

FINAL PROGRAM

RACS WA, SA & NT ANNUAL SCIENTIFIC MEETING 2021

A Safer Theatre For All

26-28 August 2021

Cable Beach Club, Broome

#tristateASM21



WELCOME

Dear Colleagues,

RACS WA warmly welcome delegates to Broome for the tristate WA, SA & NT Annual Scientific Meeting.

We kick off the event with the official Welcome Function on Thursday 26 August at Okari Deck overlooking the world famous Cable Beach.

'A Safer Theatre for All' will offer this hybrid meeting, discussions and presentations addressing futile surgery, perioperative planning, communication, conflict and mandatory reporting which will prompt us all to consider how to make our own theatres a safer environment.

On Friday night, the Kimberley Under the Stars Dinner will be held poolside at the resort with the Hanrahan Oration provided by James Brown from Cygnet Bay Pearls.

Don't forget to enjoy the Annual Shinju Matsuri festival, a celebration of the culture and heritage

Warm regards,



Dr Jacinta Cover
RACS WA, SA & NT ASM 2021
Convener



Mr Stephen Rodrigues
RACS WA, SA & NT ASM 2021
Convener



EXHIBITORS

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INVITED SPEAKERS



MR PAUL FORDEN

Paul commenced his career as an Accountant. He joined the health sector more than 25 years ago as a Director of Finance. He later moved into the role of Chief Operating Officer and has been a Chief

Executive of various organisations over the past 20 years.

Paul was Chief Executive of a number of tertiary and large hospitals in the NHS. He also spent three years in the private sector as Managing Director for Health for a private company with responsibility for number of European health businesses.

In 2016, Paul came to Perth following his appointment as Executive Director of the Fiona Stanley Fremantle Hospitals Group. In December 2017, he was made Chief Executive of the South Metropolitan Health Service.



PROF TOBY RICHARDS

Professor Toby Richards specialises in clinical trials and translational research. He developed the WA CTU with over a dozen active trials and integration with the Australian National Phenome Centre for translational

research.

He has led several international trials including PREVENTT, SUNNRise, ECST2, ITACS, CAVIAR, CREST-2 and POISE-3, all focussed on peri-operative medicine, surgery and anaesthesia. Toby has supervised 16 PhD and > 60 graduate research projects (Masters/ MSc/ BSc). He set up and leads STRIVEwa with over 130 GCP trained medical students involved in research. And with RACS CTANZ Toby leads the POSTvenTT trial incorporating > 600 trainees and medical students at 56 hospitals, making this the largest Surgical collaborative trial in Australia & New Zealand.



DR HANNAH SEYMOUR

Dr Hannah Seymour is a Consultant Geriatrician at the Fiona Stanley Fremantle Hospitals Group. Hannah has worked in Acute Orthogeriatrics at Fiona Stanley Hospital since 2015 where she shares the care of older people with orthopaedic surgeons. Hannah is passionate about using data to improve the care of older people with fractures across the world by working on the Steering Committee of the ANZ Hip Fracture Registry and as President Elect of the Fragility Fracture Network. She has presented internationally on the care of older people with fractures.

Hannah has held a number of leadership positions in Western Australia including the Falls and Aged Care Lead in the Department of Health, Leadership of the Four Hour Rule Program at Royal Perth Hospital and Clinical Commissioning Lead and Medical Director at Fiona Stanley Fremantle Hospitals Group.



DR SIMON TOWLER

Dr Towler commenced as the acting State medical Director (SMD) for DonateLife in December 2019 and then as the substantive SMD in January 2021. He is a staff specialist in Intensive Care at the Fiona Stanley Hospital, Clinical Lead for End of Life Care with the WA Cancer and Palliative Care Network and State Director of DonateLife WA.

He is a fellow of the College of Intensive Care Medicine, the Australian and New Zealand College of Anaesthetists, the Australasian College of Health Service Managers and the Australian Medical Association.

Previously the Chief Medical Officer of Western Australia from 2006 – 2012, and a former President of the AMA in Western Australia, Dr Towler has had many senior roles across WA Health. More recently he was a member of the Clinical Reference Group for the Sustainable Health Review released in 2019 and was a member of the Ministerial Expert Panel on Voluntary Assisted Dying in the same year.

In his current role as End of Life Care Clinical Lead he is extensively involved in the implementation of key commitments made by the WA Government arising from the My Life, My Choice Report.

INVITED SPEAKERS



DR CATHERINE GIBB

Dr Katy Gibb is a General Physician working at the Royal Adelaide and The Queen Elizabeth Hospitals in South Australia. Her special interest is in peri-operative physician led assessment and she established the

high risk pre-operative assessment service in 2000 which is now a full-time ambulatory service across two sites. In this clinical role she is involved in complex decision making and leads discussion on end of life care.

She has a strong interest in teaching and professionalism. She was Director of Physician Training from 2002-2006 at TQEH and was a senior instructor on behalf of the Royal Australasian College of Surgeons for the Care of the Critically Ill Surgical Patient course (CCRISP), and is a committee member and instructor on the Training in Professional Skills course (TIPS). She completed a Masters in Health Professional Education in 2015.



DR DOMINIC PEPPERELL

Dominic is a Haematologist currently working as a consultant focussed on thrombosis and bleeding disorders at Fiona Stanley Hospital in Perth.

He initially trained in the UK but prior to becoming a specialist, spent a year as an Advanced Trainee at Royal Perth Hospital, and realised that life was better in Australia. He started as a Clinical Fellow in Thrombosis and Haemostasis at Royal North Shore Hospital in Sydney and in 2015 he moved back to WA to start a post as a consultant at the brand new tertiary referral facility, Fiona Stanley Hospital. His current role involves running a tertiary referral complex thrombosis clinic, working in the state Haemophilia centre and improving thrombosis prophylaxis and anticoagulation safety.



