Provincial Surgeons of Australia 50th Annual Scientific Conference
Royal Australasian College of Surgeons Trauma Symposium

Darwin Convention Centre, Darwin, Northern Territory

A collaboration between Provincial Surgeons of Australia, Trauma Committee and Indigenous Health Committee

21-23 AUGUST

FINAL PROGRAM

Major Sponsors

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Conveners’ Welcome

It gives us great pleasure to welcome you to the Golden Jubilee Provincial Surgeons of Australia representing Rural Surgeons in Australia and New Zealand (PSA), Annual Scientific Conference and Trauma Symposium held at the Darwin Convention Centre in the Northern Territory, from 21-23 August 2014. The Conference is themed “Rural Trauma”.

We acknowledge and thank the Larrakia Nation on whose land this conference is being held.

It has been a humbling experience arranging this very special 50th conference of the Provincial Surgeons of Australia in Darwin this year. We are proud to celebrate 50 years of the PSA, recognising the immense contributions of various provincial surgeons over five decades, in initiating and sustaining these annual scientific events. The conference this year is a unique collaboration amongst the PSA, the RACS Trauma Committee, and the RACS Indigenous Committee. The annual Trauma Symposium is part of the conference on Saturday 23 August, titled “Injury in Indigenous Populations - Learning from each other”.

We welcome experts from around the world and around Australia and New Zealand; the coming together of surgeons and other professionals who serve injured patients in rural and remote areas, and Indigenous populations, will truly provide the perfect environment to learn from each other.

Multicultural Darwin, the capital of the Northern Territory is at its best at this time of year, with warm weather and glorious sunsets, and has the Darwin Festival in full flow.

Welcome to the “Top End”. Welcome to the 50th Anniversary of the Provincial Surgeons of Australia Annual Scientific Conference.

Yours sincerely,

Mr Mahiban Thomas and Dr Stephanie Weidlich
PSA Conveners 2014

Mr David Read and A/Professor Kelvin Kong
Symposium Conveners 2014
The RACS Indigenous Health Committee (IHC) was established to help improve the health of the Indigenous populations of Australia and New Zealand. The committee is responsible for developing College policies and position papers on Indigenous health, building stakeholder relationships and identifying projects that will contribute to better health outcomes for Aboriginal, Torres Strait Islander and Māori people. The College focuses on both prevention and treatment of surgical conditions and recognises that improvement of Indigenous health in Australia and New Zealand will require collaborative, cross-disciplinary efforts. The College also has a robust history of advocating for injury and disease prevention, with notable success in the area of prevention of serious trauma related injuries.

The symposium, Injury in Indigenous Populations – learning from each other, is an exciting opportunity to bring together rural health and trauma specialists, health practitioners from the Aboriginal community health sector, clinicians and policy makers, working to minimise Indigenous trauma and its impact on communities. The Symposium aims to facilitate multidisciplinary dialogue, to showcase best practice and to identify areas for future collaboration.

The symposium is open to all interested parties. This year’s symposium looks at injuries in Indigenous Populations and ways we can learn from each other. This is an exciting learning opportunity for trauma professionals.
Jim Pryor was a distinguished General Surgeon in the City of Ballarat from 1963 to 2002. Jim attended the inaugural meeting in Shepparton in 1965. He became the prime mover in structuring the PSA and insisted on high standards for papers and the conduct of meetings. An eminent knowledge of surgery together with his enthusiasm and abundance of humour was a golden strand running through all meetings he attended (and as I recall, he did not miss one).

Jim was the first Foundation Fellow in Rural Surgery at the RACS ASC in Canberra in 1992. His interest and expertise in medical work led to his appointment as the Inaugural Chairman of the Medico-Legal Section of the RACS in 1998. The Jim Pryor Begonia Prize, as a part of PSA Annual Meetings, is a fitting memorial to his contributions to country surgery.

Jim Pryor conceived the Begonia Prize session of the PSA Annual Meeting to enable surgeons to exchange views about procedures large or small, instruments they had found useful or techniques which they found worked. The presentations had to be brief and Jim instructed the Judge (usually an invited visiting Lecturer) to award extra points for originality. Country Surgeons adopting these new ideas in their day to day practice found them extremely useful and worthwhile. No other forum at any other Surgical Meeting compares with this format and it epitomises the spirit of PSA meetings (no bullshit!).

Peter Macneil 2005

Jim Pryor

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Invited Speakers

**MS DONNA AH CHEE**  
Donna Ah Chee is the CEO of the Central Australian Aboriginal Congress Aboriginal Corporation, the Aboriginal community controlled primary health care service in Alice Springs. Congress employs around 300 staff delivering services ranging from antenatal and postnatal care, early childhood development, chronic disease, social and emotional wellbeing, women’s and men’s health, a 55 place childcare centre as well as auspicing five health clinics in central Australia.

Donna has lived in Alice Springs for over 25 years and is married to a local Yankuntjarra/Arrente man and together they have 3 children. She is a Bundgalung woman from the far north coast of New South Wales. She has been actively involved in Aboriginal affairs for many years, especially in the area of Aboriginal adult education and Aboriginal health. In June 2011 Donna moved to Canberra to take up the position of CEO of the National Aboriginal Community Controlled Organisation (NACCHO) before returning to Congress in July 2012.

Donna has convened the Workforce Working Party under the Northern Territory Aboriginal Health Forum, was Chairperson of the Central Australian Regional Indigenous Health Planning Committee (CARIHPC), a member of the NT Child Protection External Monitoring Committee and jointly headed up the Northern Territory Government’s Alcohol Framework Project Team. She currently sits on the National Indigenous Drug and Alcohol Committee (NIDAC) and at a local level represents Congress on the People’s Alcohol Action Coalition (PAAC).

**MR PATRICK BADE**  
Patrick Bade has been a General Surgeon at the Royal Darwin Hospital for 18 years.

**DR JAMES BADLANI**  
James Badlani is a Consultant Maxillofacial/H&N surgeon at the Royal Darwin Hospital. James has been involved in the provision of surgical care in the arena of the H&N for over a decade. His interests are trauma, oncology, and reconstruction of the H&N.

**MR PETER FRANCIS BURKE**  
Peter Burke (MBBS FRCS FRACS FACEM DHMSA) graduated from the University of Melbourne Medical School in 1969, and, gaining his FRACS, elected to work in the N.H.S. Whilst in England he obtained the FRCS (Eng.) and pursuing an interest in medical history, the DHMSA.

On his return to Melbourne and St Vincent’s Hospital, he accepted the position of Director of Casualty. He played an active role in the development of the Australasian College for Emergency Medicine.

From late 1979 he began his involvement with the Royal Australasian College of Surgeons, particularly with the Archives Committee which he served as Secretary for 17 years, other committees included the Victorian Road Trauma Committee, the National Road Trauma Committee, the Library Committee, et alii. Dr Burke was appointed by his peers as spokesperson for the first Younger Fellows Course of the RACS in 1982, following his participation in the first EMST course held in Australia, he was awarded a travelling fellowship to study Trauma Centres in Europe and the USA. Currently, he serves the ANZ Journal of Surgery as Specialty Editor in Surgical History.

Since 1987 he has worked as a consultant general surgeon in Victoria’s Latrobe Valley in both public and private practice. In 2012 he was elected a Fellow of the A.M.A.

**MS FRANCES ABBOTT**  
Frances Abbott is a Registered Nurse working at Royal Darwin Hospital (RDH) in the Northern Territory (NT). She was born and raised in New Zealand and trained there. She then worked in Papua New Guinea in remote health services. Since 1980 she has lived and worked in the NT in remote communities and for the last 27 years at RDH. Since 2001 she has worked in a cross-cultural role at RDH supporting cultural security. This includes providing information and resources for staff in relation to patients’ culture and their care; formal and informal training sessions in cultural awareness; working with the Indigenous Liaison Officers; liaising with local refugee services; and promotion of the use of interpreters.
As Director of Padhar Hospital, he is keenly aware of the need for community development. The College of Nursing which he started in 2011 has brought about manifold benefits in empowering women, educating local Christian youth, and in generating local leadership and manpower for mission hospitals. He is also in charge of the Happy Valley English High School, catering to underprivileged children from the surrounding villages. Following the mandate of CMC Vellore to work in the mission field, he has used his talents and abilities for the glory of God, living up to the motto of his Alma Mater “Not to be ministered unto but to minister”

DR GRANT CHRISTEY
Grant Christey is a New Zealand trained General Surgeon and trauma specialist. Initially a trauma and general surgeon at Liverpool Hospital in Sydney, he is currently Director of Trauma Services at Waikato Hospital and Midland Regional Trauma System and holds an honorary academic position at the University of Auckland. Other professional interests include abdominal wall reconstruction, medical disaster response and trauma quality improvement. He is involved in a broad range of organizations in New Zealand and further afield dedicated to improving trauma care.

DR RAJIV CHOUDHRIE
Rajiv Choudhrie is a Consultant Surgeon and Chief of Surgical Services, Padhar Hospital and is probably the only qualified plastic surgeon in rural India. A 1986 alumnus of Christian Medical College, Vellore, India, he completed his postgraduation in General Surgery in 1995 and MCh in Plastic and Reconstructive Surgery in 2001. Padhar Hospital, is a multispecialty, Lutheran mission hospital situated in tribal, rural Central India. It featured internationally in 2012 with the separation of abandoned conjoined twin-girls, Stuti and Aradhana...a joint Indo-Australian endeavour!

A versatile surgeon, his main interests include oncoplastic and microvascular reconstruction. He has worked with various specialists from India, UK, Hong Kong, Germany, Switzerland and Australia.

Cleft surgery camps have been held here since the 1980s, averaging more than one hundred surgeries annually. Rajiv has almost 4000 cleft surgeries to his credit; mostly since the partnership with Smile Train International in 2003.

Invited Speakers

A/PROFESSOR PHILLIP CARSON
Phillip Carson is a General Surgeon at the Royal Darwin Hospital and Darwin Private Hospital and Associate Professor of the Flinders Northern Territory Clinical School. After graduating from Adelaide University he spent his early postgraduate years in Alice Springs and Darwin, which confirmed his desire to become a rural or remote surgeon. He trained in multiple surgical disciplines in the Northern Territory, Adelaide and England before returning as a consultant to Darwin in 1990. His current clinical areas of interest include breast and oncological surgery, thoracic surgery, endocrine surgery, urology, and surgical infection. He has research interests in breast anatomy, paediatric urolithiasis, infectious disease and the delivery of specialist services across barriers of distance and culture. The pattern of surgical practice at the Royal Darwin Hospital has resulted in extensive exposure to patients affected by trauma. The urgent nature of treatment, the distance from tertiary centers and the absence of resident sub specialist surgeons has resulted in experience in the definitive management of trauma covering most areas of surgical endeavor including neurosurgery, reconstructive surgery, facial fractures, vascular and thoracic surgery, paediatric and urological trauma, along with abdominal injuries.

DR GEORGE CHU
George Chu M.B.B.S, B.D.Sc., F.R.A.C.D.S (OMS) is a specialist Oral and Maxillofacial Surgeon practicing in all areas of the speciality and is a member of the Australian and New Zealand Association of Oral and Maxillofacial Surgeons (ANZAOMS). Dr Chu has a number of public appointments as a specialist surgeon at the Brisbane’s Princess Alexandra Hospital and Brisbane Dental Hospitals. He has a keen interest in maxillofacial trauma, orthognathnic surgery and maxillofacial infections.

DR NICK COATSWORTH
Nick Coatsworth is a Fellow of the Royal Australasian College of Physicians, and specialises in both respiratory medicine and infectious diseases. He currently holds the position of Director, Disaster Preparedness and Response at the National Critical Care and Trauma Response Centre in Darwin. Dr Coatsworth is also a
consultant physician at the Royal Darwin Hospital, regularly visits remote Indigenous communities, and has led a combined team of health professionals to the Arnhem Land community of Maningrida to eradicate endemic trachoma. In 2013 Dr Coatsworth led the second Australian Medical Assistance Team that responded to Typhoon Haiyan in the Philippines. Dr Coatsworth began his humanitarian career with the organization Medecins Sans Frontieres in 2004. He has worked in Congo-Brazzaville, Chad and Sudan in the Darfur region. As a field doctor in the Betou project in Congo he was involved in primary and hospital-based care. In Chad he led vaccination teams during an epidemic of measles, and later in Darfur he was project co-ordinator for a hospital-based project in Zalingei. Dr Coatsworth was elected to the Board of Medecins Sans Frontieres in Australia in 2008. He was elected President in 2010 and re-elected for a second term in 2011. He stepped down in 2012 and remains a director.

In 2013 Dr Coatsworth delivered the prestigious ES Meyers Oration at the University of Queensland during which he discussed his experiences in humanitarianism. Dr Coatsworth graduated from the University of Western Australia in 2001 and completed his internship at the Royal Perth Hospital before moving to the Royal North Shore Hospital in Sydney. Dr Coatsworth holds a Masters degree in International Public Health from the University of Sydney and is a Conjoint Lecturer in Population Health at the University of Western Sydney. He is a graduate of Sydney and is a Conjoint Lecturer in Population Health

DR JOHN A CROZIER

John Crozier is a Vascular and Trauma Surgeon, on staff of Liverpool Hospital, South West Sydney. He is the Chairman of the National Trauma Committee of the Royal Australasian College of Surgeons. He has been appointed Brigadier, Director General Health Services – Army Reserve from 2012. He has deployed operationally with Australian Defence Forces to Rwanda, PNG, Bougainville, East Timor, and Banda Aceh, Indonesia. He has been a faculty member on numerous national and international Definitive Surgical Trauma Care Courses from 1994. He regularly directs and teaches on Emergency Management of Severe Trauma courses.

He admires the multidisciplinary nature of both programmes and promotes the lingua franca of trauma as a bridge to understanding and cooperation. Injury prevention and trauma system improvement are his key motivations.

