Final Program
RACS ACT Annual Scientific Meeting
Systems of Care: Collaboration and Innovation

4 November 2017
Australian National University Medical School
The Canberra Hospital Campus, Garran, ACT

#CanberraASM17

Gold Sponsor
CONVENER WELCOME

Dear Delegates,

On behalf of the ACT Regional Committee of the Royal Australasian College of Surgeons, we welcome you to this region’s premier annual surgical event, the RACS ACT Annual Scientific Meeting 2017.

With an ageing population and a growing number of people living with chronic or complex health conditions, people’s health needs are changing and demands on the health system are increasing.

Today’s meeting features high calibre international and Australasian speakers. This year’s theme is “Systems of Care: Collaboration and Innovation”.

The primary goal of the meeting is educational, vocational and professional support for prospective surgical trainees, existing trainees and Fellows.

Multidisciplinary team work and seamless technological platforms are now increasingly important in the delivery of efficient and effective holistic patient care. The systems we work within are essential components of this and as clinicians we work hard to provide innovative, locally led models of care.

We would like to acknowledge the invaluable support provided by industry, in particular our Gold Sponsor WL Gore & Associates, Silver Sponsors; Avant, BOQ Specialist, Ethicon, Medtronic, MDA National, Sanofi and Teleflex. We encourage you to visit the exhibitors during the breaks.

Sincerely,

Dr Rebecca Read
FRACS
Convener
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INVITED SPEAKERS

Mr James Kong

Mr Kong was born in Rangoon. After schooling in Burma and Hong Kong, he attended Barts in London. He returned to Asia and joined the Chinese University of Hong Kong (Department of Surgery in the Faculty of Medicine) before moving to the public sector. Until the outbreak of SARS in 2003, he was a Consultant Surgeon, in charge of the Breast Service and the first Director of Trauma at the Pamela Youde Nethersole Eastern Hospital. He also established and led a multi-disciplinary breast care team (surgery, radiology, pathology and oncology) at the hospital. Furthermore, he helped to establish a breast self-help support group among his patients (the Brightening Association), which is now over 15 years old and has over 600 members.

Mr Kong led the implementation of the first public hospital information system in Hong Kong in 1990. During the SARS 2003 outbreak, he volunteered and led the Hong Kong Hospital Authority (HA) team that developed eSARS, the electronic database which helped manage the epidemic. This project was awarded 1st prize in the health category of the Stockholm IT Challenge 2004.

In 2006, Mr Kong returned to his native soil and, as Chief Hospital Administrator, managed the first 21st century hospital in Myanmar and trained a team to run the Pun Hlaing International Hospital. During his tenure there, he also consulted and treated cancer patients with significant delay in presentations.

In 2011, Mr. Kong became the Director of Surgery at Asia Medical Specialists, a multi-specialty practice, leading a team of surgeons to provide quality specialist care. He is also a visiting consultant at Raffles Medical Beijing and United Family Guangzhou Clinic.

Mr John Batten

John Batten trained at Monash University, Melbourne graduating in 1976 (MBBS Hons1), then trained in orthopaedic surgery gaining his FRACS Orth in 1984. Subsequently, John undertook two years of post-fellowship training in the United Kingdom, and now practices as an orthopaedic surgeon in Launceston Tasmania.

He is a visiting medical officer to the local public hospital, and until 2017 he ran a private practice in general orthopaedics with an interest in paediatrics. He is a senior lecturer for the University of Tasmania Medical School in Surgery, supervisor of two accredited advanced trainees in orthopaedic surgery, and is a senior member of an orthopaedic unit of eight surgeons.

He has served in many administrative roles including President of the Australian Orthopaedic Association, and Chairman of the Australian Orthopaedic Association National Joint Replacement Registry. From 1997 to 2006 John was an examiner in orthopaedics for the RACS, being the Senior Examiner in orthopaedics for the last two of those years. He was elected Councillor of the College in 2010 and since then has served on various College committees. Most recently, he was the Chair of the Court of Examiners and immediate past Censor in Chief. In 2017 he was elected College President.

On an annual basis, John leads an orthopaedics surgical team to Vanuatu, as part of the Pacific Islands Project. He has established a Ponseti program for the conservative management of clubfeet in Vanuatu.

