraoperative care for major surgery.

Hypovolaemia is a key factor in the aetiology of post-operative morbidity after major surgery. Routine cardiovascular measurements do not detect it because the body's reflex mechanisms reduce blood flow to certain organs (e.g. the gut) in order to preserve flow to the heart, lung and brain¹, leaving heart rate and blood pressure relatively unchanged. Intraoperative gut hypoperfusion has been identified in 63% of major surgery patients and was associated with increased morbidity and length of hospital stay¹. 'Goal directed' fluid administration in cardiac surgery patients reduced complications and hospital stay, with improved gut perfusion². Other groups have demonstrated impressive clinical outcome benefits in randomised controlled trials in major general, urological and gynaecological patients³, orthopaedic patients^{4,5} and colorectal patients^{6,7}.

All RCTs using esophageal Doppler used a simple fluid algorithm similar to the one shown opposite (from Wakeling⁶) (Figure 1). The principle of dynamic fluid management is clearly shown, i.e. information on fluid status is best obtained by evaluating the response to a fluid bolus. Following from our study, central venous monitoring has become far less frequently used in our institution and reliance is on the oesophageal Doppler cardiac output based information.

The detection of treatment of intraoperative hypovolaemia is associated with improved flow based haemodynamic parameters but not pressure based ones. This is shown in the graph opposite (Figure 2) where the relative changes in values after fluid optimisation in colorectal patients are compared with the values beforehand, remembering that the patients all had pre-op bowel preparation⁶. The Stroke volume SV, cardiac output CO and oxygen delivery (O₂Del) all showed significant increases but these improvements were not reflected in CVP. This indicates the insensitivity of the CVP to important changes in the circulation, important because improvements in cardiac output, stroke volume and oxygen delivery are all associated with improved patient outcome.

It is hypothesised that the primary mechanism for the reduction in side effects and improved outcome is the prevention of hypovolaemia and consequent splanchnic underperfusion. The evidence for this comes from studies relating gastric mucosal perfusion with hypovolaemia and patient outcome^{1,2}; and relating reduced gut complications, length of hospital stay and earlier return of gut function in so called fluid optimised patients¹⁻⁷ and the reduction in the neuroendocrine response to surgery if hypovolaemia is prevented (Interleukin-67 ADH⁸).

Recent Government Centre for Economic Purchasing report highlighted significant improvements in mortality, morbidity, and lengths of stay with Oesophageal Doppler. Economic analysis esti-

mated cost savings per patient between £642 and £4441 in worst and best case scenarios⁹.

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"It is hypothesised that the primary mechanism for the reduction in side effects and improved outcome is the prevention of hypovolaemia and consequent splanchnic underperfusion. The evidence for this comes from studies relating gastric mucosal perfusion with hypovolaemia and patient outcome"

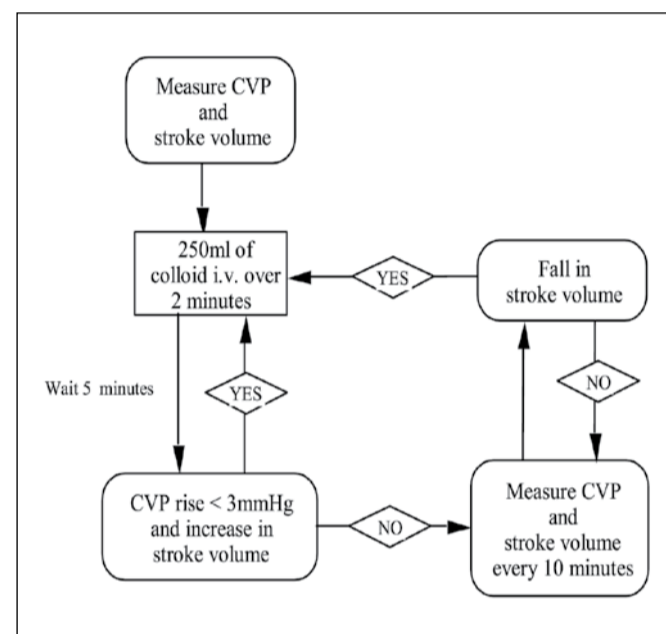


Figure 1: Simple fluid algorithm

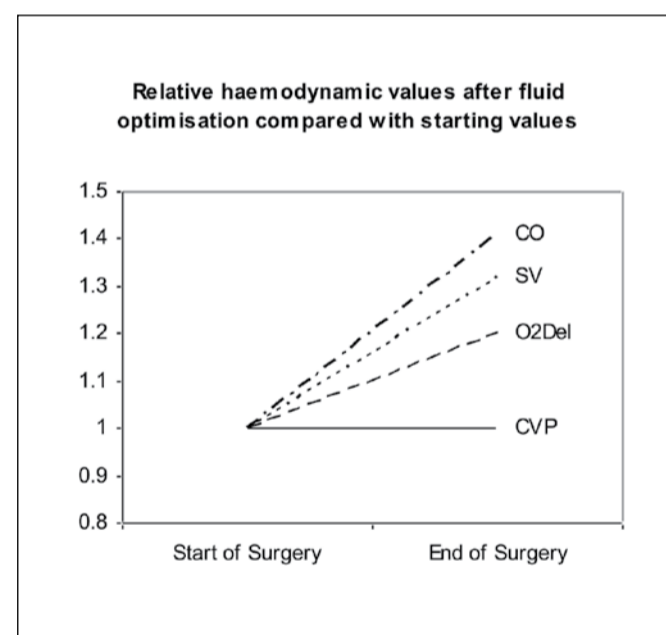


Figure 2

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Continued from page 4

94% in the MMC group compared with 95% in the CisP group.

CisP had significantly lower haematological grade 3/4 toxicity 24.7 vs. 13.4 % p<0.001, however the most severe haematological toxicity, febrile neutropenia was low (3%) in both groups.

Recurrence-free survival at three years was 75% both in patients who got maintenance therapy and in those who did not.

Overall survival at three years was 85% in patients who received maintenance therapy and

84% in those who did not.

The number of pre-treatment colostomies not reversed were similar between treatments (18 MMC vs. 14 CisP, p=0.65, Maint/No maint, p=0.23) and only nine disease-free patients had colostomies performed (5MMC, 4 CisP).

