21st ANNUAL CONFERENCE OF THE EGYPTIAN SOCIETY OF COLON AND RECTAL SURGEONS

28 - 30 August 2019 Hilton Heliopolis - Cairo

Welcome Message

Dear Friends,

Greetings! It is indeed a great privilege and honor to welcome you to our 21st Annual Conference of the Egyptian Society of Colon & Rectal Surgeons 2019.

We are happy to share with you the scientific program planned for this year.

We are having 2 workshops in addition to the main Congress.

This year, we have a distinguished faculty from Egypt, Middle East, Europe, and USA.

There will be a lot of clinical cases and discussions together with the updates in various colorectal surgery topics.

We encourage all of you to share in the discussion and to exchange your personal experience.

This year, we are having Abdominal Wall Reconstruction laparoscopic and Open Techniques workshop on Saturday and Tuesday morning Minimally Invasive Colorectal Surgery Workshop.

The program is accredited by the European association of medical education by 16 European CME .

In Cairo You can have easy access to wonderful touristic places Pharonic, Coptic, Islamic and modern.

Just 45 minutes away, you can see the pyramids and Egyptian museum. The river Nile is not far and it will be nice if you can have a chance to spend some time over there.

We seize this opportunity to thank all of you for your contribution in this meeting. Looking forward for more cooperation.

CONFERENCE GENERAL SECRETARY

Prof.Khaled Madbouly

CONFERENCE PRESIDENT

Prof.Mohamed S. Ellibishi

Conference Executive Board

Conference President

Prof. Mohamed S.Ellibishi

ESCRS President

Conference Secretary General

Prof. Khaled Madbouly

ESCRS Secretary General

Scientific Committee

" In Alphabetical Order "

Ahmed Farag
Alaa Radwan
Ali El Shiwy
Amr El Shoaib
Assem El Thani
Farok Morad
Hany Tawfic
Khaled Safwat
Mohamed Nada
Tarek Youssef
Wael Khafagy
Waleed Omar
Waleed Thabet
Magdy Mahmoud Emam

Organizing Committee

" In Alphabetical Order "

Abd Rabbo Mashhour
Ahmed Ali
Ali Zidan
Elyamani fouda
Essam fakhry Obied
Hossam El fiki
Hussien Fakhry
John kamal
Mohamed Abo El Khir
Mohamed Raslan
Mohamed Yehia
Mostafa shalaby
Radwan Abdel Sabbour
Sameh Emil

General Information

Accreditation:

"The 21st Annual Conference of the Egyptian Society of Colon & Rectal Surgeons 2019, Cairo, Egypt, 27/08/2019-30/08/2019 " has been accredited by the European Accreditation Council for Continuing Medical Education (EACCME®) with 16 European CME cred

its (ECMEC®s). Each medical specialist should claim only those hours of credit that he/she actually spent in the educational activity.

Badge

All types of badges give access to all scientific sessions, exhibition and food & beverage areas.
For security reasons, access to scientific sessions will not be granted if a session room is full.
Badges must be used at all times within the conference areas.

Bag Delivery

Get your congress bag from the registration desk while receiving the registration material.

Certificates

Certificate of attendance will be delivered starting Friday 30 August 15:00 at the registration desk after filling the evaluation form.
Or claim it online through www.escrs-eg.org 10 days after the event.

Coffee & Refreshments

Drinks, refreshments and snacks are served during the Coffee Break times as below:

Date	Coffee Break 1 Timings	Coffee Break 2 Timings
Wednesday 28 August	14:45 - 15:15	16:45 - 17:15
Thursday 29 August	11:45 - 12:15	14:10 - 14:30
Friday 30 August	11:35 - 13:00	-

Language

The official language of the ESCRS 2019 is English. All lectures and presentations will be held in English.

Lunch Breaks

Lunch will be served as follow :

Date	Lunch Timings
Wednesday 28 August	18:45 - 19:30
Thursday 29 August	18:00 - 19:00
Friday 30 August	14:50 - 16:00

Opening Ceremony

Opening ceremony will be held in the Plenary room, on Wednesday 28 August 2019 – Hilton Heliopolis, Canyon Ballroom at 13:30.

Registration Desks

Registration desks are available at the entrance of conference area. See floor Plan

Working hours:

Date	From	To
Wednesday 28 August	11:00	17:30
Thursday 29 August	08:30	17:00
Friday 30 August	08:30	16:00

Website:

http://www.escrs-eg.org/

Currencies and Banks

The EGP, Egyptian Pound is the official currency of the Arab Republic of Egypt.
1 USD = 16.65 EGP (Average)

Electricity

The electricity supply in Egypt is 220 Volt, 50 Hz.

Emergency procedures and Numbers

In case of any medical emergency, please refer back to the registration desk:
Police, 122
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ICOM

ICOM is the ESCRS 2019 official PCO
A professional, well trained team is dedicated to ensuring ESCRS 2019 is a success
ICOM team is available to serve you, providing further information and clarity where needed.
Don't hesitate to discuss your thoughts, ideas and needs with the team at any time.
www.icomgroup.org

AUDIOVISUAL INSTRUCTIONS

Dear Speaker,

You will soon be presenting at Colon & Rectal Surgeons Conference and we want this experience to go as smoothly as possible for you. On the behalf of The Egyptian Group of Colon & Rectal Surgeons conference, ICOM will manage the audiovisual center and provide you with assistance before, during and after your presentation.

* Please make sure that you received your personal program (by e-mail), we also advise that you check the final program available online.
* All speakers and case presenters are required to submit their presentations at the audiovisual center.
* Please make sure that you keep a copy of your presentation for backup.

For Case Presentations

All case presentations should be submitted at least 24 hours prior to the session

Submitting your Presentation

- All presentations should be entirely in English.
- Microsoft Power Point, Apple Keynote and Prezi presentations are supported.
- Please submit your presentation on Flash Memory or CD/DVD.
- Please make sure that the presentation contains all media and video files included in your presentation.
- It's not allowed to use your personal laptop.
- Presentations should be submitted to the audiovisual center at least one hour before the start of your session to be able to prepare it.

Inside the Hall

- Please arrive at the Congress main hall 10 minutes prior to the beginning of your session.
- Thank you for abiding by the allocated duration of your presentation.
- A computerized countdown timer will be displayed on screen and will automatically close the presentation once the time is finished

INTERNATIONAL FACULTY

(in alphabetical order)

Prof. Alaa Abduljabbar – KSA

Deputy Chairman

Consultant Colorectal Surgeon

Director, Saudi Fellowship for Colon and Rectal Surgery

Professor of Colon & Rectal Surgery, Alfaisal University

President, Saudi Society of Colon and Rectal Surgery

Prof.Anders Mellgren - USA

Dr. Anders Mellgren is Professor of Colon & Rectal Surgery at University of Illinois in Chicago. He is a graduate of Karolinska Institute in Stockholm, Sweden where he received his MD, did his basic training and defended his PhD on pelvic floor disorders in 1994. He has completed research and clinical fellowships in colon & rectal surgery at the University of Minnesota and been a Program Director for general surgery at Karolinska Hospital in Stockholm. After returning to the United States in 2003, Dr. Mellgren has been Director of Research and Director of the Pelvic Floor Center at University of Minnesota. In 2013, Dr. Mellgren was appointed Chief of Colon & Rectal Surgery at University of Illinois.

Prof.Sir R J Heald - UK

Prof. R.J. (Bill) Heald of Basingstoke, Hampshire, England, for Honorary Fellowship in the American College of Surgeons (ACS). A graduate of Cambridge University, Mr. Heald is professor of surgery at the University of Southampton, and consultant surgeon at the Basingstoke and North Hampshire Hospital National Health Services Foundation Trust. He is surgical director of the Pelican Cancer Foundation, which promotes excellence and educates health professionals in the management of patients with colon and rectal cancer.

