

Chicago Colorectal Symposium 2024

Providing Continuing Medical Education Programs

Saturday, March 16, 2024



The 12th Annual Chicago Colorectal Symposium

2024 Program

The Chicago Colorectal Symposium is designed for general and colorectal surgeons and residents. This program offers both didactic and hands-on courses and is particularly helpful for the practicing surgeon in need of concise state of the art information and Continuing Medical Education credits. Affiliated staff and students are also encouraged to attend.

Course Directors:

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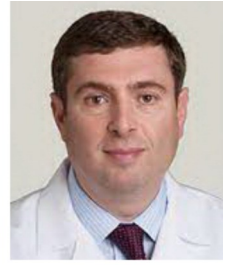
Anders Mellgren, MD, PhD
University of Illinois-Chicago

Loyola University Medical Center designates this live activity
for a maximum of 6.5 AMA PRA Category 1 Credits

ChicagoColorectalSymposium.com

Welcome

Welcome new and returning participants to the 12th Annual Chicago Colorectal Symposium! The Symposium is the only Chicago area educational event specifically focused on colon and rectal surgery. We are excited to be back in person again this year. Now in its twelfth year, the program continues to grow and evolve in exciting ways.



We endeavor to include current cutting edge topics within colorectal surgery each year. While the faculty remain primarily from the Chicago area, we have selected several

prominent national speakers to share their expertise. This year's Herand Abcarian Lecturer will be Peter Marcello, MD, from the Lahey Clinic in Boston. His address is entitled, "Advanced endoscopic resection: The time is NOW!" The ASCRS Presidential Lecture will be presented by current president Matthew Mutch, MD from Washington University in St. Louis and is entitled, "OR Ergonomics: Surgeon injury and longevity."

Please visit the exhibition hall throughout the day. The posters selected for the research competition will be displayed here. The winners will be announced at the end of the day and will receive monetary awards. We have invited select industry partners to share their latest technology, medications and procedures relevant to colorectal surgery. These partnerships are essential for the success of the Symposium; therefore, we encourage everyone to explore the exhibits.

Stick around until the end of the afternoon for the annual reception with the faculty. This is a perfect opportunity to network with the speakers, colleagues, residents and students and staff, and to learn about the colorectal programs in Chicago. We invite all participants to join us for this relaxing way to end the day.

We hope you enjoy the program and thank you for attending the 12th Annual Chicago Colorectal Symposium.

Marc Singer, MD

Konstantin Umanskiy, MD

Anders Mellgren, MD, PhD

Bruce Orkin, MD



12th Annual Chicago Colorectal Symposium March 16, 2024

The CHICAGO COLORECTAL SYMPOSIUM is designed for general and colorectal surgeons. This program offers both didactic and hands-on courses and is particularly helpful for the practicing surgeon in need of concise state of the art information and Continuing Medical Education. Affiliated staff, residents and students are encouraged to attend.

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We would like to thank our sponsors
for their generous support of this program



Platinum Level

ETHICON

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Please visit the displays in the exhibit hall

Continuing Medical Education Overview

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Loyola University Chicago Stritch School of Medicine and the Chicago Colorectal Symposium. The Loyola University Chicago Stritch School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

The Loyola University Chicago Stritch School of Medicine designates this live activity for a maximum of 6.5 AMA PRA Category 1 Credit(s)[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

ANCC Credit Designation – Nurses. The maximum number of hours awarded for this CE activity is 6.5 contact hours.

Learning Objectives

1. Discuss recent innovations and developments in the treatment of colon and rectal cancer including minimally invasive techniques.
2. Incorporate appropriate workup and evaluation of pelvic floor disorders including multidisciplinary treatment.
3. Incorporate latest surgical techniques into practice.

Disclosures

Please see the complete list of disclosures for the course directors and faculty in in the faculty list.

