

Conference Handbook



New Zealand Association of General Surgeons

New Zealand Association of General Surgeons Annual Meeting 2010

General Surgery in the New Decade

*Friday 26th March 2010 to Sunday 28th March 2010
The Sebel Trinity Wharf Hotel
Tauranga, New Zealand*



WORKZ4U
conference management

Conference Manager:

Lynda Booth, Workz4U Limited

Ph: +64 9 917 3653 Fax: +64 9 917 3651

PO Box 8422, Symonds Street, Auckland 1150, New Zealand

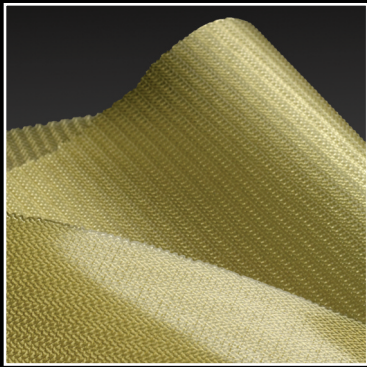
Email: events@workz4u.co.nz Website: www.workz4uconferences.co.nz

INDICATION BY DESIGN

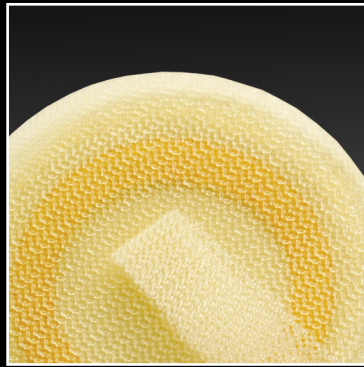
Bridging the Gap Between Preferred Mechanical Solutions and Enhanced Biocompatibility.

Atrium offers a full line of products for soft tissue repair providing ideal handling properties and enhanced healing with lightweight material and Omega 3 technology.

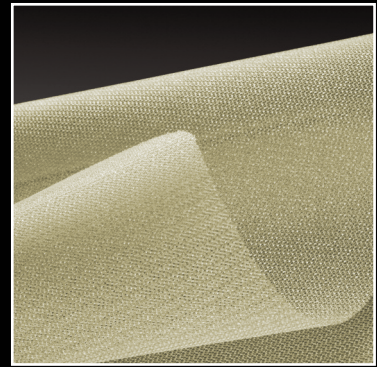
Setting the bar for clinical performance, the "Indication by Design" approach empowers the surgeon to choose the appropriate implant with both mechanical durability and enhanced biocompatibility.



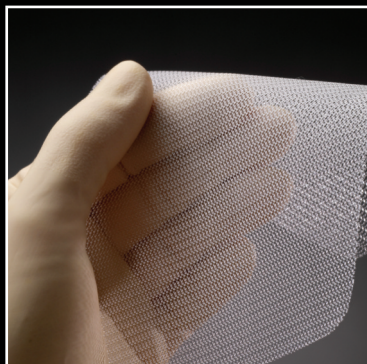
 **C-QUR™**
MESH



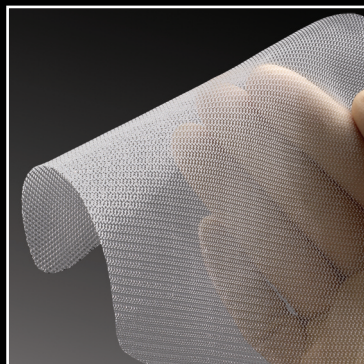
 **C-QUR™**
MESH
V-Patch



 **C-QUR LITE™**
MESH



 **ProLite™ MESH**
Polypropylene Monofilament Mesh



 **ProLite ULTRA™**
Polypropylene Monofilament Mesh



 **ProLoop™ MESH**
Polypropylene Monofilament Mesh



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Thanks To Our Confirmed Sponsors

The New Zealand Association of General Surgeons would like to thank the following sponsors, who have confirmed sponsorship at time of printing:

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ATRIUM

Supporting Sponsors



Convenor's Welcome

Dear Colleague,

Welcome to NZAGS 2010 in Tauranga.

There are a good number of registrations and this portends well for the conference.

A conference is a meeting of people and ideas serving converging social, educational and professional agendas. To this end there is a strong academic programme with "something for everyone" ably led by John Windsor from Auckland and Sean Mackay from Melbourne. Acutesurgery, colorectal cancer screening, melanoma surgery and further advances in surgical technique and technology are all "now" topics and we have an excellent bunch of invited presentations from respected colleagues and I am very grateful for the willing support I have received in this.

From the professional perspective, we are fortunate to meet and hear from the Minister of Health, Tony Ryall whose address is on Friday night. The AGS AGM also needs attendance for us to maintain our professional organisation.

There has been a surfeit of abstracts submitted for papers and posters and these have been accommodated with synchronous parallel sessions.

On the social side I would like to commend particularly the Friday night BBQ which is included in the conference fee and should be a great opportunity to mix with the fellow surgeons and trainees, including entertainment from one of the best bands in the Bay. Similarly, the Saturday night formal dinner, with further entertainment will be something special. There are organised activities on the Saturday afternoon but for those who have opted for free time, there are plenty of things to do about the Bay of Plenty. For me it is hard to beat the walk up Mount Maunganui and the Main Beach.

I look forward to seeing you all at some stage of the conference and hope that it is enjoyable and professionally greatly worthwhile.

Regards

Phillip Thwaite

Convenor
NZAGS 2010 Tauranga

Organising Committee:

Phillip Thwaite (Convenor)
Mark Morgan
Peter Chin
Bronwen Evans (NZAGS Representative)

Avi Kumar
Jeremy Rossaak
Janet Ansell
Lynda Booth (Conference Manager)

Contact

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Worzk4U Ltd
PO Box 8422
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Auckland 1150
New Zealand

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Email: events@workz4u.co.nz
Website: www.workz4uconferences.co.nz/nzags10



Keynote Speakers

The Conference Committee are delighted to announce the keynote speakers for the conference are Prof. John Windsor (The University of Auckland) and Dr Sean Mackay (St Vincent's and Box Hill Hospitals).



Professor John Windsor

*Professor of Surgery and Head of the Department of Surgery
The University of Auckland
Auckland, New Zealand*

Professor John Windsor is a Professor of Surgery and Head of the Department of Surgery, Faculty of Medical and Health Sciences, at the University of Auckland, New Zealand. He founded the Pancreas Research Group in 1992, established the Surgical Skills Training Centre in 1993 and set-up New Zealand's first HPB/Upper GI Unit at Auckland Hospital in 1994. The University of Auckland awarded him the Butland Distinguished Medical Science Award in 1997 and the Distinguished Teaching Award in 1998. Professor Windsor was awarded a personal chair in Surgery in 2003. He has a busy clinical practice including pancreatic and oesophageal surgery and he has pioneered a number of laparoscopic procedures in New Zealand. He has an active research program with a primary interest in investigating aspects of the pathophysiology of acute necrotizing pancreatitis. Other research interests include simulation and surgical skills training. Go Virtual Medical Ltd, of which he is a Director, won a Kiwi Start Up award in 2005 for the development of the Integrated Simulator. He has received numerous grants and has contributed significantly to the peer reviewed literature. In addition, he serves on the Editorial Boards of several scientific journals. He was appointed as the Secretary General of the IHPBA in 2008.



Dr Sean Mackay

*Upper GIT and HPB Surgeon
St Vincent's Hospital and Box Hill Hospital
Melbourne, Australia*

Sean is an upper GIT and HPB surgeon working at St Vincent's Hospital and Box Hill Hospital in Melbourne as well as in private practice. He is a senior lecturer in the newly established Eastern Health Clinical School, which is allied to Monash and Deakin Universities. After gaining his general surgical fellowship in 1998, he worked as a clinical fellow in 1999 (St Vincent's) and 2001 (Royal Infirmary Edinburgh), and as a research fellow in 2000 (Imperial College London). He is a member of the Victorian State Committee of the RACS, and is the Deputy Director of the General Surgery and Gastroenterology Clinical Institute for the Epworth Private Hospital Group.

Invited Speakers

Mr Andrew Audeau
Professor Ian Bisset
Dr Rob Cunliffe
Mr Matthew Clark
Mr John Dunn
Mr Peter Gilling

Mr Richard Harman
Mr Peter Heppner
Mr Li Hsee
Mr Mike Hulme-Moir
Mr Bertrand Jauffret
Mr Jonathan Koea

Dr Mark Lane
Mr Richard Martin
Dr Louise Moore
Dr Richard North
Mr Mike Rogers
Mr Garth Poole

Programme Information

Oral Presentations

All speakers should check in their visual material with the AV technician at least two hours prior to the commencement of their allocated session. Speakers who are presenting at an early morning session should check in their visual material the day before their presentation. An audiovisual technician will be available to assist with the data projection or other technical requirements. If you require assistance from a technician, please ensure you arrange this at least two hours before the commencement of your allocated session.

The session chair will greet you and discuss your requirements prior to the commencement of your session.

Poster Presentations

Poster presenters must check in at the registration desk for direction to their allocated poster area and to collect Velcro. The presenting author must be present at the poster during the allocated poster periods scheduled between 9.45am - 10.15am and 12.30pm - 1.00pm on Saturday 27 and 10.10am - 10.40am Sunday 28 March 2010 to answer any questions. Posters should be removed at the conclusion of the meeting at 1.00pm on Sunday 28 March 2010.

Social Programme

Welcome Reception

Date: Friday 26 March 2010
Time and venue: 5.30pm – 6.30pm Welcome Drinks, Industry Exhibition Area
Cost: Inclusive for registered full delegates and registrars only
Additional ticket cost: \$35.00 per ticket
Dress Code: Smart Casual

A selection (beer, wine, soft drinks) of beverages will be available at the Welcome Drinks. A cash bar is available for additional drinks.

BBQ

Date: Friday 26 March 2009
Time and venue: 7.00pm – 11.30pm Mills Reef Restaurant
Cost: Inclusive for registered full delegates and registrars only
Additional ticket cost: \$65.00 per ticket
Dress Code: Smart Casual

You will be provided with 2 drink tickets for the BBQ. This entitles you to 2 complimentary drinks (beer, wine or soft drinks). A cash bar will be available for additional drinks.

Conference Dinner

Date: Saturday 27 March 2009
Time and Venue: Pre-dinner drinks 7.00pm - 7.30pm Sebel Trinity Wharf Hotel – Industry Exhibition Area
Cost: \$125.00 per ticket (NOT inclusive of registration fee)
Dress Code: Smart Casual

Saturday Afternoon Social Activities

Deep Sea Fishing

Pick up from Sebel Trinity Wharf Hotel at 2.00pm
Returning approx 6.30pm

Golf (9-holes only)

Tauranga Golf Club, Tauranga
Pick up from Sebel Trinity Wharf Hotel at 2.30pm

Kayaking

Pick up from Sebel Trinity Wharf Hotel at 2.00pm
Returning approx 6.00pm

General Information

Conference Venue

Sebel Trinity Wharf Hotel
51 Dive Crescent
Tauranga, New Zealand
Telephone: +64 7 577 8700

Registration Desk

The Registration Desk is open during the following hours:

Friday, 26 March 2010	1.30pm – 7.30pm
Saturday, 27 March 2010	7.00am – 2.00pm
Sunday, 28 March 2010	7.00am – 1.00pm

Conference Manager: Lynda Booth 021 779 233

Name Badges

Identification badges are mandatory and are required for admission to all sessions, the exhibition and social functions included in the registration fee.

