

# CONTROVERSIES IN SURGERY

PROGRAM



June 11-13, 2015

WESTIN HOTEL  
ANNAPOLIS, MARYLAND



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LARRY HOGAN  
GOVERNOR

STATE OF MARYLAND  
OFFICE OF THE GOVERNOR

June 11, 2015  
International College of Surgeons, United States Section  
77<sup>th</sup> Annual Surgical Update – Controversies in Surgery

**A Message From Governor Larry Hogan**

Dear Friends:

I would like to welcome everyone to the 77<sup>th</sup> Annual Surgical Update for the United States Section of the International College of Surgeons. I am proud to call our region home to so many exceptional medical facilities, including the Johns Hopkins School of Medicine – the first research university in the U.S. – and Johns Hopkins Hospital – the founding institution of modern American medicine. Maryland has a rich history in medicine and thank you for choosing it as the location for this year's convention.

Founded in 1935, the International College of Surgeons has played an important role in building relationships within the regional and international surgical community. For 80 years they have served as a forum for the sharing of surgical knowledge and expertise, and I hope that after participating in this weekend's discussions you will have learned more about your profession, and built stronger collegial relationships in the process.

Congratulations to President Uretz Oliphant and everyone else whose hard work and attendance has made this year's annual convention such a success. Best wishes for a memorable weekend and for continued progress in the years to come.

Sincerely,

A handwritten signature in black ink that reads "Larry Hogan".

Larry Hogan  
Governor, State of Maryland

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TTY USERS CALL VIA MD RELAY



Michael Pantelides, Mayor  
160 Duke of Gloucester Street  
Annapolis, MD 21401-2517

Dear Friends,

I am pleased to welcome you to Annapolis for the International College of Surgeons- United States Section, 77<sup>th</sup> Annual Surgical Update. As you gather to share your surgical knowledge and expertise with other prominent surgeons from across the nation, I encourage you to enjoy the surrounding beauty of Annapolis.

While you will be discussing cutting-edge surgical techniques, I hope you will also find some time during your visit to explore some other healthy options that have been known to be effective in relieving nervous tension and stress.

Just walk out of your hotel to West Street and continue to the top of historic Main Street, where boating shoes and wing tips share the same sidewalks that George Washington and Thomas Jefferson walked along. Enjoy the fresh air coming up from City Dock, as you continue down Main Street popping in and out of our unique shops, restaurants and pubs.

End up at Ego Alley where vessels from around the world anchor for the day as they come on shore to enjoy hearing a United States Naval Academy Band concert and watch the sailboats race back and forth in front of Susan Campbell Park. While sitting at the dock enjoying an old fashioned ice cream cone, your heart will be lighter and your burdens fewer, as a colonial guide dressed in period clothing passes by calling out “Me Lords and Me Ladies”.

While I’m not sure these options can be used in any discussions regarding surgical techniques, I highly recommend them to you as our esteemed visitors, and sincerely hope you find time to relax and enjoy your stay in Annapolis.



Sincerely,

Michael Pantelides  
Mayor



Dear Colleagues,

On behalf of all Fellows in the International College of Surgeons (ICS) in over 100 countries of the world, I welcome you to the 77th Annual Surgical Update of the United States Section. The theme "Controversies in Surgery" is very appropriate at this time. The Scientific Program is very well thought out and includes many well recognized and renowned international experts in their respective fields. Hence, it is indeed my privilege and honor to be a participant in this meeting. I congratulate United States Section President Dr. Uretz Oliphant, his organizing committee and all other Fellows of the United States Section for organizing this scientific meeting in such an excellent manner. This year, we will be celebrating our 80th anniversary

of success as a global general surgical society and much of this must be attributed to the collaboration and support from our important United States Section. It is only through such active support and participation that we will continue to thrive to achieve our goals with meaningful impact upon the international community.

The theme of my two year administration as World President of the International College of Surgeons is humanitarian surgery. While the world has known for a very long time that the need for humanitarian surgery is universal and urgent, in the past two years, worldwide opinion has come together in a more unified support of and keen interest in humanitarian surgery. The founder of the International College of Surgeons, Dr. Max Thorek, gave great emphasis to humanitarian surgery and made this a core philosophy of the College. In this reference, I am confident that the several discussions focusing on "Controversies in Surgery" will relate to humanitarian surgery. The practicing surgeon of today is challenged with balancing the needs of patients in often limited resource environments, with the overall goal to improve the health of his/her patients. Just as important, the challenge of globalization with one of the main current issues being caring for the underprivileged patient, needs to be clearly recognized and addressed.

As World President, my first meeting of the ICS International Executive Council in Kaohsiung, Taiwan, was focused on humanitarian surgery and what the International College of Surgeons will do to implement actions to address the needs on a global basis. My dedicated intent is to act, and not simply talk about the needs. In so doing, we must collaborate where appropriate, as we more often than not can achieve much more by working together with other persons and organizations. In this regard, the International College of Surgeons is, as you know, strongly affiliated with the World Health Organization (WHO) as a Non-Governmental Organization, and is hence in Official Relations with the WHO. Our intent is to increasingly collaborate so as to better fulfil the mission of the College, and aspire as a college to take on a leadership role in global humanitarian surgery. We look forward to sharing our action results with you over the forthcoming months, and am absolutely delighted that Dr. Oliphant has seen appropriate to continue discussions on this theme in this 77th Annual Surgical Update.

Annapolis, Maryland served as the seat of the Continental Congress (1783-84) and being the home of the United States Naval Academy is a well-chosen venue for 77th Annual Surgical Update of the United States Section meeting. The rich historical aspects of the city and the very appealing social program will be an ideal situation to renew friendships and strengthen surgical networking ties. It is my hope our ICS fellows will also introduce their younger colleagues into the fellowship and vision of the college at this meeting.

Our ICS college vision is: "To improve the lives of patients through the development and education of our members and the advancement of the medical field." I am confident that the 77th Annual Surgical Update will bring us at least one step closer to this vision. It is therefore my sincere hope that the attendees of the 77th Annual Surgical Update will embrace the challenges that we face today, including serving the underprivileged around the world. I look forward to being with all of you, to the opportunity to become acquainted with you, and to exchanging perspectives on Controversies in Surgery in relation to humanitarian surgery.

Sincerely,

A handwritten signature in black ink, which appears to read "Yik-Hong Ho". The signature is fluid and cursive.

Professor Yik-Hong Ho  
World President  
International College of Surgeons



Dear Colleagues;

On behalf of the International College of Surgeons - United States Section I would like to extend our warmest welcome to you as we gather here in Annapolis for our 77th Annual Surgical Update, **Controversies in Surgery**. We have an outstanding educational program planned, covering important and timely topics across the broadest spectrum of surgical science and medical professional development. For the first time, we have structured two debates which will invite several lively discussions. We are honored to have Professor Yik-Hong Ho current International College of Surgeons World President joining us and taking part in our session on **Global Surgery** along with other distinguished speakers to talk about one of our organization's core missions: Humanitarian Outreach. On Friday we will honor a true giant and pioneer in surgery Dr. John Cameron as our recipient of **The Dr. Andre Crotti Award for Distinguished Service to the Profession of Surgery** and **2015 Honorary Fellow**. We are also pleased that several major innovators in the world of surgery; Dr. Frank Lewis, Dr. Thomas Scalea, Dr. Michel Gagner and Dr. Girma Tefera the newly appointed American College of Surgeon's Director of Operation Giving Back have accepted our invitation to share their expertise with us. Continuing a more than 5 year tradition, the Arno Roscher Endowed Lecture will be presented on Saturday by Dr. Ara Tilikian and encompass the topic of **Takotsubo-Stress Cardiomyopathy**.

As usual we will be joined by our colleagues of the American Academy of Neurological and Orthopaedic Surgeons. Who also have an outstanding program planned. I strongly encourage everyone to attend the joint lecture to be given by. Dr. Sergio Canavero on his ground-breaking research into **HEAVEN-GEMINI: Head Transplantation-The Future Is Now**. This should be really interesting!

Again we will have the usual excellent abstracts and papers presented by our very talented members. Also back is the always popular ethics forum which will touch on a controversial topic of the day, **How Medical Care Is Being Corrupted** by Timothy Pawlik, MD, Johns Hopkins Hospital. I appreciate the continued efforts of ICS Fellow Frank Bongiorno, MD to once again craft a topical and thought-provoking session. Join us Thursday as we welcome our newest members and Research Scholarship Competition award winners during the **Honors Luncheon**.

I would be remiss if I did not take this opportunity to thank Dr. Jonathan Efron, Interim Director of the Department of Surgery, Johns Hopkins University and his faculty, as well as Dr. Adrian Park, Chairman of the Department of Surgery and Chair of the newly created Earl Simulation to Advance Innovation and Learning (SAIL) Center of Anne Arundel Health System (AAHS) in Annapolis for their major contribution to our program and hospitality in welcoming us to Annapolis.

Finally, I hope you will take the opportunity to explore with your family and colleagues the wonderful offerings of Annapolis our historic host city.

Welcome all! I know we will have a great meeting!

Sincerely,

Uretz J. Oliphant, MD  
United States Section President

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Boca Raton, FL

**Francis J. Podbielski, MD\*\***

Thoracic Surgery  
Riverside, IL

**Sivamainthan Vithiananthan, MD+**

General Surgery  
Providence, RI

**Sharmila Dissanaik, MD**

Trauma Surgery  
Lubbock, TX

**Vichin Puri, MD +**

Transplantation Surgery  
Memphis, TN

\* Executive Committee Member  
+CME Committee Member

**Course Sponsor**

International College of Surgeons - United States Section  
An ACCME Accredited Provider

**OVERALL COURSE OBJECTIVES**

The Annual Surgical Update is designed to offer information regarding the latest surgical advancements and technology to address gaps in knowledge that may exist for practicing surgeons in all surgical specialties, residents in training, and allied health professionals. The desired outcome of this program is increased knowledge, better competency in cutting edge treatment modalities, and enhanced treatment decision making. It is the expressed goal of the course to provide enough material that upon completion of the activity the participant can make educated decisions to incorporate the latest surgical techniques and technologies as well as discern when these procedures are warranted to provide optimum patient care.

Topics presented during the Annual Surgical Update have been designed to address and improve the attendees knowledge and skills in the following competencies: patient care or patient-centered care, medical knowledge, practice-based learning & improvement, quality improvement and professionalism.

**Disclosure Policy**

It is the policy of the International College of Surgeons-US Section that any individual who is involved in planning or presenting in a program designated for AMA Physician's Recognition Award Category 1 Credit™ must disclose all relevant financial relationships with a commercial interest prior to being included in the final program. This information is disclosed to the audience prior to the activity. The ICS-US has procedures in place to address a conflict of interest should one arise. Our complete Policy on Commercial Support and Independence is available on FICS Online or by request from Headquarters. Additionally, faculty members are asked to disclose when any discussion of unapproved use of a pharmaceutical or medical device occurs.

**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 live activity for a maximum of 24 AMA PRA Category 1 Credits. Physicians should claim only the credit commensurate with the extent of their participation in the activity.



## INTRODUCING

**MICHAEL J. JACOBS, MD**

### **PRESIDENT**

**UNITED STATES SECTION - INTERNATIONAL COLLEGE OF SURGEONS**

FOR THE

TERM COMMENCING JANUARY 1, 2016

Dr. Michael Jacobs entered the field of Surgery in 1996 at Providence Hospital in Southfield, Michigan and he completed his General Surgery Residency as the Administrative Chief Resident in 2001. He completed a Complex Surgical Oncology Traveling Fellowship in 2002 from Providence Hospital that enabled him to further develop his passion and skills for complex hepatobiliary and pancreas surgery. The traveling fellowship included rotations at the Mayo Clinic and St James' in Leeds, England where he learned from the masters of complex hepatobiliary and pancreas surgery.

Dr. Jacobs entered private practice in 2002 as a member of the Surgical Teaching Faculty at St. John Providence Hospital and rose to the rank of Clinical Associate Professor of Surgery with Wayne State University, Detroit and Clinical Professor of Surgery with American University of the Caribbean. He has developed and improved surgical techniques, particularly advanced laparoscopic procedures such as totally laparoscopic hepatectomy, laparoscopic pancreatectomy, and totally laparoscopic pancreaticoduodenectomy. He has lectured on surgery worldwide, participated in surgical missionary work, and has published extensively in the realms of basic science and clinical research. He currently serves as the Associate Chair of Surgery, Director of the Hepatobiliary and Pancreas Program, and has created and currently directs the HPB Surgery Fellowship Program at St John Providence Hospital. He was the youngest President of the Academy of Surgery of Detroit and the Detroit Surgical Association. His primary passion is to enhance the field of HPB Surgery and he strives for exceptional patient safety and outcomes.

Dr. Jacobs enjoys spending time with his wife Alissa and their two children, who are the absolute highlight of his life. He particularly enjoys traveling abroad with his family and exploring new sites. His goals are to enhance the well-being of the complex surgical patient through communication and innovative surgical strategies that can be disseminated through worldwide organizations, such as the International College of Surgeons.

**That these bodies should be lent to us as long as they can afford us pleasure, assist us in acquiring knowledge and doing good to our fellow man, is a kind act of a benevolent God.**

**In his time, a physician touches many lives. Those of us whose lives these physicians touched are left greatly saddened, for they are with us no longer.**

**Yet, in the scheme of the Almighty, they will be forever honored for their noble role on earth as healers of their fellow man.**



**PEDRO A. RUBIO, MD, PhD**

ICS World President, 1995  
US Section President, 1989

Professor Pedro A. Rubio, MD, PhD passed away in late March 2015 at the age of 70. Born and raised in Mexico City, Dr. Rubio was awarded the Doctor of Medicine and Surgery degree in 1968 from the Universidad Nacional Autonoma de Mexico. After two years of training in orthopedic surgery in Mexico City, he relocated to Houston, Texas. He completed his training in general, cardiovascular and thoracic surgery at Baylor College of Medicine under the direction of Michael E. DeBakey, MD, and Denton A. Cooley, MD. Among his mentors he included Albert Sabin, MD at the University of Cincinnati College of Medicine; Helen B. Taussig, MD at The Johns Hopkins University; and Prof. Dr. Kurt Semm at Christian Albrechts Universität in Kiel, Germany. He holds a BS and an MS in Surgical Technology, and a PhD in Biomedical Technology as well as several Honorary Degrees. Dr. Rubio was certified by The American Board of Surgery and six other prestigious boards in the United States and three in Mexico. He has received countless honors from heads of state, leaders and nobility throughout the world.

Pedro Rubio was an extremely active ICS member. He held numerous leadership positions at both the national and international level. Dr. Rubio was the ICS US Section President in 1989 and then served as the ICS World President in 1995. Condolences are extended to his wife Debbie and the entire Rubio family.