Claim Your CME/ANCC Credit

To claim Continuing Education Credit, attendees must:

- Attend the entire session
- Complete the evaluation form online at <https://www.surveymonkey.com/r/CX7TYPM> or scan the QR link.
- If you are registered with CME Tracker, a certificate will be generated for download. If you do not have or wish to create a CME Tracker account, the certificate will be sent to you.



Agenda

7:30 - 8:00 am Breakfast and Registration

8:00 - 8:15 am Opening Remarks

:: Marc Singer, MD, Konstantin Umanskiy, MD,
Bruce Orkin, MD, Anders Mellgren, MD

Morning Session I: Colorectal Neoplasia

Moderators - Konstantin Umanskiy, MD; Robert Yu, MD

8:15 - 8:30 am Evolving screening and early-onset colon cancer.

:: Keith Naylor, MD

8:30 - 8:45 am Personalizing adjuvant therapy - Immunotherapy and genetic profiling

:: Blase Polite, MD

8:45 - 9:00 am Can we predict cancer recurrence? Is ctDNA the answer?

:: Joga Ivatury, MD MHA

9:00 - 9:15 am The National Accreditation Program for Rectal Cancer (NAPRC)
- Will it lead to improved patient outcomes?

:: Jan Kaminski, MD



Herand Abcarian, MD Honorary Lecture

9:15 - 9:45

Advanced endoscopic resections:

The time is NOW!

Peter Marcello, MD

Chair, Division of Colon & Rectal Surgery
Lahey Clinic, Burlington, MA



Introduction - Anders Mellgren, MD

9:45 - 10:15 am Panel Discussion

10:15 - 11:00 am

Morning Refreshment Break

Visit industry displays & review research posters

Morning Session II: Pelvic Floor and Anorectal Disorders

Moderators - Anders Mellgren, MD; Mohammad Abbas, MD

11:00 - 11:15 am

The value of physical therapy in patients with pelvic floor problems

:: Heather Moky, DPT

11:15 - 11:30 am

Multicompartment prolapse: Is ventral rectopexy the answer?

:: Liliana Bordeianou, MD

11:30 - 11:45 am

Anal Cancer Screening and Prevention: Who benefits?

:: Gerald Gantt, MD

11:45 - 12:00 am

Setons for life - Are long term setons safe and effective?

:: Kinga Olortegui, MD

12:00 - 12:30 am

Panel Discussion

12:30 am - 1:15 pm Lunch in the Exhibit Hall/Poster Viewing



ASCRS Presidential Lecture

1:15 - 1:45 pm

OR Ergonomics:

Surgeon injury and longevity

Matthew Mutch, MD

President, American Society of Colon and Rectal Surgeons
Chief, Section of Colon and Rectal Surgery
Washington University, St. Louis, MO

Introduction - Bruce Orkin, MD

Afternoon Session I: Special Presentations

Moderators - Bruce Orkin, MD; Jeremy Sugrue, MD

1:45 - 2:00 pm The Emperor's New Clothes - Does the pouch really improve patients' QOL?

:: Scott Strong, MD

2:00 - 2:15 pm How do you become an expert robotic surgeon?

:: Robert Cleary, MD

2:15 - 2:30 pm Best of the Best - top papers of 2023

:: Michael McGee, MD

Rectal Cancer Debate

Moderators - Marc Singer, MD; Marissa Anderson, MD

2:30 - 3:00 pm **Surgery for low rectal cancer—LAR vs APR in the era of TNT**

:: Anders Mellgren, MD vs Konstantin Umanskiy, MD

3:00 - 3:30 pm

Afternoon Refreshment Break

Visit industry displays & review research posters

CONSULTANTS CORNER

3:30 - 4:15 Moderator - John Park, MD

Panelists: Matthew Mutch, MD, Peter Marcello, MD,

Liliana Bordeianou, MD, Virginia Shaffer, MD, Robert Cleary, MD

4:15 - 4:25 pm **Poster Competition Awards**

Chair - David Stewart, MD

Committee - John Konen, MD; Mohamad Abdulhai, MD;

Sriram Rangarajan, MD

4:25 - 4:30 pm **Concluding Remarks**

Reception with Faculty

4:30 - 5:30 pm — Drinks and Appetizers

Symposium Faculty 2024

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Special thanks to Ethel Seltzer

The course directors would like to acknowledge the outstanding work and tireless support provided by Ethel Seltzer, our administrator and event planner.

