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The Asian Society of Stoma Rehabilitation

Proceedings of the 12th Congress
in Taipei, 2021



中華民國大腸直腸外科醫學會
SOCIETY OF COLON AND RECTAL SURGEONS, TAIWAN

The logo designates

1. Stoma symbolizing colon/urinary tract with mucosal folds,
2. Excretion of feces or urine from the stoma,
3. Ostomy everted through the abdominal wall,
4. Handmade artificiality with irregular or asymmetric shape of the stoma,
5. Society philosophy of Asian friendship and Collaboration among nurses, surgeons and co-medicals with using different three colors and Asian style letters of ASSR,
6. Continuous Cure & Care by symbols of three Cs.
7. This is not a red crescent, but we will learn from humanitarian laws and keep young like a new moon.

ASIAN OSTOMY:

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ΑΣΙΑΝ ΟΣΤΟΜΨ

VOL.12

No.1

ASSR

Asian Society of Stoma Rehabilitation
Since 1997

The Asian Society of Stoma Rehabilitation

Proceedings of the 12th Congress
in Taipei, 2021



中華民國大腸直腸外科醫學會
SOCIETY OF COLON AND RECTAL SURGEONS, TAIWAN

12th Asian Society of Stoma Rehabilitation

ASSR

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Paper

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Quality Care of Stomates with Korea's Experience

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As a WOCN, stoma marking and stoma-related consultation are provided to patients scheduled for stoma surgery through elective surgery. The stoma education is performed by WOCN, after the surgery, usually the patient received individual and group education sessions. Each individual education session usually lasts 30 minutes, during which patients practice ostomy care by themselves. The one-hour group education session is held in a separate room in the hospital. The education focus on theoretical aspects, such as the purpose of ostomy care and necessary precautions.

In fact, several studies have reported that health-related QoL decreases and the incidence of stoma-related complications increases if stoma education is not performed properly¹⁻³. The important thing in stoma management is to perform appropriate stoma marking before surgery and provide the patient with the necessary information to give them an opportunity to adapt, and after surgery, stoma education combining theoretical base and practice should be done. In order for effective stoma education to take place, healthcare professionals must be familiar with the stoma and be able to intervention competently in case of complications. For this reason, stoma education is very important for stoma patients. After discharge, an outpatient visit is usually made two weeks later. At the first outpatient visit, the stoma condition is checked and stoma supplies are provided. There is a stoma care clinic in the outpatient department of Asan medical center, so patients come to the hospital to manage stoma complications or wounds complications. Also, once a year, stoma care workshop for stomates is held to give lectures on precautions after stoma surgery and stoma management, and to answer questions from patients.

Korean Association of Wound, Ostomy, Continence Nurses(KAWOCN) is a group of nurses who treat various acute and chronic wounds, including pressure injuries, and provide pre-operative counseling and post-operative care and rehabilitation for stoma patients and incontinence management. KAWOCN was established in 2000 and was accredited by the Hospital Nursing Association in 2006.

Since its establishment, we have been working hard to specialize in wound, stoma, and incontinence nursing

areas and to strengthen nurses' competency. KAWOCN is playing a leading role in improving the quality of stoma care through a more systematic training course on wound and stoma management. In the future, we are also planning to produce online stoma educational materials such as the app. And, although our book 'Clinical ostomy management essential' is currently only produced in Korean, we would like to translate it into English and Chinese to share stoma care experience with healthcare professionals in various countries.

And, as part of a national project, we are developing XR based educational materials for stoma education for stoma patients. As such, KAWOCN has been working hard from the past to the present to improve the quality of life of stomates for 20 years, and is constantly thinking about the optimal education method in response to the trend of the times.

References

1. Chaudhri, S., Brown, L., Hassan, I., & Horgan, A. F. (2005). Preoperative intensive, community-based vs. traditional stoma education: a randomized, controlled trial. *Diseases of the Colon & Rectum*, 48(3), 504-509.
2. Forsmo, H. M., Pfeffer, F., Rasdal, A., Sintonen, H., Körner, H., & Erichsen, C. (2016). Pre-and postoperative stoma education and guidance within an enhanced recovery after surgery (ERAS) programme reduces length of hospital stay in colorectal surgery. *International Journal of Surgery*, 36, 121-126.
3. Jensen, B. T., Kiesbye, B., Soendergaard, I., Jensen, J. B., & Kristensen, S. A. (2017). Efficacy of preoperative uro-stoma education on self-efficacy after Radical Cystectomy; secondary outcome of a prospective randomized controlled trial. *European Journal of Oncology Nursing*, 28, 41-46.

The New trend of Treatment on Colorectal Cancer

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Keywords: Colorectal cancer; Surgical treatment; Malignant obstruction; Watch and wait; Stoma care

Abstract

Colorectal cancer is increasing in Japan and Asian countries. However, mortality of colorectal cancer is decreasing in European-American countries, also slightly decreasing in Japan. On the other hand, mortality of colorectal cancer is still increasing in other Asian countries. As operative methods for colorectal cancer, laparoscopic surgery is getting popular in Japan and other Asian countries. Robotic surgery is also getting prevalent after insurance cover from 2018 in Japan. Transanal mesorectal excision (Ta TME) is becoming an option with merit of keeping surgical margin especially for big tumours. However, urethral injury and local recurrence became s drawbacks of this procedure. Low anterior resection syndrome (LARS), which often occurs after excision for low rectal cancers becomes the issue for doctors and WOC nurses. Patients have to be consulted to psychiatry, and have a bad relationship with doctors due to LARS sometimes. However LARS is not often taken care by WOC nurses. These situation has to be improved. As a measure to treat obstruction by colorectal cancer, stenting has been performed. However worsened prognosis prevented the popularity. Recently, usefulness of stenting for obstructive colorectal cancers was proposed from European guidelines. As a new treatment for early colon cancers, laparoscopic and endoscopic cooperative surgery was developed in Japan. "Watch and wait" is a tactics to follow up without surgery for rectal cancer patients with complete response after chemo-radiation therapy. Survey performed for doctors in Asian countries showed that it was an acceptance option. However some doctors hesitated to perform its policy clinically due to lack of evidence and inaccuracy of diagnosis. Several new local excision procedures were developed recently, however, long-term results have to be waited.

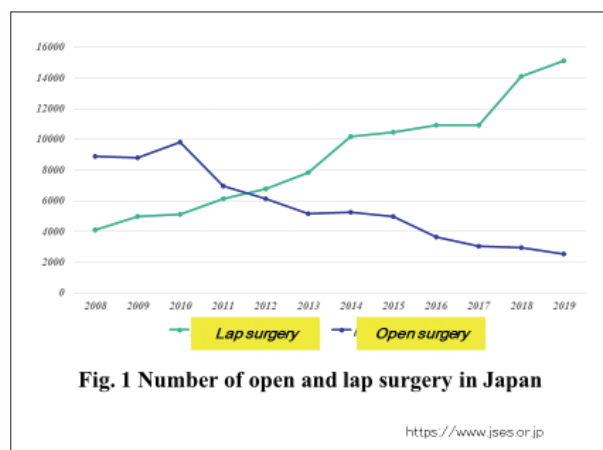
Introduction

A new trend of treatment on colorectal cancer was reviewed, especially the trend in Asian countries. Colorectal cancer is increasing in Japan and other Asian countries. Colorectal cancer is becoming a second cause of death

among cancers in Japan. However, mortality of colorectal cancer is decreasing in European-American countries, also in Japan slightly. On the other hand, mortality of colorectal cancer is still increasing in other Asian countries.

