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大腸直腸外科秋季學術研討會 Autumn Academic Symposium of Colorectal Surgery

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主辦單位

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2. 腸胃道間質腫瘤：適用於治療先前曾接受 imatinib mesylate 與 sunitinib malate 病人之局部晚期、無法切除或轉移性的腸胃道間質腫瘤病人。3. 肝細胞癌：適用於治療曾接受 sorafenib 治療的肝細胞癌 (HCC) 病人。

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禁忌症：無。

警語及注意事項：在臨床試驗中，接受 STIVARGA 治療的病人曾發生最終致死的重度藥物誘發性肝臟傷害。在多數案例中，肝功能障礙都是在治療最初 2 個月內發生，且特徵為肝細胞層級的損傷型態。[請參閱警語與注意事項 (5.1)]。在開始 STIVARGA 治療之前須進行肝功能檢測 (ALT、AST 與膽紅素)，且在治療的前 2 個月，至少每兩週要監測一次；接下來，依照臨床指示，每月至少須監測一次。肝功能檢測數值升高的病人，須每週進行肝功能檢測，直到數值低於正常值上限或基期的三倍。[請參閱警語與注意事項 (5.1)]。藉由肝功能檢測的數值上升程度與肝細胞壞死情形，可了解肝中毒的嚴重性與持續時間，進而決定暫停使用 STIVARGA 後，接下來應該暫時降低藥量或永久停用 [請參閱用法用量 3.1(2) 與使肝功能不全 (6.6)]。STIVARGA 會提高出血機率，涉及中樞神經系統或呼吸道、腸胃道或生殖泌尿道。出現重度或具生命威脅性出血症狀的病人，請永久停用 STIVARGA。接受 warfarin 的病人須更頻繁偵測其 INR 值 [藥物動力學特性 (11)]。STIVARGA 曾提高感染、高血壓、心臟缺血與梗塞、皮膚毒性風險。曾觀察到可逆性後腦白質病變症候群、胃腸穿孔或瘻管的案例。STIVARGA 有阻礙傷口癒合風險，使用此藥物病人之內皮生長因子 (VEGF) 訊號傳遞路徑被抑制，使得阻礙傷口癒合之併發症發生。因此，STIVARGA 對於傷口癒合有潛在的負面影響。擇期手術 (elective surgery) 前至少兩週停用 STIVARGA。重大手術之後至少兩週不要使用 STIVARGA，直到傷口充分癒合。傷口癒合併發症消退後再度使用 STIVARGA 之安全性尚未被建立。[請參閱警語與注意事項 (5.1)]。治療期間及治療完成後 2 個月內，須採取有效的避孕措施。

常見不良反應：疼痛 (包括胃腸疼痛與腹痛)、HFSR、無力/疲累、腹瀉、食慾減退/食量減少、高血壓、感染、發音困難、高膽紅素血症、發燒、黏膜炎、體重減輕、皮疹以及噁心。

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MA-M_REG-TW-0100-1 Approval Date: 05.2026