Faculty



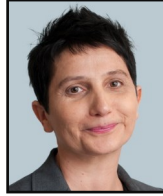
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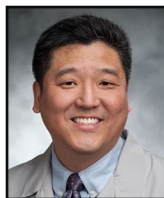
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CCRS Abstract 2024-1

Factors associated with laparoscopic and robotic conversions after abdominoperineal resection

A Mishra, N Bartschat, D Thompson, HA Lanewalla, L Weaver, A Troester, P Goffredo, I Hassan
University of Iowa

Background: Abdominoperineal resection (APR) is the treatment of choice for patients with rectal cancers (RC) ineligible for sphincter preservation. Laparoscopic (lap) and robotic (rob) APRs have been found to be technically feasible, however conversion to open may be required. We evaluated the factors associated with conversion and associated outcomes utilizing the American College of Surgeons National Surgical Quality Improvement Program (ACS-NSQIP) targeted proctectomy dataset.

Methods: Using the CPT code 45395, the database was queried for patients undergoing APR from 2016 - 2020 for cancer. Patients with an approach identified as lap-, rob- and lap- or rob- converted to open were included. Univariate and multivariate, stepwise logistic regression analyses were used.

Results: A cohort of 1,229 (17% conversion) laparoscopic and 1,088 (5.5% conversion) robotic patients was analyzed. Obesity and advanced pathologic tumor stage were independently associated with increased risk of conversion. (Table) Positive Circumferential margin (CRM) was not different after lap-conversion (13% vs 9% ($p=0.08$)) but higher after rob-conversion (20% vs. 10% ($p=0.02$)). On regression analysis lap-conversion was associated with increased risk of complications (OR 1.7; 95% CI 1.1-2.7) along with patients' functional status and ASA >3. An increased BMI was independently associated with risk of complications (BMI 35-40 (OR: 2.4, 95% CI 1.4-3.9) and > 40 (OR: 2.8, 95% CI 1.5-5.1) after rob- conversions.

Conclusion: Due to a potential selection bias there may be differences in the factors associated with conversion after lap- and rob- APRs. However regardless of approach, obesity is a significant risk factor for perioperative morbidity.

Table - Multivariable analysis of factors conversion to open.					
Variable	Referent	Laparoscopic		Robotic	
		OR	95% CI	OR	95% CI
BMI 30-35	BMI < 30	2.18	1.33-3.56	1.53	0.64-3.66
BMI 35-40	BMI < 30	3.41	1.76-6.63	2.77	0.96-7.97
BMI > 40	BMI < 30	3.39	1.51-7.61	7.03	2.81-17.61
Bleeding Disorder	No bleed.	2.76	1.05-7.30	4.51	1.22-16.68
Wound Class >3	Wound < 3	2.78	1.72-4.49	NS	NS
(y)pT3-T4 Stage	(y)pTis-(y) pT2	1.71	1.13-2.60	2.51	1.22-5.16
Neoadj. CRT	No CRT	NS	NS	0.78	0.40-1.51

NS - Not significant on univariate analysis
p < 0.05 for variables in bold text

CCRS Abstract 2024-2

The Impact of Limited English Proficiency on Perianal Fistula Treatment

M Zafar, MH Zafar, MA Roja, A Mellgren, MA Abdulhai, V Chaudhry, G Gantt, EM Bianchi, A Perez-Tamayo
University of Illinois Chicago

Background: Limited English Proficiency (LEP) can be a barrier between patients and their healthcare providers. Approximately, 8 percent (25.1 million people) in The United States, do not speak English as their primary language. In this study, we aimed to evaluate the impact of LEP in patients being treated for perianal fistula.