Conclusions

The local control rate in ACT II is substantially higher than in ACT I or in any other phase 3 trial published world-wide. We can find no evidence that this is due to a change in case-

mix (by stage or site) or gender-mix relative to ACT I, but there are minor case and gender-mix differences relative to other international trials. Possible causes of the improvement include a more intensive radiotherapy regimen and centralisation of treatment in fewer, specialist radiotherapy centres.

These findings are good in spite of the lack of evidence for an improvement in giving either cisplatin or maintenance therapy, given the high response rates and good disease control. The standard treatment for patients with anal cancer remains radiotherapy with 5FU and MMC.

Future plans

The NCRI Anal Sub Group is currently discussing different approaches. Of interest for small tumours, confined to the anal canal or margin, is the feasibility of reducing either the radiotherapy dose or field size to reduce side effects without compromising disease control. For more advanced tumours, intensifying treatment, using different chemotherapy agents and/or a biological therapy, might result in improved control. Future trials may investigate oral capecitabine as an alternative to a four day infusion of 5-FU and are likely to include better imaging (MRI and PET) of nodal disease.

Tuesday's Programme

9th June

07:15 – 18:00 Registration Open

Queen's Suite A07:15 – 08:15 Breakfast Session
Consultant Surgeons in Trouble**Auditorium**08:20 – 08:30 Welcome from Nick Carr,
President of ACPGBI

08:30 – 10:30 IBD Symposium

IA Pouch Database
John NichollsAcute Colectomy: What
should be done with the rec-
tal stump?
Steve BrownIs it safe to Fashion an Ile-
oanal Pouch for a Patient Tak-
ing Steroids?
Bruce GeorgeHow Should Ileoanal Pouch
Patients be Follow-up?
Philip BaragwanathDebate: This house believes
that training for pouch
surgery should only be car-
ried out in tertiary referral
centres.Proposing team: Peter Sagar.
Opposing team: John Macfie10:30 – 11:00 Hall Q – Exhibition/tea/coffe
Poster exhibition**Auditorium**11:00 – 11:30 Goligher Lecture: Rising to the
Challenge
Paul Finan11:30 – 12:00 BJS Lecture: Radical Resection
of Colon Cancer
Werner Hohenberger12:00 – 12:30 Oncology – Colorectal Cancer
Review
Rob Glynn-Jones, Mount Ver-
non

12:30 – 13:00 Discussion

13:00 – 14:00 Hall Q – Exhibition/tea/coffe
Poster exhibition**Auditorium**

14:00 – 15:40 BJS & Travelling Fellow Papers

Queen's Suite A

14:00 – 16:30 Nursing Forum – Ian Fretwell

Queen's Suite B

14:00 – 15:40 Video Session

15:40 – 16:15 Hall Q – Exhibition/tea/coffe
Poster exhibition**Auditorium**

16:15 – 17:45 Haemorrhoid Symposium

What are Haemorrhoids?
Jay SimsonOutpatient Management
Ian LindseyOpen versus Closed Haemor-
rhoidectomy and How to
Optimise Patient Experience
Ian FinlayPPH & HAL: less painful but are
they as good as open surgery?
Per-Olof Nyström

Panel Discussion

18:45 – 20:30 DRINKS RECEPTION
at The Royal Hall, Harrogate**CME Update – Optimisation of patient for major colonic surgery: Monday 8th June, 14:00 – 16:00, Auditorium**

Alan F Horgan

National Clinical Lead, Enhanced Recovery Programme

Consultant Colorectal Surgeon, Freeman Hospital, Newcastle, UK

Enhancing surgical recovery

Over recent years attention has been directed at improving outcomes after major colorectal surgery. Despite the pressures of quantity, targets and guidelines, an expanding number of groups have developed patient pathways aimed at improving the patient experience around the time of surgery. This involves optimising and educating patients and relatives prior to admission, as well as decreasing the surgical stress experienced by the patient during their hospital stay.

The mainstay of this new approach to patient care involves a strong focus on pre-operative preparation. In addition to optimising the patient medically, time is taken to discuss expectations, plan discharge and encourage family support. Written information detailing what the patient can expect on each day of their hospital stay and on discharge are provided. For those where the formation of a stoma is expected then the patient is educated pre-operatively in their own home by the Community Stomatherapist until proficiency is achieved.

Admission on the day of surgery for most patients can be achieved where adequate an-

aesthetic pre-admission facilities are in place. Carbohydrate supplements are provided to be taken the evening before surgery and on the morning of surgery before travelling to the hospital. Phosphate enemas are administered on arrival with no oral bowel preparation. Minimal access techniques are used for surgery when possible and drains/NG tubes avoided.

In addition to medical optimisation and risk stratification, anaesthetic considerations include the use of Individualised Goal-directed Intraoperative Fluid therapy, the use of short-acting anaesthetic agents and active post-operative pain management with the avoidance of opiates where possible.

Post-operatively patients are encouraged to mobilise as soon as possible and to take fluids orally from the day of surgery. Diet is allowed at any time and can be supplemented by high calorie liquids.

Discharge is allowed when certain criteria are met, i.e. tolerating diet, functioning GI Tract, mobile and comfortable on oral analgesia. This is achieved in the majority of patients on day four for both colonic and rectal surgery

with readmission rates of <1%.

Involvement of the patient in the recovery process is an essential part of the pathway. They are responsible for completing the progress chart, where certain goals are outlined on a daily basis. These include breathing and circulatory exercises, intake of fluid and food, mobility, stomatherapy and pain, and nausea scores. Failure to achieve goals is documented by the patient together with their perceived explanation. This allows intermittent scrutiny of the patient pathway to "fine tune" details according to local needs.

The evidence base of this approach to patient care is growing, with obvious economic advantages. The object is not to "get patients out of hospital quicker" but to reduce the stress associated with major colorectal surgery so that patients recover quicker.

Improved quality of care along with reduction in length of stay has led the Dept. of Health in April 2009, to launch an Enhanced Recovery Programme to agree principles of care across multiple specialty pathways and to spread and sustain Enhanced Recovery Principles in Practice across the NHS.

IBD Symposium: Tuesday 9th June, 08:30 – 10:30, Auditorium

The UK Pouch Registry

John Nicholls, Emeritus Consultant Surgeon, St Mark's Hospital

Visiting Professor in Colorectal Surgery, Department of Surgical Technology and Surgical Technology, Imperial College London, UK

We are obliged as a professional Association to audit our work as far as resources allow. This has been done with great success for large bowel cancer but it should also apply to other major areas of practice of which pouch surgery is one of the more important. The Association set up a pouch registry in 2005. Within a few months it collected 2,500 patients from ten centres and the results were published earlier this year in *Colorectal Disease*.