Venue Layout

A map of the conference venue is provided at the back of this handbook for your convenience.

Conference Room

Is located on the Ground Level – Trinity Rooms

Industry Exhibition

The industry exhibition is located on the Ground Level. Please refer to page 8 of this handbook for exhibition information.

Cell Phones and Pagers

These must be turned off, or set to silent mode when Conference is in session.

Refreshments

Morning tea and lunch will be served in the industry exhibition area on Saturday and Sunday.

Smoking

Smoking is not permitted in any of the Conference venues or industry exhibition area.

Special Diets

Delegates who have special dietary requirements should make themselves known at the Workz4U registration desk during refreshment breaks and prior to social functions.

Taxis

Tauranga airport is approx 10 minutes drive from the Sebel Trinity Wharf Hotel. A taxi fare will cost you approx \$20 one way. Airport transfers can be arranged with the following transport provider:

Tauranga Mount Taxi's 0800 829 477

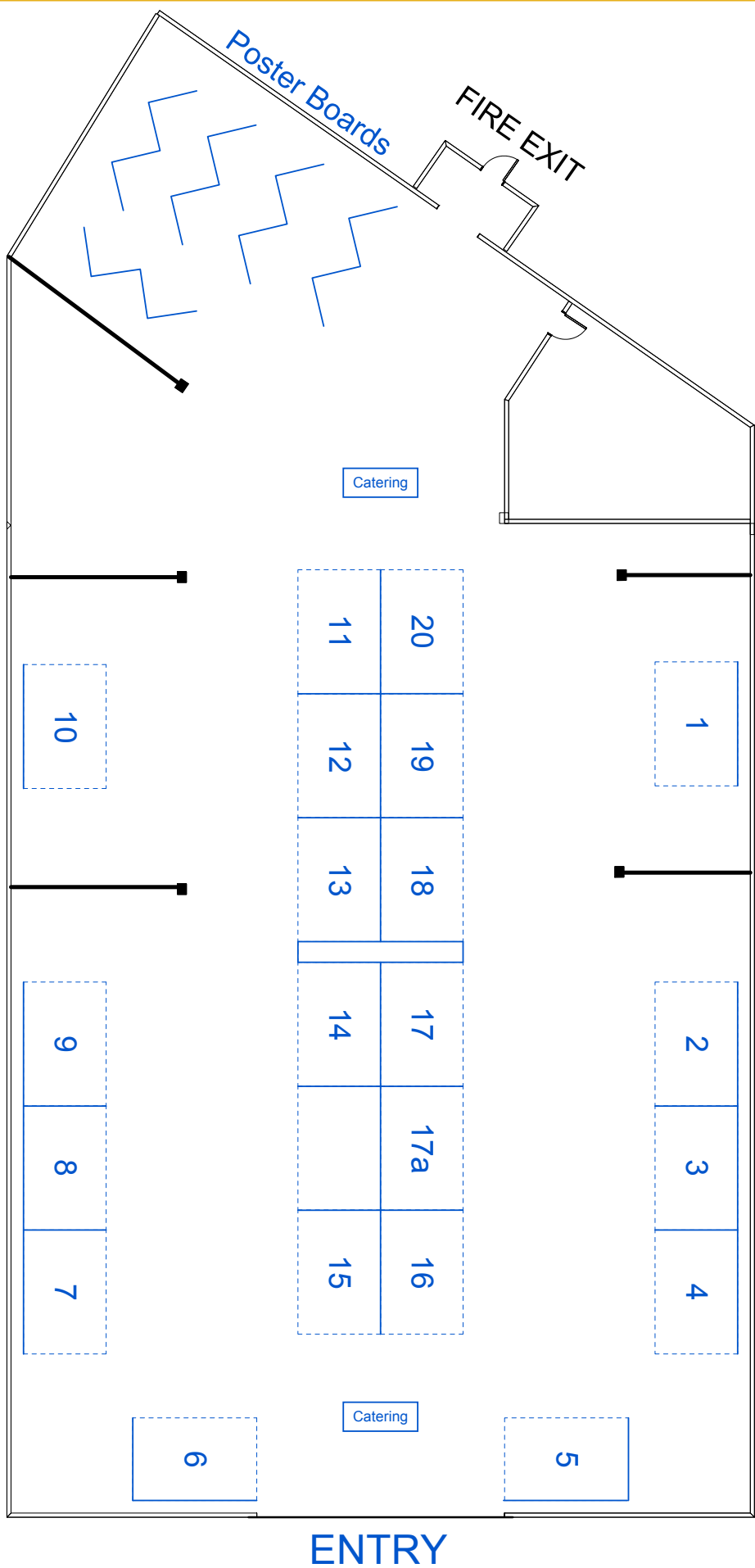
Medical

Emergency (<i>Police, Ambulance, Fire</i>)	111
Urgent Doctor Service	07 577 0010
2nd Avenue	
Southland Hospital	07 579 8000
Cameron Road	
Life Pharmacy Tauranga	07 578 3177
27 Devonport Street	

Liability Disclaimer

In the event of industrial disruption or other unforeseen circumstances, the Conference Committee or Workz4U accepts no responsibility for loss of monies incurred by delegates.

Exhibition Information



Exhibitor Listing

Booth Number	Company
001	Stryker
002	Novartis
003	Johnson & Johnson (New Zealand) Ltd
004	KCI Business Divn, Intermed Medical Ltd
005	Downs Distributors Ltd
006	Atrium Medical
007	Fisher & Paykel Healthcare
008	Smith & Nephew
009	Intra-Op Medical
010	Olympus NZ
011	Culpan Distributors Ltd
012	Roche Products
013	New Zealand Familial Gastrointestinal Cancer Registry
014	Tyco Healthcare
015	Obex Medical
016	Medipak Surgical NZ Ltd
017	Baxter Healthcare
018	SCIONZ
019	AUSSTAT / Kiwis STAT
020	Sheffmed NZ Ltd
17A	Med-Chem Surgical Ltd

Exhibitor Profiles

Atrium Medical

Stand # 006

GIRVAN, David
Level 6, 579 Harris Street, Ultimo, Sydney 2007
AUSTRALIA

Telephone (Work): 0800 630 204
Fax: +61 2 8272 3199
E-Mail: jhouston@atriummed.com
dgirvan@atriummed.com
Website: www.atriummed.com

Products on Display

Atrium's latest General Surgery Products C-QUR™ and V-Patch™ use a Bioabsorbable Omega-3 gel coating on polypropylene monofilament mesh for intraperitoneal repair. The Omega-3 coating is naturally absorbed over 90-120 days resulting in minimal tissue attachment and a strong repair of the tissue defect. C-QUR is used for ventral hernia repair and has the advantage of see-thru clarity, ability to cut to size and shape requirements and outstanding handling qualities.

V-Patch is brand new to the New Zealand market and is designed for use in repairing umbilical hernia's. V-Patch is easy to use, conforms well behind the defect and will revolutionize how you treat these patients.

Come and see these outstanding products at the Atrium booth.

AUSSTAT / Kiwis STAT

Stand # 019

EVANS, Lucy
PO Box 8875
CHRISTCHURCH 8440

Telephone (Work): +64 3 943 0962
Fax: +64 9 339 0598
E-Mail: lucy.evans@kiwisstat.com

Products on Display

AUSSTAT/Kiwis STAT is the largest medical recruitment company in Australasia. We have achieved this position by maintaining our commitment to providing doctors and hospitals a trustworthy and professional solution to their employment needs.

We specialise in the recruitment and placement of short and long term locums into positions all over Australia and New Zealand. Consultant locums have become a core part of that business. We also have a dedicated permanent placement team who have a thorough understanding of immigration and registration requirements.

Baxter Healthcare

Stand # 017

MCGRATH, Anna
PO Box 88, Toogannie, NSW 2146
AUSTRALIA

Telephone (Work): +02 8845 1607
Fax: +02 8845 1688
E-Mail: anna_mcgrath@baxter.com

Products on Display

For 75 years, Baxter has assisted healthcare professionals and their patients with the treatment of complex medical conditions. The company applies its expertise in medical devices, pharmaceuticals and biotechnology to make a meaningful difference in patients' lives.

Baxter Biosurgery's commitment to haemostatic and tissue sealing agents spans more than 30 years and more than 10 million surgeries. Our history of innovation in wound management continues today in our comprehensive range of synthetic and biological products and application devices - all the result of continuing scientific advances.

Culpan Distributors Ltd

Stand # 011

HARRIS, Maree
P O Box 25 106, St Heliers
AUCKLAND

Telephone (Work): +64 9 570 5752
Fax: +64 9 570 5754
E-Mail: marie@culpanmed.co.nz

Products on Display

Culpan Distributors Ltd aim is total customer satisfaction.

We serve the needs of healthcare professionals with products that offer patients improved efficacy and quality of life.

- Astra-Tech Exudrain, Bellovac, Abdovac™
 - Civco Intra-operative covers
 - Angiotech Biopsy
-

Exhibitor Profiles

Downs Distributors Ltd

Stand # 005

MENZIES, Margaret
Private Bag 302 041, North Harbour
NORTH SHORE CITY 0751

Telephone (Work): +64 9 415 9555
Fax: +64 9 415 6400
E-Mail: margaret@downs.co.nz

Products on Display

Downs Distributors Limited represent several agencies specialising in endoscopic equipment, hand held instrumentation and retractor systems. Stop by our stand talk to our friendly Product Specialists about these exciting ranges.

Fisher & Paykel Healthcare

Stand # 007

MCKANNY, Jacqui
PO Box 14 348, Panmure
AUCKLAND 1741

Telephone (Work): +64 9 574 0123 EXT 8030
Fax: +64 9 574 0130
E-Mail: Jacqui.McKanny@fphcare.co.nz

Products on Display

Fisher & Paykel Healthcare are the world leader in the humidification of medical gases. We have identified a problem with current laparoscopic surgery where cold dry gas is introduced into the abdominal cavity causing evaporation and cooling. There are numerous benefits in heating and humidifying this gas prior to insufflation.

Intra-Op Medical

Stand # 009

BRADSHAW, Martin
P O Box 65567, Mairangi Bay
NORTH SHORE CITY 0630

Telephone (Work): +64 9 476 2204
Fax: +64 9 476 2204
E-Mail: martin@intra-opmedical.co.nz

Products on Display

Intra-Op Medical proudly represents Chex Surgical Staplers, Lotus Ultrasonic Shears, Lagis Laparoscopic Instruments and Equimedical Absorbable Haemostats in New Zealand.