PROF GUY MADDERN

Professor Guy Maddern is the RP Jepson Professor of Surgery and Discipline Lead – Surgery at the University of Adelaide, Director of Surgery at the Basil Hetzel Institute for Translational Health Research at The Queen Elizabeth Hospital and Director, Surgical Research and Evaluation (incorporating ASERNIP-S) of the Royal Australasian College of Surgeons.

He was trained at the University of Adelaide and became a Fellow of the Royal Australasian College of Surgeons in 1989. He has been Chairman of the Australian and New Zealand Audit of Surgical Mortality since 2005 and facilitated its national rollout. His current research focus brings together the development, assessment and introduction of surgical techniques, processes and technologies into clinical practice.



DR JOSEPH HOCKLEY

Joe is a Vascular and Endovascular Surgeon with over 10 years of clinical experience in the field. He is currently a Consultant Vascular and Endovascular surgeon and Supervisor of Training at Sir Charles Gairdner Hospital, consults privately at the Hollywood Specialist Centre and operates at Hollywood and Mount Hospitals.

He provides the Vascular Surgery service to Perth Children's Hospital and King Edwards Memorial Hospital. Joe is a member of the State Sarcoma Service based at SCGH and performs most of the major arterial and venous reconstructions for soft-tissue tumours. Joe is heavily involved in vascular research at the Heart Vascular Research Institute within the Harry Perkin's Institute. He is also an Adjunct Clinical Senior Lecturer at Curtin University.

INVITED SPEAKERS



DR KAREN McKENNA

Karen is an emergency medicine specialist who has worked in almost every State and Territory of Australia over her long career.

She's currently working part-time as a Medical Advisor at the Patient Safety Surveillance Unit and the Office of the Chief Medical Officer in the WA Department of Health whilst taking a break from front-line emergency medicine work, having spent the last 5 years working at Bunbury Hospital.



ASSOC PROF PHILLIP CARSON

Phil Carson is a General Surgeon recently retired from clinical practice. He has spent most of his consultant life working in Darwin and has an abiding interest in the delivery of excellent surgical services across barriers of distance and culture.

Ways of offering safe, high quality, modern surgery in remote and regional settings have long been an interest and passion. With collaboration and innovation, he has facilitated numerous surgical advances for the people of the Northern Territory. A strong commitment to education led to appointment as Associate Professor with the Flinders Northern Territory Medical Program and extensive involvement with RACS as supervisor, examiner, councillor, Chair of Global Health, Chair of the Court of Examiners and most recently as Censor in Chief.



ADJ ASSOC PROF MING YEW

After more than a decade of pioneering a number of Australian first operations, Ming will share his insights and experience to describe a pathway to facilitate the safe introduction of new surgical procedures.

He is an endocrine, breast and general surgeon, Head of Endocrine Surgery unit, Royal Perth Hospital; and Head of General Surgery at SJOG Subiaco. He is also the current Deputy Chair of RACS WA State Committee.



DR RICHARD LEWIS

Dr. Richard Lewis is a consultant surgeon in Otolaryngology, Head & Neck Surgery in Perth, Western Australia. He was Founding Chairman of the Department of Otolaryngology, Head & Neck Surgery at

Fiona Stanley Hospital, and is now on the surgical staff of Royal Perth Hospital.

After training in ORL in Australia, he was awarded the Garnett Passe Foundation Post-Training Scholarship, and undertook a Fellowship in Head & Neck Surgery and Microsurgery in Indianapolis, followed by a Skull Base Surgery Fellowship in London. His private practice is predominantly in sleep apnoea, with public hospital work in both head and neck oncology/microvascular surgery, skull base surgery and OSA. He is the Principal Investigator for a new hypoglossal nerve stimulator trial for OSA and is involved in several other OSA research projects.



DR JAMES EDELMAN

James Edelman is a Cardiothoracic Surgeon at Fiona Stanley Hospital. He completed Fellowships at Stanford University (CA, USA), a Complex Valve Fellowship at Toronto General Hospital (Toronto, Canada), and a

Transcatheter and Minimally Invasive Valve Fellowship at Georgetown Washington Hospital Center (Washington, DC, USA).

He is a member of the multidisciplinary Transcatheter Aortic Valve Replacement Team at FSH and contributed to the International Society of Minimally Invasive Cardiac Surgery Consensus Statement on TAVR.

INVITED SPEAKERS



MR JAMES AITKEN

James Aitken was a consultant general and colorectal surgeon at Sir Charles Gairdner Hospital in Perth. He qualified at Charing Cross Hospital in London and undertook his General Surgical training in Groote Schuur Hospital, Cape Town and Edinburgh where he worked in as a consultant general and colorectal surgeon for 10 years. While in Edinburgh he was chair of the Lothian Surgical Audit and was responsible for The Lothian and Borders Large Bowel Cancer Project. He worked closely with those establishing the Scottish Audit of Surgical Mortality.

Following his move to Perth in 1998 he established the Western Australian Audit of Surgical Mortality that in 2005 became the Australian and New Zealand Audit of Surgical Mortality. In 2016 he supervised the Perth Emergency Laparotomy Audit. He is chair of the Australian and New Zealand Audit Emergency Laparotomy Audit – Quality Improvement working party.



DR STEVE BOLSIN

Steve Bolsin is a cardiac anaesthetist by training and was appointed to the Bristol Royal Infirmary as a consultant specialist paediatric and adult cardiac anaesthetist. He uncovered a high mortality rate for paediatric and adult cardiac surgery in the unit and attempted to change the service by involving the Department of Health. Within 6 years he left to become the Director of Critical Care Services in Geelong, Australia, where he was asked to develop the anaesthetic and intensive care services for a new adult cardiac surgery service.

