

75 Years of Member Driven Success

STATE OF THE ART: SURGICAL CHALLENGES AND
CREATIVE SOLUTIONS



INTERNATIONAL COLLEGE OF SURGEONS - UNITED STATES SECTION

OMNI HOTEL, JACKSONVILLE, FLORIDA
JUNE 5-8, 2013

ANNUAL SURGICAL UPDATE

PROGRAM



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Middle Row: T. Tsai, R. Lazar, S. Dissanaik, A. Nawabi, A. Roscher, A. Samra, N. Hanna, D. Alvear

Bottom Row: I. Isaiah, M. Coles, M. Elahi, M. Afshari, A. Rebel, C. Doria, E. Gonzalez

Letters of Welcome



RICK SCOTT
GOVERNOR

June 6-8, 2013

Dear Friends:

It is a pleasure to welcome you to the 75th conference of the International College of Surgeons - United States Section, at the Omni Jacksonville Hotel, in Jacksonville, Florida.

The United States Section of the International College of Surgeons is part of a world federation of general surgeons and surgical specialists dedicated to the global advancement of surgical excellence and knowledge. The mission of the International College of Surgeons is to provide continuing medical education of the highest quality to its members and serve as a forum for the sharing of surgical knowledge and expertise.

Our state is proud to host this conference, and we look forward to showcasing the hospitality that makes Florida the world's destination of choice. Enjoy the beauty of our state parks, world-class attractions, and our miles of beaches. Florida offers an endless variety of activities and remains one of the most dynamic and diverse destinations you can experience. Thank you for being our guests. I hope your stay in Jacksonville is pleasant.

Best wishes for a successful conference.

Sincerely,

A handwritten signature in blue ink, appearing to read "Rick Scott".

Rick Scott
Governor



OFFICE OF THE MAYOR

ALVIN BROWN
MAYOR

ST. JAMES BUILDING
117 W. DUVAL STREET, SUITE 400
JACKSONVILLE, FL 32202
(904) 630-1776



June 5, 2013

Dear Friends:

As mayor of Jacksonville, it is my pleasure to welcome you to the 75th Annual Surgical Update of the United States Section of the International College of Surgeons. Jacksonville is proud to host this event, and I am confident that you will find the conference to be educational and rewarding.

As researchers, professionals and medical pioneers engaged in various disciplines, you all have a unique opportunity to gain from each other's work, insights and expertise. Our city has a vibrant medical industry and community, making it the ideal location for you to come together and share this special experience.

I understand that for many, this may be your first visit to Jacksonville. I hope you enjoy your stay and will have time to experience our beaches, parks and waterways, including the beautiful St. John's River. Northeast Florida has much to offer those looking for old Florida charm and hospitality, with all the amenities of the present day. I hope this visit encourages you and your family to make Jacksonville part of your destination plans in the future.

Again, welcome to our city. Thank you for your commitment to medicine. I hope you enjoy a successful conference, and I wish you all the best.

Sincerely,

A handwritten signature in black ink that reads "Alvin Brown". The signature is written in a cursive, flowing style.

Alvin Brown
Mayor

WORLD PRESIDENT'S WELCOME



Dear Fellows of the International College of Surgeons United States Section, guests, friends, and families:

I sincerely welcome all of you to the wonderful city of Jacksonville, Florida, to attend the International College of Surgeons US Section Annual Surgical Update! I am deeply moved and impressed by the initiative of the United States Section to commemorate "75 Years of Member Driven Success". As your World President, and on behalf of all Fellows and friends of the International College of Surgeons, I thank you for this commemoration!

The focus of this scientific meeting is "State of the Art: Surgical Challenges and Creative Solutions", which is most applicable in a rapidly changing world, and, certainly, in the world of surgery. It is my hope and expectation that one or more of the conclusions of this quality scientific meeting will be that more expensive technology is not the only solution in addressing new challenges and developing creative solutions. It is the person, the surgeon, who always matters the most, and meetings like this "bring the point home".

I am very disappointed that I cannot be with you in Jacksonville this year. My most respectful thoughts are with you and will be with you into the future – you are a wonderful and great Section within the International College of Surgeons and will continue to be so! In this reference, I fully intend to be join your meeting in 2014 and very much look forward to the occasion!

I give you my best wishes for a highly successful meeting and scientific interchange.

Sincerely,

A handwritten signature in black ink, which appears to read "Adel F. Ramzy". The signature is written in a cursive style and is positioned above the typed name.

Professor Adel F. Ramzy, MD

World President

International College of Surgeons

US Section President's Welcome

75 Years of Member Driven Success



Dear Colleagues,

Welcome to the 75th Annual Surgical Update of the United States Section of the International College of Surgeons. As we gather in Jacksonville for our landmark meeting we will reflect on the past and ponder the success of our noble group. At the same time we look to the future with optimism as the organization has seen an influx of young, bright and enthusiastic members. We continue on our journey to meet the goals of our founder, Dr. Max Thorek, to advance the art and science of surgery, to help the underserved and work together as professionals from all parts of the world

As you look through this program and participate in the various sessions presented throughout our three days of education I am certain that you will gain a better understanding of what the International College of Surgeons is all about. In addition to the excellent scientific and surgical updates and papers that we have come to expect at our annual meeting, we have made a special effort to showcase our humanitarian activities.

I especially encourage everyone to join us for lunch on Thursday and Friday as we feature presentations that will demonstrate how ICS meets the goals of our founder through outreach activities. You will be amazed at the significant work that is being performed throughout the world by Fellows of the ICS and other medical professionals. Enjoy these special presentations as well as all the other educational content of our Section's annual gathering and remember that you are part of our 75 Years of Member Driven Success.

I hope you enjoy Jacksonville and find value in the 75th Annual Surgical Update of the International College of Surgeons - United States Section.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Ari Halldorsson'.

Ari Halldorsson, MD
United States Section President
International College of Surgeons

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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 attendee's 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.

Featured Presentations



OPENING LECTURE

Andrew S. Klein, MD, FICS, FACS, MBA, Director, Comprehensive Transplant Center Esther and Mark Schulman Chair in Surgery and Transplantation Medicine, Professor and Vice-Chair, Department of Surgery, Cedars-Sinai Medical Center, Los Angeles, CA

Dr. Klein received his medical degree from Johns Hopkins School of Medicine, where he also completed internships and residencies. He was a research fellow in transplantation immunology at Massachusetts General Hospital and a fellow in liver transplantation at the University of California, Los Angeles (UCLA).

Dr. Klein previously served as Chief of the Division of Transplantation at Johns Hopkins. He was the Founding Director of the Johns Hopkins Comprehensive Transplant Center, and he was a tenured professor of surgery at Johns Hopkins School of Medicine.

Dr. Klein has played a leadership role in the development of national policies for organ allocation. He is a former chairman of the United Network of Organ Sharing (UNOS) Liver and Intestinal Transplantation Committee. He also served as the UNOS Region 2 Councilor. He is presently Chairman of the UNOS Living Donor Transplantation Committee and was elected Secretary of UNOS in 2004. In addition, Dr. Klein has been elected to the Governing Board of the American Association for the Study of Liver Diseases (AASLD). Dr. Klein will present; **Barbers of Civility**.



THE DR. ARNO A. ROSCHER ENDOWED LECTURE

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 international 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 fifth 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.



Richard J. Cote, MD, FRCPath, FCAP; University of Miami Miller School of Medicine, Professor and Joseph R. Coulter Jr. Chair, Department of Pathology Chief of Pathology, Jackson Memorial Hospital, Director, Dr. John T. Macdonald Foundation Biomedical Nanotechnology Institute, Miami, FL

Dr. Cote, is a nationally recognized expert on the cellular and molecular markers of tumor progression in cancer patients. A major research area for Cote has been the molecular biology of prostate and bladder cancer. His lab has identified the pathways by which cells become malignant, and the mechanisms by which the tumors progress. Cote has led three of the largest clinical trials in breast, lung and bladder cancer, which were based on discoveries from his research that identified molecules and pathways important in assessing treatment response. Dr. Cote will present; **Dissecting Molecular Pathways In Bladder Cancer: A Rational Approach to Prognostic Profiling and Target Discovery**.



KEYNOTE PRESENTATION

Michael S. Nussbaum, MD, FACS, FICS, Professor and Chair, Department of Surgery, Division of General Surgery; Program Director, Surgery Residency; Program Director, Minimally Invasive Surgery Fellowship; University of Florida College of Medicine, Jacksonville, FL

Dr. Nussbaum completed his medical education at the University of Pennsylvania School of Medicine and his surgical residency training at the University of Cincinnati College of Medicine. His clinical special interests include: minimally invasive surgery; robotic surgery; gastroesophageal reflux; biliary disorders; inflammatory bowel disease; peptic ulcers; and endocrine disorders. His research special interests include: outcomes studies involving minimally invasive surgery, clinical pathway development, surgery for inflammatory bowel disease, and the surgical treatment of swallowing disorders. Dr. Michael Nussbaum will deliver the keynote presentation titled; **The Application of Robotic Technology in Minimally Invasive Surgery**.



DIAMOND ANNIVERSARY LECTURE

Paul M. Colombani, MD, Professor of Surgery, Children's Surgeon-in Charge, at The Johns Hopkins Hospital, Lutherville, MD

Dr. Paul Colombani has been the Children's Surgeon-in-Charge at The Johns Hopkins Hospital since December 1991. He is the Robert Garrett Professor of Pediatric Surgery and Professor of Surgery, Oncology, and Pediatrics. He attended University of Kentucky College of Medicine. His general surgery residency was done at George Washington University Hospital in Washington, D.C. He completed a Pediatric Surgery residency at Johns Hopkins in 1983 and then joined the faculty. Dr. Colombani also directs the Pediatric Transplant Program at Johns Hopkins Hospital. Dr. Colombani will present: **Twenty years Experience With Living-Related Liver Transplantation in Children**.



HONORARY FELLOW

H. Randolph Bailey MD, Clinical Professor of Surgery at the Weil Cornell Medical College and The University of Texas Health Science Center, Houston, TX

Dr. Bailey is the Chief of the Division of Colon and Rectal Surgery at the Methodist Hospital as well as the Deputy Chief of the Department of Surgery. He received his medical education and MD degree from the University of Texas Southwestern Medical School in Dallas. His general surgical training was at the University of Texas Health Science Center in Houston and his colon and rectal surgical training at the Ferguson Hospital in Michigan. He is board certified in both general and colon and rectal surgery. He has served as the president of both the American Society of Colon and Rectal Surgeons and the American Board of Colon and Rectal Surgery. He is currently a member of the Board of Regents of the American College of Surgeons. Dr. Bailey was selected as the 2012 Honorary Fellow but was unable to participate in the meeting. We are pleased that he will be able to participate this year and present; **Improving Perioperative Care - Can We Shorten Recovery and Improve Outcomes?**

Scientific Program

Thursday, June 6, 2013

OPENING CEREMONY & SPECIAL LECTURE
8:00 - 8:50 AM Salon A&B

Welcome

Nicholas Rebel, Executive Director, US Section, ICS, Chicago, IL

US Section President's Welcome and Introduction of Special Lecture

Ari Halldorsson, MD, FICS, United States Section President, Professor and Vice Chair, Program Director, Department of Surgery, Texas Tech University Health Sciences Center, Lubbock, TX

Barbers of Civility

Andrew Klein, MD, MBA, FICS, FACS, Director, Comprehensive Transplant Center, Esther and Mark Schulman Chair of Surgery, Transplant Medicine Professor, Vice-Chair, Department of Surgery Cedars-Sinai Medical Center, Los Angeles, CA

Uncivil behavior is escalating in society at large and this poses particular challenges in the surgical workplace. This presentation will raise awareness of the costs both in dollars and in human misery of incivility in the practice of medicine by looking in particular at the case of surgeons.

MANAGEMENT OF PORTAL HYPERTENSION
8:50 - 10:20 AM Salon A&B
Moderators: Dinesh Ranjan, MD & Thavam Thambi-Pillai, MD

This session will identify the treatments for portal hypertensive bleeding that are available and discuss advantages as well as significant side effects or complications, with the choice of therapy. In addition, the role of liver transplantation in the management of HCC in current clinical practice will be discussed. Upon completion of the course participants will know how to determine the most appropriate treatment for portal hypertensive bleeding thus improving patient care while reducing morbidity and mortality as well as extensive resource expenditures.

Shunting Options for Portal Hypertension

Alexander Rosemurgy, MD, Director, Surgical Digestive Disorders and GERD Center Director, HPB Surgery and Fellowship Program Southeastern Center for Digestive Disorders and Pancreatic Cancer Advanced Minimally Invasive and Robotic Surgery Florida Hospital, Tampa, FL

Role of TIPS in Portal Venous Hypertension Management
Horacio D'Agostino, MD, FICS, FACS, FSIR, Professor of Radiology, Surgery, and Anesthesiology, Chair Dept. of Radiology, LSUHSC, Shreveport, LA

Role of Liver Transplantation in the Management of Portal Hypertension and HCC

Cataldo Doria, MD, PhD, FICS, Nicoletti Family Professor of Transplant Surgery, Director, Division of Transplantation, Surgical Director Liver Tumor Center, Jefferson Medical College, Thomas Jefferson University Hospital, Philadelphia, PA

Coffee Break 10:20 - 10:30 AM Salon D

LATE COMPLICATIONS FOLLOWING REPAIR OF CONGENITAL MALFORMATIONS

10:30 - Noon Salon A&B
Moderators: Domingo Alvear, MD & Maqsood Elahi, MD

This session will identify and define long term issues and complications related to congenital malformations. Upon completion of the course participants will increase their knowledge and ability to identify complications related to various congenital malformations that occur later in life.

Late Complications Following Repair of Esophageal Atresia

Saleem Islam, MD, MPH, Associate Professor of Surgery University of Florida, Gainesville, FL

Congenital Diaphragmatic Hernia: Survival, Outcomes and Long-Term Follow-Up Issues as More Severely Afflicted Newborns Survive

David W. Kays, MD, Associate Professor and Chief Pediatric Surgery, University of Florida; Surgeon-In-Chief, Shands Hospital for Children, Gainesville, FL

Long Term Outcomes of Congenital Anorectal Malformations and Hirschsprung's Disease

Belinda Dickie, MD, PhD, Cincinnati Children's Hospital Medical Center, Cincinnati, OH

Midgut Volvulus in Adolescents and Adults; Incidence, Diagnosis and Management

Johanna Serrano, MD, General Surgery Resident, PGY2, Pinnacle Health, Harrisburg, PA



Lunch - Humanitarian Outreach Presentation
Noon - 1:30 PM Salon C

Humanitarian Outreach - Surgical Team Update and Introduction of Dr. Domingo Alvear

Gazi B. Zibari, MD, FACS Professor of Surgery, Department of Surgery, Louisiana State University Health Sciences Center, Shreveport, LA

The Global Surgical Burden of Disease - Who Can Help and How Can We Help?

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

Scientific Program

THE DR. ARNO ROSCHER ENDOWED LECTURE **1:30 - 2:00 PM** Salon A&B

Moderator: Ari Halldorsson, MD

Despite elaborate characterization of risk factors, bladder cancer is still a major epidemiological problem and the ninth most common malignancy worldwide. Urothelial carcinoma is now recognized as a disease of alterations in several cellular processes. Clinical trials for targeted chemotherapy for bladder cancer have commenced, and future trials will aim to treat urothelial carcinoma based on a patient's molecular profile to empower physicians to personalize patient treatment through increased therapeutic efficacy. The future of bladder cancer management will rely on the use of detection techniques that reliably diagnose the presence of disease, marker panels that predict individual tumor behavior, and molecular targets that allow deployment of novel therapeutics. Participants in this special lecture will have improved comprehension of detection and treatment options for bladder cancer.

Dissecting Molecular Pathways In Bladder Cancer: A Rational Approach to Prognostic Profiling and Target Discovery

Richard J. Cote, MD, FRCPath, FCAP; University of Miami Miller School of Medicine, Professor and Joseph R. Coulter Jr. Chair, Department of Pathology, Chief of Pathology, Jackson Memorial Hospital, Director, Dr. John T. Macdonald Foundation Biomedical Nanotechnology Institute, Miami, FL

VASCULAR SURGERY AND THE DIABETIC FOOT **2:00 - 3:30 PM** Salon A&B

Moderators: Dixon Santana, MD & Michael Jacobs, MD

This session will include discussion of the epidemiology of diabetic foot pathology and infections, diagnosis of diabetic neuropathy and associated conditions, the pathophysiology of diabetic foot infections giving emphasis on clinical diagnosis and use of current technology to diagnose associated local and systemic complications, surgical site infections and control of the venous circulation. Upon completion of this course participants will improve their ability to discuss, evaluate and interpret various issues related to the treatment of the diabetic foot as well as other vascular considerations.