Johnson & Johnson (New Zealand) Ltd

Stand # 003

GRUDDA, Melanie
13a Gabador Place
AUCKLAND

Telephone (Work): +64 9 574 1783
Fax: +64 9 573 6234
E-Mail: mgrudda@its.jnj.com

Products on Display

Johnson & Johnson Medical (JJM) is a major provider to the New Zealand health care systems through the provision of products and the development and implementation of support services for the medical community. The company is the leading medical device provider in New Zealand and, as a member of the Johnson & Johnson family of companies, is part of the largest medical devices and diagnostics company in the world.

KCI Business Divn, Intermed Medical Ltd

Stand # 004

GREEN, Wendy
P O Box 33268, Takapuna
NORTH SHORE CITY 0740

Telephone (Work): +64 9 415 4800
Fax: +64 9 415 9045
E-Mail: wendy@intermed.co.nz

Products on Display

InterMed Medical is the exclusive distributor of KCI's V.A.C.® Therapy. V.A.C.® Therapy is a worldwide market leader in advanced wound care helping more than 3 million people around the globe in the past 15 years.

Med-Chem Surgical Ltd

Stand # 17A

BINGLEY, Brenda
PO Box 37400, Parnell
AUCKLAND 1151

Telephone (Work): +64 9 815 2982
Fax: +64 9 815 2974
E-Mail: brenda@medchem.co.nz

Products on Display

Med-Chem Surgical Ltd specialises in instruments, equipment and consumables for operating theatres. Emphasis is on quality products that represent value for money for health sector clients. Focus is on service and education that will support quality healthcare.

Exhibitor Profiles

Medipak Surgical NZ Ltd

Stand # 016

SINGLETON, Shaun
31 Morningside Dr, Mt Albert
AUCKLAND 1025

Telephone (Work): +64 9 846 6044
Fax: +64 9 846 6808
E-Mail: ssingleton@medipak.co.nz
Website: www.medipak.co.nz

Products on Display

View the latest 2nd Generation Karl Storz HD Laparoscopic Imaging Technology.

Video Rectoscopy, Reusable single portal + Notes instrumentation and Endochameleon the first rigid scope with optical view from 0 -120°.

New Zealand Familial Gastrointestinal Cancer Registry

Stand # 013

JUVENTIN, Lou
Building 30, Auckland Hospital, Private Bag 92024
AUCKLAND

Telephone (Work): 0800 554 555
Fax: +64 9 375 4359
E-Mail: ljuvenitin@adhb.govt.nz

Products on Display

The NZ Familial Gastrointestinal Cancer Registry offers assessment and facilitates diagnoses for people at risk of hereditary gastrointestinal cancer and coordinates the associated surveillance recommendations.

Novartis

Stand # 002

SIDWELL, Nicki
54 Waterloo Road, North Ryde, NSW 2113
AUSTRALIA

Telephone (Work): +61 2 9805 3775
Fax: +61 2 9888 3408
E-Mail: nicki.sidwell@novartis.com

Products on Display

Novartis Oncology provides a range of innovative therapies and practical solutions that aim to improve and extend the lives of cancer patients in Australia and New Zealand.

Obex Medical

Stand # 015

GREEN, Jenny
Level 1, 303 Manukau Rd, Epsom
AUCKLAND 1344

Telephone (Work): +64 9 630 3456
Fax: +64 9 630 9009
E-Mail: jenny.green@obex.co.nz
Website: www.obex.co.nz

Products on Display

Products include Gelpoint for single incision surgery and Sorbafix - a new absorbable tacker. Meshes for all types of hernia repair and ChromaLUME the first plasma turbo headlight system.

Olympus NZ

Stand # 010

REID, Cahn
PO Box 303 130, North Harbour
AUCKLAND 0751

Telephone (Work): +64 9 836 9993
Fax: +64 9 836 3386
E-Mail: cahn.reid@olympus.co.nz
Website: www.olympus.co.nz

Products on Display

A leading manufacturer of professional opto-digital products, Olympus pioneers key technologies in the fields of imaging and voice products, endoscopy, microscopy, bioanalytics and diagnostics.

Roche Products

Stand # 012

GRANEY, Ellen
PO Box 12 492, Penrose
AUCKLAND 1642

Telephone (Work): +64 9 635 1526
Fax: +64 9 633 0722
E-Mail: ellen.graney@roche.com

Products on Display

The Roche group is the world's leading provider of cancer care products including anti-cancer products used in the treatment of many tumour types. Its oncology business includes an unprecedented 6 products proven to provide survival benefit.

The Roche New Zealand commitment is highlighted by a highly innovative portfolio of currently marketed oncology products including Avastin®, Herceptin®, and Xeloda® amongst others.

Exhibitor Profiles

SCIONZ

Stand 018

MISCHLER, Lukas
Unit B, 31 Cheshire Street, Parnell
AUCKLAND

Telephone (Work): +64 9 309 3480
Fax: +64 9 309 3481
E-Mail: lmischler@scionz.co.nz

Products on Display

PEAK Surgical PLASMABLADE. The precision of a scalpel and the bleeding control of traditional electrosurgery without extensive collateral tissue damage.

Medtronic Nerve Monitor- Continuous intraoperative nerve monitoring. (Facial N./Parotidectomy, RLN./Thyroidectomy).

Sheffmed NZ Ltd

Stand # 020

PO Box 40616, Glenfield Mall, Glenfield
Unit D, 3 Tait Place, Albany
AUCKLAND 0632

Telephone (Work): +64 9 9213160
E-Mail: alisa@sheffmed.co.nz

Products on Display

Rudolf Medical GMBH covering all specialties, Medor/ Porex facial implants for reconstruction and augmentation, Polytech Breast Prosthesis and other Implants, Dale Medical, Needle Management products.

Smith & Nephew

Stand # 008

PAGE, Jenny
P O Box 4421
Shortland Street
AUCKLAND 1140

Telephone (Work): 0800 807 663 XTN 731
Fax: +64 9 820 2868
E-Mail: jenny.felton-page@smith-nephew.com

Products on Display

The philosophy of innovation and support means that more often Smith & Nephew is a chosen company when life threatening and patient debilitating wounds occur.

Come to our stand and see the advanced products and medical devices we have developed for healthcare professionals. Our pioneering technologies enable nurses, surgeons and other medical practitioners to provide effective treatment more quickly and economically.

Smith & Nephew products on display include:

- Negative Pressure Wound Therapy:
 - RENASAYS
- Hydrosurgery System:
 - Versajet
- Antimicrobials:
 - ACTICOAT
 - IODOSORB
- Post Operative dressings:
 - Opsite Post Op Visible.

Stryker

Stand # 001

LAUBSCHER, Renata
515 Mt Wellington Highway, Mt Wellington
AUCKLAND 1641

Telephone (Work): +64 9 573 1890
Fax: +64 9 573 1891
E-Mail: renata.laubscher@stryker.com; mduval@con

Products on Display

Stryker Corporation is one of the world's leading medical technology companies with the most broadly based range of products in orthopaedics and a significant presence in other medical specialties. Stryker works with respected medical professionals to help people lead more active and more satisfying lives. The Company's products include implants used in joint replacement, trauma, craniomaxillofacial and spinal surgeries; biologics; surgical, neurologic, ear, nose & throat and interventional pain equipment; and endoscopic, surgical navigation, communications and digital imaging systems; as well as patient handling and emergency medical equipment. For more information about Stryker, please visit the company web site at www.stryker.com

Tyco Healthcare

Stand # 014

JARVIS, Sally
Private Bag 94315, Pakuranga
MANUKAU 2140

Telephone (Work): +64 9 573 6700
Fax: +64 9 918 3742
E-Mail: sally.jarvis@covidien.com
Website: www.covidien.com

Products on Display

Covidien (formerly know as Tyco Healthcare) continues to develop new and exciting technologies which bring 'gold standard' products to the surgical and medical device arenas.

Provisional Scientific Programme

FRIDAY 26TH MARCH 2010		
8.30am – 4.00pm	Trainee Day: Breast & Endocrine	
1.30pm – 7.30pm	Registration Desk Opens	
5.30pm – 6.30pm	Welcome Reception	
6.30pm – 7.30pm	Session 1: The first year.... Hon. Tony Ryall, Minister of Health	Trinity Rooms Session Chair: Stephen Vallance
7.30pm – 11.30pm	Trainee and Delegate BBQ	Mills Reef Restaurant & Bar

SATURDAY 27TH MARCH 2010		
7.00am – 2.00pm	Registration Desk Open	
7.30am – 8.00am	Breakfast	Exhibition Area
8.00am – 9.15am	Session 2: How to Manage Acute Surgical Problems <ul style="list-style-type: none"> Acute Care Surgery at Auckland City Hospital: Moving with the Times <i>Mr Li Hsee, Auckland City Hospital</i> Damage Control in Hepatic Trauma: Ten Simple Manoeuvres <i>Mr Jonathan Koea, The University of Auckland</i> Emergency Colonic Surgery without a Stoma <i>Mr Mike Hulme-Moir, North Shore Hospital</i> Acute Extradural Compressive Haematoma: How, When and Where <i>Mr Peter Heppner, Auckland City & Starship Hospitals</i> DISCUSSION	Trinity Rooms Session Chair: John Kyndon
9.15am – 9.45am	KEYNOTE ADDRESS: <ul style="list-style-type: none"> Cholecystectomy: Here We Go Again <i>Prof John Windsor, The University of Auckland</i> 	Trinity Rooms
9.45am – 10.15am	Morning Tea and Poster Presentation	Exhibition Area
10.15am – 11.00pm	Session 3: Contemporary Biliary Topics <ul style="list-style-type: none"> Biliary Imaging and MRI <i>Dr Louise Moore, Tauranga Hospital</i> The Gallbladder Polyp and Serendipitous Cancer <i>Mr Andrew Audeau, Dunedin Hospital</i> The Difficult Gallbladder... Tricks and Tips <i>Mr Garth Poole, Middlemore Hospital</i> 	Trinity Rooms Session Chairs: John Windsor & Sean Mackay
11.00am – 11.30am	DEBATE <ul style="list-style-type: none"> Routine Intra Operative Cholangiography Should be the Gold Standard <i>Dr Michael Rodgers, North Shore Hospital V's Mr John Dunn, Laparoscopy Auckland</i> 	Trinity Rooms Debate Chair: Phillip Commish
11.30am – 12.00pm	DEBATE <ul style="list-style-type: none"> Laparoscopic Common Duct Surgery Should replace ERCP for the Treatment of Choledocholithiasis <i>Mr Bertrand Jauffret, Rotorua Hospital V's Dr Mark Lane, Auckland City Hospital</i> 	Trinity Rooms
12.00pm – 1.00pm	Lunch and Poster Presentation	Exhibition Area
1.00pm – 2.00pm	Session 4: Laparoscopy Moving On..... <ul style="list-style-type: none"> Single Incision Laparoscopic Surgery Introduction to Cholecystectomy in Victoria <i>Dr Sean Mackay, St Vincent's and Box Hill Hospitals</i> da Vinci and 'Robotic' Surgery in the Bay of Plenty <i>Mr Peter Gilling, Bay of Plenty Clinical School</i> DISCUSSION	Trinity Rooms Session Chair: Rob Cable
2.00pm	Social Activities	
7.00pm	Conference Dinner	Exhibition Area