In 2011 he was appointed the DMS for St John of God Geelong Hospital and maintained his position as consultant anaesthetist. In 2019 he became the DMS&CG for St John of God Health Care.



DR AUDREY KOAY

Dr Audrey Koay is Executive Director of the Patient Safety and Clinical Quality Directorate in the Department of Health WA. The directorate encompasses seven discrete units: The Patient Safety Surveillance Unit, Mental Health Unit, Licensing Accreditation and Regulatory Unit, Healthcare Quality Intelligence Unit, Medicines and Technology Unit, Reproductive Technology Unit and the Executive Office, Policies and Special Projects team. Together these areas deliver the Department of Health's safety and quality portfolio with a special focus upon clinical governance, clinical audit and data systems to improve patient outcomes, mental health, safe introduction of new procedures and technologies, quality use of medicines and regulation of the private hospital sector.

Prior to the Department of Health, Audrey worked in Sir Charles Gairdner Hospital and then in academic centres of Vanderbilt and Oxford Universities, and within the commercial sector in the Roche UK and as Associate Medical Director at General Electric Healthcare's Northern European operations.



DR BERNADETTE ALIPRANDI-COSTA

Bernadette is the Manager, Safety and Quality Improvement Systems and Intergovernmental Relations at the Australian Commission on Safety and Quality in Health Care (the Commission). The Commission is an Australian government agency that leads and coordinates national improvements in safety & quality of health care, working in partnership with the Australian Government, state and territory governments, private sector, patients, clinicians, managers and health care organisations.

Bernadette holds a PhD in health outcomes research from the University of Sydney, and has lead programs of work in the health sector including developing and managing clinical trial services; developing quality reporting frameworks; designing and implementing clinical quality registries and mechanisms for reporting health system performance.

Currently, Bernadette is leading a team to finalise and implement the National Clinical Trials Governance Framework, and is conducting the national consultations on the One Stop Shop and National Clinical Trials Front Door.

PROGRAM

Program correct at time of circulation

Conveners

Dr Jacinta Cover

Mr Stephen Rodrigues

Organising Committee

Prof David Fletcher

Mr James Aitken

Date

Thursday 26 - Saturday 28 August 2021

Venue

Cable Beach Club, Cable Beach, Broome,
Western Australia

Complimentary yoga is available for Cable Beach Club guests. Please contact Hotel Reception for times & details.

Meeting Overview and Program Highlights

THURSDAY 26 AUGUST 2021

- **Welcome Reception**
Okari Deck, Cable Beach Resort

FRIDAY 27 AUGUST 2021

- **Day 1 ASM & WAASM Symposium**
- **Dinner: Kimberley Under the Stars**
Poolside, Cable Beach Resort
Dress Code: Kimberley Casual

SATURDAY 28 AUGUST 2021

- Day 2 ASM

WELCOME RECEPTION

THURSDAY 26 AUGUST, 2021

17:00 - 19:00 **WELCOME RECEPTION**
Okari Deck & Lawn, Cable Beach Club

ANNUAL SCIENTIFIC MEETING (ASM)

FRIDAY 27 AUGUST, 2021

SESSION ONE: **8:30am - 10:15am (WAASM Symposium)** **Chair: James Aitken**
Preparing The Patient Before They Come to Hospital

08:30 Welcome - Jacinta Cover

08:45 *Paul Forden, CEO FSH, WA*
Booking.com; Can We Enhance the Patient Journey?

09:05 *Toby Richards, Vascular Surgeon, WA*
Pre-Operative Blood Management

09:25 *Hannah Seymour, Geriatrician, WA*
Is Frailty Important in Older Surgical Patients?

09:45 *Simon Towler, Intensive Care Specialist, WA*
End of Life Care: Special Considerations in Surgical Practice (Virtual)

10:05 *Panel Discussion*

10:15 Morning Tea with Industry

SESSION TWO: **10:45am - 12:30pm (WAASM Symposium)** **Chair: James Aitken**
Management of the Patient When in Hospital

10:45 *Catherine Gibb, SA*
What Can a Physician Offer Before Surgery? (Virtual)

11:05 *Guy Maddern, Professor of Surgery, SA*
Assessing Patients Prior to Transfer (Virtual)

11:25 *Dominic Pepperell, Haematologist, WA*
Anti-Coagulation Management in the Peri-Operative Period

11:45 *Hannah Seymour, Geriatrician, WA*
Post-Operative Geriatric Input to the Non-Orthopaedic Patient

12:05 *Panel Discussion*

12:30 Lunch with Industry

ANNUAL SCIENTIFIC MEETING (ASM)

FRIDAY 27 AUGUST, 2021

SESSION THREE: 1:30pm - 3:05pm Chair: Paul Bumbak

Safety and Conflict in Hospital and Theatre

- 13:30 *Joseph Hockley, Vascular Surgeon, WA
Intra-Abdominal Sarcoma Surgery, Innovation & Planning*
- 13:50 *Karen McKenna, Emergency Physician, WA
Clinicians, Complexity and the Coroner's Court*
- 14:10 *Toby Richards, Vascular Surgeon, WA
Practical Aspects of Surgical Collaboratives*
- 14:30 *Philip Carson, General Surgeon, NT
Managing the Distance - Communication and Generalism in Rural Surgery (NT)*
- 14:50 *Panel Discussion*

15:05 Afternoon Tea with Industry

SESSION FOUR: 3.30pm - 4:45pm Chair: Stephen Rodrigues

Teaching Difficult & New Procedures

- 15:30 *Ming Yew, General Surgeon, WA
Scarless Thyroidectomy: Managing Risk and Ensuring Quality Outcomes When Introducing New Surgical Procedures*
- 15:50 *Richard Lewis, ENT Surgeon, WA
A New Hypoglossal Nerve Stimulator for Obstructive Sleep Apnoea*
- 16:10 *James Edelman, Cardiothoracic Surgeon, WA
TAVR in Low Risk Patients: Is Surgery for Aortic Valve Replacement Dead?*
- 16:30 *Panel Discussion*
- 16:45 *End of Day One*
- 18:00 **2021 ASM ANNUAL DINNER**
Kimberley Under the Stars
Poolside - Cable Beach Resort
Hanrahan Oration
Speaker: James Brown, Cygnet Bay Pearls

