



New Zealand Association of General Surgeons

NZAGS 2015

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NEW ZEALAND ASSOCIATION OF
GENERAL SURGEONS ANNUAL CONFERENCE

NOVOTEL ROTORUA LAKESIDE HOTEL, ROTORUA, NEW ZEALAND

14-15 MARCH 2015



CONTROVERSIES IN GENERAL SURGERY



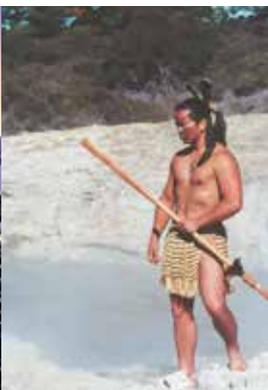
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On behalf of the NZAGS I am delighted to invite you to the NZAGS Annual Meeting, to be held at the Novotel in Rotorua from 14-15 March 2015.

Rotorua is a premier tourism destination and is ideally situated at the epicentre of New Zealand's population. Its central situation and excellent

regional airport make it readily accessible for the majority of our country's population. I anticipate a strong turnout from our General Surgical community by providing a stimulating and challenging programme.

I look forward to meeting you in Rotorua.

Kind regards
David Vernon, *Convenor*



CONTACT

MEETING OFFICE



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 CONFERENCE AND EVENT MANAGEMENT
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ORGANISING COMMITTEE

- David Vernon (Convenor)
- Maiko Kano
- Andrew Ing
- Simon Richardson
- Linda Porter
- Bronwen Evans
- Janice Chen
- Lynda Booth (Conference Manager)

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KEYNOTE SPEAKERS

The Conference Committee is delighted to announce the keynote speakers for the conference:



Mr James Church

MBChB, M Med Sci, FRACS, FACS, FACG, FASCRS, Cleveland Clinic, USA

James Church is a native New Zealander who attended medical school at the University of Auckland. His surgical training was also in Auckland, New Zealand. Following this he spent two years doing research before taking up a colorectal surgical fellowship at the Cleveland Clinic in Cleveland Ohio. In 1989 he joined the staff of the Colorectal Surgery Department in Cleveland. Dr. Church's interests include hereditary colorectal cancer syndromes, colonoscopy and polypectomy, the clinical care and molecular biology of colon and rectal cancer, anal fistulas, fecal incontinence and inflammatory bowel disease. He holds the Victor W. Fazio Chair of Colorectal Surgery and is the Director of the Sanford R. Weiss MD Center for Hereditary Colorectal Neoplasia. He is the sole author of 2 textbooks, co-editor of 6, and author of over 50 book chapters and over 300 peer reviewed articles. For 10 years he was co-editor of Diseases of the Colon and Rectum. He is regularly listed among the top doctors in America, is a fellow of the American Surgical Society and became a Distinguished Alumnus of the University of Auckland in 2008.



Prof. Robert Padbury

Divisional Director of Surgery, Flinders Medical Centre, Adelaide, Australia

Prof. Robert Padbury is Director of Surgery and Perioperative Medicine in the Southern Adelaide Local Health Network, SA Health. His predominant interest is HPB Surgery and predominant leadership is clinical practice improvement, clinical standardisation and reducing variation with clinical protocols. Prof. Padbury's research interests are predominantly clinical and epidemiological and has 89 publications.



INVITED SPEAKERS



Mr Ian Burton
*Chelsea Hospital,
Gisborne, NZ*



Prof. Ian Campbell
*Waikato DHB,
Hamilton, NZ*



Mr Rowan Collinson
*Auckland DHB,
Auckland, NZ*



Mr Tim Eglinton
*Christchurch Hospital
& University of Otago,
Christchurch, NZ*



Mr Chris Gray
*South Canterbury DHB
Timaru, NZ*



Ms Barbara Hochstein
*Lakes DHB
Rotorua, NZ*



Mr Andrew MacCormick
*The University of Auckland
& Counties Manukau DHB,
Auckland, NZ*



Dr Darren Malone
Lakes DHB, Rotorua, NZ



Mr Win Meyer-Rochow
Waikato DHB, Hamilton, NZ



Prof. Bryan Parry
*The University of Auckland,
Auckland, NZ*



Mr Michael Rodgers
*Waitemata DHB,
Auckland, NZ*



Mr Geoff Searle
*Southern Cross Health
Society, NZ*



Mr Sanjeewa Seneviratne
*The University of Auckland,
Auckland, NZ*



Mr Peter Stiven
*Tairāwhiti DHB,
Gisborne, NZ*



Dr David Theobald
*National Endoscopy
Quality Improvement
Programme, NZ*





PLEASE NOTE THAT THIS IS A PROVISIONAL PROGRAMME AND MAY ALTER PRIOR TO THE CONFERENCE

SCIENTIFIC PROGRAMME: SATURDAY, 14 MARCH 2015

SATURDAY 14 MARCH 2015		
0730	Registration Opens	Conference Foyer
0800-0830	Mihi Whakatau Welcome	Batten 2 Room
0830-1000	Session 1: General	Batten 2 Room Session Chair: David Vernon
0830-0900	Screening for Colorectal Cancer: Modern Problems and Solutions Mr James Church , <i>The Cleveland Clinic, USA</i>	
0900-0930	Clinical Standardisation Prof. Robert Padbury , <i>Divisional Director of Surgery, Flinders Medical Centre, Adelaide, Australia</i>	
0930-1000	Intestinal Failure from 'Woe' to Go Prof. Bryan Parry , <i>The University of Auckland, Auckland, New Zealand</i>	
1000-1030	Morning Tea	Rutherford Room
1030-1200	Session 2: Breast	Batten 2 Room Session Chair: Anupam Modi
1030-1100	Breast Cancer: How To Manage Regional Lymph Nodes In 2015? Assoc. Prof. Ian Campbell , <i>Professor of Breast Surgery, Waikato DHB, Hamilton, New Zealand</i>	
1100-1130	Ethnic Disparities In Breast Cancer In New Zealand: Do Indigenous Maori Get A Worse Deal? Sanjeeva Seneviratne , <i>The University of Auckland, Auckland, New Zealand</i>	
1130-1200	Breast Cancer Screening, the Never Ending Controversy. New Strategies for Approaching Population Breast Screening Dr Barbara Hochstein , <i>Radiologist, Lakes DHB, Rotorua, New Zealand</i>	
	Commitment to Education: Expand your Skills with Hands - on Workshops Paul Innes , <i>Applied Medical, New Zealand</i>	
1200-1330	Lunch & Poster Judging (12.45pm- 1.30pm)	Rutherford Room
1300-1330	NZAGS AGM	Batten 2 Room
1330-1500	Session 3: UGI/HPB	Batten 2 Room Session Chair: Warren Watson
1330-1400	Leadership in Healthcare Prof. Robert Padbury , <i>Divisional Director of Surgery, Flinders Medical Centre, Adelaide, Australia</i>	
1400-1430	Update On Index Admission Cholecystectomy Mr Peter Stiven , <i>General Surgeon, Tairāwhiti DHB, Gisborne, New Zealand</i>	
1430-1500	Endoscopy Quality in New Zealand – What The Future Holds Dr David Theobald , <i>Clinical Director, National Endoscopy Quality Improvement Programme, New Zealand</i>	
	Johnson & Johnson Medical – Celebrating 20 years of NZAGS with Innovation & Collaboration Sue Martin , <i>Johnson & Johnson, New Zealand</i>	
1500-1530	Afternoon Tea	Rutherford Room



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SCIENTIFIC PROGRAMME: SATURDAY, 14 MARCH 2015

1530 - 1730	Session 4: FREE PAPERS	Batten 2 Room Session Chair: Etienne Truter
1530 - 1540	Gastrografin in Prolonged Post-Operative Ileus – A Double-Blinded Randomised Controlled Trial Ryash Vather , <i>The University of Auckland, Auckland, New Zealand</i>	
1540 - 1550	Adherence to Sepsis Six in Acute Surgical Patients Nicola Davis , <i>Counties Manukau DHB, Auckland, New Zealand</i>	
1550 - 1600	Cost Analysis of Early Versus Delayed Loop Ileostomy Closure: A Case-Matched Study Jason Robertson , <i>Northland DHB, Whangarei, New Zealand</i>	
1600 - 1610	The Cost of Laparoscopic Colorectal Surgery in a Provincial New Zealand Hospital Benjamin Cribb , <i>Taranaki Base Hospital, Taranaki, New Zealand</i>	
1610 - 1620	Acute Cholecystectomy is Possible in Provincial NZ Delendra Wijayanayaka , <i>North Shore Hospital, Auckland, New Zealand</i>	
1620 - 1630	Anterior Resection Syndrome - A Risk Factor Analysis Cameron Wells , <i>The University of Auckland, Auckland, New Zealand</i>	
1630 - 1640	Can we achieve a Better Outcome in Emergency Laparotomy? An Audit of Auckland City Hospital Mortality Li Hsee , <i>Auckland City Hospital, Auckland, New Zealand</i>	
1640 - 1650	Rectal Enhanced Recovery After Surgery Protocol; Experience in the Bay of Plenty Shahed Yassaie , <i>Tauranga Hospital, Tauranga, New Zealand</i>	
1650 - 1700	Laparoscopic choledochotomy and flexible choledochoscopy: A Hole in one Yee Chen Lau , <i>Hawke's Bay DHB, Hastings, New Zealand</i>	
1700 - 1710	Cholecystectomy for Acute Calculous Cholecystitis: Dangerous to Delay? Andy Pun , <i>Auckland City Hospital, Auckland, New Zealand</i>	
1710 - 1720	Anastomotic leaks: just what is it about the Pelvis Lance Yuan , <i>Middlemore Hospital, Auckland, New Zealand</i>	
1720 - 1730	What Does the Excised Stomach from Sleeve Gastrectomy Tell Us? Mel Lauti , <i>The University of Auckland, Auckland, New Zealand</i>	
1900	Conference Dinner	Rutherford Room





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SCIENTIFIC PROGRAMME: SUNDAY, 15 MARCH 2015

SUNDAY 15 MARCH 2015

0730	Registration Opens	Conference Foyer
0830 - 1030	Session 5: Colorectal	Batten 2 Room Session Chair: David Griffith
0830 - 0900	Understanding Anorectal Disease Leads to Appropriate Treatment Mr James Church , <i>The Cleveland Clinic, USA</i>	
0900 - 0920	Fad or Fact? Laparoscopic Ventral Mesh Rectopexy for Rectal Prolapse Mr Rowan Collinson , <i>Auckland DHB, Auckland, New Zealand</i>	
0920 - 0940	Rectal Cancer: MRI Staging Dr Barbara Hochstein , <i>Radiologist, Lakes DHB, Rotorua, New Zealand</i>	
0940 - 1000	Mesh in Hernia Repair - What's the Evidence? Mr Michael Rodgers , <i>Waitemata DHB</i>	
1000 - 1030	Panel Discussion	
1030 - 1100	Morning Tea	Rutherford Room
1100 - 1230	Session 6: Surgeons' Health	Batten 2 Room Session Chair: Michael Rodgers
1100 - 1130	Physician Burn Out: What Is It, Who's At Risk, How To Manage It Dr Darren Malone , <i>Psychogeriatrician, Lakes DHB, New Zealand</i>	
1130 - 1230	Panel discussion on PRIVATE FEES Ian Burton , <i>Chelsea Hospital, Gisborne</i> , Ms Philippa Mercer , <i>Christchurch Surgical Associates, Christchurch</i> and Mr John Dunn , <i>Endoscopy Auckland, Auckland</i> and Mr Geoff Searle and Ms Becky Ogilvie , <i>Southern Cross Healthcare, New Zealand</i> MODERATOR: Michael Rodgers , <i>Waitemata DHB, Auckland, New Zealand</i>	
	Discussion	
1230 - 1330	Lunch	Rutherford Room
1330 - 1450	Session 7: Debate: The Establishment of a Generic General Surgery Prioritisation Tool is a Worthwhile Goal for New Zealand	Batten 2 Room Session Chair: David Vernon
	Protagonists: Mr Andrew MacCormick , <i>General Surgeon, The University of Auckland & Counties Manukau DHB, Auckland, New Zealand</i> and Mr Tim Eglinton , <i>Canterbury DHB, Christchurch, New Zealand</i>	
	Antagonists: Mr Win Meyer-Rochow , <i>Endocrine & General Surgeon, Waikato DHB, Hamilton, New Zealand</i> and Mr Chris Gray , <i>South Canterbury DHB, Timaru, New Zealand</i>	
	Adjudication	
1430 - 1450	Reoperative Abdominal Surgery...Entering Tiger Country Mr James Church , <i>The Cleveland Clinic, USA</i>	
1450 - 1500	Award Presentations and Conference Close	Batten 2 Room