Spread of laparoscopic surgery

Laparoscopic (lap) surgery for colorectal cancer became prevalent in many Asian countries. The number of lap surgery became a predominant surgical procedure in colon and rectal cancer surgery. The number of lap surgery is increasing for early and advanced colorectal cancer in Japan since 2005. Nowadays, lap surgery is the predominant procedure in colon cancer from 2012, and this trend is the same in rectal cancer in Japan (Figure 1) [1]. In specialized hospitals, almost all patients underwent lap surgery for rectal cancer. Lap surgery is especially useful in cosmesis and quick recovery as minimally invasive technique. Open surgery needs long incision, on the other hand, lap surgery has several small incisions.



Emerging of robotic surgery

Robotic surgery is also becoming popular in several Asian countries. Robotic technique is evolving year by year; from da-Vinci standard, to da-Vinci S and Si, and to Da-Vinci Xi. The number of robotic surgery is rapidly increasing from 2018 after insurance cover in Japan (Figure 2) [1]. Insurance cover was the turning point for robotic surgery. Our University is one of the center of robotic surgery in Japan, and the number of robotic surgery is increasing year by year in several surgical departments. Total number of surgery up to 2017 was 1,763 in our institute. In robotic surgery, the arm which

moves 360 degrees, facilitates a proper dissection for rectal cancer in the narrow pelvis. Our hospital started robotic colorectal surgery first in Japan, and the number of colorectal robotic surgery is also increasing in our department, especially from 2018. According to data published recently, 115 patients underwent robotic rectal cancer surgery including the patients with previous abdominal surgery in 27.8% without preoperative therapy [2]. Anastomotic leakage was observed in 5% of patients without mortality, and local recurrence in 3.5% during a median follow-up of 48 (range 12-109) months.

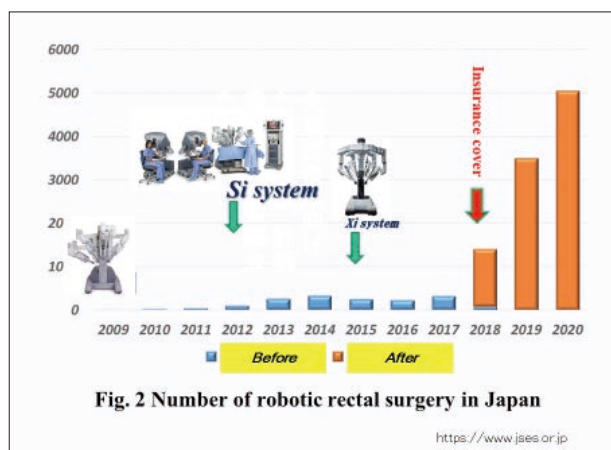


Fig. 2 Number of robotic rectal surgery in Japan

<https://www.jses.or.jp>

TaTME

Transanal total mesorectal excision (Ta TME) appeared as a new technique for rectal cancer since 2013 [3]. Mesorectal excision is performed from the anus usually through single port, recently by robotic system in some hospital. TaTME is reported to have advantages for keeping circumferential margin, and for excision of big tumors. However, urethral injury and local recurrence are reported as drawback. Actually several hospital abandoned to continue this procedure due to complications.

Anus-preserving surgery and LARS

Period	Approach	Method of surgery	Report (mainly in Japan)
1940~	Transabdominal· Transanal	pull-through	Jinnai (1961)
1960~	Transabdominal	Anterior resection(AL)	Kou(1968)
1970~	Transabdominal· Transsacral	Transsacral resection	Hejira(1979)
	Transabdominal	AL (single stapling)	
1980~	Transabdominal· Transanal	Extended LNN	Koyama· Hejira (1970')
	Transabdominal	PAA	
1980~	Transabdominal	TME	Parki (1972)
	Transabdominal	AL (double stapling)	
1990~	Transabdominal· Transanal	Nerve-sparing surgery	Heath (1982)
	Transabdominal· Transanal	Intersphincteric resection	
2000~	Transabdominal	PIDCA	Knight & Griffin (1980)
	Transabdominal	Lap.	
2010~	Transabdominal· Transanal	TaTME	Tsuchiya(1983)
	Transabdominal	Robotic	
	Transabdominal· Transvaginal et al.	NOSES	

Maeda K., et al. J Jap Surg Soc. 122, 2021

Anus-preserving surgery, intersphincteric resection

(ISR) is getting popular for surgery of very low rectal cancer in many hospitals. It started in 1990's in Europe [4], and started around 2000 in Japan (Table 1) [5, 6]. ISR is an excision procedure performed from the anus with combination of abdominal approach. By using this technique, we can excise very low rectal cancer while preserving the anus. However, several defecation disorders have been reported as low anterior resection syndrome (LARS). LARS includes frequent defecation, fecal incontinence, urgency, feeling of residual stool, incomplete evacuation and so on. It is reported that LARS occurred in more than 80 % of patients after low anterior resection [7, 8]. LARS became persistent more than 2years after surgery according our report [9].

Recently, a questionnaire survey from 31 institutes and 43 colorectal surgeons around Tokyo was published concerning LARS [10]. Diverting stoma was usually constructed in cases with low anastomosis for very low rectal cancer. Nine percent of doctors faced a bad relations with patients (Fig. 3), and sixteen percent of doctors consulted patients to psychiatry department due to LARs (Fig. 4). This means that patients were seriously worry about symptoms of LARS, and colorectal surgeons sometimes couldn't take care of the patients with LARS properly. On the other hand, LARS was taken care by WOC nursed only in 37 % of hospitals (Fig. 5). More patients should be taken care by WOC nurses.

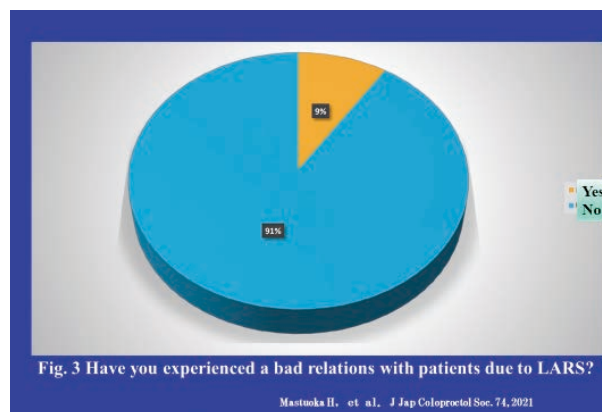


Fig. 3 Have you experienced a bad relations with patients due to LARS?