Methods: Retrospective review of patients undergoing surgical treatment for perianal fistula 2015-2020 at two large tertiary referral centers was performed. Patients who required an interpreter or preferred a language other than English were considered LEP. These patients were then matched with English proficient (EP) patients based on the complexity of the fistula and the surgical procedure used for definitive treatment. Variables evaluated included average length of post-operative follow up, time duration from seton placement till definitive repair, time duration from fistula diagnosis till definitive repair and the total number of surgical procedures performed. Patients who failed to complete their visits as recommended by their physician were considered lost to follow up.

Results: A total of 77 LEP patients were treated for perianal fistula, 25 of whom had complex fistulas. These patients were matched with 77 EP patients and both groups had similar mean age and mean BMI. Both groups had 57 patients who received definitive surgical repair. The median length of postoperative follow up for LEP patients with simple fistula was significantly less than EP

patients with simple fistula (60 days vs 127 days, $p=0.001$) which was a trend seen in complex fistula disease as well. There was no difference in lost to follow up of patients in either fistula groups (simple 42% vs 56%, $p=0.65$; complex 56% vs 64%, $p=0.34$). Time interval between fistula diagnosis and definitive repair as well as the duration between seton placement and definitive repair were not significantly different among the study populations. Similarly, neither group displayed any significant difference in the total number of surgical procedures performed for perianal fistula repair.

Conclusion: Many studies have been conducted to demonstrate the effect of LEP in healthcare. Most of them have stressed upon the delays and quality of medical care received by LEP patients. However, our results demonstrated similar surgical outcomes in LEP patients when compared to EP patients. This may be a result of providing patient instructions in the appropriate language and enhanced use of professional interpreters when treating the LEP patient population. Language is an integral component of culture and allows healthcare professionals to establish mutual trust and respect with their patients. Providing culturally competent care can mitigate potential disparities in the management of anal fistula patients.

CCRS Abstract 2024-3

Contrast enema imaging provides vital information prior to loop ileostomy reversal surgery

A O'Connor, S Sabri, S Ullah

Department of General Surgery, Tameside General Hospital, Manchester, United Kingdom

Background: Conflicting data exists on the utility of water-soluble contrast enema (WSCE) usage prior to reversal of ileostomies after anterior resection cancer surgery. Many studies suggest surgeons should use this modality selectively in males or those who received neo-adjuvant treatment. At the author's hospital, we routinely request WSCE prior to ileostomy reversal surgery but they are uncomfortable and time-consuming procedures. This study aimed to assess their utility and whether they provide pertinent information for operating surgeons.

Methods: This retrospective cohort study collected data on all WSCEs performed on oncological anterior resection patients between January 2021 and January 2023. Standard demographics were recorded alongside WSCE formal

reports. Flexible sigmoidoscopy reports that had assessed the rectum were also reviewed and the findings noted. Specific data was analysed regarding presence of leak or stricture on WSCE reports and endoscopy reports respectively.

Results: 31 WSCEs were performed over the time period. 2 WSCE revealed anastomotic leak and one of the leaks (50%) had already been diagnosed on clinical and CT grounds beforehand. 3 WSCEs showed anastomotic stricture and 2 of those (66%) were already detected via rigid sigmoidoscopy in the clinical setting. 29 patients (93%) had successful ileostomy reversal.

Conclusions: 40% of patients had positive WSCE studies without overt clinical signs. Thus they still provide an important role in the context of surgical planning and allow detection of complications prior to ileostomy reversal.