DR KEITH EDWARDS

Keith Edwards was the Chair of Kidsafe NT from 2002 until September 2012 and continues to contribute as a Board Member. Dr Edwards is currently the Community Paediatrician at Centre for Disease Control (CDC), a specialist paediatrician at Royal Darwin Hospital (RDH), a Senior Lecturer in Child Health, Flinders University and adjunct Senior Research Fellow at Charles Darwin University. As the Section Head for Community Paediatrics in CDC he supervises the community paediatric registrar. At RDH Dr Edwards covers paediatric teaching and ward service and is on-call for 3 months of the year. He is responsible for provision of regular paediatric outreach clinics to 12 Top End communities. He also undertakes weekly clinics in RDH and urban clinics in Darwin. Dr Edwards has worked closely with the Menzies School of Health Research in regard to supporting operational research into health problems affecting Northern Territory children.

DR HINEMOA ELDER

Hinemoa Elder is of Ngāti Kuri, Te Aupouri, Te Rarawa and Ngāpuhi descent. She is married with two adult children. She is a child and adolescent psychiatrist and Fellow of the Royal Australia and New Zealand College of Psychiatrists since 2006. Dr Elder is the current recipient of Health Research Council of New Zealand Eru Pomare Post Doctoral Fellowship.

Dr Elder has been an Accident Compensation Corporation provider of neuropsychiatric assessment and treatment for children and adolescents with traumatic brain injury and their families since 2006. Dr Elder’s other subspecialty area of interest is Youth Forensic Psychiatry. Dr Elder has served on the Ministry of Health committees for youth forensic service development, conduct disorder and suicide prevention. Dr Elder was a member of the expert advisory group of Blueprint II, which articulated the framework for New Zealand Mental Health service funding for the next 10 years. She is a deputy psychiatrist and member of the NZ Mental Health Review Tribunal and on the list of Specialist Assessors/Medical Consultants for assessment under the Intellectual Disability Compulsory Care and Rehabilitation Act 2003.
Dr Elder is also an invited Research Associate of the Person-Centred Research Centre and the National Institute for Stroke and Applied Neurosciences at AUT. She is a member of the Māori advisory board at the Centre for Brain Research, University of Auckland. Dr Elder has written a chapter about Indigenous concepts in “Reconsidering Rehabilitation Theory” edited by McPherson, Gibson and Leplege, Taylor and Francis in press 2015.

**DR ANDREW FRONSKO**

Andrew Fronsko is a Senior Manager, Policy and Strategy Territory Insurance Office. Andrew joined the Territory Insurance Office in 2012, having previously working with them from 2009 to 2010. He is a Senior Manager, Policy and Strategy (Statutory Lines) with a role in providing advice relating the Territory’s Motor Accidents Compensation Scheme and Road Safety.

Andrew has an extensive background in motor accident and workers’ compensation insurance, holding various senior operational and policy advice roles with TIO, Suncorp, Victoria’s Transport Accident Commission, Department of Treasury and Finance, and Premier and Cabinet.

Andrew has a keen interest and involvement in road safety. In the 1990-2000s, Andrew worked on development of Victoria’s investment in booze buses, expanded random breath testing, speed detection technologies and establishing Victoria’s Safer Road Infrastructure Program and improved governance of trauma management systems. More recently, Andrew has provided advice to the OECD on the role insurance markets can play in road safety, and is currently assisting in the coordination of efforts by key stakeholders in the Territory to reduce the incidence and severity of road trauma.

Originally qualified as an Engineer, Andrew holds an MBA [Monash School of Economics] and a Doctorate in Insurance [RMIT University].

**DR CHRISTOS GIANNOU**

Christos Giannou was born and bred in Toronto, Canada, in 1949, the son of Greek-Macedonian immigrants. Contrary to a great movement of history, he then emigrated from Toronto. The next years of exile saw him in Montreal, Mali, Algeria, France and Egypt; he managed to attend four universities (McGill, Algiers, Angers, and Cairo) and survive several coups d’etat and one expulsion before going off to war in 1980 as a surgeon with the Palestine Red Crescent Society in Lebanon, which served as the ministry of health of the Palestine Liberation Organisation.

Not knowing when to let well enough alone, he treated Phalange prisoners of war in 1981, survived as a prisoner of war of the Israeli army during the invasion of Lebanon in 1982, escaped Syrian bombardment to treat Israeli prisoners of war in the hands of the PLO in 1983, and remained in the Shatila refugee camp for 27 months under siege as hospital director and sole surgeon from 1985 to 1987.

Still not satisfied, he was sent as a delegate of the Canadian Red Cross to work with the International Committee of the Red Cross (ICRC) to Somalia in 1990, Cambodia in 1991, Somalia again in 1992, and Afghanistan and Burundi in 1993-94.

After serving as medical co-ordinator of the ICRC campaign to ban anti-personnel landmines, he set up a hospital in Chechnya in 1996 where six of his colleagues were assassinated and then went to Geneva soon to become Head Surgeon of the ICRC where the Sudan, Congo, Ethiopia, Eritrea, Uganda, Zanzibar, Liberia, Sierra Leone, Guinea Conakry, Chad, Central African Republic, Albania, Kosovo, FYROM, Nepal, Sri Lanka, Afghanistan, Yemen, Iraq and the People’s Democratic Republic of Korea kept him more or less busy.

In 2006, he semi-retired to Monemvasia, Greece, a mediaeval Byzantine city perched on a rock in the sea. He continues to perform missions for the ICRC and other humanitarian organisations. He also serves as surgical consultant to the Canadian Red Cross Emergency Response Unit rapid deployment field hospital as well as the National Critical Care and Trauma Response Centre, Darwin, Australia. He is Associate Professor in the Masters of International Trauma Surgery at the Queen Mary and Bart’s School of Medicine, University of London and is a scientific advisor to the Masters programme in Disaster Medicine at the School of Medicine, Athens University.

His publications include: Besieged: A Doctor’s Story of Life and Death in Beirut (Key Porter, Toronto, 1990); Vie et mort au camp de Chatila, Albin Michel, Paris, 1992; First Aid in Armed Conflicts and Other Situations of Violence (ICRC, 2006); War Surgery: Working with Limited Resources in Armed Conflict and Other Situations of Violence Volume I (ICRC, 2009) and Volume 2 (ICRC, 2013).

Dr Giannou is the recipient of the Star of Palestine (Executive Committee of the PLO) and was inducted a Member of the Order of Canada in 1990.
PROFESSOR DENNIS GRAY
Dennis Gray is a Deputy Director at the National Drug Research Institute at Curtin University of Technology, and a leader of the Institute’s Aboriginal Research Program. He is an eminent researcher in this area and has a long history of conducting collaborative research with Aboriginal community-controlled organisations. Professor Gray has published extensively on Aboriginal substance misuse issues and has been invited to give presentations on his research in various national and international forums.

His most recent work has focused upon the provision of alcohol and other drug services and on enhancing options for the management of alcohol-related problems in Aboriginal community-controlled health services. His research has had demonstrable outcomes at the national, state/territory and regional/local levels. He is a member of the National Indigenous Drug and Alcohol Committee, his research team was awarded the 2006 National Alcohol and Drug Award for Excellence in Research, and in 2010 – in recognition of his significant contribution to the alcohol and other drugs field – he was named on the National Drug and Alcohol Honour Roll.

PROFESSOR RUSSELL GRUEN
Russell Gruen is Professor of Surgery and Public Health at Monash University, a general and trauma surgeon at The Alfred, and Director of the National Trauma Research Institute (NTRI). Professor Gruen graduated in medicine at the University of Melbourne (1992) and received the Royal Australasian College of Surgeons (RACS) fellowship in general surgery (2005). He completed a PhD on access to surgical services from remote Aboriginal communities (2004), a Harkness Fellowship in Health Policy and a Fellowship in Medical Ethics at Harvard (2002-3), and a Fellowship in Trauma Surgery and Surgical Critical Care at University of Washington, Seattle (2005-6). Professor Gruen has also been awarded an NHMRC Practitioner Fellowship, a James IV Association of Surgeons Travelling Fellowship, and the 2013 RACS John Mitchell Crouch Fellowship, the top academic award of the RACS.

He has published over 100 articles, which have been cited over 1000 times, many in top international journals. He has received research funding totalling more than $15 million, including a prehospital trial of tranexamic acid in severely injured patients, leads Centre of Excellence in Traumatic Brain Injury Research for the Victorian Transport Accident Commission, a program grant to improve management of traumatic brain injury, and a 4-year Australian-Indian Government Grand Challenge Fund Award for research on “Reducing the burden of injury in India and Australia through improved systems of care”. Professor Gruen chairs the Australian Trauma Quality Improvement Program steering committee, co-convenes the Asia Pacific Trauma Quality Improvement Network, and is leading development of a trauma systems knowledge base for the WHO Global Alliance for Care of the Injured. He is a member of the RACS Trauma Committee, the RACS Board of Surgical Research, and is the Australian National Delegate to the International Society of Surgery.

MR KEITH NORMIE HOFFMANN
Normie Hoffmann is an Indigenous Liaison Officer at the Royal Darwin Hospital. In this role he is responsible for overseeing the patients treatment and supporting them through their journey all the way through to discharge and back home. This is in the best interest of the patient and their family.

MS ANNETTE HOLIAN
Annette Holian is a consultant Orthopaedic surgeon who graduated from the Victorian Orthopaedic training program in 1990. She initially practiced in General orthopaedics with a special interest in Paediatrics. In 1996 she started travelling as a volunteer surgeon working and teaching in developing countries, including PNG. In 1998 she responded to the PNG Aitape tsunami when her Monash civilian orthopaedic team deployed under the ADF Joint Task Force umbrella. She obtained a commission in the RAAF in 2000 to provide service in East Timor. This highlighted the need for improvements in Trauma care and she undertook 2 fellowships in Trauma - one at Royal Children’s Hospital, Melbourne and then at The Alfred, where she stayed as a fulltime Trauma surgeon from 2003-2009.

Annette has been a first responder to 2 tsunamis and one earthquake and a typhoon and deployed in uniform on many occasions - to East Timor, twice, to the Solomon’s and Indonesia with the Navy and three times to Afghanistan, the most recent being a 4 month period in 2012 when she was the senior ranking officer in the first health specialist group to work with the US Navy at the NATO Multinational Medical Unit in Kandahar Airfield.
Invited Speakers

Dr Ajay John
Ajay John is one of nine General Surgeons at the Royal Darwin Hospital since his appointment in 2010. Prior to this he worked as the Rural Fellow since January 2008. He is currently the Director of General Surgery. Additionally he manages and was instrumental in setting up the Surgical Acute Care unit at RDH in January 2011. Dr John’s early training was from the Christian Medical College at Ludhiana in the state of Punjab in India. This was supplemented by his Fellowship in General Surgery from the RACS in January 2013. General surgical work at RDH comprises a broad range of work including specialty areas like Acute Neurosurgery, Thoracic surgery and Urology owing to the tyranny of distance and lack of local resident specialists in these fields. His main interest at present is in further developing and streamlining Acute Surgery at RDH where it comprises over 50 percent of the workload.

Dr Malcolm Johnston-Leek
Malcolm Johnston-Leek is a conjoint appointment with St John’s Ambulance and is the Pre-Hospital Director for the NCCTRC. He is an Emergency Physician with extensive experience in disaster response and management beginning with the Port Arthur shooting and most recently the Queensland floods. He also has extensive experience in the pre-hospital and retrieval services. His post graduate qualifications include health management, aviation medicine (both fixed and rotary wing) and retrieval medicine. Currently he is in the Army reserve with the rank of Lt Col and has been deployed four times as well as border protection roles. Dr Johnston-Leek is a Senior Clinical instructor at University Queensland, a senior instructor for EMST, senior instructor for EMERGO Train and senior instructor for MIMMS and instructor for ALS.

After the 2002 Bali bombing he established relationships with Sanglah Hospital in Denpasar. He has been delivering training there ever since and helped establish the sister hospital relationship between Sanglah and Royal Darwin Hospital. Most recently he has helped establish the centralised dispatch system for ambulance in Bali and has been deployed to the Solomon Islands as part of the Australian Government response to the dengue outbreak. He is currently working with the Emergency Services in Denpasar in preparation for the APEC meetings later this year.

Professor Rajinikanth J
Rajinikanth J currently works at the Christian Medical College & Hospital, Vellore, India. He is a General Surgeon with a significant interest in training and ability in the areas of Head and Neck Oncology, including Microvascular reconstruction, Head and Neck Trauma inclusive of facial fracture fixation, with 8 years of work experience in India and 2 years of fellowship experience in busy Head & Neck Departments in Australia and UK.

Dr Ollapallil Jacob
Ollapallil Jacob is a General Surgeon at Alice Springs hospital and has been a senior lecturer of the Flinders University for the last 14 years. After completing surgical training in multiple disciplines in India, he worked in Port Moresby, Papua New Guinea as a general surgeon and senior lecturer of the University of Papua New Guinea for 14 years. His current clinical and research areas of interest are Trauma, acute pancreatitis and delivery of surgical services to Indigenous people across barriers of distance and culture.

Professor Thilak Jepegnanam
Thilak Jepegnanam from the Christian Medical College and Hospital in Vellore is the Clinical Lead for Trauma at this 2000-bedded Hospital. His interests are Orthopaedic Trauma and Reconstruction of the significantly damaged lower limbs, following training in India and Fellowships in New Zealand and Canada. He has worked in several rural settings in India.
Invited Speakers

**DR BRIAN KIRKBY**

Brian Kirkby was born in Adelaide the eldest of three children and attended both public and private schools before undertaking his medical degree at the University of Adelaide. He graduated in 1993 following which he relocated to Tasmania to study to become a General Surgeon. Dr Kirkby became a Fellow of the Royal Australasian College of Surgeons in 2000. He has now been a General Surgeon with a vascular interest in a consultant practice for 13 years. During this time he has broadened his horizons by gaining an honours law degree graduating in 2011 and winning the Northern Territory Supreme Court Medal in the same year. Currently Dr Kirkby is the Director of Surgery at the Launceston General Hospital. In addition he holds several senior positions in the Royal Australasian College of Surgeons (RACS) including Chair of Tasmanian State Committee, Deputy Chair of Rural Surgical Section and member of the Board. His interests include competitive motor racing, fishing, Australian Rules football, farming, cattle rearing, grazing and breeding and music in particular. Dr Kirkby has been a consultant surgeon with the Royal Australian Army in East Timor and from 2010 until now a volunteer for Disaster Relief with AUSMAT. He is married with one child.