Diabetic Foot: Prevalence & Management in India

Rajesh Shah, MD, FICS, Professor of Surgery, AMCMET Medical College, Past President: International College Of Surgeons-Indian Section, Ahmedabad, Gujarat, India

New Frontiers in the Treatment of Limb Threatening Ischemia

Albert G. Hakaim, MD, Professor of Surgery, Chair Department of Vascular Surgery, Mayo Clinic, Jacksonville, FL

Salvage of Limb with Diabetic Gangrene of the Foot

Joshua Salvador, MD, FRCS(C), Past President of the Denton Cooley Surgical Society, Hollywood, FL

Clinically Significance Incidental Computed Tomographic (CT) Finding in Patients Undergoing Endovascular Aortic Aneurysm Repair

Tze-Woei Tan, MD, Assistant Professor of Surgery, Louisiana State University Health Sciences Center, Shreveport, LA

Venous Circulation Control in the Healing of Neuropathic Ulcers

Frank P. Bongiorno, MD, FICS, Wound Specialists of Michigan, PLLC, Ann Arbor, MI

INTEGRATIVE MULTI DISCIPLINARY MANAGEMENT OF PERIPANCREATIC FLUID (A SPECIAL INTRODUCTORY LECTURE)

3:30 - 3:45 PM Salon A&B

Moderator: Dixon Santana, MD

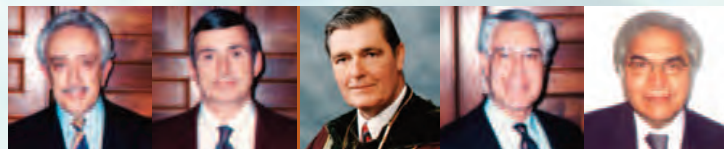
Laparoscopic Drainage of Peripancreatic Fluid Collections - A Case Presentation

Michael Jacobs, MD, FICS, FACS, Clinical Professor of Surgery, Section Chief - General Surgery, Director - HPB Program, St. John/Providence Health System, Southfield, MI

Coffee Break

3:45 - 4:00 PM

Salon D



L-R: E. Aboulafia, D. Stanley, T. Sale, J. Afnan, S. Daee

MINIMALLY INVASIVE BARIATRIC SURGERY TECHNICAL OPTIONS

4:00 - 5:30 PM

Salon A&B

Moderator: Larry S. Sasaki, MD

This session will identify current approaches, risks and advantages for Minimally Invasive Bariatric Surgery. Upon completion of this course participants will increase their knowledge of various approaches for Minimally Invasive Bariatric Surgery along with the corresponding risks and advantages.

Complications requiring Reoperation and Readmission after Laparoscopic Roux-en-Y Gastric Bypass and Laparoscopic Sleeve Gastrectomy

Jennifer Wilson, MbchB, Sunderland Royal Hospital, Sunderland, Tyne and Wear, United Kingdom

GI Bariatric Surgery: Latest Advances

Bestoun Ahmed, MD, FRCS, Assistant Professor of Surgery, University of Florida, Jacksonville, FL

Minimally Invasive Gastric Banding

Mubashir A. Sabir, MD, Farmington Hills, MI

Panel Discussion

75th Annual Surgical Update
State of the Art: Surgical Challenges and Creative Solutions
June 5-8, 2013, Jacksonville, Florida

Friday, June 7, 2013

RESEARCH SCHOLARSHIP COMPETITION

8:00 - 9:45 AM

Salon A&B

Moderators: Anthony Dardano, Jr., DO

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 Jacksonville. 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.

A True Orthotopic Gastric Cancer Murine Model Using Electrocoagulation

Jasneet S. Bhullar, MD, Surgery Resident, Providence Hospital & Medical Centers, Southfield, MI

Acute Appendicitis in Elderly: Diagnosis and Management Still a Challenge

Sushant Chaudhary, MD, MS, Resident Department of Surgery, Providence Hospital and Medical Center, Southfield, MI

Arterial Versus Venous Fluid Resuscitation; Restoring Cardiac Contractions in Cardiac Arrest Following Exsanguinations

Alireza Hamidian Jahromi, MD, General Surgery Resident, Department of Surgery, Louisiana State University Health Sciences Center, Shreveport, LA

Bupivacaine Pain Pumps in Rats Leads to Increased Adhesions and Does Not Decrease the Neuroma Formation

Gokulakrishna Subhas, MD, Resident in Surgery, Providence Hospital and Medical Centers, Southfield, MI

Review of Colorectal Anastomotic Leaks Based on Indications for Surgery, Benign vs Inflammatory Bowel Disease vs Neoplastic: a Ten Year Retrospective Study

Sunu Philip, MD, Resident, General Surgery, Providence Hospital and Medical Centers, Southfield, MI

Comparison of Mammographically and Self-Detected New Breast Lesions at a Community Breast Cancer Center

Thomas D. Willson, MD, Resident, Saint Joseph Hospital, Chicago, IL

Pathology Encountered on Short-Term Surgical Mission Trips to the Dominican Republic

Kathryn Cameron, MD, General Surgery Resident, Providence Hospital and Medical Centers, Southfield, MI

Coffee Break

9:45 - 10:00 AM

Salon D

ANNUAL INTERACTIVE ETHICS SESSION

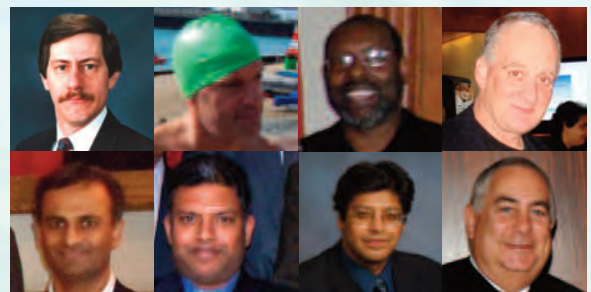
10:00 - Noon

Salon A&B

This interactive audience discussion will focus the conversation on the way the late 20th century science of bioethics often mandates ethical decisions in regards to patient care management and end of life dilemmas. This session will highlight the dialogue necessary when the contemporary science of the bioethical system interferes with the ancient art of medical ethics.

Medical Ethics vs Bioethics - When Do They Differ?

Frank P. Bongiorno, MD, FICS, Ann Arbor, MI



Top Row: F. Podbielski, F. Bongiorno, U. Oliphant, C. Xeller,
Bottom Row: C. Ramaiah, T. Thambi-Pillai, Z. Hassan, A. Klein

Lunch - Humanitarian Outreach Presentation

Noon - 1:30 PM

Salon C

Operation Hope: Humanitarian Medical Outreach

John Thomas, MD, Lubbock, TX

Scientific Program

KEYNOTE LECTURE

1:30 - 2:00 PM

Salon A&B

Moderator: Ari Halldorsson, MD

This special presentation will provide information on the role of robotic technology in minimally invasive surgery. Participants will develop a better understanding of various minimally invasive surgical approaches, particularly in the management of achalasia.

The Application of Robotic Technology in Minimally Invasive Surgery

Michael S. Nussbaum, MD, FACS, FICS, Professor and Chair, Department of Surgery, Division of General Surgery; Program Director, Surgery Residency; Program Director, Minimally Invasive Surgery Fellowship; University of Florida College of Medicine, Jacksonville, FL

INTEGRATIVE MULTI DISCIPLINARY MANAGEMENT OF PERIPANCREATIC FLUID

2:00 - 3:30 PM

Salon A&B

Moderators: Michael Nussbaum, MD & Anand Annamalai, MD

This session will discuss various approaches for drainage of peripancreatic fluid. Upon completion of this course participants will have a better understanding of the issues related to and management of drainage of peripancreatic fluid as well as how these issues relate to pancreas transplant.

Role of Total Pancreatectomy and Islet Autotransplantation in Management of Refractory Abdominal Pain Due to Chronic Pancreatitis

M. Hosein Shokouh-Amiri, MD, FICS, Clinical Professor of Surgery, LSUHSC, Shreveport, LA

Pancreas Transplantation (PTX) with Venous Drainage to IVC: Short and Long-Term Outcome

Mark R. Laftavi, MD, FICS, Surgical Director of Transplant Department at Erie County Medical Center, Buffalo, NY

Pancreatic Cancer Screening - Ready for Prime Time or Doomed to Fail?

Roberto Gamarra, MD, Assistant Clinical Professor - Oakland University School of Medicine, Farmington Hills, MI

Is There a Cure for Diabetes? Bariatric Surgery vs. Pancreatic Transplant

Vijay K. Mittal, MD, FICS, Chair and Program Director, General Surgery, Providence Hospital and Medical Centers, Southfield, MI; Associate Clinical Professor of Surgery, Wayne State University, Detroit, MI

Coffee Break

3:30 - 3:45 PM

Salon D



L-R: R. Dieter, Jr., J. Scott, K. Fathie, A. Sabbagh, J. Teplinsky

MANAGEMENT OF MEDIASTINAL PATHOLOGY

3:45 - 5:15 PM

Salon A&B

Moderator: Ari Halldorsson, MD

Young adults present to the Emergency Department with shortness of breath and pleuritic chest pain and are found to have unexplained mediastinal emphysema. This session will review optimal imaging studies required for a thorough but expeditious work-up of mediastinal emphysema in the non-trauma setting and the reduction of the number of imaging studies performed as well as in-patient hospital admissions for patients with non-traumatic mediastinal emphysema. In addition, the management of malignant pleural mesothelioma and thoracic empyema will be reviewed. Upon completion of this course participants will have obtained the necessary knowledge to improve diagnosis and management of these conditions.

Spontaneous Mediastinal Emphysema - A Clinical Quandary

Francis J. Podbielski, MD, MS, FICS, Associate Professor of Surgery, University of Massachusetts Medical School, Plymouth, MA

Trends and Practice Pattern in the Management of Thoracic Empyema

Sibu P. Saha, MD, MBA, FICS, Professor of Surgery, University of Kentucky, Lexington, KY

Controversies and Current Management of Malignant Pleural Mesothelioma

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

Saturday, June 8, 2013

CHALLENGES FOR THE ACUTE CARE SURGEON

8:00 - 9:45 AM

Salon A&B

Moderator: Uretz Oliphant, MD

This session will focus on the identification and treatment options for challenging cases in acute care 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.

The Open Abdomen: Stepping Up to the Challenge

Lou M. Smith, MD, FICS, University of Tennessee at Knoxville Associate Professor of Surgery, Knoxville, TN

Management of the Exsanguinating Patient: What the Trauma Surgeon Knows That Every Elective Surgeon Should Know

Mallory Williams, MD, MPH, FICS, Associate Professor of Surgery, University of Toledo College of Medicine Chief, Division of Trauma, Critical Care, & Acute Care Surgery, Toledo, OH

A Trauma Training Program for Countries with Developing Trauma Systems

Kelly Withum, MSPH, University of Miami Miller School of Medicine, Miami, FL

Traumatic Abdominal Wall Hernia: A Case Series From a Rural Level I Trauma Center

Lacey Stelle, MD, General Surgery Resident, Carle Foundation Hospital, Urbana, IL, Clinical Instructor of Surgery, University of Illinois, Urbana, IL

Percutaneous Retrieval of Retrohepatic IVC Missile

Jesse Flores, MD, Department of Surgery, Texas Tech University Health Science Center, Lubbock, TX

Thigh Hematoma: A Different Type of Compartment Needing a Different Type of Approach

Ashley Mekala, DO, Department of Surgery, Texas Tech University Health Science Center, Lubbock, TX

Coffee Break

9:45 - 10:00 AM

Salon D

ROBOTIC SURGERY AND OTHER TECHNOLOGY ADVANCEMENTS

10:00 - Noon

Salon A&B

Moderators: Wayne Zhang, MD & Marc Dean, MD

Covering the entire spectrum of surgery, robotic options and other technology advances will be presented during this multidisciplinary session. Upon completion of this course participants will increase their understanding of the advances presented allowing for improved patient care decisions.

TORS: How Robotic Surgery is Changing Head and Neck Surgery

Marc R. Dean, MD, FICS, Assistant Professor of Otolaryngology, LSUHSC, Shreveport, LA

Review of Cataract Surgery: Where it Has Been and Where it is Going

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

Surgical Management and Risk-Reduction in Patients with Hereditary Breast and Gynecologic Cancer Syndromes

Robin A. Lacour, MD, MPH, FICS, Clinical Assistant Professor, Gynecologic Oncology, Louisiana State University Health Sciences Center, Shreveport, LA

The Utility of Preoperative MR Breast in Changing the Surgical Management of Patient's Newly Diagnosed with Breast Cancer

Nikhil Rajadhyaksha, MD, Radiology Resident, Providence Hospital and Medical Center, Royal Oak, MI

Percutaneous Drainage of Diverticular Abscess Should Be Limited to Two Attempts for Recurrent Diverticular Abscess

Gokulakrishna Subhas, MD, Resident in General Surgery, Providence Hospital and Medical Centers, Southfield, MI



L-R: D. Litwin, A. Pino, K. Pettine, S. Vithiananthan

Lunch - Practice Management Presentation

Noon - 1:30 PM

Salon C

Moderator: Francis Podbielski, MD

Management of Legal, Tax, and Insurance Liability Risks for Practice Profitability in 2013

Victoria J. Powell, JD, LLM, President of P Inc., Ridgeland, MS

Scientific Program

HONORED LECTURES

1:30 - 2:30 PM

Salon A&B

Moderator: Larry S. Sasaki, MD

Diamond Anniversary Lecture

Twenty years Experience With Living-Related Liver Transplantation in Children

Paul M. Colombani, MD, Professor of Surgery, Children's Surgeon-in Charge, at The Johns Hopkins Hospital, Lutherville, MD

Honorary Fellow Lecture

Improving Perioperative Care - Can We Shorten Recovery and Improve Outcomes?

H. Randolph Bailey MD, FICS, Clinical Professor of Surgery at the Weil Cornell Medical College and The University of Texas Health Science Center, Houston, TX



L-R: P. Bleck, J.C. Serrato, E. Nicolo, S. Saha, V. Mittal

TRANSPLANTATION IN THE 3RD MILLENNIUM

2:30 - 3:45 PM

Salon A&B

Moderator: M. Hosein Shokouh-Amiri, MD

Transplantation has evolved into an accepted therapy for many congenital or acquired disorders. We have seen major changes in indications and transplant techniques. This session will provide updates on various types of transplantation cases and related treatment options and risks. Upon completion of this course participants will increase their knowledge and ability to discuss treatment options and risks with patients that are considering various types of transplantation.

A Novel Approach for Surgical Management of Renal Artery Aneurysm: Experience with 6 cases

Henry Huang, MD, University of Tennessee Health Science Center at Memphis, Memphis, TN

Transplantation of a Severed Arm

Joshua Salvador, MD, FRCS(C), Past President of the Denton Cooley Surgical Society, Hollywood, FL

Translational Strategies to Improve Outcomes of Liver Transplantation: From Bench to Bedside

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

Risk Factors (RF) Affecting Long-Term (LT) Outcomes in Older Kidney Transplant Recipients (KTR): 10 Year Outcomes

Mark R. Laftavi, MD, FICS, Surgical Director of Transplant Department at Erie County Medical Center, Buffalo, NY

SURGICAL ONCOLOGY

3:45 - 5:15 PM

Salon A&B

Moderators: Larry S. Sasaki, MD & Bharat Guthikonda, MD

Various oncologic issues are discussed in this session comprised of invited presentations and submitted abstracts. Participants will increase their knowledge as it relates to the unique complications of surgical oncology.