**JUAN D. ASUNCION, JR., MD**

CHINO HILLS, CA

**DOUGLASS D FEAR, MD**

ROANOKE, VA

**SABRY F. GOHARA, MD**

OTTAWA HILLS, OH

**RAUL LOPEZ-GUERRA, JR, MD**

CORPUS CHRISTI, TX

**CORAZON A. MANAYAN, MD**

LAS VEGAS, NV

**CARLOS MAX, MD**

MIAMI, FL

**PEDRO A. RUBIO, MD, PhD**

THE WOODLAND, TX

**DAVID SANDLER, MD**

SPOKANE, WA

**ROBERT P. TURK, MD**

DAYTON, OH

**THEODORE N ZEKMAN, MD**

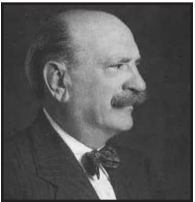
CHICAGO, IL



**JOHN L. CAMERON, MD**  
 RECIPIENT OF  
**THE DR. ANDRE CROTTI AWARD**  
 FOR  
**DISTINGUISHED SERVICE TO THE PROFESSION OF SURGERY**  
 AND  
**INTERNATIONAL COLLEGE OF SURGEONS**  
**HONORARY FELLOWSHIP**

The US Section has selected Dr. John L. Cameron to receive the Dr. Andre Crotti Award for Distinguished Service to the Profession of Surgery. Cameron, the second recipient of this prestigious award, embodies the professional excellence and achievements of Dr. Crotti, who served as the first President of the US Section.

Cameron is the Alfred Blalock Distinguished Service Professor of Surgery at The Johns Hopkins University School of Medicine. For nineteen years he served as the Chief of Surgery at The Johns Hopkins Hospital. Dr. Cameron obtained his undergraduate degree from Harvard University in 1958 and his medical degree from The Johns Hopkins University School of Medicine in 1962. All of his training in General and Thoracic Surgery was obtained at The Johns Hopkins Hospital. Dr. Cameron has had a long-standing interest in alimentary tract diseases, and specifically in pancreatic cancer. He has operated upon more patients with pancreatic cancer, and done more Whipple resections than any other surgeon in the world. He has been a leader in Alimentary Tract Surgery for many years. National leadership positions held include being President of the Society for Surgery of the Alimentary Tract, President of the Southern Surgical Association, President of the Society of Clinical Surgery, President of the Society of Surgical Chairman, President of the Halsted Society, and President of the American Surgical Association. Most recently he served as President of the American College of Surgeons.



**THE DR. ANDRE CROTTI AWARD**  
 FOR  
**DISTINGUISHED SERVICE TO THE PROFESSION OF SURGERY**

Dr. Andre J. Crotti was the first President of the US Section (1937) and the second ICS World President (1938). Dr. Crotti was Medical Director of the Free Cancer Clinic in Columbus, Ohio, an institution he had founded in 1921. The Clinic was chiefly devoted to early detection and diagnosis of cancer. Recognizing the need for large sophisticated cancer centers where first-rate scientists would work together, Dr. Crotti, in later years, directed his energy to promoting a merger of the Clinic with the Health Center at Ohio State University. His vision became a reality in 1953 when the Clinic merged with the new Cancer Research Laboratories of the Health Center at Ohio State University.

Dr. Crotti, a founding member of the College is credited with the development of the College motto: Pro omni humanitate [for all humankind] and aphorism: La science n'a pas de patrie, parce que le savoir est le patrimoine de l'humanite, le flambeau qui eclaire le monde... [Science has no country, because knowledge is the patrimony of mankind, the torch that illuminates the world.] which is of course, a quote of Dr. Louis Pasteur. Finally, Dr. Crotti was also responsible for the conception and execution of the "French Certificate" Fellowship Diploma of ICS.

Dr. Crotti's abundant contributions to the profession of surgery and the growth, success and prosperity of our United States Section are without question. He will serve as an admirable example for years to come to all those who are selected to receive The Dr. Andre Crotti Award for Distinguished Service to the Profession of Surgery.

## KEYNOTE LECTURE SPONSORED BY AANOS



Dr. Sergio Canavero is Director of the Turin Advanced Neuromodulation Group, a think tank devoted to the advancement of brain stimulation.

He entered neurosurgery with the goal of transcending human limits. In the tradition of Prof. Penfield, he believes the brain only acts as a filter to consciousness which he discusses in his book *IMMORTAL. Why Consciousness is Not in the Brain*.

Over the past 30 years, he focused on making the first head transplant possible. Along the way he worked out the genesis of Central Pain at the age of 27 (for which he has been hailed as a “benefactor of mankind” and “Italian genius” by the US website [painonline.org](http://painonline.org) following publication of his Cambridge University Press monograph in 2007), introduced surgical cortical brain stimulation for Parkinson disease, the vegetative state (featured in several international media outlets in December 2008) and stroke recovery. He has over 100 peer-reviewed publications and several books to his credit, including *Head Transplantation And The Quest For Immortality* (Dec 2014).

Recently, he made the news for pushing cortical brain stimulation in the rehabilitation of criminal psychopaths in place of the death penalty.

In the century that will see medical technology impact human life like never before, head-body transplantation will be at the cutting edge. In 1970, US neurosurgeon Dr. Robert White carried out the first cephalosomatic anastomosis (CSA) in monkeys, but could not rejoin the spinal cord. His goal: curing intractable medical disorders.

Now, in an unprecedented turn of events, and fulfilling Robert White’s prophecy, Dr. Canavero brings together many lines of research, some from the past, to recast the problem of spinal cord fusion in new terms.

In June 2015, he will push science forward and prove that a severed spinal cord can be reconnected with another one. The consequences? Not only the cure of hopeless disorders, but the opening of a new frontier: life extension. You will hear from him directly why he will be the first to achieve a full head transplant which will hold the key to the future of mankind. And more...

## THE DR. ARNO A. ROSCHER ENDOWED LECTURE



Dr. Ara G. Tilkian will present the Dr. Arno A. Roscher Endowed Lecture. Tilkian was born in the village of Kesab, Syria. He spent a formative year in Missoula, Montana as an American Field Service Exchange Student and graduated from Missoula County High School with membership in the Alpha Omega Alpha Honor Society. He attended the American University of Beirut, Lebanon and was recognized as an outstanding freshman and graduated with a Bachelor of Science degree with Distinction. He received his MD degree with Honors at the University of Illinois in Chicago. Post graduate training included 5 years at Stanford University Medical Center where he completed his cardiology training.

Dr. Tilkian moved to Los Angeles in 1975 and has been an active member of Cardiovascular Consultants Medical Group since then. He has been the director of the Cardi-

ology Program at Providence Holy Cross Medical Center in Mission Hills, California since 1989.

Dr. Tilkian has been on the clinical faculty of UCLA Medical Center and continues to participate in the teaching of cardiovascular fellows. He has published over 20 abstracts and articles in peer review journals and has written two textbooks in cardiology.

Since 2001 he has developed an interest in Stress Cardiomyopathy and has collected over 250 cases with this syndrome. He presented his observations and experience in this field at the 3rd International Medical Congress in Armenia in 2011.

He is board certified in internal medicine, cardiovascular disease and interventional cardiology. He continues the active practice of cardiology, looking for the next case of Takotsubo cardiomyopathy!

## ARNO A. ROSCHER, MD, FICS (HON.) FCAP, FASCP, LOS ANGELES, CA



Dr. Arno A. Roscher, a trained surgeon who immigrated to the United States from Germany and pursued a successful career in Pathology, has been a Fellow of the International College of Surgeons since 1968. Dr. Roscher has remained active in ICS activities throughout his over 40 years as a member. He has also held numerous elected leadership positions at both the US Section and In-

ternational levels. When he contributed \$100,000 to the US Section in 2009 the Dr. Arno A. Roscher Endowed Lecture was established. This year marks the seventh anniversary of this special lecture that has featured renowned physicians presenting on varied topics ranging from the Reduction of Health Disparities to Molecular Genetic Testing to Dr. Tilkian’s presentation this year on Takotsubo Cardiomyopathy.

**THURSDAY, JUNE 11, 2015**

**RESEARCH SCHOLARSHIP COMPETITION**

**8:00-9:45 AM**

**CAPITOL A&B**

The Scholarship Committee of the ICS-US Section accepts submissions from medical students, surgical residents and surgical fellows. Participants have submitted an original clinical research paper with pertinent clinical application for this annual competition. All papers are judged and scored by the members of the ICSUS Section Scholarship Committee prior to the Annual Surgical Update. An additional panel of judges will score the oral presentation of the research during the meeting in Annapolis. Scores will be tallied and those with the highest combined score will be awarded prizes. Participants in this session will be presented with the latest research being conducted by some of the brightest young minds in medicine and surgery.

**Moderators: Chand Ramaiah, MD & Jianzhong Huang, MD**

**Risk Factor Identification for Postoperative Groin Incision Complications and Recommendations on Treatment**

Mark Weismiller, MD, Surgery Resident, Providence Hospital and Medical Centers, Southfield, MI

**Coil Embolization of Superior Gluteal Artery Tear through Ipsilateral Popliteal Artery: A Unique Approach**

Anand Tarpara, MD, PGY-1 Resident, General Surgery, Texas Tech University Health Sciences Center School of Medicine, Lubbock, TX

**Novel Concept of Electrocoagulation and Pancreatic Tumor Cell Implantation: Creation of Minimally Invasive Orthotopic Murine Model of Pancreatic Cancer**

Jasneet S. Bhullar, MD, FICS(J), Chief Resident, Department of Surgery, Providence Hospital & Medical Centers, Southfield, MI

**Evaluation of Urine Fibrinogen Level in a Murine Model of Contrast Induced Nephropathy**

Alireza Hamidian Jahromi, MD, FICS, General Surgery Resident (PGY-III), Louisiana State University health Shreveport Center-Shreveport, Shreveport, LA

**Coffee Break - 9:45-10:00 AM**

**OPENING CEREMONY**

**10:00-10:15 AM**

**CAPITOL A&B**

The formal opening of the meeting will include introductions and welcoming remarks made by the ICS World President as well as the US Section President and Chair, of the American Academy of Neurological and Orthopaedic Surgeons.

Professor Yik-Hong Ho, MD, MBBS (Hons), FICS, International College of Surgeons, World-President, Professor of Surgery, James Cook University, Townsville, Australia

Uretz J. Oliphant, MD, FICS, United States Section President, Head, Department of Surgery, University of Illinois Urbana-Champaign, College of Medicine, Urbana, IL

William Mathews, MD, FICS, Chair, American Academy of Neurological and Orthopaedic Surgeons, Neurosurgeon, Walnut Creek, CA



**THURSDAY, JUNE 11, 2015**

**SURGICAL RESIDENT EDUCATION DEBATE AND PANEL DISCUSSION**

**10:15 AM-Noon**

**CAPITOL A&B**

**Moderator: Demetrius Litwin, MD**

A debate addressing whether surgical residents are receiving adequate training under the 80 hour work week rule established in 2003. After the debate, alternatives and possible solutions will be presented and a panel of experts will discuss the future implications of a system that places greater importance on cost savings rather than quality patient care.

**Debate - The New Surgical Training Model - Are New Graduates Ready for Practice?**

**CON:** Mayur Narayan, MD, FICS, MPH, MBA, Assistant Professor, University of Maryland, Baltimore, MD

vs

**PRO:** Sivamainthan Vithiananthan, MD, FICS, MPH, MBA, FICS, Associate Professor of Surgery (Clinical) Alpert Medical School of Brown University Chief, Minimally Invasive and Bariatric Surgery The Miriam and Rhode Island Hospitals Providence, RI

**Improving Surgical Residency Training: Future Alternatives**

Frank R. Lewis, Jr., MD, Executive Director, American Board of Surgery, Philadelphia, PA

**Panel Discussion**

**HONORS LUNCHEON**

**Noon-1:30 PM**

**CAPITOL D**

**GLOBAL SURGERY SUMMIT**

**1:30-3:45 PM**

**CAPITOL A&B**

**Moderator: Uretz Oliphant, MD**

As a world-wide organization, ICS has always attempted to provide surgical care to those in areas where it is not readily available. Traditionally, surgery has been overlooked as a health priority due to the inaccurate perception that high cost interventions benefit only a limited proportion of the population. Surgical care for approximately 2 billion people in low and middle income countries is under-prioritized and underfunded. Millions suffer and lose their lives annually because they lack access to surgical care. In May of 2014 the WHO's World Health Assembly Executive Board passed a resolution that seeks to strengthen emergency and essential surgical care around the world.

This session will include presentations from key representatives from the WHO, the ACS, the ICS and more. In addition, an interactive panel will be assembled that will discuss where we are and where we should be going to address this global health crisis.

**ICS and Humanitarian Surgery - it is More Blessed to Give Than to Receive**

Professor Yik-Hong Ho, MD, MBBS (Hons), FICS, International College of Surgeons, World-President, Professor of Surgery, James Cook University, Townsville, Australia

**The WHO Emergency and Essential Surgical Care (EESC) Program**

Meena Nathan Cherian, MD, Emergency & Essential Surgical Care Program Lead, Service Delivery and Safety Department, World Health Organization- HQ, Geneva, Switzerland

**Operation Giving Back: Advocating for the Global Surgical Patient**

Girma Tefera, MD, Professor of Surgery, Vice Chair, Division of Vascular Surgery, Medical Director, Operation Giving Back, American College of Surgeons, University of Wisconsin-Madison, Madison WI

**continued on next page**

**THURSDAY, JUNE 11, 2015**

**GLOBAL SURGERY SUMMIT (CONTINUED)**

**1:30-3:45 PM**

**CAPITOL A&B**

**Surgical Missions: How Do We Measure Success?**

Domingo T. Alvear, MD, FICS, Chief, Division of Pediatric Surgery Pinnacle Health System, Harrisburg, PA

**The Globalization of Surgical Care: State of Surgical Education**

Adrian Park, MD, Chairman of the Department of Surgery and Chair of the newly created Earl Simulation to Advance Innovation and Learning (SAIL) Center of Anne Arundel Health System (AAHS) in Annapolis, Maryland

**Power of Partnership: Essential Best Practice in International Medical Outreach**

Julie Varughese, MD, AmeriCares Medical Officer, Greenwich, CT

**Coffee Break - 3:45-4:00 PM**

**CARDIOTHORACIC AND VASCULAR SURGERY**

**4:00-6:00 PM**

**CAPITOL A&B**

**Moderators: Dixon Santana, MD & Bakir Altai, MD**

This session will focus on the identification and treatment options for challenging cases in vascular surgery. Upon completion of this course participants will improve their understanding of the various options to treat the types of cases discussed and be better prepared to provide optimum patient care.

**Is Minimally Invasive Esophagectomy a Good Option for Treatment of Esophageal Cancer?**

Daniela Molena, MD, Assistant Professor of Surgery, Johns Hopkins University, Baltimore, MD

**Endovascular Repair for Ruptured AAA is Superior to Open Repair**

Girma Tefera, MD, Professor of Surgery, Vice Chair, Division of Vascular Surgery, Medical Director, Operation Giving Back, American College of Surgeons, University of Wisconsin-Madison, Madison WI

**Update on Lung Cancer Screening Programs**

Francis J. Podbielski, MD, MS, FICS, Visiting Clinical Associate Professor of Surgery, University of Illinois, Riverside, IL

**Why the Filter: What Is All This Noise?**

Dixon Santana, MD, FICS, Associate Professor in Surgery Vascular and Endovascular Surgery, Texas Tech Health Sciences Center, Lubbock, TX

**OPENING RECEPTION**

**6:00-7:00 PM**

**SENATE A&B**

Our first day of CME ends with a chance to relax and reconnect with your friends & colleagues before you head out to explore dining & fun in our host city of Annapolis.