**MR SIMON MANZIE**

Simon Manzie was born and raised in Darwin, after 15 years of travelling the world, filming, gaining and developing many skills along the way as a cameraman, sound operator, director of photography, editor, producer, director, and writer he decided to return to Darwin in 2000 to raise his family. In 2001 he established SSTV in Darwin and has gone on to create the busiest production company in the top end. Simon’s work history attests to his skills. Simon has been a Director Of Photography/Lighting Cameraman for the last 28 years. He has shot on location in over 90 countries.

**DR DIDIER PALMER**

Didier Palmer OAM FRCS FRCP FCEM FACEM originally trained in the UK. He has been Director of the Department of Emergency Medicine in the Royal Darwin Hospital since 2000 ...... initially as a single handed consultant in an unaccredited ED and now in a multi-FACEM department seeing 70,000 patients per year with maximal specialist training accreditation. He has interests in many areas of emergency medicine including trauma resuscitation and is a course director for the Australian Trauma Team Training course currently run 5 times a year in RDH to enhance trauma team work. He sits on various National and Regional committees and is the Honorary Treasurer of the Australasian College for Emergency Medicine and Chair of the ACEM Standards Committee. In his spare time he rides horses (show jumping and dressage) and rides a motorbike to work ...... therefore he has a personal interest in the development of effective trauma systems in the Top End!

**A/PROFESSOR KELVIN KONG**

Kelvin Kong qualified as the first Aboriginal Fellow of the Royal Australasian College of Surgeons (RACS), specializing in Otolaryngology, Head and Neck Surgery. Kelvin hails from the Worimi people of Port Stephens, north of Newcastle, NSW, Australia. He completed his Bachelor of Medicine, Bachelor of Surgery at the University of NSW in 1999. He embarked on his internship at St. Vincent’s Hospital in Darlinghurst and pursued a surgical career, completing resident medical officer and registrar positions at various urban and rural attachments. Along the way, he has also been privileged in serving the rural community as part of secondments to peripheral hospitals.

Kelvin is now practising in Newcastle as a qualified Surgeon specializing in Paediatric & Adult Otolaryngology, Head & Neck Surgery (Ear, Nose & Throat Surgery). He is part of a strong, medical family, his mother is a nurse, his father a GP, his sister Marlene is a General Practitioner and her twin Marilyn, is Australia’s first Aboriginal Obstetrician and Gynaecologist. Being surrounded by health, he has always championed for the improvement of health and education, particularly pertaining to ATSI people. Complementing his surgical training, he is kept grounded by his family, who are the strength and inspiration to him, remaining involved in numerous projects and committees to help give back to the community. He is the current Chair of the RACS Indigenous Health Committee.
Invited Speakers

MR JOHN PATERSON
John Paterson was appointed Chief Executive Officer for AMSANT (Aboriginal Medical Services Alliance of the NT) in 2006, he has held senior management positions within government and Aboriginal community organisations for more than twenty five years. He is affiliated with the Ngalakan tribe from the Ngukurr region, southeast Arnhem Land.

John graduated from Edith Cowan University with a Bachelor of Social Science in Human Service. He is also a graduate and Fellow of the Australian Rural Leadership Foundation. John was recently appointed to the Top End Hospital Network Council. He also chairs the NACCHO eHealth Expert Group.

His interest includes mentoring Indigenous youth, strengthening Indigenous governance structures and gardening. John is also President of the Darwin Buffaloes Football Club.

MR ALEXANDER J. POOLE
Alexander J. Poole BA BSc MD FRCSC FACS is currently a General Surgeon at the Whitehorse General Hospital in Whitehorse, Yukon, Canada and is a fellow of the Royal College of Physicians & Surgeons of Canada and the American College of Surgeons. Mr Poole has been appointed as a Clinical Lecturer for the Department of Surgery in the Faculty of Medicine at the University of Calgary in Alberta as well as the ATLS Course Director for Alberta/British Columbia. His interests and skills include Laparoscopic Surgery, Endoscopy, C-Section, Hand Trauma, Minor Plastic Surgery, Tonsillectomy and Trauma Ultrasound.

DR SANTOSH POONNOOSE
Santosh Poonnoose completed his Neurosurgical training at Christian Medical College, Vellore, India in 2001. Pursuing his interests led him to Australia in 2004 and has been working in the Department of Neurosurgery, Flinders Medical Centre since then. His interests are primarily cranial, in the sub specialty of Neuro/Oncology, skull base surgery and epilepsy surgery. He also undertakes complex spine surgeries and has an interest in management of trauma.

He has been an inaugural member of the Flinders Medical Centre Trauma Consultants’ Committee since 2013. He also provides cover for the Northern Territory for management of neurosurgical issues which include traumatic brain injury. He works closely with local Darwin surgeons and the intensive care unit at Royal Darwin Hospital to provide appropriate and efficient care for the traumatic brain and spinal injured patients.

MR SUDHAKAR RAO
Sudhakar Rao is a surgeon with special interest in hepatobiliary - pancreatic surgery and trauma surgery. He qualified as a surgeon in Australia in 1993 and obtained further training in Boston, USA before returning to Royal Perth Hospital.

He is the Director of Trauma at the State Major Trauma Centre at Royal Perth Hospital, Western Australia’s largest and only Level I Trauma Service. Sudhakar established the Trauma Registry and the Trauma Service at RPH, Western Australia’s largest tertiary trauma centre. In 1997, Sudhakar introduced the Major Trauma Outcome Clinic (MTOC), an innovative multidisciplinary project to evaluate patient outcomes following major trauma. Sudhakar was in the first response multidisciplinary trauma team to Aceh after the tsunami disaster in Dec 2004. He received a Humanitarian Service medal from the Government of Australia in recognition of this service. Sudhakar has presented at numerous national and international conferences.

MR DAVID READ
David Read is a General Surgeon and the Director of Trauma for the National Critical Care and Trauma Response Centre/Royal Darwin Hospital. He has worked in Darwin for ten years and in that time has been heavily involved in the responses for Bali 1 and 2, Timor, Ashmore Reed and the TIO Bombing. As an army reservist he has deployed to Iraq, East Timor, Phillipines and Bali and is the secretary for the Military Section of the Royal Australasian College of Surgeons. He has an interest in trauma and burns, paediatric surgery and cancer surgery and the delivery of specialist services to remote Indigenous communities. He enjoys teaching, being an instructor for EMST, EMSB, DTSC and the new Dispersed Surgical AUSMAT course. He was awarded the Conspicuous Service Cross for his efforts at Denpasar Airport in the aftermath of Bali 1.
Government in November 2007, Warren was appointed as the Minister for Defence Science and Personnel. Warren filled this Ministerial position until June 2009 when he was appointed Minister for Indigenous Health, Rural and Regional Health and Regional Services Delivery. After the 2010 Election, Warren was appointed the Minister for Veterans’ Affairs, Defence Science and Personnel and Indigenous Health. After the 2013 election, Warren was appointed Shadow Parliamentary Secretary for External Affairs, Shadow Parliamentary Secretary for Indigenous Affairs and Shadow Parliamentary Secretary for Northern Australia.

Brian Spain has worked at Royal Darwin Hospital since 1997, and has been Director of Anaesthesia since 2001. After being born in Woomera, South Australia when it was a rocket range, quickly moved to Melbourne and grew up there including medical school at University of Melbourne. He is a keen traveller since finishing secondary school and has been across all of the continents except Antarctica. Anaesthesia training in the UK, Perth and Melbourne in the 90’s, including a Fellowship in Paediatric Anaesthesia.

Dr Spain has a long term interest in developing world medicine after a first Anaesthesia trip to West Timor in 1997 and subsequently many trips working and teaching in East Timor, Indonesia (West Timor and Flores) and Cambodia. Involved in the Royal Darwin Hospital responses to Bali bombings 1 and 2, the East Timor shooting. He is a member of faculty on all Real World Anaesthesia courses (RWAC) held in Darwin (the 5th one last year). He was deployed with Team alpha on the AusMAT response to Typhoon Haiyan in the Philippines in November 2013.

Dr Spain has an ongoing interest in teaching including simulation for Anaesthesia and teaching for peri-operative clinical care in low resource environments. Currently he is partway through a Masters of Medicine in Perioperative Medicine at Monash University.
**Invited Speakers**

**MR MAHIBAN THOMAS**
Mahiban Thomas leads the Head & Neck Services at the Royal Darwin Hospital. He is a Consultant General and Maxillofacial Surgeon. He was deeply involved in the care provided for the 2005 Bali bombing victims and has continued to provide surgical support for several United Nations (UN) and East Timor personnel. With over 18 years of experience in the field of facial trauma & H&N oncology, he has been involved as a clinician, educator to medical students, nurses, post-graduate trainees in general surgery and all aspects of head & neck surgery in the Territory for the last nine years.

**DR STEPHANIE TRUST**
Stephanie Trust is a Kidja Woman, Ngowadjadi skin. Her Aboriginal name is Ugalji. She was born and raised in the East Kimberley, went to school in Wyndham and Halls Creek before heading to Perth for Years 11 and 12. She initially trained as an Enrolled Nurse before converting this to Aboriginal Health Worker (AHW) training and worked as an AHW in the Kimberley and Pilbara region of Western Australia for approximately 12 years. In 2000 she travelled to Perth to undertake a life-long dream to become a doctor and is a Fellow of the Royal Australian College of General Practitioners.

Stephanie is a Board member of the Australian Indigenous Doctors’ Association and is currently working as the Medical Director at the Kimberley Aboriginal Medical Services Council Inc in Broome, Western Australia.

**A/PROFESSOR DARYL WALL**
Daryl Wall graduated in medicine with First Class Honours and was awarded the Alfred Hospital Prize for first position on graduation in Medicine. He commenced research into trauma and transplantation at the Alfred Hospital in 1966. He was appointed as a Transplant and Trauma Surgeon at Princess Alexandra Hospital in Brisbane in 1978 and carried out Australia’s first liver transplant in 1985. A/Professor Wall has carried out over 1000 kidney transplants and provided trauma care for over 44 years. He received an Order of Australia 2006 for his contributions to transplantation, trauma care, training and rehabilitation. A/Professor Wall has received the RACS Gordon Trinca medal for contributions to trauma care and prevention, the GSA Medal twice for contributions to General Surgery in Australia.

A/Professor Wall served as Chairman of the RACS Trauma Committee from 2009 – 2014 and is still a member of the Queensland Trauma Committee, Chairman Trauma Advisory Committee RBW and Director of EMST, CCriSP and DSTC courses. He has published over 150 papers, 3 books, 10 videos, been awarded 10 Traveling Scholarships and delivered over 100 invited lectures. A/Professor Wall’s main contribution to trauma care management is that his children practice in intensive care, trauma surgery and emergency care.
PSA Scientific Program

WEDNESDAY 20 AUGUST 2014

13:00  Registration Open
17:30  Welcome Reception

THURSDAY 21 AUGUST 2014

07:00  Registration Open
08:00  Welcome to Country
       Tibby Quall, Larrakia Nation
       Opening Ceremony
       Minister Robyn Lambley MLA
08:30  SESSION 1A: Rural Trauma
       Level 2, Waterfront Room 1
       Chairs: Mahiban Thomas and Stephanie Weidlich
08:30  Overview of Rural Trauma
       Russell Gruen
08:40  Rural Trauma in Canada
       Alex Poole
08:55  Rural Trauma in New Zealand
       Grant Christey
09:10  Rural Trauma in India
       Rajiv Choudhrie
09:25  Trauma in Austere Environments
       Christos Giannou
09:40  SESSION 1B: Rural Trauma
       Level 2, Waterfront Room 1
       Chairs: John Treacy and Ollapallil Jacob
09:40  The History of Rural Surgery in Darwin
       Phillip Carson
10:00  Morning Tea with Industry
**PSA Scientific Program**

13:00  **SESSION 3A: Rural Injuries**  
*Level 2, Waterfront Room 1*  
*Chairs: Tom Bowles and Tulsi Menon*  
13:00  Rural Injuries on the Farm  
*Grant Christey*  
13:15  Large Mammal Trauma in the Yukon  
*Alex Poole*  

13:30  **SESSION 3B**  
*Level 2, Waterfront Room 1*  
*Chairs: Phillip Carson and Carolyn Vasey*  
13:30  A 9-Year Cohort of Resuscitative Thoracotomies for Blunt and Penetrating Trauma at a Level 1 Trauma Centre  
*Peter Bautz*  
13:45  Burns Epidemiology Review Queensland 2003-2013: An Update  
*Tobias Evans*  
14:00  Emergency Neurosurgery at Royal Darwin Hospital 2010-2013: Experience By General Surgeons at a Remote Tertiary Hospital  
*Tara Luck*  
14:15  Outcomes from the Northern Territory Audit of Surgical Mortality - Comparison of Surgical Deaths of Aboriginal and Non-Aboriginal Persons  
*John Treacy*  
14:30  Treat the Patient not the X-ray  
*Thilak Jepegnanam*  
14:40  Afternoon Tea with Industry  

15:00  **SESSION 4A: Disaster Management**  
*Level 2, Waterfront Room 1*  
*Chairs: John Crozier and Julian Speight*  
15:00  The Anatomy of a Disaster  
*Christos Giannou*  
15:15  The Physiology of a Disaster (Tacloban)  
*Annette Holian and Nicholas Coatsworth*  
15:35  The Pathology in a Disaster  
*David Read*  
15:50  Panel Discussion  
17:00  Parliament House Reception  
18:30  Mindil Beach Market