The data came from already established databases held within the contributing units and showed some variance in morbidity and failure, stable long-term frequency and some increase of soiling with time. Another finding was a decline in the number of patients treated from 2002 onwards. This must be a reflection of referrals. Why should this be? Perhaps it is because gastroenterologists and specialist IBD nurses will see the patients with complications giving them a negative view of the operation. They are unlikely to see the 90% of patients who have a good or satisfactory result. Perhaps it is to do with pouchitis. While pouchitis is obviously a complication of RPC, its importance has been exaggerated with a high frequency quoted to the patient.

It is true that over a five-year period there is a cumulative incidence of around 50% after restorative proctocolectomy for ulcerative colitis but in only 5–10% of patients does pouchitis pose a chronic clinical problem. Put another way, while 50% of failures are due to sepsis, pouchitis is responsible for only 10%. Try to carry out research into pouchitis and there will be difficulty in recruiting patients because the numbers are small. Perhaps another reason for the fall in referrals is the availability of new medical treatments including biologicals. The important question is whether in the process patients' interests are best served by this trend away from surgery. We do not know but it is possible that in some cases they are not. This can only be answered by individual review of each patient



John Nicholls

in a similar manner to the MDT for neoplastic disease.

The establishment of the IBD team was one of the recommendations made by the IBD Standards Group in their report entitled 'Quality Care: Service standards for the healthcare of people who have inflammatory bowel disease (IBD)' published earlier this year. Under the chairmanship of Richard Driscoll the Chief Executive Officer of NACC, the group included representatives of the BSG, the ACPGBI, the British Society of Paediatric Gastroenterology, the Primary Care Society of Gastroenterology, the Royal College of Nursing, and the British Dietetic Association. Its brief was to recommend systems for the organisation of the management of inflammatory bowel disease with the aim of improving patient access to specialist services and more uniform treatment.

The IBD multidisciplinary specialist team was defined by a combination of relevant medical and nursing specialist staff with dietetic, pharmacological and psychological support. The team could be split geographically provided that it would be able to function as an entity. The Association of Coloproctology expressed concern that another MDT would

be practically difficult given that colorectal surgeons already had the commitment to the Cancer MDT, which in itself is time consuming. Nevertheless there will come a day when a formal interdisciplinary discussion of patients with IBD will be required.

Unfortunately, the UK Pouch Registry has withered on the vine owing to a lack of administrative manpower and the limited uptake by members of the Association. It now needs to be renewed. This has been endorsed by the Executive, which has agreed to support the Registry. With a small priming grant, the Association has come to an agreement with Dendrite Clinical Systems which will take on the running of the Registry. Dendrite manages over 70 national and international databases of many medical and surgical professional groups, including the Society of Cardiothoracic Surgeons of Great Britain and Ireland, the European Society of Vascular Society, the Association of Laparoscopic Surgeons, the British Society of Interventional Radiologists, the British Association of Endocrine and Thyroid Surgeons. It is already involved with the ACPGBI through the Malignant Large Bowel Obstruction Register and the International National Colorectal Stent Register.

The agreement between Dendrite and the Association will be for a period of five years in the first instance. Online registration of patients by members will enable user-friendly data entry. The returns will be reconciled with national data obtained from the NHS patient records to enable verification of data to reflect as far as possible the true national activity, failure rate, morbidity and function. The UK Pouch Database will be discussed among other pouch-related topics at the Annual Meeting during a Symposium on IBD to be chaired by John Abercrombie and Najib Haboubi. Those involved in the Pouch Registry including Paris Tekkis, Jason Smith, Omar Faiz and Richard Lovegrove and myself hope for a large attendance.

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History of Harrogate

Harrogate (or Harrogate Spa) is a spa town and a popular tourist destination. Its spa waters, RHS Harlow Carr gardens and Betty's tearooms are world famous visitor attractions.

Prior to the discovery of its naturally iron and sulphur rich water, Harrogate was two minor villages (High Harrogate and Low Harrogate) close to the historic town of Knaresborough. The first mineral spring in Harrogate was discovered in 1571 by William Slingsby, who found that water from the Tewitt Well possessed similar properties to that from the springs of the Belgian town of Spa, which gave its name to spa towns. The medicinal properties of the waters were more widely publicised by one Edmund Deane, whose book, *Spadacrene Anglica*, or the English Spa Fountain was published in 1626. Fol-

lowing this Harrogate developed considerable fame as a spa town.

Today, the site of the Tewitt Well is marked by a dome within the Stray. Other wells can be found in Harrogate's Valley Gardens and the Royal Pump Room museum.

During the late 19th and early 20th centuries, Harrogate was extremely popular among the English élite and was frequented by nobility from around Europe. Its popularity declined after World War I. During World War II, however, Harrogate's large hotels accommodated government offices that had been evacuated from London. This paved the way for the town's current function as a commercial conference, and

exhibition centre.

Notable former employers in Harrogate were ICI, who occupied offices and laboratories at Hornbeam Park, the Central Electricity Generating Board, (CEGB), and the Milk Marketing Board. ICI's Hornbeam Park laboratories at Hornbeam Park were the location of the invention of Crimplene in the 1950s, named after the nearby Crimple Valley and Beck.

The town hosted the 1982 Eurovision Song Contest in the conference centre.

In 2007, two metal detectorists found the Harrogate hoard, a 10th century Viking treasure hoard near Harrogate. The hoard contains almost 700 coins and other items from as far away as Afghanistan. The hoard was described by the British Museum as the most important find of its type in Britain for 150 years.



Things to do and see

There are many fine examples of building and architecture about the town, including the Royal Hall theatre, a Grade II listed building designed by Frank Matcham. As the only surviving Kursaal in Britain, the Royal Hall is an important national heritage building. Restoration work was completed in 2007, and the Hall was formally opened

on 22 January 2008, by The Prince of Wales.

Betty's is one of Harrogate's best known landmarks. Betty's Tea Rooms are regionally renowned. They are owned by Betty's and Taylors of Harrogate – the same company that makes the nationally well-known Yorkshire Tea. Betty's has a second tea room at the Harlow Carr Gardens.

The Mercer Art Gallery is home to Harrogate district's fine art collection which consists of some 2000 works of art, mainly from the 19th and 20th centuries. The collection includes works by William Powell Frith, Atkinson Grimshaw, Sir Edward Burne-Jones, Dame Laura Knight, Alan Davie and many more.