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Agenda

2026/09/19 (六) 感恩廳

From - To	Topic	Speaker	Moderator	
08:50 - 09:00	Opening Remarks		劉建國醫師	
	Systemic Treatment			
09:00 - 09:30	Optimizing Treatment Strategies in Metastatic Colorectal Cancer: Emerging Targeted Therapies and Beyond	梁逸歆醫師	張世慶醫師 陳昭仰醫師	
09:30 - 10:00	Optimizing Third-Line Therapy in mCRC: The Expanding Role of Trifluridine/Tipiracil-Based Combinations	張沛泓醫師		
10:00 - 10:30	Evolution and Future of Upfront Chemotherapy in mCRC	林炯森醫師		
10:30 - 10:40	Discussion			
10:40 - 10:50	Coffee Break			
	Hemorrhoid			
10:50 - 11:20	When Less Is Not Enough: The Continuing Role of Excisional Hemorrhoidectomy in Modern Hemorrhoid Surgery	蔡坤佑醫師	黃敬文醫師 張譽耀醫師	
11:20 - 11:50	Excision vs. Pexy ? Decision-Making in Hemorrhoids and Long-term Experience of Hemorrhoidopexy	胡哲銘醫師		
11:50 - 12:20	Rethinking Hemorrhoid Management: Clinical Insights on Laser Hemorrhoidoplasty (LHP)	謝孟樵醫師		
12:20 - 12:30	Discussion			
12:30 - 12:50	Lunch			
	Free Paper			
12:50 - 12:55	Colonoscope diagnosis of Ancylostoma ceylanicum infection : Case report	彭啓堯醫師	蔡祥麟醫師	
12:55 - 13:00	Diagnostic Dilemma of a Colonic Subepithelial Tumor: A Colonic Schwannoma Initially Suspected as Gastrointestinal Stromal Tumor	游靖皓醫師		
13:00 - 13:05	Traumatic Mesocolon Injury Resulting in Sigmoid Colon Ischemia and Subsequent Enterocutaneous Fistula: A Case Treated with Laparoscopic Colectomy	顧家宇醫師		
13:05 - 13:15	Extracorporeal Circular Left Colonic End-to-End Anastomosis: A Mechanized, Low-Learning-Curve Alternative to Hand-Sewn Reconstruction	黃恩民醫師		
13:15 - 13:25	Technical feasibility and surgical outcomes of Artisential laparoscopic surgery for the treatment of colorectal tumor: Preliminary experience from a single center	鄭宗杰醫師		
13:25 - 13:35	Advantages of Endoscopic Tattooing in Laparoscopic Surgery for Left-sided Colon Cancer	蕭于君醫師		
13:35 - 13:45	Textbook Outcome and Long-term Oncological Safety after a Domains-of-Four-Step Training Programme in Laparoscopic Colorectal Cancer Surgery (TCAR2526 Study)	陳繹中醫師		
13:45 - 13:50	Discussion			
	Minimal Invasive Surgery			
13:50 - 14:20	Small rectal neuroendocrine tumor endoscopic resection:ESD or Padlock clipping method	楊靖國醫師		蔣鋒帆醫師 許詔文醫師
14:20 - 14:50	Wisely choosing laparoscopy and robotic surgery in minimal invasive colorectal surgery	廖御佐醫師		
14:50 - 15:20	Beyond Feasibility: Choosing the Right Robotic Platform for Colorectal Surgery — Lessons from HUGO Right Hemicolectomy and Anterior Resection	柯道維醫師		
15:20 - 15:30	Discussion			
15:30 - 15:40	Coffee Break			
	Dilema in CRS			
15:40 - 16:00	Bleeding Crisis in the Lower GI Tract: Mastering Endoscopic, Surgical, and Complex Challenges	林耿立醫師	魏柏立醫師 林春吉醫師	
16:00 - 16:20	Potential Etiologies, Case Discussions, and Treatment of Lower Gastrointestinal Obstruction 下消化道阻塞的潛在病因、個案討論及治療	賴正洲醫師		
16:20 - 16:50	Palliative and Supportive Care for Colorectal Cancer Patients: Integrating Specialty Palliative Care into the Surgical and Oncologic Continuum	侯天崎醫師		
16:50 - 17:00	Discussion			
17:00 - 17:10	Closing Remark	陳自諒醫師		

Moderator



林春吉



張世慶



張譽耀



許詔文



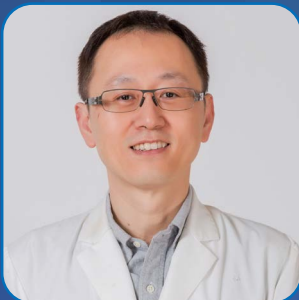
陳昭仰



黃敬文



蔡祥麟



蔣鋒帆



魏柏立

註：按姓氏順序排列

Agenda

2026/09/19 (六) 301 室

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13:45 - 13:50	Discussion		
	Innovations and Frontiers in Colorectal Surgery		
13:50 - 14:20	Crafting a Hospital-Specific AI Assistant: A Practical Guide to Training Endoscopic Vision-Language Models 打造醫院專屬的內視鏡 AI 助手：Vision-Language Model 自主訓練實戰	黃崇堯醫師	
14:20 - 14:50	Radiotherpy in Modern Rectal Cancer Management	劉士華醫師	黃文詩醫師 李克釗醫師
14:50 - 15:20	Optimizing Local-Regional Control in Colorectal Peritoneal Seedings: Present Realities (HIPEC/PIPAC) and Future Frontiers	張伸吉醫師	
15:20 - 15:30	Discussion		
15:30 - 15:40	Coffee Break		
	Trending Topics		
15:40 - 16:30	性傳染病，U=U，及標準防護	李佳雯醫師	謝寶秀醫師 藍苑慈醫師
16:30 - 16:50	性傳染疾病與大腸直腸外科	張亘成醫師	
17:00 - 17:10	Closing Remark	陳自諒醫師	

Moderator



李克釗



黃文詩



陳自諒



劉建國



謝寶秀



藍苑慈

註：按姓氏順序排列



梁逸歆 醫師

Yi-Hsin Liang, M.D., Ph.D.