Prof. David Rivadeneira – USA

Vice Chair, Surgical Strategic Initiatives - Northwell Health

Director, Surgical Services & Colorectal Surgery - Huntington Hospital

Professor of Surgery - Hofstra School of Medicine

Prof. John Jenkins – UK

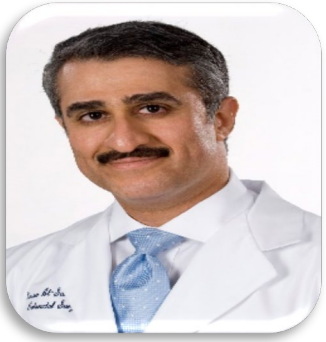
Consultant Colorectal Surgeon
Lead for Colorectal & Anal Cancer
Lead for Complex & Recurrent Cancer Service
St. Mark's Hospital, London

Prof . klaus-matzel - Germany

Klaus E. Matzel is a Professor of Surgery and the Head of the Section of Coloproctology, at the University of Erlangen, Germany. Professor Matzel graduated from Medical School University Erlangen. He pioneered the use of sacral spinal nerve stimulation in the field of Coloproctology after a research fellowship at the Department of Urology, San Francisco. He performed the first implants in 1994 and was instrumental in developing and teaching the technique worldwide.

Prof. Majid Bassuni – UK

British surgeon A.professor of surgery at Sheffield university, UK and consultant surgeon at NMC Royal hospital khalifa city, Abu Dhabi



Prof. Nasser Al-Sanea - KSA

Prof. Nasser Al-Sanea is the Head Section of Colon & Rectal Surgery at King Faisal Specialist Hospital & Research Center in Riyadh, Saudi Arabia. He is also the President of the Saudi Society of Colon & Rectal Surgery, the Chairman of the Saudi Fellowship in Colon & Rectal Surgery and the Editor-in-Chief of the World Journal of Colorectal Surgery and the Annals of Saudi Medicine. He has numerous publications in the field of colorectal cancer genomics, hereditary colorectal diseases, novel surgical techniques in the treatment of colorectal cancer and anal fistulae

Prof. Sherief Shawki - USA

Professor of colorectal surgery
consultant surgeon, Cleveland clinic foundation, Ohio

Prof. Søren Laurberg – Denmark

Professor of colorectal surgery Aarhus University Hospital.Founder and first chairman of the research committee of ESCP and previous President of ESCP. The Sir Allan Park Visiting Professor, St Mark´s Hospital 2017 and honorary member of ASCRS, ESCP, and the Spanish & British Society of colorectal surgery.SL has published more than 400 articles and supervised 35 PhD students and 8 Doctoral this is within nearly all aspects of colorectal surgery. Presently SL´s main interest is in long-term functional outcome following treatment of colorectal cancer, long-term outcome of restorative proctocolectomy for ulcerative colitis, documentation of effect of sacral nerve stimulation and use of circulating tumour DNA to improve outcome of cancer treatment

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Day 1

Hall	Colorectal Surgery Update	12:00
Main Hall		13:00

Chairperson (in alphabetical order)

Abd Rabbo Mashhour
Khaled Safwat
Waleed Thabet

12:00 - 12:12 **Comprehensive bowel management after colorectal resection and low anterior resection syndrome**
Mona Hegazy Egypt

12:12 - 12:24 **What have changed over 1 year in practice guidelines**
Mohamed Nada Egypt

12:24 - 12:36 **Colorectal cancer in Egypt: what do we know so far**
Essam Fakhry Ebied Egypt

12:36 - 12:48 **Controversy for left transverse cancer: segmental versus subtotal colectomy**
Sabry Badr Egypt

12:48 - 13:00 **Management of complicated perineal wound**
Mohamed Abou El Khir Egypt

Hall	Debate I	13:00
Main Hall	What to Do with A T2 Rectal Cancer?	13:30

Chairperson (in alphabetical order)

Magdy Mahmoud
Mohamed Mazloum
Nabil Gad el Hak

13:00 - 13:10 Surgery alone: still the standard?
Waleed Omar Egypt

13:10 - 13:20 CRT followed by local excision/ watch and wait?
Waleed Thabet Egypt

13:20 - 13:30 Discussion

Hall	Opening Ceremony	13:30
Main Hall		14:00

13:30 - 14:00 Conference President
Mohamed Saad Ellibishi Egypt

13:30 - 14:00 Conference Secretary General
Khaled Madbouly Egypt

13:30 - 14:00 Past President of EGCRS
Ahmed Farag Egypt

Hall	Beyond Borders in Colorectal Surgery	14:00
Main Hall		14:45

Chairperson (in alphabetical order)

Khaled Madbouly
Mohamed Saad Ellibishi

14:00 - 14:30 **The TME story - where from and where to?**
Bill Heald — UK

14:30 - 14:45 **Sacral neuromodulation for fecal incontinence: Long term outcomes**
Klaus Matzel — German

14:45 - 15:15 **Coffee Break**

Hall	New Trends in Management of Low Rectal Cancer	15:15
Main Hall		16:30

Chairperson (in alphabetical order)

Khaled Madbouly
Nabil Dwidar
Waleed Omar

15:15 - 15:30 **Prostato-sacral ligament: A new ligament and a new pelvic space**
Ahmed Farag — Egypt

15:30 - 15:45 **Managing Locally Advanced & Recurrent Rectal Cancer**
John Jenkis — London

15:45 - 16:00 **Colorectal Lymphoma**
Alaa Abduljabbar — KSA

16:00 - 16:15 **How to decide APR vs AR in low rectal cancer? How low is too low?**
Andreas Mellegren — USA

16:15 - 16:30 **Laparoscopy in the Pelvis: Should We Switch to Open?**
Nasser El-Sanea — KSA

Hall	Society Address	16:30
Main Hall		16:45

Chairperson (in alphabetical order)

Hany Tawfik
Waleed Thabet

16:30 - 16:45 **From Good to Great: The Story of Personalized Management in Colorectal Cancer**
Khaled Madbouly — Egypt

16:45-17:15 **Coffee Break**

Hall	New Technologies in Colorectal Surgery	17:15
Main Hall		18:15

Chairperson (in alphabetical order)

Ahmed Farag
Tarek Youssef
Wael Khafagy

17:15 - 17:35 **Update on new technologies in colorectal surgery**
David E. Rivadeneira — USA

17:35 - 17:50 **Bowel problems after treatment of colon cancer**
Søren Laurberg — Denmark

17:50 - 18:15 **TaTME for rectal cancer and Benign disease**
Sherief Shawky — USA

Hall	After Hours Debate	18:15
Main Hall		18:45

Chairperson (in alphabetical order)

Ahmed A Raaof El Geidi
Essam Fakhery Ebied
Nasser Zaghlol

18:15 - 18:25 **Intra-corporeal Anastomosis: Happy Patient or a Bridge Too Far?**
Tarek Youssef Egypt

18:25 - 18:35 **Intra-corporeal Anastomosis: Happy Patient or a Bridge Too Far?**
Mahmoud Refaat Shehata Egypt

18:35 - 18:45 **Discussion**

18:45-19:30 Lunch

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1. Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) Webmaster. Laparoscopic colon resection surgery patient information from SAGES. SAGES. https://www.fascrs.org/patients/disease-condi-tion/minimally-invasive-surgery-expanded-version. Updated March 1, 2015. Accessed Jan. 10, 2017. 2. Peters W. Minimally invasive surgery expanded version. American Society of Colon and Rectal Surgeons. https://www.fascrs.org/patients/disease-condition/minimally-invasive-surgery-expanded-version. Accessed Jan. 17, 2017. 3. Askari A, Nachiappan S, Currie A, Bottle A, Athanasiou T, Faiz O. Selection for laparoscopic resection confers a survival benefit in colorectal cancer surgery in England. Surg Endosc. 2016;30(9):3839–3847. 4. Marshall CL, Chen GJ, Robinson CN, et al. Establishment of a minimally invasive surgery program leads to decreased inpatient cost of care in veterans with colon cancer. Am J Surg. 2010;200(5):632-635. 5. Vaid S, Tucker J, Bell T, Grim R, Ahuja V. Cost analysis of laparoscopic versus open colectomy in patients with colon cancer: results from a large nationwide population database. Am Surg. 2012;78(6):635-641.