CCRS Abstract 2004-4

Bridging The Gap: The Impact Of Spanish-speaking Providers On Follow-up Adherence In Pelvic Floor Therapy For LEP Patients:

N Sweis, M Zafar, G Gantt, A Mellgren, M Abdulhai, E Bianchi, V Chaudhry, H Kapoor, M Stach, A Perez-Tamayo
University of Illinois Chicago

Introduction: Language barriers in healthcare settings pose significant challenges for patients with limited English proficiency (LEP), potentially compromising access to care and adherence to treatment plans. This study investigates the role of language-concordant providers on adherence to pelvic floor physical therapy among in patients with pelvic floor disorders, highlighting the critical importance of linguistic inclusivity in enhancing healthcare outcomes.

Methods: We conducted a retrospective chart review of patients who underwent manometry and related pelvic floor physical therapy treatments. Data on language concordance with the provider and follow-up adherence were collected, comparing LEP patients with EP patients, to assess the impact of language-concordant care on treatment continuity.

Results: Of the 422 patients reviewed, 55 had LEP. Out of these, 279 were referred to physical therapy, including 31 LEP patients. All Spanish-speaking LEP patients LEP group. Furthermore, LEP patients demonstrated a higher likelihood of folreceived care from a language-concordant provider, accounting for 91% of the low-up compared to EP patients, (P value < 0.01).

Conclusion: Our findings reveal that LEP patients, when supported by language concordant providers and, exhibit higher follow-up adherence in pelvic floor physical therapy compared to their EP counterparts. This underscores the critical role of language-concordant care in enhancing patient engagement and improving healthcare outcomes. These results highlight the need for healthcare systems to prioritize linguistic inclusivity and support services to ensure equitable access and treatment adherence for all patients, particularly those facing language barriers.

Table—Effect of LEP and language concordance on Follow-up

	EP	LEP	
	n= 248	n= 31	
Language Concordance Rate	100%	91%	P value= <0.01
Follow-up	108 (43.5%)	25 (80.6%)	P value= <0.01

CCRS Abstract 2024-5

Rectal Ejaculation: Unveiling a Seminal Vesicle-Rectal Fistula Post Endorectal Advancement Flap.

N Sweis, R Sharifi, G Gantt, J Harrison, V Chaudhry
 University of Chicago Illinois

Case: We describe a novel case of a 40-year-old male with rectal ejaculation, resulting from a seminal vesicle-rectal fistula, which occurred as a postoperative complication after an endorectal advancement flap for a cryptoglandular anal fistula. The patient's medical history was notable for numerous rectal surgeries and the placement of a diverting end-loop prasad colostomy. Diagnostic evaluation with a bilateral percutaneous vasogram confirmed the presence of a fistulous connection between the seminal vesicles and the rectum. The fistula was located anteriorly and above the anorectal junction, approximately 5 cm from the anal verge.

The treatment strategy entailed a transperineal bilateral seminal vesiculectomy and an overlapping closure of the rectal fistula. Flexible sigmoidoscopy performed intraoperatively verified a well-healed external opening of the fistula and identified a small residual fistulous tract, which was adeptly repaired. The postoperative course was marked by a brief two-day hospitalization. Subsequently, the patient had a successful colostomy reversal after imaging and repeat rectosigmoidoscopy confirmed the healing of the fistula.

Conclusion: This case highlights the rare occurrence of a seminal vesicle-rectal fistula following anorectal surgery. The condition presented diagnostic and therapeutic challenges, including the need for precise radiologic evaluation and meticulous surgical repair. The successful outcome demonstrates that with careful patient selection and a multidisciplinary approach, complex fistulas of this nature can be effectively managed via a perineal approach. This report adds to the limited literature on the condition and underscores the importance of considering seminal vesicle-rectal fistula in the differential diagnosis of postoperative complications in anorectal surgeries. To our knowledge, this is the first reported case of a seminal vesicle-rectal fistula after an endorectal advancement flap.