- Attending Physician, Department of Oncology, National Taiwan University Hospital
- Assistant Professor, Graduate Institute of Oncology, College of Medicine, National Taiwan University

Optimizing Treatment Strategies in Metastatic Colorectal Cancer: Emerging Targeted Therapies and Beyond

The management of metastatic colorectal cancer (mCRC) is increasingly guided by biomarker-driven strategies, reflecting the continued evolution toward precision oncology. Comprehensive molecular profiling, including RAS, BRAF, HER2, and microsatellite instability/mismatch repair (MSI/MMR) status, plays a critical role in informing treatment selection, sequencing, and overall treatment planning.

The therapeutic landscape of mCRC continues to expand across multiple molecularly defined pathways. Established and emerging approaches include EGFR inhibition in RAS wild-type disease, BRAF-targeted combinations for BRAF V600E-mutant tumors, HER2-directed therapies for HER2-positive disease, and strategies targeting specific KRAS alterations. Recent evidence, including findings from the phase III BREAKWATER trial, further highlights the evolving role of targeted combination strategies in selected molecular subgroups.

Beyond targeted therapies, immune checkpoint blockade has transformed the treatment paradigm for patients with MSI-H/dMMR mCRC, further reinforcing the importance of biomarker-driven treatment selection. Looking ahead, novel modalities such as antibody-drug conjugates (ADCs) and bispecific antibodies are also emerging and may further broaden the therapeutic landscape of mCRC.

In clinical practice, treatment decisions should integrate molecular characteristics with key clinical factors, including tumor burden, disease distribution, patient

condition, and treatment intent. This presentation will summarize available molecular targets and alternative therapeutic pathways in mCRC, while highlighting how targeted therapies, immunotherapy, and emerging approaches may contribute to increasingly individualized treatment strategies.



張沛泓 醫師
Pei-Hung Chang, M.D.

• 基隆長庚紀念醫院 癌症中心 主任

Optimizing Third-Line Therapy in mCRC: The Expanding Role of Trifluridine/Tipiracil-Based Combinations

Later-line treatment of metastatic colorectal cancer (mCRC) remains challenging after failure of fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy and appropriate targeted agents. At this stage, treatment should aim not only to prolong survival, but also to stabilize disease, preserve performance status, maintain quality of life, and allow patients to receive subsequent therapy. Trifluridine/tipiracil (FTD/TPI) has a distinct mechanism involving incorporation of trifluridine into tumor-cell DNA and retains activity after resistance to conventional fluoropyrimidines.

The phase III RECOURSE trial established FTD/TPI as an effective later-line treatment, while subsequent Asian and real-world studies confirmed its clinical applicability.

The phase III SUNLIGHT trial further demonstrated that adding bevacizumab significantly improves survival and disease control compared with FTD/TPI alone, establishing FTD/TPI plus bevacizumab as the most evidence-based combination in this setting. Other strategies are also being explored. The VELO trial supports FTD/TPI plus panitumumab as a potential anti-EGFR rechallenge approach in carefully selected patients with RAS/BRAF wild-type disease, particularly when circulating tumor DNA excludes resistant clones. Combinations with irinotecan or oxaliplatin have also shown promising activity, although optimal patient selection and toxicity management remain important.

Real-world evidence may help translate trial findings into routine practice. A multicenter Chang Gung Medical Foundation database analysis of 591 patients treated with FTD/TPI identified mismatch-repair status, body mass index, and the neutrophil-to-lymphocyte ratio as independent prognostic factors, suggesting that molecular characteristics, nutritional status, and systemic inflammation may refine patient selection.

The Chang Gung multicenter phase II PROTECT study further evaluated biweekly FTD/TPI combined with irinotecan or oxaliplatin in previously treated mCRC. The study demonstrated encouraging disease control and survival with manageable toxicity, while disease tempo and the chemotherapy treatment-free interval appeared relevant to outcomes. Collectively, these findings support FTD/TPI as a versatile treatment backbone. Bevacizumab currently has the strongest evidence, whereas biomarker-guided anti-EGFR rechallenge and chemotherapy combinations may expand individualized treatment options for selected patients.



林炯森 醫師

June-Seng Lin, B.M., MPH.