Provisional Scientific Programme

SUNDAY 28TH MARCH 2010		
7.00am – 1.00pm	Registration Desk Open	
7.30am – 8.30am	Breakfast	
7.30am – 8.15am	NZAGS AGM	Trinity Room1
8.30am – 10.10am	Session 5A: Free Paper Session (Trinity Room 1) Session Chair: Liz Dennett <ul style="list-style-type: none"> Quantitative Lymph Node Evaluation as an Independent Marker of Long-Term Prognosis in Stage III Rectal Cancer <i>Dr Ryash Vather, Middlemore Hospital</i> Peri-Operative Outcomes Following Short vs Long Course Radiotherapy for Rectal Cancer <i>Dr Amit Reddy, Wellington Hospital</i> Minor Anal Surgery In A Stand-Alone Day Surgical Unit <i>Mr Don Guadagni, Guadagni Surgical Ltd</i> The Validation of a Prioritisation Tool for Colonoscopy <i>Dr David Vernon, Lakes DHB</i> Experience of Sling Immobilization of the Ipsilateral Shoulder and the Development of Post-Mastectomy Fluid Collections <i>Dr Shaun Purkiss, Whangarei Base Hospital</i> Better Design of Mastectomy Flaps <i>Mr Burton King, Wellington Hospital</i> Immediate Implant-Based Breast Reconstruction Following Mastectomy: Review of Result and Outcome in a Provincial Centre <i>Dr Ian Bloomfield, Tauranga Hospital</i> Breast M.R.I.: What Impact Has it Had on Breast Surgery? <i>Dr Nita Bartlett, Tauranga Hospital</i> M.R.I Scanning in the Management of Breast Cancer <i>Dr John Harman, St Mark's Women's Hospital</i> 	Session 5B: Free Paper Session (Trinity Rooms 2/3) Session Chair: Jeremy Rossaak <ul style="list-style-type: none"> Role of Mutational Analysis in Surgical Treatment of Gastrointestinal Stromal Tumours (GIST) <i>Mr Konrad Richter, Southland Hospital</i> A multidisciplinary Classification of Invasive Procedures for Treating the Local Complications of Acute Pancreatitis <i>Dr Benjamin Loveday, The University of Auckland</i> ALT Rather than Abdominal Ultrasound to Justify Cholecystectomy in Patients Presenting with Acute Pancreatitis <i>Dr Lisa Brown, Christchurch Public Hospital</i> The Outcome of Computed Tomography Diagnosed Intussusception in Adults <i>Dr Hayley Waller, Christchurch Hospital</i> Aetiology, Management and Outcomes of Acute Intestinal Obstruction in a Provincial New Zealand Hospital <i>Dr Sanni Aschenberger, Taranaki DHB</i> Laparoscopic Sleeve Gastrectomy as a Single-Stage Bariatric Procedure <i>Dr Sanket Srinivasa, Middlemore Hospital</i> Use of a Novel Physical Activity Questionnaire to Assess the Effect of Bariatric Surgery on Physical Activity Levels <i>Dr Manmeet Salija, Whangarei Hospital</i> A Prospective Randomised Trial of Sentinel Node Biopsy for High Risk Squamous Cell Carcinoma (SNIC Trial) <i>Dr Richard Martin, Waitemata DHB</i> Accelerated Liquefaction of Pancreatic Necrosis Using Proteolytic Enzymes: A New Paradigm <i>Dr Benjamin Loveday, The University of Auckland</i>
10.10am – 10.40am	Morning Tea and Poster Presentation	Exhibition Area
10.40am -11.50am	Session 6: Malignant Melanoma <ul style="list-style-type: none"> Malignant Melanoma: The New Zealand Guidelines, Presentation and Panel/Audience Discussion <i>Mr Richard Harman, North Shore Hospital</i> <i>Mr Richard Martin, North Shore Hospital</i> <i>Dr Richard North, Tauranga Hospital</i> 	Trinity Rooms Session Chair: David Vernon
11.50am – 12.30pm	<ul style="list-style-type: none"> Update: Colorectal Cancer Screening in New Zealand <i>Prof Ian Bissett, The University of Auckland</i> Accreditation of Colonoscopists in the UK Bowel Cancer Screening Programme <i>Dr Rob Cunliffe, Tauranga Hospital</i> 	Trinity Rooms
12.30pm – 12.40pm	<ul style="list-style-type: none"> V-Patch <i>Scott Pickford-Scott, Atrium, NZAGS</i> <i>Bronwen Evans, NZAGS</i> 	Trinity Rooms
12.40pm – 1.00pm	CLOSING COMMENTS, PRIZE GIVING & CONFERENCE CLOSE	Trinity Rooms
1.00pm – 2.00pm	Lunch	Exhibition Area

Provisional Poster Programme

Lower Gastrointestinal Bleeding in Hawkes Bay Hospital
Dr Damien Ah Yen

Anastomotic Leak Following Right Hemicolectomy–
Retrospective Audit from a Single Institution
Dr Khawaia Bilal Akbar

The Use of Botox Injection in the Treatment of Anal Fissure
Dr Muhammad Asim

Actinomycosis: A Dilemma in Diagnosis
Dr Nagham Glenie

Laparoscopic Umbilical Hernia Repair: Outcomes and
Complications in 43 Consecutive Cases at Middlemore
Hospital
Dr Alexandra Gordon

Malignant Melanoma amongst Maori and Pacific Peoples in
New Zealand, 2000-2004
Dr Todd Hore

Gastrointestinal Endoscopy Training
Dr Steven Marshall Hudson

An Interesting Incidental Finding...
Dr N Hamesh Jina

Upper GI Bleeding in a Peripheral Hospital
Dr Estella Johns

The Effect of Acute and Chronic Disease Conditioned
Mesenteric Lymph on Bacterial Growth
Dr Benjamin Loveday

Compliance with Evidence Based Guidelines for DVT
Prophylaxis Fail to Meet Acceptable Standards
Dr Rajesh Patel

Retrospective Study of Serratia Marcescens Infections in
Southlands Hospital, Invercargill from 2004-2009
Dr Rakesh Premkumar, Mr Julian Speight

Left Laparoscopic Adrenalectomy of a Rare Large
Schwannoma
Dr Rakesh Premkumar, Mr Konrad Richter

Primary Carcinoma of the Small Intestine: A Rare Cause of
Anaemia in a Young Man
Giovanni Losco, Mr Konrad Richter

Rare Renal Cell Carcinoma Metastases to the Stomach,
Pancreas, and Breast: Significance of Three Case Reports,
Incidence, Therapy, and Outcome
Dr Todd Hore, Mr Konrad Richter

Use of CHAMPS Questionnaire to Evaluate Physical Activity
Levels in Morbidly Obese Patients
Dr Manmeet Saluja

The Effect of Obesity on Referral Practice for a First Specialist
Appointment (FSA) in Surgery
Dr Manmeet Saluja

The Training Perspective of Open and Laparoscopic
Appendectomy in a District General Hospital (DGH)
Dr Manmeet Saluja

Colonoscopy Audit at a Provincial New Zealand Hospital: A
Prospective Analysis
Dr Rohit Sarvepalli

Theatre Utilisation: Rockhampton Hospital
Dr Neil Scholes

Selective Use of MRCP in Clinical Practice may Miss
Choledocholithiasis in Gallstone Pancreatitis
Dr Sanket Srinivasa

Statin Use is Associated with Decreased Operative Rates in
Adhesive Small Bowel Obstruction
Dr Sanket Srinivasa

A Case of Lobular Breast Carcinoma Presents with Rectal
Stenosis
Dr Vivek Vatikutti

Lymph Node Evaluation and Long-Term Survival in Stage II
and Stage III Colon Cancer
Dr Ryash Vather

Surgical Education in Australasian Medical Schools
Dr Chieh-Tzu Yu

Case Study: Incarceration of Umbilical Hernia, post
Colonoscopy
Maxine Beetham

Friday 27th March 2010

Session 2: How to Manage Acute Surgical Problems

8.00am - 9.15am Trinity Rooms

Acute Care Surgery at Auckland City Hospital: Moving with the Times

Mr Li Hsee

Auckland City Hospital, Auckland, New Zealand

Acute care of emergent and urgent surgical problems is a major part of the day to day activities of public hospitals. At Auckland City Hospital 64% of admissions fit into this category. Traditionally management of these patients was undertaken by the surgical team of the day interspersed with their other routine activities. Surgical intervention, where necessary, was undertaken either on an elective list displacing booked cases, or after hours on an acute list. However, increasing subspecialisation within general surgery and increased pressure on elective throughput have placed that model under threat.

Lack of timely access to acute surgery is a growing problem worldwide, including in New Zealand. There are multiple factors contributing to this problem including shortage of Surgeons, increased sub-specialisation post fellowship, limited access to acute operating theatres and lack of a dedicated on call team. The concept of acute care surgery involves the provision of a surgical team and surgical resources dedicated to the treatment of acute patients. This requires a separation of staff and resources between the acute and elective streams. This principle has been established in many centres in Australasia and is now recognised by RACS in a recent position statement.

Recognising the importance of acute care surgery and its relevance for Auckland City Hospital, an Acute Surgical Unit (ASU) was set up to facilitate the assessment and management of acute general surgical patients.

Auckland City Hospital admits over seven thousand general surgical patients per annum. A Consultant led Acute Surgical team was set up in January 2009. The team consists of a full time Consultant Surgeon and part time contribution from a number of other surgeons. It also includes a full time nurse specialist, a SET four Registrar, a non-trainee Registrar and a rotating House Officer. The Acute Surgical team manages acute surgical patients from the hours of 7.30-5.00pm. Their responsibilities include the assessment of patients from the Emergency Department as well as General Practitioner and in house referrals. An acute operating theatre dedicated to General Surgery has been negotiated. The Acute Surgeon has no commitments to elective theatre or private practice, concentrating instead on supervising Registrars' operative cases and facilitating early decision making. After hours, acute care is provided by an on call Surgeon and Registrars. A key component of this acute care structure is the robust handover meeting where the acute and on call Surgeons discuss cases presented over the last 24 hours with the rest of the surgical team. It is in this forum that the clinical responsibilities for patient management are assigned, theatre cases are prioritised and tasks delegated.

Major challenges encountered during the implementation of an acute care service included access to a dedicated operating theatre, lack of staffing and limited resources. These issues were channelled through an internal steering committee. Ultimately, the aim of the ASU is to provide better, more timely management of acute surgical patients within Auckland City Hospital. Performance indicators include shorter time to assess referred patients, decreased time from decision to operating room and shorter hospital stay. Most of the acute cases are performed during the day thus minimising after hour operations. Acute care surgery also provides an important base for surgical trainees in managing emergency surgical cases. The aim is to have acute care surgery incorporated into the surgical curriculum as an integral part of surgical training. A baseline study of waiting times and process delays was undertaken.

The implementation of acute care surgery at Auckland City Hospital brings changes that are both positive and necessary. This service is moving with the times to benefit patients, health services and Surgeons in the Auckland region.

