New Zealand Association of General Surgeons

HANDBOOK

NZAGS 2016

12–13 March '16

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CONVENORS' WELCOME

Dear Colleagues

It is a great honour and a privilege to welcome you to the Annual Scientific Meeting of the New Zealand Association of General Surgeons to be held at the Spencer on Byron in Takapuna on Auckland's North Shore from 12-13 March 2016!

We live in challenging times and the field of General Surgery is not an exception. Ageing and growing population, staff shortages and restricted budgets, new technological advances - this is the everyday reality we are faced with and if we are to stay in control and ensure a bright future for our beloved profession, we need to be informed and we need to be united. Our Annual meetings are one of the best forums where we can share our ideas, meet with colleagues and catch up with the latest. They are as stimulating as they are informative and allow us to meet in a relaxed atmosphere. Our 2016 ASM will be no exception. We'll endeavour to provide a programme that is as wide-reaching as possible and will hope to stimulate debate and discussions. There will be some focus on the health and well-being of surgeons, in addition to considering how best we can improve the health of our patients. We will also explore recent issues for the surgical community including the release of surgical performance data, as well as the important issue of discrimination, bullying and sexual harassment. The other big issue for New Zealand is screening for colorectal cancer, with the bowel screening pilot in Waitemata. We hope to present some of the results of the pilot, and discuss the implications for a national roll-out of bowel screening.

Our invited overseas speakers are kindly supported by a grant from RACS, and we are extremely grateful to the college for their support of our ASM. We are welcoming Prof Sue Clark, a colorectal surgeon with an interest in inherited bowel cancer from St Marks in London. We also welcome Prof Richard Schulick, a hepatopancreatic surgeon and chair of surgery at the University of Colorado.

Peter Shapkov
Andrew Moot

Convenors

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ORGANISING COMMITTEE

Peter Shapkov (Convenor),

Andrew Moot (Convenor),

Bronwen Evans (NZAGS),

Lynda Booth (Conference Manager), Workz4U Ltd

CONTACT

W4U

WORKZ4U
CONFERENCE AND EVENTS MANAGEMENT

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KEYNOTE SPEAKER

The Conference Committee are delighted to announce the keynote speakers for the conference

Ms Susan Clark

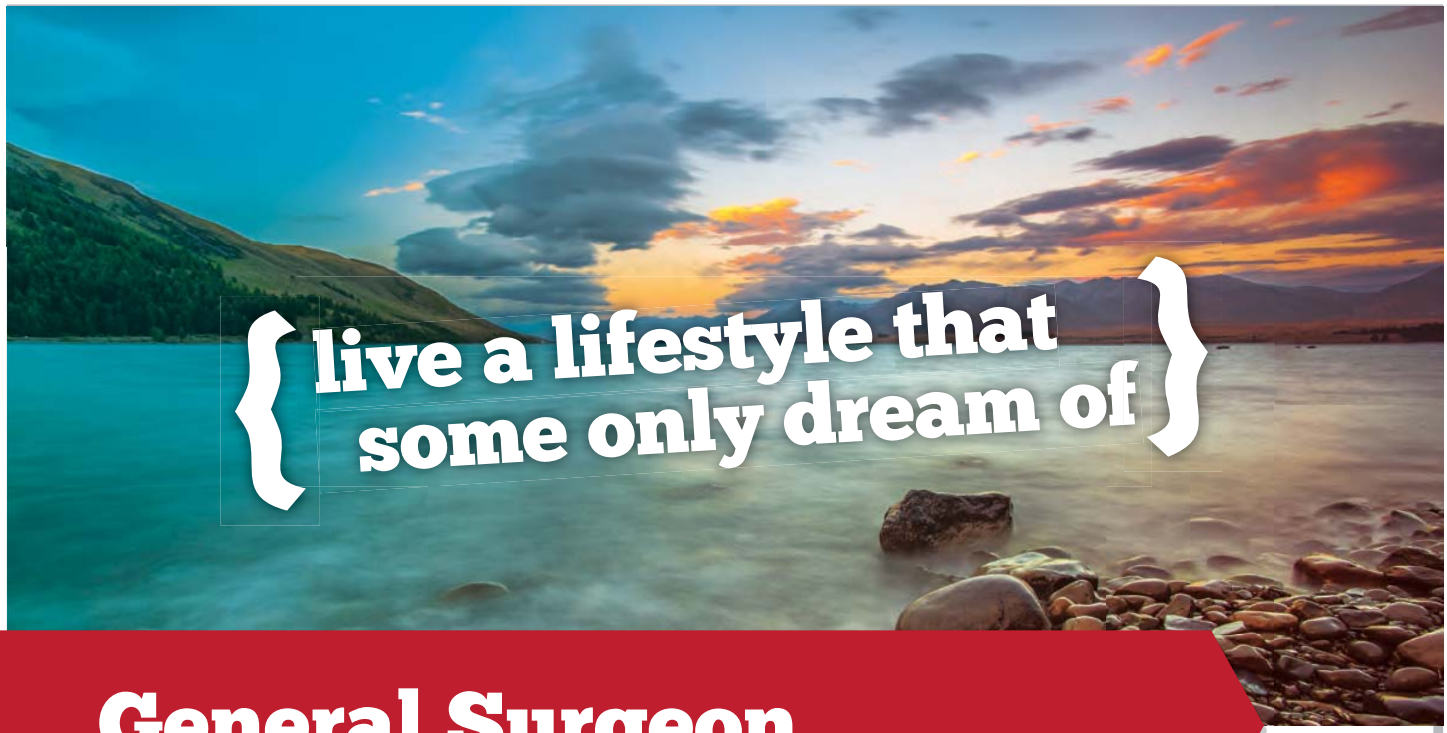
Sue Clark a Consultant Colorectal Surgeon at St Mark's Hospital, Harrow, UK and Adjunct Professor of Surgery at Imperial College, London. She is also Director of the St Mark's Hospital Polyposis Registry and Dean of the St Mark's Academic Institute. Her main clinical and research interests are inherited bowel cancer, polyposis syndromes, colorectal cancer biology and the ileoanal pouch.

RACS VISITOR PROGRAM RECIPIENT

Mr Richard Schulick

Richard D. Schulick, MD, MBA, is Professor and Chair of the Department of Surgery at the University of Colorado School of Medicine. He also holds the Aragon/Gonzalez-Giusti Chair in Surgery. Schulick came from the Johns Hopkins Medical Institutions where he was Chief of the Surgical Oncology Division. He is, currently, in charge of the Department of Surgery which has seven clinical divisions (Cardiothoracic; GI, Tumor and Endocrine; Pediatric; Plastic; Transplant; Urology; and Vascular) with 155 full-time faculty / 39 research faculty / 73 part-time faculty / 123 residents and fellows / and 68 staff. He oversees multiple lines of research with successful National Institutes of Health, Department of Defense, private foundation, industry, and internal support. As the son of a U.S. diplomat, Schulick grew up around Washington, DC, and in Burma, Thailand, and India. He received his undergraduate degree in chemical engineering in 1985, medical school degree in 1989, and master in business education in 2010, all from Johns Hopkins University, and completed a residency in General Surgery there in 1996. He completed fellowships in clinical pharmacology and immunology at the National Institutes of Health both in 1993, advanced gastrointestinal surgery at Johns Hopkins in 1997, and surgical oncology at Memorial Sloan-Kettering Cancer Center in 1999.

RACS VISITOR PROGRAM RECIPIENT



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We look forward to receiving your application directly via our Careers Site, however for us it's always been personal, so please talk to me if you wish to find out more. Phone Ross Yarrall - Senior HR Advisor on +64 (03) 687 2388 or email ryarrall@scdhb.health.nz

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INVITED SPEAKER

Patrick Alley

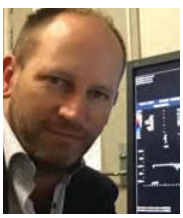
Pat Alley is a New Zealand trained general surgeon recently retired as Director of Clinical Training at Waitemata DHB. For many years he co-ordinated the Doctors Health Advisory Service in Auckland.He was also active in undergraduate surgical education and continues to teach anatomy for RACS Part 1.

Vanessa Blair

Mrs Vanessa Blair (FRACS 2009) trained in General Surgery at Tauranga, Whangarei and Auckland Hospitals. Vanessa's sub-speciality interests include breast disease, skin cancer, thyroid and parathyroid disease and endoscopy with a particular interest in familial cancer syndromes. This originates from her first postgraduate job in 1998-2000, caring for members of a large Tauranga family who were found to carry a CDH1 mutation in 1998, thus explaining their high rate of diffuse stomach and lobular breast cancer. During advanced training Vanessa did four years research, completing a PhD in familial stomach and breast cancer. During this time she worked with NZ clinicians and scientists to generate consensus guidlines on the NZ experience managing these patients - writing a paper outlining the rationale for surviellance and prophlactic surgery. She has written several papers and book chapters in this area and given talks at international and national meetings. Vanessa is a member of the International Gastric Cancer Linkage Consortium, and wrote the section on the management of risk of lobular breast cancer in E-cadherin mutation carriers in the new guidelines. Vanessa divides her working week between Auckland (St Marks Breast Center, Breast Screen Aoteroa, and locum acute surgery at Auckland Hospital), and Whangarei where she has a private practice. She, her husband and two boys live in Whangarei keeping busy trying to de-pest and fence 25 hectares of bush and farmland, on which they have built an totally off-the-grid solar/battery powered house. Life is full of water and farm based activities: surf-lifesaving, fishing, motorbiking and hunting, allowing Vanessa to indulge in her passion for cooking fresh fish, meat and heritage foods.

Michael Booth

Michael Booth is a general surgeon with an interest in Upper GI and bariatric surgery at Waitemata District Health Board.



John Bottomley MBChB, FRANZCR

Dr John R Bottomley is a New Zealand trained interventional radiologist with eight years of consultant experience as a vascular interventional radiologist in Leeds and at the Sheffield Vascular Institute in the UK, undertaking percutaneous endovascular aneurysm repair (PEVAR) of thoracic and abdominal aortic aneurysms, endovascular management of peripheral arterial disease (PAD) and treatment of a wide variety of arterial and venous conditions. He returned home to Auckland in 2012 to lead the set up the Advanced Interventional Radiology service at North Shore Hospital with a focus on clinical interventional radiology practice, tumour ablation and embolisation and the endoluminal and endovascular management of multiple organ system conditions.

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INVITED SPEAKER

Graeme Campbell

Graeme Campbell is a general surgeon. He is Chief Surgical Officer at Bendigo Health. He has a long term interest in surgical education, particularly the teaching of no- technical skills. He is a former President of General Surgeons Australia, and currently Vice President of the Royal Australasian College of Surgeons. He was a member of the RACS Expert Advisory Group on discrimination, bullying and sexual harassment.

Rosalie Fisher

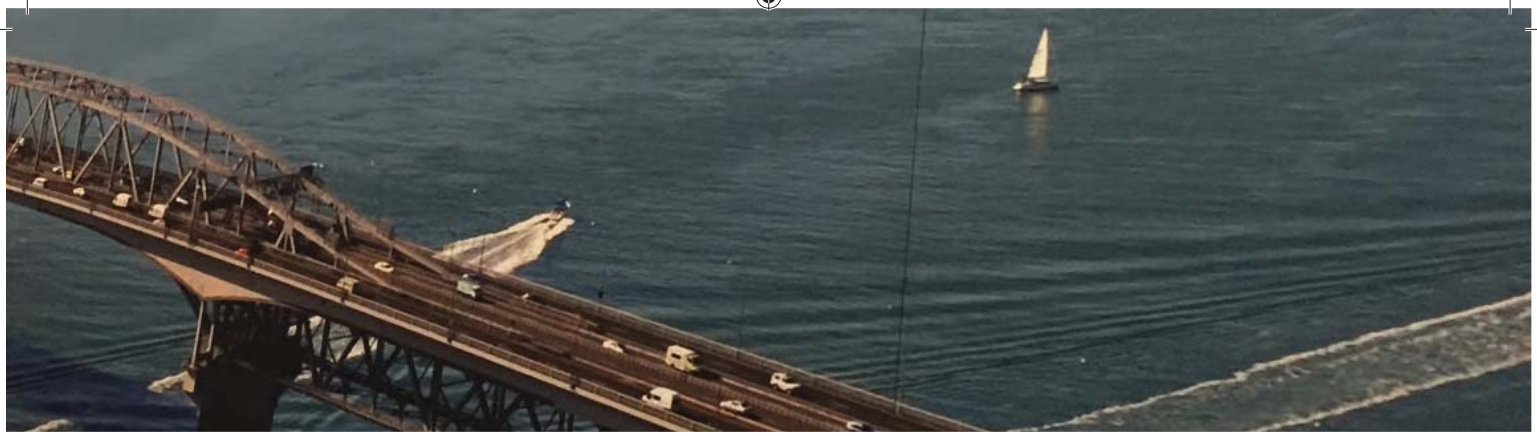
Rosalie Fisher is a medical oncologist specialising in the treatment of patients with melanoma and gynaecological cancers. Rosalie graduated from the University of Auckland School of Medicine in 2004 and completed specialist training in oncology in 2010. Between 2010 and 2013 she completed a fellowship at the Royal Marsden Hospital in London, and undertook clinical and translational research in melanoma, kidney, breast and gynaecological cancers. She published widely in peer-reviewed journals in these areas and contributed to patient and public education. In 2015, Rosalie completed her post-graduate research in tumour biology and evolution, attaining a Doctor of Medicine degree from the University of London. Rosalie has worked at Auckland Hospital since her return in 2013. She is a Trustee on the board of Melanoma NZ and melanoma is an active research focus, aiming to improve patient outcomes by access to new, improved therapies.

Cathy Ferguson

Cathy Ferguson is an Otolaryngologist, Head and Neck Surgeon from Wellington New Zealand. She has been a generally elected Councilor for RACS for the past 6 years, and is currently the Chair of the Professional Standards Committee. It was in this role that she was invited to become a member the RACS Expert Advisory Group (EAG) appointed by the College in 2015 to investigate and advise the College on the issues of discrimination, bullying and sexual harassment. This resulted in a report, which was provided to the College in October 2015, and accepted in full. From there an Action Plan has been developed to address the issues over the next few years. As part of this, Dr Ferguson has been involved in a revision.

Tony Fernando

Tony is a consultant psychiatrist at the Auckland District Health Board and a senior lecturer in Psychological Medicine at the University of Auckland. He obtained his medical degree from the University of the Philippines followed by an internship at St Luke's Roosevelt in New York and psychiatry residency and fellowship at the University of Pennsylvania in Philadelphia. Tony's research interest is in sleep medicine, psychopharmacology, medical education. He is currently pursuing his PhD at the University of Auckland studying the barriers and facilitators to compassion in medicine. He is one of the authors of the CALM website (calm.auckland.ac.nz). In 2012, he was awarded by President Aquino of the Philippines for his services to sleep medicine and medical education. He is a foodie, a cellist, a runner and trains in swimming and kickboxing.



INVITED SPEAKER

Katherine Gale BHB MBChB FRACS

Katherine Gale is a general and specialist oncoplastic breast and melanoma surgeon based in Auckland. She qualified in medicine at the University of Auckland in 2001, gained FRACS in 2011, and completed fellowship training in oncoplastic breast surgery at the Nottingham Breast Institute in the UK.
She is interested in all aspects of breast oncology and surgery, and has been an invited speaker, demonstrator and faculty member at national and international breast conferences and courses. She maintains a keen interest in research, and has published papers in both breast oncology and reconstruction. Katherine has been setting up a comprehensive Oncoplastic Breast Unit at Waitemata DHB, and is the Scientific Convenor for the 2nd Australasian Breast Congress (ABC2) in July 2016, Auckland.

She is a member of the following professional organisations: Royal Australasian College of Surgeons (RACS), New Zealand Association of General Surgeons (NZAGS), BreastSurgANZ, Australasian Society of Breast Disease (ASBD) and is registered with the UK GMC.

Alexander Heriot

Professor Heriot is a Consultant Colorectal Surgeon and is the director of Cancer Surgery at Peter MacCallum Cancer Centre in Melbourne. He qualified from Cambridge University and completed general surgery training in the UK. He has undertaken colorectal fellowships at St Vincent's Hospital, Melbourne, St Mark's Hospital, London, and the Cleveland Clinic, Ohio. He completed a doctorate at the University of London on rectal cancer and an MBA at Melbourne Business School.

Dr Heriot is a Clinical Professorial Fellow at the University of Melbourne and was awarded the John Mitchell Crouch fellowship by RACS for 2016. He was previously Chairman of the Research Support Committee for the Colorectal Surgical Society of Australia and New Zealand (CSSANZ) and is a member of the Australasian Training Board in Colorectal Surgery (TBCRS). He is the Chairman of the Binational Colorectal Cancer Audit.
He has published over 133 peer reviewed papers, multiple book chapters and 1 book. He is on the editorial advisory board for Disease of the Colon and Rectum, Colorectal Disease, and Colorectal Cancer.

Mike Hulme-Moir

Mike did his medical degree at Auckland University and went on to complete FRACS in 1998. Following this, he spent two years training in GI and Colorectal surgery at the Royal Infirmary of Edinburgh. He is currently the Clinical Head of the Colorectal unit at North Shore Hospital which is now one of the largest Colorectal Cancer units in the country. He has set up a tertiary referral service at WDHB for advanced pelvic malignancy and recurrent rectal cancer over the last few years. In addition, WDHB is one of two New Zealand training centers for CSSANZ fellows(colorectal surgical society of Australia and New Zealand). He is Clinical Director of the WDHB Bowel screening pilot which has run at WDHB for the last 4 years and has been involved with its development at WDHB since the Ministry of Health first put out a national tender for running this program. He has a strong interest in improving colorectal cancer outcomes in New Zealand.

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INVITED SPEAKER

Jonathan Koea

Jonathan Koea is a hepatobiliary surgeon who works at the North Shore Hospital in Auckland. He is a member of the Te Atiawa tribal Iwi and was educated in New Zealand before undertaking fellowships in surgical oncology and hepatobiliary surgery at Memorial Sloan-Kettering Cancer Centre in New York City. Jonathan is a member of the New Zealand Perioperative Mortality Review Committee and Vice President of the Auckland Division of the Cancer Society of New Zealand. His research interests concentrate on the management of primary and secondary tumours of the liver, gall bladder and bile ducts as well as in service provision for indigenous peoples particularly oncology and related services. Jonathan is the author of over 100 publications and is a Clinical Associate Professor of Surgery at the University of Auckland School of Medicine, where he is involved in undergraduate and post graduate teaching, as well as a Fellow in Public Health of the University of Otago.

Richard Lander MBChB, FRACS

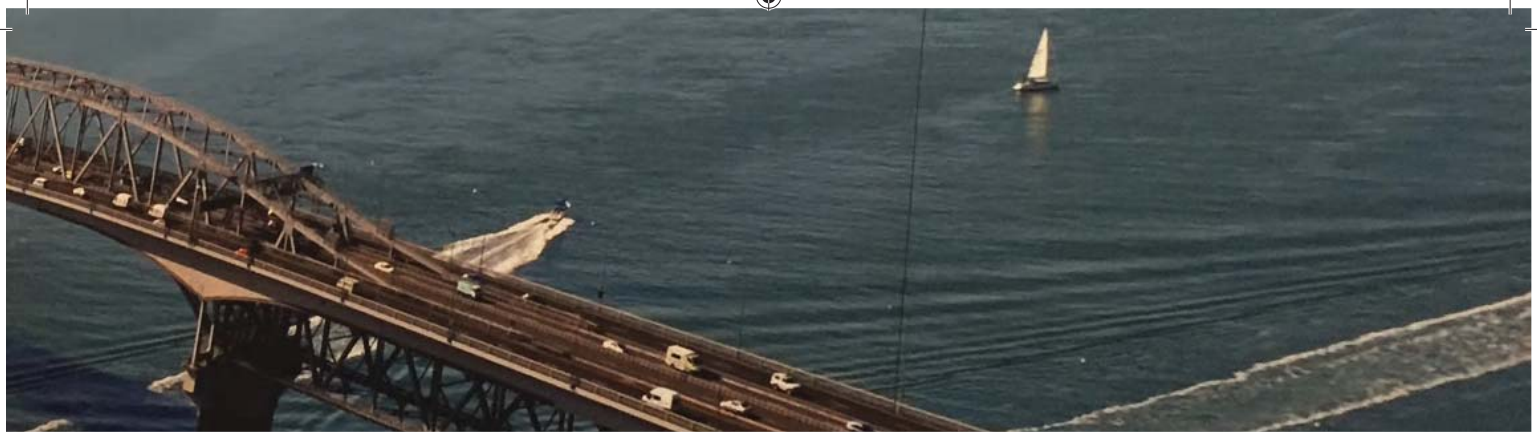
Mr Richard Lander is currently Executive Director for Surgical Affairs (NZ) for the Royal Australasian College of Surgeons and a visiting Orthopaedic Surgeon in the Department of Orthopaedic Surgery, Palmerston North, New Zealand. He is also a Clinical Senior Lecturer, Department of Surgery and Anaesthesia, University of Otago Medical School, based at Palmerston North Hospital. Richard is a Fellow of the Royal Australasian College of Surgeons, a Fellow of the New Zealand Orthopaedic Association and an International Member of the American Academy of Orthopaedic Surgeons.
Richard is a graduate of the University of Otago Medical School having graduated MBChB in 1977.
Richard has a general Orthopaedic practice with a special interest in trauma, adult reconstructive joint surgery and surgical education.

Win Meyer-Rochow

Dr. Win Meyer-Rochow is an Academic Endocrine and General Surgeon at Waikato Hospital. During 4 years of subspecialty training with the University of Sydney Endocrine Surgeons he completed a PhD on Clinical and Molecular aspects of Phaeochromocytomas. He is the lead Endocrine Surgeon at Waikato Hospital, senior lecturer with the University of Auckland and current deputy chair for the Australia and New Zealand Endocrine Surgeons Society.

Ross Roberts

Ross Roberts works as a Gastrointestinal Surgeon at Christchurch Hospital. He has an interest in surgery for benign and malignant Upper GI conditions and is currently President of the Australia & New Zealand Gastric & Oesophageal Surgery Association and Chair of the Upper GI, HPB and Obesity Surgery Section of the College.