Mastuoka H., et al. J Jap Colorectal Soc. 74, 2021

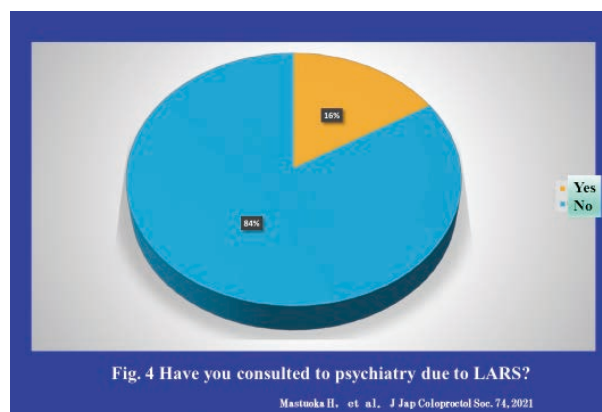
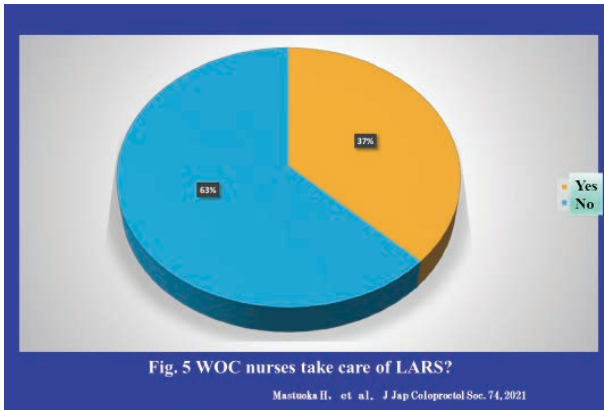


Fig. 4 Have you consulted to psychiatry due to LARS?

Mastuoka H., et al. J Jap Colorectal Soc. 74, 2021



As treatments of LARS, the most important point is to inform this possible situation before surgery to the patient, and to explain that it will subside with time in most cases.

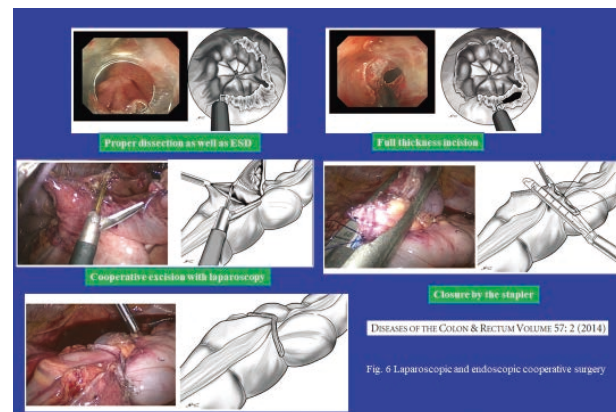
Medication by polycarbophil-calcium, pelvic floor training and biofeedback and so on. are treatment modality to be performed. Usefulness of transanal irrigation and sacral neuromodulation is also reported. Transanal irrigation is a treatment modality for severe LARS by using Peristeen instrument from Coloplast Co., Ltd. Sacral neuromodulation (SNM) is another procedure to improve fecal incontinence occurred after LARS. SNM can be indicated only for severe cases with LARS.

Stenting for colonic obstruction by cancer

Stenting is a procedure to insert the stent from the anus by using endoscopy for obstructive colorectal cancer. It is usually performed by endoscopist or colorectal surgeon. It has been reported that usage of this technique worsens the prognosis of the patients with colorectal cancer. Therefore performance of stenting has been a little be hesitated. Recently, the role of stent for colorectal cancer was published from Europe as a statement very favorably [11]. According to this statement, metallic stent is highly recommended to use for treatment of malignant large bowel obstruction as either a definitive procedure or palliation or a bridge to surgery. Bridge to surgery means a transit treatment to improve obstruction for radical surgery. The success rate of stenting is reported to be the order of 90 %. This technique is recommended to use for obstructive conditions in patients with unresectable primary and/or metastatic disease. However, this is not recommended for curable rectal cancer within 5 cm from the dentate line because of migration of the stent and pain, which occurs after stenting.

New technique for early colon cancer

A new technique, laparoscopic-endoscopic cooperative surgery was recently developed in Japan [12]. This technique was initially developed for gastric cancer. This new technique is used for early cancer, which is difficult to excise endoscopically. The technique includes initial endoscopic dissection followed by laparoscopic resection (Fig. 6). This technique allows for an excision with adequate surgical margin, and steady en-block resection. For completing this technique, steady hemostasis and anastomosis with confirmation without stenosis are mandatory. By using this technique, hospital stay became shorter with less inflammatory reaction.



Watch and wait

“Watch and wait” is tactics of just watch and wait in cases with complete response after chemoradiation therapy (CRT) for rectal cancer. Around 20 % of patients has macroscopically complete response after preoperative CRT. Current status of watch and wait for rectal cancer treatment was studied in Asia-Pacific countries. [13] This survey was performed for colorectal surgeons in Asian-Pacific countries. This survey was performed by a special committee members of Asian Pacific Federation of Coloproctology (APFCP). In fact, eighty percent of doctors accepted the watch and wait policy (Fig. 7). However about 65 % of doctors have performed this policy in clinical practice, and about 80 % of the doctors used this policy selectively for patients with clinically complete remission (Fig, 8). The main reasons of not taking this poly were inaccuracy of evaluation and lack of evidence. Actually there is still some gaps between diagnosis of complete response and histologic complete response.

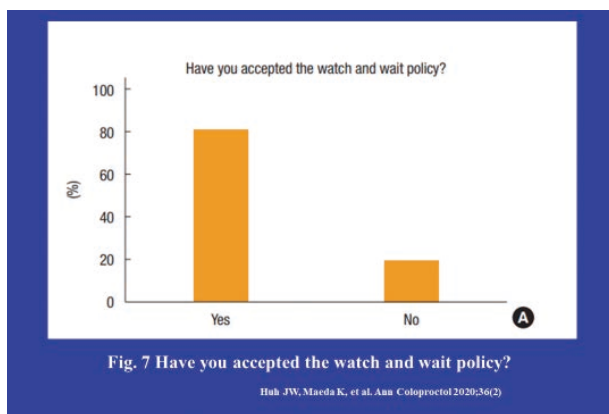


Fig. 7 Have you accepted the watch and wait policy?

Huh JW, Maeda K, et al. *Ann Coloproctol* 2020;36(2)

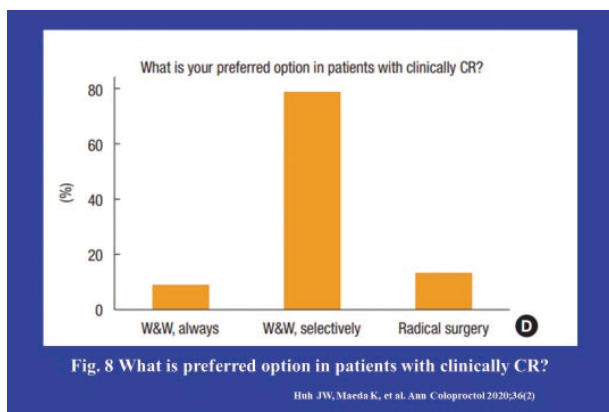


Fig. 8 What is preferred option in patients with clinically CR?

Huh JW, Maeda K, et al. *Ann Coloproctol* 2020;36(2)

New techniques of local excision for early rectal cancer

Local excision for early rectal cancer, for T1 and T2 cancer, is increasing in US. However, local recurrence rate is not small number when compared with standard radical resection even in T1 cancer [14]. According to the review, local recurrence rate after radical surgery was 0 to 3 % for T1 tumor in 9 of 12 reports. However, local recurrence rate was more than 10 % after local excision in 7 of 12 reports (Table 2) [15]. As risk factors of lymph node metastasis in T1 rectal cancer, several histological factors have been reported. However factors known before selecting surgical method are only tumor grade and depth of invasion. Lymph node metastasis is negligible in T1 tumor with sm1 invasion or depth of invasion less than 1, 000 micrometers [15]. Therefore curable resection can be performed by local excision for low-risk T1 cancer; in other words, for well to moderately differentiated adenocarcinoma with slight depth of invasion to the submucosa.