Featured Presentation

Prognostic Impact of Colorectal Liver Metastases and Locally Advanced CRC

Xishan Wang, MD, Professor of Surgery, The Second Affiliated Hospital of Harbin Medical University, Director, Department of Colorectal Surgery, Director, Cancer Center, Director, Colorectal Cancer Institute of Harbin Medical University, Harbin, China

Prognostic Significance of SUV Max Value at the Time of Initial Diagnostic 18F-FDG PET/CT in Patients with Pancreatic Adenocarcinoma

Alireza Hamidian Jahromi, MD, Resident of General Surgery, Department of Surgery, Louisiana State University Health Sciences Center-Shreveport, LA

Comparative Effectiveness and Survival Benefit of Liver Directed Therapy, Systemic Chemotherapy and Radiation Therapy in Stage Four HCC: A SEER-Medicare Analysis

Nader N. Hanna, MD, FICS, Professor of Surgery & Director of Clinical Operations Division of General & Oncologic Surgery, Baltimore, MD

Leiomyosarcoma Arising from the Right Lobe of the Liver: A Case Report

Jobelle Joyce Anne Baldonado, MD, Resident, Department of Surgery, Philippine General Hospital, Manila, Philippines

Accuracy of 18F-FDG PET/CT in the Diagnosis of Pancreatic Lesions: A Single Center Experience

Alireza Hamidian Jahromi, MD, Resident of General Surgery, Department of Surgery, Louisiana State University Health Sciences Center-Shreveport, LA



L-R: W. Vigneswaran, J. Bachicha, D. Ranjan, L. Sasaki, A. Halldorsson

Hands-On Workshops

SEEING AND STICKING WITH SOUND: ULTRASOUND GUIDED VASCULAR ACCESS AND FAST FOR SURGEONS

Friday, June 7

2:00 - 5:00 PM

Pensacola Room

Moderators: Horacio D'Agostino, MD & Annette Rebel, MD

Surgeons, anesthesiologists, ER/ED physicians who need to place central and peripheral lines or pathologists who need to biopsy solid organs currently do so without image guidance. This contributes to patient morbidity and mortality, failed procedures and unnecessary complications. This course will provide a basic knowledge of ultrasound technique through a series of didactic presentations as well as hands-on experience in ultrasound guided needle localization, vascular access, and FAST exam. Upon completion of this course the participant will understand as well as feel comfortable with basic ultrasonography and will also be able to begin using these techniques in practice.

Didactic Series Faculty

Basics of Ultrasound

Zaki-Udin Hassan, MD, FICS, Associate Professor, Director of the Simulation Center, Department of Anesthesiology, University of Kentucky, Lexington, KY

Ultrasound Guided Needle Localization

Horacio D'Agostino, MD, FICS, Professor of Radiology, Surgery, and Anesthesiology, Chair Dept. of Radiology, LSUHSC, Shreveport, LA

FAST Exam

Annette Rebel, MD, FICS, Assistant Professor of Anesthesiology, Department of Anesthesiology, University of Kentucky, Lexington, KY

Endovascular Technique

Wayne Zhang, MD, FICS, Associate Professor and Chief Vascular & Endovascular Surgery, LSUHSC, Shreveport, LA

Hands-On Workshop Instructors

Ultrasound Guided Needle Localization

Horacio D'Agostino, MD, FICS

Ultrasound Guided Vascular Access

Zaki-Udin Hassan, MD, FICS

FAST/ER Fans

Annette Rebel, MD, FICS

Asser Youssef, MD, FICS, Assistant Professor of Surgery, Chief/Medical Director, Trauma and Critical Care Surgery, LSUHSC, Shreveport, LA

Endovascular Simulation

Wayne Zhang, MD, FICS

This workshop requires a separate registration fee of \$50 in addition to the PAID general registration fee. Registration in advance is required as space is limited and will be assigned on a first come-first served basis. **Check with the On-Site Registration Desk to add this to your registration.**

CHALLENGES IN ABDOMINAL WALL RECONSTRUCTION: MANAGEMENT OF THE OPEN ABDOMEN AND COMPLEX HERNIAS

Saturday, June 8,

9:00 - Noon

Tampa Room

Moderator: Lou Smith, MD

Offering a comprehensive review of pre-clinical and clinical data this session will discuss the management of the open abdomen as well as complex hernias and the challenges posed to even the most experienced surgeon. New technologies using both biological and synthetic mesh as well as the latest applications utilizing wound closure devices will be demonstrated during a hands-on cadaver lab. During this interactive workshop participants will learn how to identify appropriate indications and appropriate operative techniques in management of the complex abdominal wall hernia. Participants will also increase their knowledge of hernia repair techniques, materials and indications for use. This workshop has been sponsored by DePuy Synthes and LifeCell

Anthony N. Dardano, DO, FICS, ICS-US Co-Chair Division of Plastic Surgery, Voluntary Assistant Professor of Surgery, Miller School of Medicine, University of Miami, Miami, FL

Jose F. Yeguez, MD, FICS, Department of Surgery at Boca Raton Regional Hospital and Delray Medical Center, Boca Raton, FL

This workshop requires a separate registration fee of \$100 in addition to the PAID general registration fee. Registration in advance is required as space is limited and will be assigned on a first come-first served basis. **Check with the On-Site Registration Desk to add this to your registration.**



Neurologic & Orthopaedic Program

SCIENTIFIC KEYNOTE SPEAKER



Pediatric Traumatic Brain Injury: Present And Future Management

David Adelson, MD, Director, Barrow Neurological Institute at Phoenix Children's Hospital Chief, Pediatric Neurosurgery/ Children's Neurosciences Clinical Professor of Surgery/Neurosurgery, University of Arizona Adjunct Faculty, School of Biological and Health Systems Engineering, Arizona State University, Phoenix, AZ

P. David Adelson, MD, FACS, FAAP, an internationally recognized neurosurgical and neuroscience expert in head injury and epilepsy in children, is the Director of the Barrow Neurological Institute at Phoenix Children's Hospital and the Division Chief of Neurosurgery.

Dr. Adelson, whose work has been published in numerous medical and scientific journals, is the principal investigator of a National Institute of Health (NIH) funded multicenter clinical trial to evaluate whether hypothermia can improve the outcome for children following severe traumatic brain injury. He has been funded through numerous extramural grants from the NIH and Centers for Disease Control (CDC) as well as through foundation support for his basic science laboratory and clinical research. He has been recognized as one of the foremost experts on pediatric head injury clinical management. His other clinical and research interests include pediatric epilepsy, brachial plexus and peripheral nerve injury, and pediatric brain tumors. He has been the recipient of multiple awards, includ-

ing The Best Doctors in America, Young Investigators Award of the Brain Injury Association, Congress of Neurological Surgeons Clinical Investigation Award and Outstanding Physician Award.

He is an active participant in multiple scientific and professional societies. Dr. Adelson is presently the President of the Congress of Neurological Surgeons and the Past Chair of the AANS/ CNS Section on Neurotrauma and Critical Care. He also sits on the Executive Committees of the Committee on Trauma of the American College of Surgeons, and previously on the Section of Neurological Surgery for the American Academy of Pediatrics, and the National Neurotrauma Society, to name a few.

Dr. Adelson was recruited to Arizona from the Children's Hospital of Pittsburgh where he served most recently as the A. Leland Albright Professor of Neurosurgery/ Pediatric Neurosurgery and Vice Chairman, (Research) at the University of Pittsburgh School of Medicine. He also served as the Director of Pediatric Neurotrauma, the Surgical Epilepsy Center, Brachial Plexus and Peripheral Nerve Center and Clinic, Center for Injury Research and Control, and Walter Copeland Neurosurgical Laboratory.

Dr. Adelson received his medical degree from Columbia University, New York, NY, and completed the neurosurgical residency program at the University of California, Los Angeles, School of Medicine, Los Angeles, Calif. He then obtained additional specialty training as a fellow in pediatric neurosurgery at Children's Hospital of Boston and Harvard Medical School, Boston, Mass., before moving on to Pittsburgh.

SOCIAL KEYNOTE SPEAKER



Safety in the OR: Lessons from the Cockpit

Ingemar Davidson, MD, PhD, FACS, Professor of Surgery, Division of Surgical Transplantation, University of Texas Southwestern Medical Center Dallas, TX

Ingemar J.A. Davidson a native of Sweden graduated at the University of Gothenburg, Sweden. Dr. Davidson's focus is organ transplantation, Dialysis Vascular Access in End Stage Renal Disease patients. He is Professor of Surgery, at the University of Texas Southwestern Medical Center Dallas, TX and Medical Director Parkland's Vascular Access Clinic. He is a member of medical professional societies, such as the American College of Surgeons,

American Medical Association, American Society of Transplant Surgeons and The Transplantation Society (International), Texas Transplantation Society (former president), and a past Board Member of Southwest Transplant Alliance (Organ Bank). Dr Davidson's research and experience is reflected in books, peer reviewed publications and proceedings. He is a current or past Reviewer for Critical Care Medicine, Journal for the American Society of Nephrology, Clinical Transplantation, Kidney International, and Juvenile Diabetes Foundation-International. He is member of the Editorial Board of Journal of Vascular Access. He has directed post-graduate programs dedicated to Transplantation and Access for Dialysis most notably CiDA (Controversies in Dialysis Access) now at its 10th year. He is a requested lecturer at congresses and symposiums in the USA and worldwide, including team building strategies. Dr. Davidson initiated and maintains a development of several clinical activities, and a co-investigator for active NIH grant supported clinical dialysis access studies.

Neurologic & Orthopaedic Program

Friday, June 7, 2013

NEUROSURGICAL AND ORTHOPAEDIC PLATFORM PRESENTATIONS

9:00 - Noon

Omni Ballroom

Welcome and Introductions

Kazem Fathie, MD, FICS, Clara Raquel Epstein, MD, FICS, Maxime Coles, MD, FICS

Moderators: Clara Raquel Epstein, MD, FICS, Jeffrey M. Epstein, MD, FICS, Lucia Zamorano, MD, FICS

International Neurosurgery - The State of Neurosurgery, Medicine and Politics in Kurdistan, Northern Iraq

Gene Bolles, MD, Neurological Surgeon, Assistant Professor, University of Colorado, Department of Neurosurgery; Denver Health Medical Center, Rocky Mountain Regional Trauma Center, Denver, CO

Current Advances in Epilepsy Surgery

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

Surgical Treatment of Arachnoid Cyst. Experience of the National Institute of Pediatrics. Mexico City

Javier Terrazo-Lluch, MD, MSc, Staff Neurosurgeon of National Institute of Pediatrics, Mexico City, Mexico

Quality Improvement Proposal: What is the Best Matrix for a Neurosurgeon Patient Care Sequence?

Hector E. James, MD, Professor of Neurosurgery and Pediatrics, University of Florida College of Medicine, Jacksonville, FL

Importance of Low-Amplitude Positive Facial Nerve Stimulation Following CP Angle Tumor Surgery

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

Emerging Technologies; Are Some Surgeons Becoming Obsolete?

Clara Raquel Epstein, MD, FICS, Neurosurgeon/CEO, The Epstein Neurosurgery Center, LLC, Boulder, CO

Neuromodulation: New Options for Old Problems

Jeffrey Epstein, MD, FICS, Neurosurgeon, Brookhaven Memorial Hospital Medical Center, Babylon, NY/Patchogue, NY

Trigeminal Neuralgia - Clinical Observations from Latin American Experience

Mauro Alberto Segura Lozano, PhD, Neurosurgery Department, General Hospital of Morelia, Mexico Mexican Neurological Surgery Board National Board of Science and Technology of Mexico, Morelia, Mexico

Scientific Key Note Speaker

Pediatric Traumatic Brain Injury: Present And Future Management

David Adelson, MD, Director, Barrow Neurological Institute at Phoenix Children's Hospital Chief, Pediatric Neurosurgery/ Children's Neurosciences at Phoenix Children's Hospital, Phoenix, AZ

Dr. Adelson will provide an overview on traumatic brain injury in children that will include a review of injury and mechanism, unique aspects of age at injury, the pathophysiology of primary and secondary mechanisms, present management through evidence based review of the literature, the pediatric guidelines recommendations, the use of advanced neural monitoring, and future approaches and targets for therapy in children and adults.

Lunch - Humanitarian Outreach Presentation

Noon - 1:30 PM

Salon C

Operation Hope: Humanitarian Medical Outreach

John Thomas, MD, Lubbock, TX

NEUROSURGICAL AND ORTHOPAEDIC PLATFORM PRESENTATIONS

1:30 - 3:00 PM

Omni Ballroom

Moderators: Clara Raquel Epstein, MD, FICS, Jeffrey M. Epstein, MD, FICS, Lucia Zamorano, MD, FICS

Applications of Neuroendoscopy in Neuro-Oncology

Chandrashekhar E. Deopujari, MD, Professor and Head, Neurosurgery, Bombay Hospital (Institute of Medical Sciences), Mumbai, India

Management of Cerebrospinal Fluid Leaks During Anterior Cervical Surgery

William Welch, MD, FICS, Professor of Neurosurgery, Chair, Department of Neurosurgery, Pennsylvania Hospital; Vice-Chair, Department of Neurosurgery, Perelman School of Medicine at the University of Pennsylvania, Philadelphia, PA

The Role of Hemicraniectomy in the Management of Patients with Space-Occupying MCA Infarction

W. Craig Clark, MD FICS, Neurosurgeon, President, The Neurosurgical Center, Memphis, TN

Neurologic & Orthopaedic Program

Hemispherectomy

Jaime Diegoperez Ramirez, MD, FICS, Neurosurgeon, Centro Neurológico CMABC, México City, México

Chronic Pain, Insomnia and Depression

Richard Gershanik, MD, Orthopaedic Surgeon, Neurological & Neurosurgical Pain Management Center, Miami, FL

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

Robert S. Mathews, MD, FICS, Orthopaedic Surgeon, First Team Institute LLC, Lancaster PA, Barnes Kasson Hospital, Susquehanna PA

Ovation Placental Tissue Based Adjunct to Spinal Fusion and Beyond

E. Jeffrey Donner, MD, Orthopaedic Surgeon, Co Founder, The Spine Institute, Loveland, CO

Penetrating and Ballistic Injuries in Neurosurgery - An Epidemic

Gene Bolles, MD, Neurological Surgeon, Assistant Professor, University of Colorado, Department of Neurosurgery; Denver Health Medical Center, Rocky Mountain Regional Trauma Center, Denver, CO

Kyphoplasty with Radiofrequency

Manuel Eduardo Soto García, MD, Villahermosa, Mexico

LESS Exposure Segmental Cervical Plating

Josue Gabriel, MD, FICS, Orthopaedic Surgeon, Spine Institute of Ohio, Columbus, OH

Paraganglioma of the Cauda Equina

W. Craig Clark, MD, FICS, Neurosurgeon, President, The Neurosurgical Center, Memphis, TN

Role of Intraoperative Near Infrared Indocyanine Green Videoangiography in Aneurysm Surgery

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

A Hemiarthroplasty Experience Using a Proximal Femoral Cerclage Cable

Gerald Greenfield, Jr., MD, FICS, Private practice Orthopaedic Surgery South Texas Spinal Clinic/ Southwest Texas Methodist Hospital Clinical Assistant Professor University of Texas health Sciences Center- San Antonio, TX

Vagal Neuralgia

Richard Gershanik, MD, Orthopaedic Surgeon, Neurological & Neurosurgical Pain Management Center, Miami, FL

Saturday, June 8, 2013

NEUROSURGICAL AND ORTHOPAEDIC PLATFORM PRESENTATIONS

9:00 - Noon Omni Ballroom

Welcome and Introductions

Kazem Fathie, MD, FICS, Clara Raquel Epstein, MD, FICS, Maxime Coles, MD, FICS

Moderators: Clara Raquel Epstein, MD, FICS, Jeffrey M. Epstein, MD, FICS, Lucia Zamorano, MD, FICS

AANOS Resident Scholarship Recipient

Safe and Effective Atlanto-Axial Stabilization with Long Term Intra-Articular Arthrodesis

Doniel Drazin, MD, Senior Neurosurgery Resident, Department of Neurosurgery, The Spine Center, Cedars-Sinai Medical Center, Los Angeles, CA

Endoscopic Transforaminal Approach for Disc Herniation and Stenosis

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

The Dorsal Root Ganglion - An Emerging Neuromodulation Target

Richard L. Weiner, MD, FACS, Vice Chair, Dept of Neurosurgery, THR-Presbyterian Hospital, Dallas, Texas, Clinical Associate Professor of Neurosurgery, University of Texas Southwestern Medical School, Dallas, TX

Buttock Pain and Sciatica: When a Herniated Lumbar Disc is Not the Cause

Arnold Graham Smith, MD, Orthopaedic Surgery, Spine Rehabilitation and Surgery, Jacksonville, FL

Lunch - Practice Management Presentation

Noon - 1:30 PM Salon C

Moderator: Francis Podbielski, MD

Management of Legal, Tax, and Insurance Liability Risks for Practice Profitability in 2013

Victoria J. Powell, JD, LLM, President of P Inc., Ridgeland, MS

Social Activities

ALLIANCE BOARD OF DIRECTORS & GENERAL MEMBERSHIP MEETING

Wednesday 2:00-3:00 PM Jacksonville Room

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.