INVITED SPEAKER

Michael Rodgers

Mr Michael Rodgers is an Auckland Medical School Graduate. He was the inaugural HPB fellow at Auckland hospital in 2000-2001 He then underwent international fellowships in Upper GI and HPB surgery at the Oregon Health Sciences University Portland Oregon, and the Royal Prince Alfred Hospital, Sydney. Since completing his fellowships he has worked as a consultant surgeon at North Shore Hospital from 2004. His surgical interests are in gastro-oesophageal and HPB oncology and he has an ongoing research interest in Pancreatic cancer. He is currently the Chief of Surgery at Waitemata District Health Board and on the Executive Committee of NZAGS.

Siraj Rajaratnam

Siraj has been a consultant general and colorectal surgeon at Waitemata DHB since February 2013. He has specific interest in pelvic floor disorders and proctology. Siraj has completed colorectal fellowships in Cambridge and Oxford, United Kingdom, where he gained expertise in modern surgical techniques such as doppler-guided haemorrhoidal artery ligation (HAL-RAR).

Shaw Somers BSc(Hons) MBChB MD FRCS

Shaw Somers has been an NHS consultant surgeon since 1998. Before this, he was a senior lecturer and honorary consultant at St James' University Hospital in Leeds, West Yorkshire and Associate Professor at The Prince of Wales Hospital in Hong Kong.

Shaw specialises in upper gastrointestinal surgery and has an extensive experience of complex upper gut surgery. He is senior clinician in the regional upper gastrointestinal cancer service in Hampshire, and is a leading laparoscopic surgery specialist. He has experience of over 3000 bariatric operations.

Shaw is honorary secretary of the British Obesity and Metabolic Surgery Society. In addition, Shaw is Discovery TV's 'Fat Doctor', and has appeared in many TV shows as a surgical expert.

Maree Weston

Maree is a consultant general and colorectal surgeon at Middlemore Hospital. She has interests in IBD, transition from paediatric surgery, proctology and laparoscopic surgery. Maree completed the CSSANZ fellowship program in February 2013 after spending fellow years in Adelaide and Melbourne.

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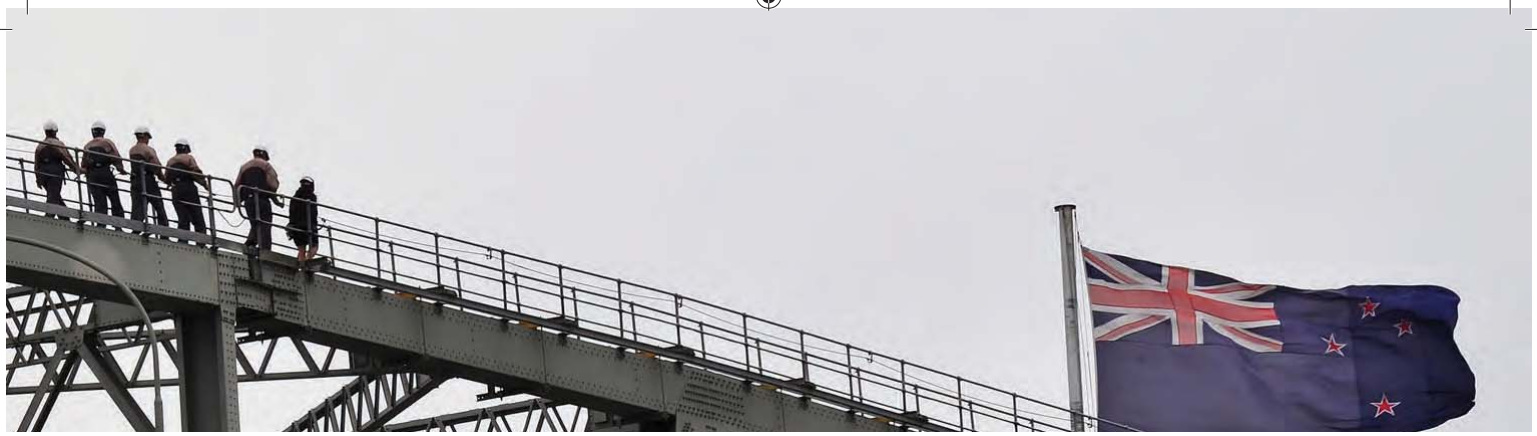
PROGRAMME

SATURDAY 12TH MARCH 2016

0730	**Registration**	
0800 - 0810	**Welcome**	
	SESSION 1: COLORECTAL	Session Chairs: Peter Shapkov & Chris Wakeman Room: Pacific/Kestrel Rooms
0810 - 0855	**Rare Colorectal Tumours** SUE CLARK, St Mark's Hospital UK	
0855 - 0925	**Interventional Radiology In GI Bleeding** JOHN BOTTOMLEY, Waitemata DHB, Auckland	
0925 - 1000	**Debate: The Best Surgical Procedure for Grade 3 Haemorrhoids Is The HAL-RAR** SIRAJ RAJARATNAM, Waitemata DHB, Auckland & MAREE WESTON, Auckland DHB, Auckland	
1000 - 1030	**Morning Tea**	Room: Tasman/Normandie Rooms
	SESSION 2: UGI	Session Chairs: Simon Bann & Grant Coulter Room: Pacific/Kestrel Rooms
1030 - 1100	**Pancreatic Cancer – What Have We Accomplished** RICHARD SCHULICK, University of Colorado, USA	
1100 - 1120	**Gallbadder Polyps. Investigate, Follow Or Fix?** JONATHAN KOEA, North Shore Hospital, Auckland	
1120 - 1140	**Surveillance For Barrett's Oesophagus: An Update** ROSS ROBERTS, Christchurch Hospital, Christchurch	
1140 - 1200	**Preliminary Results In A Prospective Randomised Controlled Trial Comparing Laparoscopic Sleeve Gastrectomy And Laparoscopic Roux en Y Gastric Bypass In The Treatment Of Type 2 Diabetes And Obesity** MICHAEL BOOTH, Waitemata DHB, Auckland	
1200 - 1300	**Lunch**	Room: Tasman/Normandie Rooms
1300 - 1330	**NZAGS AGM**	Room: Pacific/Kestrel Rooms
	SESSION 3: BETTER DATA	Session Chairs: Andrew Connolly & Andrew Moot Room: Pacific/Kestrel Rooms
1330 - 1400	**The Bowel Screening Pilot: The First Four Years And What Bowel Screening Might Look Like For New Zealand** MIKE HULME-MOIR, Waitemata DHB, Auckland	
1400 - 1430	**The Binational Colorectal Cancer Audit** ALEXANDER HERIOT, Peter MacCallum Cancer Centre	
1430 - 1500	**The UK Experience Of Consultant Outcomes Publication - Big Data At Its Worst** SHAW SOMERS, NHS Consultant Surgeon, UK	
1500 -1550	**Afternoon Tea**	Room: Tasman/Normandie Rooms



PROGRAMME

	SESSION 4: TRAINEE & FREE PAPER PRESENTATIONS	Session Chairs: John Jarvis & Jonathan Koea Room: Pacific/Kestrel Rooms
1550 - 1600	**Double Blinded Randomised Controlled Trial Of Pre-Peritoneal Local Anaesthetic In Laparoscopic Total Extra-Peritoneal Hernia Repair** SUHEELAN KULASEGARAN, North Shore Hospital, Auckland	
1600- 1610	**Reappraisal Of Normative Values For Evacuation Proctography** SOMNATH PALIT, Christchurch Hospital, Christchurch	
1610 - 1620	**Effect of Diversion Ileostomy on the Occurrence and Consequences of Chemotherapy-Induced Diarrhoea** JASON ROBERTSON, Mid-Central DHB, Palmerston North	
1620 - 1630	**Synoptic Reporting Improves The Histopathological Assessment Of Pancreatoduodenectomy Specimens** DANIEL DALY, Prince of Wales Clinical School, Sydney	
1630 - 1640	**The Impact Of The Introduction Of A Surgical Admission Unit On Numbers Of General Surgery Outliers** ALEXANDRA JACOBSON, Auckland DHB, Auckland	
1640 - 1650	**Laparoscopic Silastic Ring Omega Loop Gastric Bypass (SR-OLGBP): 10 Year Results From A Single Centre** LAILA SHEIKH, Waitemata DHB, Auckland	
1650 - 1700	**A Systematic Evaluation Of The Design And Use Of Percutaneous Drains In The Abdomen** LISA BROWN, Auckland City Hospital, Auckland	
1700 - 1710	**Implementation Of The RACS Recommendations On Discrimination, Bullying And Sexual Harassment (DBSH) At Counties Manukau District Health Board (CMDHB): A Pilot Study** SHAREENA LALA, Middlemore Hospital, Auckland	
1710 - 1720	**Moving Towards The Electronic Health Record: The Introduction Of Synoptic Operative Reporting As Part Of A New Hospital-Wide Surgical Audit** MAGDA SAKOWSKA, Canterbury DHB, Christchurch	
1720 - 1730	**Audit Of A Regional General Surgical Outpatient Clinic** AEMELIA MELLOY, Logan Hospital, Queensland	
1900 - LATE	**Conference Dinner**	Venue: Royal New Zealand Yacht Squadron

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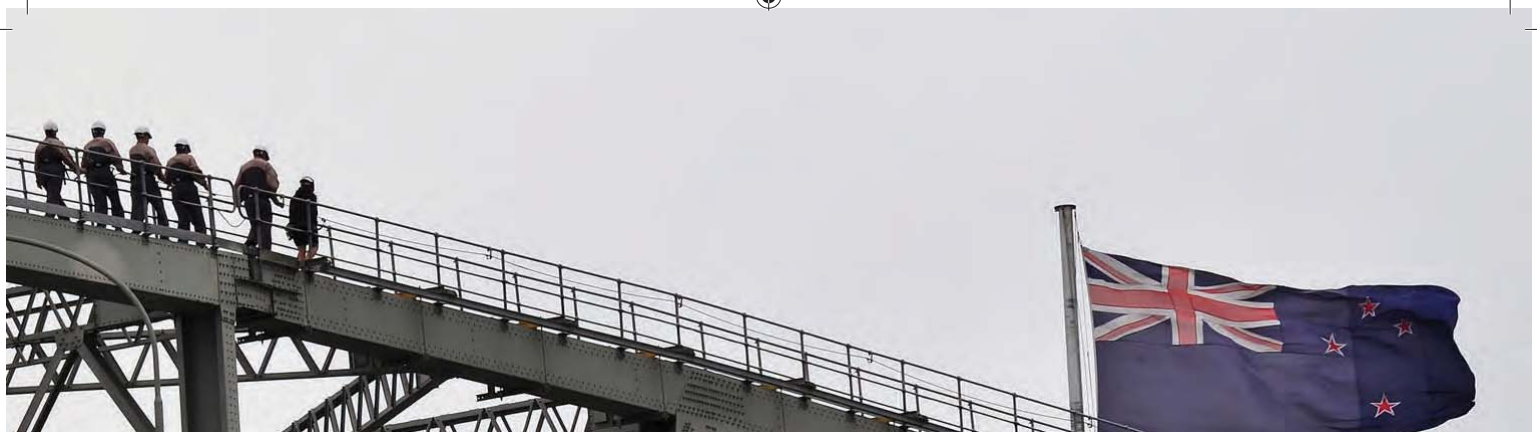
PROGRAMME

SUNDAY 13TH MARCH 2016

0730	**Registration**	
	SESSION 5: BREAST & ENDOCRINE	Session Chairs: Richard Harman & Philippa Mercer Room: Pacific/Kestrel Rooms
0830 - 0900	**Breast Surveillance Versus Risk Reducing Mastectomy In High Risk Patients: Who? When? Why? (And Why Not?)** VANESSA BLAIR, Kensington Hospital, Whangarei	
0900 - 0930	**Oncoplastic Breast Surgery** KATHERINE GALE, Waitemata DHB, Auckland	
0930 - 1000	**Metastatic Melanoma: A Chronic Disease?** ROSALIE FISHER, Auckland DHB, Auckland	
1000 - 1030	**Current Management And Changing Trends Of Treatment For Thyrotoxicosis** WIN MEYER-ROCHOW, Waikato DHB, Hamilton	
1030 - 1100	**Morning Tea**	Room: Tasman/Normandie Rooms
	SESSION 6: KEYNOTES AND DBSH SYMPOSIA	Session Chairs: Marie Weston & Andrew Moot Room: Pacific/Kestrel Rooms
1100 - 1130	**Hilar Cholangiocarcinoma in 2016** RICHARD SCHULICK, University of Colorado, USA	
1130 - 1200	**Chronic Anastomotic Leaks** SUE CLARK, St Mark's Hospital UK	
1200 - 1215	**The College Response To EAG Report** GRAEME CAMPBELL, Bendigo Health, Bendigo	
1215 - 1230	**Partnering For Cultural Change** CATHY FERGUSON, RACS, Wellington	
1230 - 1245	**Constructive Assessment And Feedback** RICHARD LANDER, RACS, Palmerston North	
1245-1300	**Q&A**	
1300 - 1400	**Lunch**	Room: Tasman/Normandie Rooms
	SESSION 7: THE SURGEONS WELFARE	Session Chairs: Peter Shapkov & Susan Gerred Room: Pacific/Kestrel Rooms
1400 - 1445	**Happiness and Compassion for Doctors** TONY FERNANDO, The University of Auckland, Auckland	
1445 - 1515	**Retirement/ Free Time** PAT ALLEY, Waitemata DHB, Auckland	
1515 - 1545	**Surgeons' Health** MICHAEL RODGERS, Waitemata DHB, Auckland	
1545 - 1600	**Conference Close**	



POSTER PROGRAMME

THE POSTERS BELOW WILL BE CONSIDERED FOR THE POSTER AWARDS:

SCREEN 1

C-reactive Protein Has A Better Discriminative Power Than White Cell Count In The Diagnosis Of Acute Cholecystitis
Andrei Belyaev, Cardiothoracic Surgical Registrar, Auckland City Hospital

Factors Affecting Length Of Stay In Patients With Cellulitis At Counties Manukau District Health Board
Megan Grinlinton, Surgical Registrar, Waitemata DHB

The Influence Of Resection Margin On Survival Outcomes In Pancreatic Cancer Surgery: A Systematic Review & Meta-Analysis
Naman Kohli, Barwon Health

Necrotising Fasciitis: 11-year Retrospective Case Review In South Auckland
Suheelan Kulasegaran, Registrar, North Shore Hospital

An Ageing Acute Surgical Population: The Auckland Experience
Hannah Linkhorn, Registrar (Non-Training), Counties Manukau DHB

Can Symptoms Be Used To Predict Proctographic Abnormalities In Patients With Chronic Constipation?
Somnath Palit, Christchurch Hospital

Initial Experience With Intraoperative X-Ray In Breast Surgery
Michael Russell, Registrar, Waitemata District Health Board

Acute Appendicitis As The First Manifestation Of Colorectal Carcinoma
Rebecca Waters, Royal Australasian College of Surgeons

Regional Recurrence After Sentinel Node Biopsy Alone - Analysis Of New Zealand Breast Cancer Registry Data.
Fraser Welsh, Southern DHB

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POSTER PROGRAMME

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SCREEN 2

Does Remoteness Of Domicile Affect Length Of Stay In An Enhanced Recovery After Surgery (ERAS) Setting?
Tacey Barnes, Registrar, Southern DHB

C-reactive Protein Measurement Is Not Associated With An Improved Management Of Acute Cholecystitis: A Plie For A Change.
Andrei Belyaev, Cardiothoracic Surgical Registrar, Auckland City Hospital

Late Two-Stage Laparoscopic Cholecystectomy Is Associated With An Increased Risk Of Major Bile Duct Injury
Andrei Belyaev, Cardiothoracic Surgical Registrar, Auckland City Hospital

Surfboard Related Injuries Presenting To The Gold Coast Hospital With Illustrative Medical Imaging.
Robyn Coombe, General Surgeons Trainee, Royal Australasian College of Surgeons

PEG Insertion - An Experience From Two Peripheral Hospitals
Benjamin Cribb, Registrar, Whangarei Hospital

Laparoscopic Completion Cholecystectomy For Remnant Gallbladder Following Prior Incomplete Cholecystectomy.
Daniel Daly, Prince of Wales Clinical School

A Review Of The Australian Experience Of Microwave Ablation (MWA) Of Liver
Dil Dooreemeah, Unaccredited Surgical Registrar, St. Vincent's Hospital

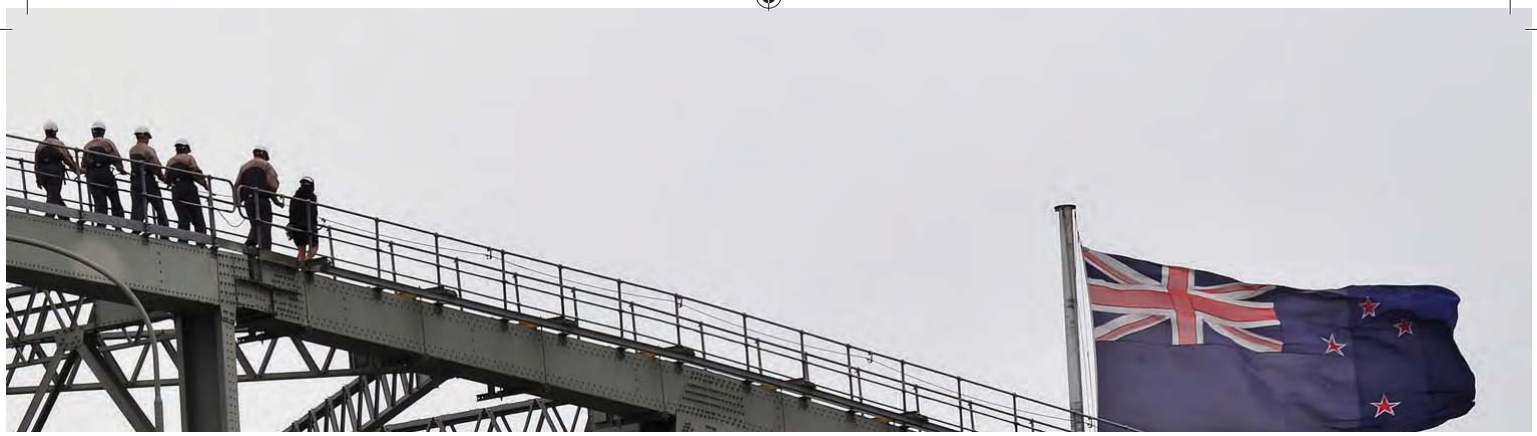
Intestinal Malrotation Presenting In Adulthood: A Retrospective Review.
Paul Fagan, Registrar, Waikato DHB

Surveillance After Breast Reconstruction For Breast Cancer - Is Imaging Necessary?
Jason Goh, Waitemata DHB

Emergency Laparotomy In Cardiovascular Intensive Care Unit At Auckland City Hospital
Jamie Harvey, Registrar, North Shore Hospital

A Modern Review Of Post-Operative Infection At The University Hospital, Geelong
Naman Kohli, Barwon Health

Patient Perspectives About Follow-Up Care And Weight Regain Following Sleeve Gastrectomy
Samantha Stevenson, Research Fellow, University of Auckland



POSTER PROGRAMME

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SCREEN 3

Impact Of Pre-Operative Imaging On The Clinical Outcome Of Emergency Department Patient With Suspected Appendicitis
Acrane Li, Radiology Registrar, Auckland City Hospital

Predictors Of Non-Sentinel Lymph Node Metastasis Post Axillary Dissection In Breast Cancer - A Study Of A Population In The Wellington Region
Yukai Lim, Registrar, Capital and Coast, Hutt Valley DHB

Outcomes Of Below Knee Endovascular Interventions
Tony Mallett, Surgery PHO, Cairns Base Hospital

Day Case Laparoscopic Cholecystectomy At A Rural Hospital
Aemelia Melloy, Surgical Principal House Officer, Logan Hospital

Breast Cancer Treated In The Taranaki Region 2003-2009
Thomas Morgan, Surgical Registrar, Auckland DHB

Chest X-ray And Vital Signs Are Poor Predictors Of A Significant Blunt Thoracic Aortic Injury - 11 Year Experience At A Level I State Trauma Centre
Anton Musiienko, Royal Melbourne Hospital

Camera Endoscopy In Small Descriptive Study; Audit And Guide To Clinical Practice In Wanganui DHB
Ahmed Omar, Surgical Registrar, Whanganui DHB

Systematic Review Of Common Investigation For Chronic Constipation
Somnath Palit, Chirstchurch Hospital

Planning For Growth In Acute Care General Surgery - Is There A Critical Breaking
Garth Poole, Counties Manukau DHB

Age Related Incidence Of Mortality Due To Trauma
Braden Pyle, Department of Surgery, Chirstchurch Hospital

Outcomes Of ERCP - A Series From A Provincial New Zealand Hospital
Simon Richards, Canterbury DHB

Impact of PET-CT Scan On Management Pf Upper GI Malignancy
Aditya Sharma, Registrar, MidCentral DHB

Chasing The Blood Tests: Do Improving Liver Function Test Parameters Predict A Passed Common Bile Duct Stone?
Aditya Sharma, Registrar, MidCentral DHB

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SCREEN 4

Less Is More! Do Higher Number Of Sentinel Nodes Obtained Correlate With Higher Positive Rate?
Aditya Sharma, Registrar, MidCentral DHB

Surgical Workload, Incidence And Outcomes Of Breast Cancer In New Zealand 2000-2013: Does It Matter Where You Live?
Nick Smith, Waikato DHB

Withdrawal Of Acute General Surgery From Small Hospitals Increases Perforation Rates In Acute Appendicitis?
Mark Stewart, Registrar, Counties Manukau DHB

Surgical Technique For Repair Of Chronic 4th Degree Perineal Tear
Stephanie BM Tan, Unaccredited Registrar, Royal Brisbane and Womens Hospital

10 Year Burns Epidemiology In Queensland: An Update From 2005 to 2015
Stephanie BM Tan, Unaccredited Registrar, Royal Brisbane and Womens Hospital

An Audit Of Trauma Management At A Tertiary Hospital
Ammar Tayaran, Surgical Registrar, Western Health

Improving The Management Of Post Thyroidectomy Bleeding In Hospital Interns
Ammar Tayaran, Surgical Registrar, Western Health

Factors Impacting Wound Infections In Colorectal Surgery
Shehan Wickramasinghe, Surgical Registrar, Monash Health

Emergency Presentation Of Small Bowel Tumours At Princess Alexandra Hospital
Adrienne Wilson, Princess Alexandra Hospital

Open Herniorrhaphy Leads To Reduced Post Operative Pain Compared To Total Extraperitoneal Repair: Factors Influencing Operative Decisions
Minjung Yoo, Surgical Resident, Monash Health

Simple Perioperative Interventions Can Minimise The Risk Of Pharyngocutaneous Fistula Following Total Laryngectomy - Experience At A Single Tertiary Institution
Daniel Youssef, Queensland Health

Current Practice Of Colonic Investigation Following Acute Appendicitis Throughout New Zealand General Surgeons
Abigail Zarrifeh, House Officer, Tauranga Hospital, Bay of Plenty DHB

SOCIAL PROGRAMME

CONFERENCE DINNER

Conference Dinner

Date: Saturday 12th March 2016
Time: From 7.00pm
Venue: Royal New Zealand Yacht Squadron, 101 Curran Street, Westhaven, Auckland
Cost: $135.00 per ticket

SPECIAL GUEST:

Raybon Kan

In 1999, two magazines, Metro and North and South, declared Raybon Kan (pronounced Can) Best Comedian. The Metro again awarded him this title in 2005. In 2005 he made it to no 37 on the Readers Digest Most Trusted New Zealander list. Also famous for the face of the Freedom Air ads and as Test the Nation champ.