John chairs a Speciality Orthopaedic Clinical Advisory Group for the Commonwealth Department of Health, advising on the introduction of new device technology in Australia.
INVITED SPEAKERS

Mr Grant Christey
Grant Christey is a general surgeon and trauma surgeon at Waikato District Health Board in Hamilton New Zealand. After surgical training in New Zealand and some time as a trauma surgeon in Liverpool Hospital in Sydney Australia, he returned to his home city in New Zealand to start up the Waikato Trauma Service and more latterly the Midland Trauma Service covering the central North Island of New Zealand.

He established the Midland Trauma Research Centre and the Midland Trauma Registry that now hosts the New Zealand National Major Trauma Registry. He is an Honorary Senior Lecturer in Surgery at Waikato Clinical School and has active interests in trauma research encompassing clinical care, system improvement and injury prevention.

Outside of daily trauma care, Grant is a general surgeon with special interests in the management of complex hernias, abdominal wall reconstruction, endocrine surgery and disaster preparedness. Patients come first in all aspects of his clinical care, research and system improvement activities.

Professor Imogen Mitchell
With a background as an intensive care specialist, Professor Mitchell is committed to improving medical delivery and education and to making a difference to practice through research and teaching that benefits patients, students and colleagues.

Professor Mitchell was the recipient of a Harkness Fellowship for Health Policy and Practice in 2013, which she undertook at Johns Hopkins Bloomberg School of Public Health in the United States. She is a nationally and internationally recognised clinical and health systems researcher, specifically in the development of sustainable processes to manage patient deterioration and the early mobilisation of intensive care patients. Her research is currently focused on improving end-of-life care.

Professor Mitchell’s teaching has been recognised with multiple awards, including Senior Fellowship of the Higher Education Academy and the Taoiseach Public Service Excellence Award (Ireland). She played a key role in the development of an innovative patient deterioration teaching program, COMPASS©, now embedded in healthcare organisations internationally.
FINAL PROGRAM

Program correct at time of printing.

SATURDAY 4 NOVEMBER 2017

8:30am  Registrations open

9:00am  Welcome
  Dr Rebecca Read

Session 1  The role of clinical trials
  Chair: Dr Justin Pik

9:10am  Axillary nodal disease following neoadjuvant chemotherapy for locally advanced breast cancer
  Dr Charles Molloy

9:20am  Lateral lymph node dissection should be performed at initial operation for medullary thyroid carcinoma to prevent recurrence
  Dr Sujen Jayakody

9:30am  The superiorly based partial rectus abdominis and external oblique flap for lower pole coverage in prosthetic breast reconstruction: A prospective cohort study
  Dr Benjamin Howes

9:40am  Immunotherapy in melanoma: From control to cure
  Dr Sayed Ali

10:00am Future of robotic surgery and innovation
  Dr Hodo Haxhimolla

10:20am Designing a clinical trial and obtaining funding
  Professor Paul Smith

10:40am  Morning tea with industry

Session 2  Health system performance
  Chair: Dr Ailene Fitzgerald

11:10am ACT Minister for Health
  Ms Meegan Fitzharris

11:20am Can surgeons from developed (sic) help under-developed (sic) countries? How to collaborate and innovate
  Mr James Kong

11:50am Microbiology in paediatric appendicitis: It’s a jungle in there
  Dr Douglas Greer

12:00pm Abdominal surgery in nonagenarians
  Dr Linda Tang

12:10pm No fixation to mesh for open inguinal hernia repair: Experience of a single centre
  Dr Ruwei Xu
# FINAL PROGRAM

Program correct at time of printing.

## SATURDAY 4 NOVEMBER 2017

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<td>12:20pm</td>
<td>Lunch with industry</td>
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### Session 3  Education and translational research

**Chair:** Dr Charlie Mosse

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<tr>
<td>1:20pm</td>
<td>Challenges in surgical education and competency-based learning</td>
<td>Mr John Batten</td>
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<td>1:40pm</td>
<td>Changing a healthcare system through hearts and minds</td>
<td>Professor Imogen Mitchell</td>
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<td>2:10pm</td>
<td>Surgical training and mental health: An unspoken problem</td>
<td>Dr Ali Mohrshami</td>
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<td>2:20pm</td>
<td>Evaluation of an intern guide to improve performance and experience in surgery: A pilot</td>
<td>Dr Anna Lowe</td>
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<td>2:30pm</td>
<td>Award presentations</td>
<td>Dr Ailene Fitzgerald and Mr John Batten</td>
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<td>3:00pm</td>
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### Session 4  Trauma and acute care