ANNUAL SCIENTIFIC MEETING (ASM)

SATURDAY 28 AUGUST, 2021

SESSION ONE:	09:00am - 10:45am	Chair: David Fletcher
	Public Reporting of Surgical Outcomes - Is There Any Choice?	
09:00	<i>James Aitken, WAASM, WA</i> <i>History Does Not Repeat Itself But It Does Rhyme</i>	
09:20	<i>Steve Bolsin, Group Director of Medical Services & Clinical Governance, SJOG, WA</i> <i>Public Reporting of Surgical Outcomes – Threat or Opportunity?</i>	
09:40	<i>Audrey Koay, Dept of Health, WA</i> <i>Does Public Reporting Improve Care?</i>	
10:00	<i>Bernadette Aliprandi-Costa, Manager, Safety & Quality Improvement Systems, NSW</i> <i>National Clinical Quality Registries – Reporting to Improve Safety and Quality in Health Care</i> <i>(Virtual)</i>	
10:20	<i>Panel Discussion</i>	
10:45	Morning Tea with Industry	
SESSION TWO:	11:15am - 1.15pm	Chair: Stephen Rodrigues
	FREE PAPERS	
11:15	<i>Stephanie Weidlich</i>	
11:25	<i>Ganesa Pon Raja</i>	
11:35	<i>Joshua Teo - VIRTUAL</i>	
11:45	<i>Uyen (Jess) Vo</i>	
11:55	<i>Molly McGuckin</i>	
12:05	<i>Jessica Haley</i>	
12:15	<i>Danika Jurat</i>	
12:25	<i>Natasha Behrendorff</i>	
12:35	<i>Robert McCusker - VIRTUAL</i>	
12:45	<i>Robert McCusker - VIRTUAL</i>	
12:55	<i>Kay Hon - VIRTUAL</i>	
13:05	<i>Sari Mouritz</i>	
13:15	Lunch with Industry END OF CONFERENCE	

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- 1 RACS INDIGENOUS SURGICAL PATHWAYS (ISP) + DARWIN PILOT
Stephanie Weidlich¹
¹ Royal Australasian College of Surgeons, Melbourne, Australia

- 2 DON'T POLLUTE THE FRED! A SURVEY OF LAPAROSCOPIC LENS SURFACTANT USE
Dr Ganesa Pon Raja¹
¹ St John of God Hospital, Bunbury, Bunbury, Australia

- 3 THE EFFECT OF EXERCISE PREHABILITATION ON FUNCTIONAL STATUS OF PATIENTS UNDERGOING BOWEL RESECTION (**VIRTUAL**)
Dr Joshua Teo¹
¹ University of Tasmania

- 4 CONTROLLING THE CONTROLS: WHAT IS NEGATIVE PRESSURE WOUND THERAPY COMPARED TO IN CLINICAL TRIALS?
Dr Uyen (Jess) Vo^{1,2}
¹Department of Vascular Surgery, Fiona Stanley Hospital, Murdoch, Australia, ²School of Surgery, University of Western Australia, Crawley, Australia

- 5 SURGERY ON THE NEONATAL INTENSIVE CARE UNIT: DEMOGRAPHICS & SAFETY
Dr Molly McGuckin¹
¹Perth Children's Hospital, Nedlands, Australia

- 6 REPAIR: RECONSTRUCTIVE PARTNERSHIP FOR LOWER LIMB OPEN FRACTURES
Dr Jessica Haley¹
¹ Royal Perth Hospital, Perth , Australia

- 7 SURGICAL PRE-OPTIMISATION WEIGHT LOSS: IS TIME RESTRICTED FEEDING AN EVIDENCE BASED OPTION?
Dr Danika Jurat^{1,2}
¹ General Surgery Department, Fiona Stanley Hospital, Perth, Australia, ² Department of Anaesthesia and Pain Medicine, Sir Charles Gairdner Hospital, Perth, Australia

- 8 INTRA-OPERATIVE ULTRASOUND-GUIDED EXCISION OF IMPALPABLE BREAST LESIONS: AN ECONOMIC EVALUATION
Dr Natasha Behrendorff¹
¹ WA Country Health Service, Bunbury, Australia

ABSTRACTS

- 9 LEARNING FROM THE COVID CRISIS – DEFINING SUITABILITY AND LIMITATIONS OF TELEHEALTH SURGICAL OUTPATIENT APPOINTMENTS FOR THE POST-COVID ERA (VIRTUAL)
Dr Robert McCusker¹
¹Womens and Childrens Hospital, North Adelaide, Australia
- 10 TUNNELLED CENTRAL LINES IN CHILDREN: 10 YEARS OF HARD-TO-REMOVE DEVICES (VIRTUAL)
Dr Robert McCusker¹
¹Womens and Childrens Hospital, North Adelaide, Australia
- 11 THE ASSOCIATION BETWEEN GRIP STRENGTH AND WOUND HEALING IN DIABETIC FOOT DISEASE (VIRTUAL)
Dr Kay Hon¹
¹Department of vascular and endovascular surgery, Royal Adelaide Hospital , Adelaide, Australia
- 12 PERIPHERAL PARENTERAL NUTRITION – SAFE AND EFFICIENT FOR THE SURGICAL PATIENT
Dr Sari Mouritz¹
¹Department of Health, Australia

ABSTRACTS

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1 RACS INDIGENOUS SURGICAL PATHWAY PROGRAM

Stephanie Weidlich¹

¹ Royal Australasian College of Surgeons, Melbourne, Australia



Biography:

Stephanie Weidlich is a general surgeon who has live and worked on Larrakia Country for just over 10 years. In 2020 she joined the RACS Indigenous Health Committee (IHC) and has led the ISPP Pilot Project in Darwin.