His sell out live shows from "An Asian at my Table" to "Raybon of the Lost Ark" have won the former lawyer a reputation for thought-provoking comedy. This reputation has spread internationally. Named by Melbourne's Age newspaper as one of the highlights of the Melbourne Comedy Festival, Raybon has also been invited twice to the Olympics of comedy, the prestigious Montreal Comedy Festival (1998 & 2001).

In 2002, his comic analysis spiced up TV3's election night coverage, and he was chosen to judge aspiring comics on TV1's reality series, 'So You Think You're Funny'.

Raybon writes a column in the Sunday Star Times, and hosts a dating game show on Newstalk ZB. Raybon has also branched into acting (in feature films "I'll Make You Happy", "Tongan Ninja" and "Spooked"), and he is the author of three books.

Dinner Transfers

Coach transfers will be available between the Spencer on Byron and The Royal New Zealand Yacht Squadron at the following times:

Spencer on Byron to RNZYS:
6.30pm
RNZYS to Spencer on Byron:
9.45pm, 10.45pm, 11.45pm

New Zealand Association of General Surgeons

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GENERAL INFORMATION

Conference Venue
Spencer on Byron Hotel
9-17 Byron Avenue,
Takapuna,
Auckland, NZ

Registration Desk.
The registration desk will be open from:
7.30am Saturday 12th March 2016,
7.30am Sunday 13th March 2016.

Conference Manager: Lynda Booth 021 779 233

Name Badges. All delegates will be given a name badge upon registration. This name badge is your official pass to the conference. It is necessary for delegates to wear their name badge at all time when on-site.

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

Refreshments. Morning and afternoon teas, and lunch will be served in the industry exhibition area.

Car Parking. A limited number of car parks are available on site. Car parking charges at The Spencer on Byron Hotel apply as follows:

- Self-park at $10 per car per entry, subject to availability
- Valet parking at $25 per car per entry, subject to availability
- Conference delegates parking at $10 per day per car on a first in first served policy (single entry)

A car park ticket can be obtained from the hotel Reception and must be displayed on the card dashboard.

If our car park is full, there is street parking available on Byron Avenue, which has a two hour maximum limit on Monday-Saturday from 8.00am to 6.00pm for $1 per hour, outside of these hours it is free.

Otherwise Wilson Car Parks has four facilities in Takapuna, at close proximity to The Spencer on Byron Hotel. There are no Early Bird rates, just a flat fee day rate for 12 hours parking:

- Northcroft St Wilson Car park (34 spaces): flat rate of $10 for 12 hours
- Takapuna Strand Wilson Car park (73 spaces): flat rate of $10 for 12 hours (closes at 6.00pm)
- Bloomfield Spa Wilson Car park (28 spaces): flat rate of $8 for 12 hours
- Como Street Wilson Car park: flat rate of $10 for 12 hours

Contact during the Conference. As a courtesy to speakers, delegates are requested to switch off mobile phones and pagers during sessions. A message board will be situated in the registration area. Delegates will need to check the message board, as we are unable to provide a personal service.

Smoking Policy. Delegates should be aware that smoking is banned in public buildings and many hotels and restaurants in New Zealand, including the conference venue.

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.

Airport Transfers. Airport transfers can be arranged with the following transport provider:

- Auckland Co-op Taxi: 09 300 3000
- Super Shuttles, Phone: 0800 SHUTTLE (0800 748 885)
- Public Transportation: SkyBus NZ$16.00 one way (Auckland Airport to City)

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BOOTH NO	COMPANY
01	Bi-National Colorectal Cancer Audit (BCCA)
02	RACS
03	Medtronic
04	Fresenius Kabi
05	MFAS
06	MFAS
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The Bi-National Colorectal Cancer Audit is an audit of colorectal cancer surgery that has been run across New Zealand and Australia since 2006. The audit has been adapted to an online system since the beginning of 2014 and an annual report of over 12,000 cases was released in May 2015. The revised audit allows individual surgeons and units to obtain instant data summary of all submitted cases at any time and the ability to download all their data at any time. It also facilitates real time benchmarking, enabling surgeons to get continuous feedback on their outcomes, compared to all other submitting units.

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FLOOR PLAN

ORAL ABSTRACTS

SATURDAY 12 MARCH 2016

SESSION 1: COLORECTAL

8.10 - 8.55

Rare Colorectal Tumours

Sue Clark, St Mark's Hospital UK, Interventional Radiology For GI Bleeding

The vast majority of colorectal tumours are colorectal adenocarcinomas or anal squamous cell tumours. However, a number of rarer neoplasia are encountered, and often cause diagnostic and management dilemmas. Current diagnostic and management options for these will be reviewed.

8.55 - 9.25

Interventional Radiology In GI Bleeding

John Bottomley, Waitemata DHB, Auckland

Acute upper and lower gastrointestinal bleeding (GIB) can lead to significant morbidity and mortality without appropriate management and treatment. There are numerous causes of acute GIB including infection, varices, vascular anomalies, inflammatory diseases, trauma, and malignancy. The diagnostic and therapeutic approach to GIB depends on its location (upper vs lower GI tract), severity, etiology, patient comorbidities and surgical risk.

The role of vascular interventional radiology (VIR) is particularly vital in patients whose GIB remains resistant to medical and endoscopic interventions. VIR offers diagnostic imaging studies and endovascular therapeutic interventions that can be performed promptly and effectively with excellent rates of successful outcomes.

Computed tomography angiography can localize the source of bleeding and provide essential information for the vascular interventional radiologist to guide minimally invasively therapeutic management with transcatheter embolization of the precise bleeding source or transjugular intrahepatic portosystemic shunts (TIPS) in the case of variceal bleeding.

9.25 - 10.00

Debate - The Best Surgical Procedure For Grade 3 Haemorrhoids Is The HAL-RAR

Siraj Rajaratnam, Waitemata DHB, Auckland & Maree Weston, Auckland DHB, Auckland

DEBATE

SESSION 2: UGI

10.30 - 11.00

Pancreatic Cancer – What Have We Accomplished

Richard Schulick, University of Colorado, USA

We will review incidence and operations used to resect. We will review the historical development of pancreaticoduodenectomy. We will study the relationship of hospital volume to results with pancreaticoduodenectomy. We will review our recent accomplishments including better understanding of molecular events, more effective systemic therapies, and the use of multidisciplinary care of patients. We will explore the results of the University of Colorado experience with laparoscopic pancreaticoduodenectomy.

11.00 - 11.20

Gallbadder Polyps. Investigate, Follow Or Fix?

Jonathan Koea, MD; FACS; FRACS, Department of Surgery, North Shore Hospital, Auckland

Gallbladder polyps (GP) are present in 5% of the population, 15% are neoplastic and 1-2% contain carcinoma. Detection is usually by ultrasound or CT scan and investigation can be supplemented with endoscopic ultrasound in those > 1 cm in diameter. Between one and two thirds of patients have associated gallstones with biliary symptoms and should be considered for laparoscopic cholecystectomy. Of the asymptomatic patients, malignant change is rare but the risk is increased in patients with gallstones, age ≥ 60 years, solitary polyps and concurrent primary sclerosing cholangitis. The polyp size cut off for cholecystectomy varies between 6-10 mm with polyps up to 15 mm in size recommended for laparoscopic cholecystectomy. Larger polyps should be considered for open resection. The risk of neoplasia in polyps 6mm in size is zero while it is 7% in those less than 10 mm in size. Without resection, radiological follow up of small asymptomatic polyps for at least 2 years is recommended.

11.20 - 11.40

Surveillance For Barrett's Oesophagus: An Update

Ross Roberts, Department of Surgery, Christchurch Hospital, Christchurch

Introduction:

Oesophageal adenocarcinoma (OA) of the oesophagus carries a poor prognosis and surveillance of Barrett's oesophagus is a common practice in the hope that the prognosis of OA can be improved through early detection. However the definition of Barrett's oesophagus, the role of surveillance and the management of dysplasia have been controversial topics.

Aims:

To discuss surveillance of Barrett's oesophagus in the New Zealand environment.

Methods:

Updated definitions and guidelines will be reviewed

Results:

Recent consensus group work has defined Barrett's oesophagus as the presence of columnar mucosa in the oesophagus and it should be stated whether IM is present above the gastroesophageal junction to avoid misdiagnosis due to a hiatus hernia or inadequate biopsy sampling. Risk factors for development of OA include age over 50, male gender, length of Barrett's oesophagus and central obesity. Surveillance is not advised for those with a limited life expectancy. A de-escalation approach for lower risk patients and escalation to intervention with follow-up for higher risk patients is advised. Endoscopic resection should be used for nodular areas. Population endoscopic screening is not recommended. It is hoped that biomarkers will allow more selective targeting of high risk individuals in the future.

Conclusion:

An approach to maximise the benefits of Barrett's oesophagus surveillance will be proposed.

References:

BOB CAT: A Large-Scale Review and Delphi Consensus for Management of Barrett's Esophagus With No Dysplasia, Indefinite for, or Low-Grade Dysplasia. Bennett C et al, Am J Gastroenterol. 2015 May; 110(5): 662 - 82

11.40 - 12.00

Preliminary Results In A Prospective Randomised Controlled Trial Comparing Laparoscopic Sleeve Gastrectomy And Laparoscopic Roux en Y Gastric Bypass In The Treatment Of Type 2 Diabetes And Obesity

Michael Booth, Waitemata DHB, Auckland

Background:

Roux-en-Y gastric bypass is proven to be effective in the management of type 2 diabetes mellitus. Observational studies suggest similar diabetes remission rates may exist following sleeve gastrectomy, however only one other randomised trial has directly compared these two procedures.

Methods:

Randomised, assessor and patient-blinded, single centre trial, evaluating the efficacy of laparoscopic silastic ring Roux-en-Y gastric bypass versus sleeve gastrectomy in 114 obese patients with type 2 diabetes mellitus. Mean (±SD) age of patients was 47±8 years and 55% were female. Mean (±SD) BMI was 43±7 kg/m2 and glycated haemoglobin 8.0±1.4%. 33 (29%) patients required insulin and 36(32%) patients had diabetes for >10 years duration. The 12-month end point was the proportion of patients with glycated haemoglobin <6% without pharmacological treatment.

Results:

Of 114 patients, 96% completed 12 months follow-up. No significant difference was seen in achievement of this end point: 52% (29 of 56 patients) following gastric bypass and 49% (28 of 58 patients) following sleeve gastrectomy. Percentage weight loss was greater in gastric bypass versus sleeve gastrectomy group (27±0.1% and 32±0.1% respectively) p<0.01. Reoperation was required in 5 patients following gastric bypass and 3 following sleeve gastrectomy.

Conclusion:

At 12 months Roux-en-Y gastric bypass and sleeve gastrectomy achieved similar remission of type 2 diabetes. Greater weight loss was seen following gastric bypass. Further on-going study of these patients will provide longer-term outcomes.

SESSION 3: SCREENING & SURVEILLANCE

13.30 - 14.00

The Bowel Screening Pilot: The First Four Years And What Bowel Screening Might Look Like For New Zealand

Mike Hulme-Moir, Waitemata DHB, Auckland

The Bowel Screening Pilot: The first four years and what bowel screening might look like for New Zealand

Waitemata DHB was awarded the right to run the Bowel Screening Pilot in a national tendering process 5 years ago. The results of the first 4 years of this pilot will be presented including cancer statistics and quality data. Possible future screening options for New Zealand will also be discussed.

14.00 - 14.30

The Binational Colorectal Cancer Audit

Alexander Heriot, Peter MacCallum Cancer Centre

Colorectal remains the second commonest cause of cancer death in Australia. There has been increased focus globally on the importance and value of audit and quality improvement in colorectal cancer surgery. The recent focus in the UK on surgical quality with publication of individual surgeons' outcomes has highlighted government and patients' interest on quality of surgery.

The Bi-National Colorectal Cancer Audit is an audit of colorectal cancer surgery that has been run across Australia and New Zealand since 2006. The audit has been adapted to an online system since the beginning of 2014 and an annual report of over 12,000 cases was released at the ASC in May 2015. The revised audit allows individual surgeons and units to obtain instant data summary of all submitted cases at any time and the ability to download all their data at anytime. It also facilitates real time benchmarking, enabling surgeons to get continuous feedback on their outcomes, compared to all other submitting units.

These issues will be explored along with the opportunities available for surgeons for quality improvement for colorectal cancer surgery, and research opportunities available through the audit.

The session will be of value to any surgeon who deals with patients with colorectal cancer.

14.30 - 15.00

The UK Experience Of Consultant Outcomes Publication - Big Data At Its Worst

Shaw Somers, NHS Consultant Surgeon, UK

The UK publication of individual surgeon outcome data in 10 NHS specialty areas was mandated in 2013. Far from being a triumph of quality data driving real improvements in care, it has been mired in controversy and has adversely affected training and service development. It has become an abject lesson in making what is measurable important and surgery suffering the consequences. The ability of politicians to 'spuriously' claim improvements in care, whilst being supported by the colleges presented most surgeons with a fait accompli. My lecture will describe the events since 2013 from the perspective of a surgeon on the receiving end of these demands for data. The pitfalls and problems and occasional merits of such data publication will be discussed.

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SESSION 4: TRAINEE & FREE PAPER PRESENTATIONS

15.50 - 16.00

Double Blinded Randomised Controlled Trial Of Pre-Peritoneal Local Anaesthetic In Laparoscopic Total Extra-Peritoneal Hernia Repair

Suheelan Kulasegaran, North Shore Hospital, Auckland

S Kulasegaran*, M Rohan ***, L Pearless **, M Hulme-Moir*

* Department of Surgery, North Shor Hospital, Waitemata District Health Board, Auckland
** Southern Cross Surgery- North Harbour, Auckland *** Faculty of Health and Environmental Sciences, Auckland University of Technology

Introduction:

Laparoscopic total extra-peritoneal hernia repair (TEP) is associated with less post-operative pain and earlier return to normal activity compared to open hernia repair (OHP). Despite this, post-operative pain remains a major issue.

Aims:

The aim of this double-blinded randomized controlled trial was to identify whether the instillation of local anaesthetic in the pre peritoneal space improves pain scores following TEP.

Methods:

One hundred patients undergoing laparoscopic total pre-peritoneal hernia repair (TEP) between the years of 2009-2014 were included. Patients were randomly assigned to receive either 20mls of normal saline or 0.25% bupivacaine with adrenaline. Visual analogue scores (VAS 0-10) were recorded post-operatively at the 4hour, 1day, 2week, 4 week and 6week mark. Secondary end points included complications, time to discharge and return to normal activity.

Results:

51 patients were allocated to the local group. 49 patients were included in the placebo group.
The baseline characteristics and demographics of patients in both groups were comparable.
Patients in the local group had similar VAS scores compared to the placebo group at both 4 hours (1.1 vs 1.4 respectively; p = 0.19) and 24 hours (2.1 vs. 2.3; p = 0.63). No statistically significant difference noted in other primary, secondary outcomes. 2 patients from the local group, and 8 from the placebo group developed urinary hesitation/retention. No other complications were noted in either group.

Conclusion:

Although the concept of pre-peritoneal local anaesthetic instillation following laparoscopic TEP is attractive, this appropriately powered study has failed to show any advantage in pain scores at 4 and 24 hours. The pain scores recorded, however, were remarkably low in both groups.

References:

McCormack K, Scott NW, Go PM, Ross S, Grant AM, EU Hernia trialists Collaboration. Laparoscopic techniques versus open techniques for inguinal hernia repair. Cochrane Database Syst Rev 2003; 1: 1-273.

16.00 - 16.10

Reappraisal Of Normative Values For Evacuation Proctography

Somnath Palit, Christchurch Hospital, Christchurch

A Somnath Palit*, B Chetan Bhan*, C Peter J Lunniss*, D Derek J Boyle*, E Mark A Gladman*, E Charles H Knowles*, F S Mark Scott*

* National Centre for Bowel Research and Surgical Innovation (NCBRSI) and GI Physiology Unit (GIPU), Barts and the London School of Medicine and Dentistry, Queen Mary University of London, Whitechapel, London, UK

Introduction:

Interpretation of evacuation proctography (EP) images is reliant on robust normative data. Previous studies of EP in asymptomatic subjects have been methodologically limited.

Aims:

The aim of this study was to provide parameters of normality for both genders using EP.

Methods:

EP was prospectively performed on 46 healthy volunteers (28 females). Proctograms were independently analysed by two reviewers. All established and some new variables of defaecatory structure and function were assessed objectively: anorectal dimensions, anorectal angle changes, evacuation time, percentage contrast evacuated and incidence of rectal wall morphological 'abnormalities'.

Results:

Normal ranges were calculated for all main variables. Mean end evacuation time was 88 sec (CI 63-113) in males and 128 sec (98-158) in females; percentage contrast evacuated was 71% (63-80) in males and 65% (58-72) in females. 26 / 28 female subjects (93%) had a rectocoele with a mean depth of 2.5 cm (upper limit 3.9 cm). Recto-rectal intussusception was a finding in 9 subjects (approximately 20% of both genders); however, recto-anal intussusception was not observed. Only rectal diameter differed significantly between genders. Qualitatively, three patterns of evacuation were present.

Conclusion:

This study defines normal ranges for anorectal dimensions and parameters of emptying as well as the incidence and characteristics of rectal wall 'abnormalities' observed or derived from EP. These ranges can be applied clinically for subsequent disease comparison.

References:

1. Mahieu P, Pringot J, Bodart P. Defecography: I. Description of a new procedure and results in normal patients. Gastrointest Radiol 1984; 9: 247-51.
2. Shorvon PJ, McHugh S, Diamant NE, Somers S, Stevenson GW. Defecography in normal volunteers: results and implications. Gut 1989; 30: 1737-49.

16.10 - 16.20

Effect of Diversion Ileostomy on the Occurrence and Consequences of Chemotherapy-Induced Diarrhoea

Jason Robertson, Mid-Central DHB, Palmerston North

Jason P. Robertson, M.B.Ch.B. • Cameron I. Wells • Ryash Vather, M.B.Ch.B. Ian P. Bissett, M.B.Ch.B., M.D., F.R.A.C.S.

Department of Surgery, University of Auckland, Auckland, New Zealand

Introduction:

The benefits of adjuvant chemotherapy in the treatment of colorectal cancer are well established.1 Chemotherapy-induced diarrhoea is a common adverse effect of these regimens.1,2 The occurrence of chemotherapy-induced diarrhoea not only directly affects patient health but may also compromise treatment efficacy because of consequent dosing alterations or discontinuation.

Aims:

This study aimed to investigate the effect of diverting loop ileostomy during chemotherapy on the occurrence and consequences of chemotherapy-induced diarrhoea.

Methods:

This was a single-institution retrospective evaluation of a prospective surgical database. All patients receiving curative adjuvant chemotherapy after anterior resection for colorectal cancer at Auckland Hospital from 2002 to 2013 were retrospectively evaluated. Patient-, perioperative-, and chemotherapy-related variables were collected. Chemotherapy-induced diarrhoea occurrence was graded according to National Cancer Institute Common Terminology Criteria for Adverse Events. Logistic regression analysis was performed to identify independent predictors for chemotherapy-induced diarrhoea occurrence, treatment modifications, and hospital admission.

Results:

A total of 109 identified patients received 691 chemotherapy cycles; 84% of patients with a diverting ileostomy experienced chemotherapy-induced diarrhoea compared with 47% in those who were not defunctioned ($p < 0.01$). On logistic regression analysis, the presence of a diverting ileostomy during chemotherapy was an independent predictor of chemotherapy-induced diarrhoea grade 3 or higher (OR, 13.6 (95% CI: 1.2–150.9); $p = 0.02$), the need for a dosing reduction (OR, 4.0 (95% CI: 1.3–12.4); $p = 0.02$), and the need for any modification in the chemotherapy regimen (OR, 3.4 (95% CI: 1.2–9.6); $p = 0.02$).

Conclusion:

The presence of an ileostomy during adjuvant chemotherapy is a predictor of severe chemotherapy-induced diarrhoea and the need for modifications in the chemotherapy regimen. This may have important consequences for long-term survival. Prospective investigation is needed to further assess the impact of diverting ileostomy on the delivery of chemotherapy and oncologic outcomes.

References

1. Jonker DJ, Spithoff K, Maroun J; Gastrointestinal Cancer Disease Site Group of Cancer Care Ontario's Program in Evidence based Care. Adjuvant systemic chemotherapy for stage II and III colon cancer after complete resection: an updated practice guideline. Clin Oncol (R Coll Radiol). 2011;23:314-322.
2. Stein A, Voigt W, Jordan K. Chemotherapy-induced diarrhea: pathophysiology, frequency and guideline-based management. Ther Adv Med Oncol. 2010;2:51-63.

16.20 - 16.30

Synoptic Reporting Improves The Histopathological Assessment Of Pancreatoduodenectomy Specimens

Daniel Daly, Prince of Wales Clinical School, Sydney

D Daly*, R Gandy*, K Haghighi*

* Department of HPB and Transplant Surgery, Prince of Wales Clinical School, University of NSW, Sydney Australia

Introduction:

Synoptic or structured standardised reporting systems are thought to improve the accuracy, completeness and consistency of histopathological assessment of surgical specimens. This is particularly important for the assessment of malignant disease, and as such major professional bodies advocate the use of synoptic reporting for major tumour types, including the Royal College of Pathologists of Australasia1. Previous studies have established the superiority of synoptic reporting to ad hoc or free text reporting in the assessment of colorectal cancer, breast cancer, and melanoma. The benefit of synoptic reporting in pancreatic malignancy is yet to be determined.

