Surgery 2007: Challenges and Innovations

International College of Surgeons

40th North American Federation Congress and Annual Meeting of the United States Section

June 9-16, 2007

Boston, Massachusetts to Montreal, Canada

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CITY OF BOSTON • MASSACHUSETTS

OFFICE OF THE MAYOR
THOMAS M. MENINO

June 2007

Dear Friends:

On behalf of the City of Boston, I send you all a warm welcome as you gather for the 40th North American Federation Congress of the International College of Surgeons – United States Section.

As a global leader in medical care and research, Boston is the ideal location to begin your journey. We have the most esteemed professionals in our world-renowned hospitals and academic institutions, and strong technical support in our colleges and universities. Furthermore, with major biomedical companies located right in our backyard, Boston leads the way in the research and development of new vaccines and antibiotics.

During your stay in Boston, I hope you will take advantage of the many things that make this city unique. I invite you to explore our friendly, historic neighborhoods, our many cultural attractions, our parks and open spaces, and our international cuisine.

I hope you enjoy your visit to Boston, and I wish you all a challenging, productive and successful conference.

Sincerely,

Thomas M. Menino
Mayor of Boston

Holland America Line Inc.

OFFICE OF THE CHAIRMAN AND CEO

Dear International College of Surgeon Members,

On behalf of the crew and officers of the ms Maasdam, I look forward to welcoming you aboard on the June 9th sailing to Canada and New England. I expect you will enjoy your time spent in this beautiful area of the world.

As I understand it, this is the second time that your organization has sailed with Holland America Line while furthering your education and learning about the latest developments in the surgical field. I'm very impressed and know that it requires a great deal of time to maintain skill levels in such a profession as yours.

Even though some of your time will be spent in the Wajang Theatre, Hudson Room and Half Moon Room, I do look forward to showing you the ports of call and I know that our ship's able Hotel Manager looks forward to bringing you the very best of Holland America Line's service, dining, and entertainment.

Once again, we all look forward to our upcoming cruise together.

Sincerely,

Captain Arjen C. van der Loo
ms Maasdam

300 Elliott Ave. West
Seattle, WA 98119
206•281-3535
Fax: 206•301-5327

From the International College of Surgeons World President
Fidel Ruiz Healy, MD

As World President, I welcome Fellows and guests to this 40th North American Federation Congress of the International College of Surgeons, presided by our North American Federation Secretary, Doctor Enrico Nicolo, and being held on this cruise from Boston to Montreal, June 9-16, 2007.

I wish to congratulate the Scientific Program Organizers, Chaired by Doctor Sibu P. Saha for organizing an interesting and relevant scientific program, dealing from current concepts to state-of-the-art issues in surgery, with such topics as: What's new in the surgical specialties, technology in surgery, surgical infection and wound healing, trauma, and business in surgery.

The vision of the International College of Surgeons is to improve the lives of our patients through the development and education of our members and the advancement of our field. The missions of the College are teaching, conducting research, communicating and leading. This Congress serves well the objectives of our College.

Your participation will make this meeting a success in many ways. It will enable you to present and exchange personal and institutional surgical experiences, broaden knowledge on new solutions to complex surgical problems, as well as strengthen friendships and meet new friends in the North American Federation.

Welcome!

Dr. Fidel Ruiz Healy
World President
International College of Surgeons

From the United States Section President
Sibu P. Saha, MD

Dear Colleagues,

It is a great pleasure to host this year's 40th North American Federation Congress of the International College of Surgeons. On behalf of the United States Section's Officers and Fellows I am delighted to welcome you to this biennial event as we set sail for a spectacular New England and Canadian Cruise, aboard Holland America's elegantly appointed *ms Maasdam*.

This congress presents original research and clinical cases of interest to general surgeons and all surgical specialists. Faculty and attendees will have an opportunity for meaningful discussion and constructive critique of the latest surgical procedures, research findings, observations made in the operating room, in the clinic, and in the laboratory. Comprehensive multidisciplinary sessions include case reports, clinical challenges, and a forum on the business of surgery.

Our efforts to enhance the global welfare of our patients will be accentuated through the participation of many well-know international physician participants. Through the diligent efforts of our Council of Surgical Specialty Chairs, whose individual and collective contributions are providing the directives to address the latest in "surgical technology and education," "surgical infection," and "trauma."

This conference promises to encourage the fraternity and exchange of new, exciting and clinically relevant information for improving patient care for ALL surgeons. I welcome you to this, our 40th North American Federation Congress, and am sure that you will find it to be an engaging and informative conference.

On behalf of the United States Section, Welcome!

Sibu P. Saha, MD
United States Section President

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United States Section Business Meetings

Wednesday **June 13, 2007**

CME Committee Meeting
Half Moon, Promenade Deck
2:00 pm-3:00 pm

Board of Regents &
Membership Committee Meetings
Half Moon, Promenade Deck
3:00 pm-4:00 pm

Executive Council &
House of Delegates Meeting
Half Moon, Promenade Deck
4:00 pm-5:00 pm

Thursday **June 14, 2007**

General Membership Meeting
Rotterdam Dining Room
2:00 pm-3:00 pm

Activities for all Cruise Participants

Saturday, June 9 **5:00 PM**

Crow's Nest on the Sports Deck

40th North American Federation Congress Anniversary Reception

Please join us as we celebrate the 40th Anniversary of the North American Federation, and kick off our cruise through New England and Canada.

Monday, June 11 **10:00 AM**

Halifax Horse-Drawn Trolley Tour

Gather in Hudson room for Departure

This short, 1.5 hour tour will be the designated Alliance event for the day. The Halifax Horse-Drawn Trolley will take you back to Halifax of the 1900s, including the old Warehouse District, the harbor front, the Halifax Citadel Hill Fortress and Founders Cemetery—the final resting place of 1812 British war heroes. Stop and smell the roses during a stroll through North America's finest Victorian Public Gardens, a nine-acre botanical garden right in the heart of Halifax. You will have to book this tour directly with Holland America, on board the ship, at the excursions desk. As this tour has two departure times, be sure to book the 10:30 am departure to ensure that you will be included with the Alliance group.

Tuesday, June 12 **1:00 PM**

Spirit of the Fiddle: Sounds of Cape Breton

Gather in Hudson room for Departure

Join us for just an hour to experience music unique to Cape Breton Island. Influenced by Scottish, Irish and Acadian traditions, enjoy professional local entertainers as they offer singing, step dancing and of course, lively fiddle playing. This special presentation is exclusively for the guests of Holland America. Meet at the World's Largest Fiddle and follow the piper to an intimate performance space in the Sydney Cruise Terminal located directly across from the ship. Refreshments, including traditional Cape Breton oatcakes will be served. You will have to book this tour directly with Holland America, on board the ship, at the excursions desk.

Wednesday, June 13 **1:00 PM**

Alliance Luncheon

Rotterdam Dining Room Promenade Deck

Since we have such a short time in port today, head back to the ship in time for a luncheon to get together, share experiences, and honor past Alliance President Judy Nicolo. Of course, everyone is encouraged to attend - not just Alliance members.

Thursday, June 14 **12:45 PM**

ICS - A 39 Year Journey

Rotterdam Dining Room Promenade Deck

During a special luncheon for all cruise attendees, ICS Honorary Fellow, and International Vice President, Dr. Arno A. Roscher, will take us on a fantastic journey through the College's past as he shares with us his travels and explorations around the globe all experienced under the auspices of ICS. From meetings and introductions to world-renowned physicians, national and international political figures and celebrities, Dr. Roschers' experiences explained with humor and admiration embody the true meaning of Fellowship in the International College of Surgeons

Friday, June 15 **Noon**

Closing Luncheon

Frontenac Room Fairmont Chateau Le Frontenac

We officially close our meeting with a luncheon at the Fairmont Chateau Le Frontenac, just steps from the ship's dock. This special event will recognize the contributions of Past President Enrico Nicolo, MD, the induction of President-Elect Vijay Mittal, MD, and of Honroary Fellow, Dr. Robert M. Mentzer, Jr., MD, finally we take a moment to honor those who have worked hard to improve the ICS and US Section over the past year.

If you did not reserve a seat in advance of the meeting please see ICS-US Staff to confirm your attendance by Noon on Wednesday June 13. After that time it may not be possible to accomodate additional guests.

Overall Conference Objectives

As surgeons we share experiences, discoveries and research for the sake of science and mankind. The common language of scientific investigation enriches the surgeon when there is a sharing of experience in a forum that encourages discussion and participation.

This program was designed to keep you abreast of current and emerging trends and technologies in surgery, surgical infection, trauma, preoperative care and the concepts of the business aspects of a competent surgical practice. The sessions being presented will offer a variety of viewpoints on new technologies that will address the need for, as well as reinforce the benefit of cooperation and communication between surgical specialists. The goals of this conference are to enhance overall technique, to advance surgical knowledge, foster continued training and improve patient care.

Who Should Attend

This conference is presented to enhance opportunities in continuing medical education for General Surgeons and Surgical Specialists at all levels of experience. Medical Students, Residents and Nurses will also benefit from this activity.

Accreditation

The International College of Surgeons-United States Section is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

Credit Designation

The International College of Surgeons-United States Section designates this educational activity for 17.5 category 1 credits toward the AMA Physician's Recognition Award.

Conflict of Interest

A potential conflict of interest exists when there is involvement between the speaker/presenter with any for-profit commercial firm or organization (FPC). This includes, but is not limited to, one or more of the following; 1)consultant, scientific advisory committee member, or lecturer for an FPC from which income is earned, 2)officer, board member, trustee, owner, or employee of an FPC, 3)stock or bond holdings in an FPC (investments entirely managed by a third party such as mutual funds and pension plans are excluded,) 4)stock options held in an FPC.

Off-Label Disclosure

(Including Generic Trade Names and Reporting Scientific Research) Presentations must give a balanced view of options. Faculty use of generic names will contribute to this impartiality. Presentations supported by a commercial entity reporting the results of scientific research must conform to the generally accepted standards of experimental design, data collection and analysis. When an unlabeled use of a commercial product, or an investigational use not yet approved for any purpose is discussed during an educational activity it is required that the speaker disclose that the product is not labeled for the use under discussion or that the product is still investigational.