Among pre-existing local excision procedures, transanal local excision was the less invasive procedure. Conventional local excision has been used widely as a standard procedure performed with direct vision. Transanal endoscopic microsurgery (TEM) was developed in 1980's by Buess, and is used as local excision procedure to access high tumors. Minimally invasive transanal surgery (MITAS) was developed by

us in 1990's [16]. This procedure includes the excision of tumor by using the stapler device with several modified surgical techniques under direct vision. Recently, similar names of transanal minimally invasive surgery (TAMIS) was developed as local excision procedure [17]. In TAMIS, gel port is inserted from the anus, and procedure is performed with forceps. Another advancement of technique is endoscopic procedure; endoscopic submucosal dissection (ESD) [18]. Local excision is performed through endoscopy in ESD. However excision of the rectum is performed at the submucosal layer. There are several characteristics in each procedure. However, we have to wait a little bit more to get the long-term results of these procedures. Treatment on colorectal cancer is changing rapidly.

Table 2 Literature reports of local recurrence after local excision and radical surgery for T1 tumors

Author (year)	local excision		Radical surgery	
	n	Local recurrence (%)	n	local recurrence (%)
Winde et al. (1996)	24	4.1	26	0
Balani et al. (2000)	7	0	17	5.9
Melgrom et al (2000)	69	18	30	0
Lee et al. (2003)	52	4.1	17	0
Nascimbeni et al (2004)	70	6.6	74	2.8
*Bentrem et al (2005)	151	15	168	3
Endreseeth et al (2005)	256	12	35	6
You et al (2007)	601	12.5	493	6.9
Ptok et al. (2007)	120	6	359	2
De Graff et al. (2009)	80	24	75	0
Nash et al (2009)	137	13.2	145	2.7
Peng et al. (2010)	58	11	66	2

* Local recurrent rate after radical surgery; 0 – 3 % in 9 of 12 reports

Maeda K, *Surgery Today* 44, 2014

References

- https://www.jses.or.jp
- Katsuno H, Hanai T, Masumori K, et al (2020). Short- and long-term outcomes of robotic surgery for rectal cancer: a single-center retrospective cohort study. *Surg Today*, 50: 240–247.
- De Lacy AM, Rattner DW, Adelsdorfer C, et al. (2013). Transanal natural orifice transluminal endoscopic surgery (NOTES) rectal resection: "down to top" total mesorectal excision (TME) – short-term outcomes of first 20 cases. *Surgical Endosc*, 27: 3165–3172.
- Schiessel, R., Karner-Hanusch, J., Herbest, F., et al (1994). Intersphincteric resection for low rectal tumors. *Br J Surg* 81: 1376–1378.
- Saito, N., Ono, M., Sugito, M., et al (2004). Early results of intersphincteric resection for patients with very low rectal cancer: an active approach to avoid a permanent colostomy. *Dis Colon Rectum*. 47: 459–466.
- Maeda K. (2021). History of anus-preserving surgery. *J Japan Surg Soc*. 122: 369–374.
- Pienowski EHA, Palmer GJ, Juul T, et al.(2019). Low anterior resection syndrome and quality of life after sphincter-sparing rectal cancer surgery: a long-term longitudinal follow-up. *Dis Colon Rectum*. 62: 14–20.
- Van Heinsbergen M, Janssen-Heijuen M, Leijten JW, et al. (2018). Bowel dysfunction after sigmoid resection underestimated: Multicentre study on quality of life after surgery for carcinoma of the rectum and sigmoid. *Eur J Surg Oncol*. 44: 1261–1267.
- Saito, N., Moriya, Y., Shirouzu, K., et al (2006). Intersphincteric resection in patients with very low rectal cancer: a review of the Japanese experience. *Dis Colon Rectum* 49: 1–10.
- Matsuoka H, Yasuno M, Takahashi K, et al. (2021). Low anterior

- resection syndrome: A questionnaire survey for colorectal surgeons in Tokyo and the surrounding districts. *J Jap Soc Coloproctol.* 74: 43-437.
11. Miller AS, Boyce K, Box B, et al. (2021). The association of Coloproctology of Great Britain and Ireland consensus guidelines in emergency colorectal surgery. *Colorectal Dis.* 23: 476-547.
 12. Fukunaga Y, Tamegai Y, Chino A, et al. (2014). New technique of en bloc resection of colorectal tumors using laparoscopy and endoscopy cooperatively (Laparoscopy endoscopy cooperative surgery- colorectal). *Dis Colon Rectum.* 57: 267-271.
 13. Huh JW, Maeda K, Liu Z, et al. (2020). Current status of "watch and wait" rectal cancer treatment in Asia-Pacific countries. *Ann Coloproctol.* 36: 70-77.
 14. You YN, Baxter NN, Stewart A, et al. Is the increasing rate of local excision for stage I rectal cancer in the United States justified?: a nationwide cohort study from the National Cancer Database. *Ann Surg.* 2007; 245: 726-733.
 15. Maeda K, Koide Y, Katsuno H. (2014). When is local excision appropriate for "early" rectal cancer? *Surg Today.* 44: 2000-2014.
 16. Maeda K, Maruta M, Sato H, et al. (2004). Outcomes of novel transanal operation for selected tumors in the rectum. *J Am Coll Surg.* 199: 353-360.
 17. Lee L, Burke JP, deBeche-Adams T, et al. (2018). Transanal minimally invasive surgery for local excision of benign and malignant rectal neoplasia: Outcomes from 200 consecutive cases with midterm follow up. *Ann Surg.* 267: 910-916.
 18. Saito Y, Uraoka T, Yamaguchi Y, et al. (2010). A prospective, multicenter study of 1111 colorectal endoscopic submucosal dissections (with video). *Gastrointest Endosc.* 72: 1217-1225.



Programme Overview



ASSR 2021 PROGRAMME OVERVIEW

Saturday, 27 November, 2021

Venue: Meeting Room 2

08:30-10:00

Opening Ceremonies

- RL-1 **Opening Remarks from 12th ASSR Congress President**
Jaw-Yuan Wang (*Taiwan*)

Keynote Speech I

Moderators: Jaw-Yuan Wang (*Taiwan*), Tzu-Chi Hsu (*Taiwan*)

- RL-2 **The New Trend of Treatment on Colorectal Cancer**
Maeda Kotaro (*Japan*)

Keynote Speech II

Moderators: Henry Hsin-Chung Lee (*Taiwan*), Shih-Hsin Hung (*Taiwan*)

- RL-3 **Standard Care and Complication Management of Stoma**
Chizu Sakai-Imoto (*USA*)

10:00-10:30

Break

10:30-12:00

Symposium 1: Preoperative Siting of Stoma

Moderators: Jy-Ming Chiang (*Taiwan*), Shih-Ching Chang (*Taiwan*), Tung-Kuang Wang (*Taiwan*)

- RL-4 **Importance of Preoperative Stoma Siting**
Chang-Chieh Wu (*Taiwan*)

- RL-5 **Role in Emergent Surgery**
Ting-Kuang Wang (*Taiwan*)