Figure - Percutaneous Vasogram Revealing Seminal Vesicle-Rectal Fistula



CCRS Abstract 2024-6

Spontaneous Coronary Artery Dissection and Ulcerative Colitis: A Case Report

T Luan, T Walker, M Gutman, H Bahna, J Ray

University of Miami - JFK Palm Beach Regional Campus

Background: Spontaneous coronary artery dissection (SCAD) is a rare and often fatal cause of acute myocardial infarction. It most commonly occurs in young postpartum females without significant cardiovascular risk factors¹. The true mechanism of SCAD is unknown. Associated risk factors include mixed connective tissue disorders, vasculitis, and inflammatory disorders. There are only a handful of reports highlighting SCAD in active inflammatory bowel disease (IBD). We present a case of a young male with untreated ulcerative colitis (UC), who suffered a myocardial infarction secondary to SCAD. The aim of this

case report is to highlight that IBD, specifically UC, may predispose patients to spontaneous coronary artery dissection.

Case: A 22-year-old man with untreated UC and no cardiovascular risk factors presented with chest pain and EKG findings of anterior and inferior ST elevations. An emergency coronary angiography revealed a 100% occluded mid LAD. The diagnosis of SCAD was made with pathognomonic angiography findings of a longitudinal filling defect that generates a double lumen. In the recovery room, the patient suffered from ventricular tachycardia. CPR was started and ROSC was achieved. A subcutaneous ICD was placed prior to discharge. Two weeks later, the patient returned with two days of abdominal distension, hematochezia, and anemia. He endorsed up to ten episodes of bloody diarrhea per day. He was diagnosed with ulcerative colitis a year ago, however, was only recently started on vedolizumab. On exam, he was distended, but not peritonitic. CT showed colitis with dilated loops of large and small bowel. Clinically, a differential diagnosis of fulminant or toxic colitis was considered. He stabilized with steroids and vedolizumab was resumed.

Discussion: SCAD is an infrequent cause of acute coronary syndromes and may be associated with connective tissue disorders, vasculitis, and systemic inflammatory^{2,3}. Other precipitating factors include stress, physical exertion, drug use, and hormonal imbalances⁴⁻⁶. Srinivas et al were the first to document coronary artery dissection in IBD with their case report of a young female with Crohn's⁷. A national survey reported that RA, SLE, and Crohn's disease are the most common autoimmune disease associated with SCAD⁸. Our case report is the first to document SCD in a male patient with UC to our knowledge. UC may predispose patients to SCAD due to the release of proinflammatory cytokines causing intramural hemorrhage and thrombosis.

Conclusion: This case elucidates that active systemic inflammatory processes such as UC may be a contributor to the development of SCAD. Further research is needed to deepen our understanding of the correlation between SCAD and UC and ideal treatment and prevention.

CCRS Abstract 2024-7

Total Proctocolectomy and IPAA with HIPEC for Synchronous Colorectal Cancer with Peritoneal Involvement

J Chin, M Kitsis, J Emolo, J Estrada, J Kaminski
Advocate Illinois Masonic Medical Center

Background: Synchronous colorectal cancers refer to the diagnosis of more than one colorectal malignancy simultaneously or within 6-12 months of an initial diagnosis. They represent ~3.5%¹ of all colorectal cancers, with a reported incidence of up to 12.4%². Compared to solitary colorectal cancers, synchronous cancers have poorer outcomes in overall survival, disease-free survival and cancer-specific survival³, highlighting the importance of a complete evaluation of the colon and rectum prior to surgical resection. There has been an increase in the incidence of both synchronous and metachronous peritoneal metastases in patients with colorectal cancer in recent years. Peritoneal involvement portends a poor prognosis. Current treatment algorithms for these patients include a multidisciplinary approach with a combination of systemic chemotherapy and/or radiotherapy, cytoreductive surgery and the consideration of HIPEC in select patients. We present a unique case of synchronous cecal and rectal adenocarcinomas with peritoneal involvement and our multidisciplinary approach.