POSTER PROGRAMME

- Poster 1: Cutaneous Melanoma In New Zealand: 2005-2009
K. Broughton *MbChB* *; **G. Tarr** *MbChb*; **R. C. W. Martin** *MBChB, FRACS, ChM. ‡*
*Waitemata District Health Board, North Shore Hospital
‡Department of Surgery, Melanoma Unit, Takapuna, Auckland, New Zealand
- Poster 2: The Cost Of Complications In Colorectal Surgery
B. Cribb*, **N. Henderson***, **F. El Haddawi***
*Department of Surgery, Taranaki Base Hospital, New Plymouth, New Zealand
- Poster 3: Case Report - Goldilocks Mastectomy In A NZ Maori Patient
J Davies, E Davenport*
*Department of General Surgery, Hastings Hospital, Hawke's Bay DHB, Hastings, New Zealand
- Poster 4: Ilioinguinal Nerve Management In Open Sutured Mesh Inguinal Hernia Repairs: A Meta-Analysis
Paul Fagan*, **Barnaby Smith****
*General Surgical Registrar, Tauranga Hospital, Bay of Plenty DHB, New Zealand
** General Surgeon, Tauranga Hospital, Bay of Plenty DHB, New Zealand
- Poster 5: Appendiceal Neoplasms In The Wellington Region
B Goodwin*, **Dr Liz Dennett** ** **Mr Ali Shekouh*****
* Department of Surgery, Capital and Coast DHB, Wellington, New Zealand
**Department of Surgery, Capital and Coast DHB, Wellington, New Zealand
*** Department of Surgery, Capital and Coast DHB, Wellington, New Zealand
- Poster 6: Laparoscopic Inguinal Hernia Repair Using A Self-Fixating Progriptom Mesh – A Review
Latif R, Moss D; Poole G
Department of General Surgery, Middlemore Hospital, Auckland, New Zealand
- Poster 7: Yersinia Enteritis; A Plausible Cause of Terminal Ileitis
C Liu*, **A Bhargava, L Hsee, I Civil**
*Acute Surgical Unit, Auckland City Hospital, Auckland, New Zealand
- Poster 8: Complication Rates Of Rectal Surgery In A Provincial New Zealand Hospital
M O'Grady*, **G Bonnet***
*Department of Surgery, Whanganui Hospital, Whanganui, New Zealand
- Poster 9: The Challenge Of Surgical Thromboprophylaxis
R. Ranjan, S. Kyle, D. Mosquera, F. Haddawi, M. Fancourt, N. Henderson, W. Gilkison, G. Farrant
Department of Surgery, Taranaki Base Hospital, Taranaki, New Zealand



POSTER PROGRAMME

- Poster 10: Acute Colonic Pseudo-Obstruction In Pregnancy
Dr M Reeves*, **Prof. F Frizelle****, **Dr C Parker*****
** Registrar, Department of Surgery, Christchurch Hospital, Christchurch, New Zealand*
*** Department of Surgery, Christchurch Hospital, Christchurch, New Zealand*
**** Department of Obstetrics and Gynaecology, Christchurch Hospital, Christchurch, New Zealand*
- Poster 11: Epidemiology Of Merkel Cell Carcinoma In New Zealand: A Population Based Study
JP Robertson1,3, **ES Liang1**, **RCW Martin1,2,3**
1. Department of Surgery, Waitemata DHB, North Shore Hospital, Auckland, New Zealand
2. Melanoma Unit, Auckland, New Zealand
3. Department of Surgery, University of Auckland, Auckland, New Zealand
- Poster 12: Trends In Interventions And Outcomes Of Severe Acute Pancreatitis At A Tertiary Level Hospital, Auckland, New Zealand
Poster 14:
Peter Russell*, **Anubhav Mittal****, **John Windsor*****
** Department of General Surgery, North Shore Hospital, Auckland, New Zealand*
*** Department of General Surgery, Royal North Shore Hospital, Sydney, Australia*
**** Department of General Surgery, Auckland Hospital, Auckland, New Zealand*
- Poster 13: The “Penny Farthing” Incision For Mastectomy:
A Novel Technique to Reduce “Dog Ear” Deformity and Improve Access To The Axilla
Sheikh, L*, **Pool, G***
** Department of General Surgery, Middlemore Hospital, Auckland, New Zealand*
- Poster 14: Accuracy of Frozen Sections Performed for Sentinel Lymph Node Biopsies within a Peripheral Hospital in New Zealand
J Tan*, **L Joblin****, **E Davenport***
** Department of General Surgery, Hawke's Bay DHB, Hastings, New Zealand*
*** Department of Pathology, Hawke's Bay DHB, Hastings, New Zealand*
- Poster 15: Concurrent Presentation of Acute Appendicitis And Cholecystitis: A Diagnosis of Rare Occurrence
Dr Jeffrey Tan*, **Dr Jamish Gandhi***
**Department of General Surgery, Waikato Hospital, Hamilton, New Zealand*
- Poster 16: Case Based Discussion for Assessment of Surgical Trainee Interns
J. Tietjens*, **S Bann****, **J Fuge*****, **J Nacey******
** Surgical Registrar, Capital and Coast DHB, Wellington, New Zealand*
***Consultant Surgeon, Capital and Coast DHB, Wellington, New Zealand*
****Surgical Programme Coordinator, Department of Surgery and Anaesthesia, University of Otago, Dunedin, New Zealand*
*****Professor of Surgery, Department of Surgery and Anaesthesia, University of Otago, Dunedin, New Zealand*



SOCIAL PROGRAMME

WELCOME RECEPTION MIX & MINGLE

Meet for a casual drink on Friday evening. This is a great time to catch up with colleagues and friends

- Date:** Friday 13th March 2015
Time: From 6.30pm
Venue: Brew Bar, 1103 Tutanekai St, Rotorua
Cost: Beverages and catering is at your own cost and paid directly to the venue

Note: This is not a formal event, but a great opportunity to meet with friends and colleagues.



CONFERENCE DINNER

Special presentation by Andrew Connolly and performance by Evelyn Falconer and Susan Morrison

- Date:** Saturday 14th March 2015
Time: 7.00pm till late
Venue: Ambrosia Restaurant & Bar,
1096 Tutanekai Street, Rotorua
Cost: \$115.00 per person



GENERAL INFORMATION



Conference Venue

Novotel Rotorua Lakeside Hotel
 Lake End/Tutanekai St,
 Rotorua 3010, New Zealand

Registration Desk

The registration desk will be open from:

- 7.30am Saturday 14th March 2015
- 7.30am Sunday 15th March 2015

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.

Industry Exhibition

The Exhibition will be held at the Novotel Rotorua Lakeside Hotel. Please ensure you participate in the Exhibitor Passport by visiting the exhibition booths.

Cell phones & Pagers

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

Car Parking

Car parking is complimentary at the hotel.

Refreshments

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

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:

- Rotorua Taxis, Phone: +64 7 348 1111
- Super Shuttles, Phone: 0800 SHUTTLE (0800 748 885)
- Public Transportation: Cityride Rotorua: Provides daily bus services to/from Rotorua International Airport, except public holidays. www.baybus.co.nz

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The Organising Committee, including the Conference Managers, will not accept liability for damages of any nature sustained by participants or their accompanying persons or loss or damage to their personal property as a result of the meeting or related events. In the event of industrial disruption or other unforeseen circumstances, the Conference Managers accept no responsibility for loss of monies.



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REM SYSTEMS LTD is a locally owned business that was founded in 1981 and is the largest privately held medical distributor in New Zealand. REM SYSTEMS employs more than 50 staff based throughout New Zealand, with additional representation in Australia.

REM represents more than 70 different suppliers and

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The Royal Australasian College of Surgeons is a non-profit organisation training surgeons and maintaining surgical standards in New Zealand and Australia. Its purpose is to be the unifying force for surgery in both countries, with the FRACS standing for excellence in surgical care. The College's nine specialty programmes, of which General Surgery is one, and its Continuing Professional Development (for Fellows) and Maintenance of Professional Standards (for vocationally registered IMGs) programmes are accredited by the Medical Council of New Zealand and the Australian Medical Council.

The College library, its professional development and skills courses and its Morbidity & Log Book Tool (MALT) are invaluable resources for surgeons and trainees. The NZ National Board acts on behalf of New Zealand surgeons to ensure surgical matters are raised and promoted with politicians and with statutory organisations and their officials.

SANOFI

STAND # 11

O'CONNOR, Bridget

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NEW ZEALAND 1010

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🌐 www.southerncross.co.nz/society

The country's largest health insurer, with over 800,000 members, Southern Cross Health Society holds a 61 per cent share of New Zealand's private health insurance market. Founded in 1961 as a not-for-profit friendly society, Southern Cross is operated solely for the benefit of its members.

In the 2014 financial year, Southern Cross incurred \$694 million in claims for elective healthcare services, which included more than 155,000 surgical operations, 370,000 specialist consultations and 784,000 GP visits. Southern Cross has maintained an A+ strong financial strength rating from Standard and Poor's for twelve consecutive years and is led by CEO Peter Tynan.

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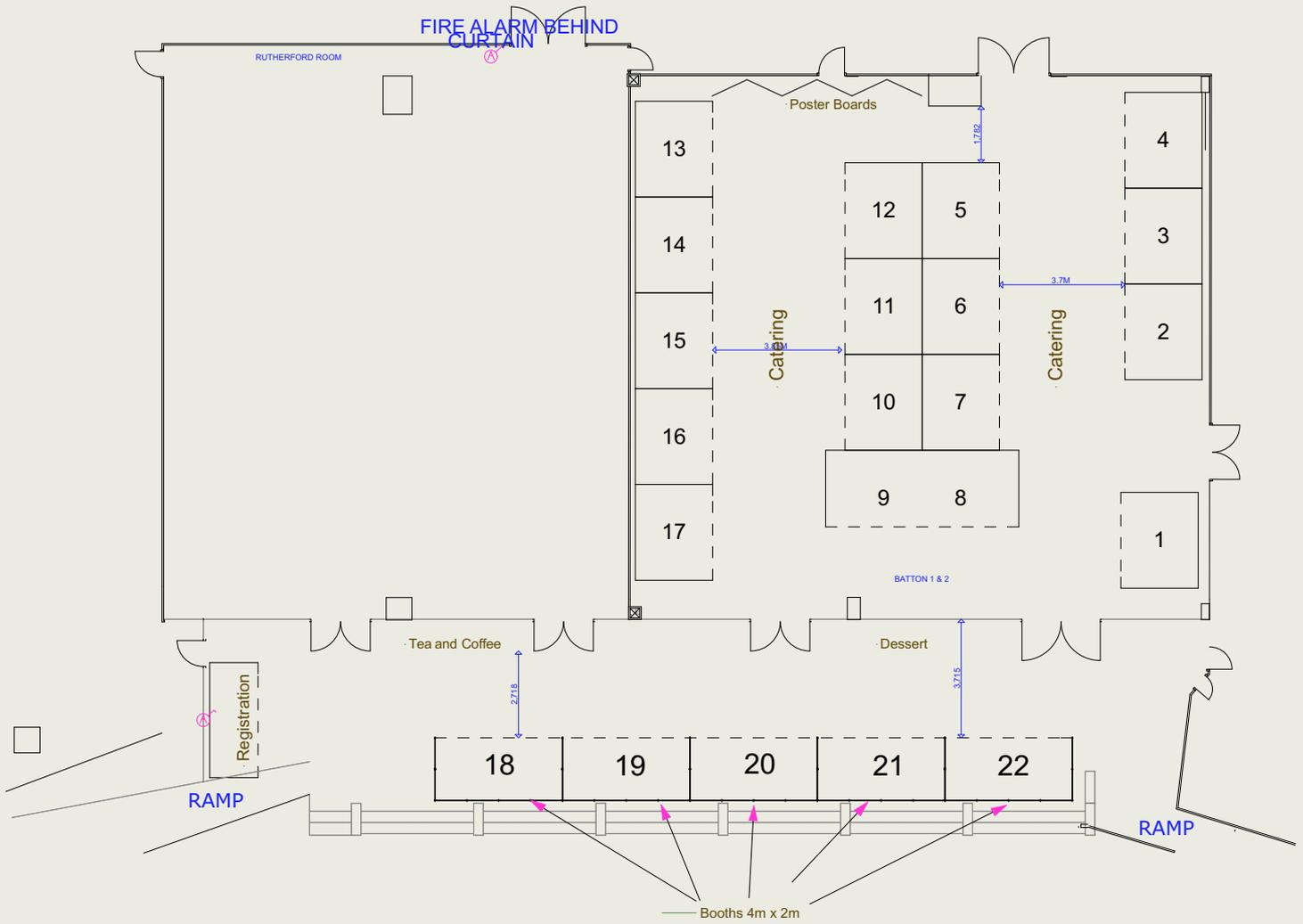
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EXHIBITION FLOORPLAN



DESTINATION INFORMATION

“Rotorua - feel the spirit – Manaakitanga” is our catch-cry ... and it holds a pretty powerful promise as well as an invitation to experience our extraordinary slice of New Zealand. A deep-rooted Maori cultural concept, Manaakitanga places a responsibility on us as your hosts to give you the best of ourselves, our time and our history. From the moment you arrive you will be truly looked after, inspired and provided with an experience you will never forget.

Located in the central North Island, the Rotorua district has a multi-cultural population of approximately 77,000 people. Rotorua is a city of spirit and adventure; an iconic international visitor destination renowned for its Maori culture and geothermal activity. Only a short drive from magnificent mountains, a host of lakes and the Pacific Ocean coastline, Rotorua offers a vast array of activities and a comprehensive range of accommodation types. Downtown there are over 250 shops, and a selection of more than 50 restaurants to choose from. The majority of the city's more than 13,000 accommodation beds are within walking distance of our leading venues.

Rotorua is a city filled with adventure and excitement, and there is something to suit everyone.

What's the Weather Like?

Rotorua enjoys a pleasant climate; plenty of sunshine in summer with crisp, clear days in winter. Rotorua averages more than 2000 sunshine hours and just over 140cm of rain annually.