**Chair:** Associate Professor Stephen Bradshaw

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<td>3:30pm</td>
<td>The benefits of visualising data in trauma care systems</td>
<td>Mr Grant Christey</td>
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<td>3:55pm</td>
<td>Outcomes of emergency neck of femur surgery in patients on direct oral anticoagulants</td>
<td>Dr Shoahaib Karimi</td>
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<td>4:05pm</td>
<td>Transfers from a regional NSW trauma centre to a major trauma centre – is it about subspecialty expertise?</td>
<td>Dr Michael Su</td>
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<td>4:15pm</td>
<td>Trauma systems of care: Past, present and future</td>
<td>Dr Ailene Fitzgerald</td>
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<td>4:40pm</td>
<td>Bomb-proof hospital in Haifa and a model for mass casualty evacuation</td>
<td>Dr Frank Piscioneri</td>
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<td>4:55pm</td>
<td>Summary</td>
<td>Dr Rebecca Read</td>
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<td>Meeting dinner and presentation of RACS paper prize</td>
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VERBAL ABSTRACTS

Free paper abstracts listed in order of presentation.

AXILLARY NODAL DISEASE FOLLOWING NEOADJUVANT CHEMOTHERAPY FOR LOCALLY ADVANCED BREAST CANCER

Charles Molloy, Jerry Lee
1Royal Brisbane and Women's Hospital

Background: The use of neoadjuvant chemotherapy (NAC) in locally advanced breast cancer (LABC) is customary. Evolving trends away from routine nodal clearance following NAC in LABC patients make it important to consider the risk of persistent axillary nodal metastasis post NAC. Investigating this at a local institutional level is essential before abandoning standard practice (axillary clearance) in these patients.

Methods: A retrospective study of RBWH patients treated for LABC (2008-2014). 49 patients received NAC for LABC and subsequently underwent AC. Chart audit of patient demographics, pre-treatment staging and pathology post-surgery was performed.

Results: Clinical incidence of nodal disease prior to treatment was measured. Thirteen of these patients had histologically confirmed nodal disease. 24 (49%) patients had axillary nodal metastasis at AC. Fourteen patients after NAC had a complete pathological response in their primary tumour. Of this group, 2 had persistent nodal disease at AC. Nodal disease incidence in clinically negative patients was measured.

Conclusion: LABC is associated with a high rate of axillary nodal disease. Patients with a clinically negative axilla have lower rates of nodal involvement. There is a strong correlation between complete response of the primary tumour to NAC and negative histology at ALND. There is still a high rate of axillary disease in those patients who did not have a complete clinical response, and this suggests surgeons should be cautious in abandoning AC in these patients.

LATERNAL LYMPH NODE DISSECTION SHOULD BE PERFORMED AT INITIAL OPERATION FOR MEDULLARY THYROID CARCINOMA TO PREVENT RECURRENCE

Dr Sujen Jayakody1, Ms Rebecca Thompson1, Assoc Prof Roderick Clifton-Bligh2, Assoc Prof Diana Learoyd2, Prof Bruce Robinson2, Prof Leigh Delbridge1, Prof Stan Sidhu1, Assoc Prof Mark Sywak1
1University of Sydney Endocrine Surgical Unit, St Leonards, Australia
2Department of Endocrinology, Royal North Shore Hospital, St Leonards, Australia

Introduction: Medullary thyroid carcinoma is a rare tumour of neuroendocrine origin. Current guidelines advocate total thyroidectomy and central lymph node dissection (CND) at initial operation. Prophylactic lateral lymph node dissection (LND) remains controversial. Our aim is to determine patterns of disease recurrence in patients stratified according to the extent of their initial surgery.

Materials and methods: A multicentre retrospective study during the period 1993-2015 of consecutive patients undergoing surgical management for MTC was performed. Patients were stratified into 3 groups: Group A - total thyroidectomy (TTX) alone, Group B - TTX and CND and Group C - TTX and LND. The primary outcome measure was the pattern of disease recurrence.

Results: A total of 157 patients were included in this study during the period 1993-2015. The majority of patients were female (57%) with a median age of 54. Recurrence of disease occurred in 18 of 54 patients in Group A (33.3%), 7 of 32 in Group B (21.9%) and 27 of 70 in Group C (38.6%). The pattern of recurrence showed 9 out of 18 recurring in lateral lymph nodes (50%) in Group A, 4 of 7 (57.1%) in Group B occurring in lateral nodes and 17 of 27 (63.0%) in Group C with distant recurrent disease.