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Day 2

Hall	Meet the Professor Breakfast	08:30
Main Hall		09:30

Hall	How I Do It?	09:30
Main Hall	Video Session	10:50

Chairperson (in alphabetical order)

Abdel Hafez Showil
Ali Elshiwy
Ali Zidan
Nasser Zaghlol

09:30 - 09:38 **LAR with intersphincteric dissection**
Mohamed Raslan Egypt

09:38 - 09:46 **Postanal minimally invasive surgery PAIMS**
Ahmed Farag Egypt

09:46 - 09:54 **One team TATME**
Ahmed Farag Egypt

09:54 - 10:02 **Medially based gluteus maximus flap in end stage fecal incontinence**
Abd Rabbo Mashhour Egypt

10:02 - 10:10 **Occult perineal hernia a cause of perineal pain**
Ahmed Aly Egypt

10:10 - 10:18 **Martuis flap: a savior in RVF**
Essam Fakhery Ebied Egypt

10:18 - 10:26 **Laser hemorrhoidoplasty**
Essam Fakhery Ebied Egypt

10:26 - 10:34 **Laparoscopic right hemicolectomy in situs inversus totalis**
Mohamed Yehia Egypt

10:34 - 10:42 **Limited PSARP in Adult female**
Waleed Thabet Egypt

10:42 - 10:50 **Lay open of high trans-sphincteric anal fistula with primary sphincter repair**
Ahmed Aly Egypt

Hall	Advanced Endoscopy and Minimally Invasive Surgery	10:50
Main Hall		11:45

Chairperson (in alphabetical order)

Farouk Mourad
Mohamed Abou El Khir
Mohamed Nada
Waleed El Shazly

10:50 - 11:05 **How to Classify and Categorize Premalignant and Malignant Polyps**
Nabil Dwidar Egypt

11:05 - 11:25 **Therabutic colonoscopy How to Decide Which Advanced Endoscopic Procedures to Perform? Now What?? Endoscopic Closure Devices**
Ibrahim Abdel Naby Egypt

11:25 - 11:45 **Fighting dogmas and optimizing patient's outcome. ERAS: is it really a must?**
Medhat Shalabi Egypt

11:45 - 12:15 **Coffee Break**

Hall	Presidential Address	12:15
Main Hall		12:30

Chairperson (in alphabetical order)

Essam El Sahwi
Mostafa Shalaby

12:15 - 12:30 Challenges that Face Colorectal Cancer Management in the Emerging Countries
Mohamed Saad Ellibishi — Egypt

Hall	Controversies in Rectal Prolapse Surgery	12:30
Main Hall		13:30

Chairperson (in alphabetical order)

Ahmed Farag
Alaa Radwan
Hamdy Hussien
Nabil Gad el Hak

12:30 - 12:45 Testing? What Helps Me Prior to Prolapse/ VR Repair?
Abd Rabbo Mashhour — Egypt

12:45 - 13:00 Ventral Mesh Rectopexy for Rectal Prolapse: "History repeats itself"
Nasser El-Sanea — KSA

13:00 - 13:15 Ventral mesh rectopexy with biological mesh for evacuation disorders with video.
Klaus Matzel — German

13:15 - 13:30 Dealing with Recurrent Rectal Prolapse
Majid Bassioni — UK

Hall	Pioneers in Colorectal Surgery	13:30
Main Hall		14:10

Chairperson (in alphabetical order)

Hussien Fakhry
Majid Bassioni
Sherief Shawky

13:30 - 13:50 **Parastomal hernia repair: is it doomed to fail?**
David E. Rivadeneira USA

13:50 - 14:10 **The complete response to Chemo- and Radio- therapy -its importance in clinical practice**
Bill Heald UK

14:10-14:30 **Coffee Break**

Hall	Oncology II	14:30
Main Hall		16:00

Chairperson (in alphabetical order)

Khaled Madbouly
Mohamed Saad Ellibishi
Nasser El-Sanea

14:30 - 14:45 **Difficulties with the anastomosis**
Andreas Mellegren — USA

14:45 - 15:00 **Bladder and sexual problems after treatment of CRC**
Søren Laurberg — Denmark

15:00 - 15:15 **Partial Resection of Denonvilliers' Fascia: Access to A Compromise Between Oncological Safety and Uro-sexual Co-Morbidity: How? and Why?**
Waleed Ghareeb — China

15:15 - 15:30 **Total mesocolic excision for right colectomy, the new concept**
Alaa Abduljabbar — KSA

15:30 - 15:45 **Controversy in management of obstructing colon cancer**
Ali ElShiwy — Egypt

15:45 - 16:00 **Cancer Cachexia & Myopenia- new directions in management"**
John Jenkis — London

Hall	Free Paper Session II	16:00
B		17:00

Chairperson (in alphabetical order)

Magdy Mahmoud
Mohamed Raslan
Osama Khalil

16:00 - 16:10 **Wireless pulse oximeter a simple intraoperative procedure to assess bowel viability**
Haitham Soliman — Egypt

16:10 - 16:20 **Erythrocyte Sedimentation Rate (ESR) and C Reactive Protein (CRP) are better predictors of colorectal anastomotic dehiscence than blood cell count indexes of systemic inflammation: a multinational study on 1,432 patients**
Abd Rabbo Mashhour — Egypt

16:20 - 16:30 **Intersphincteric Resection is the Optimal procedure for Very Low Rectal Cancer: Techniques, Morbidity, Oncologic and Functional Outcomes**
Ali Zidan — Egypt

16:30 - 16:40 **Comparison between ventral mesh rectopexy and POPS (Pelvic Organ Prolapse Suspension Surgery) in patients with rectal prolapse**
Mohamed Tamer — Egypt

16:40 - 16:50 **Reduced Port Laparoscopic Colectomy Versus Conventional Laparoscopic Colectomy for Colorectal Cancer: A Systematic review and Meta-Analysis**
Ali Mohamed Elameen — Egypt

16:50 - 17:00 **Forty-Eight Hours Hospital-Stay after Fast-Track Laparoscopic Colorectal Surgery: A Prospective Study**
Yasser Debaky — NCI

17:00 - 17:10 **Role of Endoanal Ultrasonography in Grading Anal Sphincter Integrity in Rectal Prolapse and in Predicting Improvement in the Continence State after Surgical Treatment.**
Sameh Hany Emile — Egypt

Hall	Free Paper Session I	16:00
Main Hall		17:00

Chairperson (in alphabetical order)

Abdel Fattah El Sheikh
Emad Salah
Mohamed Yehia
Sabry Badr

16:00 - 16:10 **Use of vulval flap to repair rectovaginal fistula after resection of low rectal cancer**
Medhat Khafagy — Egypt

16:10 - 16:20 **Low Anterior Resection Syndrome: Tertiary Centers Outcome**
Ahmed Aly Khalil — Egypt

16:20 - 16:30 **Enhanced Recovery Program Versus Traditional Postoperative Care for Elective Open Colorectal Cancer Surgery.**
Mohamed Ibrahim — Egypt

16:30 - 16:40 **Peritoneal carcinomatosis in colorectal cancer: Defining predictive factors for successful cytoreductive surgery and hyperthermic intraperitoneal chemotherapy – A pilot study**
Ahmed Mostafa — National Cancer Institute