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**AstraZeneca**  
*AstraZeneca* Australia, based in North Ryde, Sydney, is the largest pharmaceutical company operating in Australia. *AstraZeneca* employ almost 1,000 people, are one of the country’s largest manufacturers of medicines and are a key exporter to 35 international markets. *AstraZeneca* manufactures 100 separate product lines, namely sterile respiratory and local anaesthetic products. Of the top twenty medicines used in Australia, four are made by *AstraZeneca*. *AstraZeneca* produces medicines in six separate therapeutic areas including cancer, cardiovascular, gastrointestinal, infection, neuroscience and respiratory inflammation. *AstraZeneca* contributes significantly to clinical trials in Australia with approximately 30 concurrent trials in 190 sites across the country.
FRIDAY 22 AUGUST 2014

07:30  Registration Open

08:00  SESSION 5: Plenary
Level 2, Waterfront Room 1
Chair: Peter Hughes
Foundation Member PSA (1965)
Provincial Surgeons of Australia: Golden Anniversary 1965-2014
Orator Peter Burke
Specialty Editor for Surgical History, RACS

08:00  SESSION 6: Head & Neck
Level 2, Waterfront Room 1
Chairs: Mahiban Thomas and Sally Butchers

08:45  SESSION 7: Thoracic Trauma
Level 2, Waterfront Room 1
Chairs: Dan Campbell and Dinesh Ratnapala

09:00  Morning Tea with Industry

10:15  SESSION 8: Free Papers
Level 2, Waterfront Room 1
Chairs: Matt Oliver and Stephanie Weidlich

10:15  Oesophageal Cancer Surgery – Ten Year Experience in a Regional Australian Hospital
Harry Chow

10:30  Emergency Surgery for Colorectal Cancer in Rural Australia
Matthias Wichmann

10:45  Rural Surgery’s Contribution to the General Surgical SET Program – The NSW Example
Graham Stewart

11:00  Sigmoid Volvulus in Pregnancy
Mohit Bajaj

11:10  Medical Dispute 1984-85
Peter Hughes

11:20  Surgery Still Not Scrubbing up for Women
Saskia Irwin and Jessica Borbasi

11:30  A Surgical Dilemma
Sam Khamhing

11:40  A Prospective Randomized Trial Comparing Parietex Anatomical Mesh to Parietex Folding Slit Mesh and Ultrapro Mesh, and Comparing Mesh Fixation with Abtacks to Fibrin Glue in Tepp Inguinal Hernia Repairs
Arun Naik

11:50  A Grey Nomad Retired Surgeon’s Viewpoint on Rural, Remote Trauma and Retrieval
Graeme Richardson

12:00  SESSION 9: Vascular Trauma
Level 2, Waterfront Room 1
Chairs: Ruth Hardstaff and Shivangi Jog

12:00  Vascular Trauma
Brian Kirkby

12:15  SESSION 10: Hand Trauma
Level 2, Waterfront Room 1
Chairs: Ajay John and Jodie Williams

12:15  Hand Injuries and Rural Surgeons
Phillip Carson

12:30  Lunch with Industry

12:30  Rural Coach Meeting

13:00  Level 2, Waterfront Room 3
Sally Butchers
PSA Scientific Program

13:15  **SESSION 11: Free Papers**

*Level 2, Waterfront Room 1*

*Chairs: Patrick Bade and Brian Kirkby*

13:15  Comparison of Appendicitis and Cholecystitis Outcomes Post Introduction of Acute General Surgical Unit (AGSU)

**Wei Ming Ooi**

13:25  Does the Operator’s Experience Influence the Clinical Course after Appendicectomy?

**Vinay Goundar**

13:35  Red Blanket: A protocol for Improving ED to OR Transfer of Non-Responding, Hypotensive Trauma Patients

**Michael Muller**

13:45  Paediatric Neurosurgery in a Regional Centre

**Tracey Merriman**

13:55  The Challenges of the Supervisor of Training Role in a Regional Area

**Stephanie Weidlich**

14:05  The Initial Experience of a Newly Formalized Pelvic Exenteration Service for Locally Advanced and Locally Recurrent Pelvic Malignancies at the Royal Brisbane & Women’s Hospital

**David Taylor**

14:15  Preparing Surgeons for Rural Australia: The RACS Rural Surgical Training Program

**Aaron Chong**

14:25  The Locum Surgeon: Is it for You?

**Jeffrey Myers**


**Caitlin Young**

14:45  A Challenging Scalp Re-Implantation from the Remote Top End

**Paul Di Giovine**

14:55  Variances in Patient Satisfaction Survey – Does Diagnosis Matter?

**Imeshi Indigahawela**

15:05  **Afternoon Tea with Industry**

15:25  Jim Pryor Begonia Prize

16:20  PSA AGM

18:15  Tripartite Dinner
**FrIday 22 AuGust 2014**

08:00 - Trauma Quality Improvement

10:00 - TQI Sub-Committee

*Level 2, Waterfront Room 2*

Russell Gruen, Roslyn Wendt

08:00 - Trauma Verification Sub-Committee

12:30 - Level 2, Waterfront Room 3

Trish McDougall, Alistair Finlay

09:45 - Morning Tea with Industry

10:30 - Road Trauma Advisory Sub-Committee

12:30 - Level 2, Waterfront Room 2

Danny Cass, Monique Whear

10:30 - ASC Program Ad Hoc Working Party

11:30 - Level 2, Waterfront Room 2

Sudhakar Rao, Russell Gruen, Lyn Journeaux

12:30 - Lunch with Industry

13:15 - Trauma Committee/Regional Trauma Chairs

*Level 2, Waterfront Room 3*

John Crozier, Lyn Journeaux

15:00 - Afternoon Tea with Industry

17:30 - Trauma Committee Meeting Closes

18:15 - Tripartite Dinner

**SaTUrdaY 23 AuGust 2014**

"InJury In InDiGenouS PoPulATIonS – LEaRNiNG FRoM eAcH oTHeR"

07:30 - Registration Open

08:00 - SESSION 1A: Setting the Scene

*Level 1, Auditorium 1*

Chair: John Crozier

Welcome and Introductions

Warren Snowdon MP, Member for Lingiari, John Crozier, Kelvin Kong and David Read

08:15 - Welcome to Country

Tibby Quall, Larrakia Nation

08:30 - SESSION 1B

*Level 1, Auditorium 1*

08:30 - A Case in Point: Remote Indigenous Trauma

Panel: Phillip Carson, Hugh Heggie, Norm Hoffmann, Frances Abbott and Malcolm Johnston-Leek

10:00 - Morning Tea with Industry

10:20 - SESSION 2: Profiles of Indigenous Injury

*Level 1, Auditorium 1*

Chair: David Read

10:20 - Indigenous Trauma in New Zealand

Grant Christey

10:35 - First Nations Injury

Alex Poole

10:50 - Domestic Violence in the Northern Territory

Mahiban Thomas

11:05 - Interpersonal Violence in the Northern Territory

Didier Palmer

11:20 - Road Traffic Injury among Aboriginal and Torres Strait Islanders

Teresa Senserrick

11:35 - The Impact of Alcohol Restrictions on Aboriginal Trauma in Central Australia

Dennis Gray

11:50 - Lunch with Industry
Trauma Symposium

12:40 SESSION 3: An Indigenous Perspective
   Level 1, Auditorium 1
   Chair: Kelvin Kong
12:40 Understanding and Responding to Psychological Trauma within Aboriginal Communities as a Means to Preventing Trauma Presentations in Top End Hospitals
   John Paterson
12:55 Indigenous Trauma - A National, Regional and Local Perspective
   Stephanie Trust
13:10 Central Australian Perspectives
   Donna Ah Chee
   Hinemoa Elder

13:40 SESSION 4: Little Victories
   Level 1, Auditorium 1
   Chair: Mahiban Thomas
13:40 Paediatric Trauma and Kidsafe Northern Territory Style
   Keith Edwards
   Simon Manzie
14:10 Road Trauma in the Northern Territory and the Indigenous Population; Challenges and Road Safety Initiatives
   Andrew Fronsko
14:25 Afternoon Tea with Industry

14:45 SESSION 5: Open Microphone with Panel
   Level 1, Auditorium 1
   Chairs: Kelvin Kong and David Read
14:45 How Should the College Advocate for Change in Indigenous Injury?
   Panel: John Crozier, John Paterson, Stephanie Trust, Donna Ah Chee, Hinemoa Elder, Teresa Senserrick, Dennis Gray, Alex Poole, Grant Christey, Phillip Carson, Mahiban Thomas
16:00 Close
17:45 PSA Dinner

The Symposium Organising Committee would like to thank the National Critical Care and Trauma Response Centre and the Foundation for Surgery for their support.

The National Critical Care and Trauma Response Centre was established by the Australian Government in Darwin following the 2002 Bali bombings. It has decisively increased Australia’s capacity to help relief efforts during disasters, and provide clinical and academic leadership in disaster and trauma care.

It is a key component of the Government’s disaster and emergency medical response capabilities, as well as an important national asset, ensuring Australia, and Royal Darwin Hospital in particular, is able to respond swiftly and effectively to major onshore and offshore incidents in Australia and South East Asia.

The NCCTRC provides both a rapid response capability for deployment of large, highly trained medical teams directly to the scene of disasters in northern Australia and overseas, and a forward reception capacity for critically injured patients transferred from overseas back to Australia.

The Foundation for Surgery is the philanthropic arm of the Royal Australasian College of Surgeons. Through donations made by visionary and generous health care professionals interested in the advancement of medical endeavours and enhanced patient care, the Foundation enables the implementation of a wide range of worthy and important projects.

These projects help support pioneering research into new medical techniques, technologies and treatments, address the health inequities in Australia and New Zealand’s Indigenous, remote and rural communities and increase medical capacity, skills transfer and educational programs in our neighbouring disadvantaged countries.
GENERAL INFORMATION

VENUE - DARWIN CONVENTION CENTRE
All scientific sessions and the industry exhibition are held at the Darwin Convention Centre, Stokes Hill Road, Darwin, Northern Territory.

REGISTRATION DESK
The registration desk is open as follows:
Wednesday 20 August 2014: 13:00 - 16:00
Thursday 21 August 2014: 07:00 - 16:00
Friday 22 August 2014: 07:30 - 16:00
Saturday 23 August 2014: 07:30 - 16:00

INDUSTRY EXHIBITION
All morning teas, lunches and afternoon teas are held in the industry exhibition and is an important component of all PSA Annual Scientific Conferences. Delegates are encouraged to participate and view the latest products and information. Open Thursday to Saturday afternoon.

CONTINUING PROFESSIONAL DEVELOPMENT
This education activity has been approved in the College’s CPD Program. Fellows who participate can claim one point per hour (maximum 19 points) in Category 4: Maintenance of Knowledge and Skills towards 2014 CPD totals.

DIETARY REQUIREMENTS
Please note that the venue is responsible for all catering at the congress and RACS does not inspect or control food preparation areas or attempt to monitor ingredients used. You should contact the venue directly for all special dietary requirements during the event, irrespective of whether details have been provided to RACS. If RACS requests information about your dietary requirements for a specific event RACS will endeavour to forward the information provided to the venue (time permitting). RACS will not retain information provided for future events, so you must verify your requirements for each event. Even if information is requested or provided, RACS takes no responsibility for ensuring that the venue acknowledges your dietary requirements or that these requirements can be met. In all cases you must verify for yourself that your dietary requirements have been met and RACS refutes any and all liability for any failure to adequately provide your special dietary requirements or any consequential damage resulting from such failure.

INTENTION TO PHOTOGRAPH
Please be advised that photographs may be taken during the conference and reproduced.

ASSOCIATES’ SOCIAL PROGRAM

LITCHFIELD DAY TOUR
Thursday 21 August 2014
Departs: 07:00 Darwin Convention Centre
Returns: 16:30 Darwin Convention Centre
Bring: swimwear, towel, sunscreen, insect repellant, walking shoes and refillable water bottle.

During this tour you will experience the beauty and tranquility of Australia’s Outback. After travelling by bus to Litchfield National Park you will enjoy listening to the secrets and stories of the bush, followed by a freshly prepared picnic lunch. After lunch you will discover the fascinating mounds built by termites complete with arches and tunnels. Before returning back to Darwin you will have the opportunity to swim and relax in the beautiful waterfalls of the region.

JUMPING CROCODILE AND DARWIN HISTORY TOUR
Friday 22 August 2014
Departs: 07:00 Darwin Convention Centre
Returns: 16:30 Darwin Convention Centre
Bring: walking shoes, sunscreen, insect repellant, refillable water bottle and money for lunch.

Experience the Jumping Crocodile Cruise on the Adelaide River where crocodiles are enticed to leap out of the water so you can see them up close. Following this you will return to Darwin to explore the Darwin Art Gallery and Museum where you will have time to purchase lunch from the Cornucopia Café. You will then visit the Darwin Military Museum to learn about WWII and the bombing of Darwin.
WELCOME RECEPTION
Wednesday 20 August 2014, 17:30
Darwin Harbour Cruises, Stokes Hill Wharf, Stokes Hill Road, Darwin
Dress code: casual
Bring: camera and sunglasses

17:15  Meet at the far right hand side of Stokes Hill Wharf
17:30  Commence boarding of ‘Charles Darwin' for a Sunset Cruise
20:00  Welcome Reception concludes

PARLIAMENT HOUSE RECEPTION & MINDIL BEACH
Thursday 21 August 2014, 17:00
Parliament House, Mitchell Street, Darwin / Mindil Beach Market, Mindil Beach Reserve, off Gilruth Avenue, Darwin
Dress code: Territory Informal (smart casual, strictly no shorts, T-shirts or thongs)
Bring: camera and personalised invitation (invitation required upon entry)

16:35  Meet at entrance of the Darwin Convention Centre (or make your own way to Parliament House)
16:45  Depart Darwin Convention Centre to walk to Parliament House (approx. 15 minute walk)
18:15  Coach transfer departs Parliament House to Mindil Beach Market
21:30  Coach Transfer departs Mindil Beach to Adina/Vibe and Mantra on the Esplanade
22:00  Coach Transfer departs Mindil Beach to Adina/Vibe and Mantra on the Esplanade

TRIPARTITE DINNER
Friday 22 August 2014, 18:15
SKYCITY, Gilruth Avenue, Darwin
Dress code: smart casual

17:35  Meet at the main entrance of Vibe/Adina or Mantra
17:45  Coach transfer departs Vibe/Adina
17:50  Coach transfer departs Mantra on the Esplanade
22:30  Coach Transfer departs SKYCITY to Adina/Vibe and Mantra on the Esplanade
23:00  Coach Transfer departs SKYCITY to Adina/Vibe and Mantra on the Esplanade

PSA DINNER
Saturday 23 August 2014, 17:45
Crocodile Park, McMillans Road, Knuckey Lagoon
Dress Code: neat casual

17:05  Meet at the main entrance of Vibe/Adina or Mantra
17:15  Coach transfer departs Vibe/Adina
17:20  Coach transfer departs Mantra on the Esplanade
22:30  Coach Transfer departs SKYCITY to Adina/Vibe and Mantra on the Esplanade
23:00  Coach Transfer departs SKYCITY to Adina/Vibe and Mantra on the Esplanade
Abstracts

THURSDAY 21 AUGUST 2014
PROVINCIAL SURGEONS
OF AUSTRALIA

SESSION 1A

Overview of Rural Trauma
Russell GRUEN, Melbourne VIC

Severely injured patients often have time-critical treatment needs. In Australia, where most of the population, and designated trauma centres, are located in a relatively small number of major cities, there are real challenges ensuring people injured in rural and remote areas get the care they need. This presentation defines the challenge and the ways that the Australian and international trauma communities are breaking the deadlock between limited numbers of skilled providers and the fact that the disease burden is disproportionately distributed to where such providers are scarce.