WELCOME RECEPTION

Wednesday 6:00-7:00 PM Pensacola Room

Our first evening in Jacksonville begins with a cocktail reception. Join us as we kick off our very special 75th annual meeting; reconnect with old friends and meet members you may not have encountered before. 75 years wouldn't happen without our members, join us as we celebrate your commitment to the College.

JACKSONVILLE "TOP TO BOTTOM" WALKING TOUR

Thursday 2:00-3:45 PM Meet at Registration Desk

Your professional tour guide will meet you to show you Jacksonville from sky line views to beneath the city streets. Once known as "Cowford", the picturesque city along the river has grown to be the largest city in land area in the continental United States. Hear how Jacksonville rose from the ashes to emerge as an architectural gem of the South. The city was also the first Hollywood for movie making before the talkies. The walking tour goes inside seven buildings including an art gallery. The "Top" is an amazing panoramic view from the tallest skyscraper while the "Bottom" is the subterranean city with secret underground tunnels and bank vaults. Hear the exploits of past Presidents, great American architects, and the silent movie stars as we walk through time. The award-winning tour is rated EXCELLENT by Trip Advisor and was featured on PBS television. **Price: \$20, Check with Registration staff for on-site availability.**

ST. AUGUSTINE EXCURSION

Friday 9:30 - 3:00pm Meet at Registration Desk

During your trip to St. Augustine your tour director will weave a tapestry of stories from the Ponce de Leon discovery period, the pirate days of Sir Francis Drake, the Spanish and English colonial years, and the Victorian Flagler era. Before you know it you'll be stepping onto the cobblestones of St. George Street.

You'll have an opportunity to shop and explore the historic district on your own. Alternatively, you may want to stay with the tour guide to take a more intimate look inside the historic houses or magnificent hotels containing the stained glass work of Louis Comfort Tiffany. Your guide creates an interactive tour atmosphere which is fun for everyone. **Seats are VERY limited Price: \$90 Check with Registration staff for on-site availability.**

4TH ANNUAL AANOS FUNDRAISING EVENT AND AWARDS DINNER

Friday 7:00-10:00 PM Pensacola Room

The 4th Annual AANOS Fundraising Event and Awards Dinner will feature an elegant dinner, award presentations, and an engaging presentation by Ingemar Davidson, MD, Professor of Surgery, Division of Surgical Transplantation, University of Texas Southwestern Medical Center, Dallas, TX and American Airlines pilot Billy Nolan, who will present; **Safety in the OR: Lessons from the Cockpit**

Price: \$100 per person. Check with Registration staff for on-site availability.

UNITED STATES SECTION CONVOCATION & AWARDS CEREMONY

Saturday 6:30 PM Salon D

All attendees, families, friends and guests are invited to attend this hallmark event, the 75th Annual Convocation of the US Section. Brimming with splendor and pageantry, this impressive ceremony includes the formal induction of New Fellows and the presentation of several special awards. Join us in this celebration of the College, all its Fellows, and their accomplishments.

NEW FELLOWS RECEPTION

Saturday 7:30 PM Prefunction

Immediately following the Convocation and Presidential Recognition Ceremony, this reception will afford you the opportunity to meet your National Section and International Officers, provide you with the opportunity to meet your newest colleagues from coast to coast, and of course, honor our incoming President and award winners. All attendees are encouraged to attend.

GALA DINNER

Saturday 8:30 PM Salon A&B

We end our meeting and our week together as we started it; in Fellowship, join us as we come together for one last event to mark our Diamond Anniversary; 75 years of Member Driven success before we bid farewell until next year. We have some wonderful entertainment planned to celebrate this milestone of scientific education and fellowship. Black Tie attire is optional. The three course dinner will feature filet with shrimp scampi for the entree. There will also be a vegetarian options available. **Price: \$125 per person. Check with Registration staff for on-site availability.**



The John C. Scott, MD, Surgical Endowment Fund of the United States

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 wor-

thy 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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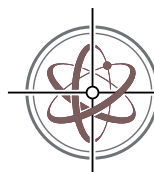
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1. Data on file, Bausch & Lomb Incorporated, SurgiVision DataLink. **2.** Pepose JS, Qazi MA, Edwards KH, Sanderson JP, Sarver EJ. Comparison of contrast sensitivity, depth of field and ocular wavefront aberrations in eyes with an IOL with zero versus positive spherical aberration. *Graefes Arch Clin Exp Ophthalmol.* 2009;247(7):965-973. **3.** Pepose JS, Qazi MA, Davies J, et al. Visual performance of patients with bilateral vs combination Crystalens, ReZoom, and ReSTOR intraocular lens implants. *Am J Ophthalmol.* 2007;144(3):347-357.

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Scientific Abstracts

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

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Scientific Abstracts

THE GLOBAL SURGICAL BURDEN OF DISEASE- WHO CAN HELP AND HOW CAN WE HELP?

Domingo Alvear, MD, FICS

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

Purpose: The access to emergency and elective surgery in the developing world is limited. It is estimated that of the 234 million operations performed annually worldwide, only 8.1 million (3.5%) are undertaken in low income countries. Surgical care is the neglected disease of global health in these countries since most of the funding is for the eradication of malaria, HIV, malnutrition and communicable diseases.

Methods: Life changing surgical procedures that can make a person "whole" are neglected as important. An estimated 6,000 short term surgical missions are undertaken every year from the U.S. to these countries to an estimated cost of 250 million dollars.

Results: This paper will discuss experience in two countries- Honduras and the Philippines- and what has been done to achieve long term and sustainable improvement of surgical care in these two countries. Potential solutions to this global crisis will be proposed.

LEIOMYOSARCOMA ARISING FROM THE RIGHT LOBE OF THE LIVER: A CASE REPORT

Jobelle Joyce Anne Baldonado, MD

Resident, Department of Surgery, Philippine General Hospital
Taft Avenue, Manila City, Philippines

Purpose: Leiomyosarcoma is a rare, high-grade smooth muscle soft tissue tumor that arises primarily from the liver in 0.1-2% of cases. Because of its rarity, the standard of care for this condition has not yet been established. We report the case of a 41 year old Filipino male who came in for hematochezia and was found to have a tubulovillous adenoma during colonoscopy. Further workup showed an incidental finding of a hepatic mass on ultrasound, eventually proving to be leiomyosarcoma by histopathology after hepatic resection.

ACUTE APPENDICITIS IN ELDERLY: DIAGNOSIS AND MANAGEMENT STILL A CHALLENGE

Jasneet Bhullar, MD, MS, Junior Fellow ICS

Surgery Resident, Providence Hospital & Medical Centers, Southfield, MI

Purpose: Acute appendicitis is a common surgical emergency affecting all age groups. Early diagnosis with appropriate management improves outcomes. With an aging population, focus has shifted on better care and outcomes in the elderly.

Methods: A retrospective chart review of 790 patients treated for appendicitis at a community urban hospital from Aug 2008 to Aug 2011 was done. Demographic features, preoperative clinical diagnosis, diagnostic workup, Alvarado score, operative interventions and postoperative morbidity were analyzed.

Results: Of the 790 patients, 51% were male and 49% female. While 14% of patients were >60, 75% were between 15-60 years of age. Mean BMI was 27 ± 7 kg/m². The WBC count of most patients (56%) was between 10800-20,000, while in 26% it was below 10,000. Diagnosis was made on clinical evaluation alone (3%), radiological basis alone (8%) or combination of both (73%). 49% of patients had an Alvarado score of 6-8 and 30% had a score of 3-5. Majority (78%) underwent laparoscopic appendectomy. Overall morbidity was 8% with 1 mortality.

Mean length of stay in <16 (1.5 ± 1.0) and 16-60 years-old age groups (2.0 ± 2.3) was significantly increased in 60-85 (4.5 ± 4.5 days) and >85 years-old age groups (6.2 ± 3.6). Increasing age (>60 vs. <60 years old) was associated with increased morbidity (14% vs. 7%, respectively, $p < 0.0001$), but not with gender or BMI ($p < 0.069$).

Conclusion: Patients over the age of 60 with acute appendicitis had an increased morbidity and length of stay as compared to younger patients. A high degree of suspicion to expedite diagnosis and management in elderly may improve outcomes.

A TRUE ORTHOTOPIC GASTRIC CANCER MURINE MODEL USING ELECTROCOAGULATION

Jasneet Bhullar, MD, MS, Junior Fellow ICS

Surgery Resident, Providence Hospital & Medical Centers, Southfield, MI

Purpose: Orthotopic mouse models of human gastric cancer represent an important in vivo tool for testing chemotherapeutic agents and for studying intraluminal factors. Currently, orthotopic mouse models of gastric cancer require an operative procedure involving either injection or implantation of tumor cells in stomach layers. The resultant tumor does not grow from the stomach's mucosal surface; thus, it does not mimic the human disease process.

Methods: A low-dose gastric mucosal coagulation was done transorally in the body of stomach using a specially designed polyethylene catheter in 16 female SCID mice. This was followed by the instillation of SNU-16 human gastric cancer tumor cells (1×10^6 cells). Five mice each were euthanized at 1 and 2 months, and 6 mice were euthanized at 3 months. Three control mice underwent electrocoagulation alone and three mice underwent cell line instillation alone.

Results: Tumors were detected in 11/16 experimental mice but not in the control mice. Tumors were noted in mice at 1 month. Over time, there was an increase in tumor growth and metastasis to lymph nodes and surrounding organs. Histopathological evaluation showed that the tumors grew from the gastric mucosa.

Conclusion: Our model is minimally invasive, easy to create, and overcomes the limitations of the existing models as the tumor arises from the stomach's mucosal layer, while mimicking the human disease in terms of morphology and biological behavior. This is the first report of a true orthotopic gastric cancer murine model. This model opens new doors for further studies which were not possible earlier.

VENOUS CIRCULATION CONTROL IN THE HEALING OF NEUROPATHIC ULCERS

Frank Bongiorno, MD, FICS

Wound specialists of Michigan Plc

Purpose: To assess the contribution of the venous circulation on wound healing

Methods: Clinical experience and methodology of treatment.

Results: Control of the venous circulation is of the utmost import to wound healing and leg salvage in all Neuropathic ulcers though this aspect of care is the most frequently ignored and the cause of many needless amputative procedures.

Conclusion: It has been estimated that 80% of amputative procedures could have and could be prevented with proper control of the venous circulation.

Scientific Abstracts

PATHOLOGY ENCOUNTERED ON SHORT-TERM SURGICAL MISSION TRIPS TO THE DOMINICAN REPUBLIC

Kathryn Cameron, MD

General Surgery Resident, Providence Hospital and Medical Center, Southfield, MI

Purpose: Surgical disease presents a large burden to the global population and far exceeds the availability of surgical care. Many methods exist for bridging this gap, but none is able to meet all the demand. One such process for providing surgical care in underserved countries is short-term mission trips. The efficiency and success of a surgical mission trip depends on appropriate pre-trip planning and knowledge of potential pathology encountered, but few reports exist to aid in predicting what pathology might be seen. Furthermore, the restrictions seen in a resource-poor setting offer a valuable opportunity for surgical residents to learn alternative surgical approaches and knowledge of the limitations that exist outside of a typical United States hospital setting. Therefore, the objectives of this study were to determine what surgical diseases are encountered on a typical mission trip, what factors limited ability to provide care, and evaluate the benefits offered to a surgical resident participating in such a trip.

Methods: The Michigan chapter of the Midwest Medical Missions group has taken annual trips to northeast Dominican Republic since 1974. This American group includes a general surgeon and resident and a gynecologic surgeon and resident, and works with local providers, publicizes ahead of time that surgeons will be available for charitable care. Patients are triaged, examined, and treated, and post-op care is provided during the one-week trip. Data collected included demographics of the patients seen, pathology encountered, and operative for two trips taken in 2010 and 2012.

Results: The surgical teams performed a total of 70 cases over the last two trips. The majority of patients who were seen by surgeons received an operation (79%), though a significant unknown number of patients were triaged by local nurses and not seen by the surgeons. Hernia repairs (28%) and tubal ligations (22%) comprised a majority of the cases performed, and most other cases were within the realm of a typical general surgical practice, including lipomas, sebaceous cysts, and hydroceles. Also, a broad range of less common pathology was seen, including conditions not able to be addressed by the team.

Conclusion: Short-term surgical mission trips need effective planning in order to treat a significant number of patients safely and efficiently. Planning depends on the foreknowledge of disease processes that will be considered and having appropriate equipment and personnel on-hand. While variability based on population and geographic region is anticipated, here we present an initial report on the experiences of a typical short-term surgical mission group's experience.

ACUTE APPENDICITIS IN ELDERLY: DIAGNOSIS AND MANAGEMENT STILL A CHALLENGE

Sushant Chaudhary, MD, MS

Resident, Department of Surgery,

Providence Hospital and Medical center, Southfield, MI

Purpose: Acute appendicitis is a common surgical emergency affecting all age groups. Early diagnosis with appropriate management improves outcomes. With an aging population, focus has shifted on better care and outcomes in the elderly.

Methods: A retrospective chart review of 790 patients treated for appendicitis at a community urban hospital from Aug 2008 to Aug 2011 was done. Demographic features, preoperative clinical diag-

nosis, diagnostic workup, Alvarado score, operative interventions and postoperative morbidity were analyzed.

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Conclusion: Patients over the age of 60 with acute appendicitis had an increased morbidity and length of stay as compared to younger patients. A high degree of suspicion to expedite diagnosis and management in elderly may improve outcomes.

PARANGLIOMA OF THE CAUDA EQUINA

W Craig Clark, MD, PhD

President and CEO, The Neurosurgical Center, Southaven, MS

Purpose: Parangliomas are benign and slow-growing neuroectodermal tumors commonly found in the adrenal medulla, carotid bodies, and glomus jugulare. Parangliomas of the cauda equina are relatively rare. We recently had occasion to treat two of these cases, and this provides an opportunity to review and discuss this interesting entity.

Methods: The data and information presented were derived from a retrospective review of patient medical records and radiographic studies, as well as a review of the relevant medical literature.

Results: Only a few cases of this distinctly uncommon tumor have been reported since the first case of spinal ganglioma was reported in 1970. They usually arise from the filum terminale and displace the nerve roots peripherally as they grow in size. Clinical symptoms are nonspecific, and patients most often present with features of a cauda equina syndrome, including back pain, radicular symptoms, and bladder disturbances. The pathogenesis remains uncertain, and several theories will be discussed. MRI features have been described, and will be discussed as well.

Conclusion: Recognition of this tumor is important because of its potential endocrine function and amine and peptide-containing secretory granules. Surgical resection is curative, and can be achieved with a careful microsurgical dissection and sectioning of the filum. Both of the cases reviewed showed neurological improvement following removal of the intradural mass.

THE ROLE OF HEMICRANIECTOMY IN THE MANAGEMENT OF PATIENTS WITH SPACE-OCCUPYING MCA INFARCTION

W Craig Clark, MD, PhD

President and CEO, The Neurosurgical Center, Southaven, MS

Purpose: The malignant cerebral edema that often accompanies MCA cerebral infarctions carries a mortality rate of up to 80% despite all tenets of medical management including endotracheal intubation, blood pressure control, osmotherapy, hyperventilation and barbiturate anesthesia. Decompressive hemicraniectomy with duroplasty helps to normalize ICP, restore compromised flow in the penumbra and adjacent vascular territories, and restore the midline position of the brainstem and diencephalon. This is NOT a new procedure, but it has been rarely performed because of the concern that it would result in survival with overwhelming neurological impairment, handicap and dependence.

Scientific Abstracts

Improvements in postoperative care and the reports of the DESTINY and DECIMAL trials make it mandatory that this issue be re-examined.

Methods: This study is a retrospective review of the relevant literature, with special emphasis on the DESTINY, DECIMAL and HAMLET trials examining the role of decompressive craniectomy and duroplasty in the management of uncontrolled cerebral swelling associated with MCA cerebral infarctions.