**FRIDAY, JUNE 12, 2015**

**TRAUMA AND ACUTE CARE SURGERY PART I**

**8:00-9:45 AM**

**CAPITOL A&B**

**Moderators: Andrew Klein, MD & Livio Romani, MD**

This two-part session offers a comprehensive review of various aspects of trauma-related surgical issues including: Appendicitis in Children, Sternal and Rib Plating, Surgical Site Morbidity, Diverticulitis, Damage Control Surgery, and Traumatic Brain Injury. Participants in this course will increase their knowledge of the topics presented to provide improved patient care and also learn about a new model for acute care surgery.

**Controversies in the Management of Perforated Appendicitis in Children - 2015**

Domingo T. Alvear, MD, FICS, Chief, Division of Pediatric Surgery Pinnacle Health System, Harrisburg, PA

**Sternal and Rib Plating for Trauma and Sternal Dehiscence**

Anthony N. Dardano, DO, FICS, Associate Professor of Biomedical Sciences, Florida Atlantic University, Charles E Schmidt School of Medicine

**Diverticulitis**

Jonathan E. Efron, MD, FICS, Associate Professor of Surgery, Interim Director of the Department of Surgery, Johns Hopkins University, Baltimore MD

**Novel Wound Management System Reduces Surgical Site Morbidity After Ventral Hernia Repair: A Critical Analysis**

Fred Eckhauser, MD, Professor of Surgery, Johns Hopkins University School of Medicine, Baltimore, MD

**Coffee Break - 9:45-10:00 AM**

**TRAUMA AND ACUTE CARE SURGERY PART II**

**10:00 AM-Noon**

**CAPITOL A&B**

**Moderators: Domingo Alvear, MD & Mayur Narayan, MD**

**The Multidisciplinary Management of Complex Hepatic Trauma**

David Efron, MD, Associate Professor of Surgery, Anesthesiology and Critical Care Medicine, Emergency Medicine Chief, Division of Acute Care Surgery, Baltimore, MD

**Acute Care Surgery Model in the World of Specialty Surgery**

Adrian Park, MD, Chairman of the Department of Surgery and Chair of the newly created Earl Simulation to Advance Innovation and Learning (SAIL) Center of Anne Arundel Health System (AAHS) in Annapolis, Maryland

**Damage Control Surgery**

Gene E. Bolles, MD, FICS, Associate Professor of Neurosurgery, University of Colorado Medical Center and Denver Health Medical Center, Denver, CO

**Innovative Management for Traumatic Brain Injury: Compartments Communicate**

Thomas M. Scalea, MD, Professor of Surgery, University of Maryland School of Medicine, Baltimore, MD

**FRIDAY, JUNE 12, 2015**

**NEUROLOGICAL AND ORTHOPAEDIC SURGERY**

**9:00-11:00 AM**

**SENATE A&B**

**Moderator: W. Craig Clark, MD**

A primary goal of the United States Section of the International College of Surgeons is to foster relationships with like-minded organizations to advance the art and science of surgery. For more than 10 years, the College has worked with the American Academy of Neurological and Orthopaedic Surgeons (Academy) to develop scientific programming in the specialties of Neurosurgery and Orthopaedic Surgery. The sessions presented on Friday and Saturday have been developed with the support and assistance of the Academy, its Board of Directors and Scientific Organizing Committee. Presentations include abstract submissions from members of both groups as well as invited presentations by renowned surgeons in these major surgical specialties.

**Surgical Management of Back Pain**

**Chad Patton, MD, MS**, Spine Surgery Medical Director, Anne Arundel Medical Center Spine Program, The Orthopaedic and Sports Medicine Center Annapolis, Maryland, Annapolis, MD

**Minimally Invasive Instrumented Surgery for Sacroiliac Joint Dysfunction**

**Gary Dix, MD**, Neurosurgeon, Maryland Brain and Spine, Annapolis, MD

**Current State of Opioid Guidelines**

**Charles Xeller, MD, FICS**, Orthopaedic Surgeon, League City, TX

**LUNCH AND THE DR. ANDRE CROTTI LECTURE**

**NOON-1:30 PM**

**CAPITOL D**

**Moderator: Uretz Oliphant, MD**

There is perhaps no story in medical science over the past 100 years more fascinating than the life of Dr. William Stewart Halsted, generally regarded as the most innovative and influential surgeon the United States has produced. The number and magnitude of Dr. Halsted's contributions to surgery are staggering. This year's Dr. Andre Crotti Award recipient, who is in his own right considered a pioneer in surgery, will remind us all about this important individual from our past.

**William Stewart Halsted: Our Surgical Heritage**

**John Cameron, MD**, 2015 Andre Crotti Award Recipient, The Alfred Blalock Distinguished Service Professor, The Johns Hopkins University School of Medicine, Baltimore, MD

**KEYNOTE LECTURE SPONSORED BY AANOS**

**1:30- 3:00 PM**

**CAPITOL A&B**

**Moderators: Uretz Oliphant, MD & William Mathews, MD**

What is surgery? Pushing the limits. That is why we became surgeons. Testing our limits and the limits of what is achievable. No more than a few decades ago, surgery on the heart was believed to be beyond our grasp, now it is routine. Same goes for the brain. Not to mention transplantation. Surgery is outsmarting nature.

When Robert White carried out his first head transplantation on a monkey, he was drowned in criticisms of all kinds. The past has given us the key to achieve spinal cord fusion and conduct the first human head transplant. By questioning what we used to believe was the correct view of motor and sensory physiology, we can now move on to tap the power of the central nervous system and make it work. This lecture will include details about and provide opportunities for discussion of HEAVEN: the head anastomosis venture project for the first human head transplantation with spinal linkage (GEMINI).

**HEAVEN-GEMINI: Head Transplantation—The Future Is Now**

**Sergio Canavero, MD**, Director, Turin Advanced Neuromodulation Group, Turin, Italy  
(See page 15 for more information.)

**FRIDAY, JUNE 12, 2015**

**THE LATEST UPDATES IN HEPATO-PANCREATO-BILIARY (HPB) SURGERY**

**3:15-5:45 PM**

**SENATE A&B**

**Moderators: Reza Saidi, MD & Michael Jacobs, MD**

Various HPB related topics will be addressed by experts from Johns Hopkins as well as by members of ICS. Using evidence-based medicine, this session is designed to provide a comprehensive overview of the surgical and medical management of patients with malignancies, neoplasms, and diseases involving the liver, gallbladder, bile ducts and pancreas.

**Debate - Controversies of Pancreatectomy**

**Minimally Invasive Approach:** Matthew Weiss, MD, Assistant Professor of Surgery, Johns Hopkins Hospital, Baltimore, MD

vs

**Open Approach:** Michael J. Jacobs, MD, FICS, Attending Surgeon Providence Hospital, Southfield, MI

**Recent Advances in Liver Transplantation: HCC, Hepatitis C, and Sharing**

Andrew Cameron, MD, PhD, Associate Professor of Surgery, The Johns Hopkins University School of Medicine, Baltimore, MD

**Cystic Neoplasms of the Pancreas**

Christopher Wolfgang, MD, PhD, Associate Professor of Surgery, Pathology and Oncology, Baltimore, MD

**Laparoscopic Pancreas Surgery**

Martin Makary, MD, MPH, Professor of Surgery Johns Hopkins Hospital, Baltimore, MD

**Controversies and Updates in Management of Patients with Intrahepatic Cholangiocarcinoma**

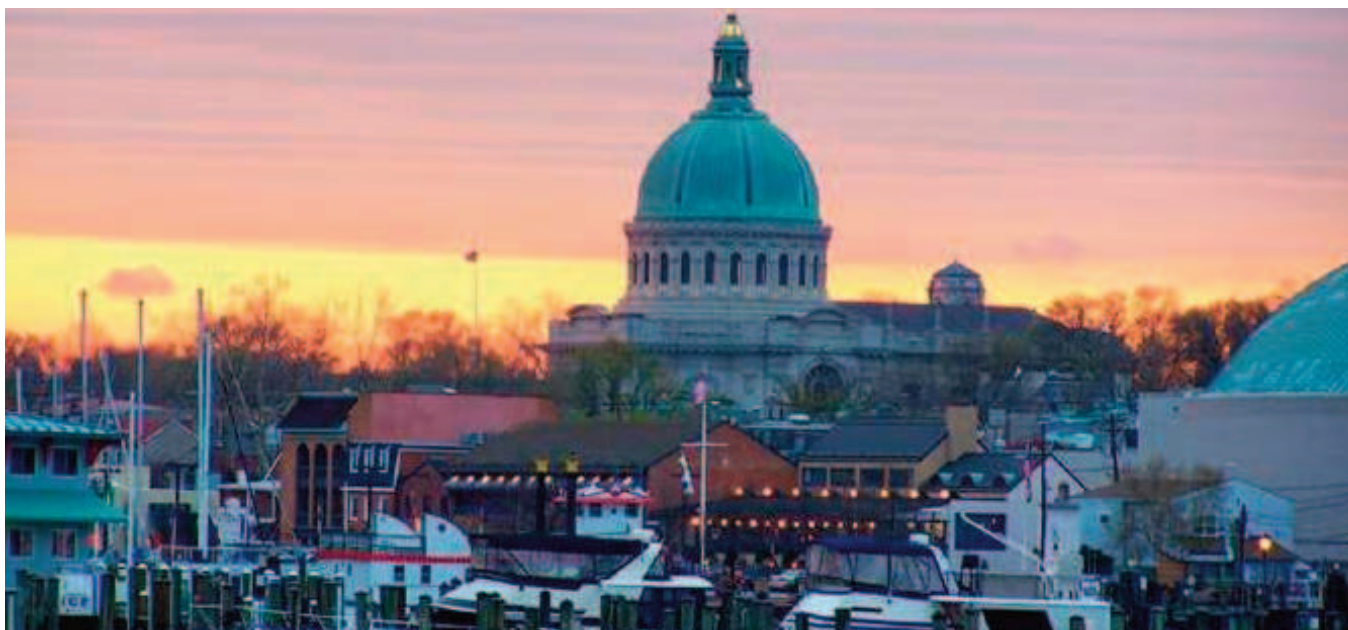
Timothy Pawlik, MD, MPH, PhD, Professor of Surgery and Oncology, Johns Hopkins Hospital, Baltimore, MD

**Incidence and Risk Factors of Deep Vein Thrombosis After Liver Transplant**

Alagappan Annamalai, MD, FICS, Cedars-Sinai Medical Center, Los Angeles, CA

**Liver Transplantation for Malignant Neoplasms**

Reza F. Saidi, MD, FICS, FACS, Assistant Professor of Surgery Division of Organ Transplantation Department of Surgery University of Massachusetts Medical School, Providence, RI



**SATURDAY, JUNE 13, 2015**

**BARIATRIC AND GENERAL SURGERY**

**8:00-9:45 AM**

**CAPITOL A&B**

**Moderators: Sivamainthan Vithiananthan, MD & Anthony Dardano, DO**

Participants in this session will learn: how to identify appropriate indications and operative techniques for the management of complex abdominal wall hernias; whether to use an endoluminal or a robotic approach for gastric surgery and which facilities can handle gastric cancer the best.

**Change in Paradigm in Bariatric and GI Surgery: Endoluminal not Robotic Approach**

Sivamainthan Vithiananthan, MD, FICS, FACS, Associate Professor of Surgery (Clinical) Alpert Medical School of Brown University Chief, Minimally Invasive and Bariatric Surgery, The Miriam and Rhode Island Hospitals Providence, RI

**Gastric Cancer: Should It Be Treated Only at High Volume Centers?**

Mark D. Duncan, MD, Chief, Surgical Oncology, Johns Hopkins Bayview Medical Center, Baltimore, MD

**Update on the Surgical Management of Breast Cancer**

David Euhus, MD, Professor of Surgery, Johns Hopkins Hospital, Baltimore, MD

**Taming the Hostile Abdomen: Management of the Open Abdomen and Complex Hernias**

Anthony N. Dardano, DO, FICS, Associate Professor of Biomedical Sciences, Florida Atlantic University, Charles E Schmidt School of Medicine

**Sleeve Gastrectomy: The Most Popular Bariatric Surgery in the USA Results of the 5th Consensus Conference**

Michel Gagner, M.D, Professor of Surgery, Herbert Wertheim College of Medicine, Florida International University, Miami, FL Hopital du Sacre Coeur, Montreal, Canada

**Coffee Break - 9:45-10:00 AM**

**COLORECTAL SURGERY SYMPOSIUM**

**10:00-Noon**

**CAPITOL A&B**

**Moderators: Bryan Butler, MD & Jonathan Efron, MD**

This session will provide general and colorectal surgeons as well as other specialists who have an interest in various aspects of colorectal surgery an opportunity to learn about the most recent advances in this field. Controversies surrounding robotic surgery, rectal cancer, diverticulitis and TAMIS will be addressed during this session.

**Management of Recurrent Rectal Cancer**

Jonathan E. Efron, MD, FICS, Associate Professor of Surgery, Johns Hopkins University, Baltimore, MD

**Controversies in Colorectal Robotic Surgery**

Bashar Safar, MD, Assistant Professor of Surgery, Johns Hopkins University, Baltimore, MD

**TAMIS (Transanal Minimally Invasive Surgery) (TAMIS)**

Bryan N. Butler, MD, FICS, Clinical Assistant Professor, Section of Colon Rectal Surgery, State University of New York at Buffalo, Buffalo, NY

**Controversies in the Current Management of Clostridium Difficile Colitis**

Aura Delgado-Cifuentes, MD, Colon and Rectal Surgery Fellow, University at Buffalo, Amherst, NY

**Fecal Incontinence: Current Options and Controversies**

Deepa Taggarshe, MD, FICS(J), Assistant Professor, Department of Surgery, Virginia Commonwealth University, Richmond, VA

**continued on next page**

**SATURDAY, JUNE 13, 2015**

**COLORECTAL SURGERY SYMPOSIUM (CONTINUED)**

**10:00-NOON**

**CAPITOL A&B**

**Squamous Anal Cancer Outcomes in HIV-Positive Men**

Tracy Sambo, MD, FICS(J), Resident Physician, Presence St. Joseph Hospital, Chicago, IL

**Colorectal Anastomotic Reinforcement with Extracellular Matrix Scaffold (ECM)**

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

**LUNCHEON**

**NOON-1:30 PM**

**CAPITOL D**

**NEUROLOGICAL AND ORTHOPAEDIC SURGERY**

**8:00-10:00 AM**

**SENATE A&B**

**Moderators: Sudhir B. Rao, MD & William Mathews, MD**

See Page 20 for description

**Constrained Fixed-Fulcrum Reverse Shoulder Arthroplasty for the Treatment of Epilepsy-Related Recurrent Shoulder Instability**

Tanujan Thangarajah, MB ChB (hons), MRCS, MSc, Research Fellow, The John Scales Centre for Biomedical Engineering, Institute of Orthopaedics and Musculoskeletal Science, Division of Surgery and Interventional Science, University College London, London, UK

**Shoulder Arthroplasty in Epileptic Patients**

Tanujan Thangarajah, MB ChB (hons), MRCS, MSc, Research Fellow, The John Scales Centre for Biomedical Engineering, Institute of Orthopaedics and Musculoskeletal Science, Division of Surgery and Interventional Science, University College London, London, UK