Rural Trauma in Canada
Alex POOLE, Whitehorse CANADA

20% of Canadians live in rural areas. 22.5% of Canadians live more than an hour away from a trauma centre. Dividing the issue of accessibility to care between urban and rural oversimplifies the issue. 95% of Canada’s 9.5 million square kilometres is considered rural, remote, and northern. In Canada’s three northern territories 40% of the citizens are defined to be in rural areas. Within those territories the urban population is within 1 hour of a level 3 trauma centre. However, none are within 1000 km of a level 2 centre, let alone a level 1 centre. This raises the issue that remoteness is as defining a factor in accessibility to advanced trauma care in Canada as is ruralness.

Rural Trauma in New Zealand
Grant CHRISTEY, Hamilton NEW ZEALAND

Over half of New Zealanders live in provincial areas, and 30% live in rural areas. Rates of serious injury tend to be higher in rural areas and are related to socioeconomic status, ethnicity, activity and domicile, with falls and road traffic crashes predominating in major trauma volumes. Large stretches open roads of variable quality, high proportions of workers in industrial or farming activities, and the tyranny of distance all contribute to an increased burden of trauma in these communities. The propensity of Kiwis to engage in risky outdoor activities is a national expectation, and New Zealand’s international reputation as an adventure sport destination adds to the burden. At the service provision level, there is downsizing of rural medical and surgical capabilities contributing to staff turnover, loss of trauma-specific skills and rerouting of skilled personnel to larger centres. It is hoped that the national development of a number of regional trauma systems with consistent systems, processes and a focus on clinical best practice and prevention will help to ensure better equity and less burden on our rural population.

Rural Trauma in India
Rajiv CHOUDHRIE, Vellore INDIA

Coping with financial, infrastructural and manpower constraints, trauma surgery in rural India is a challenge! The “Golden period of management” is a distant dream… unacceptably high morbidity, disabilities and mortality are forces to reckon with! Long term care and support systems are unaffordable and unavailable for most of the poor in rural India. Most patients coming to Padhar Hospital are uneducated tribals with 40% living below the poverty line, with no access to public health government funds. This paper attempts to compare the management of various trauma in Padhar Hospital with that available in the rest of urban and rural India.

Trauma in Austere Environments
Christos GIANNOU, Lakonia GREECE

First definitions: what do we mean by “austere”? The military of a wealthy, industrialised country often talk about an austere environment during their deployment. A civilian understanding of austere may be quite different. Austere could best be described as “limited resources in precarious circumstances”. The resources may pertain to infrastructure, equipment, supplies and logistics, finances, administrative capacity, and personnel. The circumstances may be a rural setting without guaranteed capacity to transfer patients, a natural disaster, or armed conflict. Personal reflections on working with limited resources in precarious, and sometimes dangerous circumstances.
SeSSIon 1B

The History of Rural Surgery in Darwin

Phillip CARSON, Darwin NT

The equitable provision of skilled surgical services to current residents and visitors to the Northern Territory is greatly challenged by a small population, large distances, difficult terrain and cross cultural communication. The original inhabitants and owners of the land provided limited local services at clan level. Medical issues were an important component of the failure of the first three attempt at European settlement in the north from 1824 to 1849. Permanent European settlement finally succeeded around Port Darwin in 1869. Conditions were harsh for many years. The first recorded operation, the removal of a spear from the chest of Mr Bennet, a draughtsman with Goyder’s surveying party, resulted in death within 24 hours. All medical and surgical services in the Northern Territory were provided by generalist doctors and intrepid nurses up until the middle of the twentieth century. Gold rushes, other mining and the cattle industry lead to the changing population, dominated by hard men. By the end of the 19th ethnic Chinese outnumbered European settlers. Aboriginal people were displaced, brutally or callously from their lands and suffered greatly from introduced diseases and afflictions, later, cushioned what by the establishment of missions. Leprosy, yaws, venereal diseases were common. The Commonwealth took control of the Northern Territory and its medical services in 1911. The post of chief medical officer became very powerful, especially when combined with “Protector of Aborigines”, Quarantine officer, chair of the hospital board, chair of the nurses board, chair of the medical benevolent fund as it did in the reign of Cecil Cook 1927-1939. During this time most small towns and Aboriginal missions and settlements developed small hospitals with inpatient facilities, usually run by nurses and Aboriginal nursing assistants. Medical input and help was greatly facilitated by the development of The Royal Flying Doctor Service due to the innovation, vision and persistence of the Rev John Flynn who also encourage Alfred Treager to develop a pedal powered radio transceiver in around 1926.

SeSSIon 2

Open Abdomen: Standardizing Management in the Outback

Jacob Ollapallil JACOB, Alice Springs NT
Mathew Ollapallil Jacob, Fremantle WA

INTRODUCTION

The myriad of complex abdominal pathology seen in Central Australia due to delayed presentations and geographical challenges has made the open abdomen (OA) an increasingly common strategy for the general surgeon. Current evidence supports the execution of the open abdomen in three major clinical scenarios, 1) “Damage control” following massive intra abdominal haemorrhage, 2) acute abdominal compartment syndrome (ACS) with persisting organ dysfunction despite medical measures, 3) Management of catastrophic intra abdominal sepsis.

METHODS AND RESULTS

This is a retrospective study that looks at 33 cases of open abdomen of varying etiology that has presented over a 10-year period (2005 to 2014). The primary objective of this study is to use the established Bjork classification system (Fig.1) to standardize these cases for analysis of their outcomes. We will also be reviewing the methods of initial temporary abdominal closure (TAC), delayed primary closures and planned ventral hernias. Secondary objectives of the study will look at population demographics, length of stay, complications (including pancreatic and enter-atmospheric fistulas, mesh/graft infections, MODS and ARDS) and mortality. There is no entero-atmospheric fistula as a complication of open abdomen and only one mortality in this series.
Abstracts

Challenges in Remote Urotrauma
Ajay JOHN, Darwin NT

Urotrauma at RDH is especially challenging in terms of the distances involved between accident sites and the hospital as well as between local surgeons and sub specialists. Most of the general surgeons at RDH have therefore developed sub specialty interests among them Urology. There is a great collegiate spirit between these local surgeons that enables us to back up each other in a crisis using shared experience. Support is also provided by way of a visiting Urology service from Adelaide. They also provide limited after hours phone support but are often limited in their ability to review imaging owing to systems issues. SKYPE, MMS, email and other smartphone technology often assists in these situations. We are also grateful for the interventional talents of our radiologist colleagues in managing these cases. I would like to present a case that illustrates our situation.

Hepatobiliary Trauma
Daryl WALL, Brisbane QLD

Hepatobiliary injuries (HBI) are detected in 5% of trauma admissions. Most of these patients can undergo non operative management (NOM). Severe HBI (Grade IV-V1) are associated with a mortality of 10%. Recent remarkable improvement in survival of patients with severe HBI maybe attributed to the following:-

1. Improved surgical training.
2. Standardisation of pre-hospital and Emergency Department Protocols.
3. Permissive Hypotension, Patient Warming and rapid transfer.
5. Damage Control and Liver Packing.
6. Hepatic Angio-embolisation or Right Hepatic Triad Ligation.

Pelvic Trauma
Thilak JEPEGNANAM, Vellore INDIA

In India, high velocity road traffic accidents are increasing exponentially, with the result that there is an increasing incidence of pelvic fractures requiring surgical treatment. While earlier, victims of accidents with massive blood loss never made it to an equipped centre, better ambulance services has ensured that they do arrive early to a referral centre. While most pelvic fractures were treated non-operatively or with external fixation earlier, they are more frequently being treated with internal fixation now. Pelvic trauma, by its very nature involves different specialities being involved. Cooperation and seamless functioning of these various specialities is absent in most of the Third World because of absent Level 1 trauma centres. This presentation deals with the changing trends in the management of pelvic trauma at a referral centre in India as it is in a state of evolution.

CONCLUSION
The Bjork classification has proven an appropriate system to ensure a standardized and reproducible approach for OA in central Australia. The favoured method of TAC is vacuum assisted negative pressure therapy, due its lower rates of complications. The preferred outcome of OA is delayed primary closure however if this cannot be achieved planned ventral hernia and deferred definite closure is the end point.

Pelvic Fractures

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
<th>No. Of Cases</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A</td>
<td>Clean OA, nil adherence to bowel and abdominal wall or fixity</td>
<td>7</td>
<td>-Delayed 1° no mesh</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-Delayed primary with composite mesh</td>
</tr>
<tr>
<td>1B</td>
<td>Contaminated OA without adherence/fixity</td>
<td>4</td>
<td>-Delayed 1° with no mesh</td>
</tr>
<tr>
<td>2A</td>
<td>Clean OA developing adherence/fixity</td>
<td>6</td>
<td>-Delayed 1° with underlay composite mesh</td>
</tr>
<tr>
<td>2B</td>
<td>Contaminated OA developing adherence/fixity</td>
<td>5</td>
<td>-Delayed 1° without mesh-component separation</td>
</tr>
<tr>
<td>3</td>
<td>OA complicated by fistula formation</td>
<td>1</td>
<td>-Ventral hernia with skin graft</td>
</tr>
<tr>
<td>4</td>
<td>Frozen OA</td>
<td>6</td>
<td>-Ventral hernia with skin graft</td>
</tr>
</tbody>
</table>

Fig 1: Classification and outcome of OA in Central Australia

CONCLUSION
The Bjork classification has proven an appropriate system to ensure a standardized and reproducible approach for OA in central Australia. The favoured method of TAC is vacuum assisted negative pressure therapy, due its lower rates of complications. The preferred outcome of OA is delayed primary closure however if this cannot be achieved planned ventral hernia and deferred definite closure is the end point.

Pelvic Trauma
Thilak JEPEGNANAM, Vellore INDIA

In India, high velocity road traffic accidents are increasing exponentially, with the result that there is an increasing incidence of pelvic fractures requiring surgical treatment. While earlier, victims of accidents with massive blood loss never made it to an equipped centre, better ambulance services has ensured that they do arrive early to a referral centre. While most
8. Partnerships with Anaesthetists and the use of rapid infusion cannula and pumps.
9. Use of advanced imaging (FAST, CT Angiogram).
10. Surgical teamwork through consultant to consultant coordination.

One episode of hypotension which is associated with suspected HBI requires the use of Damage Control Resuscitation and Surgery. Conventional Surgical Care is contra-indicated.

Non Operative Management demands Intensive Care support. Indications for surgery include shock, peritonitis, ongoing transfusion requirement, hollow organ injury, associated ruptured diaphragm and liver or abdominal compartment syndrome. NOM may require delayed interventions for liver abscess, subphrenic abscess, hemobilia, biliary fistula or massive liver or gall bladder necrosis.

Biliary injuries usual involve the gall bladder (60%) however; other biliary injuries are associated with injuries to the triad which are frequently lethal. Temporary occlusion followed by rapid transfer to a Surgical Centre with Liver Transplant support is required.

Pancreatic Trauma
John CROZIER, Liverpool NSW

Pancreatic injury, in the context of blunt or penetrating abdominal trauma in Australia, is infrequent in incidence, but profound in impact, particularly if it is not detected early.

Multi detector CT imaging has a high sensitivity for the detection of pancreatic injury. Thorough visual inspection of the pancreas, often necessitating extended Kocherization; entry into the lesser sac; and, occasionally, left sided medial visceral rotation, is essential if injury to the pancreas is suspected.

Damage control methods are very appropriate for the management of complex pancreatic injury. Distal pancreatic injury, particularly when it is associated with pancreatic duct laceration or transection, is reasonably managed by resection of the distal pancreas.

Complex injury to the head of the pancreas, may reasonably be managed initially with closed suction drainage. Concomitant duodenal or other bowel injury, should be managed by expedient methods which stop contamination of the peritoneal cavity by enteric content.

Formal stoma creation, extensive resection, or anastomoses involving bowel, should be avoided at the time of the initial laparotomy. Expeditious patient transfer to a major Trauma Centre, after initial damage control surgery is ideal patient management.

Splenic Trauma
Sudhakar RAO, Perth WA

Non operative management of blunt splenic trauma is now well established in trauma care. Advanced imaging using multidetector CT scans is an essential tool in providing surgeons with the information required during the acute phase. The role of Splenic Arterial embolization is also clear in the acute phase of injury. The natural history (specifically, the incidence of delayed pseudoaneurysm formation) of nonoperatively managed splenic trauma is not well documented. Questions remain about the role of repeat (planned) arterial phase CT scan and further role of splenic arterial embolization. Recent data may provide some direction in developing guidelines and answers.