In 2017 the Australian Department of Health commissioned AIDA to work with specialist medical colleges toward increasing the numbers of Aboriginal and Torres Strait Islander doctors in specialty fields. In 2019, the Council of Presidents of Medical Colleges endorsed the 9 minimum and 6 best practice standards developed by this collaboration.

In 2019 The ISPP became a key priority for the RACS Indigenous Health Committee (IHC) and in 2020 Darwin was chosen as the location for the pilot project.

Key features include;

- active, targeted recruitment
- financial and networking opportunities
- cultural and career-directed support and mentorship
- 'whole of college' cultural shift, as well as
- development of minimum standards and key stakeholder relationships

During the initial phase, focus has been on the development of promotional tools and establishment of relationships with key stakeholders. Recruitment has been targeted to a very select few junior doctors who had previously self-identified to AIDA as having an interest in pursuing a career in surgery.

The pilot project in 2021 sees the launch of the surgical careers of 2 new recruits to Royal Darwin Hospital.

A workshop will be offered to better equip RACS Fellows in leading the ISPP and providing mentorship in their respective health services across Australia.

Through the establishment of a supported recruitment and retention program, we hope to contribute significantly to the number of Aboriginal and Torres Strait Islander surgeons, working towards making a safer theatre for all.

ABSTRACTS

Program correct at the time of circulation

2 DON'T POLLUTE THE FRED! A SURVEY OF LAPAROSCOPIC LENS SURFACTANT USE

Dr Ganesa Pon Raja¹

¹ St John of God Hospital, Bunbury, Bunbury, Australia



Biography:

Ganesa graduated from University of Western Australia School of Medicine in November 2011. He is a service surgical registrar and has worked in various surgical disciplines, including plastic surgery, general surgery, trauma surgery, and orthopaedics. Ganesa has a keen interest in research, and is presently completing a Masters of Surgery.

Introduction:

In laparoscopic surgery utilising CO₂ insufflation, the use of lens surfactant such as cetrimide or FREDTN is crucial to prevent lens condensation from in humid intra-abdominal/pre-peritoneal spaces. However, understanding in theatre staff members of the correct use of surfactant is somewhat mixed, leading to impaired practice by erroneous use.

Methods:

An anonymised multiple-choice questionnaire was administered to theatre staff members engaging in laparoscopic surgery in a single private rural hospital. Intended participants included surgeons, scrub-scout theatre nurses, registrars and surgical assistants. Occupational role and number of frequency of laparoscopic surgery was queried. Subsequent questions queried use of lens surfactant. Correct practice suggests surfactant use to prevent condensation. Incorrect practices included cleaning of lens on viscera and using surfactant sponge to clean a soiled lens. Answered questionnaires were inserted into sealed envelopes and returned to theatre reception. Investigators were blinded to participant identity. Data was stratified by occupational role and frequency of laparoscopic surgery. No individual feedback was given to questionnaire participants. Data was subjected to statistical analysis using SPSS.

Results:

[RESEARCH STILL IN PROGRESS] xx surveys were collected with mixed results with n=? stating correct use, and n=? stating demonstrating erroneous practice knowledge. Correct answers in medical and nursing staff were directly correlated to frequency of laparoscopic surgery. Further education is suggested.

Conclusion:

Correct usage of lens surfactant is an important element of safety and efficiency in laparoscopic surgical practice. This single centre survey has reflected a need for specific laparoscopy education in junior medical and nursing staff.

ABSTRACTS

Program correct at the time of circulation

3 THE EFFECT OF EXERCISE PREHABILITATION ON FUNCTIONAL STATUS OF PATIENTS UNDERGOING BOWEL RESECTION: A SYSTEMATIC REVIEW (VIRTUAL PRESENTATION)

Dr Joshua Teo¹

¹ University of Tasmania



Biography:

I am Joshua Teo, principal house officer in general surgery in Hervey Bay Queensland.

Introduction:

Australia has the highest incidence of colorectal cancer in the world. On average, one in thirteen Australians develop colorectal cancer in their lifetime. Given the high incidence of bowel cancer, measures which improved patient outcomes after bowel resection would benefit a large number of patients, particularly within Australia. Prehabilitation is one method which may improve patient outcomes. The aim of this systematic review is to determine the effect prehabilitation has on postoperative functional status for patients undergoing colorectal resection.

Method:

Studies on the effect of prehabilitation on colorectal patients were gathered from online databases including MEDLINE, EMBASE, and Cochrane Central Register of Controlled Trials. Study design, study population, intervention, and outcomes were extracted from each study.

Results:

6 studies totalling 415 patients were included in this systematic review. 3 studies were RCTs and 3 were prospective cohort studies. All studies which tested participants postoperatively found that the intervention group improved their 6MWD postoperatively more so than each control group. 3 of the studies found that this result was statistically significant. Furthermore, 2 studies found that self-reported physical activity was significantly greater in the intervention group than the controls. The rate of complications or length of hospital stay was not significantly different between intervention and control groups in any study.

Conclusion:

Prehabilitation significantly improves physical fitness and self-reported physical activity but its effect on complication rate was not significant in this review.

ABSTRACTS

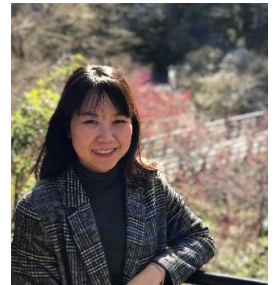
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4 CONTROLLING THE CONTROLS: WHAT IS NEGATIVE PRESSURE WOUND THERAPY COMPARED TO IN CLINICAL TRIALS?