The Importance of Identification

In order for the audience to evaluate information, analysis and opinions at presentations sponsored by the International College of Surgeons-United States Section, it is crucial that the audience be informed of any aspect of a speaker's personal or professional affiliations that might affect the speaker's attitude or judgment regarding that speaker's presentation. For any presentation, the speakers will identify any aspect of personal or professional affiliations that may reasonably affect their views prior to their presentation(s) (for instance, affiliation with the manufacturer of a drug or device related to the topic). Additionally, faculty members are required to report if their presentations include discussion(s) of investigational products or products not labeled for the described use.

All faculty members are required to comply with these policies and procedures and identify any potential conflicts and/or discussion of investigational products prior to presentation.

Disclaimer

Registrants for this course understand that medical and scientific knowledge are constantly evolving and that the views and techniques of the faculty are their own and may reflect innovations and opinions not universally shared. The views and techniques of the faculty are not necessarily those of the ICS but are presented in this forum to advance scientific and medical education.

Scientific Program Organizers

Sibu P. Saha, MD, MBA
ICS-US Section President
Professor of Surgery, University of Kentucky
Chairman, Directors Council, Gill Heart Institute
Lexington, KY

Vijay Mittal, MD
ICS-US CME Chair
Chair and Program Director, General Surgery, Providence Hospital and Medical Centers, Southfield, MI; Associate Clinical Professor of Surgery, Wayne State University, Detroit, MI

Gazi Zibari, MD
Scientific Program Chair
Professor Of Surgery
Malcolm Fiest Endowed Chair In Transplant Surgery
Director Of W.K./ L.S.U. Regional Transplant Program
L.S.U.Health Sciences Center.
Shreveport, LA

Joseph A. Bachicha, MD
Department of Obstetrics & Gynecology
Chief, Patient Education and Health Promotion
Kaiser Medical Center
Hayward, CA

Frank P. Bongiorno, MD
President, Medical Director
Wound Specialists of Michigan
Ann Arbor, MI

Anthony N. Dardano, DO
Chief of Staff, Delray Medical Center, Vice-Chief of Surgery, Boca Raton Community Hospital
Boca Raton, FL

Ari Halldorsson, MD
Professor and Vice Chair, Department of Surgery
Chief, Division of Cardio-Thoracic Surgery,
Residency Program Director General Surgery,
Texas Tech University Health Sciences Center
Lubbock, TX

Zaki-Udin Hassan, MD
Assistant Professor of Anesthesiology
University of Kentucky,
Lexington, KY

Alfonso E. Pino, MD
Chief of Surgery, CCMC
De Leon, TX

Roque J. Ramirez, MD
President, SurgeonOne, Inc.
Corpus Christi Medical Center
Corpus Christi, TX

Dinesh Ranjan, MD
Chair, ICS-US Council of Specialty Groups
Chief, Transplant Section, Director of Liver and Pancreas Transplantation
University of Kentucky
Lexington, KY

Larry S. Sasaki, MD
Assistant Clinical Professor of Surgery
Louisiana State University Medical Center
Shreveport, LA

Opening of Congress

Sunday, June 10, 2007
Gather in Half Moon Room, Promenade Deck
by 7:30 am to depart the ship.

Bar Harbor Club, McMurtry Ballroom 8:00am-8:20am

Invocation
Jay A. Bachicha, MD, FICS, Department of Obstetrics and Gynecology, Chief, Patient Education and Health Promotion, Kaiser Medical Center, Hayward, CA

Welcome and Introduction
Sibu P. Saha, MD, FICS, United States Section President, Professor of Surgery, University of Kentucky, Lexington, KY

Technology...What's New in Surgery Part I

Sunday, June 10, 2007 – 8:20am-11:30am
Bar Harbor Club, McMurtry Ballroom

This session will review advances in imaging, robotics, and virtual reality and examine the cutting-edge technology that is becoming available and how it will change surgical education and practice. Additionally, this program will explore related cost issues, how to evaluate the cost-effectiveness and benefits of new technology, and what physicians can and cannot afford.

Highlighting controversies and results, this session will provide a comprehensive review of the latest developments in all surgical arenas, including practice technique, procedure, instrumentation, and patient safety.

MODERATOR
Jay A. Bachicha, MD, FICS, Department of Obstetrics and Gynecology, Chief, Patient Education and Health Promotion, Kaiser Medical Center, Hayward, CA

8:20am-8:40am
Surgical Simulation in Continuing Medical Education
Vijay Mittal, MD, FICS, Chair and Program Director, General Surgery, Providence Hospital and Medical Centers, Southfield, MI; Associate Clinical Professor of Surgery, Wayne State University, Detroit, MI

8:40am-9:00am
Innovations in Anesthesia for Surgeons
Zaki-Udin Hassan, MD, FICS, Assistant Professor of Anesthesiology, University of Kentucky, Lexington, KY

9:00am-9:20am
Impact of Newer Imaging Studies on Acute Abdomen
Larry Chung, MD, Chair Department of Surgery, Providence Hospital, Detroit, MI

9:20am-9:40am
FDG-PET in the Staging and Surveillance for Patients with Cholangiocarcinoma
Siddhartha Rath, MD, FICS, Departments of Surgery and Physiology, Louisiana State University Health Sciences Center, Shreveport, LA

9:40am-10:00am
New Techniques in Lower Extremity Reconstruction
Anthony N. Dardano, DO, FICS, Chief of Staff, Delray Medical Center, Vice-Chief of Surgery, Boca Raton Community Hospital, Boca Raton, FL

10:00am-10:15am Coffee Break

10:15am-10:35am
One Stage Breast Reconstruction
Anthony N. Dardano, DO, FICS

10:35am-10:55am
Follow-Up of Local Control of Vestibular Schwannomas Utilizing Fractioned LINAC Stereotactic Radiosurgery
Isaac Goodrich, MD, FICS, New Haven, CT

10:55am-11:15am
Treatment of Obstructive Benign Prostatic Hyperplasia (BPH) with 120W KTP-532nm High Power System (HPS) KTP Green light Laser for Photo selective Vaporization of the Prostate (PVP)
Mahmood A. Hai, MD, FICS, Cherry Hill Medical Center, Westland, MI

11:15am-11:30am Questions and Answer Session

This session will resume on Monday, June 11, 2007 at 8:00am, followed by, the "Business of Surgery."

Technology...What's New in Surgery Part II

Monday, June 11, 2007 – 8am-10:15am
Half Moon Room, Promenade Deck

See the program description for Part I of this program, listed above.

MODERATOR
Jay A. Bachicha, MD, FICS, Department of Obstetrics and Gynecology, Chief, Patient Education and Health Promotion, Kaiser Medical Center, Hayward, CA

8:00am-8:20am
Use of Biomaterials in Complex Surgical Cases
Anthony N. Dardano, DO, FICS, Chief of Staff, Delray Medical Center, Vice-Chief of Surgery, Boca Raton Community Hospital, Boca Raton, FL

8:20am-8:40am
The Use of Small Porcine Bowel Submucosa Mesh in the Treatment of Gastroesophoagic Reflux—Long-Term Results at the Texas Endosurgery Institute
Morris E. Franklin, Jr., MD, FICS, Texas Endosurgery Institute, San Antonio, TX

8:40am-9:00am
A Ten-Year Study of Simultaneous Kidney-Pancreas Transplantation Using Portal Enteric Drainage and Venting Jejunostomy: Outcomes and Complications
Siddhartha Rath, MD, FICS, Departments of Surgery and Nephrology, Louisiana State University Health Sciences Center, Shreveport, LA

9:00am-9:20am
Laparoscopic Biliary Bypass Procedures
Morris E. Franklin, Jr., MD, FICS

9:20am-9:40am
Laparoscopic Treatment of Achalasia
Morris E. Franklin, Jr., MD, FICS

9:40am-10:00am
Open Wedge High Tibial Osteotomy (OWHTO): Literature Review and Clinical Cases
Alfonse E. Pino, MD, FICS, Chief of Surgery CCMC, De Leon, TX

10:00AM-10:15AM Questions and Answer Session

10:15-10:30AM Coffee Break

Business of Surgery

Monday, June 11, 2007 – 10:30am-12:15pm
Half Moon Room, Promenade Deck

This session will explore the daily general business practices of developing and maintaining a successful surgical practice. Financial, legal, and ethical issues, will be discussed along with the tools that are available to maintain and even market a surgical practice. Prioritization, education, and financial aspects of the practice will be explored and provide physicians with the important practice guidelines as a means of decreasing practice variation and improving patient outcomes.

MODERATOR
Enrico Nicolo, MD, FICS, North American Federation Secretary, Assistant Clinical Professor of Surgery, University of Pittsburgh Medical Center, Pittsburgh, PA

10:30am-10:50am
Why Developing Countries Need the USA
Domingo T. Alvear, MD, FICS, Chief, Division of Pediatric Surgery, Pinnacle Health Hospital, Harrisburg, PA
10:50am-11:20am
Evidence-Based Practice – Guidelines Not Laws
V. A. Ferris, MD, PhD, Tyler Gill Professor of Surgery, Co-Director of the Gill Heart Institute, Chief of Cardiothoracic Surgery, University of Kentucky, Lexington, KY

11:20am-11:40am
Changing Reimbursement for Liver Transplantation: Procedure and Subsequent Care
Dinesh Ranjan, MD, FICS, Chair, ICS-US Council of Specialty Groups, Chief, Transplant Section, Director of Liver and Pancreas Transplantation, University of Kentucky, Lexington, KY

11:40am-12:00pm
Economic Challenges of a Surgical Practice
Sibu P. Saha, MD, FICS, ICS-US Section President, Prof. of Surgery, University of Kentucky, Lexington, KY

12:00PM-12:15PM Questions and Answers

Trauma

Tuesday, June 12, 2007 – 8:00am-10:30am
Half Moon Room, Promenade Deck

This session will include common and not-so-common trauma scenarios with innovative approaches to both management and teaching. The session will cover both complex and routine emergency situations/simulations.