Aims:

The aim of this study is to evaluate whether the standardised reporting protocols improve the histopathological assessment of pancreatoduodenectomy specimens.

Methods:

A prospectively maintained database of all pancreatoduodenectomy procedures performed by a single surgeon (KSH) between January 2011 and December 2015 was evaluated. Histopathological reports prepared using a synoptic reporting system were compared with those prepared using a free text reporting method with regard to the adequacy of reporting of key pathological information, including tumour size, resection margins, degree of invasion, and grading and staging.

Results:

A total of 60 histopathology reports were identified for pancreatoduodenectomy procedures performed for tumours of the pancreas, of which 25 (41.7%) were synoptic reports. Standardised histopathology reports were more likely to adequately record specimen margins than were free text reports (92% vs 28.6% respectively, $p<0.001$), and were superior in reporting tumour grading (80% versus 14.3%, $p<0.001$) and staging (96% versus 51.4%, $p<0.001$).

Conclusion:

The introduction of synoptic histopathology reporting of pancreatoduodenectomy specimens in our practice has improved the completeness of assessment of important pathological information, and maintained consistency across involvement of multiple pathologists. This is likely to benefit surgical and multidisciplinary clinical decision-making, while also facilitating clear and consistent communication in both clinical and research settings.

References:

1. Royal College of Pathologists of Australasia (2014). Cancer of the Exocrine Pancreas, Ampulla of Vater and Distal Common Bile Duct. Structured Reporting Protocol. 1st Edition. https://www.rcpa.edu.au/getattachment/3b6a41df-939d-492e-bc6b-35fc264bd89b/Protocol-pancreatic-cancer.aspx. Accessed 2/2/2016

16.30 - 16.40

The Impact of The Introduction of a Surgical Admission Unit on Numbers of General Surgery Outliers

Alexandra Jacobson, Auckland DHB, Auckland

A Jacobson, G Poole, AG Hill, M Biggar

Department of General Surgery, Middlemore Hospital, University of Auckland, New Zealand

Introduction:

Patient care and efficiency outcomes are improved if acute patients admitted to non-specialty (outlier) wards are minimised.1 Admission units are an increasingly common initiative and may help to reduce numbers of outlier patients.2 A surgical admission unit (SAU) was recently established at Middlemore Hospital.

Aims:

This study aimed to determine the impact of the introduction of a SAU on numbers of general surgery outlier patients on post-acute ward rounds in a major teaching hospital.

Methods:

A 10-bed SAU was introduced in July 2015. At the same time 20 beds on the general surgical wards were closed. The numbers and locations of patients on post-acute ward rounds before and after the establishment of the SAU were compared. A student two-tailed t-test was used for statistical comparisons with $p<0.05$ considered significant.

Results:

A total of 1462 patient locations were analysed (743 before and 719 after the introduction of the SAU) from 71 post-acute ward rounds (35 before, 36 after). There were similar overall numbers of post-acute patients before and after the introduction of the SAU (mean 21 vs 20, $p=0.33$). There were fewer post-acute patients in outlier wards after the introduction of the SAU (mean 2.7 before vs 1.6 after, $p=0.04$).

Conclusion:

Despite a net reduction in general surgery beds and no change in the overall number of post-acute patients, the establishment of a SAU was associated with a reduction in outliers.

References:

1. Santamaria JD, Tobin AE, Anstey MH et al. Do outlier inpatients experience more emergency calls in hospital? An observational cohort study. Med J Aust. 2014;200(1):45-8.
2. Downing H, Scott C, Kelly C. Evaluation of a dedicated short-stay unit for acute medical admissions. Clin Med. 2008;8:18-20.

16.40 - 16.50

Laparoscopic Silastic Ring Omega Loop Gastric Bypass (SR-OLGBP): 10 Year Results From A Single Centre

Laila Sheikh, Waitemata DHB, Auckland

Sheikh, L*, Booth, M*,

* Department of General Surgery, North Shore Hospital, WDHB

Introduction:

The Roux-en-Y gastric bypass (RYGBP) is the most commonly performed gastric bypass for obesity. The omega loop bypass (OLGBP) represents a simpler alternative. With a single anastomosis, no closure of mesenteric defects and shorter operative times it has been associated with increased safety, better weight loss, quality of life improvement and comorbidity resolution. However, there are concerns about bile reflux, cancer risk and marginal ulcer. The placement of a silastic ring in the RYGBP has shown better long-term weight loss.

Aims:

Review of long-term outcomes from a consecutive cohort of patients that underwent a SR-OLGBP.

Methods:

Between 2005 and 2007 156 patients underwent SR-OLGBP, with a shortened afferent limb (150cm) to minimise the risk of malabsorption, by a single surgeon. Patients were reviewed at 1week then three monthly in the first year and at 18 months and 2 years. In August 2015 all patients were posted a questionnaire to assess weight, reflux, medications, complications and overall satisfaction and quality of life. These were followed up by telephone interviews and consultations.

Results:

53% response. Median follow-up - 8.8 years
Mean BMI at 1, 5 and 10 years was 27.08, 27.76 and 28.6 respectively
Mean percentage excess weight loss at 1, 5 and 10 years was 93.42%, 88.99% and 85.85% respectively
9 conversions to Roux-en-Y gastric bypass, 5 Silastic ring removed/changed
63% of patients required medication to manage reflux. 6 patients reported worsening reflux post-operatively.
4 reported gastrojejunal ulcers

Conclusion:

Silastic ring MGBP achieves effective long-term weight loss and comorbidity resolution. Post-operative reflux can be problematic. However, most can be managed with medical therapy alone.

References:

Clarke MG, Wong K, Pearless L, Booth M. Laparoscopic silastic ring mini-gastric bypass: a single centre experience. Obesity Surgery. 2013; 23: 1852-1857.

16.50 - 17.00

A Systematic Evaluation Of The Design And Use Of Percutaneous Drains In The Abdomen

Lisa Brown, Auckland City Hospital, Auckland

Sheikh, L*, Booth, M*,

* Department of General Surgery, North Shore Hospital, WDHB

Introduction:

The Roux-en-Y gastric bypass (RYGBP) is the most commonly performed gastric bypass for obesity. The omega loop bypass (OLGBP) represents a simpler alternative. With a single anastomosis, no closure of mesenteric defects and shorter operative times it has been associated with increased safety, better weight loss, quality of life improvement and comorbidity resolution. However, there are concerns about bile reflux, cancer risk and marginal ulcer. The placement of a silastic ring in the RYGBP has shown better long-term weight loss.

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17.00 – 17.10

Implementation Of The RACS Recommendations On Discrimination, Bullying And Sexual Harassment (DBSH) At Counties Manukau District Health Board (CMDHB): A Pilot Study

Shareena Lala, Middlemore Hospital, Auckland

S Lala*, G Poole*, D Moss*, A Connolly*, M Weston*, J Wagener*, J Morrow*

* Department of General Surgery, Middlemore Hospital, Auckland

Introduction:

In 2015 the RACS were required to confront longstanding issues surrounding DBSH. The College has undertaken extensive action with external and internal reviews1.
Our department felt the need to act swiftly to define and quantify issues, and prevent future occurrence. The department employs 19 consultants, 36 junior staff and teaches over 80 students; it was felt we needed a formal system rather than concepts.

Aim:

The aim of this study was to evaluate effectiveness of a specifically designed model in identifying and addressing DBSH in our unit.

Methods:

In 2015 three independent surveys quantified the issue, performed by RACS, University of Auckland, and a national junior doctor survey.

No baseline DBSH issues were identified in our department.

A seven-member taskforce was formed including four surgeons (two female), our female unit manager and two senior nurses.

A one-page document was produced based on Vanderbilt principles, with five key steps outlined:

1. Zero tolerance of DBSH
2. All staff must formally accept existence of DBSH
3. All staff/victims should react swiftly and directly to the source of DBSH
4. If resolution is unsatisfactory, a taskforce member will be approached to intervene
5. Utilise external human resources and RACS help

All interventions were recorded and kept for longitudinal analysis.

Results:

After three months two issues of DBSH have arisen, both at level of junior doctor to junior doctor.
One was stopped at level three; the other reached level four, solved with intervention from the taskforce.

Conclusion:

DBSH will only be eradicated with information, education and change. Hopefully the CMDHB process will rapidly identify and solve most problems.

References:

RACS and EAG report on DBSH, November 2015
Hickson, GB, Pichert, JW, Webb, LE, Gabbe, SG. A complementary approach to promoting professionalism: identifying, measuring and addressing unprofessional behaviours. Acad Med 2007 Nov;82(11);1040-8

17.10 - 17.20

Moving Towards The Electronic Health Record: The Introduction Of Synoptic Operative Reporting As Part Of A New Hospital-Wide Surgical Audit

Magda Sakowska, Canterbury DHB, Christchurch

Magdalena M Sakowska, Megan V Thomas, Saxon Connor, Ross Roberts
Department of General Surgery, Christchurch Public Hospital, Christchurch, New Zealand

Introduction:

Narrative operative reports have been the standard documentation of any operative procedure. However, narrative reports are not standardised and can be of variable quality and completeness1 and, unlike synoptic operative reports, do not lend themselves to easy data extraction and audit.

Aims:

To assess the utility of synoptic operative reporting introduced as part of a new hospital-wide surgical audit.

Methods:

Standardised synoptic reporting was introduced for laparoscopic cholecystectomy. Two periods of operative reports were chosen to examine for completeness of documentation: Feb-August 2014 for narrative reports, May-November 2015 for synoptic reports. Statistics: z-test, with p-value of <0.05 significant.

Results:

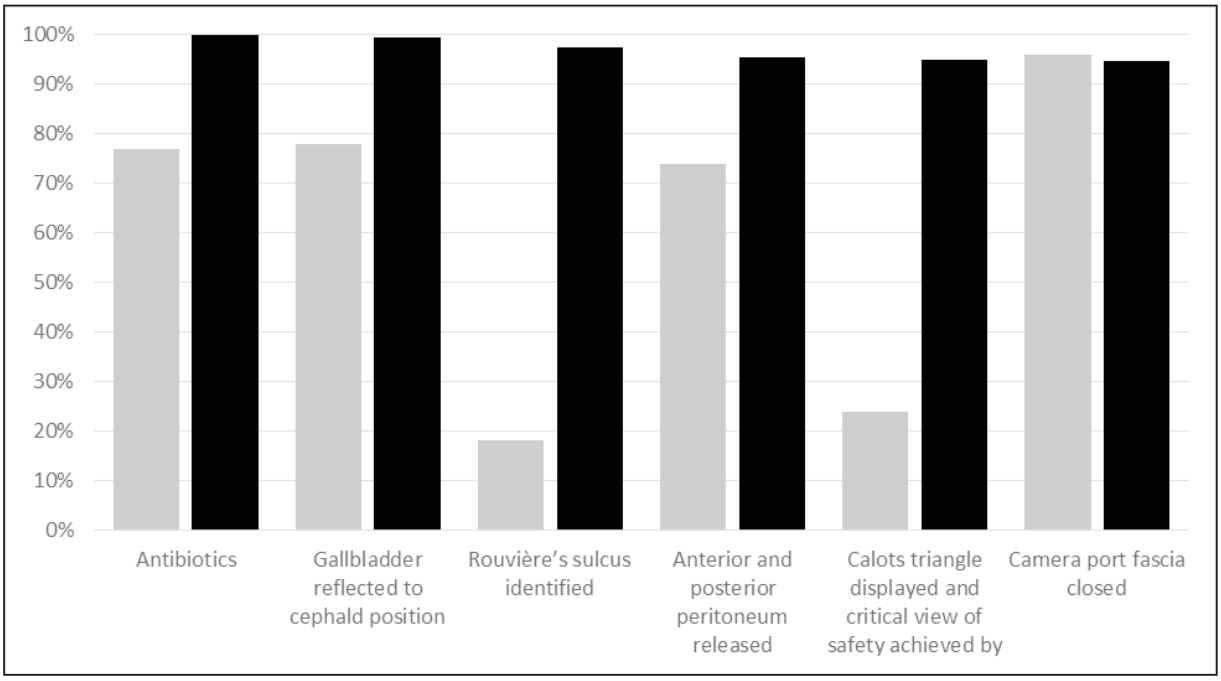
There were 243/291 (84%) laparoscopic cholecystectomies documented with synoptic reports after their introduction in May 2015; 111 narrative reports analysed prior to this (Feb-August 2014). Documentation of antibiotic use improved from 77% to 100% (p<0.0001) with synoptic reports as did the position of gallbladder retraction (78% to 100%; p p<0.0001), identification of Rouviere's sulcus (18% to 100%; p<0.0001), release of peritoneum (74% to 98%; p<0.0001) and display of Calot's triangle with documentation of the critical view of safety being obtained (24% to 95%; p<0.0001). Documentation of camera port closure remained unchanged (96% to 95%; p=0.67).

Conclusion:

Synoptic operative reporting is feasible and lends itself to a more complete operative documentation, concise health communication, and ease of data extraction for audit/quality of health care delivery and research potential. It can be successfully carried out as part of an integrated hospital-wide operative management system that can incorporate this mode of reporting.

References:

Wiebe ME, Sandhu L, Takata JL, et al. Quality of narrative operative reports in pancreatic surgery. Can J. Surg J. Can Chir. 2013 Oct;56(5):E121-127.



17.20 - 17.30

Audit Of A Regional General Surgical Outpatient Clinic

Aemelia Melloy, Logan Hospital, Queensland

Dr Aemelia Melloy*, Dr Arkadiusz Wysocki*

* Department of General Surgery, Logan Hospital, Brisbane QLD Australia

Introduction:

For many patients, the surgical outpatient clinic is the first point of contact with the hospital system. There is often a long wait to be seen for conditions, which are not deemed life threatening, however these may still have significant impact on patients' quality of life. Patients often complain that the wait for their appointment is excessive, and the consultation time with the doctor too short1. It is common that many patients that are being referred to a surgical service do not need an operation, and this means longer waits for patients that actually require the service.

Aims:

The aim of this audit was to determine the reasons why patients seen in the surgical outpatient clinic are not booked for an operation. It also aims to target common conditions, which are referred unnecessarily, in order to provide feedback to local referrers, and reduce the burden on the local health service.

Methods:

Data was reviewed from the electronic record system over a 12-month period from July 2014-June 2015 of all patients that were referred and seen in the surgical outpatient clinic as a new patient. The reason for referral, management plan, and reason why they were not booked for an operation was recorded.

Results:

There were a total of 2801 new patients seen in the surgical clinic over twelve months. 56.3% of patients were seen but not booked for an operation. The most common reasons for not booking an operation was due to the patient being unfit for an operation due to medical comorbidities (10.9%), being asymptomatic of the condition (10.4%), and not having a condition that required surgery (9.3%). The most commonly referred conditions not requiring an operation were gallstones (16.2%), haemorrhoids/rectal bleeding (14.1%), inguinal hernias/groin pain (6.9%), and umbilical hernias (6.4%). Interestingly 8.8% of patients did not want an operation.

Conclusion:

Many patients are being referred unnecessarily to surgical outpatient clinics. This could be addressed with primary care physicians to reduce the burden on the health service.

References:

1. Frcs, A. W. and Frcp, M. M. (2000), Understanding patients' views of a surgical outpatient clinic. Journal of Evaluation in Clinical Practice, 6: 273–279. doi: 10.1046/j.1365-2753.2000.00240.x

SESSION 5: BREAST & ENDOCRINE

8.30 - 9.00

Breast Surveillance Versus Risk Reducing Mastectomy In High Risk Patients: Who? When? Why? (And Why Not?)

Vanessa Blair, Kensington Hospital, Whangarei

Major advances in recent decades have identified and characterised several hereditary syndromes associated with a high risk of breast cancer. These include Hereditary Breast and Ovarian Cancer Syndrome (HBOC) related to BRCA1 or 2 mutation, Li-Fraumeni Syndrome (LFS) caused by p53 mutation, PTEN harmartoma syndrome (PTEN mutation), Hereditary Diffuse Gastric Cancer (CDH1 mutation) and Petz-Jeghers syndrome (STK11 mutation). Collectively these hereditary cancer syndromes are thought to account for approximately 5% of all breast cancers.

The evidence on the role of risk-reducing surgery and surveillance has advanced the most in HBCO, particularly for patients with a BRCA1 or 2 mutation. It is now possible to provide much clearer estimates of lifetime risk of breast and ovarian cancer in BRCA1 and BRCA2 patients, which helps to guide clinical decision making. In contrast, for the other rarer syndromes, risk estimates for breast and other cancers have been more difficult to define – accordingly decision making is particularly complex in this group of women at high risk. Likewise decisions are in many ways more difficult in high risk women where no mutation is identified. In all situations, multidiciplinary care is essential, with genetic councellors having a pivitol role.

This review will briefly define what is 'high risk' before focusing on the literature on Bilateral Risk Reducing Mastectomy (BRRM) and surveillance imaging (particularly MRI). The timing of interventions and phycosocial effects will be addressed. An overview of the key positions on BRRM and survillance as outlined in recent international guidelines (from the UK, Europe, USA and Australia) will be presented.

9.00 - 9.30

Oncoplastic Breast Surgery

Katherine Gale, Waitemata DHB, Auckland

Oncoplastic breast surgery is surgery for breast cancer that optimises both oncological and aesthetic outcomes. Partial breast reconstruction techniques make breast conserving surgery an option for appropriately selected women and

may achieve lower rates of; margin involvement, cosmetic failure, morbidity and local recurrence. Good case selection and accurate pre-operative assessment, selection & planning are essential. These techniques have been introduced to Waitemata DHB utilizing a team approach with favorable outcomes, and broadly include; volume displacement (level I techniques, therapeutic mastopexy and mammoplasty) or volume replacement techniques (chest wall perforator flaps and lipofilling). The rate of immediate breast reconstruction for suitable patients has improved, and the options for reconstruction have expanded. The results of the first year of Waitemata DHB Oncoplastic and Reconstruction Breast Service will be discussed in this presentation.

9.30 - 10.00

Metastatic Melanoma: A Chronic Disease?

Rosalie Fisher, Auckland DHB, Auckland

Systemic treatments for metastatic melanoma have advanced considerably in the last five years. New classes of drugs, such as the MAPK inhibitors and PD-1 inhibitors, have the potential to drastically alter the natural history of melanoma and as a result, ome patients have acheived durable, complete control of their tumours. Despite marked improvement in survival and other outcomes during this time, there remain many limitations to the newer drugs and there is further progress to be made in order for melanoma to become a 'chronic disease' for most patients. This presentation will provide an overview of new systemic treatments and experimental approaches, and how these may be integrated into the current surgical practice, for the treatment of advanced melanoma.

10.00 - 10.30

Current Management And Changing Trends Of Treatment For Thyrotoxicosis

Win Meyer-Rochow, Waikato DHB, Hamilton

In many centres the traditional management of thyrotoxicosis consists of pharmacological treatment followed by radioiodine ablation with surgery preserved for patients who have failed medical treatment. However, over the last two decades a shift of treatment appears to be occurring with surgery being used as the first line management for an increasing number of patients with thyrotoxicosis.

The advantages of surgery over medical treatment includes rapid treatment of thyrotoxicosis and immediate commencement of predicted thyroid replacement dose, more rapid decline of thyroid receptor antibodies, no time restriction with pregnancy or lactation after surgery, no exposure to radiation, no need for isolation, less tendency for a flare or a potential improvement an associated Graves' ophthalmopathy. The disadvantages include the potential for complications associated with thyroid surgery, general anaesthesia, discomfort associated with surgery and a surgical scar.

Some of the possible reasons leading to changing trends include the recognition by Endocrinologists of surgery providing rapid treatment thereby allowing earlier discharge back to primary care, informed patients aware of their treatment options and desire to avoid radiation, the social cost associated with radioiodine ablation and excellent outcomes with surgery for Graves' disease by experienced thyroid surgeons. In New Zealand resource restraints restrict a free choice for patients in the public sector and therefore a selective approach is necessary.

In this presentation the role of surgery, comparison of treatment costs, and our local approach for the selection of patients most likely to benefit from surgery will be discussed. Surgical preparation and surgery in the patient with thyrotoxicosis can be challenging. Preoperative preparation and surgical strategy will be discussed and outcomes from surgery for thyrotoxicosis at Waikato Hospital presented.

SESSION 6: KEYNOTES AND DBSH SYMPOSIA

1100 - 1130

Hilar Cholangiocarcinoma in 2016

Richard Schulick, University of Colorado, USA

The early description of Hilar Cholangiocarcinoma will be discussed. We will review the anatomic locations, epidemiology, risk factors, macroscopic subtypes, histologic variants, tumor markers, staging, assessment of resectability, methods of enhancing margin negative resection, and role of transplantation.

1130 - 1200

Chronic Anastomotic Leaks

Sue Clark, St Mark's Hospital UK

This will cover the management of anastomotic leaks, briefly covering the acute management stage. The main focus will be on ways to assess and treat the persistent leak, with presentation of various strategies and their outcomes.

1200 - 1215

The College Response To EAG Report

Graeme Campbell, Bendigo Health, Bendigo

1215 - 1230

Partnering For Cultural Change

Cathy Ferguson, RACS, Wellington

This talk will start by describing the current scene in New Zealand regarding bullying, discrimination and sexual harassment and then introduce the Vanderbilt model of principles of engagement in partnering or collaborating.

The RACS Action Plan - Building Respect, Improving Patient Safety will be introduced and then there will be discussion of the options for partnering with hospitals and jurisdictions within New Zealand.

1230 - 1245

Constructive Assessment And Feedback

Richard Lander, RACS Executive Director for Surgical Affairs (NZ)

Constructive assessment of, and feedback on, the performance of colleagues, trainees and others you work with, should form an integral part of daily surgical practice. Assessment can be either formative, during the period of observation, or summative, at the end. Common methods for formative assessment include direct observation and discussion of practice, 3600 assessment, question and answer sessions or formal examination. The classical summative assessment is the Final Fellowship Examination undertaken towards the end of training. Feedback should be clearly stated, specific, and based on what is observed; both the action, and behaviour and it's impact. Feedback should be descriptive not evaluative; feedback is not about personal judgement, but based on observed behaviour and actions. Feedback should only refer to behaviour that can be changed. Feedback should be given in a manner that does not constitute harassment.

SESSION 7: THE SURGEONS' WELFARE

1400 - 1445

Happiness And Compassion for Doctors

Tony Fernando, The University of Auckland

All of us want to be happy. Despite being desired by everyone, happiness is a complex phenomenon which needs to be further examined. In this talk, various routes to happiness and possible mechanisms will be discussed. Common traps to the search for happiness will be reviewed. Lastly, specific interventions, including enhancement of compassion as facilitators for happiness among doctors will be elucidated.