Places to eat in Harrogate



The Rajput

(Cuisine: Indian)

In 1992, Perveen Khan founded the Rajput Restaurant on the principles and traditions of real home-style

Indian cooking. Her aim was to provide an Indian home-cuisine experience in a restaurant setting. This is what set The Rajput apart from other Indian restaurants. It has made The Rajput a local phenomenon. The Rajput is now regarded as one of the best places to eat Indian food, throughout Yorkshire and across the whole of the country.

7-11 Cheltenham Parade,
Harrogate, HG1 1DD
Tel: 01423 562 113
www.rajput.co.uk



The Tannin Level

(Cuisine: Bar and Grill)

The Tannin Level, one of Harrogate's best known restaurants, has been taste-

fully re-furnished without losing its character and passion.

5 Raglan St.
Harrogate, HG1 1LE
Tel: 01423 560 595
www.tanninlevel.co.uk



Royal Baths

(Cuisine: Chinese)

Elegant experience of a unique Chinese Restaurant.

Central Hall, Crescent Rd.
Harrogate, HG1 2WJ
Tel: 01423 536 888
www.royalbathschineserestaurant.com



Jinnah Restaurant

(Cuisine: Asian)

Jinnah has been in Harrogate for some years now but opened these premises

in 2003, converting them from an old chapel. Situated on one of the most popular streets in Harrogate, Cheltenham Parade, close to the shops, Victoria Shopping Centre, the Harrogate Theatre and with the Harrogate International Conference Centre just five minutes away down the hill. The restaurant is large with a seating capacity of 110 yet still able to offer that intimate table for two or the larger party if required.

34 Cheltenham Parade, Harrogate, HG1 1DB
Tel: 01423 563 333
www.jinnah-restaurants.com



Thai Elephant

(Cuisine: Thai)

Wide variety of vegetarian meals, seafood curries, soups, stir fries and salads. Set menus and outside catering available.

Unit 3-4, 13-15 Cheltenham Parade
Harrogate, HG1 1DD
Tel: 01423 530 099
www.thaielephantrestaurant.com

Social Events at ACPGBI

The ACPGBI meeting is not all about the scientific programme. There are many social events that may capture your attention and help you unwind at the end of the day. Below is an overview of what is on during the four days of the meeting

	<p>Monday 8th June 18:00–19:30</p>	<p>Welcome Reception at the Harrogate International Centre This event is free for registered delegate. Drinks and canapés will be served. Price for non-delegates: £21 per person <i>Sponsored by Ethicon Endo-Surgery</i></p>
	<p>Tuesday 9th June 18:45–20:30</p>	<p>Reception at the Royal Hall, Ripon Road The Royal Hall is a stunning Edwardian theatre built in 1903 and extensively restored between 2006–2008. Musical entertainment will be provided by the Sun, Sea and Sand Steel Band. Free for registered delegates. Wine, soft drinks and canapés will be served. Price for non-delegates: £30 per person</p>
	<p>Wednesday 10th June 18:00</p>	<p>Wine tasting and dinner in aid of the Bowel Disease Research Foundation Includes: Wine tasting in the art exhibition. Dinner (a Yorkshire tapas menu will be served). Musical entertainment will be provided by Encore. After dinner speaker – Professor James Drife Price: £45 per person</p>
	<p>Thursday 11th June 14:00</p>	<p>Golf Tournament, Harrogate Golf Club The golf club is situated on the east of the town close to the A1. It will be an individual Stableford competition off full handicap. The first tee time is 14:00 Price: around £40</p>



Association of Laparoscopic Surgeons & Association of Laparoscopic Theatre Staff of Great Britain & Ireland

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PROGRAMME

Live Operating from 4 UK Hospitals & Hong Kong including Speakers & Operating from:

- Heine van der Walt** from South Africa will operate live from Benenden Hospital, Kent. He will perform a laparoscopic re-do fundoplication, a laparoscopic repair of a giant rolling hiatus hernia and a gastric bypass operation.
- Barry Salky** from the USA will perform a live laparoscopic Crohn's resection from Darent Valley Hospital, Kent.
- Michael Li** from Hong Kong will give a lecture and his unit in Hong Kong will perform a live operation linked through to The River Centre.
- André D'Hoore** from Belgium will perform a right hemi-colectomy from Medway Maritime Hospital, Gillingham, Kent.

Also featuring Simon Paterson-Brown, Royal Infirmary of Edinburgh & President AUGIS, Pete Sagar, Leeds General Infirmary, Amir Nisar, Maidstone Hospital, Faz Hassan, Benenden Hospital, Henk Wegstapel at Medway Maritime Hospital, Gillingham & Others!

PLUS

- Short Papers & DVD Sessions
- Association of Laparoscopic Theatre Staff Meeting
- Trainee Course
- Poster Exhibition
- Industry Exhibition

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Tel: +44(0)20 7973 0305
Industry Exhibition enquiries contact swilliams@asgbi.org.uk
Tel: +44(0)20 7304 4777

IBD Symposium: Tuesday 9th June, 08:30 – 10:30, Auditorium

Acute colectomy: What should be done with the rectal stump?

Steve Brown
Sheffield Teaching Hospitals
South Yorkshire, UK

About 15% of UC patients present with an acute exacerbation requiring hospitalisation and intensive medical therapy. Despite advances in medical management up to 40% require emergency colectomy. For 20 years the accepted procedure has been subtotal colectomy and ileostomy. This allows removal of the majority of disease, whilst avoiding the morbidity associated with pelvic dissection and permitting all subsequent surgical options.

The procedure is standard apart from the management of the rectal stump. Originally a mucous fistula was recommended, with intraperitoneal stump closure described as hazardous due to high rates of dehiscence and sepsis. However, with a fistula wound infection rates were high and there was significant patient dissatisfaction. An alternative involves stump closure and subcutaneous positioning, either in the midline or a separate site. This has the advantages of the mucous fistula in avoiding intra-peritoneal dehiscence without the disadvantage of a second stoma. However, up to 35% of cases result in a mucous fistula with associated wound sepsis in about 8%.

Contrary to initial fears, several subsequent studies have shown that intra-peritoneal stump closure does not result in a high rate of pelvic sepsis. Combining data from nearly 600 cases

suggests the incidence of stump related sepsis is <7% (vs. 2–6% for mucous fistula/subcutaneous closure).