MODERATOR
Dinesh Ranjan, MD, FICS, Chair, ICS-US Council of Specialty Groups, Chief, Transplant Section, Director of Liver and Pancreas Transplantation, University of Kentucky, Lexington, KY

8:00am-8:20am
Damage Control in Trauma
Vijay Mittal, MD, FICS, Chair and Program Director, General Surgery, Providence Hospital and Medical Centers, Southfield, MI; Associate Clinical Professor of Surgery, Wayne State University, Detroit, MI

8:20am-8:40am
Endovascular Techniques in Treatment of Blunt Spleen and Liver Trauma
Ari Halldorsson, MD, FICS, Professor and Vice Chair, Department of Surgery, Chief, Division of Cardio-Thoracic Surgery, Residency Program Director General Surgery, Texas Tech University Health Sciences Center, Lubbock, TX

8:40am-9:00am
Management of Penetrating Abdominal Trauma
Said A. Daee, MD, FICS, International Corporate Secretary, Greenbelt, MD

9:00am-9:20am
Update in Management of Blunt Thoracic Trauma
Ari Halldorsson, MD, FICS

9:20am-9:40am
Traumatic Brain Injury
Elpidio Sanchez-Arellano, MD, FICS, Mexico City, Mexico

9:40am-10:00am
Management of the Open Abdomen in Trauma
Ari Halldorsson, MD, FICS

10:00am-10:20am
Anti-Thymocyte Globulin (ATG) Attenuated Hepatic Ischemia-Reperfusion (IR) in Mice
Siddhartha Rath, MD, FICS, Department of Surgery, Louisiana State University Health Sciences Center, Shreveport, LA

10:20AM-10:30AM QUESTIONS AND ANSWER SESSION

Wednesday, June 13, 2007

In recognition of the fact that we are only in port until 1:30 pm today, we have not scheduled any CME in order to allow everyone time to fully expolore Prince Edward Island.

Upon returning to the ship, everyone is invited to join us in the main dining room at 1:00 pm for the Alliance Luncheon.

Surgical Infection and Wound Healing

Thursday, June 14, 2007 – 9am-12:30pm
HALF MOON ROOM, PROMENADE DECK

Beginning with the basic principles and risk factors for infection, this session will explore the latest developments in avoiding and resolving post-operative surgical wound infection. Physicians will understand the need for the use of compression therapy in complicated post-op cases, understand the composition, action and appropriate use of debriding agents, understand the necessary component of advanced wound treatment, and how the ten "basic" principles allows one to provide appropriate and approved therapy that leads to wound healing and how following the ten commonly practiced myths can lead to complications resulting in sepsis, amputation and death. Physicians will also be versed in the recognition and importance of a patient's nutritional status and how to incorporate this into perioperative care using current principles of nutrition therapy.

MODERATOR
Gazi Zibari, MD, FICS, Scientific Program Chair, Professor of Surgery, Malcolm Fiest Endowed Chair in Transplant Surgery, Director of W.K./LSU Regional Transplant Program, LSU Health Science Center, Shreveport, LA

8:00am-8:40am
Perioperative Complications: Challenges and Solutions
Jay A. Bachicha, MD,FICS, Department of Obstetrics and Gynecology, Chief, Patient Education and Health Promotion, Kaiser Medical Center, Hayward, CA
with
Mala Seshagiri, RD
Director, Department of Health Education, Kaiser Permanente Greater Southern Alameda Area, CA

8:40am-9:00am
Controversies in the Management of Perforate Appendicitis in Children – 2006
Domingo T. Alvear, MD, FICS, Chief, Division of Pediatric Surgery, Pinnacle Health Hospital, Harrisburg, PA
9:00am-9:20am
Cost Effectiveness and Efficacy in Wound Healing: Shaping and Tissue Movement
Frank P. Bongiorno, MD, FICS, President, Medical Director, Wound Specialists of Michigan, Ann Arbor, MI

9:20am-9:40am
Salvage Through Advanced Wound Treatment – The Prevention of Amputation
Frank P. Bongiorno, MD, FICS

9:40am-10:00am
Standard and Recommended Approaches to Non-Healing Wounds: What to Do, What not to Do, and Why
Frank P. Bongiorno, MD, FICS

10:00AM-10:10AM COFFEE BREAK

10:10am-10:30
The Use of Apligraft as a Means of Closing the Chronic Wound
Frank P. Bongiorno, MD, FICS

10:30am-10:50am
Management of Highly Complex Wounds Using the VAC
Anthony N. Dardano, DO, FICS, Chief of Staff, Delray Medical Center, Vice-Chief of Surgery, Boca Raton Community Hospital, Boca Raton, FL

10:50am-11:10am
Thoracic Empyema
Ari Halldorsson, MD, FICS, Professor and Vice Chair, Department of Surgery, Chief, Division of Cardio-Thoracic Surgery, Residency Program Director General Surgery, Texas Tech University Health Sciences Center, Lubbock, TX

11:10am-11:30am
The Complicated Post-Op Wound – The Role of Topical Treatments for Debridement and Antimicrobial Therapy
Lillian V. Henry, MSN, APRN, BC, CVN, Wound Specialists of Michigan, Ann Arbor, MI

11:30am-11:50am
The Role and Practical Use of Compression in Wound Healing
Lillian V. Henry, MSN, APRN, BC, CVN

11:50am-12:10pm
Case Histories in Post-Liver Transplant Infectious Complications
Cataldo Doria, MD, FICS, Jefferson Medical College, Philadelphia, PA

12:10PM-12:30PM QUESTIONS AND ANSWER SESSION

General Session

Friday, June 15, 2007 – 9:00am-10:00am
Petit Frontenac Room Fairmont Chateau Le Frontenac

MODERATOR
Wickii T. Vigneswaran, MD, FICS, Professor of Surgery, Associate Chief of Cardiac and Thoracic Surgery, Director of Lung and Heart Lung Transplantation, University of Chicago, Chicago, IL

9:00am-9:15am
The Use of Endografts for Thoracic Aortic and Carotid Trauma
Ehab Sorial, MD, Vascular Surgery Fellow, University of Kentucky, Lexington, KY

9:15am-9:30am
Laparoscopic Liver Resection
Michael Jacobs, MD, FICS, Consultant Surgeon-Surgical Oncology and General Surgery, Teaching Faculty, Providence Hospital, Southfield, MI

9:30am-9:45am
Wrong Site Surgery Revisited
Wickii T. Vigneswaran, MD, FICS

9:45am-10:00am
On-Q Pain Pump: Pain Management for the Laparoscopic Colectomy
Larry Sasaki, MD, FICS, Assistant Clinical Professor of Surgery, Louisiana State University Medical Center, Shreveport, LA

Symposium on Perioperative Care

Friday, June 15, 2007 – 10am-12:30pm
Petit Frontenac Room Fairmont Chateau Le Frontenac

This symposium will present the history and current practices of blood transfusion; highlighting the different strategies for conservation of blood during surgery. Participants will also gain knowledge on the current advances and therapies in cardiac surgery.

10:00am-10:10am Welcome and Introduction

MODERATOR
Wickii T. Vigneswaran, MD, FICS, Professor of Surgery, Associate Chief of Cardiac and Thoracic Surgery, Director of Lung and Heart Lung Transplantation, University of Chicago, Chicago, IL

10:10am-10:30am
Blood Transfusion
Sibu P. Saha, MD, FICS, Professor of Surgery, University of Kentucky Chandler Medical Center, Chairman, Directors Council, Gill Heart Institute, Lexington, KY

10:30am-10:50am
Blood Conservation During Surgery
V. A. Ferris, MD, PhD, Tyler Gill Professor of Surgery, Co-Director of the Gill Heart Institute, Chief of Cardiothoracic Surgery, University of Kentucky, Lexington, KY
10:50am-11:10am
Advances in Cardiac Science
Presented by: ICS 2007 Honorary Fellowship Recipient
Robert M. Mentzer, Jr., MD, Dean, School of Medicine, Wayne State University, Detroit, MI

11:10am-11:25am Panel Discussion

11:25am-11:45am
Present and Future of Surgery
ICS World President Lecture
Fidel Ruiz Healy, MD, FICS, Chief Service of Colon and Rectal Surgery, Centro Hospitalario Sanatorio Durango, Mexico City, Mexico

Closing Luncheon

Noon-1:30pm
Frontenac Room Fairmont Chateau Le Frontenac

Featuring:

Recognition, of Enrico Nicolo, MD
for service as 2006 US Section President

A Special Address from Professor Fidel Ruiz-Healy
ICS World President

The Installation of Vijay Mittal, MD
as 2008 US Section President,

The Installation of Robert M. Mentzer, Jr., MD
2007 Honorary Fellowship Recipient

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Scientific Abstracts

Why Developing Countries Need the USA

Author: Domingo T. Alvear, M.D., FACS, FICS, FAAP, Chief, Division of Pediatric Surgery, Pinnacle Health Hospital

The ideal basic human rights include the right to attain the highest standard of physical, emotional (mental), and spiritual health; to have equality before the laws of the land; to have freedom of expression; and to have freedom from terrorism and torture. The realities in the developing world is that adequate healthcare is not attainable due to political and economic turmoil and/or military conflicts. The expenditures for healthcare in most of these countries is not a priority, usually less than 2% of GDP compared to the U.S. which is 15-20% of GDP. Doctors in developing countries are often overworked and underpaid, and they often practice in larger cities and not in the rural areas. The rich can gain access to their healthcare, but the poor are usually denied access to much needed healthcare.

According to the World Health Organization (WHO), two billion people are at risk for crisis conditions due to conflicts, natural disasters, and disease. The surgical needs of the developing world remain unmet due to a shortage of funds and medical personnel. The Commission on Global Health of WHO concludes that poverty equals ill-health cycle so that solutions to problems must not only focus on disease but must include the social environment.

Organizations such as ACS, ICS, and the World Surgical Foundation (WSF) should be part of a global initiative to improve healthcare in developing nations. The missions and goals of the WSF are to provide healthcare to the underserved by performing free surgical procedures; donating useable equipment and supplies to healthcare facilities; educating local physicians, nurses, and paramedical personnel during the mission.

The Developing World needs the USA due to a lack of resources (funds, facilities, equipment, supplies) and a lack of access to care (facilities, physicians, and nurses). By helping them medically, we can break the cultural and socioeconomic barriers.

Controversies in the Management of Perforate Appendicitis in Children – 2006

Author: Domingo T. Alvear, M.D., FACS, FICS, FAAP, Chief, Division of Pediatric Surgery, Pinnacle Health Hospital

In spite of the availability of imaging studies, perforated appendicitis in children remains high, around 50% in children over six years of age, and can be as high as 85% in preschool children. The management of perforated appendicitis has undergone significant change since the first report of Fitz's in which surgical removal of the appendix carried a high mortality rate of 40%. Despite the virtual elimination of mortality from perforated appendicitis, there is continued controversy in regards to the methods to reduce morbidity associated with this disease entity.