Damage Control in Hepatic Trauma: Ten Simple Manoeuvres.

Mr Johnathan Koea

Department of Surgery, Auckland Hospital, Auckland, New Zealand

Hepatic trauma requiring acute operative intervention is rare in New Zealand. However all general surgeons will occasionally be called upon to operate on patients with hepatic trauma, most commonly because of ongoing haemorrhage and shock. In these cases the operative strategy is based upon rapid control of haemorrhage and preservation of hepatic parenchyma. Initial efforts should be directed at obtaining adequate exposure with a right subcostal incision and a midline incision extended to the xiphisternum. The left and right coronary ligaments should be divided so that the surgeons hand can be placed behind the left and right hemilivers. The vena cava can be exposed if necessary. An umbilical tape should be placed around the hepatic inflow pedicle via the foramen of Winslow after dividing the lesser omentum. Selective inflow of the left and right hemilivers can be obtained using umbilical tapes directed around the right and left pedicles via hepatotomies. Stellate or linear lacerations can be controlled using widely placed non-absorbable sutures often tied over a bolster of Surgicel or Gelfoam. If required hepatic packing should be undertaken in a fully mobilized liver using surgical packs to reconstitute the normal hepatic contour. Occasionally emergent division of parenchyma will be required to debride necrotic tissue or complete traumatic avulsions of hepatic segments. Parenchymal division can be carried out using the crushing clamp technique (Kellyclysis), the harmonic scalpel, or staplers. A number of topical haemostatic agents are now available to manage bleeding from the liver edge.

Emergency Colonic Surgery without a Stoma

Mr Mike Hulme-Moir

North Shore Hospital, Auckland, New Zealand

Advances in surgical technique, equipment and postoperative care have meant that primary anastomosis can be safely achieved in most acute situations requiring colonic resection. The evidence for this is largely based on case series and cohort studies. Questions remain as to which criteria should be used to decide on when to give an end stoma (Hartmans) to an acute patient. Other areas of controversy that will be looked at include on-table lavage, the use of defunctioning ileostomy and the role of colonic stenting in acute colonic obstruction.

Acute Extradural Compressive Haematoma: How, When and Where

Mr Peter Heppner

Neuro Surgery, Auckland City and Starship Hospitals, Auckland, New Zealand

General Surgeons at peripheral base hospitals are sometimes required to deal emergently with traumatic intracranial haemorrhages if the time taken to transfer the patient to a neurosurgical centre would adversely affect the outcome.

We will review options for managing these patients and specifically the indications for emergent surgery by a general surgeon.

Subsequently we will discuss the various surgical options available to the General Surgeon. This will encompass a step by step description of the surgical techniques along with equipment that can be utilised and tips to prevent and deal with complications.

Keynote Address

9.15am - 9.45am Trinity Rooms

Cholecystectomy: Here We Go Again

Prof John Windsor

The University of Auckland, Auckland, New Zealand

Session 3: Contemporary Biliary Topics

10.15am - 11.00am Trinity Rooms

Biliary Imaging and MRI

Dr Louise Moore

Radiology Department, Tauranga Hospital, Tauranga, New Zealand

To describe the recent technical advances, state of the art imaging protocols and key points of interpretation in the MR imaging of biliary disease. To discuss the limitations of MRC.

Improvements in the evolving technology of MR imaging has led to greater recognition of diseases of the hepatobiliary and pancreatic ducts at MRCP and the ability to identify and characterise disease process to provide effective guidance for treatment. Optimising technique is essential. Patient preparation with fasting and an oral contrast agent such as pineapple juice to decrease hyperintense gastric and duodenal signal are helpful. The use of modern highfield strength magnets (1.5T or greater) and state of the art multi-channel surface coil technology enable shorter imaging times reducing motion artefact. The current conventional MRCP two standard techniques include a thick slab single section sequence which provides an overview of biliary anatomy, identifying obstruction and strictures and a thin sequence multi-section sequence which helps visualise intra-ductal disease such as stones. By means of new fast recovery and parallel imaging techniques 3D isotropic MRCP allow thinner sections without gaps between slices. The 3D data set by means of post processing can generate images in any desired projection improving anatomic accuracy. T1 and three-dimensional gradient echo sequences can be used to obtain high resolution images following hepatocyte specific intravenous contrast agents which undergo partial elimination through the biliary system and enhance the intrahepatic biliary ducts. This technique is generally targeted to anatomic mapping prior to liver transplantation and used to image the biliary tract for detection of biliary leaks. Despite the new technology there still remain challenges in interpretation from the various pitfalls, artifacts and limitations of modern MRC techniques.

Management of Gallbladder Polyps and a Serendipitous Diagnosis of Gallbladder Carcinoma

Mr Andrew Audeau

Dunedin Hospital, Dunedin, New Zealand

The treatment of asymptomatic gallbladder polyps can be contentious. As a starting point, the size and number of the polyps should be taken into account. A consideration of the patient's age and medical comorbidities must also be made. Ultimately, a careful assessment of risk and benefit should be made when treating a usually benign and asymptomatic aetiology. Another controversial area is the management of a serendipitous gallbladder carcinoma detected either at surgery or on pathological assessment. Common pitfalls are confusing chronic cholecystitis with carcinoma and attempting suboptimal "radical" resections. This talk will provide a practical approach to the management of these conditions in a General surgical setting.

The Difficult Gallbladder....Tricks and Tips

Mr Garth Poole

Middlemore Hospital, Auckland, New Zealand

Bad gallbladders are bad, good gallbladders are good.

Acute and elective laparoscopic cholecystectomies (LC) are only separated in difficulty by the psychology of the surgeon, access to a reliable team and theatre access. The combination of conversion rate, operating times and main bile duct (MBD) injury rate is a good surrogate for unit performance. It is reasonable to aim for a median operating time of less than 90 minutes, a conversion rate approaching 1% and a $\leq 0.1\%$ MBD injury rate.

The public hospital system has the obligation to educate several layers of medical personnel, whilst trying to maintain outcomes that stand up to scrutiny. The key factors in successful LC are:

- Leadership
- Psychology
- Experience
- Technical ability

The operation is a balance between rigid, predictable steps that build team morale and unpredictable steps that require flexibility. In the difficult case the surgeon must regularly ask three questions:

- Am I putting the MBD at risk?
- Would the patient benefit from conversion?
- If I knew preop what this was like would I have treated it non-operatively?

DEBATE

11.00am - 11.30am Trinity Rooms

Routine Intra Operative Cholangiography Should be the Gold Standard

Dr Michael Ridgers
North Shore Hospital, Auckland, New Zealand
vs
Mr John Dunn
Laparoscopy Auckland, Auckland, New Zealand

DEBATE

11.30am - 12.00pm Trinity Rooms

Laparoscopic Common Duct Surgery Should Replace ERCP for the Treatment of Choledocholithiasis

Mr Bertrand Jauffret
Rotorua Hospital, Rotorua, New Zealand
vs
Dr Mark Lane
Auckland City Hospital, Auckland, New Zealand

Session 4: Laparoscopy Moving On...

1.00pm - 2.00pm Trinity Rooms

Single Incision Laparoscopic Surgery, Introduction to Cholecystectomy in Victoria

Dr Sean Mackay
St Vincent's and Box Hill Hospitals, Victoria, Australia

This paper describes the introduction of SILS cholecystectomy into the presenter's practice in Melbourne, Australia. The following aspects are considered: training, both using closed-box trainers and in animal labs; necessary setup for SILS (including special equipment and training of the theatre team); ethical considerations relating to the new introduction of a new technique; initial cases; consolidation and refinement of technique; involvement in training and preceptorship; and results to date.

da Vinci and 'Robotic' Surgery in the Bay of Plenty

Mr Peter Gilling
Bay of Plenty Clinical School, Tauranga, New Zealand

The first robot-assisted procedure in New Zealand was performed in November 2007 in Tauranga. Since then, further Da Vinci Robot systems have been installed in both Auckland and Christchurch. The predominant procedure performed has been Radical Prostatectomy. Approximately 1500 systems have been installed world-wide to date – with over 200,000 procedures being done in 2009.

The initial 100 cases from this site are presented – 3 being salvage procedures following failed brachytherapy. The mean patient age pre-op was 62.1 years with a BMI of 26.6, the mean PSA was 6.2 and 63% had impalpable disease (cT1c). The median console time reduced from 219 minutes for the first 20 cases to 107 min in the most recent 20. No patient required conversion to a laparoscopic or open approach – 1 patient required a delayed laparotomy (at 48 hrs) for blood loss. The hospital stay was 1.8 nights. 87% of patients had clear surgical margins.

Robot-assisted procedures – predominantly prostatectomy, partial nephrectomy, pyeloplasty and cystectomy – are firmly established in urologic surgery. Gynaecology is rapidly becoming the largest user of these machines however. General surgical applications are also increasing – predominantly bariatric surgery, nissen fundoplication and colorectal procedures.

Sunday 28th March 2010

Session 5A: Free Paper Session

8.30am - 10.10am Trinity Room 1

Quantitative Lymph Node Evaluation as an Independent Marker of Long-term Prognosis in Stage III Rectal Cancer

R Vather, T Sammour, A Kohokehr, BA Connolly, AG Hill

Department of Surgery, South Auckland Clinical School, Middlemore Hospital, New Zealand

Introduction

The prognostic significance of lymph node evaluation is not well described for rectal cancer due to lack of reproducibility in nodal counts and variable use of adjuvant and neoadjuvant therapy.

Aim: The aim of this study was to examine the role of quantitative lymph node evaluation as an independent marker of prognosis in Stage III rectal cancer.

Methods

New Zealand Cancer Registry data were retrieved for consecutive patients with rectal cancer from January 1995 to July 2003. Cases with node-negative tumours, distant metastases, death within 30 days of surgery, and incomplete data fields were excluded. Three nodal stratification systems were investigated – Total Number of Nodes examined (TNN), Absolute number of Positive Nodes (APN), and Lymph Node Ratio (LNR). Univariate and Cox regression analyses were performed with 5-year all cause mortality as the primary endpoint.

Results

The study identified 895 Stage III rectal cancer cases. The mean APN and LNR were significantly higher in patients who died within 5 years vs. those who survived. An increasing APN or LNR was associated with a significant increase in 5-year mortality. Cox regression analyses showed that the APN and LNR were powerful predictors of 5-year mortality after correcting for other factors. The TNN was of no prognostic significance.

Conclusions

Both the APN and LNR are highly effective at independently predicting and stratifying 5-year mortality in Stage III rectal cancer. The significant predictive value of the LNR is likely to be a reflection of the APN rather than one functioning in autonomy, given that the TNN was of no prognostic significance.

Peri-Operative Outcomes Following Short vs Long Course Radiotherapy for Rectal Cancer

Amit Reddy, Elizabeth Dennett, Sumeet Reddy

Department of Surgery, Wellington Hospital, Wellington, New Zealand

Introduction

Long or short course pre-operative radiotherapy is now standard neo-adjuvant therapy for patients with locally advanced rectal cancer. Anecdotal evidence¹ is that short course radiotherapy is associated with more peri-operative complications.