**Early Decompressive Craniectomy in Traumatic Brain Injuries: A Case Series from the Kingdom of Cambodia**

Paul Park, MD, PhD, Global Outreach Fellow, Korean American Medical Association, Preah Kossamak Hospital, Phnom Penh, Kingdom of Cambodia, Reno, NV

**Commodifying Human Traits: The Neuroethical Aspect**

Patricia Scripko, MD, Neurologist, Salinas Valley Memorial Hospital, Salinas, CA

**Surgical Treatment of Humerus Fractures**

Sudhir B. Rao, MD, Big Rapids Orthopaedic PC Premier Hand Center Big Rapids, Michigan, Big Rapids, MI

**Endoscopic Transphenoidal Surgery: A Transition To Neurosurgery-Ent Collaboration Producing Better Outcomes**

Bharat Guthikonda, MD, FICS, Associate Professor Director of Skull Base Research Department of Neurosurgery LSU HSC Shreveport

**Coffee Break - 9:45-10:00 AM**

**Moderators: Maxime Coles, MD & Bharat Guthikonda, MD**

**Long-Term Effectiveness of a Non-surgical Treatment for Carpal Tunnel Syndrome**

Michael Politis, PhD, Carpal Pain Solutions, Inc., Palm City, FL

**Claudication- Neurogenic or Vascular**

Gerald O. Greenfield, Jr., MD, MS, FICS, Clinical Assistant Professor, Orthopaedic Surgery University of Texas Health Sciences Center- San Antonio, San Antonio, TX

**continued on next page**

**SATURDAY, JUNE 13, 2015**

**NEUROLOGICAL AND ORTHOPAEDIC SURGERY**

**10:00 AM-Noon**

**SENATE A&B**

**Controversies in Neurosurgery: Vertebroplasty vs Kyphoplasty**

W. Craig Clark, MD, PhD, FICS, Greenwood Leflore Neurosurgery, Greenwood, MS

**Controversies in Neurosurgery: Radiosurgery vs Microsurgery for Benign Tumors in the Adult Posterior Fossa**

W. Craig Clark, MD, PhD, FICS, Greenwood Leflore Neurosurgery, Greenwood, MS

**Management and Treatment of Sports Concussions**

Gene E. Bolles, MD, FICS, Associate Professor of Neurosurgery, University of Colorado Medical Center and Denver Health Medical Center, Denver, CO

**Pitfalls in the Treatment of Distal Humerus Fractures**

Maxime J.M. Coles, MD, FICS, Orthopaedic Surgeon, Coffeyville Orthopedics, Coffeyville, KS

**Surgical Management of Epilepsy**

Lucia Zamorano, MD, FICS, Professor of Neurological Surgery, William Beaumont Oakland University School of Medicine, Birmingham, MI

**Preclinical Studies of Allogeneic Head and Body Reconstruction**

Xiaoping Ren, MD, Professor of Surgery Hand and Microsurgical Center, The Second Affiliated Hospital, Harbin Medical University, Harbin, China

**LUNCHEON**

**NOON-1:30 PM**

**CAPITOL D**

**NEUROLOGICAL AND ORTHOPAEDIC SURGERY**

**1:30-2:15 PM**

**SENATE A&B**

**Moderator: Anca Bereneau, MD**

**Dynamic Cervicomedullary Cord Compression and Alterations in Cerebrospinal Fluid Dynamics in Children with Achondroplasia**

Debraj Mukherjee, MD, MPH, MPH, Maxine Dunitz Neurosurgical Institute Department of Neurosurgery Cedars-Sinai Medical Center Los Angeles, CA, Los Angeles, CA

**The Latest Clinical Surgical Total Hip Replacement Advancements in Painful Osteoarthritis of the Hip**

Robert S. Mathews, MD, PhD, Director of First Team Institute LLC, Millersville, PA

**Clinical Depression and ACL Reconstruction: Incidence and Impact on Functional Outcome, a Prospective Cohort Study**

Hao-Hua Wu, BA, Third Year Medical Student, Perelman School of Medicine at the University of Pennsylvania, Philadelphia, PA

**ARNO ROSCHER ENDOWED LECTURE**

**1:30-2:15 PM**

**CAPITOL A&B**

**Moderators: Uretz Oliphant, MD & Arno Roscher, MD**

Participants in this special lecture will increase their awareness of issues related to Stress Cardiomyopathy in a surgical practice. Participants will also improve their knowledge of diagnosis and treatment options. (See page 15 for more.)

**Takotsubo-Stress Cardiomyopathy**

Ara Tilkian, MD, Director of Cardiology, Providence Holy Cross Medical Center, Mission Hills, California, Van Nuys, CA



**SATURDAY, JUNE 13, 2015**

**ANNUAL ETHICS FORUM**

**2:15-3:30 PM**

**CAPITOL A&B**

**Moderator: Frank Bongiorno, MD**

Many outside forces seem to corrupt and threaten the relationship between doctors and patients. A doctor's decisions may be influenced by these forces to the detriment of their patients. This session will debate how outside influences are threatening patient care and the relationship between a doctor and their patient. Various scenarios will be presented with ample time for interaction between the audience and panelists.

**How Medical Care Is Being Corrupted**

Timothy Pawlik, MD, MPH, PhD, Professor of Surgery and Oncology, Johns Hopkins Hospital, Baltimore, MD

**OPEN FORUM — FREE PAPER PRESENTATIONS**

**3:30-5:30 PM**

**CAPITOL A&B**

**Moderators: Marco Pelosi, III, MD & Joshua Mammen, MD**

This session will include submitted abstract presentations from ICS Fellows, Non-members, Residents and medical students that will address the varied surgical specialties represented within the College. Participants will increase their comprehension of the topics and cases discussed allowing for optimal patient care in a multi-disciplinary setting.

**A Team Based Intervention Can Improve Surgical Patient Satisfaction and Readmission Rates in a Teaching Hospital**

Sivamainthan Vithiananthan, MD, FICS, FACS, Associate Professor of Surgery (Clinical) Alpert Medical School of Brown University Chief, Minimally Invasive and Bariatric Surgery The Miriam and Rhode Island Hospitals, Providence, RI

**Profound Hemorrhagic Anemia with No Transfusions**

Raymond A. Dieter, MD, FICS, Cardiothoracic Surgeon, Glen Ellyn, IL

**Vaginal Surgery Under Local Anesthesia: An Emerging Paradigm**

Marco A. Pelosi III, MD, FICS, Director, Pelosi Medical Center, Bayonne, NJ

**Update on Light Adjustable Lenses**

Phillips Kirk Labor, MD, FICS, Founder, Eye Consultants of Texas, Grapevine, TX

**Successful Incorporation of Midlevel Providers in an Academic Surgical Division**

Joshua M.V. Mammen, MD, PhD, MBA, FICS, Associate Professor of Surgery and Molecular & Integrative Physiology, University of Kansas, Kansas City, KS

**Massive Gastrointestinal Bleeding From Jejunal Diverticulosis: Angiographic Localization and Resection**

Jesse Flores, MD, Resident, Texas Tech University Health Sciences Center, Lubbock, TX

**Rib Plating of Traumatic Rib Fractures: Patient Selection, Operative Planning and Technique**

Milad Mohammadi, MD, Resident, Texas Tech University Health Sciences Center, Lubbock, TX

**Non-Surgical Management of Pilonidal Disease - is it Feasible?**

Jonathan Cook, MD, General Surgery Resident, PinnacleHealth Hospitals, Harrisburg, PA

**EXPLORE ANNAPOLIS**

Thursday, June 11

10:20-11:20 AM

Senate A&amp;B

This event; geared towards Alliance members, spouses, and family members who are visiting Annapolis during the Annual Meeting will provide attendees with an overview of the history of the city, how Annapolis came to be what it is today and an understanding of the not-to-be-missed highlights of the city during your visit. A local historian will be your guide to the historical importance and highlights of our host city.

Free to all attendees but check with Registration for On-Site Availability.

**ALLIANCE BOARD OF DIRECTORS & GENERAL MEMBERSHIP MEETING**

Thursday, June 11

11:20-Noon

Senate A&amp;B

Please join us to discuss Alliance plans for the Annual Meeting and beyond. Topics will include future leaders, and current & future social activities for the Alliance. If you have ever wondered what the Alliance is or does, then this meeting shouldn't be missed.

**HONORS LUNCHEON**

Thursday, June 11

Noon-1:30 PM

Capitol D

Please join us as we induct our Section's new Fellows into the College and honor those who have contributed to the success of our meeting and our Section. The winners of the Scholarship competition will also be announced here.

**WELCOME RECEPTION**

Thursday, June 11

6:00-7:00 PM

Senate A&amp;B

Our first day's scientific session in Annapolis ends with a cocktail reception. Join us as we kick off the 77th Annual Surgical Update; reconnect with old friends welcome New Fellows and meet members you may not have encountered before.

**NAVAL ACADEMY TOUR**

Friday June 12

8:45 AM-Noon

Gather at Registration

Friday morning you may choose to depart for a historical tour of the famed United States Naval Academy. Your tour highlights include life at the U.S. Naval Academy past and present. Tour includes Lejeune Hall, Bancroft Hall, Tecumseh Court, Herndon Monument, Main Chapel (when open) and the Crypt of John Paul Jones, Revolutionary War hero.

**Everyone** 18 and older must have a government-issued photo ID. Photo copies of ID (passports, ID Cards, etc.) cannot be accepted. If you are not a US citizen, please bring your passport.

The tour will last roughly an hour & a half including transportation to and from the Naval Academy. There will be at least one mile of walking over varied surfaces and steps.

Price: \$12 per person. **Check with Registration for On-Site Availability.**

**CLOSING DINNER**

HOSTED BY

THE AMERICAN ACADEMY OF NEUROLOGICAL AND ORTHOPAEDIC SURGEONS

AND

THE INTERNATIONAL COLLEGE OF SURGEONS - UNITED STATES SECTION

Saturday, June 13

7:00-10:00 PM

Capitol D

Join us as we come together for one last event before we bid farewell until next year. Uretz J. Oliphant, MD and William Mathews, MD invite you to attend the combined closing dinner of AANOS and the ICS-US. The buffet style meal will feature complimentary wine at your table, a cash bar, award presentations and live entertainment.

Price: \$100 per person. **Check with Registration for On-Site Availability.**



The Surgical Endowment is organized to provide permanent financial resources for the future of surgery by supporting charitable programs involving medicine, including those of the International College of Surgeons-United States Section (ICS-US). The Surgical Endowment is a separate entity and has its own tax exemption under Internal Revenue Service Section 501(c)(3). A direct link exists to ICS-US through the Surgical Endowment's Board of Trustees, which has substantial representation from within the ICS-US membership.

Principal contributions to the Surgical Endowment can become a permanent asset of the Endowment if so designated. Revenue generated from investments will be allocated by the Board of Trustees of the Surgical Endowment to the programs of the International College of Surgeons-United States Section or other worthy causes. It is the goal of this fund to one day have an adequate financial base to satisfy all the needs of the programs it was organized to support.

Recently the Surgical Endowment Fund of the United States has supported scholarships and the continuing medical education program of the ICS-US.

All contributors will receive a personal letter of thanks from the President of the John C. Scott, MD, Surgical Endowment Fund of the United States, and their names will be published in the ICS-US newsletter International US Surgeon. In addition, depending on the size of your contribution, various other forms of recognition will be provided. See the ICS-US staff at the registration desk for more details.

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**Congratulations!**  
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**Dr. Stevens is also a member of the following:**

- American Board of Orthopaedic Surgeons
- American Academy Orthopaedic Surgeons
- International College AMA Advisory Task Force, Honors Committee, Ethics and Grievance, and DRS Health Board of Directors Chairman

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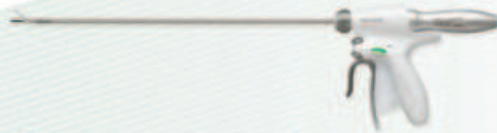
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WITH OUR THANKS

The following Abstracts are listed in alphabetical order by presenting author.

They have been reproduced as submitted with limited editing.

## **Surgical Missions : How Do We Measure Success?**

**Domingo Alvear, MD, FICS**

Chief, Division of Pediatric Surgery, Pinnacle Health System, Harrisburg, PA

**Purpose:** 11% of the Global Burden of Disease is attributable to surgical conditions. There are many barriers for success which include funding, shortage of volunteer surgeons and anesthesiologists, shortage of equipment and supplies at the facilities we visit, and foremost is the active participation of the local medical personnel. The World Surgical Foundation has participated in over 50 missions since 1997 and learned from each mission. Each of the 7 countries we visited have their own unique problems. Short term surgical missions ( 5 to 7 days) can be successful if there is local surgical participation. Collaboration with other NGO's can increase the capacity to serve many more patients. This presentation will describe how the WSF has achieved success and how others can emulate.

**Methods:** Experience of WSF since 1997 in 7 countries

**Results:** WSF now has excellent relationship with Honduras and the Philippines to achieve long term and sustainable goals

**Conclusions:** Success of surgical missions can be achieved by having collaboration with the local surgeons, collaboration with other NGO's, having surgeons in training participate to propagate the mission concept in the future as well helping them improve their skills, and most importantly help the local surgeons continue the work all year round.

## **Controversies in the Management of Perforated Appendicitis in Children - 2015**

**Domingo Alvear, MD, FICS**

Chief, Division of Pediatric Surgery, Pinnacle Health System, Harrisburg, PA

**Purpose:** In spite of the availability of imaging studies, perforated appendicitis in children remains high at 50% and even higher in preschool age. The controversies in the management of perforated appendicitis include ; 1. Immediate surgery vs. non-surgical management. 2. Interval appendectomy vs. no further surgery 3. Drainage vs no drainage 4. Close the wound vs. pack it open 5. Duration of antibiotic therapy

**Methods:** Experience in treating children with perforated appendicitis in the last 20 years

**Results:** 305 patients with perforated appendicitis were treated. Surgery is performed few hours after admission after hydration and given appropriate antibiotic therapy. The appendix is removed in all cases. Drains are placed in majority of cases. PICC line is placed for IV antibiotics which is continued at home for a total of 10 days or longer. No readmission, less than 0.1% wound infection rate and no intra-abdominal abscess.

**Conclusions:** In the last 20, we have developed a protocol in the management of perforated appendicitis in children which include appendectomy, drainage, PICC line for IV antibiotics, hospital stay for 5 days or less, home therapy for 2 to 3 weeks with excellent results

## **Incidence And Risk Factors Of Deep Vein Thrombosis After Liver Transplant**

**Anand Annamalai, MD, FICS**

Cedars-Sinai Medical Center, Los Angeles, CA

**Purpose:** Deep venous thrombosis (DVT) occurs in 0.1% of persons per year affecting 15-40% of general surgical procedures without prophylaxis. Thromboembolic prophylaxis is not commonly used after orthotopic liver transplantation (OLT) due to the risks of bleeding and coagulopathy. Cirrhosis and the association with the coagulation cascade, pre and post-transplant, are not well understood. The purpose of our study was to determine the incidence of DVT and its' risk factors after OLT.

**Methods:** We retrospectively reviewed OLT performed at our center from 2005 to 2012. We identified patients with Doppler examinations showing DVT post-OLT, platelet count and international normalized ratio (INR) at time of DVT, associated symptoms, DVT prophylaxis, and perioperative risk factors. We determined the incidence of DVT, the odds ratio of each preoperative risk factor, the difference in platelet count and INR between those with and without a DVT, and the weighted risk of each factor in the development of a DVT using logistic regression modeling.