How I Transfer a Burns Patient
David READ, Darwin NT

Subspecialisation has resulted in the majority of major (>10%TBSA) burns being managed in tertiary centres. Unfortunately, not all major burns occur within an hour of the sparsely scattered burns units in this vast nation. It therefore often falls to the provincial surgeon on call to initially manage the major burn patient until safe transfer can be arranged. The first 24 hours of the major burn patient injury hold many challenges that if handled correctly, can positively influence outcome. This talk will offer useful tips and tricks for the rural surgeon of how to systematically stabilize and transfer the patient in as good a condition as possible.

Bull Gore Injuries – A Clinical Study
Rajinikanth J, Vellore INDIA

Bull gore injuries are among the commonest injuries in India, especially the rural parts where people make their
Abstracts

The commonest injuries on New Zealand farms include musculoskeletal problems, fractures and noise-induced hearing loss. The commonest causes of farm injuries are falls, slips and trips, and loss of control of vehicles. Fatal injuries are associated with tractor and quad bike crashes and rollovers. As a result of major efforts in the sphere of farm injury prevention, rates of agricultural injury have been slowly declining since 2002. It is hoped that this trend will continue and accelerate.

Much of the burden of farm injuries is preventable with safer practice and safer equipment. The challenge is to find workable and cost effective solutions for risk reduction that are acceptable to farmers and their families.

Large Mammal Trauma in the Yukon
Alex POOLE, Whitehorse CANADA

The Yukon in Canada’s extreme Northwest is home to sixty thousand moose, seven thousand grizzly bears, four thousand wolves, and a thousand bison. All of which can occasionally be responsible for traumatic injuries. However, statistically the most dangerous large mammal in the Yukon is neither the mighty moose nor the iconic grizzly, but the domestic horse.

SESSION 3A
Rural Injuries on the Farm
Grant CHRISTEY, Hamilton NEW ZEALAND

Farm injuries are a significant contributor to the burden of injury in Australia and New Zealand, and typically result from falls or forceful interactions with machinery or animals. There are risks related to chemical use, environmental exposure, geographic isolation, rural travel, cultural influences, and exposure of people at the extremes of age to farm injury sources.

Agricultural workers tend to be self-employed, and tend to work alone. They face the challenges of hard physical labour, the stress of running a business in relative isolation from peers and professional advisors. In addition they are responsible for the safety of their families in a potentially hazardous environment. In Australia, common cause of injuries include lifting or handling objects resulting in musculoskeletal stress, handling of non-powered tools, animal handling and mobile plant and transport. About 70% of farm fatalities involve vehicles. Death rates from injury are highest in the over 65’s and the average age of farm workers is increasing.

SESSION 3B
A 9 Year Cohort of Resuscitative Thoracotomies For Blunt and Penetrating Trauma at a Level 1 Trauma Centre
PC BAUTZ, C Dobbins, CC Moller, D Trehan, C Clarke, Adelaide, SA

INTRODUCTION
Resuscitative thoracotomies are a last ditch effort in salvaging dying trauma patients. RAH has a protocol for emergency resuscitative thoracotomies (ERT), with thoracotomy initiated when the systolic BP<60mmHg with maximal resuscitation.

MATERIALS AND METHODS
Moribund trauma patients who presented to the RAH from 2005-2013. The indications were identical for blunt and penetrating trauma. ERT technique is now clam-shell thoracotomy yielding excellent exposure. Trauma surgeons were usually present on patient arrival, or within 7 minutes.
Abstracts

RESULTS
72 patients underwent an ERT. 66.6% of the penetrating ERT’s survived but only 23.2% of blunt ERT’s survived. 84.23% of emergency room thoracotomies were successful and left the ED with spontaneous circulations. Blunt ERT performed within 10 minutes of arrival had 0% survival while penetrating ERT within first 10 minutes had a 33.33% survival. If the first 10 minutes of blunt ERT’s were excluded, blunt ERT survival was 37.5%. Patients who were very unstable left theatre with damage control thoracostomies, frequently associated with laparostomies as combined thoraco-laparostomies.

CONCLUSION
The presence of trauma surgeons in ED allows ERT survival of 66.7% in penetrating trauma and up to 37.5% survival in blunt trauma.

Burns Epidemiology Review Queensland 2003-2013: An Update
Tobias EVANS, Stephanie Tan, Michael Muller, Brisbane QLD

INTRODUCTION
The Stuart Pegg Burns Centre at RBWH services the entire state of Queensland as a Tertiary Burns referral centre for adults and often receives referrals from interstate and occasionally internationally. Queensland having an immense geographical area it is important to understand the changing nature of Burn injuries and Geographical distribution. Transport of patients locally and from afar often involves complex and costly logistics. In the past ten years there has been no epidemiological study looking at the changing nature of burns injuries, this data being important in providing a sustainable effective service.

AIM
To study the epidemiology of burns in Queensland in relation to evolving pattern of burn aetiology, admission numbers, demographics, mortality and geographical referral base from 2003-2012. Anecdotally there has been a change in the above categories and we believe it is important to clarify this in order to accurately target public health awareness campaigns and again look at the feasibility of major burns surgery being performed outside of Brisbane.

METHOD AND RECRUITMENT
The burns database was utilised over a ten year period and 3219 patients were studied. On each admission to the burns unit the admitting registrar completes a standardised form and this data is entered daily into a database.

RESULTS
Higher admission numbers 3219 (10 years) compared with 4523 (20 years). Females 25.9%, Males 74.1%. 20-40yo 47% of inpatients. 90% of admissions with <20% TBSA. 90.6% of burns are described as accidental and 46% are caused by flame. Mortality overall 1.99% and 33% for TBSA>60%. The mortality rate has been consistently falling since 1976.

ETHICS
Ethics approval was obtained for the completion and publication of this study.

Emergency Neurosurgery at Royal Darwin Hospital 2010-2013: Experience by General Surgeons at a Remote Tertiary Hospital
Tara LUCK, Matthew Mathieson, Jessica Sandilands, Stephanie Weidlich, David Read, John Treacy, Brian Spain, Dianne Stephens, Darwin NT

PURPOSE
Royal Darwin Hospital (RDH) is a remote tertiary hospital, serving as referral centre for the “Top End” of the Northern Territory, parts of Western Australia and South East Asia. There is no resident neurosurgeon, and given Darwin’s geographical isolation, emergency neurosurgical procedures are conducted by general surgeons. This study aims to evaluate all emergency neurosurgical procedures performed by general surgeons at RDH between January 1, 2010 - December 31, 2013.

METHODOLOGY
This is a single center retrospective analysis conducted by review of case notes, operating theatre records, and trauma and intensive care databases. All emergency neurosurgical procedures performed for intracranial pathology between January 1, 2010 – December 31, 2013 were included. Emergency spinal surgeries were excluded.
RESULTS
This study identified a total of 86 patients undergoing 106 emergency neurosurgical procedures. An average of 26.5 procedures were conducted each year, including burr holes, craniotomies, cranietomies, elevation of skull fractures, revision of VP shunts and EVD insertion. Trauma accounted for 66% of presentations with the most common related to falls (24%), assaults (22%) and road-traffic accidents (16%). Alcohol was a factor in 67% of traumas. Non-traumatic presentations included cerebrovascular accidents, spontaneous subdural haematomas, intracranial infection and hydrocephalus. The most common intracranial pathology encountered was subdural haematoma (59%). The overall 30-day mortality was 22.1% and 19.3% for the trauma cohort.

CONCLUSION
General surgeons at Royal Darwin Hospital perform a wide range of emergency neurosurgical procedures on patients from a large geographical area, with trauma accounting for the majority of presentations.

Outcomes From the Northern Territory Audit of Surgical Mortality-Comparison of Surgical Deaths of Aboriginal and Non-Aboriginal Persons
John Treacy, John North, Therese Rey-Conde and Jennifer Allen, Casuarina NT

AIMS
To compare in-hospital surgical deaths of Aboriginal and non-Aboriginal persons and to identify patient factors plus deficiencies of care that may have contributed to the gap in life expectancy.

METHODS
Retrospective data collection and prospective audit, with independent peer review, of all in-hospital surgical deaths at all hospitals in the Northern Territory that have resident or visiting Surgeons, between 1st June 2010 and 30th June 2013, addressing causes of death, co-existing factors and deficiencies of care between Aboriginal and non-Aboriginal persons, of each death.

RESULTS
38% of the 190 audited deaths were recorded as Aboriginal persons. Aboriginal persons were significantly younger at death (53 years, (IQR 42-66) versus 69 years, (IQR 56-78), P<0.001) and had a higher incidence of diabetes (33% versus 15%, P=0.004), renal disease (29% versus 15%, P=0.022) and liver disease (35% versus 9%, P<0.001). In persons less than 60 years, serious co-factors were significantly more common in Aboriginal persons (74% versus 42%, P=0.005). There were no significant differences in the rates of complications (13% versus 19%, P=0.27), unplanned returns to theatre (18% versus 14%, P=0.50), nor whether the Surgeon (20% versus 26%, P=0.41) or the peer reviewer (14% versus 20%, P=0.56) considered in retrospect the management could have been improved.

CONCLUSIONS
A large gap of 16 years exists for age at death between Aboriginal and non-Aboriginal persons admitted as surgical patients in the Northern Territory. Aboriginal persons had significantly more co-morbidities at time of death. No significant discrepancies of surgical care were identified between Aboriginal and non-Aboriginal persons.

Treat the Patient not the X-ray
Thilak Jepegnanam, Vellore INDIA

In orthopaedic trauma, the registrar or junior staff is often under great pressure to present a perfect fixation X-ray at rounds the next day. This often results in iatrogenic trauma as this is an added assault on compromised soft tissues. This is especially true in view of a great variety of newer and newer implant systems available in the armamentarium.

This is often a recipe for disaster as the nature of injuries is complex and varied as patients can present with an injury the same day, the next day, inadequately treated or even with infected nonunion.

The most important consideration at decision making is the general condition of the patient and the state of the soft tissues.
Abstracts

SESSION 4

The Anatomy of a Disaster
Christos GIANNOU, Lakonia GREECE

Whether natural or man-made, disasters have an underlying structure that helps define the types of possible intervention. The incidence of trauma is only one aspect: a public health approach allows for a better understanding of an adequate response. The preparation, training and organisation of response teams are essential if the outcome is to be sufficient and efficient. The timing of an intervention often makes the difference between the response being productive or superfluous. “Wanting-to-help” is an essential, but not sufficient or efficient factor.

Understanding the interplay amongst local civilian and military authorities, local civil society organisations, and foreign non-governmental organisations including foreign medical teams is not a simple diplomatic or bureaucratic nuisance. A truly humanitarian response involves not only saving life and limb and alleviating suffering, but also respecting the human dignity of the victims and survivors, and of those who have toiled before the arrival of the foreign medical teams.

The Pathology in a Disaster
David READ, Darwin NT

Although every disaster is different, the pathology that presents to the surgeon in the aftermath has distinct patterns that the responder should be aware of. Firstly, whether cyclone, tsunami, earthquake or conflict, approximately 70% of the patients will present with limb wounds. The remaining will be equally divided between head & neck, abdomen and thorax. Earthquakes are associated with a higher chance of fractures, and wounds often present late and neglected. Failed primary closures are still ubiquitously seen. This talk will compare the AUSMAT surgical hospitals post Typhoon Haiyan workload with those of recent disasters and conflicts.

The Physiology of a Disaster (Tacloban)
Annette HOLIAN, Darwin NT

The success of a civilian surgical group deployed in disaster response is dependent on the prior preparedness of the members, their kitting for individual survival and their equipment and training in providing appropriate care for the circumstances, culturally appropriate to that community, at that time. The speed of response is dependent on the volume and weight of the kit to be transported. The surgical group needs to be self sufficient, along with the rest of the team, but limitations apply to what can be carried. Resupply may be impossible in the first week or two, so intent consideration needs to be given to every item sent in the first wave. The response team needs to converse with local authorities, set up their hospital in a suitable site, organise security for the facility, and arrange the tentage in a way to facilitate the timely movement of patients through the facility. Disposition of patients needs to be planned, or arrangements made to provide ongoing care in the facility. A clear mission needs to be established as to who and what can be treated by the facility, and largely complied with by the group. An ethics group comprising senior clinicians may add to the success of the mission.

The initial response may well run 24 hours a day without relief. There may be no shifts, or secure sleeping, and a grueling demand on services will occur. Systems to ensure the sustainability of the response have to be put in place, and the group must be actively managed to become an effective team.
SESSION 6

Neurotrauma
Santosh POONNOOSE, Adelaide SA

Guidelines for management of severe traumatic brain injury are constantly being reviewed to improve outcomes and standardise care.

Over the last few years the topics of interest have been:

a) the role for decompressive craniectomies in a setting of diffuse brain trauma and

b) Second impact syndrome. Awareness of these subjects are key to effective management of head injured patients. The talk briefly reviews the latest information of these topics.

Facial Skeleton
Cameron SCOTT, Darwin NT

Facial trauma in the Northern Territory is very common and ranks as some of the highest incidences in the world. The scope of facial trauma ranges from minor through to life threatening injuries.

Taking the incidence of facial trauma along with the scope and often cultural challenges of the Northern Territory, working at Royal Darwin Hospital can be confronting and often challenging.

Neck Trauma
James BADLANI, Casuarina NT

Classification of penetrating neck injuries and management.

Deep Neck Infections: Principles of Surgical Management
George CHU, Brisbane QLD

An intimate knowledge of the anatomy of the deep spaces of the neck is essential to the management of infections of the region. Decisions must be made in a timely fashion through the acute course of the disease. Interventions must be timely, and performed with the appropriate surgical and airway skill. The surgeon must decide on medical and surgical management, including: Assessment, Antibiotic selection, How to employ supportive resuscitative care, When to operate, What procedures to perform, How to secure the airway
Abstracts

To make these decisions the surgeon must understand the anatomy of the region, the etiology of infection, appropriate diagnostic workup, and medical and surgical management. This presentation provides a review of these pertinent topics.