Conclusion: Lateral lymph node disease remains the most common site of tumour recurrence in sporadic MTC and warrants an aggressive surgical approach to the lateral neck compartment at initial surgical intervention.
Free paper abstracts listed in order of presentation.

**THE SUPERIORLY BASED PARTIAL RECTUS ABDOMINIS AND EXTERNAL OBLIQUE (SPREO) FLAP FOR LOWER POLE COVERAGE IN PROSTHETIC BREAST RECONSTRUCTION: A PROSPECTIVE COHORT STUDY**

**Dr Benjamin Howes**

1The Canberra Hospital, Canberra, Australia  

**Purpose:** This study evaluated the quality of life changes and morbidity in women who had a superiorly based partial rectus abdominis and external oblique (SPREO) flap for lower pole coverage in prosthetic breast reconstruction.

**Methods:** A prospective cohort study was conducted using the SPREO flap for the purpose of prosthetic breast reconstruction. The validated BREAST-Q questionnaire and a study-specific questionnaire was used to quantify surgical outcome following this procedure. Questionnaires were completed pre and post-operatively. A paired t-test was used to compare mean BREAST-Q scores between time points perioperatively.

**Results:** Aesthetic improvements were found in all patients. Generally there was no decrease in muscle strength or marked postoperative pain. BREAST-Q questionnaires were completed by 35 women involving 54 consecutive SPREO flaps. There was a significant improvement in BREAST-Q scores in relation to satisfaction with breast and physical well-being of the abdomen following the use of the SPREO flap. There were complications in 4 cases (7.4%). Seroma occurred in two cases (3.7%) and infection in one case (1.8%), and haematoma in one case (1.8%). Although some patients complained of weakness during the post-operative period, no patients experienced long term functional deficits.

**Conclusion:** This study reports the use of the SPREO flap for lower pole coverage in prosthetic breast reconstruction. It demonstrates a significantly improved quality of life outcome with regard to satisfaction with breast and physical well-being. It is relatively simple to harvest with little donor site morbidity and should be included in our repertoire of flaps used in breast reconstruction.

**MICROBIOLOGY IN PAEDIATRIC APPENDICITIS: IT’S A JUNGLE IN THERE**

**Dr Douglas Greer**, A/Prof David Croaker  

1The Canberra Hospital, Garran, Australia,  

2ANU, Canberra, Australia  

**Aim:** To audit local practices in obtaining microbiological specimens, and determine the relevant micro-organisms, in paediatric appendicitis.

**Methods:** Chart review was conducted for patients <18 years undergoing appendicectomy in our institution between 2011 and 2015, and patients with confirmed appendicitis on histology included. Demographic details including age and gender, and presence of perforation on histology were recorded. Microbiology reports and relevant antibiotic susceptibilities for cultures of blood, urine, and peritoneal swabs were recorded and analysed.

**Results:** Five-hundred and three patients with appendicitis were identified, 106 (21%) were perforated. Ninety-three (18.5%) had blood cultures performed, 175 (34.8%) had urine cultures, and 76 (15.1%) peritoneal swabs. Three (3.3%) of blood cultures were positive, 1 (33.3%) growing E coli, 1 (33.3%) Burkeholderia, and 1 (33.3%) Desulfovibrio. Seven (1.4%) of urine cultures were positive, most commonly E coli (42.9%). Fifty-seven (75%) of peritoneal swabs were positive, the most common organisms being E coli (73.7%), then Strep milleri (45.6%), mixed anaerobes (42.1%). Monomicrobial growth was found in 29.8% of swabs, and 2 or more organisms in 70.2%.

**Conclusion:** Blood and urine cultures were not routinely taken in appendicitis as this institution. Both were low yield for identifying micro-organisms, however for the blood cultures these positive results were highly significant. Peritoneal swabs were also not routinely performed, and there is controversy in the literature regarding their utility. However, a large majority of them identified relevant micro-organisms, with results in keeping with other studies. These results have relevance in guiding empiric antibiotic treatment in paediatric appendicitis.
VERBAL ABSTRACTS

Free paper abstracts listed in order of presentation.

ABDOMINAL SURGERY IN NONAGENARIANS

Dr Linda Tang, Dr Veronica Quinn, Dr Natasha Brown, Dr Mark Muhlmann

1 Prince of Wales Hospital, Randwick, Australia,
2 University of New South Wales, Sydney, Australia

Introduction: There is minimal literature examining morbidity and mortality of the very elderly undergoing surgery. This study aims to look at mortality and morbidity of nonagenarians undergoing emergent and elective abdominal surgery.