1445 - 1515

Retirement/ Free Time

Pat Alley, Waitemata DHB, Auckland

Most doctors, particularly surgeons, are ill prepared for retirement. They underestimate their longevity,the need for careful planning and their physical and mental capability. They can over-estimate their clinical acumen and their financial requirements. This combination may lead to professional and personal dissatisfaction and may see senior practitioners working beyond the time when they should have ceased clinical practice. This presentation describes both the pitfalls and opportunities accompanying the inevitable change in clinical practice occasioned by the march of time.

1515 - 1545

Surgeons' Health

Michael Rodgers, Waitemata DHB, Auckland

POSTER ABSTRACTS

The Posters below will be considered for the Poster Awards

C-reactive Protein Has A Better Discriminative Power Than White Cell Count In The Diagnosis Of Acute Cholecystitis

Andrei Belyaev, Cardiothoracic Surgical Registrar, Auckland City Hospital

Beliaev AM*, Marshall RJ**, Booth M***

* Cardiothorarcic Surgical Unit, Auckland City Hospital, Auckland, New Zealand

** Department of Epidemiology and Statistics, University of Auckland, Auckland, New Zealand

*** Department of General Surgery, North Shore Hospital, Auckland, New Zealand

Introduction:

The diagnosis of acute cholecystitis (AC) is challenging and may result in a delay in surgery, hospital discharge, and increased mortality. To improve its diagnosis, C-reactive protein (CRP) has been proposed as a benchmark.
The aim of this study was to evaluate discriminative power of CRP against white cell count (WCC) in AC.

Methods:

This was a retrospective cohort study. Over a 5-y period, 1959 patients were identified from the audit of cholecystectomies. The exclusion criteria were coexisting acute surgical conditions, absence of blood tests within 3 d before hospital admission for elective surgery, and private patients

Results:

The eligibility criteria were met by 1843 patients. Comparison of the area under receiver operating characteristic (AUC) curve of CRP and WCC in acute on chronic, edematous, necrotic, suppurative, and gangrenous AC showed a better discriminative power of CRP. Both tests performed equally well in patients with pericholecystic abscess and gallbladder perforation. CRP was superior than WCC in mild AC, AUC = 0.93 (95% confidence interval [CI], 0.9-0.95) and 0.79 (95% CI, 0.74-0.84), P < 0.001, in moderate and severe AC, AUC = 0.99 (95% CI, 0.97-1.0) and 0.92 (95% CI, 0.88-0.97), P = 0.009, and in all forms of AC combined, AUC = 0.94; (95% CI, 0.92-0.97) and 0.83 (95% CI, 0.79-0.87), respectively, P < 0.001.

Conclusions:

CRP has a better discriminative power than WCC in most forms of AC and is a useful diagnostic marker of AC.

References:

1. Hirota, M., Takada, T., Kawarada, Y. et al, Diagnostic criteria and severity assessment of acute cholecystitis: Tokyo guidelines. J Hepatobiliary Pancreat Surg. 2007;14:78
2. Yokoe, M., Takada, T., Strasberg, S.M. et al, TG13 diagnostic criteria and severity grading of acute cholecystitis (with videos). J Hepatobiliary Pancreat Sci. 2013;20:35 ([Practice Guideline]).

Factors Affecting Length Of Stay In Patients With Cellulitis at Counties Manukau District Health Board

Megan Grinlinton, Surgical Registrar, Waitemata DHB

A Megan Grinlinton*, B Stephen Sohn**, C Jenny Wagener**

* Department of Surgery, Waitemata District Health Board

**Department of Surgery, Counties Manukau District Health Board

Introduction:

Cellulitis is a major health issue in New Zealand, and Counties Manukau District Health Board (CMDHB) has one of the highest numbers of admissions in Australasia. This disease has many negative consequences for patients, including lost workdays and productivity, decreased mobility, and chronic pain, with significant financial implications for DHBs.

Aim:

To determine the significant factors contributing towards length of stay (LOS) in patients presenting to CMDHB with cellulitis.

Methods:

We retrospectively collected data on all patients aged 18 and above who were admitted with cellulitis to CMDHB General Surgical Department between 1st January and 31st March 2014. We excluded patients with cellulitis of the head, neck and joints. A total of 198 patients were included in the study.

Results:

On univariate analysis, the factors that were shown to be associated with a longer LOS were extended-spectrum beta-lactamase (ESBL) infection (P=0.04), multi-organ failure, type two diabetes mellitus (T2DM) (P=0.012), obesity (P<0.01), raised CRP (P<0.01), raised WCC (P<0.01) and intensive care unit/high dependency unit (ICU/HDU) admission. On multivariate analysis, the subset of factors associated with a longer LOS included ethnicity (P<0.01), ICU/HDU admission (P<0.01), obesity, and elevated C-reactive protein (CRP), raised temperature and white cell count (WCC).

Conclusion:

In this retrospective observational study, the significant factors associated with increased LOS include ESBL colonisation, T2DM, obesity, raised CRP, raised WCC, multi-organ failure, ICU/HDU admission and ethnicity. Identification and medical optimisation of high-risk patients with these factors may decrease their LOS. Discharge planning should be emphasised from the point of admission amongst all multidisciplinary teams in order to reduce LOS.

References:

1. Moroeth SC, Chambers ST, Gallagher ST, Gallagher K, Frampton C, Pithie AD. Lower limb cellulitis: features associated with length of hospital stay. J Infect 2006 Jan; 52(1):23-29.

The Influence Of Resection Margin On Survival Outcomes In Pancreatic Cancer Surgery: A Systematic Review & Meta-Analysis

Naman Kohli, Barwon Health
N. Kohli, S. Nagra, S. Abbas
Department of Surgery, Geelong Hospital

Introduction:

Curative pancreatic cancer treatment remains a challenge in hepatopancreatobiliary surgery with a poor 5-year survival (7-25%) even with adjuvant therapy. The predominant neoplasm seen is ductal adenocarcinoma (approx. 85%) of which 70% lie within the head of the pancreas. Anatomically this region presents a number of challenges that may impact on achieving an R0 resection. There is no uniformity on the diagnostic criteria for resection margins however some current studies classify R1 resection as within 1mm. There is no recent systematic review showing the exact impact on survival outcomes.

Aims:

To systemically review the current literature to assess impact of standardised definitions of R1 resection margin on survival outcomes.

Methods:

Thirteen studies were captured from PubMed and Web of Science databases that assessed survival outcomes post resection. Only studies published in English were included since 2006 and outcomes included demographics, tumour characteristics and survival data.

Results:

The mean age of patients ranged from 63-69 years with a male predominance. The mean tumour size ranged from 29-38mm with > 30mm being a predictor for poorer survival. Statistically significant survival benefit was noted in patients with R0 margins (25 vs 14 months, p<0.05). When comparing R0 vs R1 resections the overall median rates were 26% and 74% respectively. The posterior and medial margins were most often associated with R1 resections. Significant predictors of overall mortality included a R1 margin, tumour differentiation, lymphovascular or perineural invasion irrespective of resection margin and presence of nodal disease.

Conclusion:

A standardised definition of R1 (within 1mm) clearance appears to more accurately reflect the survival statistics seen in pancreatic cancer. A positive R1 margin along with the described tumour characteristics independently correlate with poorer survival outcomes. Further research to develop screening and early diagnosis could certainly improve patient outcomes by way of curative surgery.

Necrotising Fasciitis: 11-year Retrospective Case Review In South Auckland

Suheelan Kulasegaran, Registrar, North Shore Hospital

S Kulasegaran*, B Cribb*, A.C. Vandal**, S McBride***, D Holland*** , A. D. MacCormick****

* Department of Surgery, South Auckland Clinical School, The University of Auckland, Auckland
** Faculty of Health and Environmental Sciences, Auckland University of Technology, Auckland
*** Department of Infectious Diseases, Middlemore Hospital, Auckland
****Department of Surgery, Manukau Health, Middlemore Hospital, Auckland

Introduction:

Necrotising fasciitis is a severe soft tissue infection. Despite improvements in surgical and critical care support, mortality is still high. Middlemore Hospital has the highest incidence in New Zealand and there are concerns that it may be increasing. This 11-year review of necrotising fasciitis constitutes the largest published single-centre series in New Zealand.

Aims:

To review our experience with necrotizing fasciitis at Middlemore Hospital and to define the trends in incidence, inpatient mortality and microbiological profile.

Methods:

A computerized search of the electronic medical records was undertaken to identify adult patients with a diagnosis of necrotizing fasciitis between January 2000 and December 2010. A retrospective review of the clinical records was performed.

Results:

138 patients with necrotizing fasciitis were identified, 129 had their diagnosis confirmed at operation. The mortality at 30 days was 20.3% (95% CI 13.9%-28.0%). There was a significant reduction in hospital mortality in each successive year of the study period with an odds ratio of 0.84 (95% CI 0.71-0.98, P = 0.03). The incidence increased until February 2004 (95% CI September 2002-July 2005) followed by a significant decrease in incidence. Clindamycin, gentamicin and penicillin provides satisfactory cover against 95% of the causative pathogens. Maori and Pacific Island patients made up 57.3% of those affected. The most common site of infection was the lower limb 56.2% and the perineum 21.9%. Streptococcus pyogenes was the most commonly cultured pathogen 35.5%.

Conclusion:

The incidence of NF has decreased since 2004. Mortality rates in our centre continue to decline due to early surgical intervention and improved intensive care support. The initial empirical antibiotic regimen in Middlemore Hospital provides satisfactory cover against pathogens.

References:

Das D et al. Increasing incidence of necrotising fasciitis in New Zealand: a nationwide study over 1990-2006. J. Infect. 2011; 63: 429-33.

An Ageing Acute Surgical Population: The Auckland Experience

Hannah Linkhorn, Registrar (Non-Training), Counties Manukau DHB

Introduction:

New Zealand has an ageing population and we predict that more elderly patients are requiring acute surgical services. We suspect that older patients have longer hospital stays and increased mortality.

Aims:

We aim to identify the number of elderly patients that have been treated by our acute surgical service Auckland City Hospital based on data from discharged patients in 2013 and 2014. We aim to illustrate disparities in the care for older patients such as length of stay, mortality and ICU rates.
Method: The clinical records database was accessed to identify all patients discharged from General Surgery and ASU during 2013 and 2014. These groups were stratified by age (over and under 80 years old). Data was collected on; number of discharges per year, length of stay, ICU admissions, number of procedures and mortality rates.

Results:

There is an increasing number of patients aged over 80 years old who were discharged from ASU; 7.02% (n=296) in 2013 and 8.20% (n=344)in 2014. Patients aged over 80 were spending 1.88 (p value <0.001) days longer in hospital than those under 80 years in 2014. Mortality rates in 2013 were 3.716 deaths per 100 admissions and in 2014 5.814 per 100 admissions. The risk ratio for patients over 80 years old was 36.4 (p value <0.001) in 2013 and in 2014 20.32 (p value <0.001) times higher risk of death in hospital than patients under 80.

Conclusion:

There is an increasing number of patients being treated by the Acute Surgical Unit at Auckland City Hospital. Over 2013 and 2014 data shows the mean length of stay and mortality rates are higher for patients over 80 years old. Mortality rates are higher in acute admissions compared to elective admissions. This identifies a need for increased care for elderly patients admitted for acute surgical care. We suggest a trial of attaching a specialist geriatrician to the Acute Surgical Unit who will provide a service for at risk patients.

Can symptoms be used to predict proctographic abnormalities in patients with chronic constipation?

Somnath Palit, Christchurch Hospital

A Somnath Palit*, B Charles H Knowles*, C S Mark Scott*

* National Centre for Bowel Research and Surgical Innovation (NCBRSI) and GI Physiology Unit (GIPU), Barts and the London School of Medicine and Dentistry, Queen Mary University of London, Whitechapel, London, UK

Introduction:

Investigations for chronic constipation are expensive and not universally available. A strong association between a specific symptom and a particular pathology may mean that some of the expensive physiologic tests can probably be avoided.

Aims:

In a cohort of patients satisfying the Rome III criteria for chronic constipation (1) we wanted to a) define the frequency of proctographic abnormalities and Rome specific symptoms, and b) assess whether any of the symptoms incorporated within the Rome Criteria can predict a specific proctographic abnormality.

Methods:

Symptom profile and proctographic abnormalities in consecutive patients, all satisfying the Rome III criteria were assessed retrospectively. Correlation between symptoms and proctographic findings were assessed using logistic regression.

Results:

500 patients (F:M=9:1), median age 51 yrs (range 15-84) were included in the study. Among the six symptoms incorporated in the Rome III criteria, a sense of incomplete evacuation was the most common (94%); followed by straining (91%); frequent passage of hard stool (84%); sense of outlet obstruction (83%); and need for manual manoeuvres (52%). Infrequent bowel movement was the least frequent symptom (38%). Proctogram was abnormal in 61.6% patients. 42% and 15% patients had significant structural and functional abnormalities respectively. Rectocoele was the commonest structural abnormality (24%) followed by an obstructing intussusception (17%). Dyssynergia was the commonest functional abnormality (14%). Functional defecation disorder was more common in men (p = 0.01). None of the symptoms evaluated had significant predictive capacity for any proctographic abnormality to be of clinical use.

Conclusion:

Subtypes of constipation should not be diagnosed using symptoms alone. Since structural abnormalities are more common than functional abnormalities, a dynamic test of evacuation (like proctography) should be incorporated within diagnostic algorithms for chronic constipation.

References:

1. Longstreth GF, Thompson WG, Chey WD, Houghton LA, Mearin F, Spiller RC. Functional bowel disorders. Gastroenterology 2006; 130: 1480-91.

Initial Experience With Intraoperative X-Ray In Breast Surgery

Michael Russell, Registrar, Waitemata District Health Board

Mike Russell*, Sepehr Sadeghi*, Susan Gerred$*, Katherine Gale@*

* Department of Surgery, Waitemata District Health Board

$ Breast Surgeon, Waitemata District Health Board

@ Oncoplastic Breast Surgeon, Waitemata District Health Board

Introduction:

The introduction of breast cancer screening programs has led to an increase in findings requiring excision biopsy, and diagnosis of non-palpable early breast cancer. Hookwire localisation of these lesions allows accurate excision. Long term follow-up demonstrates breast conserving surgery combined with radiotherapy for palpable lesions results in comparable outcomes to mastectomy1,2. A clear radial margin reduces chances of ipsilateral breast tumour recurrence by 50%3, and is accepted as best practice4. Intraoperatively, adequacy of margins is determined by specimen x-ray with or without ultrasound. At Waitemata District Health Board (WDHB), this has historically involved sending the specimen off site for radiologist assessment, with a phone call to the surgeon regarding margin adequacy, leading to prolonged operative time and potential misinterpretations. In 2015, WDHB purchased the HologicTM Trident specimen radiography system, an Intraoperative Specimen Radiography (IOSR) system, permitting direct specimen imaging and assessment by the operating surgeon. The images are electronically transferred to the off-site radiologist for viewing concurrently if required. Wang et al4 found IOSR to be a suitably accurate replacement for conventional imaging by reducing margin positivity, re-operation and operative time.

Aims:

This study aims to audit the initial 6-month experience with IOSR at a single institution. Primary outcomes are; average specimen assessment time and re-operation rate. Surgeon satisfaction with the new technology was also assessed.

Methods:

Patient, histological data & Specimen x-rays for both hookwire partial mastectomy and simple partial mastectomy for palpable lesion were audited over a 6-month period from May 2015 to November 2015. Statistical analysis was carried out to determine baseline characteristics and outcomes.

Results:

101 patients underwent partial mastectomy requiring specimen radiographs during the audit period. Specimen radiograph assessment was reduced form an average 22min (range 15-48min) pre ISOR to 20sec (range 5 sec - 55 sec) with the device. Margin re-excision intra-operatively was 38.6%, re-operation for cavity shave 14.3%, and completion mastectomy rate 7.1%.

Conclusion:

The initial experience of IOSR at WDHB has been positive, with reduced operative times and re-excision rates are within the expected range.

References:

Veronesi, Umberto, et al. "Twenty-year follow-up of a randomized study comparing breast-conserving surgery with radical mastectomy for early breast cancer." New England Journal of Medicine 347.16 (2002): 1227-1232.

Fisher, Bernard, et al. "Twenty-year follow-up of a randomized trial comparing total mastectomy, lumpectomy, and lumpectomy plus irradiation for the treatment of invasive breast cancer." New England Journal of Medicine 347.16 (2002): 1233-1241.

Moran, M., Schnitt, S., Giuliano, A., Harris, J., Khan, S., Horton, J., Klimberg, S., et al. Society of Surgical Oncology – American Society for Radiation Oncoogy Consensus Gudeline on Margins for Breast-Conserving Surgery With Whole-Breast Irradiation in Stages I and II Invasive Breast Cancer (2014). Annals of Surgical Oncology. 21(3): 704-716.

NICE (2009). Early and locally advanced breast cancer: diagnosis and treatment. Retrieved from https://www.nice.org.uk/guidance/cg80

Wang Y, Ebuoma L, Saksena M, Liu B, Specht M and Rafferty E. Clinical Evaluation of a Mobile Digital Specimen Radiography System for Intraoperative Specimen Verification (2014). American Journal of Roentgenology. 203(2): 457-462

Acute Appendicitis As The First Manifestation Of Colorectal Carcinoma

Rebecca Waters, Royal Australasian College of Surgeons
Dr Rebecca J Shine*, Dr Abigail Zarifeh**, Mr Jeremy Rossaak***
* MBChb, SET trainee, Royal Australasian College of Surgeons. Registrar General Surgery, Bay of Plenty DHB.
** MBChB, House Officer – Bay of Plenty DHB
*** FRACS, MBChB, Consultant Upper Gastrointestinal and General Surgeon, Bay of Plenty DHB.

Introduction:

New Zealand has a high rate of colorectal cancer. Early diagnosis and prompt treatment are paramount for improved outcomes, though patients presenting with classical signs/symptoms often have advanced disease. While acute appendicitis is more commonly thought to result from benign luminal obstruction it has been suggested that acute appendicitis could be the result of an undiagnosed colorectal malignancy. Thus far, there has been limited research investigating acute appendicitis as the first manifestation of underlying colorectal carcinoma.

Aims:

To establish whether patients ≥ 45 years presenting with acute appendicitis had a higher rate of subsequent diagnosis of colorectal carcinoma than the standardised population rates of colorectal carcinoma in New Zealand.

Methods:

A retrospective single-centre study looking at all patients ≥ 45 years with a proven diagnosis of acute appendicitis from the Bay of Plenty DHB electronic database, from 2003 to 2015 inclusive. Rates of colorectal carcinoma in the 36-month follow up period were compared to standardized rates of colon cancer as per the New Zealand cancer registry.

Results:

Of the 629 patients included in this study, 15 were diagnosed with colorectal carcinoma during the follow up period. Patients ≥ 45 years had a 6.3 (CI 3.6-10.2) fold increased risk of colorectal carcinoma when compared to age, gender and ethnicity standardised rates. Patients aged between 45 - 60 years had a 17 fold (CI 8-32.2) increased risk of colorectal carcinoma.

Conclusion:

The authors conclude the increased rates of colon cancer in this study population indicate a full colonic evaluation should be performed for all patients 45 years and over following an admission with acute appendicitis.

Regional Recurrence After Sentinel Node Biopsy Alone - Analysis Of New Zealand Breast Cancer Registry Data.

Fraser Welsh, Southern DHB
F Welsh*, R Shirley**, A Pillai***, Carl Dowle****, I Campbell*
* Department of Surgery, Waikato Hospital
** Waikato Breast Cancer Trust
***Auckland University
**** Department of Surgery, Hutt Hospital

Introduction:

Sentinel node biopsy (SNB) is established in New Zealand as a method for staging the clinically node-negative axilla in breast cancer. Its use is well supported from overseas trials, with low regional recurrence rates despite false negative rates of 5-10% of women with positive nodes. However local data is less extensively studied, and the impact of tumour biology and adjuvant treatment on outcome after SNB remains uncertain. These factors could potentially influence surgical treatment decisions.

Aims:

To determine the regional recurrence rate following SNB alone in New Zealand using data from four existing breast cancer registries in Auckland, Waikato, Wellington and Christchurch and identify any tumour and treatment related factors that may indicate increased risk of recurrence.

Methods:

Prospectively entered data from each registry since inception was collected for all patients undergoing SNB without axillary dissection for breast cancer. Demographic details, surgical details, primary tumour features, sentinel node findings, adjuvant therapy and outcomes were recorded in a combined database. Statistical analysis was performed by one investigator.

Results:

5931 patients were included. Regional recurrence occurred in 63 patients (1.1%) at a median follow up of 4 years 11 months. Regional recurrence occurred in 5/308 patients with positive SNB findings (1.6%) and 58/5623 without (1.0%). Neither positive SNB findings (p=0.25), Tumour Size (p=0.98), Grade (p=0.99), ER status (p=0.98), PR status (p=0.97), Her2 status (p=0.95), adjuvant radiotherapy (p=0.96), chemotherapy (p=0.96), endocrine therapy (p=0.96) nor adjuvant herceptin (p=0.98) correlated with regional recurrence in univariate analysis.

Conclusion:

Low incidence of regional recurrence (1.1%) is observed in New Zealand patients having sentinel node biopsy as their only axillary surgery for breast cancer. This study did not detect any tumour or treatment related risk factors for regional recurrence.

The assistance of the New Zealand Breast Cancer Foundation and the Cancer Society (Waikato/BOP division) is gratefully acknowledged.

POSTER ABSTRACTS

The Posters below will not be considered for the Poster Awards

Does Remoteness Of Domicile Affect Length Of Stay In An Enhanced Recovery After Surgery (ERAS) Setting?

Tacey Barnes, Registrar, Southern DHB
T. Barnes*, A. Patton*, J McCall*.
* Department of General Surgery – Dunedin Hospital, Southern DHB

Introduction:

Enhanced Recovery After Surgery (ERAS) programs have been shown to reduce length of stay by up to 3 days (1). Dunedin hospital services a large geographic area and there may be a tendency to keep patients in hospital longer after major surgery if they live remotely. We hypothesised that day stay after surgery may be influenced by remoteness of domicile from Dunedin Hospital.

Aims:

To establish whether distance of discharge location from surgical service affects length of stay following elective colorectal surgery in an ERAS setting.