Anaesthesia in Trauma
Brian SPAIN, Darwin NT

New developments in Anaesthesia for trauma relate to some advances in technology as well as better understanding of pathophysiology. There are also new developments in other aspects of Anaesthesia and Intensive Care which are translatable to care in trauma. Videolaryngoscopy has developed enormously in the last 5 years with a large number of devices available. These allow better visualisation of the larynx in patients with difficult anatomy and are very useful when intubating with in-line axial stabilisation of the cervical spine. Recent developments with bronchial blockers also allow easier lung isolation when this is required unexpectedly for patients with a single lumen tube in-situ.

Blood product transfusion has also evolved, with a recent vogue for 1:1:1 ratios of red cells, plasma and platelets after experience in combat situations. Careful evaluation of the evidence has suggested that this is probably not necessary and that 2:1 ratios may deliver the same benefit, so that Australian, Canadian and American guidelines currently do not support 1:1:1 transfusion in civilian practice. Use of pharmaceuticals such as Tranexamic acid has now also become standard practise.

Fluid management has evolved in major surgery over the last few years, with better non-invasive monitoring available to guide optimising cardiac output with respect to volume status. Large multi-centre studies are in progress. There is also some evidence that depth of anaesthesia may have some long term survival effect in major surgery. Lung protection ventilation strategies adopted from intensive care are also used early in trauma anaesthesia and may provide some longer term benefit in reducing late lung injury.

SESSION 7

Thoracic Trauma
Phillip CARSON, Darwin NT

Penetrating Thoracic trauma can be among the most dramatic and challenging of trauma presentations. For a significant proportion of victims and intercostal pleural drain is lifesaving and the definitive treatment. With an appropriate history and signs, for a rapidly deteriorating patient an emergency room thoracotomy can be effective, especially for pericardial tamponade. Many patients can be stabilised with a pleural drain and intravenous fluid and taken to theatre. The choice of incision is important and the merits and limitations of a transverse anterior thoracotomy and its variations, median sternotomy or a postero-lateral thoracotomy will be discussed. Strategies for controlling bleeding from the heart and great vessels and bleeding and airleak from the lungs will be presented.

SESSION 8

Oesophageal Cancer Surgery – 10-Year Experience in a Regional Australian Hospital
CHOW H, Lowe A, Eaton S, Deutscher D and Hadfield M, Ballarat VIC

BACKGROUND

A meta-analysis by Metzger et al. into patient survival after oesophageal surgery suggests acceptable clinical outcomes could only realistically be achieved in high-volume tertiary hospitals (performing more than twenty surgeries annually). Currently data from regional Australian hospitals which perform oesophageal surgery does not exist in the published literature. The aim of this study was to compare the mortality rates at a very-low-volume regional Australian hospital to those found in the meta-analysis.

METHODS

A ten-year retrospective audit was performed of patients who underwent oesophageal surgery within the period of 2004-2014 at Ballarat Base Hospital, a regional public hospital in Ballarat, Australia.

RESULTS

The average number of oesophagectomies performed annually over the ten-year period were less than 5, classified by Metzger as a very-low-volume hospital. 30-day mortality rates post discharge over the ten-year period was 0% with total 30-day mortality rates at 4% (±7.6% 95% CI) due to one in-hospital death.
CONCLUSIONS
This study showed lower 30-day mortality rates compared to those reported in the meta-analysis from hospitals classified as very-low-volume. This study suggests that a very-low-volume hospital was capable of achieving similar mortality rates of high-volume hospitals from the meta-analysis. Our results cast doubt over the push for oesophageal surgery to be performed only in tertiary centres. The impact of centralisation on quality of life for rural patients must be considered before such a move can be advocated.

Emergency Surgery for Colorectal Cancer in Rural Australia
Matthias W. WICHMANN, Mount Gambier SA

BACKGROUND
Emergency surgery is an important part of the work provided by rural surgeons to their communities. This study investigates the results of emergency versus elective surgery for colorectal cancer in a rural center.

MATERIAL AND METHODS
Prospectively collected data of patients operated on for colorectal cancer between 2/2006 and 6/2014 in a rural surgical center in South Australia were analyzed. Perioperative results as well as overall and stage specific survival of emergency and elective surgery were investigated.

RESULTS
During the study period 41 (16%) emergency and 220 (84%) elective operations for bowel cancer were performed. Long-term survival of emergency patients was significantly lower than survival of patients after elective surgery (42±7 vs. 76±4 months; Log Rank p<0.001). Emergency patients were older (71±2 vs. 69±1 years), stayed in hospital longer (10±2 vs. 9±1 days) and were more likely to be ASA3/4 patients (65% vs. 51%). Stage 4 disease was diagnosed in 46% of emergency and in 16% of elective patients. Multiple complications occurred in 10% of the emergency and in 9% of the elective patients. 30-day mortality differed significantly 10% (emergency) vs. 1% (elective) between both groups. Postoperative transfer to metropolitan ICU care was necessary in 15% of emergency and in 6% of elective surgical patients.

DISCUSSION
Emergency surgery for colorectal cancer represents a significant proportion of the colorectal workload for rural surgeons. These patients have a poorer long-term survival due to advanced cancer stages as well as higher 30-day mortality. This higher mortality was not due to increased surgical complication rates. Thirty-day mortality rates observed after emergency and elective colorectal cancer surgery compare very well with data reported from metropolitan centres. Colorectal cancer survival can be further improved with population wide screening which will reduce emergency presentations.

Rural Surgery’s Contribution to the General Surgical SET Program: The NSW Example
Graham STEWART, Armidale NSW

The issues surrounding post-fellowship training for Rural Surgery, continues to be a topic that exercises the attention of those involved in the provision of surgical services to Australian non-urban populations. Related to this, the current SET system has been critically appraised by many, with major changes in the training supervised through the GSA (General Surgeons Australia) occurring over the next 2 years. Issues regarding registrar training and apparent discrepancies between Rural and Metropolitan positions are frequent topics for discussion, whenever rural based surgeons meet. Some, believe that an inordinate number of SET1 trainees are placed in rural positions, placing a heavy burden on rural surgeons, resultantly responsible for developing basic technical and patient assessment skills. This in some ways reflects old concerns that general surgical training positions are used to build skills prior to selection onto other sub-speciality programs. The fairness and direct benefit to the rural sector of this situation is often questioned. Nationally, there are 148 SET1 trainees and 368 SET2-5 trainees in General Surgery, distributed over 154 hospitals. Looking specifically at NSW, there are 45 SET1 and 128 SET2-5 positions, in 52 hospitals. Rural NSW provides 15 SET1s (33%) 29 SET2-5s (23%) positions, which represents 25% of total trainee jobs, in 17 hospitals (33%). These figures can be seen to be roughly analogous to Australia as a whole. Based on these figures, the benefit surgical training as a whole derives from the rural sector will be assessed.
Approved by the Commonwealth Minister for Health. These contracts would be dictated by the Minister for Health under guidelines within the Act, which guidelines, as distinct from Regulations under an Act, would not be subject to parliamentary scrutiny or disallowance. This legislation was particularly cunning, as the Commonwealth had no power to set the terms and conditions of contracts of hospital specialists in the States, so this plan could only work if the State governments changed contracts to fit the Commonwealth requirements. Some State governments resisted for a time, but eventually all agreed.

In June 1984 the Premier of NSW recalled state parliament to pass legislation placing a seven year ban on any doctor who resigned from a public hospital. Federal and NSW governments eventually agreed to repeal the objectionable legislation, and the dispute was settled.

**Surgery Still Not Scrubbing Up for Women**
*Saskia IRWIN, Jessica BORBASI, Sunirmal Ghosh, Griffith NSW*

**INTRODUCTION**
In Australia women are significantly underrepresented in the surgical specialties; the implications for the discipline are numerous. This study investigates factors influencing medical graduates in their career choice and challenges the preconceived barriers for women.

**METHOD**
An anonymous online survey was distributed and completed by 64 participant junior doctors around Australia. The data was analysed using SPSS.

**RESULTS**
42 women and 22 men responded. Only 10% of female and 27% of male respondents wanted to be surgeons. Women, significantly more than men, rated role models of the opposite sex as important for career choice (p<0.05). Women were more likely to perceive a ‘boys club’ culture as a hindrance to considering a surgical career (p<0.05). Irrespective of gender, non-surgeons identified length of training (p<0.05) and lifestyle (P<0.01) as principal to career choice while working hours (p<0.01) and experience on a surgical attachment (p<0.05) were detractors for considering surgery.

**CONCLUSION**
The barriers focused on have long been dedicated to themes of family commitment; this study, calls for a shift...
Vascular Trauma
Brian KIRKBY, Launceston TAS

Vascular trauma is a common event that all who practice in a rural or regional setting, encounter on a regular basis. There are a number of issues that have arisen over recent years that relate to the manner in which surgeons who practice in those rural and regional centres manage vascular injuries. Surgeons who have entered consultant practice more recently have significantly reduced exposure to vascular surgery and the techniques for dealing with vascular injury and trauma. This is combined with an increasing trend for vascular services to be concentrated in major metropolitan centres.

Secondly, there has been a rapid growth in technology and techniques for dealing with vascular trauma. The emphasis has changed from open to endo-vascular surgery, requiring specialised techniques and expensive dedicated imaging equipment. This also coincides with changes to the way interventional radiology services are provided. General radiologists previously had some skills in interventional techniques, and general radiologists in rural and regional centres provided access to this service. Interventional techniques have progressed and are now provided by specialist interventional radiologists in metropolitan centres.

I will address some of the common vascular pathologies and the possible methods for dealing with them. Finally, I would like to discuss the issues that pertain to our trainees and their ability to obtain adequate access and exposure to gain the skills and confidence required to deal with vascular trauma, which they are likely to encounter upon entering consultant practice in a rural or regional centre.
a local hand injury service considering training, cooperation and equipment will be presented. The principles of hand surgery; function as the principle driver, meticulous technique and magnification, scar placement, early cover and rest and splints. Early protected mobilisation will be illustrated with a series of cases ranging across infection, fingertip loss, skin loss, nerve injury, and extensor and flexor tendon injury.

SESSION 11

Comparison of Appendicitis and Cholecystitis Outcomes Post Introduction of Acute General Surgical Unit (AGSU)
Wee Ming OOI, Natasha Pritchard, Matthew Oliver Bendigo VIC

PURPOSE
AGSU is a consultant surgeon led emergency surgery model to enable swift assessment of emergency patients and timely operations. This study aims to analyse the impact of AGSU on the outcomes of admissions for appendicitis and cholecystitis in Bendigo Hospital, Victoria.

METHOD
A retrospective comparison study on outcomes of admissions with histology proven appendicitis, and cholecystitis requiring operative management between March 2010 and February 2012 (traditional on-call model) and March 2012 and March 2014 (AGSU) was performed. Parameters compared included length of stay, after hours operation, time to theatre, laparoscopic conversion to open cholecystectomy and bile duct injuries.

RESULTS
335 and 306 cases of appendicitis were reviewed in the pre and post AGSU model respectively. There was minimal difference in time to theatre (10.2 vs. 11.8 hours) or number of cases requiring after hours operations (45% vs 42%). Mean length of stay was shorter in the AGSU period (75 vs 91 hours). 150 and 236 cases of cholecystectomies were reviewed in the pre and post AGSU model respectively. There was no difference in average time to surgery (37.5 vs 33.7 hours) and length of stay (68.5 vs 69 hours). After hours operating rates was higher pre AGSU (20% vs 16%). Conversion to open rates was low at 2% in both groups. No bile duct injuries were recorded. All results were statistically non-significant.

CONCLUSION
The introduction of AGSU has not demonstrated improvement in parameters measured. Inclusion of the initial stages of the new model being introduced may have impacted the results. Further exploration into the reasons this model has not been as successful compared to the literature suggests should be performed.

Red Blanket: A Protocol For Improving ER to OR Transfer of Non-Responding, Hypotensive Trauma Patients.
Michael MULLER, Michael Handy, Martin Wullschleger. Brisbane QLD

INTRODUCTION
In response to delayed movement of bleeding trauma patients to the operating room, in spite of best efforts and intentions, a procedure was devised by a collaborative process.

AIMS
To describe the sociological phenomenon involved in successfully introducing the procedure and to detail the outcomes.

METHODS
Data was prospectively collected on patients subjected to red blanket and a retrospective group of closely matched patients had similar data collected. Time to operating room, patient demographics, physiological parameters, blood results time to normalisation of serum lactate, blood products administered, days ventilated, ICU length of stay, exhibition of dialysis, mortality (among others) were compared between groups by Student t-test. Data presented as mean (±standard deviation)

RESULTS
The sociological phenomenon of ‘tribalism in health care’ was encountered and then enlisted to facilitate introduction. Groups were similar except for age.

<table>
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<th>Parameter</th>
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<th>Post n=47</th>
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<td>37(17)</td>
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<tr>
<td>Systolic BP</td>
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<td>81(31)</td>
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<td>37(17)</td>
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<td>INR</td>
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</tr>
<tr>
<td>Bicarb</td>
<td>17(5)</td>
<td>15(5)</td>
</tr>
</tbody>
</table>

Abstracts
Abstracts

A 6.6 fold reduction, 158(±120) V’s 24(±24) minutes p<0.001 was noted in time to OR. ICU length of stay was 13(±7) V’s 9(±10) days; p=0.19. Incidence dialysis-6%, highest Creatinine, units blood transfused, days ventilated, total hospital LOS, time to normalisation lactate were quite similar.

CONCLUSION
Non-responding, hypotensive trauma patients can be safely transferred to the Operating Room without the need for ‘resuscitation’.

Paediatric Neurosurgery in a Regional Centre
Tracey MERRIMAN, Albury NSW

Over the last three years we have twice had to perform an emergency cranietomy in two infants, one with an extra-dural and one with a subdural haematoma, in whom there was no time to arrange transfer to a tertiary Centre with dedicated Neurosurgical services. In both cases the outcome has been survival with no neurological sequelae. Details of the two cases and their management in this regional centre will be presented.