Results: Hemicraniectomy performed within 48 hours more than doubled the chances of survival, from 29 to 78%. This absolute risk reduction of 49% was highly significant and translates into a number needed to treat of 2 to avoid one fatality. In terms of disability, hemicraniectomy resulted in an increase in the proportion of patients with resulting disability. For every 10 hemicraniectomies performed for MCA infarction, 5 patients will escape death, and at 1 year of followup 1 will have mild disability, 1 will have moderate disability, and 3 will have moderate-to-severe disability (unable to walk).

Conclusion: Patients aged <60 with MCA infarcts benefit from Hemicraniectomy with duraplasty. This is true regardless of dominance of the involved hemisphere. This is true regardless of early vs. late (48 hrs) timing of surgery. This true regardless of race or sex of the patient.

DISSECTING MOLECULAR PATHWAYS IN BLADDER CANCER: A RATIONAL APPROACH TO PROGNOSTIC PROFILING AND TARGET DISCOVERY

Richard J Cote, MD

Professor and Joseph R. Coulter Jr. Chair, Department of Pathology, Chief of Pathology, Jackson Memorial Hospital, Director, Dr. John T. Macdonald Foundation Biomedical Nanotechnology Institute, University of Miami Miller School of Medicine

Despite elaborate characterization of risk factors, bladder cancer is still a major epidemiological problem and the ninth most common malignancy worldwide. Urothelial carcinoma is now recognized as a disease of alterations in several cellular processes. The more prevalent, less aggressive, recurrent, noninvasive tumors have constitutive activation of the Ras-MAPK pathway. The less common but more aggressive invasive tumors, which have a higher mortality rate, are characterized by alterations in the p53 and retinoblastoma pathways. Because of the current need for long-term and frequent follow-up, as well as the paucity of sensitive and specific noninvasive tests, bladder cancer management accounts for one of the highest costs per patient among all cancer types. Diagnostic tests have attempted to identify and characterize tumor cells exfoliated in the urine, whereas prognostic tests have tried to identify aberrations that predict tumor behavior and identify therapeutic targets. The role of various molecular determinants involved in the genesis, progression, and outcome of bladder cancer has been the focus of investigations for the past 3 decades. However, no individual marker has been prognostically powerful enough to change clinical management. Increasingly, analysis of the interplay between these molecular factors spanning different pathways is taking center stage. Technological advancements now enable detection and quantification of gene transcripts and protein products, enabling us to identify diagnostic, prognostic and therapeutic marker panels. Recent studies have therefore used multiple-marker analyses to generate informative panels that have greater clinical value for bladder cancer management. Molecular panels can provide a more objective alternative to clinical pa-

rameters for diagnosis and treatment decisions. Clinical trials for targeted chemotherapy for bladder cancer have commenced, and future trials will aim to treat urothelial carcinoma based on a patient's molecular profile to empower physicians to personalize patient treatment through increased therapeutic efficacy. The future of bladder cancer management will rely on the use of detection techniques that reliably diagnose the presence of disease, marker panels that predict individual tumor behavior, and molecular targets that allow deployment of novel therapeutics.

TORS: HOW ROBOTIC SURGERY IS CHANGING HEAD AND NECK SURGERY

Marc Dean, MD, FICS

Assistant Professor Otolaryngology, LSUHSC - Shreveport, LA

Purpose: The purpose of this talk is to update the audience on the Role of TORS in Head and neck Surgery

Methods: Literature review of current TORS Topics

Results: TORS gives surgeons unsurpassed visibility and dexterity in surgical procedures involving the pharynx,

Conclusion: TORS already provides distinct advantages for operations involving the pharynx and as technology and equipment are miniaturized there will be an ever increasing niche for TORS

SAFE AND EFFECTIVE ATLANTOAXIAL STABILIZATION WITH LONG TERM INTRA-ARTICULAR ARTHRODESIS

Doniel Drazin, MD

Department of Neurosurgery, Cedars-Sinai Medical Center Los Angeles, CA

Purpose: Stabilizing the atlanto-axial complex is a challenge due to its unique anatomy. There are several techniques which provide good fusion but they have high complication rates or sacrifice the C2 nerve root, resulting in chronic postoperative pain. We present a new C1-2 surgical technique which establishes reliable atlanto-axial fusion while sparing the C2 nerve root.

Methods: The C1-2 joint is accessed by retracting the C2 nerve root superiorly and drilling out the joint using a high-speed burr with C2 nerve-sparing. This is followed by meticulous placement of a C1 lateral mass screw and C2 pedicle screw. Arthrodesis is completed by packing the joint cavity with local autologous bone and/or recombinant human bone morphogenic protein.

Results: This surgical technique was used at Cedars-Sinai Medical Center in 47 surgical cases over an 11 year period. No vertebral artery injuries, C2 nerve injuries, or spinal cord injuries were noted. There were no cases of instrumentation failure. One patient required hardware removal for C1 screw impingement on the C2 nerve root, and at that point fusion had already taken place. Successful fusion was documented at a mean follow-up of 7.4 ± 3.1 months (range 3.3 - 80.7 months).

Conclusion: Atlanto-axial fusion using C1 lateral mass, C2 pedicle screws, C2-nerve sparing, and C1-2 intra-articular arthrodesis is safe and reliable. With high long term fusion and low complication rates, this technique is suitable for a wide variety of surgical interventions.

Scientific Abstracts

NEUROMODULATION: NEW TECHNOLOGY FOR AN OLD PROBLEM

Jeffrey Epstein, MD, FICS
St. Catherine's of Siena Medical Center

Purpose: New advancements in Neuromodulation technology give physicians the ability to obtain pain relief when we were unable to achieve it in the past. The possibilities, areas of coverage, and adaptability of the new technology far exceeds what has been achieved up to this point.

Methods: Utilizing a new 32 contact stimulating system with a novel programming platform, the ability to control current with the various lead combinations available affords the physician virtually unlimited programming combinations previously impossible to obtain, even with prior multiple current controlled systems.

Results: Areas of pain that were unable to be captured with older systems are now being covered. The ability to also utilize one implantable pulse generator where two were utilized in the past is a benefit to patients, as charging and controlling become easier.

Conclusion: The new neuromodulation system offers coverage possibilities that we are only starting to realize and understand. As work and further trials continue, physicians will be able to utilize this technology with greater adaptability than what was accomplished with older systems.

ACCURACY OF 18F-FDG PET/CT IN THE DIAGNOSIS OF PANCREATIC LESIONS: A SINGLE CENTER EXPERIENCE

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Purpose: 18F-FDG PET/CT is emerging as a useful imaging tool in the diagnosis and management of the patients with pancreatic lesions. Previous studies report high sensitivity and specificity for 18F-FDG PET/CT in the differentiation of benign and malignant pancreatic pathologies. The aim of the current study was to assess the accuracy of 18F-FDG PET/CT in the initial diagnosis of pancreatic lesions in patients who were evaluated at our center.

Methods: In this retrospective IRB approved study, charts of all patients who had 18F-FDG PET/CT from 2004 to 2011 at our center for initial evaluation of an undiagnosed pancreatic lesion were reviewed. A board certified nuclear medicine physician who was blinded to the final diagnosis evaluated all 18F-FDG PET/CT images. For all malignant lesions, final diagnoses were confirmed by tissue diagnosis; for benign or inflammatory lesions, final diagnoses were determined by tissue diagnosis and/or clinical course. Then, accuracy, sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV) of 18F-FDG PET/CT in diagnosis of pancreatic lesions were calculated.

Results: Among 176 patients that were evaluated, 89 (50.6%) patients had pancreatic adenocarcinoma [80 (89.9%) true positive (TP), 9 (10.1%) false negative (FN)], 6 (3.4%) had neuroendocrine tumors [4 (66.7%) TP, 2 (33.3%) FN] and 81 (46%) had other benign or inflammatory pancreatic pathologies [71 (87.7%) true negative (TN), 10 (12.3%) false positive (FP)]. Sensitivity, specificity, PPV and NPV of 18F-FDG PET/CT in the diagnosis of pancreatic lesions were 88.4%, 87.7%, 89.4% and 86.6%, respectively. The overall accuracy of 18F-FDG PET/CT in the diagnosis of pancreatic lesions was 88.1%.

Conclusion: In accordance with previous reports, our results show that 18F-FDG PET/CT has high accuracy, sensitivity, specificity, PPV and NPV in the initial diagnosis and differentiation of malignant from benign pancreatic lesions.

PERCUTANEOUS RETRIEVAL OF RETROHEPATIC IVC MISSILE

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Purpose: Injuries to the retrohepatic inferior vena cava (RIVC) after penetrating trauma carry a high mortality rate. Vascular control of these injuries is a daunting task. Several different methods have been used for vascular control with varying degrees of success. These include atrio-caval shunting, balloon shunting, sequential vascular clamping, and perihepatic packing. We describe a technique for endoluminal retrieval of a bullet from the RIVC in a patient who sustained a gunshot wound to the abdomen.

Method: A venocavogram and intravascular ultrasound were performed and confirmed that a bullet was lodged within the lumen of the RIVC. We were concerned for dislodgement of the bullet from the RIVC and embolization of the bullet. The patient was taken to the operating room for a total percutaneous retrieval of the RIVC bullet. A right femoral central venous approach was used to introduce a snare kit and position it around the bullet with the assistance of fluoroscopy. At the same time, a right internal jugular central venous approach was also used to place an occlusion balloon in the vena cava just above the bullet in case we had massive bleeding after bullet dislodgement from the RIVC.

Results: The bullet was successfully grasped with the snare kit and with the assistance of fluoroscopy, it was advanced toward the right groin. A groin cut down was done, along with a femoral venotomy with complete extraction of the bullet from the right femoral vein. A completion venocavogram did not show any extravasation from the RIVC after removal of the bullet. The patient did well post procedurally and was discharged home several days later.

Conclusion: It is our perception that this represents the first described percutaneous approach for the removal of a penetrating missile from the RIVC with minimal morbidity and mortality. A total percutaneous, endoluminal approach can offer an advantageous treatment option to treat such a devastating injury when compared with traditional open exposures. This approach should be bidirectional with the added protection of an occlusion balloon.

A HEMIARTHROPLASTY EXPERIENCE USING A PROXIMAL FEMORAL CERCLAGE CABLE

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Purpose: A single surgeon series of 125 hemiarthroplasty procedures is reviewed. All patients were treated at the same facility; and the majority by the same operative team. The goal was to define the efficacy of the use of a cerclage cable in the treatment of femoral neck fractures by non-cemented hemiarthroplasty.

Methods: Hospital charts for the senior author's hemiarthroplasty procedures for a three year period were reviewed. Initial and follow-up radiographs were compared for position of the prosthetic device and any postoperative change in implant position. A combination of endo- and bipolar prostheses were implanted based on the patient's pre-injury

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functional ability and joint space visible on injury radiographs. Since an ingrowth stem was utilized a prophylactic cerclage cable was placed to allow press fit while avoiding proximal femoral fracture.

Results: Patient ages ranged from 60 to 93 years of age and all patients survived their hospitalization. Blood loss ranged from 50 to 500cc with an average of 105cc. We were able to achieve three point fixation of the prosthetic stem in nearly all cases. There were no cases of proximal femur fracture or of stem migration. None of the patients complained of symptoms referable to the cerclage cable.

Conclusion: Relief of hoop stresses by placement of a cerclage cable prevented proximal femoral shaft fracture while allowing stable press fit of the prosthesis and avoiding the risks of bone cement.

IMPORTANCE OF LOW-AMPLITUDE POSITIVE FACIAL NERVE STIMULATION FOLLOWING CP ANGLE TUMOR SURGERY

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Purpose: Preservation of facial nerve function is crucial to a successful CP angle tumor resection. Intraoperative facial nerve monitoring is a routine component of CP angle surgery. We sought to correlate short-term and long-term facial nerve function with respect to the minimum amplitude of stimulation required to obtain facial nerve identification at the conclusion of tumor resection.

Methods: We performed a review of all patients who underwent CP angle tumor surgery between September, 2007 and August 2012. The minimum amplitude necessary to achieve positive facial nerve stimulation was noted in all cases. Facial nerve function outcomes (based on the House-Brackmann grading scale) were noted at 3 different post-operative times: immediately after surgery (post operative day 1), 1 month post-op and 6 months post-op.

Results: 30 CP angle tumor resections were performed in our study time span (24 acoustic neuroma, 5 meningioma, 1 ganglioglioma). Positive facial nerve stimulation was achieved in all cases at the conclusion of tumor resection. The minimum threshold to achieve this final positive stimulation ranged from 0.1 to 1 milliampere (mean = 0.34 ma). Immediate post operative facial function varied from HB 1 to HB 4 (mean = HB 1.94). 1 month post operative facial function varied from HB 1 to HB 3 (mean = HB 1.61). 6 month post operative facial function varied from HB 1 to HB 2 (mean = 1.05). A trend was observed in which the higher the stimulation required to obtain final positive stimulation, the worse the initial facial nerve outcome and the longer the deficit took to return towards normal.

Conclusion: Our study showed that final facial nerve stimulation with low amplitude led to good facial nerve outcomes in the long term. We also noted that despite some suboptimal immediate post operative facial nerve function, excellent long-term facial nerve function was seen in all patients. Our data stresses the importance of maintaining electrical integrity of the facial nerve; we advocate doing this at all costs even if a thin layer of tumor is left adherent to the facial nerve.

ROLE OF INTRAOPERATIVE NEAR INFRARED INDOCYANINE GREEN VIDEOANGIOGRAPHY IN ANEURYSM SURGERY

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Purpose: To assess the utility of intraoperative near infrared Indocyanine Green videoangiography (ICGA) in the surgical management of intracranial aneurysms

Methods: All patients with intracranial aneurysms treated by a single surgeon (BH) from 2008-2013 and who underwent ICGA during surgery were included in the study. Clip repositioning rate and correlation of ICGA and post-operative angiography for completeness of aneurysm occlusion and parent vessel compromise were analyzed.

Results: A total of 112 patients with 126 aneurysms were included in the study. Among these 120 aneurysms were in the anterior circulation and 6 in the posterior circulation. The clip repositioning rate was 8% (n=10). Aneurysm obliteration was observed in 95.2% (n=120) cases and correlated with post-operative angiography in all the cases. ICGA was useful in assessing the vascular anatomy in all but ophthalmic segment internal carotid aneurysms. No branch vessel occlusion was noted. There were no complications related to the use of ICGA.

Conclusion: ICGA is an excellent technique in assessment of clip placement and aneurysm occlusion. It correlates well with post-operative angiography and carries little technique related morbidity. Its role during surgery for ophthalmic segment aneurysms is not well defined due to complex anatomy of the aneurysm and limited exposure.

PROGNOSTIC SIGNIFICANCE OF SUV MAX VALUE AT THE TIME OF INITIAL DIAGNOSTIC 18F-FDG PET/CT IN PATIENTS WITH PANCREATIC ADENOCARCINOMA

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Purpose: The aim of this study was to evaluate the prognostic importance of the maximum standard uptake value (SUV max) at the time of initial diagnostic 18F-FDG PET/CT in patients with pancreatic adenocarcinoma.

Methods: In this retrospective IRB approved study, charts of all patients who had 18F-FDG PET/CT from 2004 to 2010 at our center for initial evaluation of an undiagnosed pancreatic lesion were reviewed. A board certified nuclear medicine physician who was blinded to the final diagnosis evaluated all 18F-FDG PET/CT images and calculated the SUV max values of the primary pancreatic lesions. Final diagnoses were confirmed by tissue diagnosis and/or clinical course. Survival of all patients with final diagnosis of pancreatic adenocarcinoma was determined. Then these patients were divided into two groups with low or high SUV max values based on the median value of SUV max in all patients. Survival was compared between these two groups using Kaplan-Meier analysis and log rank test.

Results: Seventy nine patients were diagnosed with pancreatic adenocarcinoma. The SUV max in these patients ranged from 3 to 53.6 with median value of 7.3. Thirty nine patients had SUV max of lower than 7.3 and 40 had SUV max of equal or higher than 7.3. When the survival of the patients were compared between these two groups, patients with higher SUV max were found to have significantly lower survival compared with patients with lower SUV max (mean survival 10.4± 2.7 months versus 17.6± 3.1 months; p=0.039).

Conclusion: Higher SUV max values at the time of initial diagnostic 18F-FDG PET/CT may be indicative of poor long term prognosis independent of other prognostic factors.

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RESTORING CARDIAC CONTRACTIONS IN CARDIAC ARREST FOLLOWING EXSANGUINATIONS

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Purpose: We hypothesized that intra-arterial (IA) fluid resuscitation is more effective than intravenous (IV) resuscitation in restoring cardiac contractions of cardiac-arrested mice following severe hemorrhagic shock.