• 馬偕紀念醫院 血液腫瘤科 資深主治醫師

Evolution and Future of Upfront Chemotherapy in mCRC

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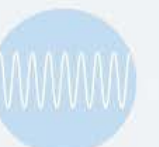


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蔡坤佑 醫師
Kun-Yu Tsai, M.D.

• 新北市立土城醫院 大腸直腸外科主治醫師

When Less Is Not Enough: The Continuing Role of Excisional Hemorrhoidectomy in Modern Hemorrhoid Surgery

Hemorrhoidal disease is highly prevalent, but current ASCRS guidelines (2024) reserve excisional hemorrhoidectomy (EH) for select severe cases. Specifically, EH is strongly indicated for symptomatic external hemorrhoids or combined internal/external hemorrhoids (Goligher grade III–IV), and for patients who fail or cannot tolerate office-based treatments. Therefore, despite the trend toward minimally invasive approaches, EH continues to play a crucial role. Standard EH techniques include the open (Milligan–Morgan) and closed (Ferguson) methods, with variations such as the tissue-preserving Parks submucosal approach and use of energy devices (LigaSure bipolar or ultrasonic shears).

Surgery is performed under appropriate anesthesia (local, spinal, or general), with triangular or V-shaped flaps at hemorrhoidal bases. The vascular pedicles are individually ligated and redundant hemorrhoidal cushions are excised while preserving intervening mucosal bridges to prevent stenosis. Meticulous hemostasis and judicious closure of the wound (suture of skin/mucosa in closed EH) limit bleeding and exposed raw area, which can mitigate pain.

Outcomes after EH are generally excellent: definitive long-term symptom control is achieved in ~95% of patients. However, the procedure is notably painful. Pain peaks in the first 1–2 days and is attributable to the raw anoderm (richly innervated below the dentate line) and reflex internal sphincter spasm. Indeed, hemorrhoidectomy ranks among the most painful of surgical procedures. On average, patients report resolution of pain by ~2 weeks and return to normal

activities within 2–4 weeks; complete wound healing may require 6–8 weeks. To optimize recovery, a multimodal analgesic regimen is essential. We routinely use scheduled NSAIDs/opioids, laxatives or stool softeners, sitz baths, and topical agents (such as nifedipine or nitroglycerin) to reduce sphincter spasm. Intraoperative measures – including local infiltration with long-acting anesthetic and limiting the extent of tissue excision – further help control pain.

Conclusions: In modern practice, the indication for excisional hemorrhoidectomy is defined by the presence of significant external components or irreversible prolapse, not by grade alone. For patients meeting these criteria, EH remains the gold-standard therapy. With careful patient selection, meticulous technique, and aggressive pain management, surgeons can maximize the benefits of EH (definitive symptom relief and low recurrence) while minimizing its drawbacks. In an era of expanding minimally invasive options, EH still has a vital role for those patients whose disease “requires more than less.”



胡哲銘 醫師

Je-Ming Hu, M.D., Ph.D.

- Assistant Professor, National Defense Medical University
- Division of Colon and Rectal Surgery, Department of Surgery, Tri-Service General Hospital

Excision vs. Pexy? Decision-Making in Hemorrhoids and Long-term Experience of Hemorrhoidopexy

Excisional hemorrhoidectomy (EH) remains the clinical gold standard with high definitive efficacy, particularly for prominent external components, bulky mixed hemorrhoids, or severe tissue redundancy. However, EH is frequently burdened by significant short-term complications, severe postoperative pain, wound-related morbidity, and an extended recovery period. While newer energy devices have mitigated some surgical trauma compared to traditional cold scalpels, concerns over early postoperative adverse events persist. In contrast, stapled hemorrhoidopexy (SH) excises a ring of redundant rectal mucosa to reposition prolapsed internal hemorrhoids and interrupt their proximal blood supply while preserving the sensitive anoderm. Consequently, SH substantially reduces early postoperative pain and expedites functional recovery in appropriately selected patients.

Nevertheless, SH may entail a higher risk of long-term recurrence, residual external skin tags, and procedure-specific complications compared with EH. Ultimately, achieving optimal clinical outcomes requires strict patient selection, meticulous surgical technique, and tailored decision-making matched to the individual hemorrhoidal phenotype.

Therefore, we explored whether it is feasible to simultaneously perform hemorrhoidopexy while concurrently excising residual external skin tags.