**Results:** Of 314 patients, the incidence of DVT was 8.6% (27/314). Between those with and without DVT there was no significant difference in age, gender, platelet count, INR, infection, hepatocellular cancer, use of venous bypass, and prior surgery. There was a significant difference in mobility, 67% vs 20% ( $p < 0.0001$ ) and the use of factor VII, 11% vs 2% ( $p < 0.05$ ). The estimated risk for of developing DVT for patients with neither of these factors was 4%; with factor VII the risk rose to 17%; with mobility difficulty the risk rose to 23%; and with both the risk was 62%. In our entire population, there were no cases of pulmonary embolism.

**Conclusions:** The risk of developing a DVT after OLT is at least 9% even with mechanical DVT prophylaxis. Consideration should be given to using both mechanical and chemical prophylaxis after OLT.

**Controversies in Neurosurgery: Vertebroplasty vs Kyphoplasty**

W Craig Clark, MD, PhD, FICS

Greenwood Leflore Neurosurgery, Greenwood MS

**Purpose:** Vertebral Compression Fractures (VCFs) are quite common in the elderly due to a combination of more fragile or brittle osteopenic or osteoporotic bone and an increased number of falls. Due to the overall increase in the aging population, we can expect an ever increasing incidence of VCFs. Maybe of even more significance are complications associated with these events due to the associated pain and secondary lack of mobility. Within the last decade minimally invasive procedures that involve the internal fixation of these fractures with bone cement have been developed. Initially this was the vertebroplasty, and later kyphoplasty. The relative advantages and disadvantages of each procedure or technique is explored, with an emphasis on complication avoidance and maximizing patient safety.

**Methods:** This study involves the retrospective review of the author's 15 year experience with cementoplasty administered for the treatment of VCF. Parameters examined include patient demographics, LOS, OR time, rates of extravasation or embolization of the bone cement, intra- and perioperative complications, and patient satisfaction

**Results:** There were in excess of 300 cases available for review and followup. The treatment groups were stratified based on vertebroplasty versus kyphoplasty. Parameters of each group will be presented with nonparametric statistical tests of significance.

**Conclusions:** Based upon the statistical analysis noted above, subgroup analysis and stratification will attempt to recommend the most efficacious, least costly and safest cementoplasty treatment of VCFs.

**Controversies in Neurosurgery: Radiosurgery versus Microsurgery for Benign Tumors in the Adult Posterior Fossa**

W Craig Clark, MD, PhD, FICS

Greenwood Leflore Neurosurgery, Greenwood MS

**Purpose:** The most common benign posterior fossa tumors in adulthood are generally recognized to be meningiomas and nerve sheath tumors. As experience developed the goal of treatment shifted from complete resection to preservation of hearing and facial function. Several large clinical series have now been published and provide the case data for this report. When should the neurosurgeon recommend open microsurgery and when should stereotactic radiosurgery be employed? How effective is radiosurgery in providing growth control of these usually slowly progressive masses? How important is "Gross Total Resection" in the management scheme?

**Methods:** Several large clinical series of the tumors in question have been reported in the literature. These studies have been combined to provide the case mix for the current report. Variables included were patient demographics, tumor size, any prior surgery in the area, preoperative hearing status and facial function, and progression free intervals during follow-up.

**Results:** The preliminary results suggest the most predictive variables were tumor size and the presence of any hearing loss or facial weakness. The data are yet to tested for statistical significance, with that information reported at time of presentation

**Conclusions:** The ability to preserve hearing is most often related to tumor size, regardless if the surgeon elects to use radiosurgery or microsurgery. There are finite limits on ideal tumor size to be treated with radiosurgery due to the risks for tumor necrosis, swelling and mass effect in the posterior fossa.

**Non-Surgical Management of Pilonidal Disease – is it Feasible?**

Jonathan Cook, MD

General Surgery Resident, PinnacleHealth Hospitals, Harrisburg, PA

**Purpose:** Pilonidal disease is a dermatologic condition affecting the sacrococcygeal region. The condition was first described by Herbert Mayo in 1833. Pilonidal disease commonly manifests as recurrent abscesses and chronic infection of hair follicles in the gluteal cleft. It is a debilitating condition and conventional surgical management can result in considerable morbidity. Despite a variety of surgical approaches and closures, excision of skin in the intergluteal region is associated with high recurrence rates and difficulties in achieving optimal wound healing. Numerous studies have recognized that hair in the natal cleft plays a central role in the etiology of primary pilonidal disease as well as in the development of recurrent disease after surgery. Laser epilation is a safe and effective outpatient method of hair removal. When utilized as part of a strategy to treat pilonidal disease, laser therapy has been shown to be effective in removing hair both in primary and recurrent pilonidal disease. Our study goals:

- \* Determine the efficacy of laser therapy as an alternative to surgery in the treatment of pilonidal disease.
- \* Evaluate laser hair removal as an adjunct to surgical management of pilonidal disease, especially in the prevention of recurrence.
- \* Develop an algorithm for the treatment of pilonidal disease that minimizes time to wound healing, discomfort, and recurrences.



Methods: \* Twenty-three patients, ages 11 – 23 were treated over a five year period, according to our treatment algorithm. Incision and drainage was undertaken when necessary, but surgical excision of intergluteal skin was not performed. \* Laser therapy consisted of alexandrite (755nm) or NdYag (1064nm), depending on hair type and Fitzpatrick skin type.

Results: \* Nine of twenty-three patients (40%) required surgery throughout the course of the study.

\* Clinical response (significant reduction in symptoms) was achieved in 100% of those treated. Complete resolution occurred in twenty-one of twenty-three patients (91%).

\* Data collection is ongoing

Conclusions: \* Laser hair removal provides a safe and effective adjunct to surgical management of pilonidal disease.

\* Although not proven to be curative in severe disease, laser therapy alone achieves excellent results in mild and moderate disease.

\* Laser treatment is less morbid than conventional surgery with less post operative pain.

\* Outcomes are improved when laser therapy is used in conjunction with surgery to prevent hair growth into healing wounds.

\* Further study is needed to determine the role of laser hair removal as an alternative to surgical therapy in the prevention of recurrences.

### **Profound Hemorrhagic Anemia with No Transfusions**

**Raymond A. Dieter, Jr., MD, FICS**

Cardiothoracic Surgeon, Glen Ellyn, IL

The first blood transfusion in DuPage County was in the early 1930's by Dr. C. A. Gutzmer for meningitis with shock and success. No crossmatch was done - only withdraw from the donor and inject the recipient. Since then, blood transfusion has been utilized frequently for treatment of shock, hemorrhage, anemia, and other diseases. More recently, the wisdom of when to transfuse has been questioned due to potential risks.

In general, hemorrhagic shock has been routinely treated with fluids and blood infusion. Initially, guidelines of 9 to 10 gram hemoglobin were felt to be an acceptable indication for transfusion. Later this level was dropped to as low as 7.0 gram hemoglobin in the postoperative period before red cell transfusion. Most non-surgeons transfusing before then. Two patient examples demonstrate that such an arbitrary level does not necessarily bode ill. A 90 year-old female was flipped off a bus onto a Chicago curb into the snow. She bled down to 1.8 gram hemoglobin, due to a large laceration. The second patient, struck by a train, bled down to a hemoglobin of 2.0 grams at age 20. Neither patient was transfused with blood. Both patients received IV fluids and walked out of the hospital with no ill consequences except feeling tired. Both patients hemoglobin rose rapidly while followed as outpatients.

### **Minimally Invasive Instrumented Fusion for Sacroiliac Joint Dysfunction**

**Gary Dix, MD**

Neurosurgeon, Maryland Brain and Spine, Annapolis, MD

Purpose: Studies indicate that for up to 25% of patients diagnosed with low back pain, their symptoms arise in their sacroiliac joints (SIJ). In those patients with intractable SIJ pain and dysfunction that have failed to respond to conservative treatment, traditional surgical intervention consists of open in-situ arthrodeses with or without instrumentation. Results for this type of operation have consistently been associated with low success rates and high morbidity. A novel minimally invasive technique for fusing the sacroiliac joint appears to significantly improve patients' functional outcomes and quality of life indices.

We present a single-surgeon series of more than 70 patients that have undergone minimally invasive, fluoroscopically-guided placement of multiple triangular, plasma-coated, titanium dowels across the symptomatic sacroiliac joint, following thorough clinical and radiographic work up. Six month and 2 year follow up results confirm excellent short and long term patient satisfaction rates, with more than 20% of patients subsequently electing to have a second operation on the contralateral side. Post operative complication rates have been low.

Minimally invasive instrumented fusion of persistently symptomatic SIJ pain and dysfunction represents a novel approach to managing this problem, with low complication rates and good long term patient outcomes.

### **Novel Wound Management System Reduces Surgical Site Morbidity After Ventral Hernia Repair: A Critical Analysis**

**Frederic Eckhauser, MD**

Professor of Surgery, Johns Hopkins University School of Medicine, Baltimore, MD, Baltimore MD

Purpose: Surgical site infection (SSI) reportedly occurs in up to 40% of patients after ventral hernia repair (VHR) and has potentially severe clinical and health care cost consequences. Negative pressure wound therapy (NPWT) using vacuum-assisted closure (VAC) has been utilized to reduce morbidity in patients with complex open wounds, but its effectiveness for decreasing SSI after VHR remains controversial. Our group developed a modified wound management system (hybrid-VAC or HVAC) with the goal of comparing its efficacy to standard VAC (SVAC) technology in reducing SSM after VHR.

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**Methods:** Between 2008 and 2013, a total of 199 consecutive VHRs were performed, including 84 (42%) who underwent SVC therapy and 115 (58%) who underwent HVAC therapy. Baseline patient characteristics, ventral hernia grade, co-morbidities, operative time, surgical repair technique were compared. The goal of surgery was to achieve primary fascial approximation whenever possible; synthetic mesh onlay reinforcement was used in all cases. Peri-operative VAC management was standardized for both groups. The primary outcome of the study was 90-day SSI. Secondary outcomes included seroma formation, wound dehiscence and enterocutaneous fistulas (surgical site occurrences or SSOs).

**Results:** Mean follow-up was 8.7 +/-9.9 months. The overall unadjusted SSI rate in the HVAC group was 9% versus 32% in the SVAC group ( $p < .001$ ). On multivariate analysis accounting for age, BMI, hernia grade, operative time, ALOS, and wound classification, HVAC use was associated with a lower likelihood of SSO, overall SSI, and severe SSI ( $P = or < .001$ ). There were no significant differences in risk-adjusted seroma rates or wound dehiscence between the groups. Compared to the SVAC group, HVAC patients had a significantly longer LOS (11 versus 7 days, respectively), but lower wound-related readmission and reoperation rates. There were no mortalities in either group and recurrence rates were similar (HVAC 2% versus SVC 6%,  $p$  NS).

**Conclusions:** HVAC is associated with reducing the rates of SSO and SSI in our VHR population. The benefit of this intervention appears to be maintained in patients with grade 2 and 3 hernias who are at higher risk because of potential or concurrent wound risk factors. We believe this intervention can help the majority of patients undergoing VHR. Propsective and cost utility analyses are warranted to validate these findings.

### **Update on the Surgical Management of Breast Cancer**

David Euhus, MD

Professor of Surgery, Johns Hopkins Hospital, Baltimore MD

The field of breast cancer surgery is changing rapidly. Some of this change is driven by recent clinical trial data and some is driven by patients and surgeons independent of data. For example, surgery for primary breast cancer is polarized now with many women opting for less and less invasive treatments while a growing number are requesting bilateral mastectomy. This presentation will explore recent trends in the management of primary breast tumors, the contralateral breast, and the axilla. In addition we will glimpse into the future of breast cancer surgery based on the trials that are currently being proposed.

### **Massive Gastrointestinal Bleeding From Jejunal Diverticulosis: Angiographic Localization and Resection**

Jesse Flores, MD

Resident, Texas Tech University Health Sciences Center, Lubbock TX

**Purpose:** The case herein describes massive lower gastrointestinal bleeding secondary to Jejunal Diverticulosis diagnosed and localized with angiography, and subsequently resected.

**Methods:** Retrospective case review: Jejunal Diverticulosis (JD) is a rare clinical condition, with a reported incidence of 0.3%-4.5% at autopsy. These false diverticula are mucosal evaginations on the mesenteric border of the Jejunum, found more commonly in older males. Major complications include diverticulitis, gastrointestinal bleeding (GIB), intestinal obstruction, and perforation.

Hemorrhage from JD usually occurs as lower GIB, although hematemesis has been described. Hemorrhage may be massive and acute, requiring emergent surgical intervention. Like that of colonic diverticula, Jejunal diverticular hemorrhage results from diverticular erosion through a perforating artery. Diagnosis can be made by computerized tomography (CT) angiography, small bowel contrast study, mesenteric angiogram and technetium-99m red blood cell scan. Bleeding Jejunal Diverticula challenge the physician to rapidly diagnose etiology and location in the hemorrhaging and potentially unstable patient. Treatment of lower GIB secondary to jejunal diverticulosis includes segmental intestinal resection with primary anastomosis.

**Results:** The patient is a 62 year-old male who presented with abdominal pain, diarrhea, and hematochezia. He underwent an EGD and colonoscopy that showed diverticulosis, but no evidence of bleeding. A tagged RBC scan was also done and was negative. He subsequently had several episodes of bright red blood per rectum and repeat colonoscopy was inconclusive due to blood in the colon.

After an episode of acute bleeding, mesenteric angiogram was performed and no source was identified. Colonoscopy was repeated, with bleeding sigmoid colon diverticuli observed. He was taken to the OR emergently for left hemicolectomy. Seven days later, he began having bright red blood from the end colostomy. Repeat mesenteric angiography revealed extravasation of contrast in the proximal jejunum. Microcatheter remained in the Jejunal arcade for intraoperative localization. Intraoperatively, several large Jejunal diverticula containing blood clots were identified in the mesenteric fat. Intraoperative injection of methylene blue localized the bleeding to this area. Segmental small bowel resection with primary anastomosis was performed. Postoperatively, he progressively recovered and was discharged home.

**Conclusions:** Jejunal diverticulosis is a rare condition that may present with massive gastrointestinal bleeding. JD may demonstrate high mortality rate due to delayed diagnosis and complications. Jejunal diverticulosis should be included in the differential diagnosis of an older patient with massive GIB.

## **Sleeve Gastrectomy: The Most Popular Bariatric Surgery In The USA; Results of the 5th Consensus Conference.**

**Michel Gagner, MD**

Professor of Surgery, Herbert Wertheim College of Medicine, Florida International University, Miami, FL  
Hopital du Sacre Coeur, Montreal, Canada, Montreal Quebec

**Purpose:** The aim of the presentation is to review the results of the 5th International Consensus conference on Sleeve Gastrectomy

**Methods:** A Survey Monkey questionnaire was distributed to 106 surgical experts with more than 1000 sleeve gastrectomies experience. Statistical analysis was performed when compared to the 2011 expert consensus.

**Results:** Best results on weight loss are achieved in the first 2 years like in the Roux-en-Y gastric bypass (>70% EWL for BMI less than 50), and followed with weight regain and gastric pouch dilatation. At 5 years, the experts surveyed, reported results of 60% EWL sustained weight loss (or BMI of 29.8 kg/m<sup>2</sup>). As we can imagine, lost to follow-up rate is about 32.6%.

