2026年11月20日(金)

Invited Lecture | 外科

10:35 ~ 11:05 | 第8会場（1F 会議室108）

Invited Lecture 1

Moderator: Seiichiro Yamamoto (Department of gastroenterological surgery, Tokai University, Japan)

[IL-1] Intracorporeal anastomosis in robotic colorectal surgery

*Mina Ming-yin Shen[1] (1. China Medical University Hsinchu Hospital, Taiwan)

Invited Lecture | 内科

12:50 ~ 13:20 | 第1会場（2F コンベンションホール1）

Invited Lecture 2

Moderator: Akira Sugita (Yokohama Municipal Citizen’s Hospital, Japan)

[IL-2] Latest Advances and Future Directions in IBD: Precision Medicine

*Stefan Wolfgang Schreiber (1. Department Medicine I, University Hospital Schleswig-Holstein, Kiel University, Germany)

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2026年11月21日(土)

Invited Lecture | 肛門科

9:50 ~ 10:20 | 第5会場（1F 会議室102）

Invited Lecture 3

Moderator: Shota Takano (Takano Hospital, Coloproctology Center, Japan)

[IL-3] Cutting-Edge Anorectal Surgery: Multimodal Strategies, Sphincter Preservation, and Transanal Innovations

*Donglin N Ren[1] (1. The Sixth Affiliated Hospital, Sun Yat-sen University, China)

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Intracorporeal anastomosis (ICA) is increasingly used in robotic colorectal surgery. Compared with extracorporeal anastomosis, ICA reduces bowel mobilization and mesenteric traction, enables flexible specimen extraction, and may decrease incision length, postoperative pain, and wound-related complications. It also allows better bowel orientation and facilitates a tension-free anastomosis. The robotic platform supports these procedures through three-dimensional visualization, wristed instruments, and precise suturing.
In right colectomy, an antiperistaltic side-to-side ileocolic anastomosis is created using a linear stapler, followed by direct closure of the common enterotomy with a single stapler firing. In left colectomy, ICA reduces the need for extensive bowel mobilization and our end-to-end technique uses a linear stapler to construct the posterior wall and a hand-sewn Connell suture for the anterior wall. After total mesorectal excision (TME), colorectal anastomosis may be performed using either the double-stapling or single-stapling technique. For single-stapling anastomosis, accurate purse-string suturing, secure anvil fixation, and reinforcement of the anastomosis are essential.
Regardless of the resection site, successful ICA requires adequate perfusion, correct bowel orientation, absence of tension, complete circumferential closure, and confirmation of luminal patency. With appropriate patient selection and standardized techniques, ICA expands reconstructive options and maximizes the benefits of robotic colorectal surgery.

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[IL-2] Latest Advances and Future Directions in IBD: Precision Medicine

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[IL-2] Latest Advances and Future Directions in IBD: Precision Medicine

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Inflammatory bowel disease (IBD) care is moving from symptom-driven escalation toward early, trajectory-guided disease control. Recent work on treatment-response trajectories shows that the first weeks after starting an advanced therapy already contain critical information: rapid and sustained improvement identifies patients likely to achieve long-term comprehensive disease control, whereas slow response trajectories mark patients not achieving disease control and other deep endpoints and therefore being at higher risk of relapse, residual inflammation and damage.

This changes the therapeutic concept. Instead of waiting for late treatment failure, early clinical, biochemical, endoscopic and molecular signals should be integrated to decide whether to continue, optimise, combine or switch therapy. Comprehensive disease control becomes the relevant target: patient-reported remission, biomarker normalisation, endoscopic and histological healing, steroid-free stability that leads to favorable long-term outcomes and hence preserved function and avoidance of hospitalisation, surgery and damage.

Early use of biologics is part of this shift. In Crohn’s disease and ulcerative colitis, earlier deployment of effective advanced therapies results in higher numbers of favorable response trajectories and may therefore the disease process before chronic tissue injury and therapeutic refractoriness develop. The GUIDE-IBD study has successfully tested whether molecular-medicine care, integrating omics data and expert algorithmic interpretation, can improve week-52 comprehensive disease control compared with best standard care.

The future of precision medicine in IBD will combine baseline risk, response trajectories, pharmacodynamic molecular readouts and patient-centred digital monitoring into adaptive treatment algorithms. The goal is to recognise early whether the individual patient is on the right path long before it is done today.

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Invited Lecture 3

Moderator: Shota Takano (Takano Hospital, Coloproctology Center, Japan)

[IL-3] Cutting-Edge Anorectal Surgery: Multimodal Strategies, Sphincter Preservation, and Transanal Innovations

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The cutting-edge of the anal surgery

The cutting-edge development in anorectal surgery aims to maximize the preservation of tissue and organ function as well as the appearance of the perineum while providing precise treatment and excision of lesions, thereby improving the quality of life for patients.

1. Hemorrhoids: Although there is debate, stapled hemorrhoid procedure remains one of the most effective and preferred methods for severe hemorrhoids with rectal mucosal prolapse. For early-stage hemorrhoids (especially those primarily characterized by bleeding), endoscopic injection and ligation are becoming increasingly common. The treatment of external hemorrhoids is a concern for both doctors and patients in Asian countries: painlessness and good appearance. One of the most important trends in the treatment of hemorrhoids over the years has been the combined use of multiple methods and techniques, such as stapled hemorrhoid procedure combined with external hemorrhoid excision, ligation combined with external hemorrhoid excision, and hemorrhoid injection therapy combined with external hemorrhoid excision.

2. Anal fistula: Incision and drainage of anal fistulas remains the most reliable method for treating anal fistulas. Despite many efforts, sphincter-preserving surgeries for anal fistulas have not been satisfactory, with high recurrence rates being disheartening! Transmuscular approaches are increasingly recognized and affirmed and have become more mature. Laparoscopic management of complex infections above the levator ani muscle is meaningful. The most valuable diagnostic tools for anal fistulas include digital rectal examination、MRI、and anorectal ultrasound. staged surgery for complex anal fistulas is an important strategy for dealing with this issue. It is necessary to re-evaluate the treatment strategies for anal fistula malignancy.

3. Rectal prolapse: Excision or fixation? Fixing the free and mobile rectum is the most important core step in treatment.

4. Transanal approaches can handle a wide variety of anorectal diseases. This approach should be valued by colorectal surgeons.

5. Low rectovaginal fistulas. The success rate of surgical treatment is much lower than that for mid and high rectovaginal fistulas. Repair or incision?

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6. Anal or anal canal cancer, with many pathological types and very few large case treatment experiences, treatment choices are highly based on pathological grounds.

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