Methods: Mice (N=22) were anesthetized using ketamine/xylazine. Arterial and venous systems accessed through cannulation of the carotid artery and the Jugular vein, respectively. As much blood as possible was aspirated from the carotid artery access. Mice were observed until the complete cessation of chest wall motions. Following 30 seconds delay, IV (N=5) and IA access (N=6) were used for fluid resuscitation using Ringer Lactate (RL) in a similar volume to the aspirated blood. Mice were observed for restoration of chest wall motions. In phase-II of the study, after cessation of chest motions, mice (N=11) underwent a thoracotomy and cardiac contractions were observed. In three mice, IV RL Infusion after cardiac arrest failed to restore cardiac contractions and was followed by IA RL infusion. In eight mice, following cardiac arrest intermittent IA RL infusion was performed.

Results: While IV RL Infusion failed to restore chest motion in mice (N=6), IA RL infusion restored chest motion in all mice examined (N=5) ($p=0.0067$). In three mice, IV RL infusion after cardiac arrest showed no effect on cardiac contractions. After failure of venous infusion, IA RL infusion was performed which resulted in restoration of cardiac contractions for 13.33 ± 1.76 minutes. In eight mice, intermittent IA infusion of RL after cardiac arrest, sustained cardiac contractions for 31.43 ± 10.9 minutes ($P=0.017$).

Conclusion: Intra-arterial fluid resuscitation is superior to IV resuscitation in hemorrhagic shock induced cardiac arrest.

COMPARATIVE EFFECTIVENESS AND SURVIVAL BENEFIT OF LIVER DIRECTED THERAPY, SYSTEMIC CHEMOTHERAPY AND RADIATION THERAPY IN STAGE FOUR HCC: A SEER-MEDICARE ANALYSIS

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Purpose: In the United States, the incidence of HCC has increased from 1.6 per 100,000 in 1975 to 4.9 per 100,000 in 2005 and is expected to continue rising. Care for HCC patients remains specialized and complex. For stage IV disease, liver directed and systemic therapy options have been utilized to improve outcomes. However little if any comparative effectiveness of various treatment modalities in stage IV HCC exists.

Methods: Medicare enrollees, older than 65 with an initial diagnosis of primary HCC between 2000-07 were followed up through the end of 2009. Data are from the SEER and linked Medicare databases, with claims generated from Medicare parts A and B. For patients with stage IV HCC, multivariate Cox proportional hazards models were used to assess overall and HCC-related mortality in relation to receipt of various/no treatments, adjusting demographics [age, race, Hispanic ethnicity], general health status [Charlson comorbidity index (CCI) = 0, 1, >1], and liver conditions [Hepatitis B or C, alcohol related liver disease, moderate-severe liver disease].

Results: Total number of patients in stage four was 1802 (40 re-

section patients were excluded). Distributions: males 70%, Caucasians 77%, African Americans 11%, Hispanics 12%; a majority (76%) was age 65-84; Hepatitis C was the most prevalent (14%). Of the 1802 patients, 70.53%, 10.71%, 9.27%, 5.99% and 3.5% received no treatment, systemic chemotherapy, radiation therapy, liver directed therapy, and combination therapy respectively. Risk of all-cause mortality was lower with any treatment. Liver directed therapy and combined systemic chemotherapy and radiation fared significantly better than chemotherapy or radiation alone. Trends maintained with HCC-mortality.

Conclusion: Among SEER-Medicare patients with stage IV HCC, all treatments were associated with significant decrease in HCC and all-cause mortality over no treatment. Liver directed therapy and concomitant systemic chemo- and radiation therapies had greater impact on reducing mortality than did radiation or chemotherapy alone.

A NOVEL APPROACH FOR SURGICAL MANAGEMENT OF RENAL ARTERY ANEURYSM: EXPERIENCE WITH 6 CASES

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Purpose: While simple renal artery aneurysms (RAA) may be amenable to endovascular repair, many complex RAA require nephrectomy for adequate excision and reconstruction followed by auto-transplantation. The purpose of our study is to study a novel minimally invasive technique for the nephrectomy, repair, and auto-transplantation using a retroperitoneoscopic approach.

Methods: This study included five patients who underwent six RAA repair from 2009-2012. Initial skin incision was made on the ipsilateral side of the RAA in an oblique fashion in the lower quadrant of the abdomen. The peritoneum was dissected at the lateral border of the rectus and the insertion of the oblique muscles and a retroperitoneal space created by blunt dissection. Gelport (Applied Medical, Rancho Santa Margarita, CA) was used as both a port entry point and hand-assist device. Two 12 mm trocars were then placed under direct vision for video and instrument insertion. Once the kidneys were removed, they were perfused with University of Wisconsin solution and cooled. RAA excision and repair was carried out on the back table. The same incision created for the nephrectomy was then used for the re-implantation.

Results: There were four female and one male patients with a mean age of 60.4 years (range 55-68). Three of the five patients had hypertension. Mean preoperative serum creatinine (Cr) was 0.86 mg/dL while mean Cr at discharge was 0.92 mg/dL. Five of the six RAA were at the bifurcation of the renal artery and in one case two RAA were located off of main branches of the renal artery. One patient had bilateral RAA. All aneurysms were deemed unsuitable for endovascular repair by vascular surgeons. Mean size of the RAA was 2.07 cm. Mean operative time was 440.7 minutes. There was no intraoperative morbidity or mortality. Average estimated blood loss was 266 ml (range 150-500 ml). Average length of hospital stay was 6.2 days (range 5-8 days). Acute renal insufficiency was observed during the immediate postoperative period in three of the five cases. Four of the six cases showed improved serum creatinine compared to preoperative values by time of discharge. One patient experienced a postoperative ileus but was discharged by the seventh postoperative day. There was one late mortality (>30 days post procedure) from pulmonary embolism.

Conclusion: RAA treated by retroperitoneoscopic nephrectomy, repair, and auto-transplantation is a novel technique which shows favorable operative and short term outcomes. Further, larger studies are required in order to determine if this safe and effective technique results in less pain, length of hospital stay, and improved overall outcomes.

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CONGENITAL DIAPHRAGMATIC HERNIA: SURVIVAL, OUTCOMES, AND LONG-TERM FOLLOW-UP ISSUES AS MORE SEVERELY AFFLICTED NEWBORNS SURVIVE

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Purpose: To define the high survival achievable in the best centers for treatment of congenital diaphragmatic hernia, and the modern methods for achieving this survival. This results in an unprecedented number and severity of CDH patients surviving into teenage years and adulthood. Predictable issues may be encountered as these children, and children grow and achieve adulthood.

BARBERS OF CIVILITY

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Purpose: This essay is meant to contribute to raise the awareness of the costs "both in dollars and in human misery" of incivility in the practice of medicine by looking in particular at the case of surgeons.

Methods: This study is intended to : 1) explore important factors which determine civility in surgical practice, 2) highlight evidence that supports a direct link between civil behavior and both clinical outcomes for patients as well as health and quality of life measures for medical professionals, and 3) offer a framework for fostering civility in the surgical workplace.

Results: Self-interest, stress, anxiety, unhappiness, and the desire for power and control conspire to undermine civility and foster rudeness. It's not just the conventions of politeness that have been eroded over the past few decades, the concern is that basic rules of social behavior have been abandoned or at least suppressed. When individuals in the stressful environment of the operating room must decide whether to cooperate or defect, there is a powerful and perhaps logical incentive to defect so as to avoid becoming the sucker... unless a culture of trust exists that assumes individuals will make respectful choices that consider the needs of others. The pathway to promulgation of such a culture is through the development of "social capital" by defining expected behaviors, consistently applying the rules of engagement and the penalties for disregarding those rules to all participants, and an organization-wide commitment to monitor compliance. One obvious way to stack the deck for success is to use interpersonal skills, or lack thereof, as a factor in selecting surgical residents, faculty, and nurses. Technical skills and fund of knowledge are necessary but not sufficient. Increased emphasis should be placed on non-technical skills such as leadership, communication, teamwork, and situational awareness. Exposure to incivility among doctors begins in their formative years. The challenge to each of us entrusted to teach the next generation of surgeons is how to nurture important surgical traits of ego strength, confidence, focus, work ethic, and dedication without abandoning the commitment to civil behavior. The point at which civility really starts to get the attention of senior hospital management is when you show a correlation with health care outcomes. Numerous studies have now demonstrated a direct correlation between civility and post-operative outcomes, lengths of stay, nurse turnover, and patient satisfaction.

Conclusion: The surgical community has an incredible opportunity to lead a civility initiative in health care. The first step is to recognize the power that civility has to improve the surgical workplace, patient outcomes, as well as the workers' quality of life. Secondly, the criteria for

recruiting staff, trainees, and faculty should include an assessment of social skills and personality traits that will nurture a culture of civility. To foster civility within the organization the staff needs to know each other. The rewards likely to accrue from the investment of time required to become acquainted with coworkers are substantial. The loss of anonymity coupled with a better appreciation of coworkers' lives decreases the likelihood that rude behavior will be initiated or accepted or that minor disagreements will escalate into damaging conflicts. And finally, the surgical leadership must model behavior for the team.

SURGICAL MANAGEMENT AND RISK- REDUCTION IN PATIENTS WITH HEREDITARY BREAST AND GYNECOLOGIC CANCER SYNDROMES

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Purpose: This presentation will provide the audience with current recommendations for counseling, screening and treatment of patients with Hereditary Breast and Gynecologic Cancer Syndromes. It will focus on identifying patients in whom surgical risk- reduction may be recommended and the techniques for those procedures.

RISK FACTORS (RF) AFFECTING LONG-TERM (LT) OUTCOMES IN OLDER KIDNEY TRANSPLANT RECIPIENTS (KTR): 10 YEAR OUTCOMES

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Purpose: The number of older patients (Pt) on the waiting list for kidney transplantation is growing. Currently, over 56% of the wait listed patients are over 50 years old. The proposed UNOS allocation policy steers older and potentially less durable donor kidneys to older KTR. To assess the factors that impact on long-term outcomes in older KTR we retrospectively analyzed the clinical course of 236 KTR who were 60 and above.

Methods: All KTR received cross match negative allografts and were treated with either Alemtuzumab (CMP) (45 mg one dose), Basilixmab (IL2R) (20mg X2doses) or low dose rabbit anti-thymocyte antibody (rATG) (3-5mg/kg, total dose). Maintenance immunosuppression consisted of tacrolimus, mycophenolic acid (MPA) and prednisone except in the CMP group where steroids were withdrawn after 1 week. Mean follow up was 52±32 months. Demographics are shown in Table 1.

Mean R age:	67±5	Mean D age:	48±16			
F	AA	DM	LD	ECD	Re-Txpl	Mean CIT
Mean HLA MM	Mean DR M					
39%	26%	37%	21%	40%	3%	15±10
3.7±1.7		0.8±.8				

Results: One, 5 and 10 year Pt and graft survivals were 95, 77, 58% and 94, 67, 50% respectively. By multivariate analysis, previous cardiovascular events RR= 6.2 (1.38-27.8), donor age RR=1.022 (1.006-1.03, p=0.006), deceased donor transplant HR= 2.8 (1.06-7.6, p = 0.03), and CMP induction HR = 3.3 (1.11-10, p= 0.04) were independent risk factors for decreased graft survival. An increase of one year in donor age resulted in a 2.2% increase in graft loss. Steroid therapy did not impact on Pt and graft survival. Compared to rATG, the rejection rate was higher in the CMP group (23% vs. 16%, p=0.01).

Conclusion: We conclude that, in addition to age, the type of transplant, cardiovascular comorbidity and the type of induction therapy affects graft survival. These additional risk factors should be considered when transplanting older RTR.

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PANCREAS TRANSPLANTATION (PTX) WITH VENOUS DRAINAGE TO IVC: SHORT AND LONG-TERM OUTCOME Mark Laftavi, MD, FICS

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Purpose: Ninety-eight percent of the whole PTX does not serve the purpose of the pancreatic transplantation and it is a major cause of surgical complications. Up to 30% of PTX recipients experienced surgical complications and require re-operation. Graft thrombosis & pancreatitis are the most common complications of PTX. Thus, different surgical techniques are described to overcome the surgical hurdles and reduce surgical complications.

Methods: In this study, for the first time, we report short and long-term outcomes of PTX with Inferior Vena Cava (IVC) venous drainage. In this technique, the IVC is dissected about 2 inches at the bifurcation. Then the side of the IVC is partially clamped by a Stansky vascular clamp. Then, the donor portal vein is anastomosed end to side to the IVC at the IVC bifurcation by 6-0 continuous prolene sutures. Then the fashioned Y arterial graft is anastomosed to the right or left common iliac artery of the recipient. The pancreas is emplaced heads down toward the pelvis. Then, two layer hand sewn side to side anastomoses are performed between the donor duodenum and the close by loop of jejunum.

Results: Forty two PTX (22 SPK & 20 PAK) were performed with this technique in our center. Donor and recipient demographics are shown in table 1.

Mean R. age±SD (range): 43±7 (30-57)	Mean D. age±SD (range): 22±9 (7-46)
Mean BMI±SD(range):30.1±5.3(18-34)	
Male% Non-white% Mean CIT±SD(range) Mean HLA MM	
Mean DRMM PRA>30% CMV D+ to R- %	
71% 13% 15±4(9-25) 4.5±1.3 1.5±0.6	
6% 33%	

No graft thrombosis occurred with this technique. Six pts (14%) required re-operation (3 bleeding, 2 anastomotic leak, 1 small bowel perforation). No patient or graft lost occurred due to surgical complications.

Conclusion: We conclude that this technique provide easy and fast dissection of the venous drainage to the PTX without the need of complete occlusion of venous outflow. Surgical complications were lower with this techniques compared to other reported techniques.

THIGH HEMATOMA: A DIFFERENT TYPE OF COMPARTMENT NEEDING A DIFFERENT TYPE OF APPROACH

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Purpose: We present management of deep thigh hematoma due to blunt trauma and its implications/relations with compartment syndromes.

Methods: This is a 74-year-old male with past medical history of neuropathy due to a previous vertebral body fracture, hemochromatosis, and atrial fibrillation treated with coumadin involved in a farming ATV rollover. On presentation he had a medial thigh bruising with erythema, exquisite pain on palpation of the thigh & significant tense muscles. There was no instability and no perception of an acute fracture. There was moderate pain with passive flexion and extension of the knee joint. Sensation was decreased, which was chronic from the patients neuropathy, but motor function was intact. There were palpable DP & PT pulses on the right.

CT angiogram of the lower extremity showed a hematoma in the rectus femoris mid-thigh along with subcutaneous edema, no extravasations of contrast & no bone fractures.

Conservative management was started. Coumadin was held, leg elevation, bed rest, and correcting the coagulopathy with fresh frozen plasma (FFP) and kept under supervised observation & monitoring for neurovascular changes.

24 hours after, the edema and pain of the right thigh improved. Patient was kept on bed rest for the next 24 hours and then with the assistance of physical therapy encouraged patient to ambulate & exercise for right leg strengthening. We started getting him out of bed on day 3 of admission.

After his initial therapy he became hypotensive & unresponsive requiring advanced cardiac life support & intubation. Once patient was stabilized, the clinical diagnosis of acute PE was entertained and confirmed by a spiral CT scan which showed a right main pulmonary artery embolus. Patient was empirically treated with Lovenox and continued with bridging to Coumadin with a goal INR 2-3.

A right lower extremity venous duplex scan showed thrombus in the right posterior tibial and perineal veins with impression of a possible residual clot in the popliteal vein. The size of the right thigh hematoma has significantly improved.

Acute blunt trauma to the thigh can cause hematoma and elevated compartment pressures, which may have a similar presentation to compartment syndrome. However, due to the thigh's anatomy being different from the calf and its ability to withstand higher pressures, management of thigh hematomas can be different from that of calf hematomas.

In our case, we had an unexpected morbidity from our nonoperative management. The patient had development of DVTs and a large pulmonary embolus. In retrospect, we learned that this presentation may be an indication for an IVC filter consideration, but this option should be highly individualized per case. We also learned that patient's with large thigh hematomas may compress the deep venous system of the thigh and could consider waiting a longer period of time before ambulating the patient. We also should consider obtaining venous duplex scans of these patients early on to rule out DVT. Our case did prove that thigh hematomas can be treated successfully with nonoperative management, but that this does carry a risk of venous thromboembolism. Further studies need to be done to investigate this in more detail.