March Temperatures

Autumn (March - May: daytime 20-25C)

ACTIVITIES



RIVER RATS RAFT & KAYAK 0800 333 900

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E: Justin Hutton: Justin@riverrats.co.nz

Welcome to River Rats, New Zealand's White Water Rafting, Rotorua Kayaking and Adventure Specialists. Based in Rotorua, River Rats Raft & Kayak have been offering quality adventures for over 25 years. We pride ourselves on a safety first culture and our attention to detail. We are also the first rafting company in New Zealand to be awarded the Qualmark Enviro Gold Award!

There's something for everyone, from a gentle grade 2 scenic raft trip suitable for participants as young as 5, through to full on grade 5 action featuring the world's highest commercially rafted waterfall. There are also plenty of Rotorua Kayaking options available as freedom hire or a guided tour. Paddle the local lakes to a secluded beach or enjoy a hot water swim only accessible by boat.





RotoruaNZ.com

Costs

RAFTING

Kaituna Grade 5	\$105
Rangitaiki Grade 3 - 4	\$139
Wairoa Grade 5	\$129
Tongariro Grade 3	Adults \$119 Children under 16 \$109
Rangitaiki Scenic Grade 2	Adults \$139 Children under 16 \$100

EFFECTIVE 01 OCTOBER 2013 TO 30 SEPTEMBER 2014

KAYAKING

Sit on Top Kayaks Rental Prices		Sea Kayaks Rental Prices	
2 hours	\$30	2 hours	\$35
4 hours	\$40	4 hours	\$50
1 day	\$60	1 day	\$70
3 days	\$130	3 days	\$150

GUIDED HOT POOLS KAYAK TRIP

Join us for a guided Kayak trip to the spectacular Manupirua Springs Hot Pools on Lake Rotoiti. This is one of the best Rotorua Kayaking options on offer! Paddle down the Ohau Channel and across Lake Rotoiti

to this amazing spot only accessible by boat. Situated right on the lake edge there are a range of hot pools of varying temperatures all fed from a natural hot spring.

Bookings are essential so please contact us to book your trip. Allow 4 hours.

Cost: \$110 per person

AGROVENTURES ADVENTURE PARK

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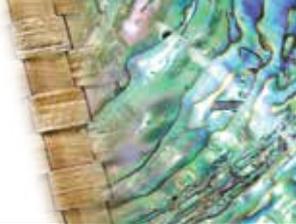
Sloop

Feel your heart beat as the anticipation increases as your raised 40 meters into the air high above the Ngongotaha stream, and then pulling a ripcord that plunges you into an exhilarating sloop towards the ground at 130kmph. Take the plunge on your own or get others to join you to make for a more intense experience.

Agrojet

Power around the purpose built watercourse in a high speed Hamilton Jet Boat. The G-force sensation is





akin to a Formula One Racing car in full throttle. Climb aboard. Snuggle into the bucket seat, click into your four-point race harness and let your pro driver show you what life's really like in the fast lane – because there is no slowing down for the corners!

Freefall Xtreme Body Flying

This is the closest you will get to be a super hero – fly unattached on a giant wind column. This activity is sure to have fellow delegates laughing till their sides hurt! Ever wanted to fly, pretend to be a superhero? Well experience the thrill of body flying; this is the only one of its kind in the southern hemisphere. Let the Freefall team guide you on the flight of your life as you step out into the flight zone.

Shweeb – Race Thru Space

Shweeb is a world first and is a human powered monorail racetrack. One to four delegates will race against the clock and each other over a 600m track in order to get the quickest time. This is a high impact challenge with anyone of all fitness levels being able to participate with ease.!

Bungy Jumping

Rotorua bungy provides some of the most spectacular views of the district, Lake Rotorua, Mokoia Island and far

below the trout filled Ngongotaha Stream. As you stand on the purpose built tower, 43 meters above scenic farmland, you'll hear your jump master call "3, 2, 1 Bungy! As you take the leap of faith. On completion pose with the Bungy crew in front of the cameras to celebrate your success.

Adventure Options	Tokens	Price	What can you get
Per Person (non-family)		NZ\$	
Single Ride	1	\$49	Any single "A" ride *
Pick Two	2	\$75	Any 2 "A" rides*
4 -Tune	4	\$99	Any 4 "A" rides* OR 1 Bungy**
VIP Adventure Pass	8	\$179	Any 4 "A" rides* + 1 Bungy** OR Any 8 "A" rides
FAMILY (up to 2 adults & 3 children)		NZ\$	
Family Starter Pack	6	\$149	6 "A" rides or 2X "A" rides + 1 Bungy
Family Mid-Range	8	\$179	8 "A"rides OR 4 "A" rides + 1 Bungy
Family Go Wild Pack	10	\$219	10 "A" rides or 6 "A" rides + 1 Bungy

- * "A" rides are any Agrojet, Freefall, Xtreme, Shweeb and Swoop (1 token for each)
- ** Bungy requires 4 tokens
- *** A family can share tokens between them. Other token options are per person only. eg: If 2 friends wish to do 4 rides each they would need 2 x 4-tune tokens and use 1 x 4-tune token each.





CANOPY TOURS

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This is the ONLY native forest zipline canopy tour in New Zealand and it is incredible - it's high, it's fun, it's beautiful, it's peaceful and you'll remember it for the rest of your life!! And it's suitable for almost everyone!! High amongst ancient native trees deep in a 500 hectare forest, this 3 hour adventure combines fun and excitement with pristine natural beauty. This is the New Zealand natural environment you have been promised!

Daily tour times

Current tour times are 9.00am, 10.00am, 1.00pm and 2.00pm, 7 days per week. Tours take 3 hours.

Current Office Hours: 8am – 6.00pm.

Cost

Adults:	\$129
15 and under:	\$85
2 adults & 2 children:	\$399

Included in the price:

- Pick up from city accommodation if required.
- Photos of your experience taken by guides
- Additional clothing such as jackets, gloves and warm hats
- All safety equipment
- No more than 10 customers and 2 guides per tour

AGRODOME

141 Western Road, Ngongotaha

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For over 40 years, visitors from all over the globe have come to the Agrodome to see our world-famous Farm Show – starring a cast of talented animals... and you! Plus, join the Organic Farm Tour to explore a real working farm, hand-feed loads of friendly animals, and sample delicious kiwifruit juice and honey from our land.

There's also the Nursery, with baby animals available for cuddles and photos all year round, and our Woollen Mill and Shearing Museum, where you'll learn the remarkable story of NZ pioneers the Bowen brothers, and discover the full process of wool from the Sheep's back to yours!





The Agrodome is one of New Zealand's must-see attractions, open in any weather, 365 days a year!!



Farm Show

Get ready for a fun-packed hour of entertainment and education for the whole family... the legendary Agrodome Farm Show! You'll hear amazing facts and have a few laughs as you're introduced to 19 breeds of sheep. Then, witness a live sheep shearing demonstration and a fun sheep auction with bidding from the floor and audience participation.

But our animal stars are not just sheep. Our remarkable farm dogs will amaze you, as they demonstrate their ability to respond to commands and keep those sheep (and ducks!) in line!

If a hands-on experience is what you want, jump up on stage for the opportunity to feed the baby lambs or even hand-milk a cow! Your ticket to the show includes access to the Farmyard Nursery, home to the smallest, cutest animals at the Agrodome.

Farm Tour

The Agrodome is located in the heart of a real 350-acre working farm. Join us for a guided tour of the farm, animals and our 100% organic fruit orchard. Climb aboard the all-weather, all-terrain vehicle as we begin

the tour. Along the way, there are fascinating things to learn - and a few laughs too! You'll get to hand-feed and take photos with all sorts of friendly animals, including Romney sheep, cattle, deer, llamas, ostrich, pigs and alpacas. You'll also explore our certified organic fruit orchard and olive grove and have the chance to taste 100% organic, natural kiwifruit juice or kiwifruit wine and delicious sweet honey that comes from the farm. Hands-on, entertaining and educational - kids and adults alike love the Farm Tour. Remember to bring your camera!

Shearing Museum

Travel half a century back in time to the Agrodome's authentic recreation of a 1950's-era Shearing Shed. Watch a sheep being shorn with vintage machinery and discover just how New Zealand became the world's number one wool growing nation! The Shearing Museum also tells the inspiring story of world champion sheep shearers the George and Ivan Bowen. Learn how these two brothers revolutionised the world's shearing and wool handling industries and see their game-changing Bowen method first hand.



ABSTRACTS — ORAL ABSTRACTS

SATURDAY 14 MARCH 2015

SESSION 1: COLORECTAL

08.30 – 09.00

Screening for Colorectal Cancer: Modern Problems and Solutions

Mr James Church, *The Cleveland Clinic, USA*

Colorectal cancer is a frustrating disease. It is common, has significant impact on patients and their families, and yet it is preventable. All colorectal cancers arise from a benign precursor lesion and removal of this lesion prevents cancer. Prognosis correlates with stage and early diagnosis results in better outcomes. Screening for colorectal cancer makes a lot of sense but its application is limited by financial, logistical and compliance issues. In this presentation, the current state of colorectal cancer screening will be discussed, highlighting present challenges and recent developments that promise better days ahead.

The preferred test for colorectal cancer screening is colonoscopy, which offers the ability to prevent cancer by removal of precancerous polyps. However it is invasive, carries a risk of significant complications, requires gut lavage, is expensive, not freely available and tends to miss lesions especially in the right colon.

Non invasive tests include fecal DNA testing, and fecal hemoglobin detection by either immunochemical analysis or guaiac. These tests are of variable sensitivity and specificity but are more affordable and less uncomfortable than colonoscopy. They need no prep. They do not allow prevention however and a positive test leads to colonoscopy.

Compliance with colorectal screening is lower than that for other cancers. There are many reasons for this. A current approach of FIT screening will find 70% of cancers.

High risk patients, with a personal or family history of colorectal neoplasia, or a history of chronic ulcerative colitis, need enhanced screening protocols.

Newer developments include enhanced fecal DNA testing, the Colon Pill Camera, and FUSE colonoscopy.

09.00 – 09.30

Clinical Standardisation

Prof. Robert Padbury

Divisional Director of Surgery, Flinders Medical Centre, Adelaide, Australia

A major problem facing healthcare is cost. There are many reasons for this including increasing technology and the expense of differentiation into an increasing number of subspecialty areas of expertise. However one problem that the profession can solve is the cost associated with waste in healthcare delivery. Recent studies from the USA and Australia have indicated that on average appropriate healthcare in the acute hospital sector is delivered around 55% of occasions of service. Clinical standardisation through implementation of protocols, and a consistent and robust approach to clinical improvement, can increase the reliability and quality of healthcare delivery and at the same time reduce waste, error and cost.



ABSTRACTS — ORAL ABSTRACTS**SATURDAY 14 MARCH 2015****09.30 – 10.00****Intestinal Failure from 'Woe' to Go'.****Prof. Bryan Parry**, *The University of Auckland, Auckland, New Zealand*

The spectrum of Intestinal failure ranges from self-limiting postoperative ileus to the extreme of intestinal transplant. Although it is an entity that surgeons commonly deal with as part of routine perioperative care, its worst manifestations can be very morbid for the patient, demanding of the surgical team, and costly for the service.

The importance of an active plan of management based on sound surgical principles in a team setting can't be emphasized enough. New research-based insights and multidisciplinary service developments offer much needed support to the individual surgeon who can feel isolated and even culpable for the patient's predicament.

SESSION 2: BREAST**10.30 – 11.00****Breast Cancer: How to Manage Regional Lymph Nodes in 2015?****Assoc. Prof. Ian Campbell** *Professor of Breast Surgery, Waikato DHB, Hamilton, New Zealand*

Why is it that surgeons are trying to do less and less treatment of regional nodes, while our radiation oncology colleagues are doing more and more?

Many early breast cancers are cured by surgery alone. They will not be cured, if disease is left behind. In this situation, we are reliant on systemic therapy and/or radiotherapy to mop up remaining cancer.

If we had therapies like we do for many lymphomas and germ cell tumours, that would be terrific, and we could avoid morbid surgery. For breast cancer, systemic therapy reduces local recurrence by only some 50%, and radiotherapy by approximately 66% (where macroscopic disease is cleared). These reductions are still a long way from our goal, and these treatments have morbidities of their own, sometimes worse than surgery.

Although axillary surgery is one of our most common treatments for breast cancer, the literature for and against axillary dissection is full of underpowered or badly interpreted studies, that have often been oversold by their investigators – ACOSOG Z0011 being one prime example.

This presentation will discuss the evidence for axillary dissection, with or without sentinel node biopsy.

11.00 – 11.30**Ethnic Disparities in Breast Cancer in New Zealand: Do Indigenous Māori Get a Worse Deal?****Dr Sanjeewa Seneviratne** *The University of Auckland, Auckland, New Zealand*

In New Zealand, Indigenous Māori women experience a significantly worse breast cancer survival compared with NZ European women. The underlying factors for this survival disparity are complex and is poorly understood.