Case: A 50 year old male was found to have synchronous invasive cecal and rectal adenocarcinomas on colonoscopy. Staging workup with MRI demonstrated a T3bN0 3 cm mid-rectal lesion with extension into the mesorectal fascia, 4.8cm from the anal sphincter. CT CAP was notable for bilateral pulmonary nodules, subsequently biopsy proven metastatic colonic adenocarcinoma. Genetic testing did not identify any known harmful variants. He was discussed at multi-disciplinary tumor board and initiated chemotherapy with FOLFOX/bevacizumab with palliative intent. After 8 cycles, he was re-staged and was found to have no residual cecal or rectal tumor on cross-sectioning imaging. There remained a solitary pulmonary nodule in the left upper lobe. He was again presented at multi-disciplinary tumor board given his remarkable response to treatment and deemed to be a candidate for curative surgical resection. He successfully underwent R0 LUL wedge resection and was scheduled for total proctocolectomy with J-pouch creation. However during abdominal exploration, he was found to have peritoneal nodules positive for adenocarcinoma and surgery was aborted. He was again presented at multi-disciplinary tumor board and recommended to undergo further systemic chemotherapy with FOLFIRI/bevacizumab. After 8 cycles, repeat cross-sectional imaging demonstrated stable disease and he was referred to Surgical Oncology for consideration of cytoreductive surgery with HIPEC. He underwent diagnostic laparoscopy with no evidence of peritoneal disease and thus was deemed a candidate for surgical resection.

He underwent total proctocolectomy with ileoanal anastomosis, creation of J-pouch, diverting loop ileostomy, cytoreductive surgery, omentectomy, peri-

tonectomy and HIPEC with mitomycin C in combination with Surgical Oncology. Abdominal exploration was first performed. His intra-operative PCI was 4 for nodules in the RLQ. Small nodules in the omentum were additionally found and resected with omentectomy. Total proctocolectomy was performed with transection of the rectum 2 cm above the dentate line. A 20 cm ileal J-pouch was constructed and ileoanal anastomosis created. Following this, the patient was cooled and heated intraperitoneal chemotherapy with mitomycin C was infused with manual shaking for 90 minutes, then removed from the abdomen. A protective loop ileostomy was then created and drains placed prior to closure of the abdomen. He recovered well and was discharged home on post-operative day 3. He continues to do well in the post-operative period. Surgical pathology was consistent with his known invasive cecal and rectal adenocarcinomas. 3/19 pericolic lymph nodes were positive for disease. No perirectal lymph nodes were positive for disease. Margins were negative. Omentectomy and peritonectomy were also negative for disease. Final pathologic classification was mypT3N1bM1c.

Conclusion: We present a unique case of synchronous cecal and rectal invasive adenocarcinomas with pulmonary and peritoneal metastases successfully managed with a combination of neoadjuvant chemotherapy, surgical resection and CRS-HIPEC therapy. The patient's excellent response to chemotherapy, young age and desire for aggressive treatment were factors that contributed to the shared patient-provider decision making process for guiding therapy. Multiple surgical and medical specialties were involved in the patient's care including medical oncology, radiation oncology, pathology, thoracic surgery, colorectal surgery and surgical oncology, highlighting the importance of a multi-disciplinary care team and tumor board discussions.

CCRS Abstract 2024-8

Use of Virtual Reality Simulator as a Tool to Understand Colorectal Anatomy and Medical Students' Interest in Colorectal Surgery

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Background: Pelvic anatomy education is being revolutionized by virtual reality (VR), moving beyond traditional methods like lectures and cadaver dissections. VR offers medical students an immersive learning experience with 3D visualizations and interactive simulations tailored to individual patients, allowing them

to view anatomical structures from any angle. Our study investigates how VR's 3D visualization affects medical students' understanding of pelvic anatomy and their interest in colorectal surgery and surgical careers.