Methods:

A retrospective review of a prospectively maintained ERAS database was performed on patients admitted for elective colorectal surgery (including closure of stomas) between November 2012-July 2015. Distances from hospital site to home, via road, were calculated for all patients using Googlemaps and divided into city residents or outside the city boundary.

Results:

A total of 461 patients were included; 265 within the city and 196 from outside the city boundary. The median length of stay prior to the introduction of ERAS was 9 days, and reduced to 7 days by 2014-15 (p=0.001). Patient characteristics were similar for city versus out of city residents. The median length of stay for city residents was 8 (range 2-64) days, and for more remote domicile was 8 (range 3-31) days. There was no significant difference based on distance from Dunedin Hospital.

Conclusion:

The length of stay was not different for patients living inside and outside the city boundary. Since the introduction of an ERAS program the length of stay has declined and is now a median of 2 days less than pre-ERAS.

References:

Spanjersberg W, Reurings J, Keus F, van Laarhoven C. Fast track surgery versus conventional recovery strategies for colorectal surgery (Review). Cochrane Collab [Internet]. 2011 [cited 2015 Dec 11];(2). Available from: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007635.pub2/full

C-reactive Protein Measurement Is Not Associated With An Improved Management Of Acute Cholecystitis: A Plie For A Change.

Andrei Belyaev, Cardiothoracic Surgical Registrar, Auckland City Hospital
Beliaev AM*, Booth M**
* Cardiothorarcic Surgical Unit, Auckland City Hospital, Auckland, New Zealand
** Department of General Surgery, North Shore Hospital, Auckland, New Zealand

Introduction:

The diagnosis of acute cholecystitis (AC) is challenging and may result in a delay in surgical treatment and increased mortality. The 2007 and 2013 Tokyo Guidelines for AC proposed to use C-reactive protein (CRP) as an additional bench mark of AC. The aim of this study was to evaluate whether CRP measurement influences management of patients with AC.

Methods:

For more than a period of 5 y (May 2004 to June 2009), 1959 patients were identified from the audit of cholecystectomies in North Shore, Waitakere and Southern Cross hospitals at Waitemata District Health Board, Auckland, New Zealand. The exclusion criteria were elective and private patients, patients without AC on histologic examination of gallbladders, and patients with acute acalculous cholecystitis.

Results:

A total of 414 patients met eligibility criteria. Compared with the non-CRP group, patients who had CRP measured had a longer time to operation theater and a greater proportion of acute gangrenous cholecystitis on histologic examination of excised gallbladders, but similar postoperative complication rate, index, and total hospital stay. Time to operation theater was not associated with development of acute gangrenous cholecystitis (odds ratio, 1.0; 95% confidence interval, 0.996-1.01; P = 0.797), but correlated with the index hospital admission length (correlation coefficient, 0.6092; P < 0.001).

Conclusions:

CRP measurement does not influence management of patients with AC. To improve quality of care and to minimize health care provider costs physiologically fit patients with more advanced forms of AC and higher values of CRP should have their operation performed earlier than patients with mild AC and a lower concentration of CRP.

References:

1. Hirota, M., Takada, T., Kawarada, Y. et al, Diagnostic criteria and severity assessment of acute cholecystitis: Tokyo guidelines. J Hepatobiliary Pancreat Surg. 2007;14:78
2. Yokoe, M., Takada, T., Strasberg, S.M. et al, TG13 diagnostic criteria and severity grading of acute cholecystitis (with videos). J Hepatobiliary Pancreat Sci. 2013;20:35 ([Practice Guideline]).

Late Two-Stage Laparoscopic Cholecystectomy Is Associated With An Increased Risk Of Major Bile Duct Injury

Andrei Belyaev, Cardiothoracic Surgical Registrar, Auckland City Hospital
Beliaev AM*, Booth M**
* Cardiothorarcic Surgical Unit, Auckland City Hospital, Auckland, New Zealand
** Department of General Surgery, North Shore Hospital, Auckland, New Zealand

Introduction:

Late laparoscopic cholecystectomy (LC) after endoscopic retrograde cholangiopancreatography (ERCP) and sphincterotomy (ES) for common bile duct (CBD) stone clearance, two-stage LC (TSLC), is associated with difficult surgical dissection and an increased rate of conversion to open procedure. The aim of the study was to evaluate whether the interval between ERCP/ES and LC is associated with major bile duct injury (BDI) and determine an optimal period for TSLC.

Methods:

This was a retrospective cohort study of adult patients who underwent LC. The exclusion criteria were absence of CBD stones on imaging or ERCP, surgical treatment of choledocholithiasis, post-operative endoscopic CBD stone clearance and open cholecystectomy.

Results:

The eligibility criteria were met by 183 patients. There were six major BDIs (3%). Comparisons of the early and late TSLC showed statistically significant difference in major BDI at 16-week cut-offs. Binomial regression analysis demonstrated that late (≥16 weeks) TSLC was associated with 10-fold increase in major BDI (95% confidence interval: 1.1-95.7, P = 0.043). Survival analysis comparing early (<16 weeks) with late (≥16 weeks) TSLC demonstrated that both groups had similar survival time (log-rank test: p=0.317).

Conclusion:

General surgeons should be aware of the increasing risk of major BDI with delaying TSLC and perform interval LC before week 16.

Reference:

1. Lu J, Cheng Y, Xiong XZ, Lin YX, Wu SJ, Cheng NS. Two-stage vs single-stage management for concomitant gallstones and common bile duct stones. World J. Gastroenterol. 2012; 18: 3156-3166.
2. Reinders JS, Kortram K, Vlaminckx B, van Ramshorst B, Gouma DJ, Boerma D. Incidence of bactobilia increases over time after endoscopic sphincterotomy. Dig. Surg. 2011; 28: 288-292.

Surfboard Related Injuries Presenting To The Gold Coast Hospital With Illustrative Medical Imaging.

Robyn Coombe, General Surgeons Trainee, Royal Australasian College of Surgeons

RF Coombe (MBBS)*, PP Eriksen (MBBS)**, C Buchan (MBBS, FRANZCR)***

* Department of Surgery, Lyell McEwin Hospital, South Australia, Australia

**Department of Radiology, The Queen Elizabeth Hospital, South Australia, Australia

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Introduction:

The introduction of the leg rope in the 1970's has resulted in a new pattern of surfing related injuries that occur when the surfer comes into contact with their own board1. Wave conditions are generally dependent on environmental factors such as wind strength and direction and the seascape over which the wave breaks. For surfers, these conditions also dictate the possible risk of injury2. Little long-term data exists that examines the prevalence and patterns of injury in large groups of professional or amateur surfers.

Aims:

To identify the severity and types of surfboard related injuries presenting to the Emergency Department of the Gold Coast Hospital Health Service (GCHHS) in the Gold Coast, Queensland, Australia; a coastline famous for its world-class waves and surfers.

Methods:

Retrospective cohort study of all surfboard related injuries with illustrative medical imaging examples. Outcomes measured include patient demographic, injury location, type and severity, admissions and required intervention.

Results:

610 cases were identified over a 30-month period. The head and lower limbs were the most commonly injured body parts with the most common injury being lacerations and soft tissue injuries. Severe injury patterns requiring admission occurred in 9% of the cohort.

Conclusion:

Our research provides a descriptive account of surfboard related injury type and severity providing clinicians with improved understanding of the range and, perhaps more importantly, the frequency and trajectory of surfboard related injuries. This aids in appropriate investigation and timely management of such injuries and ensures treating clinicians have an appropriate suspicion of serious pathology.

References:

1. Nathanson A, Haynes P, Galanis D. Surfing Injuries. Am J Emerg Med 2002 May;20(3):155-60.
2. Nathanson A, Bird S, Dao L, et al. A Prospective Study of Surfing- Related Injuries Among Contest Surfers. Am J of Sports Med 2007;35(1):113-17.

PEG Insertion - An Experience From Two Peripheral Hospitals

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Introduction:

Percutaneous endoscopic gastrostomy (PEG) can provide a useful route for enteral feeding. Their insertion is a common request to the general surgeon in peripheral hospitals.

Aims:

To review the experience with PEG insertion from two New Zealand peripheral hospitals over a 3 year period.

Methods:

All patients who underwent PEG insertion at Whangarei Hospital and Taranaki Hospital between January 2012 and December 2014 were identified from an electronic database and hardcopy logbook.
The electronic records were reviewed and demographic information, indication for insertion, complications, and mortality information collected.

PEG tube exchanges were excluded.

Results:

76 patients had PEG insertions over the study period (29 patients from Whanagarei and 47 from Taranaki). The mean age was 67 years with the majority of patients being male (70%) and New Zealand European (84%).
The majority of PEGs were inserted for oropharyngeal cancer, neurological disorders and dysphagia.
The most common complication identified was stomal site infection which occurred in 7 patients (9%). 2 Patients (2.6%) had re-admissions for abdominal pain and 2 patients (2.6%) developed pneumonia following PEG insertion.

There were no cases of peristomal leakage or complications related to bleeding recorded.
The complication rates are similar to those reported in the literature.
All cause mortality was assessed with 46 deaths to date. 10 patients died within 1 month of PEG insertion (13%). 29 patients died within 6 months of PEG insertion (38%) and 38 patients died within 1 year of PEG insertion (50%).

Conclusion:

A surgeon led PEG insertion service can be safely provided in peripheral hospitals. PEG site infection was the most common complication and therefore we advocate for the use of prophylactic antibiotics prior to PEG insertion.

We also identified high mortality rates in these patients and we therefore advocate for a multi-disciplinary team decision (which involves surgeon input) to decide on the appropriateness of PEG insertion.

Laparoscopic Completion Cholecystectomy For Remnant Gallbladder Following Prior Incomplete Cholecystectomy

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Introduction:

Persistent upper abdominal pain following cholecystectomy has many possible causes. Recurrent cholelithiasis

is a recognised outcome of subtotal cholecystectomy, in which an incomplete resection is intentionally performed due to concerns of safety of further dissection in the setting of a difficult gallbladder. A separate entity exists and remains poorly recognised, in which inadvertent incomplete resection results in a remnant gallbladder that may become recurrently symptomatic.

Aims:

The aim of this study is to present the largest case series to date describing symptomatic remnant gallbladder requiring completion surgery. Additionally, it aims to discuss technical pitfalls that may contribute to this condition, and to propose standard terminology to differentiate between the complications of intentional subtotal cholecystectomy and inadvertent incomplete cholecystectomy

Methods:

A prospectively maintained database was reviewed for patients who underwent completion cholecystectomy of a remnant gallbladder, performed by a single surgeon (KSH) between 2011 and 2015. Further details were obtained by review of the medical record and related correspondence.

Results:

Seven patients underwent laparoscopic completion cholecystectomy of a remnant gallbladder. All 7 patients had previously undergone an intended cholecystectomy for acute cholecystitis, performed by different surgeons. Five of these procedures where via laparoscopic approach, while 2 were performed as open surgery. A difficult dissection was recognised in only one case, which was described as a “near complete” open cholecystectomy. The remaining 6 cases were reported as complete and uncomplicated cholecystectomy.
Subsequent laparoscopic completion cholecystectomy and intraoperative cholangiogram identified cholelithiasis in a remnant gallbladder in all 7 cases. All patients made uneventful recoveries and had successful resolution of symptoms.

Conclusion:

Remnant gallbladder with associated cholelithiasis or cholecystitis is an under recognised complication of subtotal and incomplete cholecystectomy. Although uncommon, this diagnosis should be considered in any patient with recurrent biliary symptoms following cholecystectomy.

A Review Of The Australian Experience Of Microwave Ablation (MWA) Of Liver

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Introduction:

Hepatocellular carcinoma (HCC) accounts for 90% of primary liver cancers1. The liver is also the second most common site of metastatic disease2. Several thermal ablation techniques have been developed to achieve local control of unresectable primary or secondary liver tumours

Aims:

The aims of our study were to evaluate 1) the efficacy and safety of microwave ablation (MWA) of liver tumours guided by intra-operative ultrasound (US) and 2) local recurrence and overall survival.

Methods:

Between February 2009 and November 2014, 34 patients (6 women and 28 men) with a total of 63 liver tumours were treated with open (n =14) or laparoscopic (n = 20) US-guided MWA. Clinicopathological data and outcomes were prospectively collected in order to determine efficacy, safety, local recurrence and overall survival.

Results:

The primary tumours were colorectal cancer (n =9), hepatocellular carcinoma (n =32) and neuroendocrine/carcinoid (n = 22). The median size of the ablated tumours was 16.5 mm (range, 4-52 mm). The median number of ablation cycles was 1.25 (range, 1 -3 cycles) and median ablation time 6 min (range, 3 - 12 min). The technical success rate was 100 %. The radiological effectiveness was 91.2 % with complete coverage of the tumours by an avascular coagulation zone evaluated on computer tomography 4 weeks post-ablation. The length of stay in the laparoscopic group was 2.1 days (range: 1-8) versus 6 days (range: 3-10) for the open group. There was no 30-day mortality and peri-operative morbidity was 2%. During a median follow up of 16 months (range: 1-64 months), 5 patients had died from their disease and local recurrence was seen in 14.7% of the 63 treated metastases.

Conclusion:

US-guided MWA of liver tumours is an efficient and safe ablation technique with low morbidity and mortality rates in Australia.

References:

1. Swan, R.Z. et al., 2013. Operative microwave ablation for hepatocellular carcinoma: complications, recurrence, and long-term outcomes. Journal of gastrointestinal surgery : official journal of the Society for Surgery of the Alimentary Tract, 17(4), pp.719-729. Available at: http://link.springer.com/10.1007/s11605-013-2164-y.
2. Vogl, T.J. et al., 2014. Thermal ablation of liver metastases from colorectal cancer: radiofrequency, microwave and laser ablation therapies. La Radiologia medica, 119(7), pp.451-461. Available at: http://link.springer.com/10.1007/s11547-014-0415-y.

Intestinal Malrotation Presenting In Adulthood: A Retrospective Review

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Introduction:

Intestinal malrotation has until recently1 been considered a diagnosis of infancy. However, over the last decade an increasing number of patients have presented to Waikato Hospital in adulthood.

Aims:

The purpose of this study was to investigate the presentation and management of intestinal malrotation in adults compared to that of the paediatric population.

Methods:

A retrospective review of all patients diagnosed with intestinal malrotation at Waikato Hospital from 2005-2015 was performed. The following data was collected; Age, presentation, diagnostic modality, operative procedure, outcome, time between symptom onset and diagnosis, and time between diagnosis and definitive treatment. Patients were divided into two age groups; Paediatric (<15 years) and Adult (≥15 years).

Results:

21 patients were included, 11 paediatric and 10 adults. Paediatric cases presented fairly uniformly within days of symptom onset. The adult cases in contrast had a bimodal distribution and were either diagnosed within one week, or presented with a much longer duration of vague symptoms. Paediatric cases were usually diagnosed with UGI contrast study and adults with CT. However in both groups (~50%) of cases were diagnosed intraoperatively. The rate of operative intervention was higher in the paediatric population (100%-vs-70%) for adults. Furthermore surgical intervention at the time of first diagnosis was higher in paediatric cases (90%-vs-30%) for adults. Complete resolution of symptoms after first surgical intervention was similar in both groups (73%-vs-71%).

Conclusion:

We found that a significant proportion of patients were diagnosed in adulthood. Adults wait longer from symptoms to diagnosis, and operative intervention at diagnosis is performed less frequently in adults with comparable rates of post-operative symptom resolution. The small study size makes recommendations difficult; however surgical intervention for adults presenting with symptomatic malrotation in the absence of a competing diagnosis should be considered.

References:

Intestinal malrotation: Varied clinical presentation from infancy through to adulthood. Nehra D, Goldstein AM. Surgery 2011;149(3):386.

Surveillance After Breast Reconstruction For Breast Cancer - Is Imaging Necessary?

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Introduction:

There is no consensus in regards to surveillance of women after mastectomy and reconstruction for breast cancer. Mammographic detection rates are low for surveillance after reconstruction and whilst there is insufficient evidence to support annual mammography in these women, there is widespread variation in its use.

Aims:

We aimed to investigate the mode of detection of recurrent disease and comment on the use of surveillance mammography in our population of women undergoing mastectomy and reconstruction

Methods:

Data were retrieved from the Auckland Breast Cancer Registry (ABCR). All women with recurrence after mastectomy and reconstruction between 2000 – 2013 were identified from the database. Clinical records were reviewed for type of reconstruction, site of recurrence and mode of detection.

Results:

1565 women underwent mastectomy and reconstruction. There were 224 locoregional or distant recurrences. There were 54 women with LRR (3.4%) and 134 with distant disease (8.5%). Of all women with LRR, 51 women (94%) presented with a palpable mass and the remaining 3 women had their recurrence detected on mammography. They had DCIS in their original histology. Only 16 of the 54 women had at least one surveillance mammogram. 12 of 16 women had a normal mammogram less than 9 months prior to diagnosis of recurrent disease.

Conclusion:

There is no evidence to support regular mammographic surveillance after mastectomy and reconstruction. We advocate a careful history and examination with targeted imaging.

References:

1. Freyvogel M, Padia S, Larson K, Dietz J, Grobmyer S, O'Rourke C, Valente S. Screening Mammography Following Autologous Breast Reconstruction: An Unnecessary Effort. Ann Surg Oncol. 2014; 21: 3256-3260
2. Schneble EJ, Graham LJ, Shupe MP, Flyn FL, Banks KP, Kirkpatrick AD, Nissan A, et al. Current Approaches and Challenges in Early Detection of Breast Cancer Recurrence. Journal of Cancer. 2014; 5(4): 281 - 290

Emergency Laparotomy In Cardiovascular Intensive Care Unit At Auckland City Hospital

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Introduction:

Abdominal complications from post cardiac surgical patients in the Cardiovascular Intensive Unit (CVICU) are often critical. Mesenteric ischaemia is an important differential diagnosis. At Auckland City Hospital, Acute General Surgeons provide the surgical expertise in performing emergency laparotomy, on demand. The aims of this study are to audit the outcomes of CVICU surgical patients requiring emergency abdominal surgery and gain understanding of the surgical pathology.

Methods:

CVICU patients who had cardiothoracic procedures with laparotomy from January 2013-March 2015 were included in the audit. Patients' demographics, type of cardiac/abdominal operations and clinical outcomes were collected retrospectively using ADHB Concerto and PiMS systems.

Results:

36 patients had 61 laparotomy events performed during the study period. Median age was 69. The M:F ratio was 7:2. Median LOS for the surviving patients was 21 days. The index cardiothoracic operations were: 8 CABG, 4 valve replacement, 8 mixed, 9 others and 5 thoracic operations. Median number of laparotomies per patient was 1.8. 36% of patients required bowel resection. The resected bowel pathology was reported as full-thickness ischemia; however the causes (emboli, global hypoperfusion, microvascular occlusion or portal vein occlusion) remain elusive. 70% of laparotomy patients underwent primary closure with 30% temporary laparostomy either due to high intra-abdominal pressure or planned re-look. Abdominal CT's were performed pre-operatively in 50% of patients. Others went directly to theatre due to clinical complications. Pre-operative CT predicted bowel ischemia accurately in 83% of patients. Mortality in those that underwent bowel resection was 58.3%.

Conclusion:

Overall mortality was high in CVICU patients who required emergency laparotomy, in particular those requiring bowel resections. The pathology of full thickness bowel ischaemia was common however the causes remained unclear. Most patients went for a laparotomy without CT scans. When performed, abdominal CT provided a good diagnostic tool and correlated well with laparotomy findings.

A Modern Review Of Post-Operative Infection At The University Hospital, Geelong

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Introduction:

Surgical intervention carries a risk of infection despite preventative measures and can cause significant morbidity and mortality. There is limited literature reflecting modern trends in pathogen prevalence and resistance profiles particularly on a regional basis.

Aims:

To evaluate surgical patients with post-operative infections within Geelong Hospital to recognise the causative agents and improve patient outcomes.

Methods:

A retrospective analysis of the General Surgery Units including HPB/Upper GI from 2010 -2015 capturing patients with post-operative infection at the University Hospital, Geelong. Patients were tracked utilising ICD-10 code T81.4. The dataset included demographics, duration of stay, index admission outcome and microbiological profile. Patients with positive micrology results but were deemed to be colonised were excluded. Statistical significance was deemed with p- value < 0.05.

Results:

Thirty-nine patients (8.4%) were identified with post-operative infection amongst 467 general surgical patients. There were 24 males (62%) and 15 female patients (38%) with a median age of 61 (± 15.8) years. Median hospital stay was found to be 24 (± 50.5) days in patients with a post-operative infection compared to 9 (±27.7) days in those without ($p < 0.0001$). The most prevalent pathogen was Candida Albicans in 13% of patients followed by Escherichia Coli (E. coli) in 8%. All isolated E. coli were only resistant to amoxicillin.

Conclusion:

Post-operative infection led to a significantly longer index hospital admission. Candida albicans and amoxicillin-resistant E. coli were the commonest agents. Earlier sampling of the source and subsequent targeted treatment should be emphasised to improve care and outcomes.

Patient Perspectives About Follow-Up Care And Weight Regain Following Sleeve Gastrectomy

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Introduction:

Weight regain following sleeve gastrectomy is an increasingly recognised and important problem. Similar to other centres, we have noticed an association between the onset of weight regain and discharge from the bariatric service.

Aim:

To elucidate the patients' perspective around follow-up care and weight regain following sleeve gastrectomy.

Methods:

Patients at least two years from sleeve gastrectomy, who had experienced weight regain, were invited to participate in a focus group discussion. Participants were asked to complete a demographic survey and discussions were audio-recorded. Transcripts underwent content analysis using an inductive approach.

Results:

Thirty-eight participants participated in one of seven focus group discussions. The majority of participants were female, European and satisfied with the surgery and follow-up care. Participants described positive and negative aspects of the surgery, their follow-up care and causes of weight regain. Important emergent themes included the desire for more support that is delivered within the overarching principles of providing individualised, specialised care by providers that maintain good rapport and assist in maintaining motivation. Furthermore, this follow-up support may be delivered in non-traditional ways rather than conventional face-to-face consultations.

Conclusion:

Explorative focus group discussions in a group of patients who had regained weight following sleeve gastrectomy revealed a desire for more support after discharge from the bariatric service. Information obtained from this study will be useful in developing follow-up pathways acceptable to bariatric patients.

Impact Of Pre-Operative Imaging On The Clinical Outcome Of Emergency Department Patient With Suspected Appendicitis

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Introduction:

There has been increased utilization of imaging in the management of appendicitis. Computed tomography and ultrasound have been shown to improve diagnostic accuracy compared with clinical judgement alone. However the impact of imaging on clinical outcomes is less clear, especially in the setting of the Emergency Department.