The Initial Experience of a Newly Formalized Pelvic Exenteration Service For Locally Advanced and Locally Recurrent Pelvic Malignancies at The Royal Brisbane & Women’s Hospital
TAYLOR DG, Stevenson ARL, Petersen DJ, Tan SBM, Heriot AG, Brisbane QLD

PURPOSE
Up to 12% of primary rectal cancers are locally advanced at the time of diagnosis and 20-50% [1] of patients undergoing rectal cancer resections will represent with local recurrence in the absence of metastatic disease. Radical resectional surgery, including pelvic exenteration is the only proven therapy with curative potential in the treatment of advanced primary and recurrent rectal cancers [1-2] along with many other pelvic malignancies. Clear resection margins along with acceptable patient morbidity and mortality are the primary goals when undertaking this surgery. Appropriate training and surgical technical ability along with multidisciplinary clinical, departmental, organizational and financial support are major factors required when embarking on formalizing a service of this nature.

METHODS
From January 2012 to July 2014, 27 patients were treated through this service. Patient demographic, tumour characteristic, operative clinical, chronologic and histological data as well as length of hospital stay, morbidity and mortality data have been collected retrospectively and will be presented.

RESULTS
27 patients underwent surgery. Median age = 57 years (range 31-78). Median length of stay =24 days (range 6-69). Median operative time = 573 minutes (286-1149). 30 day Mortality = 0. R0 resection - 93%, R1 resection - 7%, R2 – 0%.

CONCLUSION
Our experience confirms that radical resectional pelvic surgery including exenteration can be safely performed with favorable results during the establishment phase of a dedicated tertiary service.

The Challenges of the Supervisor of Training Role in a Regional Area
Stephanie WEIDLICH, Darwin NT

There are many factors to overcome when faced with the challenge of supervising SET Registrars in a Regional or Rural setting. These include the already demanding pressures of the Rural Surgeon to perform clinical duties, the lack of administrative support, the perceptions of the rotations as ‘second-rate’ as often not highly specialized Units with often no prized Professors, the placement of the ‘trainee in trouble’ in an unfamiliar and unsupported location, and often the dependence on other staff such as Unaccredited Registrars and IMGs (most often much more skilled than SET Registrars), but with restrictions to meet logbook and other training requirements for the SET Registrars.

With 5 General Surgical Trainees (1 part-time), 1 Paediatric Surgical Trainee and 8 unaccredited trainees (3 of these fully qualified overseas trained Surgeons) to start the year in 2014, and a Departmental philosophy/commitment to provide all levels of staff with a good experience, this is no easy task!
The Locum Surgeon. Is it for You?
Jeffrey MYERS, North Turramurra NSW

You may be contemplating going on the Locum Circuit. “How”, “When”, “Where”, “Why” may be your questions. The presentation will outline my experience and what I have learned on the Locum Circuit, and perhaps answer those questions.

Caitlin YOUNG, Melbourne VIC

This presentation will include a review of the current literature on heat wave mortality, and outline the Victorian Institute of Forensic Medicine (VIFM) research into mortality during a heat wave in Victoria in January 2014. During this heat wave, the maximum temperature for four days in a row in Victoria exceeded 40°C with significantly elevated minimum temperatures. At this time the VIFM experienced a major increase in mortuary admissions.

At the VIFM we have commenced gathering data to examine causes of death submitted to the Coroners Court of Victoria by forensic pathologists during the January 2014 Victorian heat wave. The project aims to describe the demographics, circumstances and cause of death reported during the heat wave period. There is evidence that mortality increases during heat waves and a number of risk factors have been identified, however large heterogeneity has been observed between communities. In the January 2009 heat wave, the Victorian government reported 374 excess deaths1. Limited research has been conducted in Victoria, or Australia more broadly particularly with regards to causes of death during heat waves. This is an internationally recognised area of importance for research, as the frequency of extreme weather events is predicted to increase. Understanding heat wave mortality in Victoria has the potential to make a significant impact on public health policy and prevention of heat wave related deaths in the future.

REFERENCES:
A Challenging Scalp Replantation from the Remote Top End  
*Paul Di Giovine, Jack Harbison, Shibly Ninan, Darwin NT*

Scalp avulsion is a disfiguring injury caused by shearing forces acting obliquely at the interface between periosteum and galea. Before the advent of microsurgery these injuries were managed by relaying the avulsed segment as a composite graft, with failure resulting in areas of scarred non-hair bearing scalp. While it is recognized that success decreases substantially after 5-6 hours of ischemia time, there have been reports of good outcomes with longer periods before revascularization. This is of particular relevance in Australia, where geographical isolation results in extended periods of ischemia before treatment can be delivered. Here we present a case of a 23 year old girl who sustained an avulsion of her left temporoparietal scalp after her hair was caught in a bore pump on a remote outback station. She was retrieved by plane to the Royal Darwin Hospital with a warm ischemia time of 5 hours, and total ischemia time of 13 hours. In theatre the avulsed scalp and the scalp defect were prepared concurrently, and a single artery and vein anastomosis were sufficient to revascularize the flap. Two weeks postoperatively the flap has healed well with a small area of distal necrosis, which is being allowed to heal by secondary intention, and her hair is begun to re-grow. Despite the extended ischemia time, replantation of this scalp defect has been successful and will have significant impact on this young girl’s life, avoiding the stigma that can be associated with obvious disfigurement.

**Variance in Patient Satisfaction Survey – Does Diagnosis Matter?**  
*Imeshi Indigahawela, Melbourne VIC*

Patient Satisfaction Surveys are often undertaken in Surgical settings. However, the science is inexact, and the accuracy of the findings may be affected by factors other than those assessed.

We set out to study the effect of the degree of interaction that individual patient groups had with a given surgical unit, to attempt to establish if continuing clinical encounters with such a unit changed the satisfaction overall. We have studied separate pathologies, and present the results.
This suggests that population-based studies may not adequately reflect the issue. The factors of remoteness, age, and distinct geography may be contributing to a high rate of first nations trauma. The data and injury profiles within the Canada’s Yukon Territory and its first nations population will be discussed.

**Domestic Violence in the Northern Territory**  
Mahiban THOMAS, Darwin NT

Improved capture of data in regards to DV has recorded a spike in incidence around the world. In the NT, the incidence of DV within the subset of patients who were treated for fractures of the facial skeleton defines the divide between Indigenous and non-Indigenous victims. This talk presents the most accepted definitions of DV, assesses the cost to the NT, and reports new data on the incidence, the age at incidence, male/female ratios, aetiology and the Indigenous perspective.

**Road Traffic Injury Among Aboriginal and Torres Strait Islanders**  
Teresa SENSERRICK, Sydney NSW

One of the leading causes of injury for Aboriginal and Torres Strait Islanders is road traffic crashes. While this is also true for non-Indigenous Australians, several disparities exist. On a population basis, Aboriginal Australians are 2-3 times more likely to have a transport-related fatal injury and almost one-third more likely to have a serious injury. Further while most crash-related fatalities are vehicle occupants for both Aboriginal and non-Aboriginal Australians, for Aboriginal Australians this is more likely as a passenger than as a driver. Moreover, Aboriginal Australians experience a much greater proportion of road fatalities as pedestrians. This presentation will report on the latest research into Aboriginal road traffic injury and contributing factors.

**The Impact of Alcohol Restrictions on Aboriginal Trauma in Central Australia**  
Dennis GRAY, Perth WA

In response to high rates of alcohol consumption and related harm among both Aboriginal and non-Aboriginal people in Alice Springs and Central Australia, the Northern Territory Licensing Commission has introduced various additional restrictions on the availability of alcohol. Commencing on a trial basis in 2002, these restrictions have since included reductions in trading hours for takeaway outlets, prohibition of sales of beverages other than light beer before 11:30 am on licensed premises, restriction of alcohol consumption in public places, and banning purchase by persons taken into protective custody three times during a three-month period. While all have had some positive impact, the most effective of the restrictions has been the prohibition of sales of table wine in containers of >2 litres and fortified wine in containers of >1 litre. This is an indirect price control measure as it removes from the market the most inexpensive beverage types. This presentation examines the impact of the measure on: the mean wholesale price of per standard drink; per capita consumption; and, hospital separation rates and Emergency Department presentations for both Aboriginal and non-Aboriginal persons. In particular, the restrictions led to significant reductions in rates of assault – especially among Aboriginal women. The results are consistent with the international literature demonstrating the importance of price as a means of reducing alcohol-related harm and they support calls by peak Aboriginal bodies for broader price-related interventions including a minimum price per standard drink and tiered volumetric alcohol taxation.

**SESSION 3**

**Understanding and Responding to Psychological Trauma within Aboriginal Communities as a Means to Preventing Trauma Presentations in Top End Hospitals**  
John PATERSON, Darwin NT

Psychological trauma is recognised as a significant contributor to the poor health and compromised social and emotional wellbeing (SEWB) of Indigenous people. Trauma presentations at Top End hospitals related to violence, suicidal behaviour, self harm, mental health crises and substance misuse are strongly related to underlying psychological and emotional trauma. This presentation argues that recognising, understanding and responding appropriately to psychological trauma is critical for those working with Aboriginal Australians, as they suffer a greater burden of complex intergenerational trauma. Indeed, resourcing community services to better understand and respond to psychological trauma within Aboriginal communities is seen as a vital step toward preventing the hospital trauma presentations listed above.
Abstracts

To this end, the Aboriginal Medical Services Alliance has commenced a trauma project, which aims to support and expand a trauma informed approach to work within the Community Controlled Health Services throughout the NT.

Indigenous Trauma - A National, Regional and Local Perspective
Stephanie TRUST, Kimberley WA

The Australian Indigenous Doctors’ Association (AIDA) is the peak body for Aboriginal and Torres Strait Islander doctors and Medical students and advocates on Aboriginal and Torres Strait Islander health issues. In an Aboriginal and Torres Strait Islander context health is broader than a bio-medical approach. Aboriginal and Torres Strait Islander concepts of health and wellbeing are holistic, they incorporate the social, emotional, physical, and spiritual, it extends beyond the self, incorporating family, community and place. Working holistically in health, with the understanding there are a number of social and cultural determinants, provides the ability to work at a number of levels in seeking sustainable change, at both a systems level and an individual level. For AIDA, it provides the space to compliment activity in health, education and workforce development. This involves partnerships, shared leadership, culturally respectful ways of working, including working in with and acknowledging with expertise of the Aboriginal and Torres Strait Islander Health Workforce. Key to this is the role which Aboriginal and Torres Strait Islander doctors play in the provision of quality health service delivery in Australia. This presentation will talk to these issues.

Dr Stephanie Trust will also explore concepts of injury in an Aboriginal and Torres Strait Islander context, by providing examples of the types of injuries she has observed, treated and managed, including the health impacts of returning home to communities after injury with a particular focus on the Kimberley in Western Australia.

Central Australian Perspectives
Donna AH CHEE, Alice Springs NT

The Central Australian Aboriginal Congress has for many years been working to address the underlying social determinants of injury and trauma as well as providing effective treatment. A key determinant is alcohol addiction and in many ways alcohol related interpersonal violence is the most harmful and preventable form of injury and trauma. In this brief presentation I will therefore demonstrate through data from a longitudinal study done in Alice Springs the impact that price based alcohol supply reduction has had in reducing hospital admissions for assault for Aboriginal women. A more recent point of sale alcohol supply reduction measure here in Alice Springs, known as Temporary Beat Location, or TBL has seen police assault data and alcohol related emergency presentations fall by nearly 50%. Although the determinants of injury are multiple and complex the single most important measure that can have the largest and immediate effect in preventing injury and trauma in Aboriginal communities in the NT is effective alcohol supply reduction. In addition to injury, alcohol addiction is one of the major causes of lack of responsive parenting and stimulation for young children as well as the exposure of young children to traumatic events such as domestic violence in the home. Many Aboriginal children have experienced repeated traumatic events in their early years which is a major cause of a life-long disability in terms of lack of self-control and impulsivity. I will conclude by discussing the potential for key evidence based early childhood programs reduce the exposure to injury and trauma in the early years.

Hinemoa ELDER, Auckland NEW ZEALAND

International and New Zealand research shows that indigeneity is a risk factor for traumatic brain injury (TBI). Different patterns of TBI have been described compared to non-Indigenous groups. Despite these differences, no previous studies have been identified that specifically target Indigenous knowledge as a resource in shaping responses to TBI prevention, treatment and rehabilitation.

This paper presents a brief overview of the Indigenous TBI literature before outlining the authors doctoral and post-doctoral research.
Abstracts

A theoretical framework and a practical approach for working with Māori with TBI and their whānau will be presented. This work may have application in other fields dealing with injury and trauma in other Indigenous communities.

SESSION 4

**Paediatric Trauma and Kidsafe Northern Territory Style**

*Keith EDWARDS, Darwin NT*

Aboriginal children in the Northern Territory live in remote aboriginal communities where roads and infrastructure are less well maintained than in urban areas. Statistically, they are more likely to be injured or die than non-aboriginal children living in Urban areas. KidsafeNT is a non-government not for profit organisation which has been monitoring and trying to address these inequalities. Communication and language barriers are key to educating people about the dangers. The new child restraint in vehicles legislation shows promise to help prevent road traffic injury and death in Aboriginal children. The challenge is to provide safe seating for children in vehicles in remote settings. KidsafeNT’s role will be discussed in this presentation.

**Road Trauma in the Northern Territory and the Indigenous Population; Challenges and Road Safety Initiatives**

*Andrew FRONSKO, Darwin NT*

Road crashes are one of the main causes of death among Indigenous Australians, with Indigenous people significantly over-represented in hospital admissions due to transport-related injury. In the Northern Territory, Indigenous people make up around 28 per cent of the population, yet represent about half of all road deaths. This presentation will provide an update on recent statistics and trends in road-crash related trauma, and provide an overview of initiatives being implemented within the Northern Territory to reduce the incidence of road crash trauma, with particular focus on community partnership programs targeting road safety in remote and Indigenous communities.
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