16:40 - 16:50 **Novel Values of BRG1, SDF-1& Vinculin combined expression in neoplastic and adjacent non-neoplastic colonic mucosa of Colorectal Carcinoma (CRC) Patients. An Immunohistochemical Study**
Ola A. Harb — Egypt

16:50 - 17:00 **Case Presentation and Video Vignette Laparoscopic D3 TME-CME with central vascular ligation of middle rectal carcinoma**
Mahmoud Abdelnaby — Egypt

17:00 - 17:10 **Sohag university general surgery Center 5-year experience in colonic continuity restoration after Hartmann's procedure: a retrospective comparative study between open versus laparoscopic surgery**
Mostafa Farrag Mohammed — Egypt

Hall	IBD Controversies	17:10
Main Hall		18:00

Chairperson (in alphabetical order)

Ahmed Farag
Mohamed Amin Saleh
Nabil Dwidar
Osama Ebada

17:10 - 17:22 **IBD Medication: Promise or Poison? How much medical therapy is too much? Including Anti-Fibrotics for IBD**
Khaled Hamdy — Egypt

17:22 - 17:34 **Dysplasia and cancer: risk stratification & management Modern management of colitis-associated dysplasia – Chromo-endoscopy or Colectomy?**
Eslam Safwat — Egypt

17:34 - 17:46 **The Ileal Pouch Surgery J, S, & K pouch**
Sherief Shawky — USA

17:46 - 17:58 **Changing Indications for Surgery in Biologic Era? What Is the Added Morbidity and Can We Now Consider Pouches for Crohn's Disease?**
Tarek Youssef — Egypt

18:00-19:00 **Lunch**

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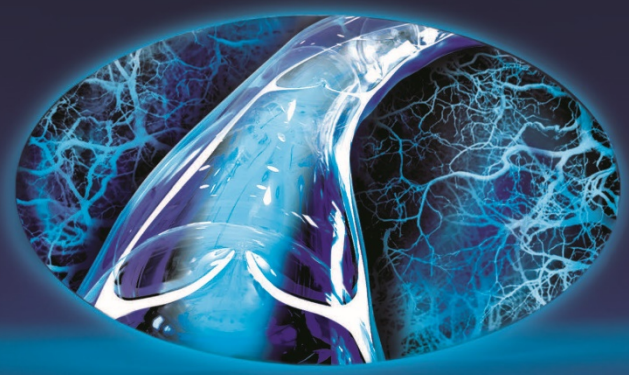

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***The illustration represents a vein and its valve*

1 - Pascarella L et al. Mechanisms in experimental venous valve failure and their modifications by Daflon 500 mg. *Eur J Vasc Endovasc Surg.* 2008;35:107-110. 2 - Nicolaides A et al. Management of chronic venous disorders of the lower limbs: guidelines according to scientific evidence. *Int Angiol.* 2014;33(2):126-139.

15 DN 5022 IA

Day 3

Hall	Anorectal	10:00
Main Hall		10:50

Chairperson (in alphabetical order)

Abd Rabbo Mashhour
Mohamed Mazloum
Mohamed Saad Ellibishi
Mohamed Ibrahim Anany

10:00 - 10:10 **The complex and refractory pilonidal**
Assem El Thani Egypt

10:10 - 10:20 **Flaps for rectovaginal Fistulas: Endorectal, Martius, Gracilis**
Hossam Elfeki Egypt

10:20 - 10:30 **Is recurrent anal fissure really recurrent?**
Mohamed Arnous Egypt

10:30 - 10:40 **Relapse or inadequate treatment for haemorrhoids**
Mohamed Fathi Egypt

10:40 - 10:50 **Do fistulas recur or persist? Tips and tricks for reoperative surgery**
Mostafa Shalaby Egypt

Hall	Controversies in the Management of Diverticulitis	10:50
Main Hall		11:35

Chairperson (in alphabetical order)

El Yamany Fouda
Khaled El Shaar
Waleed Omar

10:50 - 11:05 **Management of acute diverticulitis What to Do?**
Waleed El Shazly Egypt

11:05 - 11:20 **Follow-Up after Diverticulitis – When is a Colonoscopy Appropriate?**
Alaa Radwan Egypt

11:20 – 11:35 **Interval colectomy after acute diverticulitis**
El Yamany Fouda Egypt

11:35 - 13:00 **Coffee Break and Friday Prayer**

Hall	Key Note Lecture	13:00
Main Hall		13:30

Chairperson (in alphabetical order)

Essam Fakhery Ebied
Gamal Metwally
Wael Khafagy

13:00 - 13:15 Update in rectal cancer management
Hany Tawfik Egypt

13:15 - 13:30 Management of colorectal peritoneal metastasis with cytoreductive surgery and HIPEC
Wael Abdel Gawad Egypt

Hall	Free Paper Session (Benign Colorectal I)	13:30
B		14:40

Chairperson (in alphabetical order)

Mohamed Raslan
Tarek Youssef
Waleed Thabet

13:30 - 13:40 **Study of The Outcome of Staged Cutting Seton in Treatment of High Perianal Fistula**
Abd Elfattah Morsi Egypt

13:40 - 13:50 **Complete Mesocolic Excision and Central Vascular Ligation In Colon Cancer Surgery, Feasibility and Outcome**
Mohamed Ibrahim Egypt

13:50 - 14:00 **One stage fistulectomy for high anal fistula with reconstruction of anal sphincter without fecal diversion.**
Mohamed Yehia Egypt

14:00 - 14:10 **Ligation of the Intersphincteric Fistula Tract Procedure and its Modifications**
Mohammad Ahmad Abd-ElRazik Egypt

14:10 - 14:20 **Colovesical fistula: Surgical Protocol**
Ahmed Sabry Egypt

14:20 - 14:30 **Endoscopic Pilonidal Sinus Treatment: Long-Term Results of a Prospective Series**
Mostafa Shalaby Egypt

14:30 - 14:40 **Anorectal injuries: Management outcomes and prognostic factors**
Abdullah Atyah Ali Egypt

Hall	Free Paper Session (Benign Colorectal II)	13:30
Main Hall		14:40

Chairperson (in alphabetical order)

Abd Rabbo Mashhour
Essam Elsheikh
Mohamed Abou El Khir
Mohamed Yehia

13:30 - 13:40 **Surgical Treatment of Pilonidal Disease: Primary Excision and Closure versus Flap Reconstruction after Excision**
Mohamed Tag El-din Egypt

13:40 - 13:50 **Comparison between laparoscopic and open abdominal rectopexy for full-thickness rectal prolapse: controlled clinical trial**
Omar Abdelraheem Egypt

13:50 - 14:00 **Outcome of Modified Park Complex Anal Fistula**
Mohammed Elsaid Egypt

14:00 - 14:10 **Assessment of oral Meteronidazole in pain Management post Haemorrhoidectomy**
Sahar Mahmoud Nmr Egypt

14:10 - 14:20 **Abdominal Coccoon: report of two cases**
Doaa Ali Saad Egypt

14:20 - 14:30 **laparoscopic ventral mesh rectopexy (An Early experience) (video presentation)**
Mohammed Ezzat Algazar Egypt

14:30 - 14:40 **Efficacy of biofeedback in school age anal incontinence. Analysis of 150 patients with functional non-retentive fecal incontinence (FNRFI)**
Mohamed Ibrahim Abu Elnasr Egypt

14:40 - 16:00 **Lunch**

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ABSTRACS

Surgical treatment of pilonidal sinus:Different Flap Reconstruction Techniques

Mohamed Tag El-din Mohamed Sayed- *Qena General Hospital, Qena, Egypt*

Backgrounds: Pilonidal sinus is a common chronic disease of the sacrococcygeal region. Although many surgical methods have been described for treating pilonidal sinus disease, controversy still exists as to the best surgical technique. The aim of this prospective study is to compare between the outcomes of management of pilonidal sinuses by different reconstruction flap techniques (mainly Rhomboid flap Versus Oval flap).