From a population based study conducted in the Waikato, Māori women were observed to have a significantly worse cancer specific survival rate, and an age adjusted risk of death from breast cancer, more than double that for NZ European women. More advanced stage at diagnosis appeared to be the major factor contributing to excess breast cancer mortality in Māori, while other factors including differences in treatment, comorbidities, smoking, and obesity made significant



ABSTRACTS — ORAL ABSTRACTS

SATURDAY 14 MARCH 2015

contributions. Differences in cancer biological characteristics contributed minimally to the survival disparity for early stage cancer and for overall survival inequities. Differences in cancer stage, biology, treatment, comorbidities, smoking, and obesity explained almost all the observed survival disparity between Māori and NZ European women.

Equity focused improvements to healthcare, including increasing mammographic screening coverage for Māori women and providing equitable high quality and timely cancer care has the potential to significantly improve the survival disparity between Māori and NZ European women.

11.30 – 12.00

Breast Imaging, Future Directions in Population Screening, New Imaging Technology in Screening and Symptomatic Patient

Dr Barbara Hochstein *Radiologist, Lakes DHB, Rotorua, New Zealand*

Breast screening (usually with mammography) continues to be a very controversial topic. Over the last 25 years there have been conflicting recommendations about the benefit of screening for breast cancer. Mammography is an imperfect screening test, missing biological aggressive cancers and picking up indolent cancers that may not need treatment. In recent years “over diagnosis” and “over treatment” have become hot topics.

Is there a middle ground? Are there new approaches in risk stratified screening with better functional breast imaging tools?

This talk will focus on some of the background controversies in breast cancer screening and discuss the new tests being developed in the radiology community. 2D digital mammography, 3D digital mammography, contrast enhanced digital mammography, fast (3 min) MRI and molecular breast imaging. Risk stratified screening based on the Procas study “Predicting Risk of Cancer at Screening” by Prof Gareth Evans UK unit will also be discussed.

Commitment to Education: Expand your Skills with Hands - on Workshops

Paul Innes, *Applied Medical New Zealand*

As a new generation medical device company, Applied Medical offers educational training programs on the latest advancements in minimally invasive techniques for General, Gynaecologic, Colorectal, Bariatric and Urologic Surgeons. As educational needs have evolved, Applied Medical has implemented advanced high fidelity simulation and laparoscopic trainer programs to ensure a comprehensive training experience.

SESSION 3: UGI/HPB

13.00 – 14.00

Leadership in Healthcare

Prof. Robert Padbury, *Divisional Director of Surgery, Flinders Medical Centre, Adelaide, Australia*

Leadership is a much used phrase without clear and shared understanding of what it means in healthcare. There is a considerable disconnect between administrative and clinical groups in the understanding of the mechanisms of leadership of the respective groups. There is considerable evidence to support a distributed model of leadership in the clinical groups but this seems somewhat counterintuitive to the administrative streams who generally prefer a model of hierarchial





ABSTRACTS — ORAL ABSTRACTS

SATURDAY 14 MARCH 2015

accountability. The goals of the 2 groups should ultimately be aligned (i.e. excellent patient care) but a clear understanding of the mechanisms of clinical leadership is essential to this goal and will be explored in the presentation.

14.00 – 14.30

Update on Index Admission Cholecystectomy

Mr Peter Stiven, *General Surgeon, Tairāwhiti DHB, Gisborne, New Zealand*

Index admission cholecystectomy is the gold standard of care for patients presenting acutely with gallstone pathology. There are significant logistical hurdles for a department to provide this service, particularly in smaller centres and centres without ready access to ERCP. Here we explore the evidence and some novel solutions to the problems.

14.30 – 15.00

Endoscopy Quality in New Zealand – What the Future Holds

Dr David Theobald, *Clinical Director, National Endoscopy Quality Improvement Programme, New Zealand*

The National Endoscopy Quality Improvement Programme (NEQIP) has now established use of the NZGRS methodology in all publicly funded endoscopy units in the country. Results of the three national census points will be presented highlighting areas of improvement as well as impediments to units making further progress.

The need for an accreditation scheme and an underpinning governance structure to ensure long term sustainability will be examined in some detail as will the role the Royal Colleges may take in this area.

Johnson & Johnson Medical – Celebrating 20 years of NZAGS with Innovation & Collaboration.

Sue Martin, *Johnson & Johnson, New Zealand*

Providing accessible, affordable, high-quality health care to patients and consumers in a sustainable manner is one of society's most difficult and important challenges. It is also the greatest hope for a better future for every individual, every family, every community and every country. Johnson & Johnson works at the very center of this challenge, across the broadest base of any company in global health care. Every day we are working to help people throughout the world live longer, healthier, happier lives. Our broad base, ranging from pharmaceuticals to devices and diagnostics to consumer products, gives us a unique perspective on the needs, wants and hopes of people around the world.

We have over 128,000 employees worldwide, supporting over 250 operating companies and supply products to over 175 countries.

Within New Zealand our Medical Devices & Diagnostics, Pharmaceutical and Consumer businesses deliver thousands of innovative products and services, provide significant investment in education and training for local clinicians and HCP's and employ 160 New Zealanders.

Companies like J&J and industry as a whole are critical stakeholders and we look forward to being an active participant as we navigate change in delivering high quality, affordable health care to all New Zealanders.



ABSTRACTS — ORAL ABSTRACTS

SATURDAY 14 MARCH 2015

SESSION 4: FREE PAPERS

15.30 – 15.40

Gastrografin in Prolonged Post-Operative Ileus – A Double-Blinded Randomised Controlled Trial

R Vather, R Josephson, R Jaung, A Kahokehr, T Sammour, IP Bissett

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

Introduction: Gut wall oedema is central to the pathogenesis of prolonged post-operative ileus (PPOI). Hyperosmotic, orally-administered, water-soluble contrast media such as Gastrografin are theoretically capable of mitigating this oedema.

Aim: To investigate the therapeutic value of Gastrografin in shortening duration of PPOI following elective colorectal surgery.

Methods: A double-blinded, placebo-controlled, randomised trial was conducted. A standardised definition of PPOI was prospectively applied to the post-surgical cohort to identify those with the condition. Participants were allocated to receive 100ml of Gastrografin (Exposure Group) or flavoured distilled water (Control Group) administered enterally. Other aspects of management were standardised. Resolution of PPOI was assessed 12-hourly. The primary outcome was duration of PPOI.

Results: Eighty patients were randomised equally, with five in the Exposure Group and four in the Control Group excluded from analysis. Participants were evenly matched at baseline. Mean duration of PPOI did not differ between Exposure and Control Groups (83.7 vs. 101.3 hours; $p=0.191$). When considering individual markers of PPOI resolution, Gastrografin did not affect time to resolution of nausea and vomiting (64.5 vs. 74.3 hours; $p=0.404$) or consumption of oral diet (75.8 vs. 90.0 hours; $p=0.297$). However, it accelerated time to flatus or stool (18.9 vs 32.7 hours; $p=0.047$) and resolution of abdominal distension (52.8 vs 77.7 hours; $p=0.013$). There were no significant differences between groups in nasogastric output; analgesia, antiemetic or fluid requirement; complications; or length of stay.

Conclusion: Gastrografin is not clinically useful in shortening an episode of PPOI characterised by upper and lower gastrointestinal symptoms. It may however be of therapeutic benefit in the subset of PPOI patients who display lower gastrointestinal symptoms exclusively.

15.40 – 15.50

Adherence to Sepsis Six in Acute Surgical Patients

N Davis^{1*}, N Hodges^{2*}, K Rapson^{3}, J Barnard^{4***}, L Humphreys^{5*}, H Hammodat^{6*},
L Hsee^{7**}, A Connolly^{8***}**

** Waitemata DHB, Auckland, New Zealand*

***Auckland DHB, Auckland, New Zealand*

**** Counties Manukau DHB, Auckland, New Zealand*

Introduction: The Sepsis Six is a set of medical interventions designed to reduce mortality in septic patients. The six include: delivery of high flow oxygen, taking blood cultures, administration of empiric IV antibiotics, measurement of serum lactate and FBC, IV fluid resuscitation and accurate urine output measurement. Compliance with Surviving Sepsis guidelines have been associated with a reduction in mortality by a third.

Aims: To review our compliance with Sepsis Six in acute surgical patients presenting with sepsis.





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Methods: In conjunction with SPARCS as part of an international multicenter audit we ran an audit of all general surgery acute patients presenting to the 3 Auckland DHB's between the dates of 21 Oct - 27 Oct 2013. Compliance with the components of Sepsis Six was recorded for each patient.

Results: There were 402 acute admissions to the 3 general surgery departments, 69 of these had sepsis. Adherence to Sepsis Six was generally poor with delivery of high flow oxygen 5 (7%), taking of blood culture 22 (32%), administration of antibiotics 58 (84%), administration of IVF 47 (68%), measurement of lactate 23 (33%), FBC 69 (100%) and UO 19 (28%).

Conclusion: We recommend staff education and a sepsis pro forma to prompt admitting staff which should result in improved compliance and as a result better patient outcomes.

15.50 – 16.00

Cost Analysis of Early Versus Delayed Loop Ileostomy Closure: a Case-Matched Study

Jason Robertson*, Hannah Linkhorn, Ryash Vather*, Rebekah Jaung*, Ian P Bissett***

*Department of Surgery, The University of Auckland, Auckland, New Zealand (JP Robertson MBChB, R Vather MBChB, R Jaung MBChB, IP Bissett MD FRACS)

**Department of Surgery, Auckland DHB, Auckland, New Zealand (H Linkhorn MBChB)

Introduction: The optimal timing for closure of loop ileostomies remains controversial. In order to address stoma related morbidity, early ileostomy closure (EC) (within 2 weeks of the index operation) has been advocated in selected patients^{1, 2}. EC is performed during the same admission as the index operation and therefore increases the initial hospital stay (and associated costs). However, EC also eliminates the need for community stoma nursing, ongoing stoma appliances and the subsequent readmission to undergo ileostomy reversal. It has been hypothesized that these benefits combined with potential reductions in stoma related morbidity may translate into significant healthcare savings.

Aims: The aim of the current study is to investigate if EC results in significant healthcare savings when compared to late closure (LC).

Methods: A retrospective review of all patients with available cost data that underwent EC between January 2008 and December 2012 at Auckland City Hospital were compared against matched patients undergoing LC during the same period. Post-operative complications and direct hospital costs for the two groups were compared.

Results: There were 42 EC patients and 61 matched LC patients. EC patients had significantly less ileostomy related complications ($p < 0.001$) and hospital readmissions ($p < 0.001$). Operative time ($p < 0.001$) and operative cost ($p = 0.002$) were also both significantly less in the EC group. Community nursing costs favoured the LC group ($p = 0.047$). The EC group had an increased post-closure wound infection rate ($p = 0.02$). The mean total direct cost per patient was NZD\$13724 (SD\$3736) for EC and NZD\$16728 (SD\$8028) for LC. Representing an average costs saving of NZD\$3004 per patient favouring EC ($p = 0.012$).

Conclusion: Although EC increases the post-closure wound infection rate, EC reduces ileostomy complications, hospital readmissions and operative costs resulting in significant healthcare savings. In order to improve patient outcomes and make EC even more cost-effective efforts should focus on reducing wound infections.



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References:

1. Alves A, Panis Y, Lelong B, Dousset B, Benoist S, Vicaut E. Randomized clinical trial of early versus delayed temporary stoma closure after proctectomy. *Br J Surg.* 2008;95(6):693-8.
2. Omundsen M, Hayes J, Collinson R, Merrie A, Parry B, Bissett I. Early ileostomy closure: Is there a downside? *ANZ J Surg.* 2012;82(5):352-4.

16.00 – 16.10

The Cost of Laparoscopic Colorectal Surgery in a Provincial New Zealand Hospital

B. Cribb*, N. Henderson*, F. El Haddawi*

** Department of Surgery, Taranaki Base Hospital, New Plymouth, New Zealand*

Introduction: Laparoscopic colorectal surgery has been associated with improved post operative outcomes and shorter length of inpatient hospital stay compared with open surgery^{1,2}. However, there are concerns regarding the potential higher cost of laparoscopic colorectal surgery.

Aim: To assess and compare the cost of laparoscopic and open colorectal surgery at Taranaki Base Hospital.

Methods: Data was prospectively collected on all patients who underwent a colonic resection (both acute and elective) over a 12 month period from the 9th December 2013 to 8th December 2014. Costing data was collected from the Taranaki District Health Board Management Information Unit and were based on national common costing standards from the Ministry of Health. Detailed costs were calculated for both the operation and inpatient stay.

Results: 91 patients underwent colonic resection during the study period. The majority of patients underwent open surgery (63%, n=57), had left sided resections (70%, n=64), elective surgery (71%, n=65), and had a malignant indication for surgery (78%, n=71).

The mean operative time was longer for laparoscopic surgery than for open surgery (164 mins vs 122 mins). The mean length of inpatient stay was on average shorter for laparoscopic surgery than open surgery (9 days vs 13 days).

Mean theatre cost was more expensive for laparoscopic surgery compared with open surgery (\$11,577 vs \$8,397). The mean inpatient cost was less expensive for laparoscopic surgery than open surgery (\$14,120 vs 17,727). Overall, the mean total cost was less expensive for laparoscopic surgery than for open surgery (mean: \$26,149 vs \$26,330).

Laparoscopic surgery was also on average less expensive than open surgery for both left and right sided colonic resections (means: left \$27,047 vs \$27,890, right \$21,120 vs \$23,990).

Conclusion: In this study laparoscopic colorectal surgery was not more expensive than open surgery. This study suggests that there may be potential cost savings with laparoscopic colorectal surgery.