- RL-6 **In Temporary and Permanent Stoma**
Miki Masada (*Japan*)

Panel Discussion

12:00-13:00

Luncheon Symposium

Sponsored by Ethicon

Moderators: Pao-Shiu Hsieh (*Taiwan*), Po-Li Wei (*Taiwan*)

- 1 **Surgical Technique and Products to reduce Anastomotic Leakage**
Jun Watanabe (*Japan*)

- 2 **Lap CME/CVL with intracorporeal anastomosis for right colon cancer**
Yoon-Suk Lee (*Korea*)

13:00-14:30 **Symposium 2: Variation of Stomas for Malignancies and for Benign Disease**

Moderators: Tzu-Chi Hsu (Taiwan), Chang-Chieh Wu (Taiwan), Chou-Chen Chen (Taiwan)

RL-8 **Stoma Construction in Japan: The Current State of the Art**
Yoshito Akagi (Japan)

RL-9 **Inflammatory Bowel Disease and Stoma Construction**
Kenichi Hakamada (Japan)

RL-10 **Variation of Stomas for Carcinoma of Colorectum**
Chang-Chieh Wu (Taiwan)

Panel Discussion

14:30-15:30 **Symposium 3: Quality Care of Stomates**

Moderators: Gina Jiang (HongKong), Chin-Wen Shiao (Taiwan), Ching-Wen Huang (Taiwan)

RL-11 **Quality Care of Stomates from the Doctor's Point of View**
Gina Jiang (HongKong)

RL-12 **(Peristomal) Medical Adhesive Related Skin Injuries and the Impact to Skin Health**
Chin-Wen Shiao (Taiwan)

RL-13 **Quality Care of Stomates with HongKong's Experience**
Chak-Hau Pang (HongKong)

RL-14 **Quality Care of Stomates with Korea's Experience**
Hyun-Jung Yeo (Korea)

Panel Discussion

15:30-16:00 **Break**

16:00-17:30 **Symposium 4: Debate Issues on Stoma Care**

Moderators: Henry Hsin-Chung Lee (Taiwan), Chien-Chih Chen (Taiwan)

Debate Issues on Stoma Care-Diverting Stoma- Ileostoma vs Colostoma

RL-16 **Diverting Stoma- Ileostoma**
Bo-Wen Lin (Taiwan)

RL-17 **Diverting Stoma- Colostoma**
Hsiang-Lin Tsai (Taiwan)

Group Discussion

Debate Issues on Stoma Care-Protruding vs Flat Stoma

RL-18 **Protruding Stoma**
Shih-Chang Chang (Taiwan)

RL-19 **Flat Stoma**
Ching-Kuo Yang (Taiwan)

Group Discussion

Debate Issues on Stoma Care-Irrigation vs Non-irrigation of Stoma

RL-20 **Irrigation of Stoma**
Mariam Mohd Nasir (*Malaysia*)

RL-21 **Non-irrigation of Stoma**
Jui-Ping Lin (*Taiwan*)

Group Discussion

18:00- **Gala Dinner**

Sunday, 28 November, 2021

Venue: Meeting Room 2

08:30-10:00 **Patient Session**

RL-22 **Address from 12th ASSR Congress President**
Jaw-Yuan Wang (*Taiwan*)

Keynote Speech

Moderator: Jaw-Yuan Wang (*Taiwan*)

RL-23 **The Treatment Update on CRC**
Tzu-Chi Hsu (*Taiwan*)

RL-24 **How Can Live with Stoma**
Po-Jui Yu (*Taiwan*)

Asian Ostomates Association Sharing

RL-26 **Mariam Mohd Nasir (*Malaysia*)**
Chak-Hau Pang (*Hong Kong*)



Abstract



Saturday, 27 November, 2021 8:30-10:00

Venue: Meeting Room 2

ASSR Opening CeremoniesKeynote Speech I Moderators: Jaw-Yuan Wang (*Taiwan*), Tzu-Chi Hsu (*Taiwan*)Keynote Speech II Moderators: Henry Hsin-Chung Lee (*Taiwan*), Shih-Hsin Hung (*Taiwan*)**RL-1 Opening Remarks**

Jaw-Yuan Wang (*Taiwan*)
*Kaohsiung Medical University Chung-Ho Memorial
Hospital, Kaohsiung, Taiwan*

Dear distinguished guest, colleagues and friends,
It is my great honour to extend our personal greeting to each and every one of you who are joining us for the 13th Congress of Asian Society of Stoma Rehabilitation which will be held on November 28 to 29, 2021 in Taipei, Taiwan.

The need for long-term support for the variety of challenges faced by cancer survivors with ostomies. In 2015 an international study have shown that the majority of ostomates have issues related to leakage and ballooning which, among other things, have a negative effect on sleep, or lead to unplanned appliance changes for approximately 40% of the respondents. Throughout the past years, we strived to make this event a symbolic gathering of stoma care professionals in the worldwide region. This joint congress aims to promote an exchange of the most up-to-date progress on optimal stoma care.

The theme of this year's congress are stoma nursing and patient care with the following emphases: (1) Standard and quality of stoma nursing; (2) Latest innovation of stoma treatment and experience sharing from patients. It is essential to highlight the importance of identifying and disseminating best practices for stoma care. Innovative stoma care strategies and better clinical practice can be achieved through integrating academic research.

We aim to provide an ideal and cordial platform for networking, sharing experiences, exchanging views, discussing the advancements and breakthroughs in the field of stoma care.

**RL-2 Keynote Speech I
The New Trend of Treatment on
Colorectal Cancer**

Kotaro Maeda (*Japan*)
Fujita Health University Hospital, Aichi, Japan

Colorectal cancer is increasing in Japan and other Asian countries. On the other hand, mortality of colorectal cancer is decreasing in European-American countries, and is slightly decreasing in Japan. However it is still increasing in other Asian countries.

Laparoscopic surgery became prevalent in many Asian countries. It is especially useful in cosmesis and quick recovery as minimally invasive technique. Nowadays, laparoscopic colorectal surgery is the predominant procedure for colorectal cancer in Japan. Furthermore, robotic surgery is also becoming popular in several Asian countries. The number of robotic surgery is rapidly increasing after insurance cover in Japan. TaTME is reported to have advantages in keeping circumferential margin, and in excision of big tumors. However, urethral injury and local recurrence is reported as drawback. Intersphincteric resection for very low rectal cancer became a standard surgery. However, several defecation disorders have been reported as low anterior resection syndrome (LARS). LARS was taken care by WOC nursed only in 37 % of hospitals. As treatments of LARS, informed consent to the patient about this possible situation before surgery is important. Medication by polycarbophil-calcium and pelvic floor training are treatment modality to be performed. Transanal irrigation and sacral neuromodulation can be an option for severe LARS. Stenting for obstructive colorectal cancer became prevalent, and its feasibility and safely were recently clarified from Europe. Watch and wait is tactics of just watch and wait in cases with complete response after CRT for rectal cancer. Current status of watch and wait for rectal cancer treatment in Asia-Pacific countries and local treatment of rectal cancer will be shown in the lecture.