Methods: At an urban academic center, 24 M1-M3 students were recruited. They engaged with VR pelvic models, based on CT and MRI scans from rectal cancer patients scheduled for surgery, using a 3D headset. We assessed changes in their perceived anatomy comprehension, confidence in participating in pelvic surgery, and interest in a career in colorectal surgery through pre- and post-activity surveys on a Likert scale.

Results: The study showed improvements in students' perceived understanding of pelvic anatomy, with mean scores rising from 2.76 to 4.75. Confidence in pelvic surgery participation increased, with scores going from 2.57 to 3.88. Interest in colorectal surgery careers also grew, from 1.57 to 3.63. Using the Wilcoxon signed-rank test, 7 out of 8 post-activity scores significantly improved, each with a p-value of <0.001.

Conclusion: Integrating VR into medical education enhances the students' perceived understanding pelvic anatomy understanding and sparks interest in colorectal surgery, proving to be a valuable teaching tool. This innovation provides increased interest in surgical careers with a specific increased interest in colorectal surgery.

CCRS Abstract 2024-9

Factors affecting colonoscopy completion secondary to disparity in health at Cook County Hospital Chicago. What can we do better?

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Background: Colorectal cancer (CRC) is the second most common cause of cancer deaths in the USA. In the past few decades, the incidence of CRC has increased in younger populations. Colonoscopy is the gold standard for diagnosis and therapy for removal of polyps. Hispanic/Latinos are one of the most vulnerable groups at risk of being diagnosed with advanced colorectal cancer, worse prognosis, and higher costs. Our aim is to identify factors that lead to lower rates of screening colonoscopies in this population.

Methods: A retrospective review of scheduled colonoscopies by primary physicians was conducted from 2018 to 2023 at Cook County Hospital Chicago. Demographic data and documented reasons for refusal or cancellation of the colonoscopies were collected and analyzed using SPSS v.29 by IBM.

Results: A total of 42,202 colonoscopies were scheduled between 2018 to 2023. The median age of the population was 61 (53 – 67) and sex distribution was 52% and 48%, male and female respectively. The incidence rate of cancellations/no-show appointments was 36% in the total study. In our study, 35% identified as Hispanic/Latino. Of those that identified as Hispanic/Latino, the median age was 56 (49 – 65) and sex distribution was 48% and 52%, male and female respectively. When focusing on this population alone, they had a 29.8% incidence rate of cancellations/no-show appointments. Women were more adherent to recommendations by primary providers. Reasons for cancellation/no-shows were lack of transportation, lack of insurance, no time-off work, no escort, fear of contracting COVID-19 infection, and lack of explanation by health practitioners. However, accurate proportions of these reasons were hard to calculate due to inconsistent reporting of reasons in the electronic medical record.

Conclusion: There is abundant data in disparity in care, however the specific limiting factors have not been fully elucidated, Hispanic/Latinos are an at-risk population of developing advanced colorectal cancer due to lack of screening. Use of the socio-ecological model can be used to assess the complex interplay between factors that contribute to poor health outcomes in at-risk populations. Improved identification and documentation of barriers to completion screening colonoscopies, especially in vulnerable populations, may increase colorectal screening rates.

	Total Population
Sex	
• Male	21611 (52%)
• Female	20159 (48%)
Median Age in Years (IQR)	61 (53 – 67)
Cancelled or No-Show Appointment	15061 (36%)
IQR – Interquartile Range	

	Hispanic (N=14700)	Non-Hispanic (N=27071)
Sex		
• Male	7054 (48%)	14557 (54%)
• Female	7644 (52%)	12515 (46%)
Median Age in Years (IQR)	56 (49 – 65)	63 (56 – 68)
Cancelled or No-Show Appointment	4380 (29.8%)	10681 (39.5%)
*421 did not identify an ethnicity IQR – Interquartile Range		

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