References:

1. Abraham NS, Young JM, Solomon MJ. Meta-analysis of short term outcomes after laparoscopic resection for colorectal cancer. *Br J Surg.* 2004;91:1111-1124.
2. Braga M, Vignali A, Gianotti L, et al. Laparoscopic versus open colorectal surgery : a randomized trial on short-term outcome. *Ann Surg.* 2002;236:759-767.



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16.10 – 16.20

Acute Cholecystectomy is Possible in Provincial New Zealand**D Wijayanayaka*, W Watson*****General Surgery, Rotorua Hospital, Lakes DHB, Rotorua, New Zealand*

Introduction: The timing of cholecystectomies for acute gallstone disease is controversial, however there is evidence to suggest that acute surgery leads to decreased overall morbidity and cost¹. In New Zealand, acute cholecystectomy for acute gallstone disease is becoming the standard of care in tertiary centres. However, previously published data² suggest that due to resource constraints this may be unfeasible in provincial New Zealand.

Aims: To evaluate if it is possible to offer timely and safe acute cholecystectomies for acute gallstone disease in a provincial New Zealand hospital.

Methods: Retrospective audit of all acute cholecystectomies performed at Rotorua Hospital between July 2013 and July 2014.

Results: A total of 142 cholecystectomies were performed in Rotorua Hospital over the study period. Ninety four (66%) were performed on the acute operating list. Of those performed on the acute operating list, where a pre-operative ERCP was not required (87/94), the average door to theatre time was 54.15 hours and 76.3% of patients received surgery within 72 hours. 67% of patients received surgery within 24 hours of being placed on the acute theatre list. The overall open conversion rate was 17.2%. The average post-operative length of stay was 2.57 days, and the average total length of stay was 5.13 days. Thirty day mortality was 1.1%.

Conclusion: These data suggest that it is possible to offer timely and safe acute cholecystectomies for acute gallstone disease in a provincial New Zealand hospital.

References: Gutt CN, Encke J, Köninger J, Harnoss JC, Weigand K, Kipfmüller K, Schunter O, Götze T, Golling MT, Menges M, Klar E, Feilhauer K, Zoller WG, Ridwelski K, Ackmann S, Baron A, Schön MR, Seitz HK, Daniel D, Stremmel W, Büchler MW. Acute cholecystitis: Early versus delayed cholecystectomy, a multicenter randomized trial (ACDC Study, NCT00447304) *Ann Surg.* 2013;258(3):385–393.

Welch MJ, Moot AR. Timely cholecystectomy for acute gallstone disease: an ongoing challenge in a New Zealand provincial centre. *NZMJ.* 2014;127(1392):48-57

16.20 – 16.30

Anterior Resection Syndrome – A Risk Factor Analysis**C Wells*, R Vather*, M Chu*, J Robertson*, I Bissett***** Department of Surgery, The University of Auckland, Auckland, New Zealand*

Introduction: Evacuatory dysfunction after distal colorectal resection varies from incontinence to obstructed defaecation and is termed anterior resection syndrome.

Aims: This study aimed to identify risk factors for the development of anterior resection syndrome.

Methods: All anterior resections undertaken at Auckland Hospital from 2002-2012 were retrospectively evaluated. An assortment of patient and peri-operative variables were recorded. Cases were stratified by occurrence of anterior resection



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syndrome symptoms from 1-5 years post-operatively.

Results: 277 patients were identified. Prevalence of anterior resection syndrome decreased progressively from 61% at 1 year to 43% at 5 years. Univariate analysis identified anastomotic height, surgeon, pT stage, procedure year and temporary diversion ileostomy as recurring significant correlates ($p < 0.05$). Logistic regression identified lower anastomotic height (OR 2.12, 95%CI 1.05-4.27; $p = 0.04$) and obstructive presenting symptoms (OR 6.71, 95%CI 1.00-44.80; $p = 0.05$) as independent predictors at 1 and 2 years respectively. Post-operative chemotherapy was a predictor at 1 year (OR 1.93, 95% CI 1.04-3.57; $p = 0.03$). Temporary diverting ileostomy was an independent predictor at 2 (OR 2.49, 95% CI 1.04-5.95; $p = 0.04$), 3 (OR 4.17, 95% CI 1.04-16.78; $p = 0.04$), 4 (OR 8.05, 95%CI 1.21-53.6 $p = 0.03$), and 5 years (OR 49.60, 95% CI 2.17-1134.71; $p = 0.015$) after correcting for anastomotic height.

Conclusion: Anastomotic height, post-operative chemotherapy and obstructive presenting symptoms were independent predictors at 1 and 2 years. Temporary diversion ileostomy was an independent predictor for the occurrence of anterior resection syndrome at 2, 3, 4, and 5 years even after correcting for anastomotic height. Prospective assessment is required to facilitate more accurate risk factor analysis.

16.30 – 16.40

Can We Achieve a Better Outcome in Emergency Laparotomy? An Audit of Auckland City Hospital Mortality

L Hsee FRACS*, A. Merrie FRACS*, I Civil FRACS*

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

Introduction: Emergency laparotomy is a common surgical procedure. The resources available for emergency laparotomy are often less readily available than for high-risk elective surgery due to a multitude of factors raising the possibility of less satisfactory outcomes. Recently studies have been published in the UK addressing this issue. The National Emergency Laparotomy Audit (NELA) UK revealed the unadjusted 30-day mortality was 14.9% and 24.4% for patients over 80. The development of a quality improvement bundle resulted in improved outcomes.

Aims: Our aim is to evaluate our outcomes after emergency laparotomy over a twelve-month period.

Methods: The ADHB Business Intelligence Unit compiled the patient data for this study. 'Emergency Laparotomy' was defined by consensus of ADHB Surgeons and Anaesthetists and included various clinical presentations and surgical pathologies. The relevant surgical codings were extracted using the hospital Patient information Management Systems (PIMS) to identify patients having surgery between 1 January and 31 December 2012.

Results: There were 376 patients who underwent emergency laparotomy; M: F 196:180. The overall 30-day mortality was 6.6%. The 90-day mortality was 9.0%. The mortality rate increased significantly for patients > 75 years old (6%) and > 85 years old (25%). Seventy patients were admitted to ICU. Consultants were the primary surgeons in 42% of cases while 54% of patients were operated on by Fellows/Senior Registrars. The mortality rate increased with ASA (ASA4-20.8% & ASA 5-66%).

Conclusion: The Auckland City Hospital results were comparable with the NELA report. As the result, a peri-operative Care Pathway is being developed at our institution. The pathway includes timely senior input, formal assessment of risk of death, ready availability of investigations, goal directed therapy and routine ICU assessment.



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16.40 – 16.50

Rectal Enhanced Recovery after Surgery Protocol; Experience in the Bay of Plenty**S Yassaie***, **J Gudex****, **M Omundsen*****, **H Collins******** Surgical Registrar, Tauranga Hospital, Tauranga, New Zealand**** House Officer, Tauranga Hospital, Tauranga, New Zealand***** Colorectal and General Surgical Consultant, Tauranga Hospital, Tauranga, New Zealand****** Colorectal Nurse Specialist, Tauranga Hospital, Tauranga, New Zealand*

Introduction: The Bay of Plenty DHB has had successful implementation of ERAS protocols for operations involving small bowel and colon resections since September 2012. In July 2013 a new protocol was implemented for patients undergoing rectal resections.

Aims: To analyse the patient outcomes after implementation of the new rectal ERAS protocol.

Methods: All patient notes from Tauranga and Whakatane hospital who underwent elective rectal resections were retrospectively reviewed over a 13 month period July 2013 when the new ERAS protocol commenced. A historical control consisted of all patients in Tauranga and Whakatane Hospital from January 2012 to February 2013 who underwent elective rectal resections and who would have been eligible for the new ERAS protocol.

Results: 38 patients had elective resections from July 2013 to August 2014. 5 patients were excluded as the surgeon declined complete involvement in the ERAS protocol. 41 patients had resections from January 2012 to February 2013 (pre-ERAS). 12 patients were excluded from the same surgeon who declined ERAS involvement.

Pre-ERAS vs. ERAS group length of stay was 10.2d vs 10.1d (p 0.9). There was no significant difference in complication and re-admission rates between groups.

Conclusion: This retrospective cohort study does not show a reduction of day stay with the use of ERAS protocol in rectal resection.

References: Nygren, J., Thacker, J., Carli, F., Fearon, K. C. H., Norderval, S., Lobo, D. N., ... & Ramirez, J. (2012). Guidelines for perioperative care in elective rectal/pelvic surgery: Enhanced Recovery After Surgery Society recommendations. *Clinical Nutrition*, 31(6), 801-816.

16.50 – 17.00

Laparoscopic Choledochotomy And Flexible Choledochoscopy: A Hole In One**YC Lau***, **S Srinivasa***, **B Jauffret***** Department of Surgery, Hastings Memorial Hospital, Hastings, New Zealand*

Introduction: Technological improvements have made laparoscopic treatment for choledocolithiasis reliable. Procedure related complications and long term CBD stones recurrences after ERCP are substantial issues. In our organization both approaches are available.

Aims: To evaluate respective resources consumptions and ductal clearance rates of single stage laparoscopic CBD clearance through choledochotomy and cholecystectomy versus two stage ERCP ductal clearance prior to laparoscopic cholecystectomy.



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Methods: A Prospective comparative study of 2 treatments for complicated choledocolithiasis was carried out from April 2013 to October 2014; laparoscopic one stage versus endoscopic and laparoscopic two stages. Only sentinel presentations were included. Primary outcome was length of stay. Secondary outcomes were CBD clearance, theatre time, admissions number, 30 day morbidity/mortality. A recruitment of 24 patients in each arm was required for a significant day stayed difference of 1 day ($p < 0.05$).

Results: Demographics between both groups were similar. One stage: 24 patients with 100% ductal clearance. Two stages: 27 patients, 6 failed cannulation, 5 had no CBD calculi identified, 16 ductal stones identified with 88% ERCP clearance. Failed ERCP patients were all cleared laparoscopically. Length of stay for 1 stage group was 6 versus 9 days ($P = 0.007$). Theatre time was similar at 168 (1 stage) versus 163 minutes respectively ($P = 0.71$). Total admission was 1 for 1 stage versus 2 ($p = 0.001$). One patient died in the 2 stages group after the cholecystectomy. Morbidities in each arms were similar, 29% (1 stage) versus 18% for 2 stages ($P = 0.51$). Of which 1 procedure related complication in 1 stage group; a bleed requiring reoperation, versus two procedure related complications; a pancreatitis and an ERCP bleed requiring re-intervention.

Conclusion: With shorter stay, less admissions, higher clearance rate and fewer procedures, single staged laparoscopic approach is more efficient and cost effective than 2 staged approach.

17.00 – 17.10

Cholecystectomy for Acute Calculous Cholecystitis: Dangerous to Delay?

Andy Pun*, Albert Wu*, Lindsay Fairfax, Li Hsee***

**Acute Surgical Unit, Department of Surgery, Auckland City Hospital, Auckland, New Zealand*

***Trauma Services, Department of Surgery, Auckland City Hospital, Auckland, New Zealand*

Introduction: Cholecystectomy remains the preferred definitive treatment for acute calculous cholecystitis [ACC]. However, not all patients are appropriate for surgery acutely on index admission.

Aims: This study reviews the constraints to acute surgery and resulting outcomes for initial non-operative management of ACC under at Auckland City Hospital.

Methods: The records of patients first admitted between January 2010 and December 2012 with imaging-confirmed ACC were reviewed, and were divided into operative [OP] and non-operative [NON] groups. NON included management with antibiotics or percutaneous cholecystostomy drainage. Mortality, readmission, length of stay [LOS] and complications data were obtained. Readmission was defined as representation within 28 days of the initial admission.

Results: 366 patients with ACC were admitted during the study period, with 87 (24%) in the NON group. More NON patients were readmitted compared to the OP group (24% vs. 7%, $p < 0.05$). 9 of 21 readmitted NON patients required acute cholecystectomy. Initial average LOS for both groups was similar (6.5 vs. 6.2 days). Readmission LOS was 6.4 days. The most common factors precluding acute surgery were co-morbidities (46%), improvement of symptoms at first admission (16%) and patient's choice to decline acute surgery (17%).

Conclusion: There is a high readmission rate in patients with ACC managed non-operatively and they often require acute surgery on readmission. While factors such as patient's co-morbidities cannot be modified at acute admission,



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patient's refusal and surgeon preference may be influenced by awareness of the possible consequences of non-operative management. Acute cholecystectomy remains the gold standard management for ACC.

17.10 – 17.20

Anastomotic Leaks: Just What is it about the Pelvis?**L Yuan, W Baraza, I Bissett***Auckland City Hospital, Auckland, New Zealand*

Introduction: One of the most debilitating complications for patients in colorectal surgery is the anastomotic leak. Leak rates vary widely as do the treatment modalities and outcomes. There are limited data on how intestinal leaks are managed once they present.

Aims: We aimed to determine the incidence, management and outcomes in patients suffering an anastomotic leak after undergoing intestinal anastomoses of the small and large bowel.

Methods: The setting was a large teaching hospital in New Zealand. A retrospective review of the Otago Clinical Audit (OCA) and theatre coding databases was performed to select all relevant cases that underwent anastomosis. A further search of the OCA database, theatre and patient records was performed to identify those who had had a leak and to ascertain how they were managed.