Strictures were reported around 2.2%. They also reported a leak rate of 2.5%, typically occurring several days later near the GE junctions. Increasingly, leaks are treated with endoscopically placed fully covered nitinol stents, left in place for several weeks, and drainage (34% of experts favored this approach). But some experts recommended a laparoscopic exploration, adding drains and feeding jejunostomy (47%). Chronic leaks are treated with a gastric bypass but more experts (41.5%) are using the new Roux-en-Y fistula-jejunostomy (21.7%), leaving the sleeve in place, a lesser traumatic intervention. Conversions for weight loss failures of sleeve to other types of operations were reported to be 4.8%, while for refractory GERD to be 2.9%. GERD reflux is improved in 80% of patients, but in some it may remain and require wither prolonged medical therapy or conversion to Roux-en-Y gastric bypass.

**Conclusions:** Most participants of the 5th International Conference on Sleeve Gastrectomy are convinced that this bariatric/metabolic operation remains a procedure of choice for weight loss, and achieve the best balance in the equation risks-benefits, even including late conversions (7.7%) 5-10 years following this modus operandi.

## **Claudication- Neurogenic or Vascular**

**Gerald Greenfield, Jr, MD, MS, FICS**

Clinical Assistant Professor of Orthopaedic Surgery  
University of Texas Health Sciences Center- San Antonio, San Antonio TX

**Purpose:** The purpose of the report is to define the difference between claudication based on a neurological versus a vascular factors.

**Methods:** Historical perspective for claudication and its definition will be reviewed along with the anatomical bases for the diagnoses. Testing option for differentiation between the two disorders.

**Results:** Results will define the difference in the two clinical situations and treatment for neurogenic claudication (ESI), distraction, decompression.

**Conclusions:** Attendees will have a concrete understanding of the basis for both neurogenic and vascular claudication. Several noninvasive methods to differentiate the two.

## **Endoscopic Transphenoidal Surgery: A Transition to Neurosurgery-ENT Collaboration Producing Better Outcomes**

**Bharat Guthikonda, MD, FICS**

Associate Professor, Director of Skull Base Research, Department of Neurosurgery, LSU HSC Shreveport, Shreveport LA

**Purpose:** Endoscopic transphenoidal surgery has become a mainstay in the treatment of pituitary adenomas, craniopharyngiomas, CSF leaks, and other anterior and middle skull base pathologies. Many centers employ a collaborative management team consisting of a skull base neurosurgeon working together with an ENT surgeon with expertise in advanced endoscopy. Other centers may utilize a single service strategy for management of these lesions. After performing a single service management of these lesions for the past few years, we have recently converted to a collaborative team approach for skull base endoscopy. We have appreciated significant improvements in our outcomes, especially as they relate to the rate of conversion to open (microscopic) approach and extent of resection of tumors.

**Methods:** A review of a prospectively maintained database was performed. We included all endoscopic transphenoidal procedures performed from August 2007 until the present time. We evaluated all endoscopic transphenoidal procedures that were performed by the neurosurgical service alone and separately evaluated those performed by a collaborative neurosurgery / ENT team. Our primary endpoint was the rate of conversion to an open microscopic procedure. Secondary endpoints were extent of resection of the neoplastic lesions, CSF leak recurrences (in the cases performed for CSF rhinorrhea), and intraoperative blood loss. Complications were also assessed and compared between the two subsets of cases.

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Results: A total of 75 endoscopic transphenoidal cases were evaluated. 50 were performed by neurosurgery alone and 25 were performed by the combined neurosurgery / ENT team. There was a conversion to open microscopic approach rate of 18% in the cases done by neurosurgery alone and 0% in the combined neurosurgery / ENT cases. There was one failed CSF leak repair requiring a subsequent transcranial repair in both subsets. Extent of resection of pituitary macroadenomas was better and overall blood loss was lower in the cases performed by the combined neurosurgery / ENT team.

Conclusions: Our experience has supported the concept of achieving better outcomes in endoscopic transphenoidal surgery by using a combined neurosurgery / ENT team. We have noted a lower rate of conversion to open microscopic surgery, less blood loss, and improved extent of tumor resection.

### **Update on Light Adjustable Lenses**

Phillips Labor, MD, FICS  
Grapevine, TX

For almost 20 years Intraocular lenses have been made available to cataract surgeons as a way to simultaneously correct surgically-induced aphakia and presbyopia. These lenses have been constructed so that they function primarily through accommodative or multifocal modalities. This presentation will show how this same corrective and functional endpoint may be achieved through the use of uniquely designed monofocal lens.

### **Successful Incorporation of Midlevel Providers in an Academic Surgical Division**

Joshua Mammen, MD PhD MBA, FICS

Associate Professor of Surgery and Molecular & Integrative Physiology, University of Kansas, Kansas City, KS

Midlevel Providers serve important roles in the delivery of healthcare in many primary care settings and emergency departments. Surgeons, particularly those who practice in academic settings, have had challenges in identifying opportunities to work most efficiently and with greatest efficacy with midlevel providers. The purpose of this presentation is to describe the effective incorporation of midlevel providers within an academic surgical division. The surgical oncology division at the University of Kansas is composed of five attending physicians and three surgical residents. In addition, two midlevel providers are members of this division for the previous one year. The midlevel providers function as liaisons with patients (returning complex phone calls, communicating results), examine post-operative patients elective and emergently, and initiate evaluations of patients with complex cancer diagnoses. In addition to responsibilities in the outpatient setting one of the midlevel providers also assists in the operating room. Residents on the service value the role of the midlevel provider and appreciate their role on the team. The training of the midlevel providers (both of whom had no surgical experience but extensive primary care experience) had several elements. Both midlevel providers spent extensive time evaluating patients in the clinics of their collaborating attending physician in order to learn the critical elements of the evaluation and treatment of pre-surgical and post-surgical patients. Additionally, they would be present in the operating room often. Finally, they were included in the all patient decisions via email to ensure that they were aware of the thought process involved in decisions. The successful incorporation of midlevel providers can serve as a model for other academic or non-academic divisions.

### **The Latest Clinical Surgical Total Hip Replacement Advancements in Painful Osteoarthritis of the Hip**

Robert Mathews, MD, PhD, FICS

Director of First Team Institute LLC, Millersville, PA

Purpose: In the severely painful osteoarthritic hip joint, the synovium appeared to react to the rigors of joint motion on ambulation. The femoral head debris lost via repetitive microfracture on motion tended to self-perpetuate the inflammatory process and attack mast cells and histiocytes. The inability of the scavenger cells to cope with this degenerative process brought cellular lysosomal enzymic release and cell death in bone which served to self-perpetuate the painful inflammatory process

Methods: We have identified afferent peripheral fibers in the hip joint, tendons, synovium, capsule, periosteum bone, and the scarified tissue near articular cartilage as well as nerves in the bone cortex and cancellous red marrow of human joints. These nerves supply the capsule, the periosteum and the soft tissue of the hip joint. Nerves appear throughout the bone. The intramedullary, endosteal unmyelinated and myelinated fibers enter the bone through the nutrient foramen with the nutrient artery and travel toward the epiphysis and follow along the trabeculae. The myelinated and unmyelinated fibers of bone were found near the vascular elements. On occasion, a few fibers extended to the endosteal wall of the femoral cortex (Plate I).

Results: The anatomic data in our total hip replacement patients was correlated with the clinically evaluated pain before and after surgery. Each patient seen post-operatively had significant relief of pain. In all, we achieved 95 percent hip pain relief in these patients.

Furthermore, other progress by all of us included: Polyethylene improved, Collarless femoral prosthetics which decrease stress risers, Cement technique, Titanium porous, Length control, Ceramics and Antibiotics in cement

Conclusions: In all, we achieved 95 percent hip pain relief in these patients

## Rib Plating Of Traumatic Rib Fractures: Patient Selection, Operative Planning and Technique

Milad Mohammadi, MD

Resident, Texas Tech University Health Sciences Center, Lubbock, TX

**Purpose:** Herein we present cases of rib fixation for trauma patients with disrupted respiratory mechanics secondary to clinical flail chest. We also describe operative technique with a titanium plate and screw system. This is the first report in the Western literature that describes plating of the 2nd rib.

**Methods:** This retrospective case review includes operative management conducted at a University Level I Trauma Center for patients who suffered traumatic rib fractures. Operative candidates had radiographic or clinical flail chest, fractures with displaced ribs, chest wall deformity, severe pain, and inability to liberate from mechanical ventilation due to altered mechanics of respiration.

**Results:** In 2009, over 300,000 patients with rib fractures were seen in U.S. emergency departments. Significant morbidity associated with traumatic rib fractures includes respiratory failure, pneumonia and prolonged hospitalization. Studies have shown improved clinical outcomes following operative stabilization of flail segments.

Open reduction internal fixation of ribs is most beneficial in patients who have clinical flail chest (paradoxical chest motion with respiration), persistent instability of the chest wall with inability to liberate from the ventilator, and non-intubated patients with deteriorating pulmonary function in the setting of flail chest.

Rib fixation is predominantly described in specialty trauma centers and practiced by a minority of trauma, cardiothoracic or orthopedic surgeons. Publications describing operative techniques are rare, and there are no known publications in the Western literature which describe 2nd rib fixation. The cases herein demonstrate successful titanium plate and screw stabilization of disrupted chest wall mechanics secondary to clinical flail chest, including plating of the second rib. Our preferred technique of stabilization using titanium plating and screws is also detailed.

Two patients had 6 and 7 fixation levels respectively. They had successful plating of their 2nd ribs, and both liberated from the ventilator within 24hrs postoperatively. The patients were discharged within 4 days of surgery.

**Conclusions:** Despite numerous studies detailing improved outcomes in rib fracture patients with surgical stabilization, this operation has not yet become the standard of care. Prospective trials are sorely needed to define which patients will benefit from the procedure, and also to describe the benefits and reduction in morbidities.

## Early Decompressive Craniectomy in Traumatic Brain Injuries: A Case Series from the Kingdom of Cambodia

Paul Park, MD, PhD

Global Outreach Fellow, Korean American Medical Association, Preah Kossamak Hospital, Phnom Penh  
Kingdom of Cambodia, Reno, NV

**Purpose:** Decompressive craniectomy (DC) is a controversial treatment option for malignant cerebral edema associated with traumatic brain injury (TBI). A recent multi-center study in the U.S. showed that early DC did not significantly improve mortality rates when compared to medical therapy in patients with TBI related refractory intracranial hypertension. In developing countries, however, where intensive care unit (ICU) support may be minimal and intracranial monitoring technology may be nonexistent, early DC may be preferable to maximize chances for survival.

**Methods:** A customized database was created for collection of patient information at a government hospital in Phnom Penh, Cambodia. A retrospective analysis was performed on patients who underwent DC for TBI during a 5-month period. The indications, midline shift, outcomes, and complications were analyzed for a series of 12 patients.

**Results:** All DC patients were male with an average age of 26 years (SD=7; range 19-43 years). Indications for DC included acute subdural hematoma (n=9), epidural hematoma (n=3), brain contusion (n=5), and subarachnoid hemorrhage (n=1). Average GCS prior to DC was 9 (SD=3, range=5-15). The average midline shift (MLS) was 9.4 mm (SD=2.8; range=8.0-16.5 mm), and MLS of 16.5 mm resulted in death even with DC. The mortality rate was 8% (n=1). Five patients (42%) made a good recovery without any significant disability [Glasgow outcome scale (GOS) score of 5]. Average hospital stay was 15 days (SD=7; range 10-32 days). Complications were primarily postoperative and included bone flap infection at site of abdominal storage (n=2) and hygroma (n=2).

**Conclusions:** Early DC may be preferable over medical therapy when ICU support and intracranial monitoring capabilities may be minimal or nonexistent. Early DC may not increase survival in TBI patients with MLS > 16 mm. DC in developing medical settings, such as the Kingdom of Cambodia, can be performed safely and effectively with minimal risk and favorable outcomes.

## Vaginal Surgery under Local Anesthesia: An Emerging Paradigm

Marco Pelosi III, MD, FICS

Director, Pelosi Medical Center, Bayonne, NJ

**Purpose:** The feasibility of effectively and efficiently performing a variety of commonly performed gynecologic procedures under strict local anesthesia is demonstrated.

**Methods:** A fifteen-year review of gynecologic procedures done under strict local anesthesia at the Pelosi Medical Center was performed spanning the interval from January 1, 1998, through January 1, 2013. Patient selection criteria, procedure selection criteria, anesthetic protocols, surgical protocols, perioperative protocols, patient report visual pain scores and treatment outcomes were evaluated.

**Results:** A total of 2,761 gynecologic procedures initiated under strict local anesthesia were identified. All procedures were successfully completed. There were no anesthetic complications. Sixty six patients (2.4%) required supplemental sedation. There were no intraoperative complications. Postoperative complications were limited to 21 urinary tract infections (0.076%).

**Conclusions:** Gynecologic procedures can be performed effectively under strict local anesthesia with an infrequent need for supplemental sedation with proper patient and procedure selection and adequate protocols.

## Update on Lung Cancer Screening Programs

Francis J. Podbielski, MD, MS, FICS

Visiting Clinical Associate Professor of Surgery, University of Illinois, Chicago, Riverside, IL

**Purpose:** It is estimated that 159,260 Americans died of lung cancer in the year 2014. Lung cancer is the leading cause of cancer deaths in both men and women in the United States and accounts for 27% of all cancer related mortality. Efforts have been underway to identify a group of patients at risk for lung cancer who would benefit from screening. A small reduction in lung cancer mortality has the potential to save thousands of lives annually.

**Methods:** Study inclusion criteria: Age 55-74 years (pack-years = packs per day \* years smoked), > 30 pack-years history of cigarette smoking, former smokers: quit smoking within the previous 15 years, ability to lie on the back with arms raised over the head, signed informed consent form. Data from institutions with lung cancer screen programs was analyzed. Consensus statements were developed from a multi-society collaborative effort and evidence-based guidelines formulated.

**Results:** Reduction of lung cancer mortality across the studies is estimated at 20%. Re-analysis of the data shows that the degree of mortality reduction depends largely on stratification by risk for development of the disease. Number of false positives per lung cancer death prevented is highest in the lower risk group.

**Conclusions:** Using the current inclusion/exclusion criteria for low-dose CT scan lung cancer screening, approximately 8.6 million Americans are eligible to participate in this program. Current data suggests a potential reduction of 12,000 lung cancer deaths per year. Costs of the program and management of false positive findings remains a challenge in developing optimal screening recommendations.

## Long-Term Effectiveness of a Non-surgical Treatment for Carpal Tunnel Syndrome

Michael Politis, PhD

Carpal Pain Solutions, Inc., Palm City, FL

**Purpose:** Abundant data indicate that most patients who undergo carpal tunnel release surgery could have effectively managed their carpal tunnel syndrome non-surgically. However, long-term efficacy data on alternative nonsurgical therapies are sparse and difficult to ascertain. One alternative therapy is soft tissue manipulation as performed by an automated device called Carpal Rx, which has been in use for several years. Patients report highly effective results but long-term data have not been published. This study obtained long-term patient satisfaction results to help determine if this device is an effective means for lasting, non-surgical treatment of carpal tunnel syndrome.