Aims:

In this retrospective study, we aim to compare the clinical outcomes of adults with suspected appendicitis in whom imaging was used with those who were managed based on clinical indicators alone.

Methods:

In the 6 months from January to June 2013, the records of all patients in Auckland City Hospital adult emergency department referred to General Surgical service for suspected appendicitis were assessed. Patients were divided into two groups - those in whom imaging was performed and those who had no imaging.

Results:

206 patients were included in this study with a mean age of 33.3 years; 63% female. Pre-operative imaging decreased the rate of negative operations (8.3% vs 24.6%, p=0.025). Imaging did not improve post-operative outcomes, but was associated with a decreased 30 day-readmission rate for patients in whom operation was not considered necessary (11.5% vs 28.6%, p=0.031). A subgroup of clinically assessed male patients, who were not imaged, also had a particularly low negative appendicectomy rate (7.4%).

Conclusion:

In patients with suspected appendicitis referred from ED, pre-operative imaging was associated with a reduced negative appendicectomy rate, particularly in women but was not associated with improved post-operative outcomes.

References:

1. Markar SR, Karthikesalingam A, Cunningham J, et al. Increased use of pre-operative imaging and laparoscopy has no imapct on clinical outcomes in patients undergoing appendicectomy. Ann R Coll Surg Engl. 2011;93(8):620-3.
2. Lahaye MJ, Lambregts DM, Mutsaers E, et al. Mandatory imaging cuts costs and reduces the rate of unnecessary surgeries in the diagnostic work-up of patients suspected of having appendicitis. European Society of Radiology. 2015;25(5):1464-70.

Predictors Of Non-Sentinel Lymph Node Metastasis Post Axillary Dissection In Breast Cancer - A Study Of A Population In The Wellington Region

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Introduction:

Axillary lymph node dissection (ALND) when compared to Sentinel lymph node biopsy (SLD) carries with it more

risk and potential comorbidities which includes lymphedema, paresthesia, pain, and limiting shoulder movement. The ACOSOG Z011 trial has shown that in T1 or 2 tumours, there was no survival benefit in ALND compared to SLD in their short follow up period. The proposed algorithm from the Z011 trial suggest that perhaps that may be certain population, if selected, that might benefit from a limited/ Sentinel lymph node dissection.

Aims:

Aim of the study was to determine, in a real world scenario, if any particular factor could predict of predispose a patient to have other positive nodes that were not identified radioactively and required to have a complete axillary dissection. The ability to stratify these patients will allow us to better select (and reduce) those that require complete dissection.

Methods:

Retrospective study on all patient who have had a Sentinel Lymph node biopsy and a completion Axillary dissection in Wellington Hospital for a 5 year period from 2010 to 2014. Data was obtained from a breast database. Potential predictive factors included were age >50 years, grade of tumour, extranodal extension, lymph node invasion, size of tumour >2mm, size of metastasis > 2mm, and Hormone receptor status. Primary outcome was the presence of additional node involvement.

Results:

The results of 83 patients were analysed for this study. Size of the metastasis >2mm (OR3.66, 95% CI 1.03- 13) and Size of the primary cancer >20mm (OR17.05 95% CI,2.35 to124.0) were predictive of having additional nodes. More than 50 years of age, having more than 1 sentinel node, Extranodal extension, lymphovascular invasion, and the grade of tumour did not increase the chances of having additional lymph node metastasis. Receptor analysis result is pending.

Conclusion:

The sizes of both the primary cancer >20mm and the size of the metastasis were predictive of the presence of additional node involvement. More studies are needed to investigate this to further determine if there are further predictors to help us select patient in which ALND could be avoided.

References:

Giuliano AE, Hunt KK, Ballman KV, Beitsch PD, Whitworth PW, Blumencranz PW, Leitch AM, Saha S, McCall LM, Morrow M. Axillary dissection vs no axillary dissection in women with invasive breast cancer and sentinel node metastasis: a randomized clinical trial. JAMA. 2011 Feb 9;305(6):569-75. doi:10.1001/jama.2011.90. PubMed PMID: 21304082.

Outcomes Of Below Knee Endovascular Interventions

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Introduction:

Endovascular intervention is increasingly important for treating claudication, tissue loss and for limb salvage. The angiosome concept, where a discrete anatomic unit of tissue fed by a source artery, has been borrowed from plastic surgery and is useful to identify target vessels. There is limited data regarding the outcomes of such endovascular interventions below the knee.1

Aims:

Assess below knee vascular disease in a regional population.
Determine the short and long term effectiveness of endovascular interventions.
Assess the complications of interventions.

Methods:

This was a retrospective review of all patients with below-knee vascular interventions at Cairns base hopsital from June 2014 to October 2015. Patient demographics, angiographic findings, interventions, immediate patency and longer term limb/wound outcomes and complications were recorded.

Results:

There were 32 patients and 42 procedures were performed. Tissue loss was present in 60% of cases with acute ischaemia (19%) and claudication (17%) being less common. Three vessel disease (52%) was more common than 2 vessel (31%) and single vessel (17%) disease. Vascular disease proximal to the knee was common (67%). Treatment below the knee was predominantly via angioplasty with 2 patients requiring stenting for recurrent recoil. Angiosome directed therapy was completed in all patients with vascular wounds. This was primarily in 70% of cases , with 68% of these achieving longer term wound healing. Treatment of acute ischaemia was successful in 7 out of 8 patients and intermittent claudication was successful in all cases.

Groin haematoma was the most common complication (3 cases) and resolved with pressure.

Conclusion:

Endovascular intervention was safe and effective for below knee vascular disease in this group.

References:

1. Siracuse, J. Gill, H. Cassidy, S. et al. J Vasc Surg. 2014 Aug; 60(2):356-361.

Day Case Laparoscopic Cholecystectomy At A Rural Hospital

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Introduction:

Patients undergoing elective laparoscopic cholecystectomy (LC) generally have an overnight stay due to post-operative pain, nausea and vomiting. Day-case surgery, while reducing the financial burden on the health care system, may also offer patients more comfort by being able to recuperate in their own environment. Day-case elective LC has been shown to be safe in select patient groups with an unanticipated admission rate of 3.4% to 24.3%1-2. Establishing a surgical service in a rural hospital is of benefit both to the patient, who has the convenience of being in close proximity to the hospital, but also the hospital staff, who are able to establish and maintain skills. There are no reports of routine day-case laparoscopic cholecystectomy at a rural hospital.

Aim:

The aim of the study was to assess the outcomes of day-case laparoscopic cholecystectomy at Beaudesert Hospital, a 40-bed hospital 70km southwest of Brisbane, QLD.

Methods:

All patients admitted consecutively under the care of one surgeon at Beaudesert Hospital were included in the study over a two-year period. Patients were referred to the surgical outpatient clinic by their General Practitioner, and a decision regarding suitability for day case laparoscopic cholecystectomy was determined by the operating surgeon.

Results:

Between October 2013 and November 2015, there were 51 laparoscopic cholecystectomies performed at Beaudesert Hospital by one general surgeon. 38 patients were female, 13 were male. 49 patients had a history of typical biliary colic. Median BMI was 27, and ASA 2 (range 1-2). Nasser Grade 1 operative difficulty was encountered in 20 operations, Grade 2 in 19, and Grade 3 in 12. Post-operatively there were no major

complications. A retained CBD stone was encountered in one patient. Median length of stay was 5.5 hours. Three patients required overnight admission for nausea, vomiting, or pain.

References:

1. Fleming, W.R., I. Michell, and M. Douglas, Audit of outpatient laparoscopic cholecystectomy. Universities of Melbourne HPB Group. Aust N Z J Surg, 2000. 70(6): p. 423-7.
2. Lau, H. and D.C. Brooks, Predictive factors for unanticipated admissions after ambulatory laparoscopic cholecystectomy. Arch Surg, 2001. 136(10): p. 1150-3.

Breast Cancer Treated In The Taranaki Region 2003-2009

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Introduction:

Breast Cancer is an important disease in New Zealand, with a significant number of patients receiving their treatment in rural centers. Taranaki is a rural province in New Zealand where breast cancer is treated by general surgeons with oncology services provided by a regional service.

Aims:

The aim of this study was to compare the outcomes of patients treated in a rural New Zealand center with local and regional standards.

Methods:

A retrospective audit of all patients presenting to secondary care in Taranaki for breast cancer treatment between Jan 1 2003 and Dec 31 2009.

Results:

Overall 5 year survival of all patients presenting with breast cancer was 78.7%. Disease specific survival was 83.4%. Of those presenting with early breast cancer, overall 5 year survival was 85.1% and disease specific survival was 87.7. Patients were more likely to undergo mastectomy over breast conserving surgery.

Conclusion:

Breast cancer can safely be treated in a regional center in New Zealand. Patients may elect to undergo mastectomy as opposed to breast conserving surgery with radiotherapy due to the need to travel.

Chest X-ray And Vital Signs Are Poor Predictors Of A Significant Blunt Thoracic Aortic Injury - 11 Year Experience At A Level I State Trauma Centre

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Introduction:

Blunt Thoracic Aortic Injury (BTAI) is a severe, potentially life-threatening injury. There is a significant variability in clinical presentation of BTAI and a missed injury can be catastrophic. Appropriateness of the diagnostic computed tomography arteriography in clinically stable patients is a matter of debate.

Aims:

To analyse presentation, management and outcomes of BTAI over a 11 year period and to determine the frequency of significant BTAI in patients with normal vital signs and admission chest x-ray (CXR).

Methods:

All patients with BTAI presented to a level 1 trauma centre from 2003 to 2013 were included in a retrospective analysis of the prospective trauma database.

Results:

A total of 66 patients with BTAI were identified, with a mean Injury Severity Score of 38. BTAI was managed in 62 of these (3 died of other injuries, and 1 was transferred to another centre). Fourteen patients (21.2%) had normal vital signs. 62 patients had a CXR and in nine (14.5%) it was normal. 42 (67.7%) patients were managed endovascularly, 16 (25.8%) conservatively and 4 (6.5%) had an open repair. 64.3% of patients (9 out of 14) with normal vital signs, and 55.6% patients (5 out of 9) with a normal CXR required a surgical intervention. Overall mortality was 15.2%, with 77.7% of fatalities occurring within 8 hours of arrival to emergency department.

Conclusion:

Normal vital signs and chest x-ray do not exclude BTAIs, including those aortic injuries that necessitate a surgical intervention. CT arteriography scanning of the high-risk patients should be based on the mechanism of injury, rather than on the clinical examination or chest radiographic findings.

Camera Endoscopy In Small Descriptive Study; Audit And Guide To Clinical Practice In Wanganui DHB

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Introduction:

Wireless Video camera endoscopy (CE) is a non-invasive technique to investigate gastrointestinal disorders, most commonly bleeding and iron deficiency anaemia. Despite being an uncommonly requested investigation in our DHB, this small descriptive study was done to primarily audit CE requests.

Aims:

Whether it affects our clinical decision making, and whether an alternative investigation could have been done instead of CE.

Methods:

We analysed data from 28 patients who underwent CE from December 2011 to December 2015, including age, gender, indications for CE, waiting time, prior upper and lower GI endoscopy, CE results, and alternative investigations if considered.

Results:

20 patients (71%) were referred for CE due to anemia, 5 patients (20%) for abdominal pain, and 9% for other cause causes. Average waiting time was two months. Positive findings were reported in 16 patients, there were 16 positive finding (57.1%), with 5 patients had small bowel ulceration, 4 angiodysplasia, 3 with small bowel polyps, three with small bowel inflammation, and one patient with small bowel stricture. 12 patients had normal findings, with four of them requiring further investigations, CT confirmed duodenal cancer (D4) in one patient, small bowel diverticulum in one patient. Complication recorded in one case with camera stuck in small bowel and required surgery for retrieval.

Conclusion:

Our study had limited number of candidates, which did not permit proper statistical analysis. CE were diagnostic in 57.1% of cases but missed one case with cancer and caused a complication in another case. CE has been documented to miss lesions in upper GI and relatively contraindicated in small bowel strictures. We propose a further regional study to gain more data from a larger sample size, and to investigate whether CT should be done before requesting CE, particularly if upper small bowel lesions/strictures were suspected.

References:

1. Pasha SF, Leighton JA, Das A, et al. Double-balloon enteroscopy and capsule endoscopy have comparable diagnostic yield in small-disease: a meta-analysis. Clin Gastroenterol hepatol 2008; 6:671

Systematic Review Of Common Investigation For Chronic Constipation

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Introduction:

Balloon expulsion test (BE), anorectal manometry (ARM) and evacuation proctography (EP) are among commonly used investigations for chronic constipation. Protocols, methodology and interpretation of these tests can vary significantly making it difficult to compare results.

Aims:

To perform a systematic review of the diagnostic yield of BE, ARM and EP.

Methods:

The online database of PUBMED and MEDLINE was searched for relevant manuscripts published as full text articles in English between 1975 and 2014. The search terms used were 'balloon expulsion', 'anorectal manometry', 'defecography' and 'evacuation proctography'. Eligible studies were methodologically scored according to previously published guidelines [1]. Preferred Reporting Items for Systematic Review and Meta-analysis (PRISMA) guidance was followed.

Results:

A total of 1920 patients (16 studies), 1210 patients (13 studies) and 1196 patients (13 studies) were included for BE, ARM and EP respectively. Significant methodological difference precluded a meta-analysis. Among included studies, overall gender ratio was female:male = 10:1. The rate of dyssynergia was 17-79% (median 47.5%) with BE, 22-100% (median 51%) with ARM and 6-52% (median 26%) with EP.

Conclusion:

Similar to previous reports [2], diagnostic yield for dyssynergia was investigation dependant. There is significant heterogeneity among common tests for evacuatory dysfunction which is partly driven by lack of consensus on what should be considered 'abnormal'. Large well designed studies are needed to identify predictors of response to treatment which will help us work towards a gold standard investigation.

References:

1. Lijmer JG, Mol BW, Heisterkamp S, Bonsel GJ, Prins MH, van der Meulen JH, et al. Empirical evidence of design-related bias in studies of diagnostic tests. JAMA 1999; 282: 1061-6.
2. Rao SS, Ozturk R, Laine L. Clinical utility of diagnostic tests for constipation in adults: a systematic review. The American Journal of Gastroenterology 2005; 100: 1605-15.

Planning For Growth In Acute Care General Surgery - Is There A Critical Breaking

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Introduction:

ACGS admissions can increase due to population growth and demographic change.
An ACGS system has both "fixed" (eg: theatre) and "flexible" (eg: staffing) capabilities that are required to manage the average workload and the extremes of daily fluctuations.

Aims:

- To assess the current CMDHB modular acute system using Key Performance Indicators (KPI's)
- To assess the impact of the new surgical assessment unit (SAU) and discharge lounge (DL)
- To use modelling to predict future volumes and daily fluctuations through to 2025

Methods:

KPI's of historical ACGS admission and theatre data were analysed. Current daily fluctuations in admissions were quantified. Projections were made using 2010-2015 as a baseline and utilising NZ census projections for gender, age and ethnicity. A confidential survey of current consultant staff was performed.

Results:

Annual admissions to CMDHB ACGS have increased by 13% from 7873 in 2010 to 8866 in 2015. ACGS now requires 1.35 theatres each day.

Theatre utilisation has increased to 77% and the median length of stay has shortened in three high volume areas. This has been achieved by increasing the number of modules (teams), increasing theatre access and utilisation of SAU and DL.

By 2025 ACGS admissions are predicted to have grown by 34%, reaching 11916. Daily theatre requirement will increase to 1.90.

In 2015 there was a daily mean of 24.3 admissions, with 16% of acute days exceeding 30 admissions. This will increase to 67% by 2025

Conclusions:

The modular system has so far absorbed this growth by increasing flexible components (teams) and fixed components (theatre) and by creating the SAU and DL.
Future growth and daily fluctuations will require both increased "fixed" resources and increased "flexible" resources, including the formation of new teams.

Age Related Incidence Of Mortality Due To Trauma

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Introduction:

Historically the main focus of Trauma presentations has been on young adults given that they makes up a large proportion of the trauma presentations. Recently evidence shows that there is an increasing burden on systems of trauma in the elderly1. This combined with an ageing population2 means the burden will continue to climb.

Aims:

To identify the age specific burden of admission and mortality of trauma on the elderly.

Methods:

Patients were retrospectively identified for the time period 2012-2014 inclusive from trauma coded CTs at Christchurch Hospital. A review of their electronic notes was performed. Admission rate, number and type of injury, ICU admission, type of surgery and mortality were recorded. Age specific rates of admission and mortality were calculated. This was compared to 2013 census data for population by age in the Canterbury District Health Board catchment area2. Age specific incidence of mortality was calculated.

Results:

Annually there was a higher percentage of young (<60 years old) people presenting with trauma, 81.1%, 79.5% and 79.2% of trauma presentations for (2012 to 2014 respectively). The more striking result was when compared with the population data from the 2013 Census the incidence of trauma mortality was much higher in the elderly group; 4.0 vs 1.8, 7.0 vs 1.3, 3.0 vs 1.6 (per 100,000 population for years 2012 to 2014 respectively).

Conclusion:

While we know that high comorbidity results in higher mortality with trauma, the incidence of trauma related mortality is much higher in the elderly. Given that the population is continuing to become more aged and retain the ability to participate in activities that can result in trauma a closer look at how best to manage these patients may need to be considered.

References:

Hashmi A, Ibrahim-Zada I, Rhee P et al. Predictors of mortality in geriatric patients: A systematic review and meta analysis. J Trauma Acute Care Sure. 2014 Mar;(76)3:894-901
2013 Census district health board statistics tables. New Zealand: Statistics New Zealand; 2014 [updated 29 April 2014; cited 1 December 2015]. Available from: http://www.stats.govt.nz/Census/2013-census/data-tables/dhb-tables.aspx

Outcomes Of ERCP - A Series From A Provincial New Zealand Hospital

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Introduction:

ERCP is an essential tool in the management of pancreaticobiliary pathology. It is technically demanding and has the potential to cause significant morbidity and mortality. Several trials have identified small centres and lower hospital volume as a risk factor for lower success rates and higher complication rates.1 Taranaki Base Hospital (TBH) is a provincial hospital with a catchment of 100 000, providing its population with an on-site ERCP service. The nearest tertiary hospital is 240km away and transporting patients would incur significant costs to both the patient and DHB.

Aims:

- Determine the outcomes of performing ERCP at TBH and compare these with published figures.
- Determine if it is a safe and effective option for patients in this region.

Methods:

An ambi-directional study of all ERCP procedures at TBH between January 2011 and December 2015 was conducted. Data was collected prospectively between December 2014 and December 2015, and retrospectively prior to December 2014. Patient demographics, procedure indication and procedural details were captured via ProVation® MD and endoscopist's notes. Complications were identified through patients notes and recorded if

occurring within 30 days of the procedure. All complications were graded mild, moderate or severe based on a grading system described by Cotton et al.2

Results:

A total of 445 procedures were performed. Bile duct cannulation rate was 92.3% and therapeutic success rate was 89.9%. Complications occurred in 8.99% of patients and ERCP specific mortality was 0.22%. Haemorrhage occurred in 1.35% of patients, pancreatitis in 5.2% and perforation in 0.45%. When compared with other studies our results compare favourably.

Conclusion:

ERCP at TBH has been shown to be both a successful and safe procedure. Complication rates are similar to other published studies. Ongoing audit is needed to ensure the ongoing provision of a safe and effective service.

References:

1. Varadarajulu S, Kilgore ML, Wilcox CM, et al. Relationship among hospital ERCP volume, length of stay, and technical outcomes. Gastrointest Endosc 2006;64:338-47.
2. Cotton PB, Lehman G, Vennes J, et al. Endoscopic sphincterotomy complications and their management: an attempt at consensus. Gastrointestinal Endoscopy 1991;37:383-393.

Impact of PET-CT Scan On Management Pf Upper GI Malignancy

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Introduction:

Upper Gastrointestinal (UGI) cancer often presents at an advanced stage1. Curative treatments carry significant morbidity and mortality. Hence, accurate pre-treatment staging is important. Positron emission tomography combined with Computed Tomography (PET-CT) scan utilizes physiological differences between malignant and normal tissues which may precede structural changes seen on traditional CT scan2. However, it is an expensive modality and not readily available in New Zealand. There is no published New Zealand data on the impact of PET-CT scan on UGI cancer.

Aims:

To describe how PET-CT scan changes management in UGI cancer.

Methods:

This single centre retrospective descriptive study included 79 patients with UGI cancer referred to the MidCentral Health Regional Cancer Treatment Service between June, 2004 and June, 2014. These patients had no evidence of metastatic disease on intravenous contrast CT scan and were medically fit for curative treatment, who were subsequently referred for PET-CT scan. We defined change in management if PET-CT scan showed evidence of metastatic disease or other lesions requiring further investigation.

Results:

Of the 79 patients, 59 (74.7%) had IV contrast CT scan showing no evidence of metastatic disease. Of these patients, PET-CT scan changed management in 14 patients (23.7%). The remaining 20 of 79 patients (25.3%) had IV contrast CT scan showing indeterminate lesions. Of these, PET-CT scan changed management in 8 patients (40%).

Conclusion:

Our study confirms the value of including PET-CT scan in pre-operative staging of upper GI cancer, with a greater impact on patients with an IV contrast staging CT showing indeterminate lesions.

References:

1. Flanagan F, Dahdashti F, Siegel B, Trask D, Sundaresan S, Patterson GA. Staging of esophageal cancer with 18F-Fluorodeoxyglucose positron emission tomography. AJR 1997; 168:417-424.
2. Strauss LG, Conti PS. The applications of PET in clinical oncology. J Nuci Med 1991. 32:623-648

Chasing The Blood Tests: Do Improving Liver Function Test Parameters Predict A Passed Common Bile Duct Stone?

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Introduction:

Endoscopic retrograde cholangiopancreatography (ERCP) is the gold standard for treatment of choledocholethiasis but is invasive, expensive and not readily available1. There is limited evidence whether improvement in Liver Function Tests (LFTs) can predict passage of a common bile duct (CBD) stone.

Aim:

Whether improving LFTs can predict a passed common bile duct stone.

Methods:

This single centre retrospective case control study, included 387 patients between June 2012 and June 2015. Patients were divided into 'stone' and 'no stone' groups based on presence or absence of stone on ERCP. We included patients with symptoms/signs suggesting biliary pathology and imaging suggesting biliary obstruction. Patients with strictures, malignancies and those with previous biliary decompression were excluded. LFTs on day of ERCP were compared to those at time of referral. The change in LFTs were divided by the number of days between the two tests to standardise results.