Results: The data from the period January 2008 – December 2013 was obtained. There were a total of 1456 anastomoses fashioned. The median time to leak detection was 6 days (1-162, IQR 5.5). The median time to treatment from first signs of a leak was 2 days (0-32, IQR 4). The overall leak rate was 6.5%. The leak rate was highest in low anterior resections (10.4%) and pouches (18.4%) Surgery was required in 58% of leaks (type C leaks). 16% of patients were managed with transanal or radiological drainage (type B). 26% of patients were managed conservatively (type A). Patients with a defunctioning stoma had a significantly lower chance of having a type C leak ($p=0.0016$). 25% of patients initially graded as a type A leak subsequently required more aggressive treatment.

Conclusion: Anastomotic leaks occur most commonly after low anterior resections and diagnosis may be delayed. A defunctioning stoma may reduce the requirement for laparotomy. There is scope for interventions that reduce the incidence of this complication.

17.20 – 17.30

What Does the Excised Stomach from Sleeve Gastrectomy Tell Us?**M Lauti*, S Gormack**, J Thomas**, J Morrow***, H Rahman***, A MacCormick******* Research Fellow & Surgical Trainee, The University of Auckland, Auckland, New Zealand**** Resident Medical Officer, Middlemore Hospital, Auckland, New Zealand***** Bariatric Surgeon, Middlemore Hospital, Auckland, New Zealand*

Introduction: Bariatric surgeons are divided as to whether pre-operative endoscopy should be routine or selective prior to sleeve gastrectomy. Bariatric surgeons at Middlemore Hospital perform selective endoscopy, referring pre-operative patients for gastroscopy when they are symptomatic or undergoing revisional surgery. We wanted to investigate whether occult gastric histologic diagnoses were associated with staple-line leak or bleed – the most serious early complications of sleeve gastrectomy.



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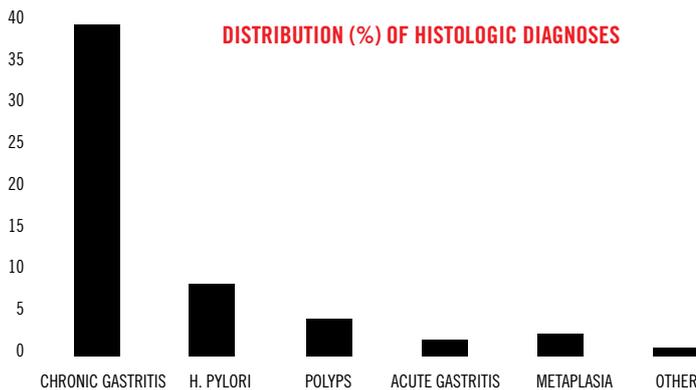
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Aims:

- To describe the excised stomach histology in a series of sleeve gastrectomy specimens.
- To explore whether histologic diagnosis is associated with post-operative leak or bleed.
- To comment on the use of endoscopy prior to sleeve gastrectomy.

Methods: Consecutive patients undergoing laparoscopic sleeve gastrectomy from March 2007 to May 2014 were included in the study. All final histologic reports were coded and investigated against whether or not the patient had a post-operative leak and/or bleed. Associations were explored using Fisher's exact test.

Results: Over this period, 976 laparoscopic sleeve gastrectomies were performed. More than half of all gastric specimens showed an abnormality. The distribution of histologic diagnoses can be seen in the chart below. There were no incidental findings of malignancy but 12% of specimens exhibited features of premalignant change. There were no associations between histologic diagnosis and post-operative leak or bleed.



Conclusion: Although a histologic diagnosis is common in the resected stomach from sleeve gastrectomy, it is not related to post-operative bleed or leak. Histologic examination of the resected stomach may aid in identifying patients at increased risk of adenocarcinoma in the remnant. These findings support selective endoscopy in pre-operative sleeve gastrectomy patients.



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SESSION 5: COLORECTAL

08.30 – 09.00

Understanding Anorectal Disease Leads to Appropriate TreatmentMr James Church, *The Cleveland Clinic, USA*

Operating on anorectal conditions is generally not done well. It is not a particularly glamorous job and the anorectum is not top of the list for conversation around the dining table. However disorders of the anorectum are very symptomatic, often chronic (due to a reluctance on the part of patients to report the symptoms) and usually tricky to diagnose. There is a lot of complex anatomy and physiology, and surgery in such a confined and potentially dirty area can easily make matters worse. The aim of this talk is to demystify anorectal surgery by enhancing understanding of physiology and by laying down rules for operating. The presentation will cover common anorectal conditions such as haemorrhoids, fissure, fistula, rectocele and incontinence.

Understanding anatomy and physiology

There is a marked variation in anal anatomy and physiology. Important considerations include the tightness and sensitivity of the anal sphincters, bowel habit (vis a vis straining), and the cause of bowel irregularity. Prior surgeries cause scarring and often make matters worse.

Correct diagnosis

This is obviously crucial to effective treatment, but symptoms overlap. Pain can be from the internal sphincter (anismus, fissure, cancer), haemorrhoids (thrombosed external haemorrhoids, IVth degree internal haemorrhoids), sepsis (abscess or fistula) or the pelvic floor (levator spasm). Bleeding can be from haemorrhoids, polyps, fissure, abscess, fistula, cancer, radiation, ulceration, excoriated skin, STD, IBD, fragile vessels, AVM, straining at stool. Lumps can be haemorrhoids, hypertrophied papilla, polyps, cancer, epidermal inclusion cysts, warts, lipomas. Faecal incontinence can be due to damaged sphincters, weak sphincters, rectocele, irritable bowel syndrome, gastroenteritis, colitis.

Principles of operating on the anorectum

- No deadspace
- No tension
- No ischemia
- No undrained cavity
- No cautery

09.00 – 09.20

Fad or Fact? Laparoscopic Ventral Mesh Rectopexy for Rectal ProlapseMr Rowan Collinson, *Auckland DHB, Auckland, New Zealand*

Laparoscopic Ventral Mesh Rectopexy (LVR) for external rectal prolapse has become the procedure of choice in many centers over the last 10 years. Good results in these patients has generated enthusiasm for surgery on internal rectal prolapse also, historically a surgical 'untouchable'. Adoption of the technique has a sound theoretical basis, as will be expanded upon. The concept is not new - anterior fixation approaches to rectal prolapse date back over to over a century ago. However, the evidence base for LVR still remains at the level of case series, with no randomized trials ever performed.



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There are significant long-term functional and safety concerns still to play out. Detractors of the procedure would say that for these reasons LVR is a surgical 'fad' which is far from standard of care, while supporters maintain that LVR is now a surgical 'fact' of life. As usual, the truth probably lies somewhere in the middle.

09.20 – 09.40

Rectal Cancer: MRI Staging

Dr Barbara Hochstein, *Radiologist, Lakes DHB, Rotorua, New Zealand*

Rectal cancer is a common and serious disease. Several studies have been published that show the ability to accurately stage rectal cancer with MR (magnetic resonance) imaging. MR imaging is now an essential tool to enable the oncology team to make appropriate treatment decisions. As we enter the era of individualized patient care, imaging takes on increasing importance. Rectal cancer evaluation with MR is a challenge; the mnemonic "DISTANCE" enables you to have a systematic approach. This is based on Dr. Gina Brown's teaching at Royal Marsden Hospital, England.

DIS = distance from inferior part of the tumour to the transitional skin

T = T staging

A = Anal complex

N = Nodal staging

C = Circumferential resection margins

E = Extramural vascular invasion

09.40 – 10.00

Mesh in Hernia Repair - What's the Evidence?"

Mr Michael Rodgers, *Waitemata DHB, Auckland, New Zealand*

Most General Surgeons routinely use synthetic mesh for the repair on inguinal hernias. Given the level of public concern about complications associated with implanted Mesh this talk will review the current literature and local data to determine if public concerns are well founded or otherwise.

SESSION 6: SURGEON'S HEALTH

11.00 – 11.30

Physician Burn Out: What is it, Who's at Risk, How to Manage it

Dr Darren Malone, *Psychogeriatrician, Lakes DHB, Rotorua, New Zealand*

Physician burnout is all too common and we all suffer from this to some degree at some stage in our career. This will be a snappy presentation which will cover the definition of burnout, prevalence, the different stages, protective and risk factors for burnout. How to identify and helpful tips on how to manage burnout.



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11.30 – 12.30

Panel on Private Fees

Mr Ian Burton, *Chelsea Hospital, Gisborne*, **Ms Phillipa Mercer**, *Christchurch Surgical Associates, Christchurch* & **Mr John Dunn**, *Endoscopy Auckland*,
and **Mr Geoff Searle & Ms Becky Ogilvie**, *Southern Cross Healthcare, New Zealand*

Moderator: **Mr Michael Rodgers**, *Waitemata DHB, Auckland, New Zealand*

SESSION 7: DEBATE: THE ESTABLISHMENT OF A GENERIC GENERAL SURGERY PRIORITISATION TOOLS IS A WORTHWHILE GOAL FOR NEW ZEALAND

13.30 – 14.30

DEBATE: The Establishment of a Generic General Surgery Prioritisation Tools is a Worthwhile Goal for New Zealand

Protagonists: **Mr Andrew MacCormick**, *General Surgeon, The University of Auckland & Counties Manukau DHB, Auckland, New Zealand* &

Mr Tim Eglinton, *Canterbury DHB, Christchurch, New Zealand*

Antagonists: **Mr Win Meyer-Rochow**, *Endocrine & General Surgeon, Waikato DHB, Hamilton, New Zealand* &

Chris Gray, *South Canterbury DHB, Timaru, New Zealand*

14.30 – 14.50

Reoperative Abdominal Surgery...Entering Tiger Country

Mr James Church, *The Cleaveland Clinic, USA*

Abdominal surgery is a serious business. The diseases that require surgery are serious, and the sequelae of the operations themselves are also concerning. Adhesions occur after almost every laparotomy and result in bowel obstruction in about 10% of cases. Complications of bowel resection such as anastomotic leak, abscess and fistula can be life threatening while ventral hernias and mesenteric torsions can also present as emergencies. Reoperating on patients who have had an index abdominal surgery can be daunting. In this era of minimally invasive surgery, experience with maximally invasive surgery is declining and there is a danger of losing some of the principles that underpin safe and effective reoperative technique. The aim of this presentation is to describe the circumstances that demand reoperation and to provide some technical tips to make reoperation easier and safer.

Challenges of Reoperative Abdominal Surgery:

- Adhesions
- Altered Anatomy
- Absent Planes

Strategies for Reoperative Abdominal Surgery:

- Knowledge
- Defining aims
- Preparation
- Timing
- Quitting

Techniques for Reoperative Abdominal Surgery:

- Stay away from trouble
- Do the easy bits first
- Be aware of the state of the tissues
- Beware the mesenteric margin
- Dissect adhesions safely
- Hemostasis
- Anastomose or divert
- Quarantine granulations
- Check for damage
- Repair serosal tears



ABSTRACTS — POSTER ABSTRACTS

POSTER 1:

Cutaneous Melanoma in New Zealand: 2005-2009

K. Broughton MbChB*; G. Tarr MbChB; R. C. W. Martin MBChB, FRACS, ChM. ‡

*Waitemata DHB, North Shore Hospital ‡Department of Surgery, Auckland, New Zealand

Introduction: Incidence of cutaneous melanoma (CM) has previously been published for the years 1995 – 1999 and 2000 – 2004. Here we present the trends in New Zealand's cutaneous melanoma for 2005 – 2009.

Aims: To provide up-to-date information on the trends of CM in New Zealand by analysis of the New Zealand Cancer Registry from 2005 to 2009.

Methods: The New Zealand Cancer Registry data was obtained through a computerized search of CM ICD-10 (172) codes from 2005 to 2009. Only one entry per person was allowed in the data analysis. Exclusion criteria included melanoma-in-situ, benign naevi and data that was incomplete or inaccurate.

Results: Compared to the previous years studied, the incidence of CM has increased from 41.2 per 100 000 in the 1995 – 1999 period to 47 per 100 000. There were 10,732 cases of cutaneous melanoma diagnosed in New Zealand during this five-year period. As with the previously analysed years, CM incidence was higher in males who again had thicker Breslow thicknesses (0.92 mm compared with 0.83 mm in women, $p < 0.0001$). The average Breslow thickness increased from 0.8 mm to 0.87 mm. Again, Taranaki District Health Board demonstrated the highest rates (69.8 per 100 000) and Southland the lowest (27.6 per 100 000).

Conclusion: New Zealand (NZ) has one of the highest CM rates in the world. Being male and over the age of 54 years confers the highest risk for development of CM in NZ. Despite increased knowledge and awareness about melanoma, the increasing incidence and Breslow thicknesses of CM indicates the increased need for prevention and early detection.

References: Liang J, Robinson E and Martin R. Cutaneous melanoma in New Zealand: 2000-2004. Aust. N. Z. J. Surg 2010; 80: 312-316.

POSTER 2:

The Cost of Complications in Colorectal Surgery

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Introduction: Assessment of the costs to the health care system of post operative complications is important to promote the development of strategies for complication prevention.

Aim: To assess the costs associated with complications following colorectal surgery, with a focus on preventable complications.

Methods: Data was prospectively collected on all patients who underwent a colonic resection (both acute and elective) over a 12 month period from the 9th December 2013 to 8th December 2014. Costing data was collected from the Taranaki District Health Board Management Information Unit and were based on national common costing standards from



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the Ministry of Health. Costs for operative interventions, inpatient stay, and readmissions were assessed. Cost data was collected on all patients with no post operative complications. These costs were compared with the costs of patients with complications within 30 days post operatively.