RL-3

Keynote Speech II
Standard Care and Complication
Management of Stoma

Chizu Sakai-Imoto (USA)
Cleveland Clinic, Ohio, USA

During this presentation, the presenter would like to share the experience of stoma care and the role of WOC nurse in the WOC nursing team at Cleveland Clinic, Cleveland, Ohio, in the USA. Cleveland Clinic is known as the first place to create enterostomal therapist by Dr. Rupert Turnbull Jr. and Norma Gill in 1958. Since then, our team grow larger than ever but still respect our own history and value of education from previous enterostomal nurses (now we are titled as WOC nurses). The presentation will include basic skill to select right kind of pouching systems to prevent peristomal complication or trauma to the stoma. Addressing some of complication that would happen during ostomy care and discuss how to manage each situation in WOC nurse's point of view.

Symposium 1 Preoperative Siting of Stoma

Moderators: Jy-Ming Chiang (Taiwan), Shih-Ching Chang (Taiwan), Tung-Kuang Wang (Taiwan)

RL-4 Importance of Preoperative Stoma Siting

Chang-Chieh Wu (Taiwan)
Tri-Service General Hospital Keelung Branch, Keelung,
Taiwan

Stoma care education and siting before surgery is very important. Most patients needing ostomy have no prior experience with stoma. Good preoperative education and siting could improve postoperative quality of life as well as surgical outcome.

Stoma care education and siting procedures are commonly provided by ostomy care nurses following evidence-based practices and should be done in a private environment. Marker pens, stoma location disks, human body model, wafers and pouches, must be prepared before the procedure. Ostomy care nurses doing the procedures should be familiar with the upcoming surgical operations.

Several factors could help to determine the best placement. Patient's mobility, occupation, lifestyle, habits and cultural practices should be taken into consideration.

Ostomy must be placed over one of the four quadrants of abdomen between the umbilicus and iliac crest (or rib) and above the rectus abdominis muscle. The skin area should be smooth and flat allowing adequate adhesive surface contact and secure attachment between the pouch and the skin. If possible, stoma site should be easily visible to the patient, which may help future ostomy care.

The selected site(s) should be marked by an indelible marker such that it remains visible after the surgical scrub. Also, the selected site(s) should be documented to make sure the surgeon would understand the intent of the mark in the operating room. The surgeon may still have a different decision during the operation.

RL-5 Preoperative Siting of Stoma - Role in Emergent Surgery

Ting-Kuang Wang (Taiwan)
Taipei Municipal Wan Fang Hospital, Taipei, Taiwan

Colonic emergencies remain major life-threatening conditions associated with high morbidity and mortality rates. Non-specific abdominal symptoms account for their delayed presentation especially in elderly patients with multiple comorbidities and limited metabolic reserves. Emergency stomas are associated dehydration, renal failure, and an inability to reverse the stoma as well as risks from the stoma reversal procedure. Emergency stomas where the site has not been marked preoperatively by a stoma therapist are more prone to complications. These complications may severely affect a patient's quality of life.

Selecting a good site enhances the probability of patient independence in stoma care and the resumption of normal activities. Patients who saw a stoma therapist preoperatively presented significantly lower rates of stoma complications and anxiety. A patient offered preoperative preparation is more likely to be an active participant in the postoperative education of others. It has been shown that patients and family members who receive comprehensive information concerning overall ostomy rehabilitation have lower anxiety rates. Patients and family members included in the rehabilitation plan are more apt to adapt successfully to the ostomy.

Stoma siting before surgery was a risk factor for stoma-related complications regardless of the type of stoma. Pre-operative stoma site marking that we recommended.

RL-6 In Temporary and Permanent Stoma

Miki Masada (*Japan*)

Mitoyo General Hospital, Kagawa, Japan

Stoma site marking (“SSM”) is a pre-operative procedure to determine the most appropriate position of the stoma site for the purpose of ensuring that the patient will be able to manage their own ostomy as well as for preventing post-operative stomal complications. Regardless of whether the patient will have a temporary or permanent stoma, it is, therefore, important to select a position that provides a flat surface to which the skin barrier can adhere securely. The appropriate position should be determined with Cleveland Clinic Principles” in mind. Standard SSM may however not be appropriate for emergent surgery that results in a stoma. In such cases it is often difficult to determine whether the stoma will be temporary or permanent. Similarly, SSM for palliative care may affect pathological changes and stoma management after surgery. With the recent introduction of laparoscopic and robotic technology there is furthermore a need to take into account the positioning of the devices associated with these surgical procedures. In such cases the nurse responsible for SSM should consult with the surgeon. Appropriate SSM will be determined based upon a balance of both medical judgment and factors to provide for relatively easy stoma management. In this symposium we will examine a number of cases to discuss SSM in a step-by-step manner from various perspectives for being able to provide both effective treatment and high-quality nursing care.”

Saturday, 27 November, 2021 13:00-14:30

Venue: Meeting Room 2

Symposium 2 Variation of Stomas for Malignancies and for Benign Disease

Moderators: Tzu-Chi Hsu (Taiwan), Chang-Chieh Wu (Taiwan), Chou-Chen Chen (Taiwan)

**RL-8 Stoma Construction in Japan:
the Current State of the Art**Yoshito Akagi (Japan)
Kurume University, School of Medicine, Fukuoka, Japan

Colorectal cancer and inflammatory bowel disease and are now on the rise in Japan. Colostomy or ileostomy has come to be enforced for the chemotherapy for highly advanced colorectal cancer and other diseases as palliative surgery. The ostomates are increasing year by year for diverse purposes.

The background of the disease which requires stoma construction is complicated, and various considerations are necessary in the operation.

The procedure of colostomy and ileostomy itself is basically a less difficult surgery. However, the unsigned surgery becomes difficult to the management of stoma after the operation. Difficult stomas reduce the patient's QOL.

In this symposium, I would like to talk about various situations that require stoma construction and the ostomy.

**RL-9 Inflammatory Bowel Disease and
Stoma Construction**Kenichi Hakamada (Japan)
Department of Gastroenterological Surgery, Hirosaki
University Graduate School of Medicine, Hirosaki, Japan

Inflammatory bowel diseases (Crohn's disease (CD) and ulcerative colitis (UC)) have been treated with various surgical procedures depending on the pathology and disease activity. Stoma construction is an effective treatment, especially for the management of severe cases and intractable anal lesions. In addition, the timing of stoma placement (one to three staged surgery), the location of the stoma (ileum or colon), and the method of stoma placement (loop stoma or endo-stoma) were discussed depending on the pathology. In recent years, as the number of patients responding to anti-TNF α agents and biologic agents has increased, the number of patients who can avoid surgical treatment, including stoma construction, has also increased. In this presentation, I will review the changes in the surgical treatment of inflammatory bowel disease and report the timing, location, and method of stoma construction and stoma-related complications for each disease.

RL-10 **Variation of Stomas for Carcinoma of
Colorectum**

Chang-Chieh Wu (*Taiwan*)
*Tri-Service General Hospital Keelung Branch, Keelung,
Taiwan*

Indications of stoma creation on colorectal cancer patients include tumor-related obstruction, protection for anastomosis after colectomy operation, and after abdominal perineal resection (APR) surgery. There are different types of stomas, including colostomy or ileostomy and loop or end types. Variation of stomas is meant for better diversion of the fecal stream.