Results:

Comparing 'stone' and 'no stone' groups, there was no significant difference ($p>0.05$) in the change in bilirubin (-2.52g/L/day vs. -1.82g/L/day), ALP (1.0g/L/day vs. -3.13g/L/day), GGT (-6.59 g/L/day vs. -12.7g/L/day), AST (-15.0g/L/day vs. -14.4 g/L/day) or AST (-18.0 g/L/day vs. 15.7 g/L/day). On day of ERCP, in the 'stone' group, 53.6% had normal bilirubin, 50.6% had normal AST, 36.8% had normal ALP, 32.2% had normal ALT and 12.6% had normal GGT. Patients in the 'stone' group were significantly ($p<0.05$) older (67.5yrs vs. 58.2yrs), had more males (48.1% vs. 35.1%) and a shorter time between referral and ERCP (9.0 days vs. 15.5 days).

Conclusion:

Improving LFTs is not a predictor of a passed CBD stone. If choledocholethiasis is suspected and an ERCP is planned, serial LFTs are unlikely to affect management.

References:

Sica G, Braver J, Cooney M, et al. Comparison of Endoscopic Retrograde Cholangiopancreatography with MR Cholangiopancreatography in Patients with Pancreatitis. Radiology 1999;210: 605-610.

Less Is More! Do Higher Number Of Sentinel Nodes Obtained Correlate With Higher Positive Rate?

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Introduction:

Axillary nodal status is an important prognostic indicator in women with early breast cancer, which was traditionally obtained by Axillary lymph node dissection (ALND). However, this procedure is associated with complications including lymphedema, seroma and infection1. Sentinel Node Biopsy (SNB) technique was developed to predict axillary nodal status with less morbidity than ALND2. There is limited evidence whether removing more sentinel nodes results in a higher positive rate.

Aims:

To compare the different number of sentinel nodes obtained to their positive rates.

Methods:

This single centre, retrospective cohort between January 2002 and January 2013, included 480 consecutive women with breast cancer who underwent SNB using blue dye and/or lymphoscintigraphy. Male breast cancer and in-situ disease was excluded. Patients were divided into four groups depending on the number of sentinel node obtained (1, 2, 3 and ≥4).If metastasis was present in any of the nodes, it was considered positive. Patients with a positive sentinel node underwent completion ALND.

Results:

Sentinel nodes were positive in 120 (25%) patients. Sentinel node positive rates were similar between groups 1 to ≥4 (24.8%, 24.7%, 25%, 26.2%, p>0.05) respectively. Mean age at surgery (61.7yrs, 61.7yrs, 58.7yrs, and 59.6yrs), Tumor size (1.96cm, 1.99cm, 2.16cm, and 2.11cm) and grade (2.16, 1.96, 2.04, and 1.97) were similar (p>0.05) between the groups 1 to ≥4 respectively.

Conclusion:

Obtaining more sentinel nodes did not result in a higher positive rate. Long term axillary recurrence needs to be assessed in a further study.

References:

1. U Veronesi, A Luini, V Galimberti, et al. Extent of metastatic axillary involvement in 1446 cases of breast cancer. Eur J Surg Oncol 1990;16:127-133.
2. Armando E, Hunt K, Ballman K et al. Axillary Dissection vs No Axillary Dissection in Women With Invasive Breast Cancer and Sentinel Node Metastasis: A Randomized Clinical Trial. JAMA. 2011;305(6):569-575.

Surgical Workload, Incidence And Outcomes Of Breast Cancer In New Zealand 2000-2013: Does It Matter Where You Live?

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Introduction:

Breast cancer is a common condition in New Zealand. It makes up to 28% of all cancers in females with approximately 3000 diagnoses and 600 deaths per year. It is unknown if breast cancer presents similarly across the country or if regional variations exist. Identifying regional differences in breast cancer incidence may help to target limited health resources more appropriately.

Aims:

To identify if a difference in breast cancer incidence exists in New Zealand women between the 20 different District Health Boards (DHBs).

Methods:

The number of invasive breast cancer notifications for women aged 20 years and older were collected per DHB for the years 2000 – 2013 from the National Cancer Registry (NCR). DHB total female population estimates were collected from Statistics New Zealand. World Health Organisation (WHO) age standardised rates were calculated and a two tailed paired T-test was performed for each DHB rate comparing against the national average.

Results:

Waitemata and Canterbury DHBs had the most notifications with both having a mean of 311 invasive cancers per year. Tairawhiti and West Coast DHBs had the least with a mean of 29 and 19 per year. The WHO age standardised national yearly rate was 142 registrations per 100,000 female population. Auckland DHB and Wellington DHBs were both statistically above the national rate at 150 registrations per 100,000 ($p = 0.014$ and $p=0.009$ respectively). Counties Manakau, South Canterbury and Southern DHBs were below the national rate.

Conclusion:

There appears to be a difference in the rates of invasive cancer between certain DHBs. Multiple factors could contribute to this including ethnic disparities, rates of screening participation, and access to specialist care. Further analyses regarding these to be presented.

References:

1. Ministry of Health. (2000-2010) Mortality and demographic data. Wellington: Ministry of Health
2. National Cancer Registry. Ministry of Health.

Withdrawal Of Acute General Surgery From Small Hospitals Increases Perforation Rates In Acute Appendicitis?

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Introduction:

This study was prompted by several audits1 in a rural New Zealand hospital which suggested an increase in the rate of complicated cases of appendicitis. The removal of onsite acute general surgical services in 2002 necessitated transfer of cases to the closest referral centre (>2 hours road travel time), and this delay was proposed as the mechanism responsible for the observed poorer outcomes2.

Aim:

To determine whether patients transferred from Kaitaia hospital (outlying) have higher rates of complicated appendicitis and its attendant morbidity, compared to patients who present directly to Whangarei Base Hospital (referral centre).

Method:

A retrospective cohort study was undertaken comparing time to care, pathology and clinical outcomes for patients transferred from Kaitaia with those presenting to Whangarei. A random sample of 200 cases from a data set of 1000 were assessed spanning a 4.5 year period (2010 to 2014). 179 patients in total were analysed after excluding duplicates and out-of-area cases.

Results:

The incidence of gangrenous or perforated cases in Kaitaia patients was 0.54 (7/13), and for Whangarei patients 0.40 (63/166) on formal histology (RR=1.35, 95% CI=0.95-1.90). Operative findings correlated well with histology. Readmission occurred for no Kaitaia patients and 11 (6.6%) Whangarei patients.

Conclusion:

There is no statistically significant difference in the proportion of complicated appendicitis cases for patients transferred from Kaitaia hospital compared with direct presenters to Whangarei hospital. Increased morbidity as measured by readmission was also not demonstrated.

References:

1. Unpublished data, Kaitaia Hospital, 2012.
2. Maroju, N. K., Robinson Smile, S., Sistla, S. C., Narasimhan, R. and Sahai, A. (2004), Delay in surgery for acute appendicitis. ANZ Journal of Surgery, 74: 773–776.

Surgical Technique For Repair Of Chronic 4th Degree Perineal Tear

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Introduction:

In many low-income countries, especially in rural areas, perineal tears at time of vaginal birth are not repaired at time of delivery, resulting in a large number of women with chronic 4th degree tears.

Aims:

In developed countries, significant post partum perineal tears are often repaired acutely by obstetricians. Repaired perineal tears with ongoing anorectal symptoms can be referred to the colorectal department for investigation and management. The aim of this study is to describe a surgical technique for management of the chronic 4th degree tear performed without flaps, and short-term follow up on anal incontinence symptoms using a validated questionnaire.

Methods:

Women presenting to fistula camps in western Uganda with chronic 4th degree tears were interviewed using the Cleveland Clinic Incontinence Score (CCIS). Interviews were undertaken pre-operatively, at 4 to 6 weeks and at 12 months post-operatively. Surgery was performed with repair of the 4th degree tear in layers together with an overlapping anal sphincter repair and reconstruction of the perineal body, without flaps. All women were examined prior discharge from hospital.

Results:

68 women completed pre-operative CCIS and were included in the study. The majority of women (59%) complained of incontinence to solid stools daily prior to surgery. Over 70% of women complained of restriction to lifestyle due to the chronic 4th degree tear. Mean pre-operative CCIS was 14.7. At 4 to 6 weeks postoperatively, mean CCIS was 0 (n=61). 1 woman had superficial breakdown of wound on Day 2. The woman was brought back to theatre for re-suturing and had no further complications.

Conclusion:

This study highlights the nuances in the surgical technique of chronic 4th degree tear repairs. These tears have significant impact on quality of life and anal continence. Short-term results are promising.

10 Year Burns Epidemiology In Queensland: An Update From 2005 to 2015

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Introduction:

The Stuart Pegg Burns Centre at the Royal Brisbane and Womens Hospital (RBWH) was established after epidemiological studies confirmed the need for a dedicated centre. This study allows comparison of the epidemiological data of the past 10 years compared to the previous 20 years to allow evaluation of the needs of burns patients.

Aims:

To study the epidemiology of burns in Queensland and evaluate changes in burns aetiology, admissions numbers, demographics, mortality and geographical referral base over a 10 year period compared to the previous 20 years(1).

Methods:

The RBWH Burns Unit Database was accessed and data from the 10 year period of July 2005 to June 2015 was extracted.

Results:

3534 admissions. 72.9% male, 27.1% female. Age: 44.8% in 21-40 year age group, 13.4% under 20 years, 28.4% in 41-60 age group and 13.4% over 61 years. TBSA: 89.1% under 20% burns, 7.2% with 21-40% burns, 2% with 41-60% burns and 1.6% with >61% burns. Causes: 45.3% flame, 26.7% scald, 15.8% contact, 5.2% chemical, 3.2% electrical, 3.8% other. Place: 59.9% occurred domestically, 8.3% in a vehicle, 13.3% at a workplace, 9.2% recreational, 0.7% in a hospital or care facility and 8.6% other. Inhalational Injuries: 9% of patients were intubated. 95% of burns are accidental. Mortality: Overall mortality 1.6%.

Conclusion:

There is a large increase in admissions from the previous 20 years reflecting the growing population and increasing ease of patient transfer. There is a considerable fall in flame and workplace burns due to Occupational Health and Safety Measures. There is an increase in patients aged over 60 admitted, reflecting an aging population. There are an increasing number of patients referred from outer metro hospitals. Overall decrease in mortality rate.

References:

1. Pegg SP. Burn epidemiology in the Brisbane and Queensland area. Burns. 2005 Jan;31 Suppl 1:S27-31.

An Audit Of Trauma Management At A Tertiary Hospital

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Introduction:

Despite two major trauma centres in Melbourne other metropolitan hospitals, including Footscray, are still required to manage trauma.

Aim:

Review trauma care at Footscray hospital, assessing current practice and outcomes.

Methods:

A retrospective audit of trauma admissions to general surgical units at Footscray hospital, has been conducted over six months during 2014. Age, gender, mechanism of injury sustained, the use of imaging (X-rays, computed tomography (CT) and magnetic resonance imaging (MRI)), surgical interventions, referrals to other disciplines, use of structured trauma admission forms, outcome and length of stay were recorded on a spreadsheet.

Results:

119 trauma admissions were reviewed. 95% of patients were admitted from the Footscray Emergency Department, the remainder transferred from other hospitals, and represent 5% of general surgical admissions. Motor vehicle accident (40%) and falls (23%) were the main mechanisms of injury. Trauma forms, prompting complete primary and secondary surveys, were used in one third of patients. 116 patients were investigated with a CT scan: cervical spine 87%, head 63%, abdomen/pelvis 61% and chest 57%. MRI was used in 12% of patients to image the cervical spine. 42% of patients had no significant injuries. The commonest injuries were fractured limbs, ribs and vertebrae, 19%, 16% and 12% respectively. 10% of patients had intra-abdominal injuries. Orthopaedics (29%) Neurosurgical (26%), Pain (8%) and Thoracic (7%) units were consulted. Orthopaedic procedures and laparotomy were required in 20% and 4% respectively. The mean length of stay was 3 days and 81% of patients were discharged home from the general surgical unit, the remainder transferred to other units with one mortality, due to respiratory failure from fractured ribs.

Conclusion:

Although not a trauma hospital, Footscray manages trauma when required. With support from radiology and other surgical disciplines safe trauma care is provided. Use of trauma forms needs improvement.

Improving The Management Of Post Thyroidectomy Bleeding In Hospital Interns

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Introduction:

Post thyroidectomy bleeding (PTB) is an uncommon, but life-threatening complication. The interns, the most junior medical staff, are the first to be notified when there is an issue in the patients' post operative recovery.

Aims:

We assessed interns' baseline knowledge of identifying and managing PTB and examined the efficacy of a brief educational program in improving their knowledge.

Methods:

During one of our routine educational sessions for junior medical staff, interns were recruited for this protective study. They completed a de-identified pre-test of eight questions regarding the clinical features and management of PTB. A 30-minute interactive multimedia presentation including photos and a video on PTB was given. Three months later, the interns repeated the initial test. The pre- and post-tests data were matched, and the results analysed using McNemar's test.

Results:

There were 31 participants. Pre-test findings demonstrated that interns had a good baseline understanding of priority, diagnosis and action for PTB.

Questions	PRE-TEST (%)	POST-TEST (%)	P EXACT (2-SIDED)
How common	10 (32%)	10 (32%)	> 0.050
Priority	21 (68%)	24 (77%)	0.25
Symptoms & Signs	14 (45%)	19 (61%)	0.063
Diagnosis	17 (55%)	25 (81%)	0.008
Action	20 (65%)	28 (90%)	0.008
Stridor	7 (22%)	6 (19%)	> 0.050
Thyroid tray	10 (32%)	21 (68%)	0.001
Layers	17 (55%)	22 (71%)	0.063

Following the presentation, post-test showed improvement in almost all questions. Significant improvement was shown in diagnosis, action and location of the thyroid tray, which were the most clinically relevant components. Interns scored poorly in the question regarding causes of stridor both in the pre- and post-test, which may have been due to poor understanding of the question.

Conclusion:

We have demonstrated that providing a brief, interactive lecture on an uncommon but critical surgical complication of PTB improves sustained knowledge.

Factors Impacting Wound Infections In Colorectal Surgery

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Questions Pre-test (%) Post-test (%) P exact (2-sided)

How common 10 (32%) 10 (32%) > 0.050

Priority 21 (68%) 24 (77%) 0.25

Symptoms & Signs 14 (45%) 19 (61%) 0.063

Diagnosis 17 (55%) 25 (81%) 0.008

Action 20 (65%) 28 (90%) 0.008

Stridor 7 (22%) 6 (19%) > 0.050

Thyroid tray 10 (32%) 21 (68%) 0.001

Layers 17 (55%) 22 (71%) 0.063

Introduction:

Surgical site infections (SSI's) are amongst the most common hospital acquired infections within surgical patients. It increases morbidity and healthcare costs.

Aim:

The aim of this project was to look at risk factors for surgical site infections.

Methods:

Univariate analysis was done on the infected and non infected groups comparing variables that potentially contribute to surgical site infections. Multivariate analysis was then performed on each of the significant findings to ascertain if the results were still significant after adjusting for age, operative time and ASA scores. A p value of <0.05 was considered statistically significant.

Results:

Forty-eight out of the 620 patients that underwent colorectal surgery during 2013 and 2014 had wound infections (7.74%).
A statistically significant SSI association is seen for open surgery (OR 6.13, P= 0.003), emergency operations (OR 2.15, P=0.01), peritoneal contamination (OR 3, P=0.001), stoma formation (2.18, p= 0.01), skin closure with staples (OR 2.82, p=0.009) and skin closure with absorbable sutures (OR 0.18, p=0.001). Even though both staples and absorbable sutures were significantly associated with SSI's, the odds ratio was greater with staples. On multivariate analysis all of the above variables were independently associated with wound infection after adjusting for age, operative time and ASA.

Conclusion:

The study shows that commonly accepted factors such as open surgery, contaminated abdominal cavities, emergency operations and stoma formation increases the likelihood of SSI's. Using staples to close skin may also increase the likelihood of SSI's compared to absorbable sutures.

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Emergency Presentation Of Small Bowel Tumours At Princess Alexandra Hospital

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Introduction:

Small bowel tumours are rare, accounting for less than 5% of all gastrointestinal tract neoplasms [1]. Primary malignant small bowel tumours include adenocarcinoma, carcinoid, GIST and lymphoma however tumours such as melanoma can metastasize to the small bowel. Small bowel tumours can often present as a surgical emergency and can be challenging to diagnose in the early stages.

Aims:

To determine how different types of malignant small bowel tumours present as a clinical emergency and assess short term patient outcomes.

Methods:

Retrospective analysis of 108 patient charts with histologically proven malignant small bowel tumours that presented to the Princess Alexandra Hospital, Brisbane between 2006-2011. Patients were identified using ICD-10 codes for small bowel tumours. 38 out of 108 patients with small bowel tumours presented as an emergency. Emergency presentations include small bowel perforation, small bowel obstruction (SBO) and gastrointestinal bleed requiring greater than two units of packed red blood cells.

Results:

32% of small bowel tumours presented as an emergency. Adenocarcinoma was the commonest pathology (32%) followed by melanoma (27%) and carcinoid (18%). Adenocarcinoma, melanoma and carcinoid presented predominantly as a SBO. Lymphoma, GIST and secondary malignancies presented commonly as a gastrointestinal bleed. The diagnosis was suspected preoperatively in 77% of cases. 23% of tumours were discovered intra-operatively. 84% of cases underwent surgery. The one-year mortality was 23%.

Conclusion:

SBO secondary to primary adenocarcinoma was the commonest type of emergency presentation. All bowel obstructions and perforations underwent a laparotomy. The high incidence of metastatic melanoma in this series may be a reflection of the local prevalence of primary melanoma in Queensland.

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Open Herniorrhaphy Leads To Reduced Post Operative Pain Compared To Total Extraperitoneal Repair: Factors Influencing Operative Decisions

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Introduction:

Totally extraperitoneal laparoscopic herniorrhaphy (TEP) has not shown to be superior to open repairs in such areas as recurrence, chronic pain and intra-operative complications. The purpose of this study was to determine the post-operative pain levels of patients who underwent TEP and open herniorrhaphy.

Methods:

We conducted a retrospective analysis of all patients who underwent herniorrhaphy between November 2013 and November 2014 at Dandenong Hospital. Patients were identified through a prospectively maintained data base. All patients were contacted to complete a questionnaire tool aimed at evaluating post-operative pain and overall satisfaction levels. This study was approved by the Monash Health Ethics Committee.

Results:

A total of 132 patients were included, 84 open and 48 TEP hernia repairs. Open herniorrhaphy was associated with less post-operative pain ($p=0.0085$) and less post-operative pain at 6-12 months ($p=0.004$). TEP herniorrhaphy was more likely to be chosen for bilateral and recurrent hernias (43.6% compared to 23.8%, and 20.8% compared to 8.3% respectively). While post-operative pain for bilateral and recurrent hernias was comparable across the two groups, male patients under the age of 55 with BMI <35 were more likely to be selected for TEP herniorrhaphy. There was no difference in recurrence rates between the two groups.

Conclusion:

Open herniorrhaphy is associated with less post-operative pain when compared to TEP hernia repair and are equivalent in post-operative pain for bilateral and recurrent hernias. Future research is necessary to determine the indication for TEP approach with post-operative pain as part of the decision making process.

Simple Perioperative Interventions Can Minimise The Risk Of Pharyngocutaneous Fistula Following Total Laryngectomy - Experience At A Single Tertiary Institution

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Introduction:

Pharyngocutaneous fistula following total laryngectomy represents the most frequent complication in the early post-operative period with incidence reported in the literature varying from 2.6 to 65.5%. Patient morbidity and mortality results from prolonged hospitalisation, delayed oral feeding, increased risk of catastrophic vascular haemorrhage and delays to commencement of adjuvant radiotherapy.

Meta-analyses have described well established positive predictive factors such as an unfavourable tumour subsite and advanced size, positive surgical margins and performance of salvage surgery1,2.

The Royal Brisbane & Women's Hospital experience has evolved. Whilst wide variability in practice existed prior to August 2013, a standardisation in the perioperative management of our patients was established that seems to correlate with a marked reduction in the fistula rate.

The changes instituted relate to modifiable, non-morbid interventions. Specifically:

A three-layer pharyngeal closure with the first layer comprising an inverting suture technique

A novel dressing technique intended to minimize strain of the pharyngeal closure, minimise haematoma and promote wound healing

Perioperative administration of metronidazole until commencement of oral feeding

Aims:

To assess the independent effect of the change of practice on the fistula rate at our instituition.

Methods:

Here we present a retrospective review of a cohort comprising consecutive patients undergoing total laryngectomy between January 2010 and August 2015.

Results:

A fistula rate of 10 percent occurred in the cohort of 80 patients. A dramatic reduction in fistula rate can be seen comparing the groups before and after the change of practice - 16.3 percent (8/49) versus 0 percent (0/31). The two groups are otherwise similar accounting for known predictors including salvage surgery. Here, we present a statistical analysis of the attributable effect of each standardised intervention.

Conclusion:

Seemingly, simple non-morbid interventions can dramatically reduce the fistula rate in favour of more morbid procedures.

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Current Practice Of Colonic Investigation Following Acute Appendicitis Throughout New Zealand General Surgeons

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Introduction:

Recent studies have suggested underlying colonic neoplasm may precipitate acute appendicitis in elderly patients. Lai et al (2008) reported an almost 40 fold increased odds ratio of underlying colorectal cancer for patients over forty presenting with acute appendicitis. To date there is minimal recent research investigating rates of colonic carcinoma associated with acute appendicitis.

Aim:

To identify current post-operative management by New Zealand general surgeons of older patients diagnosed with acute appendicitis with regards to further colonic investigations.

Methods:

An online survey was sent out to all New Zealand general surgeons enrolled in NZAGS (New Zealand Association of General Surgery) to establish current practices regarding post-operative colonic investigations of older patients diagnosed with acute appendicitis.

Results:

114 general surgeons responded to the survey, which equated to a response rate of 52%. 62 responders (55%) answered 'NO' to question one, indicating no further investigation was necessary if acute appendicitis was diagnosed in a 65-year-old patient. If the patient had a preoperative CT scan, 66% of responders would not perform any further colonic investigation.

Conclusion:

This research reveals there is no current consensus regarding colorectal investigations following acute appendicitis in adult populations in New Zealand general surgery practice.

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