Results:

- 91 patients underwent colonic resection during the study period.
- 63% of patients underwent open surgery (n=57) and 71% had elective operations (n=65).
- The mean total cost for those patients that experienced no post operative complications was \$21,816. The mean total cost for those patients that experienced a post operative outcome was \$7,985 more expensive than those patients with no complications (n=39 patients).
- Sixteen patients were diagnosed with a post operative ileus with a mean total cost that was \$14,030 more expensive than patients without complication.
- Wound infections occurred in six patients with a mean total cost that was \$10,040 more expensive. Post operative pneumonia and urinary tract infections each occurred in 10 patients with mean costs that were more expensive by \$22,342 and \$12,091 respectively.
- Thromboembolic complications and anastomotic leaks each occurred in two patients with mean costs that were more expensive by \$9,248 and \$26,996 respectively.
- Twelve patients were readmitted to hospital within 30 days costing on average \$17,083 more than patients without complication. Five patients required a second operation with an increased cost of \$17,083 on average.

Conclusion: Complications following colorectal surgery are costly. Prevention of post operative complications has the potential for significant cost savings.

POSTER 3:**Case Report - Goldilocks Mastectomy in A NZ Maori Patient****J Davies, E Davenport***

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Introduction: Goldilocks mastectomy is a novel oncoplastics technique. It provides a simple alternative to standard mastectomy or breast conservation surgery, particularly useful in obese or large-breasted women. Co-morbidities often deem these women unsuitable for more comprehensive reconstructive techniques or for adjuvant radiotherapy required in breast conservation, leaving options limited. Standard mastectomy can leave a poor cosmetic and functional result in this patient group due to massive asymmetry and a troublesome lateral fat bulge. Goldilocks mastectomy has the benefit of avoiding these issues by leaving a moderate-sized (B to C cup) breast without the risks associated with more complex surgery.

Aims: Here we describe the case of a morbidly obese Maori woman who underwent bilateral Goldilocks mastectomies for infiltrating ductal carcinoma. We aim to provide an overview of the technique, indications, risks and benefits of this procedure, which until now has not been commonly available to New Zealand patients.

Methods: Mrs X underwent a bilateral Goldilocks mastectomy, left sentinel lymph node biopsy and axillary node dissection. These were performed as Wise pattern skin-sparing mastectomies with de-epithelialisation of the inferior flaps to provide



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an autologous breast mound. She recovered well and was discharged home post-operative day 3.

Results: The patient was highly satisfied with her cosmetic result, denied irritation from lateral flaps or asymmetry and was left with C-cup breasts bilaterally.

Conclusion: Goldilocks mastectomy provides a useful alternative to traditional mastectomy, particularly for patients with macromastia, obesity and significant co-morbidities as seen in our patient. With New Zealand's current obesity epidemic, increasing numbers of patients could be suitable candidates for this technique, providing a superior cosmetic and functional outcome without adding significant complexity.

References: Richardson H, Ma G. The Goldilocks Mastectomy. *Int J Surg.* 2012;10:522-6.
Macmillan RD. Techniques of mastectomy: tips and pitfalls. In: Dixon JM, editor. *Breast Surgery: Companion to Specialist Surgical Practice.* 5th ed. China: Saunders Elsevier; 2014. p. 71-108.

POSTER 4:

Ilioinguinal Nerve Management in Open Sutured Mesh Inguinal Hernia Repairs: a Meta-Analysis

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Introduction: Chronic groin pain is a morbid and difficult to manage complication of open inguinal hernia repairs. Decreasing the frequency of this would have huge benefits to patients and society. A number of studies have compared division and preservation of the ilioinguinal nerve with the aim of reducing post-operative chronic pain, however a universal consensus has not been reached¹.

Aims: The objective was to perform a definitive meta-analysis to compare the incidence of chronic pain, numbness and paraesthesia as well as other commonly reported postoperative complications after the preservation or division of the ilioinguinal nerve in open hernia repairs with mesh.

Methods: A systematic review was performed to identify studies comparing the outcomes of mesh repairs with ilioinguinal nerve resection and ilioinguinal nerve preservation. Results were analysed at short term (less than 3 months), medium term (3-9 months) and long term (9-24 months).

Results: Our meta-analysis pooled data from 905 recruited patients in 10 randomized controlled trials and 1 prospective trial. There was a statistically significant difference between the two groups that favoured nerve resection in both absolute pain and in pain scores. Pain was reduced in the neurectomy group at follow-up at short term 0.68 [0.52,0.90] and medium term 0.12 [0.61,0.92]. Significant reduction in pain scores at short term -0.81[-0.22,-0.40], medium term -0.4[-0.65,-0.15] and long term -0.21[-0.41,-0.01] follow-up were also observed when neurectomy was performed. There were no statistically differences between the resection and preservation groups in objective or subjective sensory change or commonly reported complications.

Conclusion: Routine excision of the ilioinguinal nerve during open sutured mesh inguinal hernia repairs decreases the incidence of post-operative pain without a corresponding increase in objective numbness or perception of paraesthesia.

References:

Wayne Hsu, Ching-Shyang Chen, Hung-Chia Lee et al, Preservation Versus Division of Ilioinguinal Nerve on Open Mesh Repair of Inguinal Hernia: A Meta-analysis of Randomized Controlled Trials, *World J Surg* (2012) 36:2311–2319.





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POSTER 5:

Appendiceal Neoplasms in the Wellington Region

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Introduction: Cancer of the appendix is uncommon usually being an incidental finding at the time of surgery for appendicitis. Studies cite an incidence of 0.9-1.4% for all neoplasms (1) of which 0.3–0.9% are neuroendocrine tumours (NET).

Aims: The aim of this study was to determine the incidence of appendiceal neoplasm in our population and whether initial operative technique influenced outcomes.

Methods: A retrospective review of all cases of appendicectomy over an 18 month period was performed. All cases of appendiceal neoplasm were identified and information on initial operative technique, histology and any further procedures was collected.

Results: Over the 18 month period 606 appendicectomies were performed of which eleven (1.8%) had a neoplasm. Six (1%) were neuroendocrine tumours (NETs), the remaining five (0.8%) were low grade mucinous neoplasms. Two of the six NETs required further surgery in the form of right hemicolectomy as the mesoappendix had not been resected at the time of first surgery.

Conclusion: In our population the rate of appendix neoplasm seems to be higher than the rates in published literature. The NET rate is also at the upper limit of the quoted rates. Given that it is infrequently suspected and often not appreciated at the time of surgery and the consequences of questionable resection margins are further major surgery, removal of the mesoappendix at the time of the index surgery should be routine.

References:

1. McCusker ME1, Coté TR, Clegg LX, Sobin LH.
Primary malignant neoplasms of the appendix: a population-based study from the surveillance, epidemiology and end-results program, 1973-1998. *Cancer*. 2002 Jun 15;94(12):3307-12.
2. Stinner B1, Rothmund M. Neuroendocrine tumours (carcinoids) of the appendix. *Best Pract Res Clin Gastroenterol*. 2005 Oct;19(5):729-38.

POSTER 6:

Laparoscopic Inguinal Hernia Repair Using a Self-Fixating Progridtm Mesh – a Review

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Introduction: Chronic pain following laparoscopic inguinal hernia repair is a well-recognized problem. It is postulated that the tacks used to secure the mesh contributes to this pain. Self-fixating mesh was developed to avoid the need for tacks and has been shown to be successful in open inguinal hernia repairs with low rates of recurrence. In the last year, we have adopted the use of a self-fixating mesh for laparoscopic inguinal hernia repair and we present our early experience.

Aims: This study aims to demonstrate that using a self-fixating mesh is safe, cost effective, with low rates of recurrence and chronic pain.



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Methods: Data was collected retrospectively from patient notes and were analysed for 81 patients from October 2013 to December 2014. There was a total of 87 inguinal hernias. All patients included had undergone laparoscopic inguinal hernia repair using ProGrip™ mesh. Complications, analgesic requirement, time to return to work and patient satisfaction were assessed.

Results: Most patients were very satisfied with their hernia repair with only minor complications reported (seroma, bruising) and only 1 hernia recurrence.

Conclusion: This study shows that using a self-fixating mesh in laparoscopic inguinal hernia repair is safe, cost-effective and results in a low rate of post-operative chronic pain.

References: Birk D, Hess S, Pardo GC (2013) Low Recurrence Rate and Low Chronic Pain Associated with Inguinal Hernia Repair by Laparoscopic Placement of Parietex ProGrip™ Mesh: Clinical Outcomes of 220 Hernias With Mean Follow-up at 23 Months. *Hernia* 17:313-320

POSTER 7:

Yersinia Enteritis; A Plausible Cause of Terminal Ileitis

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Introduction: Terminal ileitis has classically been a pathognomonic feature of Crohn's Disease. In reality, the differential diagnoses of ileitis encompass a wide array of disease entities ranging from vasculitis and ischaemia to infection. *Yersinia pseudotuberculosis* and *Yersinia enterocolitica* are two important microbiological causes of infectious ileitis [1]. New Zealand has high rates of Yersiniosis compared to other countries. Between August and October 2014, New Zealand experienced an outbreak of "food poisoning" secondary to *Yersinia pseudotuberculosis*. As a result, there was an increase in the number of patient admissions to the Acute Surgical Unit in Auckland City Hospital with right sided lower abdominal pain.

Aim: Our aim is to present the cases admitted to the surgical service and their management outcomes.

Methods: This study presents data on 33 patients who presented between August and October 2014 to the acute general surgical service of Auckland City Hospital and were diagnosed with terminal ileitis based on radiological evidence. Stool and/or serology tests were subsequently conducted to detect the presence of *Yersinia*.

Results: During the 3 month study period, 33 patients had confirmed terminal ileitis based on radiological investigation. Thirteen patients tested positive for *Yersinia* either on stool culture or serology. The presenting clinical features and treatment plans for these patients were widely variable.

Conclusion: Not all patients with terminal ileitis have Crohn's disease. *Yersinia enteritis* is a very plausible cause in New Zealand and the disease poses clinical challenges due to its non-specific presentation features and the lack of established treatment guidelines. Evidence is lacking and further research into this not-uncommon problem is needed.

References:

1. Dilauro S, Crum-Cianflone NF. Ileitis: when it is not Crohn's disease. *Curr Gastroenterol Rep*. 2010 Aug;12(4):249-58.





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POSTER 8:

Complication Rates of Rectal Surgery in A Provincial New Zealand Hospital

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Introduction: New Zealand's geography and population distribution provide a barrier to access to tertiary hospitals for subspecialised elective surgery. Over 1.5 million or well over a third of the population reside more than one hour from a tertiary hospital.¹

Numerous authors and health care policy-makers have advocated for the regionalization of rectal cancer services to high-volume centres, arguing lower complication rates and better outcomes for patients. However, making policy decision based solely on volume-outcome association does not consider the impact on rural patients, including costs and inconvenience incurred with travelling, and isolation from support networks. Providing rectal surgery in provincial hospitals could provide better patient satisfaction, however patient outcomes and complication rates need to be comparable to those in tertiary centres.

This study examined rectal cancers treated at Whanganui Hospital, and compared complication rates to published data.

Aims: To examine treatment of patients undergoing surgery for rectal cancer at Whanganui Hospital, and compare complication rates with published data.

Methods: A retrospective audit was conducted examining patients' clinical records. All patients undergoing rectal cancer surgery at Whanganui Hospital from 2012 to 2014 were included. The incidence of important outcomes including 30 day mortality, prolonged post-operative ileus, infection, and need for reoperation were measured.

Results: In total 21 patients underwent surgery for rectal cancer, 16 anterior resections, three abdominoperineal resections, one transanal wide local excision and one palliative loop colostomy. 30 day mortality, and anastomotic leak rate was zero. Complications were prolonged ileus (14%), pelvic abscess (4%) and pneumonia (4%). 3 patients required a further operation, all for stoma revision.

Conclusion: Complication rates for patients undergoing rectal surgery in Whanganui Hospital are comparable to those achieved in the Bi-National Colorectal Cancer Audit. This suggests ongoing provincial rectal cancer treatment is feasible, and should remain an option for the third of the population who do not live close to a tertiary hospital.

References: Brabyn L, Skelly C. Modeling population access to New Zealand public hospitals. International Journal of Health Geographics 2002;1:3.

POSTER 9:

The Challenge of Surgical Thromboprophylaxis

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Introduction: Venous Thromboembolism (VTE) is a major cause of morbidity and mortality affecting 1% of all hospitalized patients. Pulmonary embolism is the leading cause of preventable death.

Surgical patients represent a high risk group for VTE.



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Health Quality and Safety commission of New Zealand have emphasized need for VTE assessment and prevention in all New Zealand Hospitals. Guidelines for VTE prophylaxis have been established and is the responsibility of every surgeon.

Aims:

1. Assess adherence to VTE prophylaxis guidelines in surgical inpatients.
2. Assess adherence to guidelines after implementation of hospital and ward based strategies.
3. Compare results with previous local data (2009).

Methods: Prospective case controlled study at a provincial New Zealand Hospital.

Snapshot analysis used. Surgical ward patients assessed for VTE risk and adherence to prophylaxis guidelines at a specific point in time (snapshot). Snapshots repeated every 2-3 weeks.