Colostomy is to artificially create a hole (stoma) at the colon, while ileostomy is to create a hole (stoma) usually at the last portion of the small intestine (terminal ileum), and then connect the hole at colon or small intestine to the abdominal wall. Loop-type ostomy is usually temporary and end-type ostomy may be permanent or temporary. Colostomy could be performed at different sites of the mobile colon, including transverse colon, sigmoid colon or cecum (rare), according to the location of tumor or anastomosis. For colorectal carcinoma patients, stoma should be selected at more distal part of colon or small bowel but proximal to the anastomosis or tumor location.

In temporary condition, loop-type stoma is preferred.

Symposium 3 Quality Care of Stomates

Moderators: Gina Jiang (*HongKong*), Chin-Wen Shiao (*Taiwan*), Ching-Wen Huang (*Taiwan*)

RL-11 Quality Care of Stomates From the Doctor's Point of View

Gina Jiang (*HongKong*)
*The Chinese University of Hong Kong (CUHK),
 HongKong, China*

In a typical hospital setting, a doctor spends only minutes seeing a patient each time. For a stomate, not only is the doctor-patient encounters a tiny fraction of his or her journey living with the condition, the time constraint of these visits often is only enough for technical solutions, but not enough for a comprehensive review of how the treatment, rehabilitation, and everyday care and maintenance are in relation to the quality of life he/she desires.

Over the past 15 years, a growing number of interdisciplinary professionals and experts are coming together to change this medical and health care status quo. In this 10-minute presentation, Dr. Jiang will share a case study at the Fu Jen Catholic University Hospital of working with an unconventional team to bring quality care and solutions to stomates' everyday life, and her systematic approach to redesigning stomate care by focusing on people, process, place. She aims to encourage interest healthcare providers to reimagine the possibilities of quality care for patients.

RL-12 (Peristomal) Medical Adhesive Related Skin Injuries and the Impact to Skin Health

Chin-Wen Shiao (*Taiwan*)
National Taiwan University Hospital, Taipei, Taiwan

Creation of an ostomy is a life-changing event, resulting in alterations in body image, urinary or fecal elimination, peristomal skin status, and multiple components of health-related quality of life.

While the exact prevalence is not known, there are estimated to be up to 1 million people with an ostomy in the United States alone.

According to study found that 36.7% experienced a peristomal skin complication (PSC) during the first 90 days following ostomy surgery; These patients had a higher likelihood of subsequent hospital admissions and health care costs were approximately \$80,000 (USD) higher than patients without Peristomal Skin complications .

The most common types includes peristomal moisture-associated skin damage (MASD), irritant dermatitis, hypersensitivity and allergic responses of the skin, and mechanical damage related to the use of medical adhesives in various pouching systems.

Today's presentation will look at MARSİ in general and how it can be related to support Peristomal MARSİ.

We will look at the 5 clinical presentations that exist for peristomal MARSİ and relate them to ostomy care as well as look at some strategies that can be used to help reduce the incidence of peristomal MARSİ.

RL-13 **Quality Care of Stomates with HongKong's Experience**

Chak-Hau Pang (*HongKong*)
Vice-chairperson, Hong Kong Enterostomal Therapists Association, HongKong, China

Stoma care is a basic needs for patient with stoma. Even in the time of COVID pandemic and lock down of the society, the numbers of new ostomates were not decreased. Increased social distancing and No-visitor policy have much impact on the peri-operative care for stoma patients, stoma care nurses has to be manipulative and innovative in order to overcome the obstacles.

RL-14 **Quality Care of Stomates with Korea's Experience**

Hyun-Jung Yeo (*Korea*)
Asan Medical Center, Seoul, Korea

Clinical practice is the core practice of WOCN's work. Stoma marking and stoma-related consultation are provided to patients scheduled for stoma surgery. The stoma education is performed by WOCN, after the surgery, usually the patient received 2 rounds of individual education sessions and 1 round of a group education session. The education focused on theoretical aspects, such as the purpose of ostomy care and necessary precautions. After discharge, an outpatient visit is usually made two weeks later. At the first outpatient visit, the stoma condition is checked and stoma supplies are provided. KAWOCN is a group of nurses who treat various acute and chronic wounds, including pressure injuries, and provide pre-operative counseling and post-operative care and rehabilitation for stoma patients and incontinence management. This year, KAWOCN published 'Clinical ostomy management essentials'. Based on the Clinical Nursing Practice Guideline and WCET Guideline, this book is designed to enhance understanding with illustrations and photos, and to explain it through actual cases so that it can be easily applied to clinical practice. As part of a national project, we are developing XR based educational materials for stoma education for stoma patients. As such, KAWOCN has been working hard from the past to the present to improve the quality of life of stomates for 20 years, and is constantly thinking about the optimal education method in response to the trend of the times.

Symposium 4 Debate Issues on Stoma Care

Moderators: Henry Hsin-Chung Lee (*Taiwan*), Chien-Chih Chen (*Taiwan*)

**RL-16 Debate Issues on Stoma Care
-Diverting Stoma- Ileostoma vs
Colostoma [Ileostoma]**

Bo-Wen Lin (*Taiwan*)
National Cheng Kung University Hospital, Tainan,
Taiwan

Total mesorectal excision and intersphincteric resection are standard treatment for middle and low rectal cancer. In order to reduce leakage related complications, surgeons often perform diverting stoma, either loop ileostomy (LI) or loop colostomy (LC).

Several condition also involving stoma creation, such as cancer obstruction, diverticulitis ruptured, ischemia bowel or other advanced pelvic surgery. However, there is no evidence on which is better technique to adopt.

We review some randomized trails and meta analysis, concerning timing of stoma creation, peristomal complications, nursing care problems, quality of life, nutrition status, mortality and mobility. There are no conclusive results. Surgeons should perform these procedures according to patient's condition, hospital facilities and personal experiences.

**RL-17 Debate Issues on Stoma Care
-Diverting Stoma- Ileostoma vs
Colostoma [Colostoma]**

Hsiang-Lin Tsai (*Taiwan*)
Kaohsiung Medical University Chung-Ho Memorial
Hospital, Kaohsiung, Taiwan

Fecal diversion is an important tool in the surgical armamentarium. There is much controversy regarding which clinical scenarios warrant diversion. As the years have progressed, we have come to acknowledge that the ostomy is a tool that improves, palliates, and facilitates several complex situations and plays an integral role in surgical decision making. Palliative stoma creation should be considered in patients at high risk of colonic anastomotic leakage or metallic stent failure. However, it is unclear whether ileostomy or colostomy is superior.

Ileostomy or colostomy formation is an important component of many surgical procedures performed for a wide range of disorders of the gastrointestinal tract. Several stoma related complications can occur following ileostomy or colostomy formation. The incidence of stoma related complications ranged from 2.9% to 8.1%. While the risk of developing a complication remains lifelong, the incidence is highest in the first 5 years after stoma formation. In this debate, I will state the advantages and disadvantages of colostomy based on real-world practice.

**RL-18 Debate Issues on Stoma Care
-Protruding vs Flat Stoma
[Protruding Stoma]**

Shih-Chang Chang (*Taiwan*)
Cathay General Hospital, Taipei, Taiwan

Creating an intestinal stoma is commonly the final aspect of an often emergent or complicated operation.

Some patients must live with the stoma for the remainder of his life.

While the creation of a protruding, tension-free, and well-vascularized stoma is often straightforward, but surgeons must be prepared for some challenging situations.

A successful stoma starts with attentive preoperative planning including site marking, thoughtful consideration of alternatives, and attention to technical detail.