Dr Uyen Vo^{1,2}

¹Department of Vascular Surgery, Fiona Stanley Hospital, Murdoch, Australia,

²School of Surgery, University of Western Australia, Crawley, Australia



Biography:

Dr Uyen Vo is a pre-vocational surgical registration with an interest in Vascular Surgery career. Dr Vo completed her medical degree at the University of Western Australia in 2017. Currently, she is working in the Vascular Surgery Department at Fiona Stanley Hospital, Perth. She is also undertaking a master's in clinical research at the University of Western Australia.

Purpose:

Closed incision negative pressure wound therapy (ciNPWT) appears to reduce surgical site infection (SSI). However, randomised controlled trials have compared to 'standard wound care' but there appears no standard and care is variable. The aim of this review was to assess the control arms compared in trials of ciNPWT for potential confounding variables that could influence the rates of SSI and therefore the trial outcomes.

Methods:

A mapping review of the PubMed database was undertaken in the English language for randomised controlled trials comparing use of ciNPWT to alternative dressings on closed surgical wounds and with surgical site infection as an outcome. Data regarding ciNPWT duration and frequency of change were documented. In the comparator arm potential factors that may influence SSI rates were reviewed including method of wound closure, control dressing type and frequency of change and patient washing were extracted.

Results:

27 studies were included in the review. Most studies did not control for skin closure method or consider differences in patient showering. There was heterogeneity in terms of ciNPWT duration and whether this was changed. There was little control in the comparator arms. A variety of control dressings were compared and overall these were changed more frequently than the ciNPWT dressing in most studies.

Conclusion:

In randomised trials of ciNPWT there was no control over 'standard of care' comparison dressings. Various potential confounders could influence SSI rates. Future studies should aim to control the controls when assessing the efficacy of ciNPWT for SSI prevention.

ABSTRACTS

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5 SAFETY OF EMERGENCY SURGERY ON THE NEONATAL INTENSIVE CARE UNIT

Dr Molly McGuckin¹

¹Perth Children's Hospital, Nedlands, Australia



Biography:

Dr McGuckin is a Resident Medical Officer currently working in Perth Children's Hospital. She completed her medical training in University College Dublin, Ireland, and interned at the Mater Misericordiae University Hospital before moving to Perth.

SAFETY OF EMERGENCY SURGERY ON THE NEONATAL INTENSIVE CARE UNIT

McGuckin, M*; Gera, P; Hullett, B; Thomas, R.

Aim:

Perth Children's Hospital has the facility to perform surgery in the NICU theatre room. We investigate its usage, the cohort of patients operated on, type of procedures and any complications or safety concerns which arose.

Methods:

This was a retrospective study. A chart review was performed on all patients who underwent surgical procedures on the NICU between June 2018 and March 2021.

Results:

23 procedures were performed on the unit during this time. 34.7% weighed under 1000g at the time of procedure. Most patients were extremely premature (30.4%) or term corrected (34.7%). Laparotomy was the most common procedure (56.5%), with congenital diaphragmatic hernia repair (17.4%) and ligation of patent ductus arteriosus (26.1%) also performed. The reason for operating on the unit was ventilatory instability in 43.5% of cases, with extreme prematurity (30.4%) another common indication. There were no major intraoperative complications in 78.3% of cases. Ventilatory and inotropic requirements pre- and post-procedure were recorded. Intraoperative respiratory complications were seen in 30.4% of cases, with cardiovascular complications in 47.8%. Blood products were administered in 69.6% of procedures. Moderate post-operative hypothermia was seen in 13% of patients. Three post-operative complications were noted including pneumothorax, surgical site infection and acute kidney injury.

Conclusion:

This audit provides valuable information on procedures performed on the NICU. We hope to use this to guide future decision-making in similar cases, and optimise surgical safety for these patients.

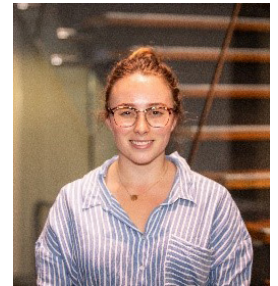
ABSTRACTS

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6 REPAIR: RECONSTRUCTIVE PARTNERSHIP FOR LOWER LIMB OPEN FRACTURES

Dr Jessica Haley¹

¹ Royal Perth Hospital, Perth, Australia



Biography:

Dr Jessica Haley is a current Plastics and Reconstructive Surgery Service Registrar, based at Royal Perth Hospital.

Open lower limb fractures can carry significant morbidity, and at present there are no Australian guidelines regarding the management of complex lower limb trauma. Royal Perth Hospital (RPH) is the only level 1 trauma centre in Western Australia (WA), and as a consequence receives the majority of the state's lower limb open fractures.

This study evaluated the processes and pathways for those presenting to RPH with a lower limb open fracture/s, with the aim of optimising the current management practices. This study was conducted as part of a Medical Service Improvement project with strict DMAIC methodology.

The timeline and management for 204 patients presenting to RPH in 2018 with open lower limb fractures was evaluated, with 88% of patients receiving debridement within 24 hours of admission and 18.3% patients requiring referral to Plastic and Reconstructive Surgery (PRS). An average of 8.8 emergency PRS patients were postponed from surgery as a consequence of the current pathway for 'fix and flap' operations.

Various additional outcomes including the number of operations, time to reconstruction and post-operative complications were measured, and staff and patients were consulted regarding their interpretation and feedback of the current processes.

Extensive collaboration between PRS, Orthopaedics and Trauma Surgery created a new Standard Operating Procedure which has thus far resulted in a decreased length of stay and earlier operative management for lower limb trauma patients. Furthermore, this pathway has also significantly reduced the number of PRS patient's having their surgery postponed, and an overall subsequent decreased length of stay.