The current controversies in the management of perforated appendicitis in children include: 1) The use of conservative management without surgical intervention which requires a hospital stay from 7 to 21 days using intravenous antibiotic therapy followed by elective interval appendectomy 4 to 6 weeks later or no further surgery necessary. 2) The use of interventional radiologist to drain localized abscesses without prior surgical intervention. 3) If surgical intervention is chosen, will it be done laparoscopically or open technique? 4) If an abscess is found, would drainage be sufficient or can an appendectomy be safely performed? 5) If irrigation is used, will it be normal saline or an antibiotic mixture? 6) To drain or not to drain? Penrose drain or close drain system? Is the drain brought out through the lateral end of the wound or through a separate incision? 7) Type of antibiotic coverage, is it single or multiple? 8) Is the wound closed or is it packed open? Retrospective study of all patients who had acute appendicitis from age 0 to 16 years of age in the Pinnacle Health hospitals in the last 15 years was included in the study. 908 patients with acute appendicitis were identified and 158 had perforated appendicitis at the time of diagnosis and treatment. The management of patients with perforated appendicitis includes appropriate preoperative hydration, single antibiotic coverage using Cefoxitin or Cefotetan followed by surgical intervention within a few hours of admission. Appendectomy is carried out in all cases. The small bowel is carefully inspected four to five feet proximally to look for interloop abscesses. The abdominal cavity and the pelvis are irrigated copiously with normal saline until return is clear. Drains are placed only if there is a localized abscess or if there is phlegmon. No drains are placed when there is generalized peritonitis and no localized abscess. If drains are used, they are brought out through the lateral end of the wound. The wound is closed loosely and not packed open. Postoperative care includes the use of nasogastric suction until peristalsis has set in, usually within 48 hours. A Foley catheter is inserted to monitor urinary output for 48 hours. IV fluids are given until oral intake is sufficient. IV antibiotics are given while in the hospital and the patient is sent home with a PICC line for IV antibiotics for a total of ten days of antibiotic coverage. Discharge criteria for the patient include a normal temperature, normal WBC and differential, decreasing CRP values, fully ambulatory, and eating a regular diet. Following this protocol, there is 0% mortality, there is less than 0.1% intraabdominal abscess rate, and 0.1% wound infection rate.

Many children continue to present with perforated appendicitis in spite of the use of imaging studies. Diagnosis of appendicitis in general becomes more difficult in children of preschool age (under 6 years of age), because it can mimic many other causes of abdominal pain. The use of C-reactive protein has been beneficial in determining the severity of appendicitis and can be a good marker to determine if there is an ongoing infection postoperatively. Once the appendicitis perforates, the management from the time of diagnosis to discharge and to care at home has been controversial. This is true in the U.S., Canada, and the U.K. A protocol has been established at the Pinnacle Health System which includes an appendectomy in all cases and decreasing morbidity that prevents the development of intraabdominal abscess or wound infection.

Perioperative Complications Challenges and Solutions

Jay Bachicha MD, Department of Obstetrics and Gynecology; Chief, Patient Education and Health Promotion, Kaiser Medical Center, Hayward, CA; Mala Seshagiri RD, Director, Department of Health Education, Kaiser Permanente Greater Southern Alameda Area, CA

The perioperative period is a time of heightened risk for surgical patients and problems with surgical wounds are commonly encountered by surgeons in every field. This presentation will include discussion of common surgical complications and methods to address them. Such problems as wound healing, infection, fascial disruption, and nerve entrapment will be discussed and management solutions will be proposed. The nutritional status of patients is of critical importance in wound care and healing and this issue will be addressed by a trained nutritionist.

Scientific Abstracts

Cost Effectiveness And Efficacy In Wound Healing: Shaping And Tissue Movement

Author: Frank P. Bongiorno, M.D., Wound Specialists of Michigan, Ann Arbor & Grand Rapids, Michigan, United States

Purpose: The purpose of this presentation is to describe the use of surgical shaping and tissue movement as the most cost effective and efficient means of treating chronic wounds: post op wounds, traumatic wounds, and wounds resulting from extended and complicated hospitalization.

Methods: The application of General Surgery skills including flap creation and tissue movement to a variety of chronic wounds situations is described. Visual demonstration will include case studies and results. Included will be a discussion of other treatment modalities with comparison of cost and effectiveness.

Results: Trapping, tunneling, bacterial pockets, failure of maturation and contraction which perpetuate wound chronicity and non healing are eliminated by surgical architectural redesign.

Conclusion: By using this technique the surgeon addresses immediate concerns of life or limb threatening bacterial infection as well as future closure leading to more rapid wound healing and cost savings associated with less treatment time.

Salvage Through Advanced Wound Treatment - The Prevention Of Amputation

Author: Frank P. Bongiorno, M.D., Wound Specialists of Michigan, Ann Arbor & Grand Rapids, Michigan, United States

Purpose: To describe alternatives to amputation when all vascular reconstruction attempts are exhausted or inappropriate in the clinical situation for the care and treatment of an advanced lower extremity wound.

Method: The techniques and treatment of advanced wound care are presented describing maintenance and ultimately the possible healing of the wounds. Cost of care and quality of life issues for patients with amputation are critical in the current medical milieu.

Results: In the great majority of cases salvage is accomplished with the cooperation of medical staff, nursing staff and family. The goal is progression to healing.

Conclusions: Using the principles of progression to healing, eliminating the factors contributing to the demise of the limb, and most importantly the patience of long term goals amputation can be and is avoided in the great majority of clinically advanced limb wounds.

Standard And Recommened Aproaches To Non Healing Wounds: What To Do, What Not To Do And Why

Author: Frank P. Bongiorno, M.D., Wound Specialists of Michigan, Ann Arbor & Grand Rapids, Michigan, United States

Purpose: The purpose of this presentation is to present and discuss the ten basic principles of wound treatment and the ten most commonly practiced myths of wound healing from the surgical perspective.

Methods: The principles are elucidated explaining appropriate useage. Ten commonly practiced myths will be discussed including how to avoid these practices and the results of these practices.

Results: The surgeon will gain new knowledge that combined with his surgical skills will increase his proficiency and success in healing chronic wounds and post operative complicated wounds.

Conclusion: Following the ten principles of wound treatment allows one to provide appropriate and approved therapy that leads to wound healing. Following the ten commonly practiced myths can lead to complications resulting in sepsis, amputation and death.

The Use Of Apligraft As A Means Of Closing The Chronic Wound

Author: Frank P. Bongiorno, M.D., Wound Specialists of Michigan, Ann Arbor & Grand Rapids, Michigan, United States

Purpose: To present the use and application of apligraft as a wound healing adjunct in those wounds that are trapped in one of the three phases of the healing process despite treatment utilizing the standards of advanced wound care.

Methods: Apligraft, a bylayed living skin construct is described and its application to the clinical situation presented. The wound bed preparation and precursor treatments (silver and promogran) are demonstrated.

Results: In venous and diabetic lower extremity wounds the healing time is markedly shortened and closure is rendered possible for those wounds that have failed with standard wound management.

Conclusions: Apligraft is now part of the armamentarium of the surgical wound specialist and is becoming a necessary component of advanced wound treatment.

Genetic Variations in Response to Aspirin

Ferraris VA, Ferraris SP, Fisher RG, Chambers ER, Weber NK, Settles JD, Camp PC. From the Division of Cardiovascular and Thoracic Surgery & the Linda & Jack Gill Heart Institute, University of Kentucky, Lexington, KY

Background: Patient response to aspirin (ASA) varies. Irreversible inhibition of platelet cyclo-oxygenase (COX) is thought to be the main enzyme

system altered by ASA. Because there are significant variations in response to ASA, we hypothesize that ASA alters gene expression involving non-COX enzyme systems to varying degrees in certain individuals and that this alteration accounts for different clinical responses to ASA.

Methods: Three volunteers with normal response (CONT) and two with hyper-responsiveness (HYPER) to ASA were identified from a pool of volunteer blood donors. HYPER were identified by template bleeding times greater than 15 minutes on the day following administration of a single dose of ASA (325mg). Bleeding time ≤ 7 minutes after ASA identified CONT volunteers. RNA was extracted from peripheral blood and subjected to gene microarray analysis of the expressed sequence tags (m-RNA) of the entire human genome in both HYPER and CONT before and after ASA. Genes with known function that were different between CONT and HYPER before ASA were subjected to real-time polymerase chain reaction (PCR) to verify differences between the two groups.

Results: 15 genes were significantly different between CONT and HYPER before ASA. There were 38 genes newly expressed in HYPER and 26 genes in CONT after ASA. m-RNA expression disappeared after ASA in 43 genes in HYPER and 5 genes in CONT. ASA induced significant differences in 73 genes in CONT and 84 genes in HYPER. Of the 15 genes that were significantly different between pre-ASA HYPER and CONT, only 8 were verified by real-time PCR (table).

Individual Variation in Pre-ASA Gene Expression

Gene Description	Function	HYPER v. CONT
P4HB - Protein disulfide isomerase-associated gene 1	Interactions with nitric oxide, especially transport of intracellular NO to the membrane surface	Decrease
ITGB3 – Integrin beta3, glycoprotein IIIA, CD61	Codes for protein that is part of the gpIIb/IIIa complex	Increase
ABCA7 – ATP binding membrane transporter	Preferentially expressed in platelets – involved in lipid transport.	Decrease
ATP8A1 – P-type ATP	Transports amphipaths across membranes	Increase
DSCR3 – gene on chromosome 21 near Down's syndrome gene	Responsible for many of the characteristics of Down's syndrome	Increase
HADH2 – hydroxyacyl – Coenzyme A dehydrogenase II.	Elevated in brain tissue from Alzheimer's	Decrease
APBB1 – Alzheimer's disease gene	May be responsible for the syndrome of Alzheimer's disease	Increase
CD44 – antigen	Involved in cellular integrity, e.g. fibroblast migration	Increase

Conclusions: There are significant differences in gene expression after administration of ASA. These differences are not uniform among volunteers with normal response to ASA compared to those with accentuated response to ASA. Using microarray to examine gene expression differences in small samples requires confirmation by an independent method (real-time PCR). Multiple common cellular pathways appear to be involved in ASA-induced gene expression. Genes other than COX are likely to participate in patient response to ASA and genetic profiling with microarray analysis may allow prediction of drug response.