Design: Retrospective review of prospectively collected data from medical records of all patients over 90 years of age who underwent elective and emergent abdominal surgery in Prince of Wales Hospital between 2011 and 2015 was conducted.

Results: We had data for 24 patients (median age 92.5) over 90 years of age. The average length of stay was 14.2 days and 58.3% (n=14) of patients were admitted to ICU/HDU post operatively. In-hospital mortality was 33.3% (n=8) and remained the same at 30 days' post procedure. The mortality at 180 days and 365 days was 54.17% (n=13) and 58.33% (n=14) respectively. The emergent group demonstrated a greater in-hospital and 30-day mortality at 37.5% (n=6) compared with 25% (n=2) in the elective group but similar 365-day mortality (56.25% vs 62.5%). Of the patients who suffered in hospital mortality, 62.5% (n=5) of patients who were deemed to have a high P-Possum mortality score of >10%. Only 33% (n=5) of patients with a high P-Possum mortality score suffered in hospital mortality.

Conclusion: Abdominal surgery in the very elderly is associated with considerable morbidity and mortality. Close to 60% of nonagenarians who underwent abdominal surgery die within one year of their surgery. P-Possum was not a good predictor of mortality in this age group.

NO FIXATION TO MESH FOR OPEN INGUINAL HERNIA REPAIR: EXPERIENCE OF A SINGLE CENTRE

Dr Ruwei Xu1, Dr Bi-Wen Lau1, Mr Stephen Rodgers-Wilson1

1 Dandenong Hospital, Monash Health, Melbourne, Australia

Introduction: Inguinal hernia affects 5-10% of the adult population worldwide. Lichtenstein hernioplasty with mesh has been the most widely performed procedure for its treatment. Chronic pain has been reported in 10-30% of patients, which may be as a result of fixation of the mesh with sutures, tacks and glues. It has been postulated that fixation induces local tissue injury or trapping of nerves and muscle that may lead to pain and/or recurrence. Therefore an ideal repair with no fixation of the mesh is desirable to minimise acute and chronic pain.

Method: We report our experience with open inguinal hernia Prolene mesh repair with no fixation after 6 years (median, 3-9 years) of follow up. We surveyed over 100 patients and separated them into fixation and non-fixation groups after open inguinal hernia repair. We found that non-fixation mesh repair significantly reduces acute (6 months or less) post-operative pain compared with that with fixation. Both groups had low incidence of chronic post-operative pain (over 6 months, 1 in each group). Reassuringly, there was no difference in hernia recurrence (1 in each group).

Results: Patients in the non-fixation group experienced a higher rate of sensory change in the groin in comparison to the fixation group. Other complications such as wound infection, urine retention were comparable between the two groups.

Conclusion: Open mesh repair without fixation was therefore found to be non-inferior to standard fixation repair, and may offer a benefit in minimising acute post-operative pain.
VERBAL ABSTRACTS

Free paper abstracts listed in order of presentation.

SURGICAL TRAINING AND MENTAL HEALTH: AN UNSPOKEN PROBLEM
Dr Ali Mohtashami1, Dr Jane Cross1, Dr Sally Butchers1
1Lismore Base Hospital, Lismore, Australia

**Purpose of study:** Surgical trainees are driven individuals focused on their end career goals and often more meticulous in caring for their patients than they are for themselves, at the same time it is important to acknowledge that they are not immune to mental health problems, but according to a British medical journal study, surgeons seem to be less likely than other doctors to seek help for these problems.

**Method:** An online survey was distributed to Surgical JMOs and Registrars and other medical professionals in a regional hospital in NSW, and a compression study was done between Surgical and none Surgical trainees, respondents were asked a series of questions regarding their prospective health care status.

**Results:** Our study showed 55% of respondents were unable to access medical care due to scheduling issues, hence they self-diagnosed, 25% were concerned about the confidentiality of their medical data. 62% reported that they were asked by other colleagues to prescribe them medications.

**Conclusions:** Surgical trainees face multiple specific stressors, such as long working hours, short breaks and everyday pressures along with perceived barriers in relation to being open about mental health concerns. These apparent barriers, including concerns over confidentiality, fear of being seen as weak, and concerns in relation to mandatory reporting, reduce the number of people that seek help, thereby increasing the impact on individuals. Recognition of these barriers by each hospital administration is the first step in finding solutions.