Constructing a high-quality stoma will decrease stoma complications and improve the patient's quality of life.

**RL-19 Debate Issues on Stoma Care
-Protruding vs Flat Stoma
[Flat Stoma]**

Ching-Kuo Yang (*Taiwan*)
MacKay Memorial Hospital, Taipei, Taiwan

Types of stomas: Colostomy; ileostomy; urostomy. They can be loop or end, permanent or temporary

Ideal healthy stoma

- moist
- Beefy red
- Round
- Budded/Protruding
- Appropriate stoma location

Flat stoma (flush stoma)

Definition: The mucosal level with the skin

It may be the result of a surgeon's technique (tension for example), or may occur over time

May result of weight gain or loss

The most common stomal complication (8.5%)

Intervention and management (1)

1. most flat stoma do not cause problems

2. If stool leakage from pouching bag,

-Use soft or shallow convexity (a special pouch with a curved back)

Intervention and management (2)

Botulinum toxin A injection (BoNT-A)

Some doctors try Botox peri-stomal injections if using convex bag to manage flat stoma failure.

Management for denuded peristomal skin around a flat stoma

Place several layers of powder and sealant on the skin

Empty pouches when one-third to one-half full

Apply antifungal powder if Candidiasis

Dietary intake, consider bulking agent

Summary

Most Flat (flush) stomas do not cause problems

The result of a surgeon's technique, or may occur over time

If stool leakage, use soft or shallow convexity BoNT-A may be a promising treatment

**RL-20 Debate Issues on Stoma Care
-Irrigation vs Non-irrigation of Stoma
[Irrigation of Stoma]**

Mariam Mohd Nasir (*Malaysia*)
Malaysia Enterostomal Therapists Association, Malaysia

Stoma Care irrigation should be seen as an option for those who can choose especially those who are having permanent colostomy.

This will enable the ostomate to empty their bowel at the same time each day and helps to avoid constipation and regulate bowel movements. This will give them a kind of empowerment and in control of their bowel movement again and ultimately their life.

It is a cost saving decision and living without pouches is always a choice of life for anyone who need to use a bag for the rest of their life. When the bowel has been regulated well, the ostomates will be able to plan better on their daily activities, travelling especially their intimacy moment with their partner.

Even with so many difficulties, I think an ostomate who wanted to have stoma irrigation as an option, should be encouraged and motivated to do so.

As the say goes “no harm trying” but the ostomate must be well informed all the challenges that they need to face before it become successful, and it also will take some time to adjust to this new kind of life.

Mentally they must be strong, and family and friends support are as well as important aspect and key to success.

Many ostomate reported having difficulties in performing stoma irrigation but at the same time we also heard many successful stories too. At the end of the day the decision is up to the ostomate either to do or not.

We as health care providers especially an Enterostomal Therapist (E.T.) should always play a role in identifying the needs and to assist them accordingly.

**RL-21 Debate Issues on Stoma Care
-Irrigation vs Non-irrigation of Stoma
[Non-irrigation of Stoma]**

Jui-Ping Lin (*Taiwan*)
Taipei Veterans General Hospital, Taipei, Taiwan

Colostomy irrigation (CI) may be used by patients with colostomies to regulate bowel evacuations by stimulating emptying of the colon at regularly scheduled times. The Evidence-Based Report Card reviews the effect of colostomy irrigation on frequency of bowel evacuation, flatus production, odor, and health-related quality of life. Colostomy irrigation reduces the frequency of bowel evacuations when compared to spontaneous evacuation and containment using a pouching system. Regular irrigation is associated with reductions in pouch usage. This change in bowel evacuation function frequently results in absence of bowel evacuations for 24 hours or longer, enabling some to discontinue ongoing use of a pouching system. Subjects using CI report reductions in flatus and odors associated with presence of a colostomy. One study was identified that found persons using CI reported higher health-related quality of life than did those who managed their colostomies with spontaneous evacuation using the Digestive Disease Quality of Life-15. Instruction on principles and techniques of colostomy irrigation should be considered when managing patients with a permanent, left-sided colostomy. But it is not recommended for the following problems lack of motivation, poor manual dexterity, irritable bowel syndrome, serious heart disease, visual impairment, serious kidney disease.

Sunday, 28 November 2021 8:30-10:00

Venue: Meeting Room 2

Patient Session

Keynote Speech Moderator: Jaw-Yuan Wang (Taiwan)

RL-22 Opening Remark and Keynote Speech

Jaw-Yuan Wang (Taiwan)
Kaohsiung Medical University Chung-Ho Memorial Hospital, Kaohsiung, Taiwan

RL-23 Keynote Speech The Treatment Update on CRC

Tzu-Chi Hsu (Taiwan)
MacKay Memorial Hospital, Taipei, Taiwan

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Because of recent advances in medical technology and new findings of clinical trials, treatment options for colorectal cancer are evolutionally changing. Therefore, we need to update the treatment options and strategies so that patients can receive optimal and tailored treatment.

Although new surgical technologies including TaTME, robotic surgery, laparoscopic lateral pelvic lymph node dissection are rapidly merging. Surgeons should notice the risk of adverse outcomes associated with unfounded and uncontrolled use of these novel techniques. Surgeons need to carry out their preparations with the most studious care to prevent unfavorable outcomes in patients.

Even for laparoscopic surgery, surgeons should keep in mind that recent RCT, the ALaCaRT and ACOSOG Z6051 trials could not show non-inferiority of laparoscopic surgery to open surgery for rectal cancer in terms of pathological results...

The recent progress of preoperative and postoperative treatment is also promising. However, development of new biomarkers seems essential for further improvement in the treatment outcomes of colorectal cancer patients.

RL-24 **Keynote Speech**
How Can Live with Stoma

Po-Jui Yu (*Taiwan*)
Fu Jen Catholic University Hospital, New Taipei City,
Taiwan

The transition from hospital to home can be a worrying period of time for a patient with a newly formed stoma. It is well documented that community care is important, however this transition has been seen as a weak link in the care for a patient with a stoma. In most cases following discharge from hospital, the nurse specialist in stoma care will visit the patient at home as a means of maintaining continuity of care. It is also important that the patient's GP, home care nurse and other relevant community services are introduced to ensure a cohesive approach to the patients care at home. This article therefore aims to offer the community nurse an overview of stoma care nursing in order to provide the continuity of care much needed by this group of patients.

RL-26 **Asian Ostomates Association Sharing**

Mariam Mohd Nasir (*Malaysia*)
Malaysia Enterostomal Therapists Association, Malaysia

Currently in Malaysia we have our Malaysian Ostomy Association (MOsA) as a support group for ostomates besides that we also have Colorectal Cancer Survivorship Society, Malaysia (CORUM).

MOsA is affiliated and a member of Asia South Pacific Ostomy Association (ASPOA). We recently had our Annual General Meeting but unfortunately the membership among ostomate was very few and most of the Enterostomal Therapist is the one who managing the society.

Recruitment is a big challenge since majority patients not interested to join the society, but the society is trying their best to promote and recruit more members. Up to date we have less than 50 members and they normally will join any events related but not as an active member. However, CORUM are more active, and they have a continuous program especially in educating the patient including family members and also gathering.

The traders and M&T Network Consultancy Services Sdn Bhd, an Enterostomal Nursing training centre is also supporting the society on some activities especially the World Ostomy Day celebration.

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Since 1997