Aims

To determine if there is a difference in peri-operative outcomes for patients having had short course radiotherapy [SRT] cf. to those who received long course chemo-radiotherapy [LCRT].

Methods

All patients with rectal cancer who received either SRT or LCRT between 01/01/2002 and 31/10/08 in Wellington Hospital were identified. Charts were reviewed and data extracted including: length of hospital stay, requirement for TPN, successful introduction of clear oral fluids (COF) as a surrogate marker of ileus) and septic complications (major = intraperitoneal collections, pneumonia, central line sepsis, epidural abscess, minor = superficial wound infection, fever of unknown origin, UTI and C. difficile +ve diarrhoea).

Results

97 patient charts were studied (40 SRT:57 LCRT). There was no statistically significant difference between the 2 groups for length of hospital stay ($p=0.5$), requirement for TPN ($p=0.2$) or total number of septic complications ($p=0.7$).

However, when septic complications were analysed as major or minor there was a statistically significant difference. The odds of a minor septic complication after SRT were 4 times that of LCRT (OR 3.85, CI 1.15-12.77, $p=0.02$).

The time to the successful introduction of COF was also statistically significantly different. LCRT had COF successfully introduced at 3.2 days cf. 6.4 days for SRT ($p=0.03$).

Conclusions

Patients having SRT (cf. LCRT) appear to have more minor septic complications and take longer to return to normal bowel function however this does not significantly increase their hospital stay.

References

1. Personal communication with Colorectal Surgeons / Oncologists. Wellington Region

Minor Anal Surgery In A Stand-Alone Day Surgical Unit

Mr Don Guadagni

Guadagni Surgical Limited, Whakatane, New Zealand

Introduction

Minor Anal Surgery (eg. Operative Haemorrhoidectomy) is normally performed in New Zealand in an overnight facility. I have over 10 years experience with doing such surgery in a stand-alone Day Surgical Unit.

Aims

My aim is to present my experience in this area, focusing on technique, risks, and benefits of doing anal surgery as a Day Case. This will include a description of V-Y Anal-Plasty for Anal Fissure and my experience with this procedure.

Methods

I have reviewed my audit results of all minor anal surgery I have done in my unit from 1999 – 2009.

Results

During this time I did 197 Operative Anal Procedures. 88 Operative Haemorrhoidectomies (and 201 Rubber Band Ligations), 66 procedures for Anal Fissure (16 Closed Lateral Internal Sphincterotomies and 50 V-Y Anal-Plasties), 10 Fistulotomies, 6 drainage of Peri-Anal Abscess, 3 Transanal Resections for benign tumours and 23 others (eg. EUA's, Excision of External Haemorrhoids). Our post op complication rate was comparable to in patient care and no cases needed admission to hospital post op. Only 2 cases needed to be seen postoperatively; one for urinary retention and one for bleeding that stopped spontaneously.

Conclusion

Safety and patient satisfaction with many anal operations make the economic benefits of doing them as a day case quite justified.

The Validation of a Prioritisation Tool for Colonoscopy

Dr David Vernon

Lakes DHB, Rotorua, New Zealand

Introduction

In Lakes District Health Board (LDHB), approximately 1200 colonoscopies annually are performed. Demand outstrips capacity, which has resulted in a waiting list. Patient selection for colonoscopy lists based upon each patient's circumstances is problematic. Furthermore, the Ministry of Health requires DHBs to use prioritisation tools to rank those waiting, which are unvalidated.

Aims

The aim was to develop a database of patients waiting for colonoscopy which automated ranking to not only allow ease of theatre scheduling but also which was valid with respect to the probability of colorectal cancer.

Methods

Since April 2006, patients booked for colonoscopy have been prospectively entered into an Access database, which produces an arbitrary index score (IS) based upon factors associated with symptoms, past or family history, signs and laboratory tests. A time delay factor based on the time from referral is multiplied in as an acknowledgement of the potential lack of validity of the IS as a predictor. The database thus creates a ranked waiting list of patients which is used to schedule endoscopy lists.

Results

2180 records have been entered into the database, with 1499 completed colonoscopies. The database has simplified the task of patient selection. The pathologies found included: no abnormality (41.5%), adenomata (18.6%) and cancer (4.2%). The median (interquartile range) of IS was 1000 (350-2550) for all non-cancer diagnoses versus 5880 (1180-77236) for cancers ($p < 0.0001$). Logit transformation on the cancer probability data ranked by IS also produced a significant linear correlation ($r = 0.46$, $p = 0.03$).

Conclusion

The use of a prospective database for entering patients onto the colonoscopy waiting list has achieved its aims of making prioritisation and scheduling simple and consistent. Furthermore, we have validated its ability to rank patients as to the probability of cancer.

Experience of Sling Immobilization of the Ipsilateral Shoulder and the Development of Post-Mastectomy Fluid Collections

Dr Shaun Purkiss, L Norris, M Sanders, U Shan, S Dunn, G Snyman

Breast Unit, Whangarei Base Hospital, Whangarei, Northland

The development of postoperative fluid collection after mastectomy and axillary lymph node surgery (M+ALND) remains a significant problem. An incidence of between 20-50% has been reported. This has significant implications to the patient and can lead to secondary effects such as infection and protein, nutrient and mineral depletion. We examined the hypothesis that early immobilisation of the arm after M+ALND with a sling for 7 days can alter the healing process to effect a reduction in seroma incidence.

Forty seven patients were examined for the presence or absence of seroma after mastectomy and axillary lymph node dissection over a single fiscal year. Sling immobilisation was offered to most patients during this time but not all received or accepted treatment. All operations were performed by consultants with an interest in breast disease. Sling immobilisation of the ipsilateral arm was performed for seven days after the patient had returned to the postoperative ward. At this point the patients were examined by a breast care nurse and a physiotherapist. The presence of a seroma as assessed by fluctuance and or aspiration was recorded and the secondary observation of shoulder function was recorded by the physiotherapist.

Forty one patients were available for assessment; the incidence of post operative seroma was 17(43%). Table I illustrates the numbers in each group stratified for outcome.

Treatment Group	Seroma	No Seroma
Sling for 7 days	14	16
No Sling	3	8

Fishers exact test 0.3092 (NS)

No significant difference in seroma incidence could be attributable to the use of the sling. Shoulder movement was also not appreciably affected by the weeks delay in physiotherapy.

Better Design of Mastectomy Flaps

Mr Burton King, C Mouat, Y Salama

Department of General Surgery, Wellington Hospital, Wellington, New Zealand

Introduction

In mastectomy incisions, lateral and medial dog-ears can be a problem especially in large-breasted women. These are unsightly and cause discomfort with prostheses. Techniques to correct this include lengthening the scar, excising underlying subcutaneous tissue and "fish- tail" incisions.

The ideal mastectomy incision design should have a teardrop shape. We describe a method of designing this shape and a novel oncoplastic technique for addressing the lateral dog-ear.

Methods

The medial and lateral points of a transverse breast axis are marked. The breast is then retracted with a flat hand caudad and the two points joined with a straight line, this is repeated with cephalad breast retraction. The medial end of the resultant teardrop is retracted laterally with an index finger and the indented marking "concavity" is restored, this is repeated with medial retraction with the lateral (broader) end of the teardrop.

After completion of the mastectomy in patients with a larger body habitus the lateral end of the ellipse is retracted medially - a lateral rhomboid shaped area of skin is deepithelialised – the skin flaps are then closed transversely with the medial point of the rhomboid incorporated into the wound line.

Results:

We have used the teardrop pattern for 9 years and deepithelialisation of the lateral fold in 20 patients with maintenance of the reduction at long term follow-up.

Conclusion

These surgical techniques are simple and provide an acceptable cosmetic result.

References

Mirza M, Sinha KS, Fortes-Mayer K: Tear-drop incision for mastectomy to avoid dog-ear deformity. Ann R Coll Surg Engl 2003, 85:131.

Devalia H, Chaudhry A, Rainsbury R, et al: An oncoplastic technique to reduce the formation of lateral 'dog-ears' after mastectomy. International Seminars in Surgical Oncology 2007, 4:29.

Immediate Implant-Based Breast Reconstruction Following Mastectomy: Review of Result and Outcome in a Provincial Centre

Dr Ian Bloomfield, Mr Peter Chin

Tauranga Hospital, Tauranga, New Zealand

Introduction

Current best-practice guidelines recommend that appropriate patients who require a Mastectomy should be offered the option of immediate reconstruction. With improvement in implant technology, Implant-based reconstruction can now achieve a high level of aesthetic outcome in the properly selected patient.

Aims

The aim of this study is to assess the outcome and results achieved for implant-based reconstruction in a provincial practice.

Methods

All patients with breast cancer who were operated on by a single breast surgeon between February 2006 and August 2009 were included in this study.

Results

There were a total of 281 cases of which 157 were breast conserving and 124 mastectomies. Immediate reconstructions were performed in 41 cases: implant-based (28, 2 bilateral), Lat Dorsi (9) and TRAM flap (4, in conjunction with plastic surgeon). 15 patients underwent second stage procedures (e.g. implant exchange, contralateral symmetry surgery). 13 patients have completed all necessary procedures with 2 patients awaiting nipple reconstruction.

12 patients received chemotherapy (mean duration 58 days post-op), 9 patients received radiotherapy with 3 patients still awaiting. 3 patient developed capsular contracture after radiotherapy and required revisional surgery.

There were 5 cases where implant removal was necessary. These were due to extensive disease (2), implant infection during chemotherapy (1), radiotherapy-related wound breakdown following implant exchange (1) and patient request (1). There were 2 cases of wound edge necrosis, 1 case of implant rotation and 1 case of port site rotation requiring surgical revision.

Conclusion

Implant based technique is a satisfactory option for immediate reconstruction but requires careful case selection and counselling regarding complication risks and need for revisional/symmetrisation surgery.

We plan to follow on with a quality of life survey, numerical analogue scale and an independent visual outcome analysis to complete this study.

Breast MRI: What Impact has it had on Breast Surgery?

Dr Nina Bartlett¹, K Williams², A El-Dieb², P Chin¹

¹Department of Surgery, Tauranga Hospital, Tauranga, New Zealand

²Department of Radiology, Tauranga Hospital, Tauranga, New Zealand

Introduction

Over the past decade, the utility of Breast MRI has evolved in parallel with advances in technology. Guidelines on its use are regularly updated as breast clinicians continue to gain knowledge of its benefits and limitations.

Aim

We aim to evaluate the clinical impact of Breast MRI in the management of breast diseases.

Methods

A retrospective review of patients who underwent Breast MRI for the evaluation of breast problems at Tauranga Hospital (January 2008 and June 2009).

Results

A total of 46 cases of breast MRI were performed over the study period. These were for pre-operative assessment(19), diagnostic evaluation(20), screening(5) and post-operative evaluation(2).

In the pre-operative group, MRI was used for assessment of lobular cancer(6), DCIS(4), ductal cancer(6) and axillary mass(3) with unremarkable conventional breast imaging. An occult breast cancer was detected in 1 of the latter cases.