Materials and methods: This study included 70 patients with pilonidal sinus who were treated at sohag university hospital and qena general hospital from January 2013 to December 2017. Patients with pilonidal sinus that were divided into 2 parallel groups; each of them included 35 patients. Group A was subjected to pilonidal excision and Rhomboid flap reconstruction, while group B was subjected to pilonidal sinus excision and Oval flap reconstruction. The collected results were statistically analyzed and the two groups were compared taking the following in consideration: duration of operative procedure (in minutes), postoperative complications (infection, flap edema, hematoma, seroma, and wound dehiscence), length of hospital stay (in days), duration of intolerability of work (in days), postoperative recurrence.

Results: Both groups showed excellent results regarding; Duration of surgical duration (in minutes) in-group A (mean 37.80±5.24) was similar operative time in-group B (mean 38.81±7.08). Postoperative complications as group A (4 patients develop wound infections 11.4%, 2 patients develop flap edema 5.7%, 1 patient develop hematoma 2.8%, 1 patient develop seroma 2.8%, 3 patients developed wound dehiscence 8.5%) noticed more postoperative complications than group B (3 patients develop wound infections 8.5%, 1 patients develop flap edema 2.8%, 2patients develop seroma 5.7%, 2patients develop wound dehiscence 5.7%). Length of hospital stay (in days) as group A (mean 3.65±1.13) was more hospital stay than group B (mean 2.35±0.75). Duration of intolerability of work (in days) as group A (mean 5.42±1.98) was similar time off work for group B (mean 5.76±2.03).As regard postoperative Recurrence in both groups only 1 patient from both groups had recurrence (from group A) =1.4% only. As regard wound healing there was good wound healing with both groups, also there was no wound disfigurement both groups.

Conclusions: Based on this study, it is clear that reconstruction flap techniques are preferred treatment of the pilonidal disease. The techniques can be mastered easily and provide an effective procedure for primary as well as recurrent pilonidal sinus disease with few complications and low recurrence rates.

Keyword: pilonidal sinus, surgical treatment, flap reconstruction, rhomboid flap, oval flap.

Surgical Treatment of Pilonidal Disease: Primary Excision and Closure versus Flap Reconstruction after Excision

Mohamed Tag El-din Mohamed Sayed- *Qena General Hospital, Qena, Egypt*

Backgrounds: Pilonidal sinus is a common chronic disease of the sacrococcygeal region. Although many surgical methods have been described for treating pilonidal sinus disease, controversy still exists as to the best surgical technique. The aim of this prospective study is to compare between the outcome of management of pilonidal sinuses by primary excision versus excision and reconstruction by flap.

Materials and methods: This study included 30 patients with pilonidal sinus who were treated at sohag university hospital from October 2013 to October 2014. Patients with pilonidal sinus that were divided into 2 parallel groups; each of them included 15 patients. Group A was subjected to pilonidal excision and local flaps reconstruction, while group B was subjected to pilonidal sinus excision followed by approximation of the subcutaneous tissue and skin (primary direct closure technique).

The collected results were statistically analyzed and the two groups were compared taking the following in consideration: duration of operative procedure (in minutes), postoperative complications (infection, flap edema, wound dehiscence), length of hospital stay (in days), duration of intolerability of work (in days), time of stitch removal (in days), postoperative recurrence

Results: Significant difference excited between both groups regarding; Duration of surgical duration (in minutes) as group A (mean 65.70±6.24) was longer operative time than group B (mean 37.81±7.08). Postoperative complications (infection, wound dehiscence and flap edema) as group B (6 patients develop wound infections 45%, 3 patients developed wound dehiscence 20%) noticed more postoperative complications than group A (4 patients develop wound infections 30%, 3patients develop wound dehiscence 20%, 1 patients develop flap edema 7.5%). Length of hospital stay (in days) as group A (mean 4.96±1.13) was more hospital stay than group B (mean 2.65±0.45). Duration of intolerability of work (in days) as group A (mean 17.82±2.98) was more time off work than group B (mean 14.97±3.03). As regard wound healing there was better wound healing with less keloid formation in-group A than in-group B, also there was no wound disfigurement in group A comparing to group B.

Conclusions: Based on this study, it is clear that wide excision with oval rotational flap technique is a preferred treatment of the disease. The technique can be mastered easily and provides an effective procedure for primary as well as recurrent pilonidal sinus disease with few complications.

Keyword: pilonidal sinus, flap reconstruction, primary excision, surgical treatment.

Outcome of Modified Park's Technique for Treatment of Complex Anal Fistula

Mohammed Elsaid - Mansoura University

Background: Treatment of complex anal fistula (CAF) can be associated with high rates of recurrence and fecal incontinence (FI). Park suggested drainage of the affected intersphincteric anal gland for treatment of cryptoglandular anal fistula; however, recurrence after this technique was high. We modified the original Park's technique by extending the internal sphincterotomy to ensure adequate drainage of the intersphincteric space. The aim of this study was to evaluate the incidence of recurrence and FI after modified Park's
technique in treatment of CAF.

Methods: Adult patients of both genders with CAF were evaluated before undergoing modified Park's technique with Wexner continence score, clinical examination, and endoanal ultrasonography or MRI. Postoperatively, patients were examined every 2 wk until complete wound healing. The continence state was evaluated with Wexner continence score, and quality of life was assessed before surgery and at 6 mo postoperatively by Short Forme36 questionnaire.

Results: Thirty-two patients (27 male) of a mean age of 38 y were included. Median followup
was 12 mo. Two patients (6.25%) experienced recurrence and 5 (15.6%) developed complications. One patient (3.1%) developed new-onset FI postoperatively. Twenty-eight (87.5%) patients were completely satisfied with the procedure. Quality of life showed significant improvement at 6 mo postoperatively.

Conclusions: The modified Park's technique is a promising procedure for the treatment of CAF with low recurrence and FI rates, and improved quality of life

Assessment of oral Meteronidazole in pain Management post Haemorrhoidectomy

Sahar Mahmoud Nmr - Damanhour National Medical Institute

Background: Haemorrhoids are a very popular disease. Approximately 50% to 66% of people have problems with haemorrhoids at some point in their lives. The pathophysiology of haemorrhoids is not

exactly well known. Theories were developed trying to understand the pathophysiology of haemorrhoids e.g., varicose vein theory, anal lining sliding theory, hyperactivity of internal sphincter theory and vascular hyperplasia theory. Diagnosis is made by integration of available clinical data (symptoms), clinical examination and investigations. Although, we are using the term to refer to the disease resulting from their congestion and swelling, it is hard to evaluate the exact prevalence of haemorrhoids in a certain community as a lot of people suffering from the condition don't seek for medical advice Objectives: This thesis study was done to assess the efficacy of oral metronidazole administration in management of post haemorrhoidectomy pain. Patients and

Method: This study was conducted at El Demerdash Hospital and Damanhour National Institute in 1/1/2018 to 30/6/2018. 80 patients presented to the General Surgery Clinic and met the inclusion criteria in six month duration. The participants were divided into two groups 40 in each group. Results: When the results of both groups were put in a comparison, it showed that group A had a significant lower pain values in day 1 and 3 than group B but both groups(p=0.043*,p= 0.004)results were equivocal in day seven with no significant difference(p=0.268). Also results showed that group B needed more analgesics than group A and that confirms that metronidazole do decrease pain experienced by the patients after the operation and decreased their need for analgesics(p=0.043). Otherwise, both groups show no significant differences according to the time of first bowel movement(p=0.967).

Conclusion: Oral Metronidazole administration post haemorrhoidectomy significantly decrease the postoperative pain and decrease the need for more analgesics with no significant effect on the time of the first bowel movement.