Aspirin users have a slight, but significant, increase in blood product usage after CABG (0.5 units of non-autologous blood per patient). Other anti-platelet drugs are more potent with varying half-lives, and available evidence suggests significantly increased bleeding if these drugs are taken close to the time of cardiac operation, especially if taken along with aspirin.

Variability in response to aspirin and other anti-platelet drugs is common. Between 5 and 10% of ASA users have an increased anti-platelet effect from a single dose of aspirin (hyper-responders) while a similar number have a sub-therapeutic response to the same low doses of aspirin (aspirin resistance). There is a similar variability in response to thienopyridines, and likely to other anti-thrombotic agents.

Consensus recommendations of available blood conservation techniques for high-risk patients include: 1) drugs that increase preoperative blood volume (e.g. erythropoietin) or decrease postoperative bleeding (e.g. aprotinin), 2) interventions that conserve blood (e.g. intra-operative blood salvage or off-pump procedures), 3) other interventions that protect the patient's own blood from the stress of operation (e.g. autologous predonation or blood sequestration), or more likely 4) combinations of all of the above.

Evidence-Based Practice – Guidelines not Laws

Ferraris VA, Ferraris SP, Saha SP. From the Division of Cardiovascular and Thoracic Surgery & the Linda & Jack Gill Heart Institute, University of Kentucky, Lexington, KY

Background: Practice guidelines offer a means of decreasing practice variation, improving patient outcomes, and protecting surgeons in medicolegal matters. For example, guidelines are available for the use of anti-platelet drugs during cardiac operations. Increased bleeding and blood transfusion may result from the effect of these drugs. Guidelines are available to help manage anti-platelet drug use during cardiac procedures. An understanding of the process of guideline development helps practicing cardiothoracic surgeons.

Methods: Available evidence regarding risk factors for increased postoperative bleeding and interventions aimed at manageing postoperative blood transfusion was reviewed. Analysis of the possible mechanisms of increased bleeding and treatment options to limit bleeding are included in this review. Consensus opinion and summation of available evidence resulted in recommendations for identification of high risk patients and the limitation of blood transfusion in these patients.

Results: A minority of patients having cardiac procedures (15-20%) consume more than 80% of the blood products transfused at operation. Available evidence suggests that there are high-risk patients who can be identified from preoperative characteristics. Preoperative variables associated with excessive peri-operative blood loss include advanced age, low preoperative red blood cell volume (small body size or low preoperative hematocrit), anti-thrombotic drugs taken just before operation, prolonged cardiopulmonary bypass time, urgency of operation, and

other non-cardiac co-morbidities. non-CABG or redo operation and. Blood conservation interventions are likely to be most productive in this high-risk subset.

Aspirin users have a slight, but significant, increase in blood product usage after CABG (0.5 units of non-autologous blood per patient). Other anti-platelet drugs are more potent with varying half-lives, and available evidence suggests significantly increased bleeding if these drugs are taken close to the time of cardiac operation, especially if taken along with aspirin.

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Consensus recommendations of available blood conservation techniques for high-risk patients include: 1) drugs that increase preoperative blood volume (e.g. erythropoietin) or decrease postoperative bleeding (e.g. aprotinin), 2) interventions that conserve blood (e.g. intra-operative blood salvage or off-pump procedures), 3) other interventions that protect the patient's own blood from the stress of operation (e.g. autologous predonation or blood sequestration), or more likely 4) combinations of all of the above.

Conclusions: Evidence-based guidelines can help guide therapy and reduce practice variation, but are associated with some uncertainty based on the normal Gaussian response to any drug or device therapy. The highest risk patients consume the most blood products and benefit the most from evidence-based interventions. Evidence-based options for patients at increased risk of bleeding include some or all of the following: 1) preoperative identification of high-risk patients, 2) preoperative cessation of anti-platelet drugs (especially ADP receptor blockers), if clinical circumstances permit, 3) selective peri-operative use of evidence-based blood conservation interventions (such as aprotinin, off-pump procedures, and use of intra-operative blood conservation techniques), and 4) use of transfusion algorithms and multimodality blood conservation interventions.

Conclusions: Evidence-based guidelines can help guide therapy and reduce practice variation, but are associated with some uncertainty based on the normal Gaussian response to any drug or device therapy. The highest risk patients consume the most blood products and benefit the most from evidence-based interventions. Evidence-based options for patients at increased risk of bleeding include some or all of the following: 1) preoperative identification of high-risk patients, 2) preoperative cessation of anti-platelet drugs (especially ADP receptor blockers), if clinical circumstances permit, 3) selective peri-operative use of evidence-based blood conservation interventions (such as aprotinin, off-pump procedures, and use of intra-operative blood conservation techniques), and 4) use of transfusion algorithms and multimodality blood conservation interventions.

Laparoscopic Treatment Of Achalasia. The Texas Endosurgery Institute Experience.

Author: Morris E Franklin JR, MD FACS
Co-authors: Guillermo Portillo MD, Jefrey L glass MD FACS, John J Gonzalez JR MD, Texas Endosurgery Institute

Introduction
The cause of achalasia is unknown. Theories on causation invoke infection, heredity or an abnormality of the immune system that causes the body itself to damage the esophagus (autoimmune disease).

Treatments for achalasia include oral medications, dilation or stretching of the lower esophageal sphincter (dilation), and the injection of botulinum toxin (Botox) into the sphincter. All this forms of treatment have high recurrence rates. The most effective treatment for achalasia is surgery, We describe our experience with the esophagomyotomy by laparoscopic means, with a follow up of 11 years

This prospective study analize the long term result of laparoscopic esophagomyotomy in the Texas Endosurgery Institute.
Methods
Thirty five patients were found to have achalasia, they were prospectively follow, 18 females and 17 males. The surgery indications were, failure to medical treatment (n=15), failure to pneumatic dilatation (n=13), failure to botulinum toxin (n=13).

Results
In 100% of the patients esophagomyotomy of Heller modified was completed, Dor funduplication was performed in 34 and Nissen funduplication in 1 patient.

There were no conversions to open surgery.

With a mean follow up of 6 years (6 months -12 years), five patients developed dysphagia, two of them required pneumatic dilatations but there has been no recurrences to date.

Conclusions
The treatment of achalsia continues to be a surgical challenge. Laparoscopic esophagomyotomy is safe and effective, and should be considered the treatment of choice.

Key words: achalasia, laparoscopic, esophagomyotomy, funduplication

Scientific Abstracts

The Use Of Small Porcine Bowel Submucosa Mesh, In The Treatment Of Gastroesophagic Reflux. Long Term Results At The Texas Endosurgery Institute

Author: Morris E Franklin JR, MD FACS
Co-authors: Guillermo Portillo MD, Jefrey L glass MD FACS, John J Gonzalez JR MD, Texas Endosurgery Institute

Introduction
Gastroesophagic reflux disease is present worldwide, it has a ratio of 360 in 100,000 persons, being the most common esophagic disease, accounting for 75% of cases
One of the most common complications after antireflux surgery is the migration of the fundoplication into the mediastinum , leading to recurrent GERD symptoms. To prevent postoperative intrahoracic wrap herniation, some authors have advocated the closure of the hiatus and the use of prosthetic materials. There is debate over what material should be used.

Objectives
Prospective follow up of 6 year experience in laparoscopic treatment of recurrence-prone hiatal hernia with the use of small porcine bowel submucosa (SIS Cook Biotech Incorporated, West Lafayette, IN, USA) at the Texas endosurgery Institute.

Methods
All patients submitted to laparoscopic hiatal hernia repair procedures in our institution from January 2000 to December 2006 were included in the study.

The indications for the use of prosthetic material were: Recurrent hiatal hernia, crus defect > 5 cm, obesity, Chronic obstructive pulmonary disease, despaired healing (n=5, lupus diagnosis, 80 years or older), or incarcerated hiatal hernia.

Results
In 46 patients laparoscopic Nissen fundoplication and hiatal hernia repair using a bioabsorbable prosthetic mesh was completed. Twenty six females and 21 males, with a mean age of 59 years (range 32-91 years)
Ten patients had a hiatal hernia smaller than 5 cm (52%), 15 patients had a hiatal hernia larger than 5 cm (48%). 10 of the patients had a recurrent hiatal hernia (30%). 1 patient had an incarcerated hiatal hernia (2%).
All cases were completed laparoscopically with just one conversion (2%) due to severe adhesions present at the hiatal hernia, this patient had prior antireflux surgery.

The mean operating time was 175 minutes with a range of 75-400 minutes. 17 patients (34%) had severe adhesions present at the hiatal hernia.

Key words: laparoscopic, surgisis, hiatal hernia

Follow-Up of Local Control of Vestibular Schwannomas Utilizing Fractionated LINAC Stereotactic Radiosurgery

Authors: Isaac Goodrich, MD; Robert Sinha, MD; Jonathan Haas, MD; Francis Cardinale, MD; Justin-Barry Jerome, MD; Vanna Dest, APRN

Purpose/Objective:
Vestibular schwannomas are the most common primary cerebellopontine angle tumor occurring in the United States. Between 2500 and 3000 new cases are diagnosed each year. A variety of therapies have been utilized in the past for this tumor, including observation, surgery (suboccipital craniectomy, translabyrinthine, middle fossa, combined approaches), and stereotactic radiosurgery/radiotherapy (appropriate for lesions 2.5 centimeters or less in diameter).

In 2004, we reported on our initial experience of results with fractionated LINAC stereotactic radiotherapy for vestibular schwannomas at the American Society of Therapeutic Radiology and Oncology (ASTRO). The purpose of this paper is to provide a follow-up of previously reported cases, as well as additional cases compiled since then.

Materials/Methods:
Retrospective review of all patients who underwent fractionated stereotactic radiotherapy for vestibular schwannomas at the Hospital of Saint Raphael (Saint Raphael Healthcare System) in New Haven, Connecticut between 1998 and 2006 was accomplished. A total of 60 patients were identified. Patient age ranged from 26 to 81 (median 55). 41 (68%) patients had useful hearing prior to treatment. Therapy was accomplished with a Varian® 600C linear accelerator with an attached BrainLab® micro-multileaf collimator. The total dose of radiation varied from 46.8 Gy to 54 Gy (median 50.4 Gy). Daily fractions of 1.8 Gy prescribed to the 90th percentile isodose line were utilized. Static beams were utilized for all patients with 7 to 16 (median 16) per treatment plan. Target volumes ranged from 0.17 cc to 21.34 cc (median 3.75 cc). In all cases, the percent isodose volume/target volume ranged from 1.49 to 2.76 (median 1.55).