Overall, the surgical treatment was influenced in 10 out of 19 cases. 8 patients had mastectomy rather than breast conservation and 2 had bilateral mastectomies.

20 patients had MRI for diagnostic evaluation where conventional imaging was negative/non-conclusive. 3 were for evaluation of implant related problems with rupture confirmed(3) requiring corrective surgery. The rest had no significant abnormalities.

MRI was used for screening(5) with 3 BRCA mutation carriers.

One patient had MRI post-operatively for evaluation of residual DCIS after breast conservation. Further DCIS was demonstrated requiring MRI-guided hookwire placement for re-excision.

Conclusion

In our review, MRI influenced the operative treatment in 23 out of 46 patients. There is a trend towards an increase in the mastectomy rate as a result of MRI and this is reflected in our study. With a better understanding of its limitations, Breast MRI will continue to be a valuable tool in the evaluation of breast diseases.

MRI Scanning in the Management of Breast Cancer

Dr John Harman

St Mark's Women's Health, Auckland, New Zealand

MRI has been increasingly touted by radiologists in particular, as an important modality in firstly the diagnosis of breast cancer and secondly the assessment as to the extent of the breast cancer.

We know historically that at the time of diagnosis of a solitary breast cancer in one breast there is a 3% chance that there are other lesions in that breast. However, we also know historically that when a mastectomy is performed there can be up to 30% more extensive disease in the breast when the final histology returns. When performing partial mastectomy it has become our practice to liberally use MRI can to confirm that the lesion is solitary in the one breast to identify the extent of the lesion and confirm that it is suitable for a partial mastectomy.

We have had 45 MRI scans performed on our patients at St Marks over the past 18 months. These MRI scans have been helpful in most cases, extremely helpful in few cases. The particular area where MRI has been of most use is in lobular breast cancer. We believe that all patients who are undergoing partial mastectomy should have an MRI performed. Some overseas studies have shown that the new lesion rate seen when patients are sent for MRI is up to 10%.

The MRI scan should be performed by experience Radiologists who are familiar with it and perform both mammographic and ultrasound screening of the breast currently. It also should be performed by people who have MRI biopsy facilities available for use. Any lesions biopsied under MRI should also be localised at the time of MRI so that if they return as positive they can be identified and removed at the time of surgery or histologically examined appropriately.

With the use of screening MRI in high risk patients being recommended by the American Cancer Society there will be an increasing number of patients who present with abnormal MRI's that require both diagnostic and surgical workup.

It is important that we as clinicians become familiar with the pros and cons of MRI as it can be wrong in up to 30% of cases. On the one hand this can lead to over diagnosis of the breast and in some studies the mastectomy rate has increased from 29% to 56%. There are a number of trials that are underway in assessing the utility of using MRI for DCIS, one of which is running currently in Auckland. I will report on the early findings of this trial.

Role of Mutational Analysis in Surgical Treatment of Gastrointestinal Stromal Tumours (GIST)

Konrad Klaus Richter¹, Alexander Dempster², Rakesh Premkumar¹, Thomas Elliot³

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Introduction

GISTs are characterized by activation of either C-KIT or PDGFRA tyrosine kinase. Up to 30% of GISTs may be malignant at presentation and 20% of small GISTs are already metastatic. It has been suggested that response to Imatinib (Glivec®), a selective inhibitor of tyrosine kinase signalling enzymes, depends on the type of the exon mutation in c-kit and PDGFRA.

Aims

Here, we present two surgical cases of stomach GISTs that demonstrate the complexity in diagnosing and treating these potentially malignant tumours.

Methods

Two patients with stomach GISTs presented to our hospital and were operated with stomach wall resection and partial Gastrectomy, respectively. Specimens were studied on frozen formalin-fixed, paraffin-embedded tissue for immunohistochemistry and mutational analysis.

Results

The first GIST was strongly positive immunohistochemically for CD117. C-Kit mutation analysis demonstrated C-Kit positivity of Exon 11_c.1674_1676delGGT. The second 5 cm specimen was weakly positive immunohistochemically for CD 117. C-KIT Mutation Analysis demonstrated negativity for exons 9, 11, 13, and 17, and negativity for PDGFRA exon 18. The additional mutational analysis to assess the rare PDGFRA exons 12 and 14 mutations was negative as well. Therefore, a wild-type GIST is most likely, however, the differential diagnosis includes a synovial sarcoma that sometimes can be weakly positive for CD117. Both patients do not show any signs of recurrence one and a half year after surgery.

Conclusion

The first GIST represents a typical low grade GIST that does not require further medical therapy. The second tumour has a high risk for recurring and metastasizing. Molecular analysis of KIT and PDGFRA may allow individualized treatment and surgeons should be knowledgeable about GIST mutations and their implications for surgical and medical treatment.

A Multidisciplinary Classification of Invasive Procedures for Treating the Local Complications of Acute Pancreatitis

Benjamin PT Loveday¹ MBChB, Maxim S Petrov¹ MD MPH, Saxon Connor² FRACS, Jeremy I Rossaak³ PhD FRACS, Anubhav Mittal¹ MBChB, Anthony RJ Phillips^{1,4} MBChB PhD, John A Windsor^{1,5} MD FRACS FACS, for the Pancreas Network of New Zealand

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Introduction

Standardising terminology is a strategy to improve the effectiveness of communication. The lack of a system to classify invasive procedures to treat the local complications of acute pancreatitis is an obstacle to comparing interventions

Aims

This study aimed to develop a comprehensive and multidisciplinary classification and to determine its acceptability and reliability.

Method

International Classification of Diseases terminology was used to develop a system to classify procedures based on three key components: how the target lesion is visualised (V), the anatomical route (R) taken during the procedure, and the procedure's purpose (P). Gastroenterologists, radiologists, and surgeons from three centres in New Zealand assessed the classification and independently classified fifteen published technique descriptions. The classification's clarity, ease of use and potential to achieve its objectives were rated on a Likert scale. Inter-rater reliability was calculated for each component of the classification.

Results

The technique descriptions were classified by 22 clinicians (6 gastroenterologists, 11 radiologists, 5 surgeons). The classification's clarity, ease of use, and potential to achieve its objectives had median scores of 4/5. Inter-rater reliability for visualisation, route and purpose components was substantial at 0.73 (95% CI 0.63 to 0.82), 0.79 (0.70 to 0.87), and 0.64 (0.53 to 0.74), respectively.

Conclusions

This paper describes the development and validation of a multidisciplinary classification for the wide range of procedures used to treat the local complications of acute pancreatitis. This VRP Classification has substantial inter-rater reliability and high acceptability, which should enhance communication between clinicians and facilitate comparison of different procedures.

Alanine Transaminase Rather than Abdominal Ultrasound Could be used to Justify Cholecystectomy in Patients Presenting with Acute Pancreatitis in a Center Without Endoscopic Ultrasound

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¹ *Surgical Registrar, Christchurch Hospital*

² *Trainee Intern, Christchurch School of Medicine*

³ *Hepatopancreaticobiliary Surgeon, Department of Surgery, Christchurch Hospital*

Introduction

In acute pancreatitis, abdominal ultrasound is used to confirm a biliary aetiology as it is highly specific, although its sensitivity is poor. Alternatively, an elevated alanine transaminase (ALT) has been shown to predict a biliary aetiology in acute pancreatitis.

Aims

To investigate the predictive value of an elevated ALT for biliary acute pancreatitis and reconsider the need for abdominal ultrasound.

Methods

All patients admitted to Christchurch Public Hospital with acute pancreatitis (first presentation) between 07/05-12/08 were identified from a prospectively collected database. Peak ALT within 48 hours of presentation was recorded. Aetiology was determined on the basis of history, abdominal ultrasound and other relevant investigations.

Results

A total of 543 patients met inclusion criteria. Patients with biliary acute pancreatitis had significantly higher median (range) ALT (200 units/l (63-421) vs. 33 units/l (18-84), $p < 0.001$), older median (range) age (63 years (44-75) vs. 51 years (34-68), $p < 0.001$) and were more frequently female (58% vs. 46%, $p = 0.006$) than those with non-biliary causes. ALT was strongly predictive of biliary acute pancreatitis. The probability of a biliary aetiology was proportional to the ALT. An ALT > 300 had a sensitivity of 36%, specificity of 94%, positive predictive value of 87% and positive likelihood ratio of 5.6 for gallstones. An elevated ALT and negative abdominal ultrasound had a probability of gallstones of 21-80%.

Conclusion

An elevated ALT strongly supports a diagnosis of gallstones in acute pancreatitis. Abdominal ultrasound effectively confirms this diagnosis however a negative ultrasound in the presence of a raised ALT does not exclude gallstones. Consideration should be given to proceeding to laparoscopic cholecystectomy based on ALT alone.

References

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The Outcome of Computed Tomography Diagnosed Intussusception in Adults

H Waller, R Bassari, C Fernando, T Eglinton

Christchurch Hospital, Christchurch, New Zealand

Introduction

The advent of modern multi-slice computed tomography (CT) has seen an increase in the diagnosis of intussusception in adults. This ranges from a transient phenomenon detected incidentally to a potentially life threatening problem, producing a dilemma as to the appropriate management

Aims

To document the outcome of patients after CT diagnosed intussusception and identify factors which predict the need for intervention.

Methods

All cases of CT diagnosed intussusception in adults from 2004 to 2008 in Christchurch Hospital were identified by searching the COMRAD database. The case notes were reviewed and data extracted including; indication for CT, history of cancer or previous abdominal surgery, site and length of bowel involved and outcome.

Results

Sixty eight cases of CT diagnosed intussusception were identified (mean age 54.1yrs). Intussusceptions were classified as small bowel in 46 cases (68%), ileocolic in 11 (16%) and colonic in 11 (16%). In total 33 (49%) patients underwent laparotomy following the CT. Intussusception was confirmed at laparotomy in 10 (15%) patients. Five (7%) patients had a negative laparotomy, while 28 (41.2%) patients had a therapeutic laparotomy. In the remaining 35 (51%) patients who did not undergo intervention, there were no clinical or CT recurrences over a median follow up of 21.2 months (0-59). In the group who underwent a therapeutic laparotomy, the mean age was higher (63.1yrs vs 47.8yrs, $p=0.002$), the mean reported intussusception length greater (68.9mm vs 35.5mm, $p=0.0001$) and an abdominal mass and large bowel location more frequent (21% vs 0%, $p=0.003$ and 32% vs 5%, $p=0.005$).

Conclusion

Many CT diagnosed intussusceptions are not clinically significant. Factors associated with the need for laparotomy include older age, intussusception length, large bowel location and the presence of an abdominal mass.

Aetiology, Management and Outcomes of Acute Intestinal Obstruction in a Provincial New Zealand Hospital

S Aschenberger, F Haddawi, M Fancourt, W Gilkison, S Kyle, D Mosquera

Department of General Surgery, Taranaki Base Hospital, Taranaki, New Zealand

Introduction

Intestinal obstruction is a common cause for acute surgical admission but there are few studies reporting management and outcomes in New Zealand.