To address residual one-quadrant prolapsed lumps or skin tags following conventional stapled hemorrhoidopexy (cSH), we investigated a hybrid stapled

hemorrhoidopexy (hSH) strategy combining stapled hemorrhoidopexy with a modified Ferguson procedure or electrocautery excision. We conducted a retrospective study comparing clinical outcomes between cSH and hSH in patients with internal hemorrhoids and limited external components. Our findings demonstrate that hSH offers cosmetic and anatomical benefits with comparable surgical efficacy when postoperative pain is properly managed. Building on these results, this presentation outlines a practical, phenotype-driven decision-making algorithm for tailoring surgical approaches between EH and SH.

Adopting such an individualized strategy ensures the optimal balance among complete symptom resolution, rapid recovery, minimal morbidity, and long-term therapeutic durability.



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Rethinking Hemorrhoid Management: Clinical Insights on Laser Hemorrhoidoplasty (LHP)

Many surgical techniques have been developed to treat hemorrhoidal disease. Although excisional techniques are effective, they are associated with significant postoperative pain and prolonged recovery times. Consequently, less invasive modalities have been introduced to address these limitations, with laser hemorrhoidoplasty (LHP) emerging as a prominent option.

LHP provides a minimally invasive alternative to traditional excisional hemorrhoidectomy. By delivering focused laser energy to the hemorrhoidal plexus, LHP effectively shrinks the submucosal venous tissues, thereby reducing vascularity, minimizing bleeding risk, and downsizing prolapsed tissue.

Recent data highlight the clinical efficacy of LHP, particularly in the management of Grade II to III hemorrhoids. Compared to excisional hemorrhoidectomy, LHP demonstrates distinct advantages, including significantly reduced postoperative pain, lower rates of bleeding and urinary retention, and a faster return to daily activities.

In this presentation, I will outline the clinical applications of LHP in hemorrhoid management, present my specific patient selection criteria, and provide a comparative analysis between LHP and energy-based excisional techniques, such as LigaSure hemorrhoidectomy.

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Small rectal neuroendocrine tumor endoscopic resection: ESD or Padlock clipping method

Background:

Rectal neuroendocrine neoplasms (NENs) are increasing in incidence. Endoscopic submucosal dissection and endoscopic full thickness resection (EFTR) were suggested for small rectal NETs.

Methods:

From 2020 Oct. to 2026 Feb, 15 small rectal NETs (size from 12 mm to 5 mm) diagnosed by colonoscopy. 10 cases received endoscopic submucosal dissection (ESD) and 5 cases received Padlock clipping endoscopic resection (full thickness resection, EFTR).

Results:

Median tumor size of ESD group: 7.5 mm; Padlock group: 8.0 mm; median operative time of ESD group: 38 minutes; Padlock group: 18 minutes; all lesions are neuroendocrine neoplasm. ESD group: all G1 lesions; Padlock group: four G1 lesions and one G2 lesion; two margin positive in ESD group and all margin negative in Padlock group.

Conclusions:

Padlock clipping method can offers full thickness resection for small rectal NETs and it also a simple method which has shorter learning curve than ESD.



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Wisely choosing laparoscopy and robotic surgery in minimal invasive colorectal surgery

Since its clearance by the United States Food and Drug Administration in 2000 for adult and pediatric general laparoscopic surgical procedures, the da Vinci Surgical System (Intuitive Surgical, Sunnyvale, CA) has experienced substantial technological evolution, progressing from the Classic, S, Si, and Xi platforms to the 5th generation da Vinci and single-port (SP) systems. The technical advantages of robotic surgical platforms have supported their sustained global adoption, and colorectal surgery has become one of the most rapidly expanding fields for the application of robotic technology.

Accumulating clinical evidence in colorectal cancer surgery has suggested that robotic surgery may overcome several mechanical limitations of conventional laparoscopic surgery including shorten the learning curve, and enhanced maneuverability allowing surgeons to perform minimally invasive procedures with greater consistency and precision. In this lecture, the author's experience will be shared regarding standardizing robotic procedures for right-sided and left-sided colon cancer surgery, with particular emphasis on D3 lymph node dissection, complete mesocolic excision and low ligation in the robotic setting.



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Beyond Feasibility: Choosing the Right Robotic Platform for Colorectal Surgery—Lessons from HUGO Right Hemicolectomy and Anterior Resection

The introduction of multiple robotic platforms has fundamentally changed the landscape of colorectal surgery. The central question is no longer whether robotic surgery is feasible, but rather how surgeons should determine which platform is most appropriate for a specific operation. As clinical experience expands beyond a single robotic system, platform selection has become an integral part of operative planning rather than a purely institutional or economic decision.