Weekly follow-up occurred during radiotherapy and at 3-6 month intervals thereafter. Treatment failure was defined as an increase in 2mm or more in size in any one direction noted on follow-up MRI scans. Acute side effects were defined as any ill effect that occurred during radiotherapy or within 90 days of its completion. Long term side effects have been defined as any adverse effect lasting or occurring greater than 90 days after completion of radiotherapy.

Results:
The median follow-up was 37 months (range 4.7 to 76.4 months). Local control was achieved in 58 of 60 patients (96.7%). Twenty (33.3%) patients had a decrease in size of their tumor and 18 (30%) patients exhibited evidence of central tumor necrosis on follow-up MRI scans. Thirty-five (85%) patients retained useful hearing. Sixteen (26.7%) patients with tinnitus prior to treatment re-

ported resolution after therapy completed. Eight (5/60) percent of patients reported transient worsening of tinnitus and 15% (9/60) reported no change in tinnitus. Nineteen (32%) patients reported improved tinnitus with radiotherapy.

Short term or acute side effects were relatively frequent but self limiting and included: fatigue (55%), increased tinnitus (30%), headache (22%), transient disequilibrium (18%), transient facial hypesthesia (10%), otalgia (7%), and transient taste alterations (3%). Long term side effects are infrequent in this population. However, two (3%) patients developed cranial nerve V and VII dysfunction. Ten percent of patients have noted decreased to loss of previous useful hearing.

Conclusions:
Fractionated LINAC stereotactic radiotherapy utilizing a micro-multileaf collimator is a useful treatment option for patients with appropriately sized (< 2.5 cm in diameter) vestibular schwannomas that is very well tolerated. Over a median period of 37 months, useful hearing can be preserved in the vast majority of patients with functional hearing. Local control rates with other cranial nerve preservation thus far are excellent. Still further follow-up will be required to ascertain the durability of these results.

Treatment Of Obstructive Benign Prostatic H;Yperplasia (Bph) With 120w Ktp-532nm High Power System (Hps) Ktp Greenlight Laser For Photoselective Vaporization Of The Prostate (Pvp)

Author: Mahmood A. Hai, M.D., F.I.C.S., Affiliates in Urology, Cherry Hill Medical Center, Westland, Michigan, United States

Purpose: To show that although lasers in medicine have undergone an evolution from theory to clinical use, this practical application in urology has demonstrated increased popularity in the treatment of BPH. Previous studies have established the long term outcomes of KTP GreenLight laser (1,2) This study confirms the high efficacy and low morbidity of this treatment modality.

Methods: Our study is based on 64 patients with obstructive BPH treated with the HPS 120 watt GreenLight Laser on an outpatient basis as a minimally invasive treatment. All procedures were performed under local anesthesia and intravenous sedation.

AUA Symptom Index Score	25.5
Maximum Flow Rate (Qmax)	8.7 ml/second
Post void residual volume	188.3 ml.
Prostate volume (TRUS measurement)	89.2 cc.
Lasing Time	34.6 minutes
Laser Energy used	181 kilojoules

Results: All patients were done as outpatients in a well equipped and staffed office setting. There were no operative morbidities or complications. The mean baseline values were:

Conclusions: High Power System (HPS) GreenLight PVP is proving to be the new gold standard in the treatment of obstructive BPH because of its high efficacy, low morbidity and complications and the ability to be done as an outpatient office procedure.

The Complicated Post-Op Wound – The Role Of Topical Treatments For Debridment And Antimicrobial Therapy

Author: Lillian V. Henry, MSN, APRN, BC, CVN, Wound Specialists of Michigan, Ann Arbor & Grand Rapids, Michigan, United States

Purpose: The purpose of this presentation is to describe the composition, action and appropriate use of debriding agents and numerous types of antimicrobial treatment that can be and should be used at the local wound site.

Methods: The debriding agents and antimicrobial treatments will be identified and categorized by composition and action with slide illustrations of the appropriate therapeutic use for each category.

Results: The practitioner will be able to incorporate these therapeutic agents into their practice.

Conclusion: By using these agents the practitioner will attain much more rapid and successful wound healing in the most difficult post op and other chronic wounds encountered.

The Role And Practical Use Of Compression In Wound Healing

Author: Lillian V. Henry, MSN, APRN, BC, CVN, Wound Specialists of Michigan, Ann Arbor & Grand Rapids, Michigan, United States

Purpose: The purpose of this presentation is discuss the need for and understanding of the use of compression therapy in complicated post op cases and other types of wounds.

Methods: Discussion, slide illustration and demonstration will be used to convey knowledge of disease conditions requiring compression for optimum wound healing in post operative and chronic wounds. Types of compression, their use, correct compression application, and adjunctive topical agents are presented.

Results: The practitioner will be able to incorporate the use of compression therapy into his surgical practice in treating difficult post operative and chronic wounds.

Conclusion: Compression therapy will be used when necessary to attain optimal wound healing in disease processes where edema and chronic venous hypertension are major inhibiting factors.

Scientific Abstracts

Open Wedge High Tibial Osteotomy (OWHTO): Review Literature, and Clinical Cases

Alfonso E. Pino, MD, FICS, DeLeon, Texas

Congenital Genu Varo or acquired after meniscectomy is seen frequently by orthopedist. When the patient is in his fifth decade Total Knee Replacement (TKR) is very effective for pain relieve and improve standing and gait , but when you are in the middle thirties or early forties patients with a unilateral painful knee you can be a candidate for a OWHTO because after a TKR a revision will be needed soon due to high demands applied to the implant at this age. We review here the history of this procedure, indications, contraindications, complications, the procedure done in a 38 years old men and the results obtained in a limited number of cases. It Is important to the Orthopedic Surgeon to have this procedures in the list of operations available as another option.

Economic Challenges of a Surgical Practice

Sibu P. Saha, MD, MBA, Professor of Surgery, University of KY, Alley-Sheridan Fellow, John F. Kennedy School of Government, Harvard University

We are practicing in a market driven healthcare system. Surgical Practice is burdened with reduced reimbursement, managed care, increasing cost for liability insurance and office overhead.

The objective of this presentation is to enhance understanding of the following economic issues facing surgical practice.

- Practice Management
- Medical Malpractice
- Contracts
- Pay – for - Performance

The Use Of Endografts For Thoracic Aortic And Carotid Trauma

Ehab Sorial M.D., Sibu Saha M.D., Eric Endean M.D., David Minion M.D., Donald Patterson M.D., Matthew langenberg M.D., University of Kentucky Medical Center, Department of Cardiovascular Surgery

Purpose: Traumatic thoracic aortic transections and carotid injuries are two serious vascular injuries in trauma patients. Open repairs of traumatic aortic injuries are associated with high morbidity and mortality. Endografts provide a minimally invasive option to control injuries in vascular trauma with lesser morbidity and mortality. The purpose of this paper is to provide our experience with seven cases, five of aortic and two of carotid injuries.

Methods: Retrospective review at our institution identified five patients who underwent Endografts placement to treat traumatic aortic transections. Two other patients with Carotid injuries were treated using an Endograft in one and open repair in the other. Total number of patients treated with Endografts is six and one patient was treated using an open technique. Outcomes evaluated including postoperative complications of stroke and paraplegia.

Results: All patients were followed in the postoperative period and they had no long term vascular complications from their vascular intervention. No postoperative complications of paraplegia or stroke were encountered in all patients. One patient who was treated with an Aortic Endograft was taken back later for placement of a proximal stent due to bird's peaking of the proximal graft. The only patient who underwent open carotid repair was included in our paper to demonstrate the necessity of having a good judgment as to when to choose open versus endovascular management.

Conclusions: The use of Endografts in the management of vascular trauma of the Thoracic Aorta and the Carotid is a feasible option with low morbidity and mortality

A Ten Year Study Of Simultaneous Kidney-Pancreas Transplantation Using Portal Enteric Drainage And Venting Jejunostomy: Outcomes And Complications

AUTHOR: Siddhartha Rath MD
CO-AUTHORS: Atta Nawabi MD, Neville R. Dossabhoy MD, Kevin N. Boykin, MD, Frank Moore, Kenneth D. Abreo MD, Gazi B. Zibari, MD, Departments of Surgery and Nephrology, Louisiana State University Health Sciences Center-Shreveport

Purpose: Our purpose was to evaluate the long-term outcomes associated with a novel approach to simultaneous kidney-pancreas (SKP) transplantation, combining portal enteric drainage (PED) with a temporary venting jejunostomy (VJ).

Methods: All SKP transplants with PED and VJ performed at our institution from 1996-2005 were evaluated (n = 56). We ascertained recipient and donor characteristics, acute rejections, medical and surgical complications, and both short and long-term allograft survival (using Kaplan-Meier survival analysis).

Results: The mean follow-up period was 36 months. The mean age at transplantation of recipient and of donor was 44 and 23 years respectively; average HLA match was 2. The mean cold ischemia time for renal and pancreatic transplants was 12 and 13 hours respectively. Eighteen episodes of acute pancreatic rejection occurred in 16 patients, and 39 episodes of acute tubular necrosis. The following surgical complications were noted: pancreatic artery thrombosis (1), anastomotic leak (1), anastomotic bleed (3), cholecystitis (3), ventral hernia (6), and lymphocele (4). Once allograft function was stable, the VJ was taken down (mean-11 month post-transplant. Pancreatic survival rates at 1, 3, 5, and 7 years were 93%, 81%, 81%, and 74% respectively. Corresponding renal survival rates were 95%, 79%, 75%, and 58% respectively and patient survival rates were 96%, 93%, 87%, and 87% respectively.

Conclusion: Simultaneous kidney-pancreas transplantation combining portal enteric drainage with a temporary venting jejunostomy is a safe technique with minimal complications and long-term allograft and patient survival rates are comparable to, or exceed, those using the more traditional techniques.