Key words: Haemorrhoidectomy, postoperative pain, metronidazole, analgesics

Abdomina Coccoon: Report of Tow Cases

Doaa Ali Saad - Minia University hospital

We report a male who presented with intestinal obstruction. At surgery the entire small bowel was found to be encased within a dense fibrous sac and the diagnosis of abdominal cocoon was made. The gut adhesions were lysed. Outcome was satisfactory

Introduction: Abdominal cocoon is a rare condition that refers to total or partial of the small bowel by a fibrocollagenous membrane or cocoon with local inflammatory infiltrate leading to acute or chronic bowel obstruction1. It was first described by Owtschinnikow in 1907 as "peritonitis chronica fibrosa incapsulata"2 and termed "abdominal cocoon" by Foo in 1978.2 The condition is acquired and the cause in usually unknown. Most cases are diagnosed incidentally at laparotomy3.

We present a rare case of a young male presenting with abdominal cocoon leading to recurrent intestinal obstruction.

Case report :A 57 year old male presented in the Surgery emergency with complaint of abdominal pain and distension and vomiting for the past 5 days. Patient gave past history of similar attacks 2 months back which was managed conservatively. Patient gave history of constipation since 5 days. Conservative management was done in the form of Ryle tube insertion, catheter, and intravenous fluids. The patient was heavy smoker. There was no history of diabetes mellitus or hypertension. Examination of the abdomen revealed tympanic resonant abdomen; central bulge; audible intestinal sounds and empty rectum on digital rectal examination.

Plain X-ray abdomen in the erect posture showed no significant dilated gut loops and no gas under the dome of diaphragm. U/S showed enlarged liver and moderate ascites, CT scan of the abdomen and pelvis revealed cirrhotic liver changes, ascites and left transverse and splenic flexure colonic wall thickening with proximal colonic dilatation. All Laboratory data were within normal ranges. Exploratory laparotomy through a mid-line incision was performed. It revealed cirrotic liver and a clear ascetic fluid which was aspirated for cytology. All small and large intestines were found to be covered by a dense white fibrous membrane [Fig 1], on opening the mass small gut coils were found to be encased inside, removal of the membrane from the intestine was easy, adhesiolysis was performed to release the gut loops. There was less involvement of the colon and stomack by the membrane, the intestinal content was drawn off into the colon. The white fibrous membrane pieces were sent for histopathology examination which revealed chronic nonspecific inflammation. Postoperative course was good, patient bowel movement was returned 24 hours later, pt allowed oral fluids after 24 hours, the drain was removed and patient discharged.

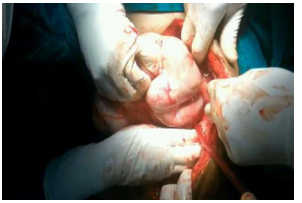

Fig. (1): dense fibrous membrane enclosing small and large intestine

Case no (2)
Female pt 45 year, come to our emergency unit by acute abdominal pain On abdominal examination she had rigid tender abdomen, abdominal ultrasonography showed no abnormality, plain x-ray abdomen and pelvis in erect position showed gaseous distention Exploration was done which revealed thin fibrous membrane include small intestine from duodenum to iloceacal junction (fig)

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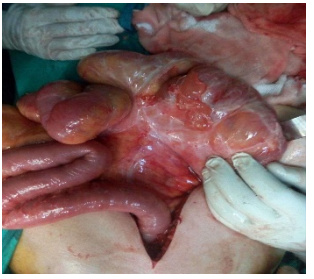
Female pt 45 year, come to our emergency unit by acute abdominal pain On abdominal examination she had rigid tender abdomen, abdominal ultrasonography showed no abnormality, plain x-ray abdomen and pelvis in erect position showed gaseous distention Exploration was done which revealed thin fibrous membrane include small intestine from duodenum to iloceacal junction (fig)



Adhesiolysis was done , the membrane was quite easily pealed from the intestine which was completely healthy , other abdominal organs showe no abnormakity apart from inflamed appendix so appendectomy was done The membrane and the appendix were sent for histopathological examination; which reavealed thick fibrotic stromal tissue surrounding lobules of necrotic fat cells and choronic appendicitis with no malignancy. Postoperatively; the bowel movement retained the second postoperative day; AOF, low grade fever , but the patient give small intestinal contents , charcool test was positive. Conservative management of the intestinal fistula was adopted and the patient was good discharged after that

laparoscopic ventral mesh rectopexy (An Early experience) (video presentation)

Mohammed Ezzat Algazar - Zagazig University

introduction: According to ASCRS guidelines for the Treatment of Rectal Prolapse rectal prolapse cannot be corrected nonoperatively. ventral mesh rectopexy is an acceptable option for operative management of complete rectal prolapse.

Aim of the study: assessment of short term outcome of laparoscopic ventral mesh rectopexy

patients and methods: our study started at August 2017 till now, included 5 cases of complete

rectal prolapse, with no preoperative functional disorders like constipation or incontinence. The study includes 3 males and 2 females with age range from 16 -45 years.
all cases subjected to laparoscopic ventral mesh rectopexy
Results: The mean operative time was 96 min (85-110 min) .no intraoperative complications nor conversion .follow up showed no recurrence till now nor mesh related complications. With acceptable patient satisfaction and better quality of life.Conclusion: ventral mesh rectopexy is an acceptable option for management of rectal prolapse in short term outcome results.

Role of Endoanal Ultrasonography in Grading Anal Sphincter Integrity in Rectal Prolapse and in Predicting Improvement in the Continence State after Surgical Treatment.

Sameh Hany Emile - Mansoura University

Background: Rectal prolapse can be associated with fecal incontinence (FI) that may not completely resolve after surgical treatment. We aimed to examine the utility of endoanal ultrasonography (EAUS) in identifying pattern of anal sphincter affection in rectal prolapse and in predicting the improvement in continence state after surgical treatment.
Methods: Records of patients of rectal prolapse who underwent surgical treatment and were evaluated with EAUS before surgery were screened. According to the degree of anal sphincter affection in preoperative EAUS, four grades of anal sphincter affection were recognized (0-III). The preoperative patient characteristics and outcome of surgery in each group were compared. Results: Fifty-nine patients (33 male) of a mean age of 36.2 years were included to the study. Forty-four (74.5%) patients complained of FI preoperatively. There were 12 (20.3%) patients with grade 0 affection, 29 (49.1%) with grade I, 7 (11.8%) with grade II, and 11 (18.6%) with grade III. Patients with grade III presented more with external rectal prolapse, had significantly longer duration of symptoms, and had underwent previous surgery for rectal prolapse significantly more than the other three grades. Patients with grade II and grade III anal sphincter affection had significantly higher incontinence scores and lower anal pressures than patients grade 0 and grade I.
Conclusion: Preoperative EAUS is a useful tool for assessment of anal sphincter affection in patients with rectal prolapse and for predicting improvement in FI after surgical treatment as higher grades of sphincter affection were associated with less continence improvement than lower grades.

Efficacy of biofeedback in school age anal incontinence. Analysis of 150 patient with functional non-retentive fecal incontinence (FNRFI)

Mohamed Ibrahim Mohamed Abu Elnasr - Benha University hospital

Background: Functional non retentive fecal incontinence (FNRFI) is an entity of fecal incontinence that is defined according Rome III classification as fecal incontinence in a child with mental age more than 4 years with no evidence of metabolic, inflammatory or anatomical cause. It is psychologically frustrating shameful problem with bad impact on children.
Aim of this study is to evaluate early and late impact of Biofeedback therapy as a treatment of FNRFI.
Methodology: The current study included 150 patients with mean age of 10±3 years with FNRFI who are eligible for biofeedback therapy that was designed for 3 months. Anorectal manometric findings were recorded before and after treatment. Vaizey incontinence score was recorded and compared with baseline patient's score.
Results: According to our schedule of biofeedback therapy there was significant improvement in the mean squeeze pressure from 97±15 mmHg to 169±26 mmHg with significant improvement of incontinence score (Vaizey score) from 6-20 to 0-6 before and after biofeedback therapy respectively.