Even with intraperitoneal closure, many advocate attaching the stump to the peritoneal surface of the midline incision. This and mucous fistula/subcutaneous closure techniques require a long stump. Does the residual length of inflamed mucosa result in significant rectal symptoms? Data available suggests that symptoms occur equally frequency whatever length of stump. It may even be disadvantageous to shorten the stump. Evidence suggests a higher dehiscence rate as well as more difficult subsequent surgery. Infra-pelvic resection certainly increases morbidity and even retention of the anal canal alone results in unrelenting symptoms in a significant proportion.

One situation where intra-peritoneal closure may be contraindicated is the pregnant patient requiring colectomy. This group may have a higher incidence of pelvic sepsis, the consequences of which are dire for the developing foetus and difficult to treat radiologically. Conversely a subcutaneously placed midline stump is not possible due to the expanding uterus. The safest option may therefore be a laterally placed subcutaneous position or mucous fistula.

In order to reduce the incidence of rectal de-

hiscence a rectal catheter has been advocated. There is anecdotal evidence of retention of mucous and blood from the inflamed rectal mucosa resulting in rectal dilation and a potential 'blown stump'. Two retrospective studies suggest a protective role for such a catheter. Although definitive evidence would require a study of over 2,000 patients pragmatically such a catheter does little harm and as such should be recommended in any technique involving stump closure.

If the stump is to be closed should it be stapled, sutured or both? The evidence is poor but the retrospective data available would suggest that it makes no difference whatever technique is employed.

With the caveat that evidence from the literature is very weak some common sense recommendations can be made when dealing with the rectal stump, such as:

- A mucous fistula is rarely necessary. Indeed the only occasions that it may be required is if the resected distal bowel is so inflamed that it will not hold sutures/staples or perhaps in the pregnant patient.
- In most situations a subcutaneous or intra-peritoneal position for the closed stump is appropriate with the balance being between the small increased risk of wound or peritoneal sepsis respectively.



The blown rectal stump. Sagittal views show a dilated rectum. The intraperitoneal stapled closure has dehiscence resulting in a stump abscess

- A longer intra-peritoneal stump is less likely to dehiscence, and allows easier subsequent surgery, especially compared with an infra-pelvic resection.
- The idea that a longer stump results in more rectal symptoms appears unfounded.
- The rectum may be closed with sutures or staples.
- A rectal catheter should be used to reduce the potential for rectal distension.

IBD Symposium: Tuesday 9th June, 08:30 – 10:30, Auditorium

Is it safe to fashion an ileoanal pouch for a patient taking steroids?

Bruce D George
John Radcliffe Hospital, Oxford, UK



Bruce D George

The debate about pouch surgery in patients on steroids is principally concerned with non-urgent indications for surgery. The morbidity of proctocolectomy and pouch reconstruction in acute severe colitis is unacceptably high¹.

The most common indication for non-urgent surgery for ulcerative colitis is "failure of medical therapy". This includes patients who cannot be weaned off steroid therapy, patients with complications of steroid therapy and patients with chronic symptoms despite optimum medical therapy. There is controversy as to whether or not it is reasonable to undertake proctocolectomy and pouch reconstruction (+/- covering ileostomy) in patients taking steroid medication. The more conservative approach is colectomy with ileostomy initially, followed by proctectomy and pouch reconstruction several months later.

Clinical evidence

In ulcerative colitis

Several non-randomised studies have looked at the association between

steroids and septic complications following pouch surgery. Cohen et al² suggested that steroids were a risk factor for anastomotic leaks, whereas Ziv et al³ found that steroid therapy was not associated with an increased risk of septic complications. Two more recent studies^{4,5} have demonstrated in multivariate analysis that steroids are associated with increased septic complications. Furthermore both demonstrated a dose response effect.

In inflammatory bowel disease

A recent meta-analysis in patients with inflammatory bowel disease undergoing abdominal surgery showed a significant increased risk of postoperative infectious complications with steroid use (odds ratio 1.68, 95% confidence interval 1.24–2.28)⁶.

In general surgery

Similarly in general surgical patients Stuck et al⁷ showed that steroid use over 10mg/day was associated with a significant increase in infectious complications. No difference in infectious complications was noted at doses less than 10mg/day.

Scientific evidence

The pharmacological effects of steroids are well known and include: fluid and electrolyte imbalance, hypertension, hyperglycaemia and increased susceptibility to infection. Numerous experimental animal models have demonstrated impairment of wound healing and intestinal anastomotic healing with steroid administration^{8,9}.

Surgical debate

There seems to be little doubt that steroid use is associated with an increased risk of septic post-operative complications in patients un-

dergoing pouch surgery. Although a causal relationship is not proven, the importance of septic complications and ultimate pouch function cannot be overemphasised. Minimising subclinical episodes of peri-anastomotic sepsis may be important in improving later pouch function.

This increased risk of septic complications must be weighed against the risks of additional surgery if a preliminary colectomy and ileostomy is undertaken.

A pragmatic approach is to aim to wean all patients off steroids prior to elective pouch surgery. If patients remain on high dose steroids (over 20mg/day), then a preliminary colectomy and ileostomy should be undertaken. If the steroid dose can be reduced to 10mg/day or less for at least four weeks then it is probably reasonable to undertake proctocolectomy and pouch with a covering ileostomy. At intermediate doses (10–20mg/day) the correct approach is debatable. My preferred approach is the more conservative colectomy and ileostomy.

In recent years the additional concerns of the safety of pouch surgery in patients taking immunomodulator or biologicals has arisen. Immunomodulators appear not to increase the risks of surgery. Data on infliximab in patients with ulcerative colitis is conflicting.

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5. Lim et al 2007
6. Subramanian et al 2008
7. Stuck et al
8. Aszodi and Ponsky 1984
9. Jung et al 2001

Nursing Forum: Tuesday 9th June, 14:00 – 16:30, Queen's Suite A

ACPGBI Nurses Forum/Symposium

Ian A Fretwell
Nurse Consultant Colorectal & Endoscopy
Royal Hospital NHS Foundation Trust, Calow Chesterfield, Derbyshire, UK

Firstly, a warm welcome to Harrogate and I am looking forward to another engaging Nurse's Forum at our annual conference. Our afternoon will start with a brief yearly report on activities and duties performed by the committee members as part of our annual general meeting. One of the actions from last year was to assess the viability of a joint three yearly nursing conference with our colleagues and partners from the Royal College of Nursing (RCN) Gastrointestinal and Stoma Care Forum, and the World Congress of Stoma Therapists (WCET). Unfortunately after presenting this notion to WCET and the Council of the ACPGBI we are unable to proceed with any further planning of such an event.