This review examines the concept of **platform–procedure matching** through two representative colorectal operations: right hemicolectomy and anterior resection. Current evidence indicates that HUGO-assisted colorectal surgery is technically feasible and can achieve perioperative outcomes comparable to those reported with established robotic systems in appropriately selected patients. However, the available literature remains limited by retrospective study design, heterogeneous docking strategies, variable port configurations, and the absence of high-quality comparative trials. Consequently, existing evidence supports feasibility but does not justify claims of overall platform superiority.

The two procedures illustrate distinct technical demands. Right hemicolectomy follows a relatively reproducible operative sequence centered on central vascular ligation, mesocolic dissection, bowel mobilization, and intracorporeal anastomosis. In contrast, anterior resection requires seamless transition across multiple operative fields, including splenic-flexure mobilization, vascular dissection, total mesorectal excision, and pelvic reconstruction. These differences expose important

interactions between robotic architecture, instrument reach, docking geometry, bedside assistance, and workflow efficiency.

Experience accumulated during HUGO implementation highlights that technical performance depends not only on the robotic platform itself but also on the degree of alignment between platform characteristics and procedural requirements. External arm interference, limitations in instrument reach, repeated instrument exchanges, changing traction vectors, and increased dependence on the bedside assistant become more prominent when operative complexity exceeds the strengths of the platform. Many of these challenges can be mitigated through standardized port placement, predefined docking strategies, disciplined instrument assignment, and coordinated team training, whereas others reflect intrinsic mismatches between platform design and operative demands.

The future of robotic colorectal surgery lies not in identifying a universally superior robotic system but in developing a rational strategy for platform selection. Successful robotic surgery requires matching patient anatomy, operative objectives, robotic architecture, operating-room configuration, and team experience before the first incision is made. As robotic technology continues to diversify, understanding **which platform best fits a given procedure** will likely become more important than asking **which platform is best**.



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Bleeding Crisis in the Lower GI Tract: Mastering Endoscopic, Surgical, and Complex Challenges

Acute lower gastrointestinal bleeding (LGIB) frequently presents as a life-threatening crisis, requiring rapid risk stratification using tools like the Oakland score to guide initial clinical decisions. Given that LGIB has now surpassed upper gastrointestinal bleeding to become the predominant gastrointestinal emergency, colonoscopy is essential for diagnosis, direct hemostasis (such as hemoclips and thermal coagulation), and precise anatomical localization to facilitate accurate surgical intervention.

For severe, urgent, or refractory cases, alternative rescue modalities—including computed tomography angiography (CTA) and transcatheter arterial embolization—serve as valuable therapeutic options. Nevertheless, surgery remains the definitive final defense in crisis scenarios, particularly for massive bleeding triggered by acute diverticular disease or ischemic colitis. Supported by clinical experience and literature evidence, the effective synergy of endoscopic and surgical management allows over 90% of LGIB cases to be successfully controlled.

Finally, complex clinical challenges—such as managing critically ill patients with stress-related mucosal disease (SRMD), addressing rare Dieulafoy's lesions, and navigating the delicate perioperative antithrombotic management in high-risk cardiovascular patients—remain core dilemmas in this field.

By bridging current clinical guidelines with hands-on surgical expertise, this presentation aims to provide colorectal surgeons with clear, reliable, and actionable decision-making strategies when confronting high-risk acute LGIB crises.



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Potential Etiologies, Case Discussions, and Treatment of Lower Gastrointestinal Obstruction

This speech explores the causes of Lower Gastrointestinal (LGI) Obstruction, categorizing them into three main types: malignant, benign, and functional. Malignant tumors are the most common cause, including primary colon malignancies that lead to complete obstruction or intussusception, as well as invasion or external compression from colon malignancies or other metastatic abdominal tumors. Furthermore, the speech covers benign and functional causes, such as colonic volvulus, incarcerated hernia, diverticular stricture, inflammatory bowel disease (IBD) stricture, post-operative anastomotic stricture, fecal impaction, and acute colonic pseudo-obstruction (Ogilvie Syndrome). Finally, the presentation will feature practical case sharing and clinical discussions based on the speaker's prior experience in managing these various causes of LGI obstruction.