**Methods:** A total of 66 patients who used the Carpal Rx more than 24 months were contacted by telephone. A 17 question survey was used to assess patient satisfaction based primarily on the Michigan Hand Outcomes Questionnaire (MHO) for symptoms relief and a standardized Product Satisfaction Questionnaire (PSQ) for overall product/patient satisfaction. Other information obtained included symptoms severity, co-morbidities, age, gender, Carpal Rx use history/schedule, and whether surgery was/is considered/scheduled/performed. Both questionnaires required a response based on a subjective opinion scale of 0-10 (representing least to most symptoms resolution or product satisfaction). Rank-sum nonparametric analyses were used to analyze results.

**Results:** Of the patients contacted, 52 completed the telephonic survey; 11 declined participation for reasons not related to the product; 3 declined for reasons related to the product. No other information was gathered from non-participants. The mean

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time from initial use of the Carpal Rx was 27.4 months. In 88% and 12% of patients, overall MHQ results indicated at least a 91.4% and 85.9% symptoms resolution, respectively; and 62% and 88%, respectively, reported needing to use the product on a periodic basis within the past 12 months to maintain or restore symptomatic relief. Mean product satisfaction was 92.2% in overall categories surveyed. In general, both MHQ and PSQ results coincided with respect to symptoms resolution and product satisfaction. There was a slight inverse correlation between symptoms severity and patient satisfaction.

Conclusions: The current research supports prior published short-term data on the use of the Carpal Rx for relieving carpal tunnel syndrome. The high level of symptomatic relief and patient satisfaction suggest that this device is an effective alternative to carpal tunnel release surgery. These data support the use of the Carpal Rx for effective long-term management of carpal tunnel syndrome.

### **Surgical Treatment of Humerus Fractures**

**Sudhir Rao, MD**

Big Rapids Orthopaedic PC, Premier Hand Center, Big Rapids, Michigan

Fractures of the Humerus can be challenging to treat in any age group. In the pediatric age group fractures usually involve the epiphysis or metaphysis and often require surgery. One must be aware of vascular injury and growth impairment. In the adult the fracture pattern and treatment methods vary based on the age of the patient, type of fracture and other parameters. There is a wide spectrum of surgical options ranging from percutaneous pinning, internal fixation to arthroplasty. This paper will discuss various clinical situations and treatment options

### **Preclinical Studies of Allogeneic Head and Body Reconstruction**

**Xiaoping Ren, MD**

Professor of Surgery Hand and Microsurgical Center, The Second Affiliated Hospital, Harbin Medical University, Harbin, China

Purpose: Previously, our work has led to the design and completion of the world's first successful composite tissue allotransplantation (CTA), in preclinical swine models, and initiation of the US first clinical hand allograft procedure and according to the hand and face conversion, achieved a successful clinical representative of the CTA. Joint immunosuppressive regimen and immune rejection taxonomy and other important scientific indicators adopted from these studies have been clinically validated for more than 10 years, and now are internationally adopted. However, there is still no effective way in which to saving the lives of patients with a healthy mind dying of other organ failure in the body. The only surgical treatment strategies, CTA next frontier, allogeneic head and body reconstruction (AHBR) has been subject unable to complete necessary preclinical experiments did not establish an effective biological animal model and thus hinder the clinical translational of the AHBR.

Methods: Our approach, pioneered in mice, involves retaining the donor brainstem and transplanting the head with the remainder of the brain. This allows for retention of breathing and circulatory functions, and this is supported by preliminary data in mice. This is the first successful use of this model to date. To build the AHBR research platform, we plan to further develop AHBR model in mice and establish the model in monkeys in order to evaluate outcomes relevant to translation, including long-term survival and mental function.

Results: Forty Kunming mice and forty C57 wild type underwent the AHBR procedure. After transplantation, 18 mice survived for 3 hours after the ventilator was disconnected. As anticipated, they were capable of breathing spontaneously, because the donor brainstem remained intact. The rate of respiration was  $140 \pm 15$ /minute. During these 3 hours, the mice awakened and displayed cranial nerve function and characteristic responsiveness (blinking, whiskers moving, etc.). After the mice awoke, electroencephalogram (EEG) recordings were made directly from the cortex of the transplanted cephalons. Because blood supply was maintained at an adequate level during surgery by anastomosing the donor and recipient carotid and jugular vessels, the intra- and post-operative EEG and ECG show electrophysiological activity. The systolic blood pressure was maintained above 50 mm/Hg. Although ECG and EEG monitoring shows an unstable curve postoperatively, there was neither significant tachycardia nor bradycardia, and no lethal arrhythmia. The heart rate was  $300 \pm 20$ /minute. Interestingly, the mice did not show postoperative decerebrate rigidity.

Conclusions: This study has developed critical surgical procedures, which allow for the cross-circulation to avoid brain ischemia, retention of donor brainstem, preliminary data for PEG study to promoting CNS function recovery and developing optimization of immune-suppressive treatments to reach AHBR long-term survival. Successful clinical translation of AHBR will become another milestone of human medical history and potentially could save millions of people.

### **Liver Transplantation for Malignant Neoplasms**

**Reza F. Saidi, MD, FICS**

Assistant Professor of Surgery, Division of Organ Transplantation, Department of Surgery  
Alpert Medical School of Brown University, Providence, RI

Purpose: To review the correct data on liver transplantation for hepatic tumors.

Methods: Literature Search/Review

Results: Liver transplantation for malignancies has emerged as proven treatment modality for selected group patients. Currently, around 30% of all liver transplants performed in US are for hepatocellular cancer (HCC). Hepatoblastoma is an excellent indication in pediatric patients with unresectable tumors. Similarly, liver transplantation for HCC in the adult population yields good results

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for patients whose tumor do not exceed the Milan criteria. It remains to be determined whether patients with more extensive tumors can be reliably selected to benefit from the procedure. Adjunctive procedures like radiofrequency ablation, chemoembolization, or cryotherapy might be indicated to limit tumor progression for patients on waiting lists. Epithelioid hemangioendothelioma is also an appropriate indication for liver transplantation. Metastatic liver disease is not an indication for liver transplantation, with the exception of cases in which the primary is a neuroendocrine tumor, for which liver transplantation can result in long-term survival and even cure in a number of patients. Cholangiocarcinoma might qualify if aggressive neoadjuvant therapies, including chemotherapy and radiotherapy followed by liver transplantation, are carried through. Survival in these selected patients can approach that for other patients with end-stage liver disease.

Conclusions: Liver transplantation is an valuable option in selected patients with liver tumors.

### **Squamous Anal Cancer Outcomes in HIV-Positive Men**

**Tracy Sambo, MD, FICS (Jr)**

Resident Physician, Presence St. Joseph Hospital, Chicago, IL

Purpose: There is an increased incidence of anal cancer in the HIV-positive population. Accepted guidelines recommend treatment of HIV-positive patients diagnosed with squamous cell carcinoma of the anus (SCCA) with the same combined-modality regimen as their HIV-negative counterparts; however available literature shows mixed results for local-regional control and colostomy-free survival in this population subset. INTRODUCTION: There is an increased incidence of anal cancer in the HIV-positive population. Accepted guidelines recommend treatment of HIV-positive patients diagnosed with squamous cell carcinoma of the anus (SCCA) with the same combined-modality regimen as their HIV-negative counterparts; however available literature shows mixed results for local-regional control and colostomy-free survival in this population subset. Here we investigate outcomes of such combined modality therapy when applied to HIV-positive patients diagnosed with SCCA at a community institution notable for high volume HIV-positive patients.

Methods: HIV-positive patients on highly active anti-retroviral therapy (HAART) diagnosed and treated for SCCA between January 2002 and December 2013 were identified in a single community hospital for retrospective chart review. Statistical analysis of patient demographics, overall-survival, colostomy-free survival, and relapse rates was performed.

Results: Twenty-two patients that met our inclusion criteria were identified. All patients were male with age range from 36 to 62 years at time of diagnosis. Median follow-up time from completion of therapy was 21 months (range 6 to 89 months). Kaplan-Meier survival curves demonstrated overall survival at three and five years was 100% and 80%, respectively. One- and 2-year colostomy-free survival rates were 83.3% and 74.1%, respectively. Average time to local recurrence was 12.1 months (range 5-30 months); all recurrences required surgical intervention with creation of end colostomy. Multivariate analysis of age, stage, tumor size, nodal status, and histologic pathology did not reveal any statistically significant associations with survival times.

Conclusions: HIV-positive patients on HAART with SCCA may be treated with the same treatment regimen as their HIV-negative counterparts with similar overall survival and local-regional recurrence rates. While there are studies that demonstrate inferior outcomes when combined-modality therapy is used to treat SCCA in HIV-positive patients; this data is largely the result of studying a pre-HAART population. Thus, in modern day, our study provides further evidence to support the present SCCA treatment guidelines for the HIV-positive patient.

### **Innovative Management for Traumatic Brain Injury: Compartments Communicate**

**Thomas Scalea, MD**

Professor of Surgery, University of Maryland School of Medicine, Baltimore MD

Purpose: Traditional treatment for intracranial hypertension is all directed at treating the brain. Therapies such as elevating the head of the bed, hyperosmolar therapy and even mild hyperventilation, reduce ICP by directly affecting the brain. Recently, we have described a novel alternative treatment strategy.

Methods: Through a series of case reports and then two full length manuscripts, we have described the use of abdominal wall decompression to treat intracranial hypertension. This therapy was successful, even with modestly elevated intraabdominal pressures. The principles of compartment syndrome are well understood. Pressure rises in a compartment, limiting venous return. Pressure continues to rise until the pressure within the compartment exceeds perfusion pressure, resulting in ischemia.

Results: The cranium, thorax, mediastinum and abdomen sit immediately adjacent to one another. Pressures in the chest or abdomen can be transmitted to the cranium likely via the large veins. In patients without brain injury, this is likely unimportant, but rises in intracranial pressure in patients with brain injury can be very deleterious. We have demonstrated that abdominal wall decompression is an effective way to decrease intracranial pressure. Moreover, patients can develop a constellation of physiologic abnormalities that we have termed Multiple Compartment Syndrome, where pressures in one compartment affect another and then feed back to increase pressure in the original compartment. This downward spiral can be reversed by decompressing either the abdomen or chest.

Conclusions: Decompression in compartments remote from the head can be effective in reducing intracranial hypertension. This represents the first therapy for brain injury not directed at the brain itself. Targeted resuscitation strategies may be very helpful in limiting intracranial hypertension and guiding the need for decompression.



## Commodifying Human Traits: the Neuroethical Aspect

Patricia Scripko, MD

Neurologist, Salinas Valley Memorial Hospital, Salinas CA

We are in an age of rapidly advancing neuroscience and technology. With these advances, come ethical questions. This presentation addresses those controversies specific to manipulating or altering the brain for the purpose of medical restoration or enhancement. It explores the argument: that which defines what is human life lies in the brain. Conclusions are drawn using comparisons between how we define human life at different stages based on arguments made in realms concerning abortion, stem cell research, brain death, and human enhancement (cosmetic, physiological, and cognitive). The potential dangers current and theoretical technologies concerning the brain are posed, and a general set of guidelines for the role and responsibilities of physicians practicing in an era of these advancing technologies is suggested.

## Constrained Fixed-Fulcrum Reverse Shoulder Arthroplasty For The Treatment Of Epilepsy-Related Recurrent Shoulder Instability

Tanujan Thangarajah, MB ChB (hons), MRCS, MSc

Research Fellow, The John Scales Centre for Biomedical Engineering, Institute of Orthopaedics and Musculoskeletal Science, Division of Surgery and Interventional Science, University College London, The Royal National Orthopaedic Hospital, Stanmore, London UK

**Purpose:** Epileptic seizures can cause shoulder dislocation and instability. The incidence of dislocation during a seizure is approximately 0.6% but this is probably an underestimation since go undetected. The majority of non-arthroplasty surgical strategies focus on restoration and/or augmentation of the bony glenohumeral joint while also addressing arthritis, which can be a long-term complication. Despite technically satisfactory reconstruction procedures some patients still experience persistent instability and increasing arthritis symptoms.

The Bayley-Walker shoulder (Stanmore Implants Worldwide Ltd, UK) is a constrained fixed-fulcrum reverse anatomy (FF-RSA) prosthesis that was specifically conceived for the treatment of patients with difficult shoulder reconstruction problems. The center of rotation is placed medially and distally to the axis of the normal shoulder, which increases the lever arm of the deltoid, but to a lesser degree than most existing non-linked reversed anatomy prostheses. These features make it a potential treatment option for patients with epilepsy-related recurrent shoulder instability and sufficient glenoid bone stock for secure primary fixation of the glenoid component. There are no reports of this management strategy in the current published literature.

The aim of this study was to report the functional outcome following FF-RSA for epilepsy-related recurrent shoulder instability and establish its role in the management of this challenging condition.

**Methods:** Between November 1996 and June 2013 five shoulders in five patients underwent FF-RSA for epilepsy-related recurrent shoulder instability. The index dislocation occurred a mean of 13 years (range, 2-38) before surgery. The cohort consisted of four males and one female. Four patients had anterior instability and one had multidirectional instability. FF-RSA was performed after an average of two previous stabilisation procedures (range, 0-5).

Preoperative and postoperative radiographic imaging was performed in all cases. Scapular notching was classified by the size of the defect on the anteroposterior radiograph using the four-part grading system devised by Sirveaux et al. Preoperative and postoperative clinical outcome measures included active forward elevation, active external rotation, the Oxford Shoulder Score (OSS) and the Oxford Shoulder Instability score (OSIS).

**Results:** The mean follow-up was 3.6 years (range, 2.4 - 6.4 years). There were no further episodes of instability or persistence of apprehension, and no further stabilisation procedures and no revision procedures were performed or anticipated. No cases of scapular notching or loosening of either the humeral or glenoid component were noted. Mean active forward elevation improved from 710 preoperatively (range, 45-1300) to 850 postoperatively (range, 80-900). Mean active external rotation improved from 150 preoperatively (range, 0-800) to 400 (20-700) postoperatively. The mean OSIS improved from 7 preoperatively (range, 1-15) to 27 postoperatively (range, 16-37). The mean OSS improved from 7 preoperatively (range, 4-13) to 26 postoperatively (range, 15-34). An increase was noted in the mean SSV, which improved from 17 (range, 0-50) preoperatively to 54 (range, 30-70) postoperatively.

**Conclusions:** In our series, FF-RSA eliminated recurrent instability and improved overall functional outcome. An improvement in pain and range of movement (external rotation) was also noted. The procedure should therefore be considered in this highly selected patient population as an alternative to arthrodesis or non-surgical treatment.

## Shoulder Arthroplasty In Epileptic Patients

Tanujan Thangarajah, MB ChB (hons), MRCS, MSc

The John Scales Centre for Biomedical Engineering, Institute of Orthopaedics and Musculoskeletal Science, Division of Surgery and Interventional Science, University College London, The Royal National Orthopaedic Hospital, Stanmore, London Middlesex, UK

**Purpose:** Epileptic seizures can cause dislocation of the shoulder joint and recurrent instability. Significant bone loss from the glenoid and humeral head is thought to be responsible for the high recurrence rate and is recognized as being pathognomonic of the condition. Owing to a poor bone stock further reconstruction is challenging. Arthroplasty may therefore represent a suitable treatment option but there have been no reports of this in the published literature.

continued on next page

We report our 17-year experience with shoulder arthroplasty in patients with epilepsy-related recurrent shoulder instability to assess the results and rate of revision.