Fdg-Pet In The Staging And Surveillance For Patients With Cholangiocarcinoma

Siddhartha Rath, MD; Kerry Byrnes, MD; Markus John, MD; David Lilian, Ph.D; Lester W. Johnson, MD;
Richard H. Turnage, MD; Gazi B Zibari, MD, Departments of Surgery and Physiology—Louisiana State University State University Health Sciences Center, Shreveport

PURPOSE: FDG-PET is a valuable tool in both staging and surveillance of multiple malignancies. Cholangiocarcinoma is rare and frequently presents late. Computed tomography has become the gold standard in staging cholangiocarcinoma, however has weaknesses. The purpose of this study is to assess the value of conventional FDG-PET in both the staging and surveillance of patients with cholangiocarcinoma.

METHODS: All patients with a diagnosis of cholangiocarcinoma from 1999-2004 were identified and reviewed retrospectively. Patients who underwent PET scanning as part of their staging preoperative workup and surveillance were selected. Concomitant computed tomography scans were reviewed when available. Pathology reports and operative findings were reviewed in detail. The sensitivity of both PET imaging and computed tomography was determined.

RESULTS: Thirteen patients with cholangiocarcinoma who underwent FDG-PET scanning were identified. A total of 19 PET scans were obtained of which eight were performed as pre-operative staging; the remaining eleven underwent PET for surveillance. All patients who had pre-operative PET scans underwent surgery, (7 laparotomies, 1 laparoscopy), and in all cholangiocarcinoma was confirmed by histology. The sensitivity of PET in detecting primary disease was 100%. In two patients distant disease existed and PET scan accurately identified one of these. Eleven surveillance (post-operative) PET and CT scans were performed in seven patients. The sensitivity of PET in detecting recurrence was 100%. In comparison, computed tomography detected recurrence with a sensitivity of 33%.

CONCLUSIONS: PET scan is a valuable tool for pre-operative staging of cholangiocarcinoma and compares favorably to conventional computed tomography as a surveillance tool.

Anti-Thymocyte Globulin (Atg) Attenuated Hepatic Ischemia-Reperfusion (Ir) Injury In Mice

AUTHOR: Siddhartha Rath MD

CO-AUTHORS: Kerry Byrnes MD, Xinje Mu MD, Kevin N. Boykin MD, Gazi B. Zibari MD, Department of Surgery, Louisiana State University Health Sciences Center-Shreveport

PURPOSE:
Hepatic ischemia-reperfusion (IR) injury is characterized by both a local and systemic inflammatory process. We have previously shown that: a) reperfusion of ischemic hepatic tissue causes neutrophil adhesion and tissue injury; b) modulation of neutrophil adhesion attenuates hepatocyte injury. Potential abrogation of hepatic I/R injury may prevent primary non-function of transplanted organs, increasing long-term graft survival by limiting the initial pro-inflammatory phenotype. We hypothesized that immunomodulation with anti-thymocyte globulin (ATG) would prevent reperfusion-induced liver injury by abolishing neutrophil-mediated tissue injury.

METHODS:
Male C57BL6/J mice were used for all experiments and divided into the following groups (n=8): sham, IR, sham + ATG(20mg/kg), and IR +ATG(20mg/kg). IR groups underwent clamping of the vascular pedicle to the left lateral hepatic lobe for 45 minutes and reperfusion for one hour. In the groups receiving ATG, this was administered at the time of reperfusion. Following reperfusion, rhodamine was administered intravenously and leukocyte dynamics were directly visualized using intra-vital microscopy. In separate experiments, following reperfusion, tissue was sent for histology and serum was sent for hepatocellular enzyme assay.

RESULTS:
Following IR, we observed a significant decrease in all measured parameters (rolling, saltation, and aggregation) in the ATG group. Additionally, there was a significant attenuation of hepatocellular injury (decreased AST/ALT) in the ATG group. Histological comparison between sham and ATG groups approached, however, did not reach significance.

CONCLUSION:
From these data we conclude that ATG at a physiologic dose attenuates hepatic IR injury by contributing to inhibition of leukocyte activation and/or adhesion in the hepatic microcirculation.

Universal Protocol To Avoid Surgical Errors: Where Do We Stand Today?

Wickii T. Vigneswaran, MD, FACS, FICS, Professor of Surgery, University of Chicago, Chicago, IL
Associate Chief of Cardiac and Thoracic Surgery and Director of Lung and Heart-lung Transplantation

The Universal Protocol was implemented in July 2004 following endorsement by the leading surgical societies, nursing associations and healthcare leadership in hospitals around the country by the Joint Commission on Accreditation of Healthcare Organizations. The purpose of the implementation is to reduce and ultimately eliminate the Wrong Site, Wrong Procedure and Wrong Person Surgery. The presentation will examine the experience and current status as well as the barriers to consistent compliance with the set forth Protocol and explore other potential strategies to eliminate surgical errors from our practices.

General Meeting Information

The official language of this conference is English, and all sessions and events shall be conducted in English.

Meeting-related fees must be paid in US funds, drawn on a US bank, made payable to the ICS-US. Company or cashier checks or Visa, Master Card, and American Express credit cards are acceptable forms of payment.

All prices and currencies listed in this brochure are in US Dollars unless otherwise noted.

Continuing Medical Education (CME) Information

CME Program Evaluation Forms will be distributed prior to the commencement of each day's educational session.

To receive CME Credit, you must complete a Program Evaluation Form for each day of educational sessions you attend.

Program Evaluation Forms must be completed and returned to the Meeting Registration Desk prior to the conclusion of the conference. You may also mail your forms to:

ICS-US Headquarters
Department of CME
1516 North Lake Shore Drive
Chicago, IL 60610-1694

The deadline for submission of all CME Program Evaluation forms is Monday, July 9, 2007.

Meeting Registration

Everyone attending or participating in educational sessions, including faculty, is expected to register for the meeting.

Pre-registered attendees will be given their conference materials at the start of the Sunday June 10 CME Session in Bar Harbor. If you don't receive your materials at that time you may see ICS-US Staff at the registration desk outside the Half Moon room each morning before the start of the CME session.

Meeting-related fees must be paid in US funds, drawn on a US bank, and made payable to the ICS-US. Company or cashier checks or Visa, Master Card, and American Express credit cards are acceptable forms of payment.

Cancellation Policy

The cancellation deadline was May 9, 2007. Refunds will be issued, minus a $50 processing fee, upon receipt of written notification via fax or mail. Cancellations after May 9 will not be honored. Please allow four to six weeks after the meeting for your refund.

Special Needs and Questions

If you have any special needs that must be addressed to ensure your comfort, please see the staff at the ICS-US Registration Desk.

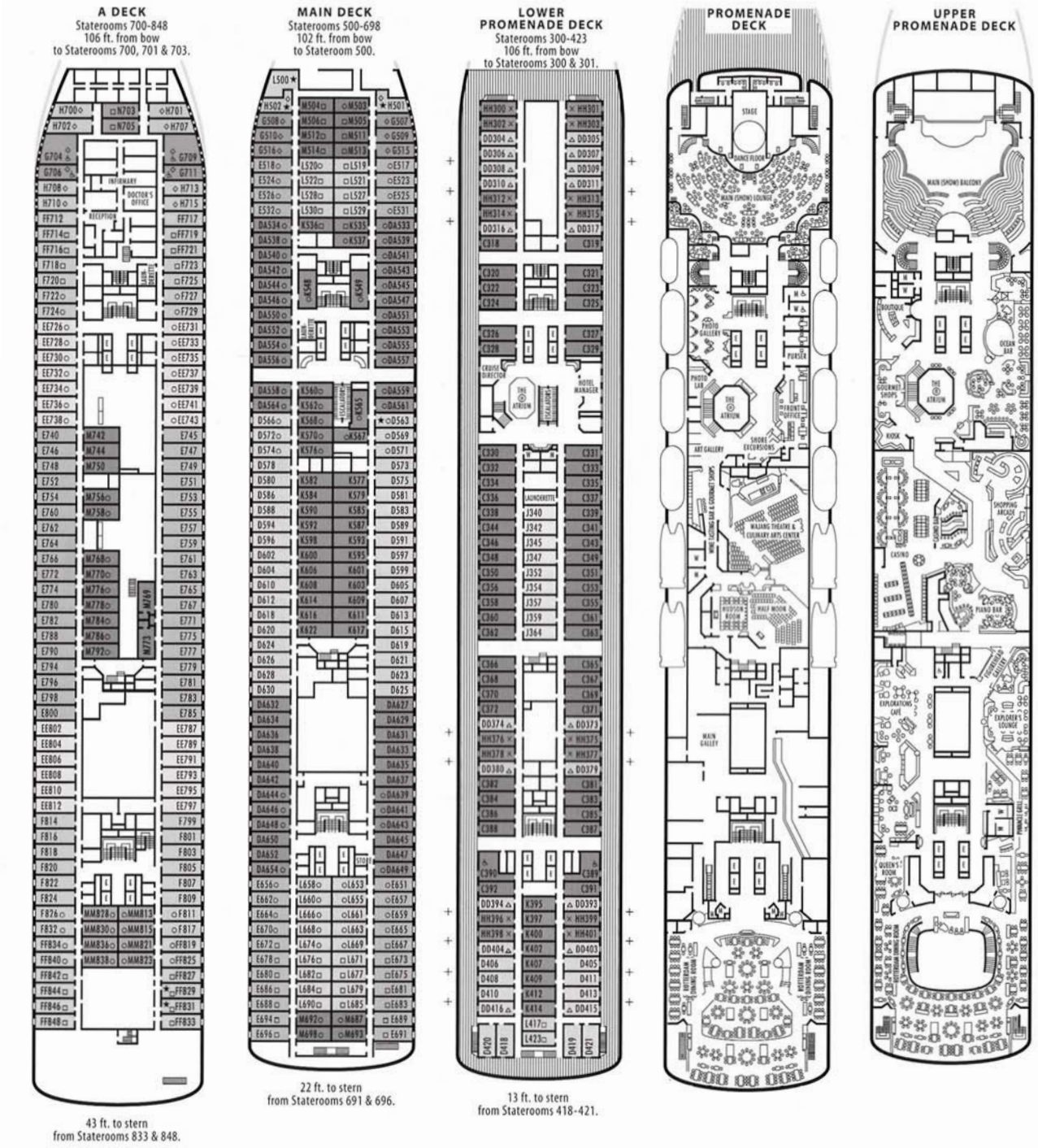
Attire

Business casual attire is recommended in educational sessions. We suggest casual clothes that can be layered easily and possibly an umbrella or lightweight windbreaker. Remember any Holland America excursions you book will proceed regardless of weather. Bring a swimsuit; the ship has both a pool and a whirlpool. Casual attire is appropriate for most social events. Evening attire is required for two evenings, during which women usually wear cocktail dresses and men business suits or tuxedos.