KEYNOTE PRESENTATION: THE APPLICATION OF ROBOTIC TECHNOLOGY IN MINIMALLY INVASIVE SURGERY

Michael Nussbaum, MD, FICS

Methodist medical Center Professor and Chair, University of Florida College of Medicine-Jacksonville

Purpose: Review the history of robotics in surgery. Describe the application of robotics in surgery. Use the management of achalasia as an example of studies comparing laparoscopic to robotic operations.

Methods: Historical and literature review

Results: A variety of results will be reviewed

Robotic Technology allows: Enhanced 3D visualization, Improved dexterity, Increased range of motion, Improved access, Procedure conversion to MIS increases procedure value, which can attract higher patient volume, Allows use of single site laparoscopic procedures, Advanced robotic technology increases operational standards, Increased technical precision, Better outcomes

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REVIEW OF COLORECTAL ANASTOMOTIC LEAKS BASED ON INDICATIONS FOR SURGERY, BENIGN VS INFLAMMATORY BOWEL DISEASE VS NEOPLASTIC: A TEN YEAR RETROSPECTIVE STUDY

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Purpose: Anastomotic leaks after colorectal surgery are associated with significant morbidity, increased hospital stay and poor functional outcomes. In addition anastomotic leaks after colorectal cancer surgery may compromise oncological outcomes. Recent literature has emphasized the role of early diagnosis of anastomotic complications and a selective policy of non operative intervention in reducing morbidity. Our aim was to examine trends in the presentation, diagnosis and management of colorectal anastomotic leaks based on indications for surgery at a non academic community hospital.

Methods: A retrospective review was performed of morbidity and mortality conference data, chart codes and operative reports to identify all patients who had sustained anastomotic complications after colorectal surgery over a ten year period from Jan 2002 to Dec 2012. Medical records of all such patients identified were reviewed. A leak was defined as a partial or complete anastomotic dehiscence identified at reoperation or strongly suggested by radiological imaging that had directly contributed to the clinical presentation and required intervention with intravenous antibiotics, percutaneous drainage or reoperation. A total of 46 patients were identified (23 male, 23 female).

Results: The average age of the sample was 65 (range 18-90). The median time to the diagnosis of the leak was 10 days (range 1-40). In 17(36 percent) patients the anastomotic leak was identified after discharge. Twenty seven (58 percent) patients were re-operated on for an identified anastomotic leak and of this group 18(66 percent) patients underwent a takedown of the anastomosis and construction of a stoma. A total of 8 out of 46 were managed with percutaneous drainage. Eight patients were treated with intravenous antibiotics alone. Seven patients treated for an anastomotic leak demised. It is noted that these seven patients had multiple medical co-morbidities. Five of these 7 patients had a reoperation, 1 was treated with percutaneous drainage and 1 with intravenous antibiotics only. In the 20 patients operated for cancer, ten were managed with antibiotics or percutaneous drainage. In 9 patients who had surgery for inflammatory bowel disease, only 2 were successfully managed non-operatively. Five of the 7 patients managed successfully with percutaneous drainage had a localised pelvic abscess on imaging.

Conclusion: Anastomotic leaks remain a significant source of morbidity. The clinical presentation is variable. Successful nonoperative management was possible in only a minority of patients despite liberal and early use of imaging. Patients who developed anastomotic complications after surgery for inflammatory bowel disease were less likely to have successful resolution with non operative management. A well localised pelvic abscess predicted success of non-operative management in this series. Reoperation often necessitated a takedown of the anastomosis and construction of a stoma. Despite appropriate intervention, colorectal anastomotic leaks can lead to patient mortality, especially in association with medical co-morbidities

SPONTANEOUS MEDIASTINAL EMPHYSEMA A CLINICAL QUANDARY

Francis J. Podbielski, MS, MD, FICS

Associate Professor of Surgery, University of Massachusetts Medical School, Worcester, MA

Purpose: Spontaneous mediastinal emphysema is a poorly understood condition that occurs in adolescents and young adults. Patients occasionally report an episode of forceful coughing or strenuous physical activity, but frequently have no antecedent symptoms except the acute onset of cervical and mid-thoracic discomfort and mild shortness of breath. Radiographic evaluation in the hospital emergency department includes either a contrast esophagram or computed tomography of the chest with oral contrast that demonstrates free air surrounding the mediastinal structures with no evidence of contrast extravasation and no pneumothorax.

Methods: This is a retrospective review of all patients presenting to the Jordan Hospital from March 2010 to November 2012 with a diagnosis of spontaneous mediastinal emphysema. Patients were identified by querying the hospital database with an ICD-9 code of 518.1 (interstitial emphysema). Exclusion criteria for the study included any type of trauma, esophageal perforation, or co-existing pneumothorax. Patient demographics, presenting history, radiographic evaluation, treatment plans, and outcomes were reviewed.

Results: Three patients met inclusion criteria for this study. The medical records of two males and one female, average age of 18.7 year (median 17 years) were abstracted. One patient's findings were correlated directly with an asthma attack. Two patients had no obvious etiology for this condition. Two patients had a history of anxiety disorder. All patients had spontaneous resolution of their symptoms within 5 days after evaluation.

Conclusion: A precise mechanism to explain spontaneous mediastinal emphysema remains elusive. In the absence of trauma, esophageal disruption, or spontaneous pneumothorax, dissection of air through the tissue planes of mediastinum is a disconcerting finding for both the patient and medical practitioner. Speculation exists in the literature about rupture of subpleural blebs into the mediastinal space to account for this condition, although radiographic evidence of these blebs is lacking. Some investigators have postulated that acute changes in intrathoracic pressure create a shearing effect on tissue planes that results in this problem. In all cases, those reported here and others in the literature, spontaneous mediastinal emphysema appears to be a self-limiting problem that can safely be managed on an outpatient basis.

MANAGEMENT OF LEGAL, TAX, AND INSURANCE LIABILITY RISKS FOR PRACTICE PROFITABILITY IN 2013

Victoria Powell, JD, LLM

President of P Inc., Member of the Texas and Florida Bars

Purpose: Examine developments in the legal, tax, and liability risk arena associated with surgical practices with a focus on reducing the costs to the practice and increasing profitability.

Methods: Research case law, new legislation, new developments in malpractice prevention techniques, and current Income tax and fiscal planning techniques.

Results: Every year legislation is passed which affects the practice of medicine and case law is handed down which impacts the way in which existing legislation is interpreted. At the time of this abstract, the legislation for addressing the fiscal cliff is pending, and will re-

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sult in tax law changes, regardless of action taken by Congress. The current law will be examined in detail and the tax ramifications updated to explain the changes, all of which are not known at the time of submission of this abstract. The author will update the data at the earliest pertinent time. Current research demonstrates many techniques available to increase practice profitability through the use of appropriate corporate structures, tax planning and malpractice prevention protocols.

Conclusion: Choice of corporate legal structures for practice protection, tax planning for annual savings, liability reduction strategies will all be updated in 2013 by legislation and case law. Current techniques have been reviewed and provide a myriad of solutions for surgical practices to employ to improve in all above areas, and 2013 updates will be added to this abstract and presentation for up to date management of these problems faced by every practice.

THE UTILITY OF PREOPERATIVE MR BREAST IN CHANGING THE SURGICAL MANAGEMENT OF PATIENTS NEWLY DIAGNOSED WITH BREAST CANCER.

Nikhil Rajadhyaksha, MD

Radiology Resident, Providence Hospital and Medical Center

Purpose: The objective of our study is to demonstrate how preoperative MR breast changes surgical management in patients newly diagnosed with breast cancer.

Methods: This was a retrospective review of all newly diagnosed breast cancer patients that underwent preoperative breast MR at a mid sized community hospital between Jan 2008 to Nov 2012. New suspicious lesions found on breast MR were either biopsied under MR guidance or evaluated further by ultrasound. Lesions that remained suspicious on ultrasound were biopsied under ultrasound guidance. Biopsies that were carried out and pathologically proven to be breast cancer or ductal carcinoma in situ were evaluated to determine if surgical management changed.

Results: Preoperative MR breast yielded a number of biopsies that were pathologically proven to be breast cancer or ductal carcinoma in situ, and subsequently did altered surgical management.

Conclusion: MR breast remains a useful tool for the surgical management of patients newly diagnosed with breast cancer.

SHUNTING OPTIONS FOR PORTAL HYPERTENSION

Alexander S. Rosemurgy, M.D.

Director, Surgical Digestive Disorders and GERD Center, Director, HPB Surgery and Fellowship Program, Southeastern Center for Digestive Disorders and Pancreatic Cancer, Advanced Minimally Invasive and Robotic Surgery, Florida Hospital, Tampa, FL

Purpose: Widespread application of Transjugular Intrahepatic Portosystemic Shunt (TIPS) continues despite the lack of trials documenting efficacy superior to surgical shunting. TIPS has become the modality of choice for complicated portal decompression. Herein is 18-year follow-up of a prospective randomized trial comparing TIPS to Prosthetic H-Graft Portacaval Shunts (HGPCS) for portal decompression. Furthermore, this presentation will present our findings on a study undertaken to determine outcomes after TIPS and the utility of TIPS as a "bridge" to transplantation.

Methods: Beginning in 1993, patients were prospectively randomized to undergo TIPS or HGPCS as definitive therapy for portal hypertension due to cirrhosis. Complications of shunting and long-term outcome were noted. Failure of shunting was prospectively defined as: inability

to place shunt, irreversible shunt occlusion, major variceal rehemorrhage, unanticipated liver transplantation, or death. Survival and shunt failure were compared using Kaplan-Meier curve analysis. Median data are reported.

Results: Patient presentation, circumstances of shunting, causes of cirrhosis, severity of hepatic dysfunction (e.g., Child class, Model for End-stage Liver Disease (MELD) score), and predicted survival after shunting did not differ for patients undergoing TIPS (n=66) or HGPCS (n=66). Survival was significantly longer after HGPCS for patients of Child Class A (91 vs. 19 months, p=0.009) or Class B (63 vs. 21 months, p=0.02). Shunt failure occurred later after HGPCS than TIPS (42 vs. 19 months, p=0.04). Also, TIPS decreased portal vein- IVC gradients from 17 to 5 mmHg, p< 0.001. Reinterventions were undertaken in 54 patients (21%). Survival after TIPS was 26 months; liver transplantation was undertaken in 35 (14%) patients.

Conclusion: Compared to TIPS, survival after HGPCS was superior for patients with better liver function (e.g., Child Class A or B). Shunt failure after HGPCS occurred later than after TIPS. Rather than TIPS, application of HGPCS is preferred for patients with complicated cirrhosis and better hepatic function. TIPS effectively decompresses portal hypertension, but leads to frequent reinterventions and short survival. After TIPS, liver transplantation is uncommonly undertaken. TIPS is a "bridge" to transplantation that is seldom "crossed" and TIPS continues to be plagued by frequent reinterventions. Outcomes after TIPS and the infrequency of transplantation following TIPS make it difficult to recommend on merit.

TRENDS AND PRACTICE PATTERNS IN THE MANAGEMENT OF EMPYEMA

Sibu P. Saha, MD, MBA

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Purpose: Variability in healthcare is often blamed for high cost and poor outcome. The purpose of this study was to assess the practice pattern in the management of empyema in the United States. We compared outcome of various operative approaches in academic and non-academic centers.

Methods: We queried the STS Database via the Duke Analysis Center for patients undergoing thoracic procedures with primary diagnosis of empyema from 2009 to 2011. Cases were classified as being performed at an academic (AMC, n=1101, 28.3%) or Non-academic (n-AMC, n=2790, 71.7%) medical center based on a list of training programs we provided. Relative rates of treatment via thoracostomy (n=325, 8.4%), thoracoscopy (VATS, n=1992, 51.2%) or thoracotomy (n=1574, 40.5%) were compared between the two groups. Sub-analysis compared outcomes after VATS between AMCs and n-AMCs.

Results: Academic medical centers had higher rates compared to non-academic of treatment by thoracostomy (13.8% vs. 6.2%); similar treatment rates by thoracoscopy (49.9% vs. 51.7%) and lower rates by thoracotomy (36.3% vs. 42.1%, p for variation across all treatment groups <.001). This was despite AMCs treating almost twice the rate of empyema with fistulas (11.4% vs. 6.5%, p<.001).

In the subgroup of VATS patients, discharge mortality, return to the O.R. and other major complications were not significantly different between the AMC (n=549) and n-AMC (n=1443) cases. Postoperative length of stay was higher in the AMCs (interquartile range [IQR] 5-13 days vs. 4-11 days, p=.001) while mechanical ventilation greater than 48 hours was more frequent in the n-AMCs (7.6% vs. 4.4%, p=.013).

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Conclusion: Surgical approach to the management of empyema depends on the stage of the disease. Surgeons in both academic and non-academic centers select procedures according to the clinical condition of the patient with equally good results.

SALVAGE OF LIMB WITH DIABETIC GANGRENE OF THE FOOT

Joshua Salvador, MD, FICS, FRCS (C)

Past President of the Denton Cooley Surgical Society

Purpose: To draw attention to a new method of leg salvage when the foot is endangered with diabetic gangrene.

Methods: Open drainage of infection. (Method will be presented with slides.)

Results: Leg salvage with minimal debridement.

Conclusion: We should be open minded to new methods of salvage if literature indicates otherwise.

TRANSPLANTATION OF A SEVERED ARM

Joshua Salvador, MD, FICS, FRCS (C)

Past President of the Denton Cooley Surgical Society

Purpose: Insuring the success of transplantation of a severed arm from other surgeons experience.

Methods: Arterial graft to bridge the gap between segments of the severed vessels.

Results: Success of the method.

Conclusion: Sometimes a surgeon could be inspired by the experience of others--the value of attending conventions.

MIDGUT VOLVULUS IN ADOLESCENTS AND ADULTS: INCIDENCE, DIAGNOSIS AND MANAGEMENT

Johanna Serrano, MD

General Surgery resident, PGY2, Pinnacle health, Harrisburg, PA

Purpose: Intestinal malrotation is a congenital anomaly closely associated to midgut volvulus, a life-threatening condition. This entity is commonly diagnosed in infants and rarely in adolescents and adults (<1%). In midgut volvulus, a faulty mesentery may allow rotation of the small bowel around the superior mesenteric artery, resulting in compromised blood flow and ischemia. Awareness of this process and a high index of suspicion by the general surgeon is essential to prevent this dreaded complication. While delayed diagnosis is more common later in life, its prompt recognition and surgical treatment can lead to successful outcomes.

This report describes a 17 year old male presenting with intermittent midgut volvulus. Our patient had chronic vague abdominal symptoms that included early satiety, abdominal pain, nausea, and weight loss. Diagnosis was made based on an upper gastrointestinal series with successful surgical treatment. A retrospective review of this case and a ten-year literature review of similar cases are included.

Intestinal malrotation in teenagers and adults is often associated with a delay in diagnosis. It is important to recognize the different clinical presentations of this entity to allow adequate diagnosis and management. Enhanced awareness of this anomaly and its dreaded complications is essential for improved prognosis.

ROLE OF TOTAL PANCREATECTOMY AND ISLET AUTOTRANSPLANTATION IN MANAGEMENT OF REFRACTORY ABDOMINAL PAIN DUE TO CHRONIC PANCREATITIS

Hosein Shokouh-Amiri, MD, FICS

Clinical Professor of Surgery, LSU, Shreveport, LA

Purpose: Chronic pancreatitis is associated with many manifestations. Refractory abdominal pain is one of the major manifestations of chronic pancreatitis which affects patient's quality of life. This creates a situation which make the patients seek narcotics all the time. Chronic pancreatitis can lead to DiabetesMellitus too. In the presence of pancreatic ductal dilatation procedures such as Puestow have been used to relieve the pressure in the ductal system, but the results have not been uniformly satisfactory. Total pancreatectomy by disconnecting the gland from its nerve supply should help to relieve the pain. If the islet cell function still is preserved, then isolation of islets cells and auto-transplantation of them can prevent the very brittle diabetes that is the consequence of total pancreatectomy. encouraging results have been achieved lately by this approach, and I will discuss our own experience and overall experience dealing with this problem.