**Methods:** Between November 1996 and July 2013 179 patients with epilepsy underwent shoulder surgery. Of these, eight shoulders in eight patients underwent arthroplasty for recurrent instability. These included three total shoulder replacements (TSR) and five humeral resurfacing hemiarthroplasty procedures. All patients suffered from grand mal seizures. The cohort consisted of seven males and one female. Six patients had anterior instability and two had posterior instability. Arthroplasty was performed after an average of two previous stabilisation procedures (range, 0-3).

All radiographs were reviewed for the presence of glenohumeral subluxation, periprosthetic lucency and alteration in the position of the components. Radiographs for patients who underwent hemiarthroplasty were also examined for glenoid erosion. Clinical outcome measurements included active forward elevation, active external rotation, active abduction and pain. Pain was graded as 4 which indicated no pain; 3, mild pain; 2, moderate pain; 1, severe pain; and 0, unbearable pain. In addition, all patients were assessed using the subjective shoulder value (SSV).

**Results:** Mean age of the cohort was 33 years (range, 17-44) and follow-up was for a mean of 3.2 years (range, 1.5 - 5.8 years). Following surgery six patients continued to have grand mal seizures but did not have any further episodes of instability/dislocation. No further stabilisation procedures were performed in the cohort. Six patients were found to have developed degenerative changes at the time of surgery.

Two patients with hemiarthroplasty required further surgery due to painful glenoid erosion. In one, revision to a total shoulder replacement was undertaken and in the other, an isolated glenoid replacement was performed. No revisions were undertaken in the TSR group.

There was a mean increase in pain score of 1.1 points, from a mean of 0.8 (range, 0-1) preoperatively to a mean of 1.9 (range, 0-3) postoperatively. This was accompanied by an increase in the mean SSV, which improved from 33 (range, 10-80) preoperatively to 52 (range, 15-90) postoperatively. Mean active forward elevation improved from 1110 preoperatively (range, 70-1500) to 1160 postoperatively (range, 70-1700). A similar gain was also noted in mean active external rotation, which improved from 310 preoperatively (range, 10-600) to 390 (20-700) postoperatively.

**Conclusions:** In our series, hemiarthroplasty was associated with a high rate of revision even with a short-term follow-up. However, shoulder arthroplasty did eliminate recurrent instability, reduce pain and improve range of movement. This was accompanied by an increase in the mean SSV. The procedure should therefore be considered in this selected patient population.

### **Power of Partnership: Essential Best Practice in International Medical Outreach**

Julie Varughese, MD

AmeriCares Medical Officer, Greenwich, CT

**Purpose:** AmeriCares supports more than 1,200 volunteer medical teams traveling on short-term trips to over 80 countries each year. Recognizing the diversity of these teams and the lack of standards to ensure their effectiveness, AmeriCares proposed a set of best practice guidelines and administered a web-based survey to understand current practices, identify common resource gaps, and the extent to which partnership influences best practice application

**Methods:** An anonymous survey, emailed to 1,561 recipients of an AmeriCares product donation traveling within the past 1.5 years, yielded a 36% response rate.

**Results:** The majority of respondents (80%) were licensed health care providers of which half focused on primary care and 39% performed surgeries. Most (82%), make trips at least once a year and 36% more than once a year. Nearly all teams (98%) partnered with an in-country host organization (usually a local clinic or hospital) with almost half (47%) maintaining a relationship of over five years. Further analysis shows that the longer a team works with a partner organization, the more likely they are to complete a pre-trip assessment ( $r=0.103$ ,  $p<0.05$ ,  $a=0.05$ ) and thus agree upon health outcomes with the partner ( $r=0.258$ ,  $p<0.01$ ,  $a=0.01$ ). Surgical teams' strong partnerships also result in capacity building through hands on knowledge transfer (89%) and medical seminars or lectures (48%).

**Conclusions:** These results inform AmeriCares best practice framework for Medical Outreach that recognizes partnership as a key indicator of success. Teams with more frequent trips and longer partnerships may incorporate other best practice activities such as preparation, assessments, education, evaluation, and reporting.

### **Change In Paradigm In Bariatric And GI Surgery: Endoluminal Not Robotic Approach**

Siva Vithiananthan, MD, FICS, FACS

Associate Professor Of Surgery (Clinical), Alpert Medical School of Brown University, Site Director, Surgical Residency and Medical Student Programs, The Miriam Hospital, Providence, RI

**Purpose:** As the obesity epidemic grows surgical interventions only treat about 1% of the eligible patients. Safety profile of surgery has made tremendous strides however acceptance of surgery remains static. Robotic surgery was a tremendous boost for urologic interventions in the last decade. This presentations looks at robotic and endoscopic technology's effect on future of bariatric surgery

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Methods: Review volume trends and safety profile of bariatric surgery and acceptance of surgery as a valuable tool in addressing the obesity epidemic. Evaluate the effect of robotic surgery on growth of bariatric surgery and safety profile in comparison to endoscopic interventions and new treatment options in the horizon

Results: compare results on the impact of robotic and endoscopic technology in treating the obese patient and dealing with surgical failures and complications

Conclusions: Assess existing and new technology of robotic and endoscopic treatment modalities and their impact in future of obesity treatment in a surgical practice

**Clinical Depression and ACL Reconstruction:  
Incidence and Impact on Functional Outcome, a Prospective Cohort Study**

Hao-Hua Wu, BA

Third Year Medical Student, Perelman School of Medicine at the University of Pennsylvania, Philadelphia, PA

Purpose: Although recent literature has suggested that depression is a potential risk factor for poor functional outcome following orthopaedic procedures, the recognized impact of depression on the outcome of anterior cruciate ligament reconstruction (ACLR) is still controversial. The purpose of this investigation was to quantify the incidence of major depressive disorder (MDD) and correlate depression symptoms with patient-rated knee function in patients undergoing ACL reconstruction (ACLR).

Methods: In this IRB approved, multi-center prospective cohort study, 82 consecutive adult patients undergoing primary ACLR were given a Quick Inventory of Depressive Symptomatology Self-Report (QIDS-SR16) preoperatively and at 6 weeks, 12 weeks, 24 weeks, and one year postoperatively to assess MDD symptoms. International Knee Documentation Committee (IKDC) Subjective Form and Lysholm scores were also obtained at similar time points. Patients with concomitant ligamentous injuries or revision surgery were excluded. A QIDS score of 6 or greater served as a validated threshold for diagnosis of MDD. MDD and non-MDD groups were assigned based on preoperative QIDS scores.

Results: Among the 82 patients enrolled in the study, 37 (44%) scored 6 or greater on the QIDS preoperatively and were categorized in the MDD group. There were no significant differences found between the two groups with respect to demographics, BMI, smoking history, concomitant knee pathology and postoperative complications. The average QIDS score of the MDD group was significantly higher than that of the non-MDD group at all five time points ( $p < 0.05$ ). In addition, MDD patients scored 14.1 points lower on their Lysholm at baseline (50.8 vs. 64.9;  $p < 0.001$ ) and 13.2 points lower on their Lysholm at one year (75.2 vs. 88.4;  $p = 0.04$ ), as well as 13.3 points lower on their IKDC at baseline (43.7 vs. 57.0;  $p < 0.001$ ) and 17.5 points lower on their IKDC at one year (71.8 vs. 89.3;  $p = 0.001$ ) in comparison to the non-MDD group. A moderate inverse correlation between QIDS and Lysholm ( $r = -0.51$ ) and between QIDS and IKDC ( $r = -.053$ ) were also found at each time point.

Conclusions: This study suggests the incidence of self-reported MDD among patients undergoing ACLR may be as high as 44% preoperatively, and that these patients have significantly worse clinical self-reported one year postoperatively. Continued poor perception of knee function postoperatively for MDD patients may manifest in greater limitation in daily activity, lengthen time needed to return to competition and adversely impact sport performance. Thus, further studies are warranted to determine whether this subset of MDD patients can benefit from multidisciplinary preoperative intervention and postoperative management to improve ACLR outcomes.

78TH ANNUAL SURGICAL UPDATE \* MARK YOUR CALENDARS



June 16-18, 2016  
Troy, Michigan

**Cancellation Policy**

The cancellation deadline is May 24, 2015. Refunds will be issued, minus a \$75 processing fee, upon receipt of written notification via fax or mail. Verbal or written cancellations after May 24 will not be honored. Please allow four to six weeks after the meeting for your refund.

**Fees**

Meeting-related fees must be paid in US funds. Checks as well as Visa, Master Card, and American Express are acceptable forms of payment. Unless noted, all prices within this brochure are in US dollars.

**LANGUAGE**

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

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When does the Circulator trolley operate? Monday through Saturday - 7:30 am to 11:00 pm Sunday - 8:00 am to 8:00 pm.

**PARKING**

Self and Valet Parking Facilities \$10-20 USD per day. See the Hotel concierge for assistance with rental car arrangements.

**ATTIRE**

Business casual attire is recommended in educational sessions and on-site social activities. Casual attire is appropriate for most off-site social events.

**MEETING REGISTRATION**

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

**SPOUSE/GUEST SUPPLEMENT**

Anyone attending the meeting who is not a registered attendee should be registered as a spouse/guest. The \$150 fee covers the costs such as lunches, breakfasts and coffee breaks etc. This includes: Spouses, Domestic Partners and Relatives. This category is not appropriate for physicians who will attend CME Sessions.

**To register for the meeting, please visit the Meeting Registration Desk.**

**CONTINUING MEDICAL EDUCATION (CME) INFORMATION**

CME Program Evaluation Forms are included in each registrant's packet. To receive CME Credit, you must complete a Program Evaluation Form for each educational session you attend. Leave the packets intact, including any blank sessions.

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 13, 2015.**

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A laptop computer has been setup near the registration area. Speakers who did not submit their presentations in advance of the meeting should load their PowerPoint files the day before their presentation. Speakers may also use this laptop to preview/review their files.

**SPECIAL NEEDS AND QUESTIONS**

If you have any special needs that must be addressed to ensure your comfort and/or if you require information not listed in this brochure, please see the ICS-US Staff at the Registration Desk during the hours listed above. Every effort will be made to facilitate your request.

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Tickets for social events MAY be available onsite on a VERY limited basis. However, staff is not responsible for events that are sold-out/unavailable or cancelled. Check with the Meeting Registration Desk as soon as possible.

**TRANSCRIPTS**

You must return your CME evaluation booklet to receive CME credit for this meeting. Transcripts will be made available to attendees 30 days after the conclusion of this meeting following completion of a post-meeting survey which will be emailed to you individually.

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# WESTIN ANNAPOLIS



Westin Annapolis  
Lobby

**WEDNESDAY  
JUNE 10**

**REGISTRATION  
7:30-4:00 PM  
Prefunction**

**OFFICER BREAKFAST  
7:30-9:00 AM  
Prefunction**

**ENDOWMENT FUND,  
BOARD OF TRUSTEES  
MEETING  
8:30-9:00 AM  
Capitol A&B**

**US SECTION STANDING  
COMMITTEE MEETINGS  
(AMA, BYLAWS,  
BOARD OF TRUSTEES,  
ETHICS, PAST PRESI-  
DENTS, HONORS &  
SCHOLARSHIP)  
9:00-10:30 AM  
Capitol A&B**

**CME COMMITTEE AND  
COUNCIL OF SPECIALTY  
GROUP CHAIRS  
10:30 AM-Noon  
Capitol A&B**

**OFFICER LUNCHEON  
Noon-1:00 PM  
Caucus I&II**

**BOARD OF REGENTS  
MEETING  
1:00-2:00 PM  
Senate A&B**

**EXECUTIVE COUNCIL &  
HOUSE OF DELEGATES  
JOINT MEETING  
2:00-4:00 PM  
Senate A&B**

**THURSDAY  
JUNE 11**

**REGISTRATION  
7:00-4:00 PM  
Prefunction**

**BREAKFAST  
7:30-9:00 AM  
CAPITOL D**

**RESEARCH SCHOLAR-  
SHIP COMPETITION  
8:00-9:45 AM  
CAPITOL A&B**

**OPENING CEREMONY  
10:00-10:15 AM  
CAPITOL A&B**

**SURGICAL RESIDENT  
EDUCATION DEBATE &  
PANEL DISCUSSION  
10:15 AM-NOON  
CAPITOL A&B**

**EXPLORE ANNAPOLIS  
10:20-11:20 AM  
SENATE A&B**

**ALLIANCE BOARD OF  
DIRECTORS & MEM-  
BERSHIP MEETING  
11:20-NOON  
SENATE A&B**

**HONORS LUNCHEON  
NOON-1:30 PM  
CAPITOL D**

**GLOBAL SURGERY  
SUMMIT  
1:30-3:45 PM  
CAPITOL A&B**

**CARDIOTHORACIC &  
VASCULAR SURGERY  
4:00-6:00 PM  
CAPITOL A&B**

**OPENING RECEPTION  
6:00-7:00 PM  
SENATE A&B**

**FRIDAY  
JUNE 12**

**REGISTRATION  
7:00-4:00 PM  
Prefunction**

**BREAKFAST  
7:30-9:00 AM  
CAPITOL D**

**TRAUMA AND ACUTE  
CARE SURGERY PART I  
8:00-9:45 AM  
CAPITOL A&B**

**NAVAL ACADEMY  
TOUR  
8:45 AM-NOON  
GATHER AT  
REGISTRATION**

**NEUROLOGICAL AND  
ORTHOPAEDIC  
SURGERY - PART 1  
9:00-11:00 AM  
SENATE A&B**

**TRAUMA & ACUTE  
CARE SURGERY PART II  
10:00 AM-NOON  
CAPITOL A&B**

**LUNCH &  
THE DR. ANDRE  
CROTTI LECTURE  
NOON-1:30 PM  
CAPITOL D**

**KEYNOTE LECTURE  
SPONSORED BY  
AANOS  
1:30- 3:00 PM  
CAPITOL A&B**

**THE LATEST UPDATES  
IN HEPATO-PANCRE-  
ATO-BILIARY (HPB)  
SURGERY  
3:15-5:45 PM  
SENATE A&B**

**AANOS BOARD  
MEETING  
4:00-5:30 PM  
Caucus I&II**

**SATURDAY  
JUNE 13**

**REGISTRATION  
7:00-4:00 PM  
Prefunction**

**BREAKFAST  
7:30-9:00 AM  
CAPITOL D**

**BARIATRIC AND  
GENERAL SURGERY  
8:00-9:45 AM  
CAPITOL A&B**

**NEUROLOGICAL AND  
ORTHOPAEDIC  
SURGERY - PART 2  
8:00-2:15 PM  
SENATE A&B**

**LUNCHEON  
NOON-1:30 PM  
CAPITOL D**

**COLORECTAL SURGERY  
SYMPOSIUM  
10:00-NOON  
CAPITOL A&B**

**ARNO ROSCHER  
ENDOWED LECTURE  
1:30-2:15 PM  
CAPITOL A&B**

**ANNUAL ETHICS  
FORUM  
2:15-3:30 PM  
CAPITOL A&B**

**OPEN FORUM - FREE  
PAPER PRESENTATIONS  
3:30-5:30 PM  
CAPITOL A&B**

**CLOSING DINNER  
7:00-10:00 PM  
CAPITOL D**