Our session will continue with our sponsors 'Coloplast' presenting an update on the professional developments for stoma care and colorectal nursing, followed by our partners from 'Salts' who will also present their latest nursing annual programme.

This year our focus for the symposium is on 'research' and in particular 'How to submit an abstract'. This will feature nurse abstract submissions, a presentation from the chair of marking of abstract for the ACPGBI, a presentation from a leading nurse educationist on the principles of writing papers for submission, followed by a discussion on whether we should look at separating nurse abstracts from the main scientific abstracts with separate marking for nurse papers. Following this discussion we will take a vote as to how to take this forward for 2010.

We have invited the chair of the RCN Gastrointestinal and Stoma Care Forum – Ricky Forbes-Young to present an update on the plans and future of the



Ian A Fretwell

RCN GI Forum. We are also hopeful of receiving the document from the Stoma Care Competency Project, led by Janet Kimble with our colorectal and stoma care nursing partners from clinical settings within the stoma care field of practice.

The past two to three years have focused heavily on the 'Proposed new arrangements under Part IX of the Drug Tariff for the provision of stoma and urology appliances – and related services – in primary care' with the now final 'Summary of responses to the Consultation published 09 June 2008 (April 1st 2009)'. We will present and discuss this final document and the impact to our stoma care nursing profession. We are also aiming to highlight potential issues and new ways of commissioning stoma care services following this document.

Finally, after two years as chair and four years as a committee member my total of six years in office has come to an end. I would like to thank everyone who has supported me especially my fellow committee members, my work colleagues in Chesterfield and our sponsors 'Coloplast'. I will hand-over the role of chair to Anna Wordley (Colchester) and wish her every success in continuing the voice of nursing within the ACPGBI.

Wednesday's Programme10th June

07:15 – 18:15 Registration Open

Queen's Suite A07:15 – 08:15 Breakfast Session
National Clinical Trials**Queen's Suite B**07:15 – 08:15 Breakfast Session
How to Complete an ACCEA Application**Auditorium**

08:30 – 09:50 Short papers

Queen's Suite A

08:30 – 09:50 Short papers

Queen's Suite B

08:30 – 09:50 Short papers

Auditorium10:00 – 10:30 Arris and Gale Lecture: Sacral Nerve Stimulation for Bowel Dysfunction
Michael Jarrett10:30 – 11:00 Hall Q – Exhibition/tea/coffee
Poster exhibition**Auditorium**

11:00 – 15:50 Short papers

Queen's Suite A

11:00 – 14:50 Short papers

Queen's Suite B

11:00 – 14:50 Short papers/oral posters

12:30 – 13:20 Hall Q – Exhibition/tea/coffee
Poster exhibition**Auditorium**15:15 – 15:45 Radical Surgery for Lateral Pelvic Wall Recurrent Rectal Tumours
Michael Solomon

15:45 – 17:30 Consultants' Corn

18:00 KING'S SUITE/KING'S SUITE
LINKWAY**Thursday's Programme**11th June

08:00 – 13:30 Registration Open

Auditorium08:30 – 09:05 How to Cope with the EWTD
Michael Horrocks09:05 – 09:20 National Laparoscopic Colorectal Surgery Training Programme
Mark Coleman09:20 – 09:35 Laparoscopic Colorectal Surgery Training in Australia
Michael Solomon09:35 – 09:55 The Optimal Training Programme for a Laparoscopic Colorectal Surgeon
Mark Gudgeon

09:55 – 10:55 Video Session

10:55 – 11:00 Induction of new President

11:00 – 11:30 Exhibition/tea/coffee
Poster exhibition

11:30 – 12:00 Good News from the Bowel Disease Research Foundation (BDRF)

12:00 – 12:20 Ensuring High Quality Data within the National Bowel Cancer Audit
Paul Finan12:20 – 12:40 How Large Databases Can Contribute to Improving Quality in Cancer Outcomes
David Forman

12:40 Close of Meeting

International Colorectal Stent Registry**Have you registered yet?****The International Colorectal Stent Registry (ICSR) has been operating since 2007 and is the result of collaboration between the ACPGBI and Dendrite Clinical Systems**

Mr Mike Parker, Consultant Laparoscopic and Colorectal Surgeon at Darent Valley Hospital, commented: "The International Colorectal Stent Registry is used to report on the use of colorectal stents for the treatment of lower bowel obstruction (LBO) due to colonic malignancies. We are grateful to the Association of Coloproctology of Great Britain and Ireland and to the various commercial organisations that have supported this important project."

The key objective of this Registry is to collect individual patient records and track these procedures as either a bridge to surgery or for palliative care. The data from the ICSR will be utilised to publish a comprehensive report on the use of colorectal stents for the treatment of LBO due to co-

lonic malignancies. This will be achieved through the collection of data at the individual patient level, which can then be used to track individuals and groups of patients after stent placements for either bridge-to-surgery or palliative care.

The Registry can be accessed using a standard web-browser, without the need to install additional software or perform any complex system configurations. It is open to international participation and cases entered will remain the property of the participating surgeons and the Association of Coloproctology of Great Britain & Ireland. All contributors will receive a free copy of the published report derived from the registry data.

If you or a colleague/s are interested in



Mike Parker

registering, please complete the online registration form: <http://icsr.e-dendrite.com> or alternatively, email registrationsupport@e-dendrite.com or phone +44 (0)1491 411 288.

Haemorrhoid Symposium: Tuesday 9th June, 16:15 – 17:45, Auditorium**PPH & HAL – less painful but are they as good**

Professor Per-Olof Nystrom
Karolinska Institutet
Stockholm, Sweden

Painless haemorrhoid surgery is certainly a goal in itself because so many other goals can also be achieved in the absence of pain. The anus is an exceptionally sensitive region of the body. If patients ever lightly heartedly will accept anal surgery they must be assured that the chance is a reasonable pain. Pain can be controlled in the large majority by the combination of local perianal block, a tailored operation, and adequate post-operative pain medication. Ninety percent can have day surgery and expect a fifty-fifty chance to be back to work within a week. This is the level of care that we try to improve.