EVALUATION OF AN INTERN GUIDE TO IMPROVE PERFORMANCE AND EXPERIENCE IN SURGERY: A PILOT
Dr Anna Lowe1, Dr Omar Mansour1
1Ipswich Hospital, Ipswich, Australia

**Introduction:** A surgical term remains a core rotation to fulfil requirements of medical registration in Australia. Intern satisfaction in surgery remains contentious. The literature reports low intern satisfaction levels with surgical rotations, decreased teaching and mentorship, diminished contact with registrars and long working hours. Identifying areas that need mentorship and improving satisfaction can enhance the experience and improve patient outcomes.

**Methods:** Interns rotating through a surgical term at a Brisbane Hospital were surveyed and undertook performance appraisal. Identified domains in the intern guide developed were: patient assessment, communication, documentation and procedural task related. Post intervention surveys assessed for change in self-reported confidence and preparedness. Objective supervisor feedback was compared to this data.

**Results:** Twelve interns rotating through a surgical rotation received an intern guide and a structured performance appraisal. Individual learning objectives were identified and performance plans were developed. Interns identified preoperative patient assessment, handover, referrals, fluid/anti-coagulation management, and communication with patient/families as areas of need. The identified learning needs received direct mentorship and facilitated access to opportunities. The post-intervention surveys demonstrated improved self-confidence and observation surveys demonstrated better performance.

**Conclusions:** Interns rotating through a surgical rotation have specific work-readiness requirements relating to the discipline. The learning experience currently varies as a result of many factors, such as supervision, experience, confidence and departmental expectations. The use of an intern guide and performance appraisal has the potential to identify key domains and structure a plan to address them. This leads to improved learning opportunity, confidence, safety and satisfaction for the intern.
VERBAL ABSTRACTS

Free paper abstracts listed in order of presentation.

OUTCOMES OF EMERGENCY NECK OF FEMUR SURGERY IN PATIENTS ON DIRECT ORAL ANTICOAGULANTS

Mr Shoahaib Karimi1, Dr Chyn Chua2, Dr Frank Hong2

1Melbourne University, Parkville, Australia
2Austin Hospital, Heidelberg, Australia

Background: Direct oral anticoagulants (DOACS) are increasing in popularity, and the lack of validated protocols to reverse bleeding can pose problems in emergency surgery. The elderly often suffer multiple co-morbidities, more likely to be on anticoagulants and sustain neck of femur (NoF) fractures. NoF surgery should be performed within 48 hours to ensure improved outcomes. We hypothesise that patients on DOACs are likely to have worse outcomes when undergoing emergency surgery compared to patients who are not on DOACs.

Methods: Patients underwent emergency NoF surgery between 01/01/2015 to 31/12/2015 at Austin Hospital. Patients were grouped into 4 groups; no anticoagulation, warfarin, antiplatelet and DOACs (apixaban, dabigatran or rivaroxaban). Outcome measures collected included length of time from presentation to surgery and red cell transfusion requirements. SPSS statistics software was used for descriptive analysis and graphs.

Results: 147 patients were analysed; no anticoagulation (n=70), warfarin (n=11), antiplatelet (n=58) and DOACs (n=8). DOAC patients had increased time from presentation to surgery when compared to the no anticoagulation group (41 hours versus 32 hours) and slightly increased length of stay, however patients on DOACs had no requirements for transfusion (preoperatively and postoperatively) with the lowest haemoglobin drop and no deaths overall.

Conclusion: While it takes longer for patients on DOACs to undergo surgery, it has not impacted transfusion requirements or mortality. Further work is required to increase the sample size of this study.

TRANSFERS FROM A REGIONAL NSW TRAUMA CENTRE TO A MAJOR TRAUMA CENTRE – IS IT ABOUT SUBSPECIALTY EXPERTISE?

Dr Michael Su1, Dr Jeremy Hsu1, Associate Professor Brian Burns2

1Westmead Hospital, Sydney, Australia
2Sydney HEMS, Australia

Purpose: To examine the interventions and outcomes of trauma patients transferred from a regional NSW catchment to a major trauma centre.