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Palliative and Supportive Care for Colorectal Cancer Patients: Integrating Specialty Palliative Care into the Surgical and Oncologic Continuum

The origin of professional cancer palliative care can be traced back to the landmark randomized controlled trial published by Temel et al. in the New England Journal of Medicine in 2010. This study demonstrated that early integration of palliative care for patients with metastatic non-small-cell lung cancer not only improved quality of life (QoL) and reduced depressive symptoms but also prolonged overall survival. Recognizing its profound impact, the World Health Organization (WHO) incorporated early palliative care into its clinical guidelines in 2016. Furthermore, numerous large-scale randomized trials and meta-analyses have consolidated robust evidence supporting its efficacy in enhancing patient QoL.

With the maturation of early palliative care strategies, specialty palliative care (SPC) has emerged as a distinct entity from traditional hospice care. Unlike primary palliative care—which is often provided by family medicine or general practitioners, universally applied to end-stage diseases, and primarily focused on pain control, prognostic disclosure, do-not-resuscitate (DNR) designations, and hospice care—SPC involves an interdisciplinary team dedicated to managing complex illnesses such as cancer. Initiated and co-managed by oncologists, the SPC team utilizes disease-specific prognostic tools and shared decision-making models to identify the optimal balance between symptom palliation and oncologic treatment. Crucially, SPC services span the entire continuum of cancer care rather than being confined to the terminal phase. According to a 2017 study by Ferrell et al. published in the Journal of Clinical Oncology, initiating SPC within eight weeks of a cancer diagnosis is an effective strategy to improve both survival and QoL.

Additionally, a meta-analysis by Hoerger et al. (2019) indicated that compared to standard oncologic care alone, SPC increased the 1-year survival rate by 14% and extended mean survival by 4.6 months. To accurately measure patient well-being, universal instruments such as the EORTC QLQ-C30, along with other condition-specific tools, have been well-developed to quantify QoL effectively.

This presentation aims to review recent frontier studies on core topics of SPC in colorectal cancer (CRC), addressing critical clinical dilemmas of interest to colorectal surgeons. The core topics include: (1) Recommendations and comparative analyses of self-expandable metal stents (SEMS) versus colostomy in specific vulnerable populations, including frail, elderly, multimorbid, and near-end-of-life patients; (2) The ongoing controversy regarding primary tumor resection versus diverting colostomy alone for patients with incurable metastatic CRC; (3) Strategic considerations for the surgical resection of synchronous colorectal liver metastases; (4) The comparative efficacy of prehabilitation versus postoperative rehabilitation for the aforementioned palliative procedures; and (5) Clinical recommendations for the initiation and appropriate timing of withdrawal of total parenteral nutrition (TPN) in patients with malignant bowel obstruction, specifically distinguishing between surgical candidates and those nearing the end of life.

By addressing these issues, this presentation will conclude by illustrating, from the perspective of a palliative care specialist, how the SPC team can synergistically collaborate with colorectal surgeons and oncologists to navigate these complex scenarios and optimize patient-centered care.

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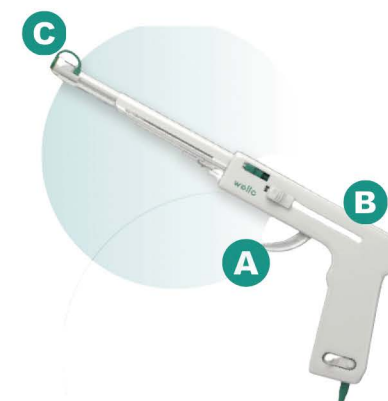
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Crafting a Hospital-Specific AI Assistant: A Practical Guide to Training Endoscopic Vision-Language Models

In recent years, AI-assisted endoscopic diagnosis has advanced rapidly, bringing significant convenience to clinical practice. However, addressing the unique patient demographics, rare cases, and specific clinical workflows of individual hospitals often requires more flexible, tailor-made solutions. With the democratization of AI Foundation Models, leveraging a hospital's own imaging assets to train customized, localized AI is no longer out of reach.

This presentation aims to share the latest trend in medical AI: empowering clinicians to build their own specialized Vision-Language Models (VLMs). Through a live demonstration using Microsoft's open-source MedImageInsight model and the GastroVision dataset, we will walk you through the practical steps of model fine-tuning. We hope this session will demonstrate how to utilize foundation models to transform general AI technology into a dedicated clinical assistant perfectly aligned with your specific needs, working together to advance localized precision medicine.