Are patients and surgeons prepared to trade less pain and quicker recovery for somewhat less effectiveness? It is certainly a matter of degree. Rubber banding is much less painful than haemorrhoid excision but also much less effective. It is expected that patients may return in the future with new complaints for a second treatment. Surgeons, or patients, do not speak of failure after

banding. But they certainly do after an operation for haemorrhoids.

Recently, I saw an immigrant patient under my care for a pending stapled transanal rectal resection (STARR) procedure for obstructed defecation. In the interval she visited her country of origin and was operated for haemorrhoids which cured her anal prolapse but not her defecation problem. The anal examination now revealed absence of the external haemorrhoid plexus, absence of the dentate line, and absence of the internal haemorrhoids and piles. All had been removed and left her with a rather narrow anal tube. It had been painful for several weeks. This lady had had the most effective operation for haemorrhoids which will never recur.

Symptomatic haemorrhoids are a wide spectrum of ano-haemorrhoidal prolapse. There is a minor proportion in which the prolapse requires manual reduction, grade III, and an even smaller proportion where the anodermal prolapse has enlarged into fixed polyps and tags, grade IV. These categories are the prime target populations for haemorrhoid surgery. There will also be some patients with grade II in whom bleeding was not controlled by banding.

What are the treatment goals for these three stages of haemorrhoids? Quite clearly, stop the bleeding in grade II, remove the prolapse in grade III, and excise the external component in grade IV. Can operations be devised that accomplish the goals with minor pain? How is extensiveness of the operation balanced against the risk of recurrence? Conceptually, the extensiveness of the operation, postoperative pain, and the risk of recurrence are interrelated. If haemorrhoid excision is taken as reference with 90% effectiveness then 85% effectiveness might be acceptable for an operation that gives less pain. This is the magnitude of difference for haemorrhoidectomy compared with PPH and HAL both of which are less painful. Perhaps HAL should be used for grade II, PPH for grade III and diathermy excision for grade IV, and all performed under local perianal block in day surgery.

In the past ten years there have been a thousand articles on haemorrhoids in the PubMed. Two hundred were randomised clinical trials and 20 were systematic reviews and meta-analyses. If we still do not know the best way to treat symptomatic haemorrhoids we were perhaps not asking the right questions.

Working in partnership for a modern surgical service

Claire Weston
Clinical Marketing Manager, Northern Europe
KCI Medical Ltd

As surgical practice and technology advance and evolve, and the Department of Health drives the National Health Service to modernise, the service options we offer our patients should also evolve. Lord Darzi's vision for the NHS1 not only calls for 'high quality healthcare' for patients but challenges healthcare purchasers and providers to review the services they offer, and ultimately this will impact on the surgical services clinicians can offer to their patients. Over the next few years, and within the shadow of financial crisis and drivers for greater efficiency, the NHS may come to rely on partnerships with industry to support and drive a cost-effective modern surgical service.

So how can partnering with industry help to shape a modern surgical service? By choosing evidence-based therapies with significant impact on clinical and health economic outcomes a clinician can enhance and shape their service. For example, a recent RCT of V.A.C.* Therapy in vascular leg ulcers showed significantly

faster wound bed preparation ($p < 0.005$) time of 7 versus 17 days (median)². If, rather than just referring a patient for surgical review and paying for an in-patient tariff for surgical treatment, the PCT chose V.A.C. Therapy to actively clean up and granulate the wound bed prior to hospital admission, the hospital may be able to reduce in-patient stay pre-operatively or even treat the patient on a day case basis. This would mean a lesser tariff fee for the PCT, a freed hospital bed allowing another patient to leave the waiting list and commence treatment within the 18-week target, and a patient who has avoided hospital admission returning home for post operative care. Not only does the patient receive a fast and efficient service but more patients are able to be treated within existing and finite resources. Having the technology is an important step but if you do not then receive a supportive package of training, education, access to therapies when and where you need them with a 24-hour route to clinical and technical advice you will not receive value for money and a truly efficient new service.

KCI Medical prides itself on our partnership approach to healthcare provision and our

innovative clinical and economic solutions. As a global medical technology company with leadership positions in advanced wound care with negative pressure wound therapy (NPWT), pressure area care with therapeutic support systems (TSS), Bariatric support for obese patient management and regenerative medicine for complex surgical hernia repair and breast reconstruction procedures, KCI has been providing clinically innovative and cost-effective therapies that continue to change the standard of healing for more than 30 years.

Partnering for healthcare provision in the 21st century is a must. We owe it to our patients and ultimately, as tax payers we owe it to ourselves.

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Surgery for colorectal liver metastases

Ulf Haglund
Professor of Surgery
Uppsala University, Uppsala, Sweden

During the past ten years surgical treatment of colorectal liver metastases has undergone fundamental changes. Part of this is reflected in original reports published in the *British Journal of Surgery* (BJS). Surgery for colorectal liver metastases is today part of the surgical routine care. The indications for surgical treatment have become much broader. Patients now undergo surgery with a high number of liver metastases even if located in both lobes as long as at least one segment in addition to segment one is free. Portal venous embolization as well as two staged operations is used to achieve resectability. Older patients are accepted for surgery as are patients with significant co-morbidities. Still the postoperative mortality is much reduced and many procedures are done without blood transfusion. Preoperative chemotherapy has more and more become the standard. Such pre-treatment may impair liver function, increasing the postoperative risk for liver insufficiency and fatal outcome within 90 days from surgery, but may further increase long term survival.

For patients with synchronous liver metastases without significant symptoms from the primary tumour neoadjuvant chemotherapy and resection of the liver metastases before dealing with the colorectal primary has become an interesting option. This allows a better selection of patients who will benefit from surgery and it focuses on the most life-threatening part of their disease. This option allows active treatment while waiting for the local effects of radiation therapy in rectal cancer. The first paper reporting experience from this "liver mets first" type of management, by Mentha, Majno, Andres and co-workers from Geneva, Switzerland, was published in BJS 2006 (2006; 93: 872-878). The authors reported 20 consecutive patients with non-occlusive colorectal tumours, less than 70 years of age and with at least two liver metastases, treated according to these principles. They were given two to six cycles of chemotherapy (oxaliplatin and irinotecan with 5-FU and leucovorin). Sixteen of them responded to this treatment and went on to liver resection. Overall four years survival was 56% – for those 16 with liver resection 61%. This was not a randomised controlled trial but has proven the concept is feasible. The results of this study have encouraged others to treat suitable patients with synchronous liver metastases using this modality. The study will be discussed in more detail during the session. A few additional papers published in BJS during the last years, highlighting technical aspects of liver surgery for colorectal metastases such as portal venous embolization to increase the remnant part (Riberio et al 2007; 94: 1386 – 1394), the outcome following very extensive liver resections (Lodge et al 2005; 92: 340 – 347), and the effects of liver steatosis on post-operative morbidity (Gomez et al 2007; 94: 1395 – 1402) will also be commented upon.