Aims

The aim of this study was to assess the aetiology, management and outcomes of acute intestinal obstruction in a provincial New Zealand hospital.

Methods

This was a prospective audit on a consecutive series of adult patients who were admitted acutely to Taranaki Base Hospital under surgical services with a diagnosis of small (SBO) or large bowel obstruction (LBO) in a one year period (1st December 2008-30th November 2009). Morbidity and mortality data were collected on a standardized pro-forma.

Results

There were 91 admissions in 82 patients with acute intestinal obstruction, 69 (76%) of those were SBO and 22 (24%) LBO. The most common cause for SBO was adhesions (79%,n=54) whereas the leading underlying pathology of LBO was malignancy (77%,n=17). 51% (n=35) of the patients with SBO were managed conservatively but 77% (n=17) of LBO required surgery. 50 (91%) procedures were open (laparotomy/open hernia repair), 5 (9%) patients were treated laparoscopically and one colonic stent was placed. Overall thirty-day mortality was 10% (n=9), 5% (n=1) for LBO and 12% (n=8) for SBO, respectively. 21 (23%) patients suffered from local or general complications and 4 patients needed more than one operation during one admission. The median length of stay was 7 days for all the patients, 5 days for SBO and 8 days for LBO, respectively.

Conclusion

This study reports aetiology, management and outcomes for intestinal obstruction in a provincial New Zealand hospital which are comparable with figures published in international literature.

Laparoscopic Sleeve Gastrectomy as a Single-Stage Bariatric Procedure

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¹Department of Surgery, South Auckland Clinical School, Middlemore Hospital, University of Auckland, Auckland, New Zealand

²Department of Surgery, Middlemore Hospital, Auckland, New Zealand

Background

Laparoscopic sleeve gastrectomy is increasingly being used as a stand-alone procedure in bariatric surgery, with medium term follow-up data now emerging. We present our early experience in patients with a mean BMI in the super-obese range.

Methods

Review of prospectively collected data for the first 100 patients who underwent laparoscopic sleeve gastrectomy at Counties Manukau District Health Board between March 2007 and July 2008.

Results

One hundred patients were identified, with a mean age of 43 years (range 20 – 60). Maori and Pacific Islanders made up 31% of the patient subset. Patients had a mean BMI of 50.3 kg/m² (range 34.5 – 72.8). Forty five patients were super-obese. The median hospital stay was 2 days (range 1 – 7). Mean follow-up was 12.0 months (range 0.9 – 23.3). Mean excess weight loss was 62.9% (range 7.2 – 129.0). Twenty five percent of patients were diabetic, and 45% of patients were hypertensive pre-operatively. Diabetics and hypertension resolved or improved in 72% and 60% of patients, respectively. There was a major complication rate of 7%, including 3 staple-line leaks (one requiring laparotomy), 2 staple-line bleeds (one requiring laparotomy), and 1 infected haematoma. There were no deaths.

Conclusion

In this public hospital setting, laparoscopic sleeve gastrectomy has achieved satisfactory weight-loss results with an acceptable complication rate in the medium term.

** We anticipate presenting results of approximately 300 patients with medium term follow-up at the time of the conference. This study is currently under way and shall be completed by mid-January. Hence, we have submitted this abstract of our first 100 patients.*

Use of a Novel Physical Activity Questionnaire to Assess the Effect of Bariatric Surgery on Physical Activity Levels

Dr. Manmeet Saluja, Katherine Megchelse, Mr. Shaun Purkiss

Department of Surgery, Whangarei Hospital, Whangarei, New Zealand

Background

Bariatric surgery has become a mainstay in the treatment of morbidly obese patients. However, surgical treatment should aim to achieve positive outcomes in multiple dimensions of health. In this study we evaluate the effect of bariatric surgery on physical activity levels with correlation with short term weight loss and quality of life.

Methods

Patients that were enrolled in the Northland Bariatric Program and had bariatric surgery between July 2007 and October 2009 were asked to fill out Community Health Activities Model Program for Seniors (CHAMPS) and SF-36 questionnaires retrospectively correlating to their life pre-operatively and three months post-operatively. An estimate of energy expenditure per week was calculated from the CHAMPS questionnaire and health-related quality of life was derived from the SF-36 questionnaire. Participant's weights were obtained from outpatient clinic appointment records. Data was analyzed using p-values, confidence intervals and paired t-tests.

Results

A total of 16 participants were recruited with a response rate of 76.2%. Participants were predominantly women (87% female) and mean age was 47.1 years +/-9.8 years. Mean weight loss over 3 months after surgery was 27.66kg (19.12% of the pre operative weight). Analysis of CHAMPS showed that weight-standardized physical activity levels improved from a total of 4081.6 kcal/week to 7715.5 kcal/week (p<0.01). Furthermore moderate and vigorous intensity exercises were responsible for a greater proportion of overall energy expenditure post operatively. Quality of life increased significantly in all eight domains of SF36 questionnaire including the summarized physical and mental components of health (p<0.05).

Conclusion

This study provides evidence that bariatric surgery significantly improves short-term weight, quality of life and physical activity levels. CHAMPS questionnaire can be used as an appropriate tool in measuring the effectiveness of bariatric surgery on physical activity levels.

A Prospective Randomised Trial of Sentinel Node Biopsy for High Risk Squamous Cell Carcinoma (SNIC Trial)

RCW Martin, W Kelder, K Roth, J Clark

Waitemata DHB, North Shore City, New Zealand

Background

Non-melanoma skin cancers are the most common cancers in the world. The majority of squamous cell carcinomas (SCC) do not metastasize, but those that do cause significant morbidity and mortality. Certain risk factors have been identified that will predict those at highest risk of lymph node metastases. By using the Sentinel Node Biopsy (SNB) we can identify and treat those that have metastasized at an early stage.

Hypothesis

Identification of early metastases and their treatment will improve survival and surgical morbidity of patients compared to more extensive surgery for delayed, more advanced lymph node metastases.

Aims

Primary aim:

To analyse disease specific and overall survival for patients with high SCC who undergo wide excision and SNB and immediate completion lymph node clearance in case of a positive sentinel node versus patients who undergo wide excision of the primary lesion with postoperative serial ultrasound observation of the regional lymphatic basin.

Secondary aims:

To analyse disease free survival and to monitor the morbidity of SNB and early versus delayed lymphadenectomy in high risk non-melanoma skin cancer. To detect genetic profiles in the primary tumour that predict metastatic disease. To analyse cost effectiveness and quality of life.

Design

The trial is a phase III, international, multicentre, randomized trial. In arm 1 of the study, the treatment will be wide local excision of the skin tumour and sentinel node biopsy, followed by immediate completion lymphadenectomy if the sentinel node is positive. In arm 2 of the study, the treatment consists of wide local excision and nodal observation with ultra-sound. Lymph node metastases in the follow up will be treated by delayed lymphadenectomy. The study will run over 5 years.

Accelerated Liquefaction of Pancreatic Necrosis Using Proteolytic Enzymes: A New Paradigm

Benjamin PT Loveday¹ MBChB, Anubhav Mittal¹ MBChB, Anthony Phillips^{1,2} MBChB PhD, John A Windsor^{1,3} MBChB MD FRACS FACS

¹Department of Surgery, ² and School of Biological Sciences, University of Auckland, Auckland, New Zealand; ³HBP/Upper GI Unit, Department of Surgery, Auckland City Hospital, Auckland, New Zealand

Introduction

Infected pancreatic necrosis is a local complication of acute pancreatitis, and its treatment requires major surgery or repeated and highly-specialised minimally invasive intervention. Removing necrotic tissue by accelerating its dissolution with enzymatic treatments may offer a better treatment modality.

Aims

The aim of this study was to: 1) characterise the architecture and composition of normal and necrotic human pancreatic tissue in order to identify potential targets for accelerated dissolution; 2) determine the efficacy of enzymatic dissolution.

Methods

Normal cadaveric pancreas (n=3) and necrotic pancreatic tissue (n=10, patients undergoing necrosectomy for acute pancreatitis) was collected. Samples were analysed by microscopy and Fourier transform infrared spectroscopy (FTIR) to characterise architecture and composition. Necrosum was incubated for 24 hours at 37C in a range of solutions (saline, collagenase, trypsin/chymotrypsin, or bromelain). Incubations were performed in dissolution chambers with solutions pumped through the chambers at 10L/24 hrs. Change in wet and dry mass, architecture and composition was determined. Change in mechanical properties of the tissue (peak force and work of extrusion from a syringe) was determined using a texture analyser. Saline was used as the common control for analyses.

Results

Necrosum lacked normal cellularity and extracellular matrix elements, and had an absence of vascular and lymphatics structures. Collagen dominated necrotic tissue architecture, although there was marked heterogeneity with regards to its pattern of deposition. Following incubation, saline incubated tissue gained wet weight and lost 20% of its dry weight, with no difference between solutions. Collagenase and bromelain reduced the peak force of extrusion ($p<0.05$), and all three enzymes reduced the work of extrusion compared with saline ($p<0.05$).

Conclusions

Significant architectural and compositional changes exist between normal and necrotic pancreatic tissue. Enzyme treatment of tissue had mechanical advantages over saline alone in extruding tissue, giving evidence that enzymatic dissolution of necrosum is feasible.

Session 6: Malignant Melanoma

10.40am - 11.55am Trinity Room 1

Malignant Melanoma: The New Zealand Guidelines, Case Discussions

Mr Richard Harman, North Shore Hospital, North Shore City, New Zealand

Mr Richard Martin, North Shore Hospital, North Shore City, New Zealand

Dr Richard North, Tauranga Hospital, Tauranga, New Zealand

Update: Colorectal Cancer Screening in New Zealand

11.55am - 12.10pm Trinity Room 1

Prof Ian Bissett

The University of Auckland, Auckland, New Zealand

For a condition to be considered as suitable for screening it should meet the following criteria; a suitable test, effective and accessible treatment for patients with the condition detected early, high quality evidence that screening is effective in reducing mortality or morbidity, benefit should outweigh potential harm, the health care system should be capable of supporting all necessary elements of the screening pathway and there is consideration of social and ethical issues. Information in support of colorectal cancer screening in each of these areas will be presented .

Colorectal cancer rates in New Zealand are among the highest in the world and screening for early detection of colorectal cancer has been investigated by the Ministry of Health for several years. The presentation will particularly address questions around the evidence for screening, the screening test, implications on the workforce and overcoming the impediments to screening implementation. This presentation will describe how New Zealand is progressing with towards the introduction of colorectal cancer screening nationally.

Accreditation of Colonoscopists in the UK Bowel Cancer Screening Programme

Dr Rob Cunliffe

Tauranga Hospital, Tauranga, New Zealand

The UK bowel cancer screening programme was rolled out in 2006. As predicted, the programme has generated a substantial colonoscopic workload, both from screening derived and subsequent adenoma surveillance procedures. The standard of colonoscopy across the UK was known to be variable. Strict criteria were therefore developed for the accreditation of screening colonoscopists in order to ensure high quality procedures and to minimise the risk of complications within the programme.

Notes

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Tauranga Map