ABSTRACTS

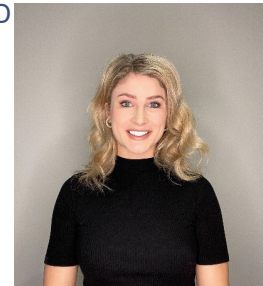
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7 SURGICAL PRE-OPTIMISATION WEIGHT LOSS: IS TIME RESTRICTED FEEDING AN EVIDENCE BASED OPTION?

Dr Danika Jurat^{1,2}

¹ General Surgery Department, Fiona Stanley Hospital, Perth, Australia,

² Department of Anaesthesia and Pain Medicine, Sir Charles Gairdner Hospital, Perth, Australia



Biography:

Dr Danika Jurat is an unaccredited surgical registrar working in Perth, Western Australia.

Purpose:

Obesity increases the risk of poor surgical outcomes and presents an additional challenge in the operating theatre for safe transfers, positioning and procedures(1). This critical appraisal assesses whether, in the adult population, time-restricted feeding (TRF) is a superior weight loss option compared to non-temporal caloric consumption (NTCC).

Methodology:

The literature search was undertaken via OneSearch and Google Scholar. Close assessment of electronic sources incorporated PubMed, EMBASE, MEDLINE and Cochrane.

Keywords utilised were Medical Subject Headings (MeSH) terms. These included “adult”, “time restricted feeding”, “intermittent fasting”, “weight loss” and “caloric restriction”. Inclusion criteria incorporated: human studies, age > 18 years, TRF as the independent variable, body composition as a measured outcome and recorded caloric intake with no overall discrepancies in total intake between study arms.

Three randomised control trials (RCT) Moro, Stote, and Tinsley et al. met the inclusion criteria and were analysed via CONSORT checklists for this critical appraisal of the literature(2–4).

Results & Conclusion:

Moro and Stote et al. support TRF as a superior weight loss option, specifically fat mass reduction, compared to NTCC(2,3). Whilst both RCTs, the level of evidence was downgraded due to study limitations and elements of bias. The calibre of the studies lend low to moderate levels of credit to internal validity of the trials but recommend further research for external cogency as per the GRADE approach(5,6). Tinsley et al. demonstrated no difference between groups(4). Therefore, the authors provide a low-level recommendation in favour of TRF for weight loss.

ABSTRACTS

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8 INTRA-OPERATIVE ULTRASOUND-GUIDED EXCISION OF IMPALPABLE BREAST LESIONS: AN ECONOMIC EVALUATION

Dr Natasha Behrendorff¹

¹ WA Country Health Service, Bunbury, Australia



Biography:

Dr Behrendorff is a current general surgical service registrar at Bunbury Hospital. Previous to this she spent over 16 months as an expedition medical officer in Antarctica, and thus managed to avoid the 'real world' for all of 2020. She has a background in anatomy teaching and has a PhD in the physiology of the exocrine pancreas.

Purpose:

There are a variety of methods used to localise impalpable breast lesions. The two most commonly used approaches are hookwire-guided excision (HWGE) and intraoperative ultrasound (IOUS) guidance. The purpose of this study was to compare these approaches in terms of their economic costs.

Methods:

This study retrospectively analysed the electronic medical records (EMR) of patients undergoing an IOUS or a HWGE between January 2015 and March 2019, in a large teaching hospital (Princess Alexandra Hospital (PAH), Brisbane, Australia). Time-stamped data were extracted from the EMR and compared between groups.

Results:

Although the duration of the surgical procedure was not significantly different between groups, the HWGE patients spent significantly longer in the operating theatre and a significantly longer time in hospital overall. These delays were attributed to the time required to report on the surgical specimen in the radiology department while the patient remained in theatre, and the time needed to place the hookwire pre-operatively. Using costings provided by the PAH Finance Department, we accounted for the cost of the radiology procedure as well as the additional nursing and theatre costs of a HWGE.

Conclusion:

In comparison with a HWGE, we estimate that IOUS could save approximately \$1000 per patient, in addition to the uncalculated costs and decreased risk to the patient of the shorter hospital stay.

ABSTRACTS

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9 LEARNING FROM THE COVID CRISIS – DEFINING SUITABILITY AND LIMITATIONS OF TELEHEALTH SURGICAL OUTPATIENT APPOINTMENTS FOR THE POST-COVID ERA

(VIRTUAL PRESENTATION)

Dr Robert McCusker¹

¹Womens and Childrens Hospital, North Adelaide, Australia



Biography:

Registrar in Paediatric Surgical Training program.

Aim:

To establish a surgical outpatient triaging system that understands the suitability and limitations of telehealth to meet consumer health care needs with efficient use of resources and clinics.

Background:

The traditional paradigm of face-to-face surgical outpatient consultation was abruptly challenged by the COVID-19 pandemic. Telehealth consultation was rapidly rolled out or up-scaled in many places. The use and pitfalls of this technology is not well described at such a large scale.

Methods:

Prospective patient data was collected at point-of-care in Paediatric Surgery outpatients by clinicians. In a second phase, consumer surveys were provided to parents to outline their experience from a face-to-face appointment to see if telehealth may have been feasible.

Results:

Data was collected for 521 consultations. 45% of appointments were with Consultant surgeons. 148 (28.5%) were new consultations. 125 patients (24%) were seen face-to-face, 155 (30%) were called by telephone, and 234 (45%) had a video-call. According to the clinician, the needs of the consultation was not met in 6 face-to-face (4.8%), 25 telephone-calls (16%), and 19 video-calls (8.2%). 96 surveys were returned. 25 (26%) of respondents said they did not require physical examination. 3 of these had been offered telehealth but declined.