First Announcement and Call for Abstracts

The Association of Coloproctology
of Great Britain and Ireland



2010 ANNUAL MEETING
Bournemouth International Centre, Bournemouth
28 June – 1 July 2010

Thursday 11th June, 09:20 – 09:35, Auditorium

Colorectal Laparoscopic Training in Australasia

Professor Michael J. Solomon
Surgical Outcome Research Centre (SOURe) University of Sydney, & Chairman of the Post Fellowship Training Board in Colorectal Surgery of CSSANZ & RACS

Laparoscopic colorectal surgery was initiated in the early 1990s for benign conditions¹ and extended to colorectal malignancy in isolated specialised units within Australasia. Dissemination of colorectal laparoscopic surgery for cancer awaited the results of our local RCT ALCAS published last year as well as meta-analyses of the international RCTs^{2,3,4,5}. Like many international units awaiting the results of these RCTs the dissemination and popularity of the laparoscopic procedure has risen exponentially in the past two years despite the results of these trials suggesting equivalence only to open procedures but short-term safety. Although short-term outcomes have been only modestly in favour of laparoscopic surgery at best, general dissemination of laparoscopic colorectal surgery has occurred both within the specialised training units and throughout Australasia necessitating a much greater need for training in laparoscopic surgery at the advanced general surgical trainee stage, the post-fellowship trainee as well as surgeons already in established surgical practices. The latter group pose the greatest difficulty in providing an adequate framework of training and preceptor supervision to safely initiate and persist with safe laparoscopic colorectal surgery. Laparoscopic training comes in the form of simulation, animal, cadaver and "on the job" training as well as a good preceptor to watch and call for advice and watch cases

when in established practice.

Darzi et al have suggested graduated simulated laparoscopic training is the best approach (*Am J Surg*, 2007) and certainly virtual reality training has been shown to improve speed of learning and laparoscopic trainees economy of movement (Grantcharov et al *Br J Surg*, 2004).

The post fellowship training programme in Australasia was established in 1988 and currently has over 20 trainees at any time with 74 having completed the two-year programme in 18 accredited training units. The Board supervises and ensures the training and experience in all aspects of colorectal surgery not only laparoscopic surgery and as such does not have a specific laparoscopic training programme. An audit of all fellows logbooks from 2003–2006 demonstrated that fellows average 504 major colorectal operations and 74 laparoscopic major colorectal operations during their two-year training (cf 70 TME procedures). This proportion has doubled in most accredited colorectal units in the past triennium. The learning curve for laparoscopic colorectal surgery ranges from 30–70 cases for colon (55 right hemicolectomy and 62 left hemicolectomy) but is unknown for rectal procedures. The training board also has available four-day training courses every 4–12 weeks to specialised laparoscopic units in Brisbane, Adelaide and Sydney. A HALS cadaver course is now available twice a year. The Board



Circa 1997 Fellow Andrew Stevenson and Michael Solomon trialing the first "robot" assisted laparoscopic colorectal procedure

has started a research project of prospective mentor audit of fellows ability in laparoscopic cases using a component of laparoscopic surgery assessment monthly during their two years of training and the initial results will be available at the end of 2009. The Council of the CSSANZ has published this year guidelines for accreditation of differing levels of laparoscopic colorectal surgery based on training, experience and ongoing audit. The post-fellowship programme as always offers ongoing preceptor training not only for the fellow but more often than not the established surgeon (see photo).

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Thursday 11th June, 12:20 – 12:40, Auditorium

How large databases can contribute to improving quality in cancer outcomes

Professor David Forman
Information and Analysis Lead, National Cancer Intelligence Network
University of Leeds, UK

Dr Eva Morris
Cancer Research UK (Bobby Moore Fund) Career Development Fellow
University of Leeds, UK

Whilst all colorectal cancer patients should receive the best possible treatment there is evidence to suggest significant variations exist in both management and outcomes across the UK. The equalisation of services and ensuring quality of care for all is a top priority. Quantifying such disparities and measuring the effects of interventions intended to equalise them is, however, very difficult. The 2007 Cancer Reform Strategy recognised that good quality routine data could aid in achieving this aim. It emphasised the importance of population-based datasets to monitoring practice and outcomes, directing commissioning, enabling clinical governance, informing patient choice, and, ultimately, improving patient outcomes.

The challenge, however, is ensuring that routine data are both robust enough and sufficiently comprehensive to reliably achieve these aims. Across the UK, numerous disparate data sources exist and contain valuable information about different aspects of patient management but none contains all the information that is needed to monitor care nationally. To address this the new National Cancer Intelligence Network (NCIN), established by the Cancer Reform Strategy, is taking steps to link these various resources together to generate a dataset that allows each



David Forman

patient's treatment pathway to be mapped from diagnosis to cure or death. It is intended that this will allow the hospital careers and outcomes of colorectal cancer patients to be monitored at a population level and the clinical performance of the NHS to be scrutinised.

This first iteration of the National Cancer Data Repository (NCDR) is now in existence and is based on linked cancer registry and Hospital Episode Statistics data. This dataset has enabled analyses to be undertaken

that compare surgical practice and outcomes across England and examples will be discussed in this presentation. We will present a study that aims to quantify the impact of specialist or high workload surgical management on outcomes and, thereby, provide an evidence base for any future recommendations on the minimum workload for specialist colorectal surgeons. Results of other analyses examining variation in rectal surgical practice, the frequency of resection of colorectal cancer hepatic metastases and post-operative mortality rates will also be shown.

The NCIN is actively trying to increase the scope of the NCDR by incorporating further data sources into the resource. These include datasets from primary care, the National Bowel Cancer Screening Programme, clinical trials, outpatients and the National Bowel Cancer Audit Programme. Once these amalgamations have been completed the NCDR will be an extremely powerful data resource. Appropriate interrogation of its contents will produce analyses that will have the potential to inform and support all aspects of colorectal cancer research from laboratory studies to the delivery of clinical care. Ultimately, the knowledge obtained from the resource should lead to an improvement in colorectal cancer survival.

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*KCI data on file

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