There was also a significant improvement of rectal sensation and compliance after biofeedback therapy.
Conclusion: Biofeedback is a reliable, easy, noninvasive, fast and effective method for treatment of FNRFI with satisfactory early outcome.
Keywords: fecal incontinence, Biofeedback, Anorectal manometry

Comparison between laparoscopic and open abdominal rectopexy for full-thickness rectal prolapse: controlled clinical trial

Omar Abdelraheem - Sohag University
Background: Abdominal rectopexy is an appropriate treatment option for full-thickness rectal prolapse (FTRP). Our aim is to evaluate the effectiveness and surgical outcome of laparoscopic posterior mesh rectopexy in treatment of FTRP by comparing this procedure with the traditional open approach.
Methods: Thirty consecutive cases with FTRP were included and subjected to abdominal posterior mesh rectopexy from September 2013 to February 2016 at Sohag University Hospital. Thirteen patients were managed laparoscopically and 17 patients underwent open posterior mesh repair. Demographic data and surgical outcome were compared in both groups.
Results: Laparoscopic group showed an earlier tolerance to oral feeding (1.26±0.42 versus 2.16±1.36 days, p=0.03), and earlier hospital discharge and return to work (5.63±2.91 versus 8.24±4.64 days, p=0.016, 18.28±2.61 versus 28.64±3.82 days, p=0.032, respectively). The mean consumed postoperative analgesics per day was less among laparoscopic group (1.63±16.2 versus 2.68±34.21 ampoule/day, p=0.012). Incidence of wound infection, wound dehiscence, prolonged ileus and postoperative chest infection were more in open group. There were significant postoperative improvement of continence status, rectal bleeding and abdominal pain in each group. Incidence of postoperative constipation was slightly increased in both groups, but without significant difference. Recurrence occurred in one case only in open group. There were no mortalities in both groups.
Conclusion: Laparoscopic posterior mesh rectopexy for FTRP can be done safely even in elderly patients. It offers less postoperative pain, low incidence of postoperative morbidities, early hospital discharge and return to work, in addition to cosmetically better outcome. Laparoscopic rectopexy has the same functional outcome as open technique.
Keywords: Laparoscopy, Rectopexy, Transabdominal

Comparison between ventral mesh rectopexy and POPS (Pelvic Organ Prolapse Suspension Surgery) in patients with rectal prolapse

Mohamed Tamer - Cairo University
Aim of the study: Comparison between ventral mesh rectopexy and POPS (Pelvic Organ Prolapse Suspension Surgery) in patients with rectal prolapse regarding the efficacy in treatment of rectal prolapse and associated symptoms including anal incontinence and constipation, recurrence of prolapse, operative time, hospital stay and post-operative pain.
Methods: Prospective study on 60 female patients with complete rectal prolapse divided into two equal groups, 30 patients had ventral mesh rectopexy and the other 30 had POPS as a surgical treatment for complete rectal prolapse. The results of the 2 samples had been compared 6 months postoperatively regarding, operative time, post-operative pain, hospital stay, complications of surgery including recurrence of the rectal prolapse, the efficacy of each procedure in treatment of rectal prolapse and associated symptoms including constipation and anal incontinence.

Results: The patients were assessed 6 months postoperatively and their continence and constipation score postoperatively were assessed using Wexner and Farag score. There was no significant
difference regarding hospital stay and postoperative pain. Operative time was significantly less in POPS compared to Ventral mesh Rectopexy (mean 20 minutes in POPS vs 54 minutes in rectopexy). Ventral mesh rectopexy showed much more improvement subjectively according to constipation and continence scores (mean improvement of Wexner constipation score by 20% and incontinence score by 14% compared to POPS where mean improvement in constipation and in continence scores was 15 %, 4.35 % respectively). ventral mesh rectopexy showed less complications compared to POPS. (complications with Rectopexy happened only with 3 patients compared to POPS which happened to 14 patients), 1 case of recurrence in rectopexy group compared to 3 cases of recurrence in POPS.
Conclusion: Although ventral mesh rectopexy had good outcomes regarding anatomical repair, symptomatic treatment and had less complications, results are still statistically insignificant compared with the newly developed technique POPS which is easier and less technically demanding than ventral mesh rectopexy.
Key words: (POPS, Ventral mesh rectopexy, Rectal prolapse).

One stage fistulectomy for high anal fistula with reconstruction of anal sphincter without feca diversion.
Mohamed Yehia - Cairo University
Background and Aims: Perianal sepsis and fistula is a troublesome disease in the field of colorectal surgery in term of recurrence and fecal incontinence. The aim of our study is to evaluate the role of 'one stage complex anal fistula excision with reconstruction of anal sphincter without stool diversion' regarding fecal incontinence and recurrence.
Methods: This was prospective cohort study on 175 patients of complex high peri-anal fistulae, the patients were subjected to fistulectomy and reconstruction (primary suture repair) of anal sphincter without stool diversion. The patients were followed up 1 year postoperatively after complete healing of the wound regarding their continence to stool and gases using Wexner score and recurrence of the fistula which is examined clinically and radio-logically using MRI.
Results: Among the 175 patients only four had developed fecal incontinence with varying degrees in which 2 patients developed gas incontinence and 2 patients developed soiling. After 3 months 8 patients had recurrence and after 6-9 months 6 patients developed recurrence . Also at the end of follow up period upon performing the confirmatory MRI, 2 patients showed hidden fistulous tracts ending into a high abscess cavity. This ends up into total of 16 recurrent cases. Five patients experienced delayed wound healing.
Conclusion: Compared to other treatment modalities for complex anal fistula found in literature, it had been found that one stage surgery (fistulectomy with primary sphincter repair) has good results regarding healing of the fistula with low risk of incontinence, low recurrence rate and good wound healing.
Keywords: Perianal fistula; Trans-sphincteric fistula, fistulectomy; sphincter repair; sphinctroplasty

Use of vulval flap to repair rectovaginal fistula after resection of low rectal cancer

Medhat Khafagy - National Cancer Institute, Cairo University

Two patients underwent repair of rectovaginal fistula by a left vulval flap. Their age was 52 and 67 years. The fistula occurred about 10 days after intershicteric resection for low rectal cancer. Both received preoperative radiochemotherapy before resection for rectal cancer. The fistula was repaired by two layers, 1st layer closing the Vagina with tissues around it vertically and second layer with a rotational flap from left vulva.Sutures were done with interrupted 3/0 PDS. Post operative course was uneventful.

Conclusion: Rectovaginal fistula could be repaired primary without diversion of stools before operation with such technique

Ligation of the Intersphincteric Fistula Tract Procedure and its Modifications

Mohammad Ahmad Abd-erRazik Awad-Allah - Ain-Shams University

Purpose: Treatment of anal fistulae is regarded as a challenge due to the diverse nature of this disease and its countless complications. Ligation of the intersphincteric fistula tract procedure and its modifications have been popularized among many surgeons worldwide due to their simplicity and promising outcomes. The main purpose of this article was to conduct a comprehensives review of the published literature on ligation of the intersphincteric fistula tract procedure and its modifications.

Method: , the Cochrane database and Ovid were searched from January 2007 to June 2017. Fully published peer-reviewed studies which applied ligation of the intersphincteric fistula tract procedure and its modifications for the treatment of anal fistulae of cryptogenic origin with follow-up of median 12 months were eligible. Uncompleted studies, case reports, reviews, abstracts, letters, short communication, comments, and studies which did not fulfill inclusion criteria were excluded. The primary outcome was to measure primary healing, overall healing, failure, and recurrence of ligation of the intersphincteric fistula tract procedure and its modifications.