Study divided into 2 phases

1. Assessment of adherence to guidelines (Dec 13 – Jun 14)
2. Re-assessment of adherence to guidelines after implementation of ward and hospital based improvement strategies (Jun 14- Dec 14).

Results:

1. Total of 256 patients.
2. Adherence to mechanical prophylaxis was 41% (phase 1) improving to 69% (phase 2) compared to 82% previously (2009).
3. Adherence to chemical prophylaxis was 67% (phase 1) improving to 81% (phase 2) compared to 70% previously (2009)

Conclusion: Adherence to VTE prophylaxis guidelines is poor but can be improved with ward and hospital based strategies. Maintaining and building on this to achieve appropriate standards however still continues to be a challenge.

POSTER 10:

Acute Colonic Pseudo-Obstruction in Pregnancy

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Introduction: Acute colonic pseudo obstruction is most common in elderly hospitalized patients with significant underlying co-morbidities especially following surgical intervention and the use of peri operative opiate analgesia. This condition is rarely seen in young patients, however when seen the most common predisposing condition in young women is pregnancy, especially following caesarian section.

Aims: To review a single institution's experience with acute colonic pseudo obstruction in post partum patients and develop an algorithm for management based on a literature review.

Methods: Patients were identified over a two year period by checking all deliveries in Christchurch Women's Hospital against diagnosis codes for bowel obstruction and ileus. Clinical records and radiology were then reviewed to identify those





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with acute colonic pseudo-obstruction, and the management of these patients was reviewed. The literature was searched (pubmed, English language; 1980 to 2014) using pseudo-obstruction; Ogilvie's syndrome; colonic ileus as keywords.

Results: Over the study period seven patients were identified from 10240 deliveries. Two patients required laparotomy and the rest resolved without surgical intervention. One patient was treated with neostigmine and three with erythromycin. One patient had an unsuccessful attempt at endoscopic decompression, however symptoms resolved without further intervention following this.

A management algorithm was developed based on the literature review.

Conclusion: Acute colonic pseudo obstruction occurs in post partum patients more frequently than suspected with potentially morbid results. The management needs to be active with early correction of electrolyte abnormalities, avoidance of narcotic pain relief and early mobilisation. Timely administration of neostigmine or endoscopic decompression can reduce the incidence of colonic ischaemia and perforation and the need for surgical intervention.

References: Saunders MD and Kimmey MB. Systematic review: acute colonic pseudo-obstruction. *Alimentary pharmacology & therapeutics*. 2005; 22: 917-25.

POSTER 11:

Epidemiology of Merkel Cell Carcinoma in New Zealand: a Population Based Study

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Introduction: Merkel cell carcinoma (MCC) is a rare and highly malignant cutaneous neuroendocrine tumour¹. Ultraviolet (UV) radiation exposure is thought to play a major role in the pathogenesis of MCC². New Zealand (NZ) has some of the highest rates of UV related skin cancers in the world, however to date no published reports have evaluated the status of MCC in NZ.

Aims: This study aims to determine the incidence (and associated trends) of MCC in NZ and also describe the patient demographics and clinical characteristics of identified cases.

Methods: From 01/01/2002 – 31/12/2011 all cases of MCC were reviewed from the New Zealand Cancer Registry (NZCR) by way of electronic search of ICD 10 codes. Demographics and clinical characteristics were evaluated and age-adjusted incidence rates (per 100 000 person-years) were calculated for sex, year of diagnosis and 5-year age group using direct standardization to the U.S. standard 2000 population. Linear regression was used to investigate trends in incidence by calendar year.

Results: 356 cases of MCC were identified from the NZCR. MCC mainly occurred in the elderly patients of European ethnicity (mean age = 77 years). MCC mostly affected sun exposed sites such as with the head and neck region accounting for 49% of cases. The national overall age-standardized incidence of MCC in NZ was 0.88 / 100,000, with men having a higher age-standardised incidence than women (1.05 / 100,000 vs 0.74 / 100,000) ($p = 0.041$). The incidence of MCC also increased significantly over the study period.

Conclusion: The observed patient demographics and anatomical distributions further support the importance of UV



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radiation in the pathogenesis of MCC. NZ has the highest reported national incidence of MCC in the world and its incidence is increasing. Further investigation of aetiological factors and treatment outcomes in the New Zealand population are warranted.

References:

1. Goessling W, McKee PH, Mayer RJ. Merkel cell carcinoma. *J Clin Oncol.* 2002;20:588-598.
2. Becker J, Schrama D, Houben R. Merkel cell carcinoma. *Cellular and Molecular Life Sciences.* 2009;66:1-8.

POSTER 12:

Trends in Interventions and Outcomes of Severe Acute Pancreatitis at a Tertiary Level Hospital, Auckland, New Zealand

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Introduction: Severe acute pancreatitis (SAP) requiring intensive care unit (ICU) admission is traditionally associated with a high mortality and morbidity. Intervention and outcome data from 1988 to 2001 in patients with SAP from Auckland Hospital has previously been collected and presented¹.

Aims: This study aims to compare recent data, in patients with SAP from 2003 to 2014 from Auckland Hospital, to the prior study from the same institution¹, to determine trends in management and relate to outcomes.

Methods: Retrospective review of prospective data of patients admitted to the Department of Critical Care Medicine (DCCM), Auckland City Hospital with SAP from 2003 to 2014. Data were extracted from several sources.

Results: Eighty-six patients (men 53, women 33, mean age (\pm SD) 56.2 ± 16 years) with 87 episodes of SAP admitted to DCCM in the 12 year period were compared to 112 patients during the earlier 13 year period. Aetiology was gallstones (34.5% vs 42%, $P=0.307$), alcohol (31% vs 29%, $P=0.755$) and other (34.5% vs 29%, $P=0.539$). At admission to DCCM the median duration of symptoms was 3 days (range 0 – 116) compared to 7 days (range 1-100) and the mean (\pm SD) Acute Physiology and Chronic Health Evaluation II score was 15.5 ± 7.3 compared to 19.9 ± 8.2 previously ($P=0.0001$). The number of patients who had an open or minimally invasive necrosectomy was 20 (23%) compared to 36 (32%) ($P=0.203$). New techniques were developed in the latter period including videoscopic and nephroscopic debridement. Twenty-six patients (29.9%) had percutaneous drainage initially, which was increased from 14 (13%) ($P=0.004$). Overall mortality was 21.8% (19 patients) from 31% (35 patients) previously ($P=0.151$).

Conclusion: In two comparative patient groups separated by time there is earlier admission to DCC and a higher proportion managed with percutaneous drainage initially. There is also a trend towards lower necrosectomy rates and a lower overall mortality.

References: Flint, R., Windsor, J. & Bonham, M. 2004. Trends in the management of severe acute pancreatitis: Interventions and outcome. *ANZ J. Surg.* 74:335-342.



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POSTER 13:

The “Penny Farthing” Incision for Mastectomy: A Novel Technique to Reduce “Dog Ear” Deformity and Improve Access to the Axilla

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Introduction: Medial and lateral “dog ear” deformities are a common problem with mastectomy incisions. The challenges include different skin tensions superiorly and inferiorly and variable BMI. The standard mastectomy incision is also not in the optimal place for sentinel node biopsy access. No published technique is universally applicable and some advanced techniques require excess dissection and operative time.

Aims:

1. To perform a literature search for all published techniques
2. To pilot test a new, simple incision

Methods:

A literature search using PubMed was performed that revealed eight previous techniques ⁽¹⁾.

A new, simple technique was developed to incorporate most of the historical principles. Circles of different sizes are marked out medially (small) and laterally (large). The lateral circle incorporates the optimal position for access to the axilla for sentinel node biopsy or axillary clearance. These circles are joined by asymmetrical superior and inferior lines to encourage rotation during closure. Tumour size and position are taken into consideration. Wound closure begins from the centre. This allows the wound to “choose” its own corners and tuck them inwards therefore minimising “dog ear” formation.

Results:

- Seventy- five consecutive patients had the procedure by a single surgeon over a 14 month period
- At the conclusion of each procedure there was no residual “dog ear” deformity at either wound end
- Of the 27 patients seen for 12 month follow up only one (BMI 42) has required revision of the wound.

Conclusion: The “Penny Farthing” incision is a novel, simple and promising technique to deal with “dog ear” deformity in mastectomy.

Reference:

1. Thomas R, Mouat C, King B. Mastectomy flap design: the ‘waisted teardrop’ and a method to reduce the lateral fold. ANZ Journal of Surgery. 2012; 82: 329-333.

POSTER 14

Accuracy of Frozen Sections Performed for Sentinel Lymph Node Biopsies within a Peripheral Hospital in New Zealand

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Introduction: Sentinel Lymph Node Biopsy (SLNB) with frozen section remains an acceptable option for surgical treatment for the majority of breast cancers treated with wide local excision. Frozen sections for SLNB are controversial. Although patients benefit by proceeding directly to axillary node dissection (AND) if positive and therefore only requiring one



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operation, there are downside such as false negatives, pathology time and cost and uncertainty around operating theatre time. In addition, recent studies (in particular, the Z0011 trial (1)), have questioned the benefit of AND in patients with limited SLNB disease. Therefore, in order to justify the ongoing use of frozen sections for SLNB, there needs to be strict auditing of results.

Aims: The aim of the present study was to determine the false negative rate of frozen sections performed for sentinel lymph node biopsies at a peripheral hospital in New Zealand, and to compare this to internationally accepted levels.

Methods: Consecutive frozen sections performed for SLNB over a period of one year at Hawke's Bay District Health Board were analysed in this prospective observational study. Frozen section results were compared with histological reports for discrepancies.

Results: Of eighty frozen sections performed, there were two false negatives. One was for a micrometastasis and the other for a macrometastasis.

Conclusion: The false negative rate of frozen sections in this study was 2.5%. This is well within the accepted international standards.

References: Giuliano AE, Hunt KK, Ballman KV, Beitsch PD, Whitworth PW, Blumencranz PW, Morrow M. (2011). Axillary dissection vs no axillary dissection in women with invasive breast cancer and sentinel node metastasis: a randomized clinical trial. *Jama*, 305(6), 569-575.

POSTER 15:

Concurrent Presentation Of Acute Appendicitis And Cholecystitis: A Diagnosis Of Rare Occurrence

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Introduction: It is a rare occurrence for acute appendicitis and acute cholecystitis to occur synchronously. This is uncommon and is important to be aware of the possibility so appropriate and timely management can be undertaken.

Case Report: A 67 year old female with severe central abdominal pain migrating to the right upper and lower quadrants ongoing for 2 days. Her past medical and surgical history included hypertension, hysterectomy for dysfunctional uterine bleeding and bilateral total hip joint replacements. She was tachycardic with a heart rate of 100 with other vitals within limits. Her abdomen was soft to examine but tender to percussion over the right upper quadrant and right iliac fossa. Rovsing's sign was negative. She had grossly elevated inflammatory markers, with a white blood cell count of 18.5, neutrophil count of 16.8 and a C reactive protein count of 265. Her liver function test and urinalysis were unremarkable. A CT abdomen/pelvis revealed appendicitis and an impacted calculi in the cystic duct as well as features consistent with acute cholecystitis. She underwent laparoscopic appendicectomy and cholecystectomy, with intraoperative findings consistent with radiological findings. Histology results confirm dual concurrent pathology of acute appendicitis and cholecystitis. She was discharged home after an uncomplicated recovery.

Conclusion: Concurrent presentations of acute appendicitis and cholecystitis are very rare and the clinician must be open to the possibility of a double pathology occurring. A radiological opinion is advised to avoid multiple scans which can be time consuming and expensive, more importantly a delay in diagnosis could lead to increased morbidity and mortality.





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References: Jonas P. DeMuro. Simultaneous acute cholecystitis and acute appendicitis treated by a single laparoscopic operation. Case Reports in Surgery. Volume 2012, article ID 575930

POSTER 16:

Case Based Discussion For Assessment Of Surgical Trainee Interns

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Introduction: Medical education is an evolving field and is an integral part of a Surgeon's practice. Case based discussion and problem based learning are increasingly used for assessment. This format not only helps retain information regarding particular disease processes, but also helps to formulate a management plan for the treatment of common conditions that are encountered in everyday surgical practice.

Aims: Design and implement a novel method of assessment as an additional tool for appraisal in the surgical rotation of trainee interns at Wellington Hospital, followed by an evaluation of its effectiveness.

Methods: Survey of trainee interns in representative methods of assessment during their medical training. Trial of case based discussion for end of surgical rotation assessment, as well as feedback from students as to its relevance and usefulness in learning.

Results: The majority of students surveyed felt problem based learning was effective in assessment of competence. Feedback from students who trialled the case based discussion found it to be a useful tool for both accumulating and appraisal of knowledge. Most students found the one-on-one bedside interaction with a senior doctor to be a great teaching aid.

Conclusion: Interaction with students during their surgical rotation is key to impart knowledge and prepare them for a career in medicine. It also allows the Surgeon to pass on an interest in surgery as a profession. Case based discussion is an effective tool for conveying information, and has now been implemented in assessment of surgical trainee interns through the Wellington School of Medicine.

References: Epstein, R. Assessment in medical education. New England Journal of Medicine (2007), 387-96.
Jyothirmayi, R. Case based discussion: assessment tool or teaching aid? Clinical Oncology (2012) 649-53.