Conclusion:

Telehealth is an important tool in the delivery of healthcare in the post-COVID era. Telehealth safely meets the needs of the treating physician, patient and caregiver. Refinement of triaging and selection of consultation method will improve the effectiveness of healthcare delivery.

ABSTRACTS

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11 TUNNELLED CENTRAL LINES IN CHILDREN: 10 YEARS OF
HARD-TO-REMOVE DEVICES (VIRTUAL PRESENTATION)

Dr Robert McCusker¹

¹Womens and Childrens Hospital, North Adelaide, Australia



Biography:

Surgical Registrar in Paediatric Surgical Training program

Aim:

To review tunnelled central line removals and investigate factors that are associated with difficulty or complication.

Background:

Tunnelled central lines are an important part of the management of children with complex, severe, or chronic conditions. Risks and complications during insertion are well described. The risks at time of removal are less understood and potentially underestimated.

Method:

All line removal (Ports, Hickman®, Broviac® etc) over the last 10 years were reviewed. Operative reports were used to identify 'complicated' procedures where additional steps were performed.

Results:

634 Line removals were performed from January 2010 to January 2021. 140 (22%) were external devices (Hickman/Broviac), and 494 (78%) were implanted ports. 47 (7.4%) were 'complicated.' Complications occurred in 45 ports (9% of port removals), and 2 Hickmans (1.4% of external lines). Devices were in-situ for a Mean of 1300 days prior to removal (range 19 - 3428). The commonest complication was neck incision for adherence (46/47). 12 lines could not be removed by the surgeon, 8 were intentionally cut and left in-situ, 4 fragmented. These lines were in-situ for mean 1608 days (650 - 3416). 5 fragments were retrieved by interventional radiology, the rest remain in-situ without additional morbidity. No 'complicated' lines had a history of infection prior to removal.

Conclusion:

Line removal is challenging in up to 9% of cases. It's more often challenging in Port removals, and if the line has been in-situ for an extended period. A history of line infection does not appear to be a risk factor.

ABSTRACTS

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10 THE ASSOCIATION BETWEEN GRIP STRENGTH AND WOUND HEALING IN DIABETIC FOOT DISEASE

(VIRTUAL PRESENTATION)

Dr Kay Hon¹

¹Department of vascular and endovascular surgery, Royal Adelaide Hospital, Adelaide, Australia



Biography:

Second year surgical resident at the Royal Adelaide Hospital with interest in vascular surgery.

Purpose of study

Diabetic foot disease is a serious and common complication of diabetes mellitus and it is significantly associated with mortality. Understanding the predicting factors for wound healing in diabetic foot disease would guide clinicians in providing optimised care to patients. One such predictors has been identified to be sarcopenia, which can be objectively measured with hand grip strength. The purpose of the study was to prospectively evaluate the association of grip strength with time to healing in diabetic foot disease.

Statement of methods

The study was a prospective observational study of diabetic patients with foot wounds reviewed by a major vascular surgery unit in South Australia over 22 months. Participants were followed-up for 12 months and outcome data on wound healing were recorded. Competing risks model via the Fine and Gray approach was used to assess the association.

Summary of results

A total of 153 participants were recruited and data from 152 subjects were available for interpretation. It was found that there was a statistically significant association between time to healing in diabetic foot disease and hand grip strength (SHR=0.50, 95% CI: 0.32, 0.78, global P value=0.002)

Conclusion

The association of grip strength with time to wound healing signifies that sarcopenia is likely to be associated with wound healing in diabetic foot disease. As such, comprehensive assessment of sarcopenia should be considered to ensure positive surgical outcome in diabetic patients.

ABSTRACTS

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12 PERIPHERAL PARENTERAL NUTRITION – SAFE AND EFFICIENT FOR THE SURGICAL PATIENT

Dr Sari Mouritz¹

¹Department of Health, Australia



Biography:

Sari Mouritz is a Resident Medical Officer with a keen interest in General Surgery. After working as a Critical Care Nurse, Sari underwent undergraduate medical training at the University of Western Australia. Her post graduate medical career has been focused on gaining experience that will support a career in general surgery.

Purpose:

Determine safety, efficacy and outcome of administration of peripheral parenteral nutrition (PPN) in the form of preformulated triphasic PeriOlimel N4 to patients in need of acute surgical care at risk of insufficient nutrition.

Method:

An audit was completed of all surgical patients admitted to Fiona Stanley Hospital (FSH) Acute Surgical Unit (ASU) receiving PPN. Data was collected through retrospective review of documentation over an 18 month period from commencement of use of PPN at FSH dated 28/10/2019. Specific audit components included patient demographics, comorbidities, indication, contraindication, nutritional assessment, nutritional efficacy, electrolyte stability, prescribing, administration, complications and 25 day mortality.

Results:

PeriOlimel N4, preformulated in 2L bag, provides 50.6g of protein and 5858kj of energy per 24 hours when infused at the maximum recommended rate of 83ml per hour. As per ESPEN and NICE clinical guidelines, energy, protein and fluid requirements are calculated at the rate of 125 kj/kg /day, 1.2g/kg/day and 35ml/kg/day respectively, in patients who are post-operative or suffering hypermetabolic state such as infection or malignancy. Data collected demonstrates that PPN provides an average of 62.5% energy, 56.5% protein and 74.5% fluid requirements per patient in a 24 hour period. The calculated rate of complication, including phlebitis, extravasation and other was 0.5%. There was no increased morbidity or mortality associated with PPN administration.

Conclusion:

This research concludes that PPN is a safe and efficient means of nutrition for the surgical patient.

WA / NT Office Contact

Telephone
+61 8 6389 8600

Email
college.wa@surgeons.org

SA Office Contact

Telephone
+61 8 8239 1000

Email
college.sa@surgeons.org