Patients & Methods: Trauma related presentations to Bathurst, Orange and Dubbo Hospitals requiring admission or transfer to Westmead Hospital between 1 January 2013 and 31 December 2015 were examined. Primary outcome was the proportion requiring intervention at Westmead Hospital. Secondary outcomes were mortality, hospital LOS, ICU LOS and interventions at the primary referral site and/or Westmead Hospital. Student’s t-test and Pearson Chi-squared tests were used.

Results: 521 patients were included in the analysis. Most patients were managed locally at each respective regional hospital (n=368, 70.6%). Mortality was higher at regional centres (n=23, 6.3% vs n=4, 2.6%; p=0.09) but was secondary to early mortality (<24 hours). Mean hospital LOS (2.0 SD 1.7 vs 8.4 SD 7.3, p<0.01) and ICU LOS (7.0 SD 7.7 vs 11.8 SD 17.2, p<0.01) were shorter for regional centres. Most patients transferred required definitive surgery (n=83, 54.2%) compared with patients managed locally (n=65, 17.7%; p<0.01). Subspecialty operative management at Westmead was predominantly spinal surgery (n=17, p<0.01), neurosurgical (n=10, p<0.01), plastic surgery (n=14, p<0.01), maxillofacial surgery (n=9, p<0.01) and hand surgery (n=9, p<0.01). A majority of definitive orthopaedic (n=31, 50.8%) and laparotomy (n=8, 88.9%) procedures were managed locally.

Conclusion: Operative management was required for most patients transferred to Westmead Hospital with a subspecialty predominance for spinal, neurosurgery and OMFS/plastic surgery. Central-West NSW regional centres provided a notable proportion of orthopaedic and laparotomy-related operative care with good outcomes.
A STUDY OF THE PATTERN OF THYROID CANCER INCIDENCE  
Dr Sujen Jayakody

COMPARISON OF ADENOMA DETECTION RATES BETWEEN GASTROENTEROLOGISTS AND COLORECTAL SURGEONS  
Ms Adele Lee

EFFICACY AND SAFETY OF LAPAROSCOPIC GASTRIC BYPASS AFTER FAILED GASTRIC BANDING  
Dr Ahmed Rahman

IMPACT OF MESH FIXATION TECHNIQUES ON SHORT-TERM POST-OPERATIVE PAIN  
Dr Eesyn Tan
GENERAL INFORMATION

VENUE
The meeting is being held at ANU Medical School, Building 4, The Canberra Hospital, Garran, ACT.
The scientific sessions and industry exhibition will be located in the Auditorium and the Auditorium Foyer respectively.

CANCELLATION POLICY
Cancellations must be received in writing by the meeting organiser to: college.asm@surgeons.org.
Cancellations received by Friday 13 October 2017 will incur a 20% cancellation fee. Cancellation received after this date will not be refunded.

NAME BADGES
Your name badge is essential for entry into all sessions and the official function and must be worn at all times.

INDUSTRY EXHIBITION
Lunch, morning and afternoon tea will be served in the exhibition area, located in the Auditorium Foyer, ANU Medical School.

CAR PARKING
There is limited free parking on campus, time restrictions may apply.

MEETING DINNER
Saturday 4 November
6:00pm
Monster Kitchen and Bar
Hotel Hotel, Acton
Cost:
Fellow - $110.00
Trainee/IMG/Other - $65.00
Dress: Lounge suit / cocktail dress
To purchase a ticket, please visit the registration desk. Tickets are subject to availability.

INTENTION TO PHOTOGRAPH
Please be advised that photographs will be taken during the meeting and reproduced by the meeting organiser. These photographs may be used for the following purposes:
- Projection on-site
- Reporting on the meeting in online and hard copy publications
- Marketing a future meeting, including online and hard copy publications
- Publishing in RACS publications
If you do not wish to be included in a photograph, please advise the photographer.

CONTINUING PROFESSIONAL DEVELOPMENT (CPD) PROGRAM
This educational activity is accredited. Fellows who participate can claim one point per hour (maximum 6 points) in Maintenance of Clinical Knowledge and Skills towards 2017 CPD totals. CPD points will be automatically updated for all Fellows who have provided their RACS ID.

SPECIAL DIETARY REQUIREMENTS
Please note that the caterer is responsible for all catering at the meeting and RACS does not inspect or control food preparation areas or attempt to monitor ingredients used. You should contact the caterer directly for all special dietary requirements during the meeting, 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 caterer (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 caterer 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.

CERTIFICATE OF ATTENDANCE
A certificate of attendance will be emailed after the meeting.
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