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Radiotherapy in Modern Rectal Cancer Management

The management of locally advanced rectal cancer has shifted from total mesorectal excision (TME) with preoperative chemoradiotherapy (CCRT) toward total neoadjuvant therapy (TNT), driven by the recognition that distant metastasis, not local recurrence, is now the dominant pattern of failure. This talk briefly reviews the level I evidence establishing radiotherapy's role in local control and MRI-based risk stratification, then focuses on the major TNT trials — RAPIDO, PRODIGE 23, STELLAR, and CAO/ARO/AIO-12 — comparing their sequencing strategies and outcomes, including the survival benefit shown with induction FOLFIRINOX in PRODIGE 23.

Organ-preservation approaches (OPRA, watch-and-wait) and PROSPECT's evidence for selectively omitting radiotherapy are discussed, along with the importance of testing for mismatch-repair deficiency and practical considerations for Asian populations. The talk concludes with a risk-stratified treatment algorithm and a summary of long-term toxicity and functional outcomes.

The presentation will also share the multidisciplinary experience of the Department of Radiation Oncology, MacKay Memorial Hospital, in delivering advanced radiotherapy techniques — including intensity-modulated radiotherapy, MRI simulation, and image-guided radiotherapy — to enhance treatment precision, reduce normal-tissue toxicity and long-term side effects, and ultimately deliver better outcomes for individual patients.



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Optimizing Local-Regional Control in Colorectal Peritoneal Seeding: Present Realities (HIPEC/PIPAC) and Future Frontiers

Background:

Peritoneal metastases from colorectal cancer (CRC-PM) present a formidable clinical challenge with historically dismal outcomes. Over the past two decades, cytoreductive surgery (CRS) combined with hyperthermic intraperitoneal chemotherapy (HIPEC) redefined the standard of care for carefully selected patients. However, the post-PRODIGE 7 era and the rise of pressurized intraperitoneal aerosol chemotherapy (PIPAC) have transformed the treatment algorithm, challenging dogmas regarding drug selection and regional delivery mechanics.

Present Realities (HIPEC vs. PIPAC):

High-level evidence underscores that complete macroscopic cytoreduction (CC-0/1) is the essential foundation of long-term survival. In the HIPEC landscape, the lack of added benefit from short-course oxaliplatin has driven a global pivot toward optimized mitomycin C protocols and rigorous biological selection based on PCI, RAS/BRAF status, and response to systemic therapy. For patients with unresectable peritoneal burden, PIPAC has emerged as a valuable minimally invasive modality. By utilizing repeated laparoscopic aerosol delivery under pressure, PIPAC achieves superior drug tissue penetration, documented histological regression (PRGS), and symptom control with minimal systemic toxicity, occasionally downstaging borderline disease to curative-intent cytoreduction.

Institutional Experience & Future Frontiers:

Synthesizing our center's clinical experience across extensive CRS-HIPEC and PIPAC procedures, we outline patient-tailored pathways designed to minimize perioperative morbidity while maximizing locoregional control. Looking ahead, local-regional oncology is advancing beyond standard liquid perfusion. Frontiers including electrostatic precipitation (ePIPAC), nanoparticle-based drug formulation, targeted intraperitoneal immunotherapy, and ctDNA-guided surveillance represent the next wave of precision treatment for peritoneal disease.

Conclusion:

Effective local-regional control in CRC-PM requires a modern, dual-track paradigm: aggressive, curative-intent CRS-HIPEC for low-to-moderate volume resectable disease, and repeatable, tissue-penetrating PIPAC for palliation and conversion. Integrating molecular profiling and novel delivery technologies will drive the future standard of peritoneal surface oncology.



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性傳染病，U=U，及標準防護



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The connection between sex transmitted disease and colorectal surgeon

性傳染疾病與大腸直腸外科

性傳染疾病一直以來是大腸直腸外科門診病人組群中，佔比不高但卻需要多加注意的一個族群。也因為佔比不高，不少時候臨床醫師難免對於這些疾病稍微生疏。

這次大腸直腸外科醫學會再次與疾管署聯合，一起針對性傳染疾病的防治與推廣上強強聯手，除了更新治療以及防治上的最新資訊，也藉由性別友善門診的成立，鼓勵民眾不要害怕，積極面對也減少傳播。這次也將呈現大腸直腸外科在性病防治上的不可或缺性，並鼓勵會員踴躍參加這次的計畫。



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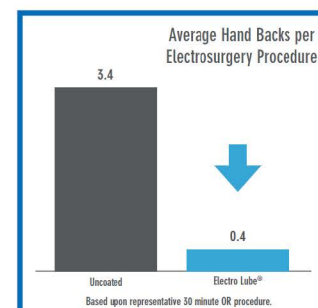


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