Results: Twenty-two studies were identified with only ten studies meeting criteria of inclusion. Original ligation of the intersphincteric fistula tract was performed in five studies with a population of 199 patients while the remaining five studies showed four different modifications of the ligation of the intersphincteric fistula tract with a total number of 147 patients. Both original LIFT and its modifications have promising as well as potentially similar outcomes; primary healing in the original ligation of the intersphincteric fistula tract (73.95%) (95% CI 60.3-85.6) performed less than the modifications (82.3%) (95% CI 64.8-94.7). Overall healing in the original ligation of the intersphincteric fistula tract (78.9%) (95% CI 58.5-93.7) performed relatively less than in the modifications (93.6%) (95% CI 81.4-99.6). Failure in the original ligation of the intersphincteric fistula tract (17.9%) (95% CI 4.9-36.5) performed almost the same as the modifications (17.7%) (95% CI 5.3-35.2). Recurrence in the original ligation of the intersphincteric fistula tract was 9.7% (95% CI 1.7-23.2). However, there was no recurrence in the modifications.

Conclusion: Ligation of the intersphincteric fistula tract and its modifications are effective and simple procedures in treating simple anal fistulae, especially high transsphincteric ones. However, more trials should be performed to evaluate its effectiveness regarding complex fistulae.

Colovesical fistula: Surgical Protocol

Ahmed Sabry - Alexandria Faculty of Medicine

Background: Diverticular disease of sigmoid colon can rarely be complicated by a connective track to urinary bladder. Pneumaturia and fecaluria are the pathognomonic symptoms. Resection surgery is

the preferred treatment to overcome the renal sequellae of the disease. The purpose of this study is to propose a guiding classification to help general surgeons during surgical management of diverticular disease complicated by sigmoidovesical fistula (SVF).

Patients and methods: The data of 40 cases with colovesical fistula due to diverticular disease of sigmoid colon were retrospectively analyzed. Clinicopathological variables, imaging reports, types of treatment and patient outcome were evaluated.

Results: There were 36 men (90%) and four women (10%) in which the ages ranged from 32 to 79 with a mean of 58.1 years. Pneumaturia was the most common presenting symptom in 38 cases (95%) followed by urinary symptoms in 35 cases (87.5%) then fecaluria in 33 cases (82.5%). 37 patients underwent surgical resection while three patients were in poor general condition to withstand major resection. 16 patients underwent one stage resection and anastomosis, 16 patients were managed by two stage procedure and the remaining 5 patients were treated by three stages operation.

Conclusions: Adequately performed CT followed by colonoscopy is the mainstay for diagnosis. Type 1 SVF should be treated in a single stage by complete resection and immediate anastomosis without a stoma. Type 2 cases are best managed in two stages while those with type 3 SVF are emergently managed by three stage procedure. Treatment of type 4 should be individualized.

Keywords: Diverticular disease Left colon Colovesical fistula

Endoscopic Pilonidal Sinus Treatment: Long-Term Results of a Prospective Series

Mostafa Shalaby - Mansoura University

Background and Objectives: Pilonidal sinus is a common problem in the sacrococcygeal region, especially in obese, sedentary young men. The ideal surgical solution is still under debate, and there is a high rate of recurrence. In the present study, we analyzed the long-term results of a video-assisted minimally invasive technique for the treatment of sacrococcygeal pilonidal disease: endoscopic pilonidal sinus treatment (EPSiT).

Methods: From October 2013 through November 2015, a total of 77 consecutive patients (69 Males and 8 Females, median age: 23 y) were referred to our colorectal units. Sixty-eight patients had a primary sacrococcygeal pilonidal sinus, and 9 had recurrent pilonidal sinus; all underwent EPSiT. A fistuloscope was introduced through an external opening and the sinus cavity was completely ablated under direct vision. Postoperative complications, wound infection rate, recurrence rate, time until return to work, and patient satisfaction score were recorded during follow-up or at the last interview. Clinical data were obtained at 7, 15, and 30 days and at 6, 12, and 24 months after surgery.

Results: All patients completed the follow-up (median follow-up was 25 (range, 17–40) months. Median operative time was 18 (range, 12–30) minutes. The median hospital stay was 6.5 (range, 5–9) hours, and the median time to return to work was 5 days. Median healing time was 26 (range, 15–45) days. There were no major or minor complications. Six patients experienced recurrence. The overall satisfaction rate was 97%.

Conclusions: The ideal surgical treatment for pilonidal sinus disease should be simple and effective. In our experience, EPSiT can be performed as a day surgery, with early return to daily activities. This technique is an uneventful procedure, with good aesthetic results and a low recurrence rate.

Key Words: Endoscopic pilonidal sinus treatment, Minimally invasive surgery, Pilonidal sinus disease

Anorectal injuries: Management outcomes and prognostic factors

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Introduction: Injuries to the anus and rectum are common surgical problems. They result from wide variety of iatrogenic and accidental mechanisms. There is evidence-based discussion regarding elective fecal diversion, delayed versus primary repair, overlapping versus direct muscle end apposition, the need for bowel confinement, and the use of an artificial bowel sphincter in cases of anal sphincter trauma but still debatable.

Methods: This is a prospective descriptive study that includes 32 patients of different age group who were admitted at Sohag University Hospital with anorectal injury. Study was done over the period between October 2016 and October 2017, with at least three months of follow-up after the date of admission to the hospital.

Results: There were 12 girls and 20 boys with ages ranging between neonate 0.05 year (20 days) and 55 years (mean 23.03 years). The mechanism of injury was variable and associated injuries were common. 21 cases were extraperitoneal, 9 cases were intraperitoneal, while 2 cases were extra and intra peritoneal. There were multiple modes of injuries. A total of 32 cases, 6 cases were with rectal hematoma, and small anal injuries and treated by conservation and follow up with no surgical intervention, 16 cases repair of anal sphincter and anal wound was done, 4 cases repair of anal wound only, 2 cases repair of rectal injury, 2 cases repair of serosal tear, and 2 cases closure of distal rectal stump. 32/22 cases, repair with no fecal diversion, 32/10 repair was done with fecal diversion. Follow up period ranging was about 3 weeks in all cases. Complete healing and fecal continence was preserved in 26 patients, wound infection and fecal incontinence developed in 5 patients, and there was one mortality due to polytraumatized patient.

Conclusions: Primary repair of the perineal wound and anal sphincters can be performed safely in most cases given hemodynamic stability. Fecal diversion should be saved for cases with severe perineal involvement or cases with substantial associated injuries and concern of gross contamination.

Keywords: Anorectal injury. Anal sphincter repair. Perineal injury. Rectal trauma

Vestibular Fistula, Multiple Approaches

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Introduction: Different operative techniques are using for repair of a vestibular fistula which constitutes many challenges to a pediatric surgeon. Herein, we compare four different techniques regarding postoperative complication, continence and, cosmetic appearance.

Patients and methods: It is a prospective comparative study did on Upper Egyptians female children with vestibular fistula during the period from January 2016 to January 2019. A female child with rectovaginal fistula or imperforate anus without fistula or double anus include vestibular one were excluded from the study. Operative interventions were done using TSARP, classic ASARP, ASARP with external sphincter preservation and PSARP techniques.

Results: Total number of cases was 84 cases. The incidence of vestibular fistula among all admitted cases was 2.27%, while the incidence of vestibular fistula among anorectal malformation was 10.7%. The P-value for Perineal scarring was 0.028 with the lowest percentage for the TSARP group. The P-value for constipation was 0.022, while P- value for voluntary bowel control was 0.032 higher with **TSARP and Modified:** ASARP groups.

Conclusion: TSARP is the best choice operative technique for vestibular fistula and it's suitable for infants and adults. We can see the external muscle sphincter after complete dissection of the rectum in TSARP technique without the need of midline skin incision in modified ASARP.