Weather

While in Bar Harbor, you should anticipate highs in the low 70s F. Canadian port temperatures will range between the high 60s to the low 70s F. Plan on light layers when packing.

MS MAASDAM



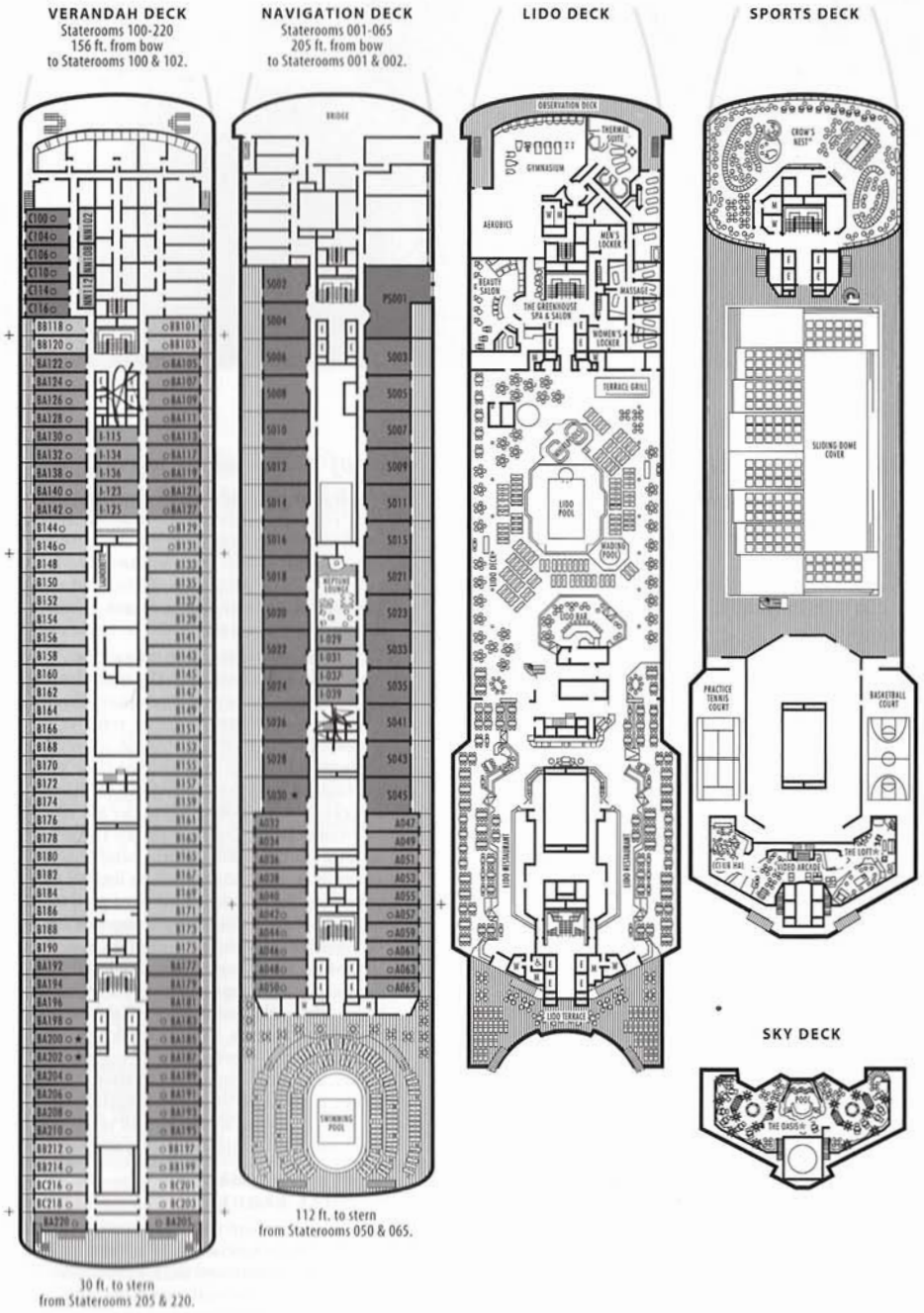
SHIP SPECIFICATIONS & FACILITIES

- 1,258 Guests
- 55,451 Gross Tons
- 720 Feet Long
- Automatic Stabilizers
- 10 Guest Decks
- 8 Guest Elevators
- 15 Public Rooms
- 3 Restaurants
- 2 Outdoor Swimming Pools (one with sliding glass roof)
- Spa & Salon
- Movie Theatre
- Duty-free Shops
- Library
- Casino
- Internet Center
- Practice Tennis Court
- Basketball Court

STATEROOM SYMBOL LEGEND

- ✻ Shower only
- ○ Triple (2 lower beds, 1 sofa bed)
- □ Quad (2 lower beds, 1 sofa bed, 1 upper)
- △ Partial sea view
- X Fully obstructed view
- \+ Connecting rooms
- ◇ These staterooms have portholes instead of windows
- ★ Staterooms H501, H502, L500, D563, FF829, FF831, BA200, BA202, S030 are modified accessible, shower only with small step, step into bathroom, standard interior and exterior door size.
- ♿ Staterooms C389, C390, G704, G706, G709 & G711 are wheelchair accessible, roll-in shower only, wheelchair-accessible doorways.

Deck Plan



ms Maasdam
ms Veendam

DECK PLANS & STATEROOMS

The deck plans are color-coded by category of stateroom, and the category letter precedes the stateroom number in each room. All staterooms are equipped with DVD player, flat-panel television, telephone and multi-channel music.

Important Note: Not all staterooms within each category have the same furniture configuration and/or facilities. Appropriate symbols within the rooms on the deck plans describe differences from the stateroom descriptions below.

VERANDAH SUITES

PS

Penthouse Verandah Suite: Bedroom with 1 king-size bed, oversize whirlpool bath & shower, living room, dining room, dressing room, private verandah, pantry, 1 sofa bed for 2 persons, mini-bar, refrigerator, guest toilet, floor-to-ceiling windows.

S

Deluxe Verandah Suites: 2 lower beds convertible to 1 king-size bed, whirlpool bath & shower, large sitting area, dressing room, private verandah, 1 sofa bed for 2 persons, mini-bar, refrigerator, floor-to-ceiling windows.

A B BA BB BC

Verandah Suites: 2 lower beds convertible to 1 queen-size bed, whirlpool bath & shower, sitting area, private verandah, mini-bar, refrigerator, floor-to-ceiling windows.

OUTSIDE STATEROOMS

C D DA DD E EE F FF G H

Large: 2 lower beds convertible to 1 queen-size bed, bathtub & shower. All DD-category staterooms have partial sea views.

HH

Large: 2 lower beds convertible to 1 queen-size bed, bathtub & shower. All HH-category staterooms have fully obstructed views.

INSIDE STATEROOMS

I J K L M MM

Large: 2 lower beds convertible to 1 queen-size bed, shower.

N NN

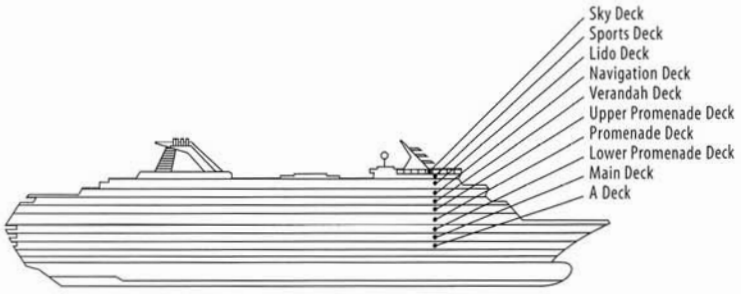
Standard: 2 lower beds convertible to 1 queen-size bed, shower.

PUBLIC ROOM NAMES

	MAIN (SHOW) LOUNGE	LIBRARY
ms Maasdam	Rembrandt Lounge	Leyden Library
ms Veendam	Rubens Lounge	Hugo De Groot Library

*The *ms Maasdam* has Club HAL area in lieu of The Oasis & The Loft.

*The *ms Veendam*'s Crow's Nest has a different configuration.



Schedule at a Glance

Saturday June 9, 2007

Opening Reception
Crow's Nest
5:00 pm-6:00 pm

Sunday June 10, 2007

Formal Opening Of Congress
Bar Harbor Club
McMurtry Ballroon
8:00 am-8:20 am

Technology...What's New in Surgery – Part I
Bar Harbor Club, McMurtry Ballroon
8:20 am-11:30 am

Monday June 11, 2007

Technology...What's New in Surgery – Part II
Half Moon, Promenade Deck
8:00 am-10:15 am

Alliance Tour: Halifax Horse-Drawn Trolley Tour
Gather in Hudson Room
to depart ship together
10:00 am-Noon

Business of Surgery
Half Moon
10:30 am-12:15 pm

Tuesday June 12, 2007

Trauma
Half Moon, Promenade Deck
8:00 am-10:30 am

Alliance Tour: Spirit of the Fiddle Sounds of Cape Breton
Gather in Hudson Room
to depart ship together
1:00 pm-2:30 pm

Wednesday June 13, 2007

Alliance Luncheon
Rotterdam Dining Room
1:00 pm-2:00 pm

CME Committee Meeting
Half Moon, Promenade Deck
2:00 pm-3:00 pm

Board of Regents & Membership Meetings
Half Moon, Promenade Deck
3:00 pm-4:00 pm

Executive Council & House of Delegates Meetings
Half Moon, Promenade Deck
4:00 pm-5:00 pm

Thursday June 14, 2007

Surgical Infection and Wound Healing
Half Moon, Promenade Deck
9:00 am-12:30 pm

ICS-A 39 Year Journey Luncheon
Rotterdam Dining Room
12:45 pm-2:00 pm

General Membership Meeting
Rotterdam Dining Room
2:00 pm-3:00 pm

Friday June 15, 2007

General Session & Symposium on Perioperative Care
Fairmont Chateau Le Frontenac
Petit Frontenac Room
9:00 am-11:45 am

Closing Luncheon
Fairmont Chateau Le Frontenac
Frontenac Room
Noon-1:30 pm

Registration Desk

ICS-US Staff will be available every morning outside the Half Moon Room on the Promenade Deck to assist you with any questions you may have regarding the meeting.