TRAUMATIC ABDOMINAL WALL HERNIA: A CASE SERIES FROM A RURAL LEVEL I TRAUMA CENTER

Lacey Stelle, MD

General Surgery Resident, Carle Foundation Hospital, Urbana, IL,
Clinical Instructor of Surgery, University of Illinois, Urbana, IL

Purpose: Traumatic abdominal wall hernias (TAWH) are a rare cause of morbidity in cases of blunt abdominal trauma and can be difficult to detect. High energy TAWH are often associated with other intra-abdominal pathology. In this study, we describe four cases of TAWH that presented at our rural level I trauma center between 2008-2010, as well as a review of the literature. All of these hernias were located in the anterior abdominal wall and all were managed operatively. In one case, a jejunal perforation was also identified and repaired primarily.

BUPIVACAINE PAIN PUMPS IN RATS LEADS TO INCREASED ADHESIONS AND DOES NOT DECREASE THE NEUROMA FORMATION

Gokulakrishna Subhas, MD

Resident in Surgery, Providence Hospital and Medical Centers
Southfield, MI

Purpose: Pain pumps aim to reduce acute post-operative pain by continuous low-dose bupivacaine infusion at the operative site. Interestingly, in the long term follow-up of patients using pumps after inguinal hernia mesh repair, none had any chronic groin pain. One of the reasons for chronic groin pain has been attributed to neuroma formation at the cut ends in the operative site. Therefore, we hypothesized that bupivacaine infusion near a cut nerve in rats in the immediate post-operative period would lead to decreased neuroma formation.

Methods: The common peroneal nerve was transected in sixty rats. An osmotic pump placed near the transection site, delivered either bupivacaine or saline at 2 μ L/hour for 100 hours. Fifteen rats from each group were then euthanized at post-operative days 30 and 90. The nerve was dissected looking for adhesions. Distal end was excised for histological analysis of neuroma (S-100 stain) and inflammatory infiltrates (H&E stain).

Results: More adhesions were seen in the bupivacaine group compared to the control at both 30 (P=0.02) and 90 days (P=0.01). A trend for a smaller neuroma size was seen in the bupivacaine group at 30 days (P<0.06); no difference was seen at 90 days (P=0.78). However, fewer inflammatory cells were found in the study group at 30 days (P=0.04); both groups showed decreased but comparable numbers of cells by day 90 (P=0.78).

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Conclusion: Immediate post-operative perineural bupivacaine infusion causes decreased neuroma formation and inflammatory cells only in the early post-operative period, with increased fibrotic reaction and adhesion formation at the infusion site. These increased adhesions should be considered while using bupivacaine pain pumps in surgeries where there is a potential for re-operation such as in case of hernia recurrence.

PERCUTANEOUS DRAINAGE OF DIVERTICULAR ABSCESS SHOULD BE LIMITED TO TWO ATTEMPTS FOR RECURRENT DIVERTICULAR ABSCESS

Gokulakrishna Subhas, MD

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Purpose: A diverticular abscess >2 cm is first drained percutaneously with the aim to perform a definitive single-stage operation, thus avoiding an ostomy. Management of a recurrent diverticular abscess poses a big challenge to the surgeon. Currently there are no guidelines for the number of percutaneous drainages to be performed in recurrent diverticular abscesses before attempting surgery. To formulate a guideline on percutaneous drainage, we reviewed patients who presented with a diverticular abscess.

Methods: All patients (n=117) who presented with computed tomography scan-proven diverticular abscess from July 2008 to June 2011 were studied. Forty-two patients underwent percutaneous drainage of their diverticular abscess: 6 patients underwent =3 drainages, 9 patients underwent 2 drainages and 27 patients had 1 drainage. Aspiration of pus with needle without placement of drainage catheter, re-adjustment of drain, flushing of drain and upgrading the drain size were not considered as separate drainage procedures. The patients were divided into 4 groups based on the number of drainages.

Results: There was no difference between the distribution of patients in groups with regards to their age or sex (Table). The average number of days between drains for patients with more than 1 drain was 72 days (range 20-180). The size of abscess cavity was significantly higher for the patients who had =3 drainages (P<0.001). A Hartmann's procedure was performed in the majority of patients in the =3 drainage group (83%), but in decreasing frequency as the number of drainages performed dropped: 2 drainage group (44%), 1 drainage group (15%) and no drainage group (19%). There was a significantly higher pre-operative hospital stay for drainage and antibiotics in the patients from the =3 drainage group (P<0.001).

Conclusion: Patients with a recurrent diverticular abscess are very likely to undergo a Hartmann's procedure after 2 attempted drainages. By performing additional percutaneous drainages in an attempt to avoid ostomy, we are prolonging the inevitable and increasing morbidity. Furthermore, patients are at an increased risk of sepsis and peritonitis, with prolonged antibiotics and increased healthcare costs. We recommend limiting percutaneous drainage procedures to 2 attempts to cool down recurrent diverticular abscess prior to definitive surgery.

CLINICAL SIGNIFICANCE INCIDENTAL COMPUTED TOMOGRAPHIC (CT) FINDING IN PATIENTS UNDERGOING ENDOVASCULAR AORTIC ANEURYSM REPAIR

Tze-Woei Tan, MD

Assistant Professor of Surgery, Louisiana State University Health Sciences Center, Shreveport, LA

Purpose: Preoperative and follow-up CT scan is the standard of following patient after endovascular aortic aneurysm repair (EVAR). We examined the incidence of clinically significant incidental CT finding in this population of generally higher risk and more elderly patients.

Methods: Clinical records and computed tomographic angiograms (CTA) of patients who had undergone EVAR between January 2004 and December 2008 in our center were reviewed retrospectively. 180 consecutive patients with preoperative CTA and more than 24 months follow-up were included in this study. Official CT reports were reviewed. Findings were considered clinically significant if they warrant further treatment, workup or follow-up. Data was analyzed with student t test and p < 0.05 is considered to be significant.

Results: Fourteen percent (25/180) had significant clinical finding on pre-operative and postoperative surveillance CT scan. 28% (7/25) had finding consistent with neoplasm requiring further treatment (renal carcinoma; n = 4, pancreatic neoplasm; n = 2; lung cancer; n = 1). Other common finding include lung mass > 1cm and adrenal incidentaloma > 1.5cm. Overall incidence of neoplasm was 4% (7/180). There were no differences with age, gender and maximum aneurysm size between two groups.

Conclusion: As computed tomography continues to impact all areas of surgical practice, it has become increasingly apparent that the significance of incidental findings be examined and documented. The results of this study demonstrate that the CT scans used to monitor and evaluate AAA before and after repair may yield additional benefits for the patient with early detection. Further studies should be done to examine whether these incidental findings lead to surgical intervention or management that impacted patient's overall morbidity or mortality.

COMPARISON OF MAMMOGRAPHICALLY AND SELF-DETECTED NEW BREAST LESIONS AT A COMMUNITY BREAST CANCER CENTER

Thomas Willson, MD

Resident, Saint Joseph Hospital, Chicago, IL

Purpose: Breast self-examination (BSE) has been widely recommended for more than 70 years despite a lack of data supporting the practice. In 2009, the United States Preventive Services Task Force issued new guidelines including a recommendation against teaching women BSE. This study was performed to elucidate yield of BSE in terms of new malignancies discovered.

Methods: A total of 389 patients presenting for breast complaints between January 2009 and December 2011 at St. Joseph Hospital in Chicago, IL USA were reviewed retrospectively. Of these, 113 were follow-up visits, 12 were men, and 26 were lost to follow up. The remaining 238 comprised a cohort of women with new breast complaints over the three-year period. Records were reviewed for demographics, method of initial diagnosis, BIRADS score, and final diagnosis.

Results: Lesions were identified by mammography in 117 patients (49.2%), by self-examination in 113 patients (47.5%) and by other methods in 8 patients (3.4%). Of these lesions, 109 were malignant with 52.3% mammographically identified. Patients with self-identified lesions were younger, but there was no statistical difference in BIRADS score between self-identified and mammographically identified lesions, nor between lesions requiring operation in either group. The BIRADS score was statistically different in patients with self-detected lesions who underwent surgery versus those who did not (3.8 vs 3.3, p=0.00047), suggesting that patients are open to their surgeons' recommended management.

Conclusion: Although prior studies have failed to demonstrate reductions in overall mortality from BSE, this study demonstrates that BSE is an effective method for detecting breast cancers. Physicians should encourage breast self-examination at all ages and at minimum refer women who detect unexplained cystic or solid lesions for imaging and perform biopsies when indicated.

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COMPLICATIONS REQUIRING REOPERATION AND READMISSION AFTER LAPAROSCOPIC ROUX-EN-Y GASTRIC BYPASS AND LAPAROSCOPIC SLEEVE GASTRECTOMY

Jennifer Wilson, MbchB

Sunderland Royal Hospital, Sunderland, Tyne and Wear, UK

Purpose: Laparoscopic Roux en Y Gastric Bypass and Laparoscopic Sleeve Gastrectomy are the two most commonly performed bariatric procedures. These are major operations with a definite associated morbidity and mortality. The purpose of this study was to find mortality, reoperation and readmission rates with these two procedures in a large NHS Bariatric Unit.

Methods: Retrospective analysis of a prospectively maintained database was performed. Reoperation and readmission rates were classified as "early" if within 30 days and "late" after 30 days.

Results: A total of 910 laparoscopic gastric bypasses and 223 sleeve gastrectomies were performed in our unit between January 2003 and September 2012. The median age was 47 (range 19-70) years. 79.7% patients were female. No 30 day mortality was observed in this study. There were 2 late deaths observed after bypass. Early and late readmission rates post-bypass were 4.84 % (n=44) and 7.8% (n=71) respectively. Corresponding figures post-sleeve gastrectomy were 3% (n=7) and 5.15% (n=12). Early and late reoperation rates after bypass were 2.19% (n=20) and 4.39% (n=46) respectively. After sleeve gastrectomy, early and late reoperation rates were seen in 0.89% (n=2) and 2.15% (n=5) patients.

Conclusions: This study showed zero 30 day mortality with laparoscopic gastric bypass and sleeve gastrectomy. Late mortality was 0.2% after bypass. No long term mortality was recorded in the sleeve gastrectomy cohort. 30 day reoperation rates was lower in sleeve patients (0.89%) compared to bypass patients (2.19%).

A TRAUMA TRAINING PROGRAM FOR COUNTRIES WITH DEVELOPING TRAUMA SYSTEMS

Kelly Withum, MSPH

Research Associate, University of Miami Miller School of Medicine, Department of Surgery, Miami, FL

Purpose: Trauma is an even significant cause of morbidity and mortality in less developed nations, particularly those with less experience with trauma systems and trauma care. International collaborations allow for the promulgation of U.S. systems and methods of trauma care. This project describes a trauma-training program for international trauma providers.

Methods: Brazilian physicians and nurses participated in a 6-week trauma-training program at a large academic medical center. It was divided into 2 sections: 3 weeks of training with all providers, with an additional 3 weeks for the nurses. The first 3 weeks included: trauma lectures, clinical skills labs, team training patient simulation, ASSET (Advanced Surgical Skills for Exposure in Trauma) course, ATOM (Advanced Trauma Operative Management) course, PRIDE (Planning and Response Integration for Disasters and Emergencies) course, Combat Extremity Surgery Course, mass casualty exercise, and trauma clinical observations in the Resuscitation Unit, Trauma ICU, OR, and clinic. The second 3 week period included: data and documentation procedures, trauma registry procedures, organ procurement procedures, blood bank procedures, ride-alongs with EMS teams, and observations in ER, Resuscitation Unit, OR, Trauma ICU, Pediatric ICU, and Neurological ICU.

Results: International providers included 6 general surgeons, 1 neurosurgeon, 3 anesthesiologists, 1 adult intensivist, and 1 pediatric intensivist for a total of 12 physicians. There were six registered nurses. The majority (17/18; 96%) of the physicians and nurses agreed the program successfully prepared the participants for trauma care. The highest rated courses were: ASSET, ATOM, PRIDE, mass casualty exercise, and the team training simulation. The first 3 week program included 30 hours of trauma lectures, 8 hours of clinical skills lab, 16-hour team training simulation, 8-hour ASSET course, 8-hour ATOM course, 4-hour Combat Extremity Surgery Course, 8-hour mass casualty exercise, 16-hour PRIDE course, and over 72 hours of clinical observations.

Conclusion: The trauma training program was highly rated by the international participants. Training for international providers can assist in the development of trauma centers and trauma systems in countries with less experience in organized trauma care. Future encounters will involve physicians and nurses from the academic medical center traveling to Rio de Janeiro to provide on-site training, helping to develop their trauma center and trauma system.

ENDOSCOPIC TRANSFORAMINAL APPROACH FOR DISC HERNIATION AND STENOSIS

Lucia Zamorano, MD, FICS

Professor of Neurological Surgery, William Beaumont Oakland University School of Medicine, Birmingham, MI

Purpose: Minimally invasive spine surgery has become extremely important in the management of disc herniation and stenosis. Transforaminal approach has been used to for a percutaneous intradiscal surgery. We present a technique that uses an endoscopic transforaminal approach to reach the spinal canal to treat disc herniations, intraforaminal, extruded herniations, foraminoplasty.

Methods: Technique: patients were positioned in lateral decubitus with a roll placed under the flank. The Joimax TESSYS system was used. Using a 25cm 18 gauge needle and discogram was done. Sequential reamers were used to enlarge the foramen by removing the ventral aspect of the superior facet. The beveled working cannula, 8mm was placed over the dilators. Rotating of the beveled canula and the endoscope allowed visualization of the annulus, exiting and traversing nerve root. The beveled end of the working canula was also used as a nerve root retractor. The diamond drill was used to enlarge the foramen. Forceps and were used to grasp fragments of disc. A flexible end bipolar coagulator was used for hemostasis and exploration of the canal and epidural space. All patients were monitored with intraoperative EMG. A transforaminal epidural steroid injection was done to reduce postoperative nerve irritation.

Results: We present our experience on the first 25 cases. All patients responded well during the immediate postoperative period. No complications were observed. Follow up is schedule at 3, 6 and 12 months from procedure.

Conclusion: Endoscopic transforaminal approach to herniated disc and stenosis has proven to be safe and effective. Advantages of the approach includes small incision, maintained spinal stability, no scar formation, decreased risk of complications in patients with prior surgeries including fusion. Future advances of instrumentation will allow performance of placement of cages and fusion to bring endoscopy as a full adjuvant to spinal surgery.

Notes

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

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

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Meeting Registration

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

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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.

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Attendee Check-In

Pre-registered attendees may retrieve their conference materials from the ICS-US Meeting Registration Desk located on the second floor in the **Pre-Function area of the Omni Jacksonville**. The Meeting Desk will be staffed throughout the meeting as follows.

Wednesday, June 5	8:00-4:00 pm
Thursday, June 6	7:00 am-4:00 pm
Friday, June 7	7:00 am-4:00 pm
Saturday, June 8	7:00 am-4:00 pm

Attire

Business casual attire is recommended in educational sessions. Casual attire is appropriate for most social events. Evening attire is recommended for the Convocation and New Fellows Reception. Black tie is optional for the Gala Banquet.

Convocation

Pre-registered participants in the convocation should return to the registration area by 5:30 pm to receive your gown, and ceremony instructions. Anyone who arrives after this time will not be able to participate in the convocation. If you did not meet the April 8, pre-registration deadline it will not be possible to participate in this year's ceremony

You may prefer to leave your suit jacket with a friend or relative or hang it at the Registration Desk during the Ceremony. (please do not leave any valuables with the jacket). Participants will be formally processing in to the event, please do not carry anything with you (bags, cameras, etc.)

Convocations guests should be seated in Florida Ballroom Salon D by 6:20pm to allow the ceremony to begin on time.

Language

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

Omni Select Guest Gold Level Benefits

- Complimentary Wi-Fi Service
- Complimentary Morning Beverage Delivery
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- Complimentary Bottled Water (Night Of Arrival)
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- Express Check-In And Check-Out
- Complimentary Newspaper Of Your Choice Daily
- Customized Room Preferences
- Evening Housekeeping Service, Including Turndown

Attendees may enroll at the: **Omni Registration Desk**

Parking

Valet parking (\$20) with unlimited in/out privileges
City self parking (\$12) does not include in/out privileges
Enterprise car rental office located on-site

Speaker Prep Area

A laptop computer has been set-up 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 slides.

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.

Tickets/Workshop Registration

Tickets for social events and workshop registration 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.

Memphis 2014

MARK YOUR
CALENDARS



HILTON, MEMPHIS, TN



JUNE 11-14, 2014

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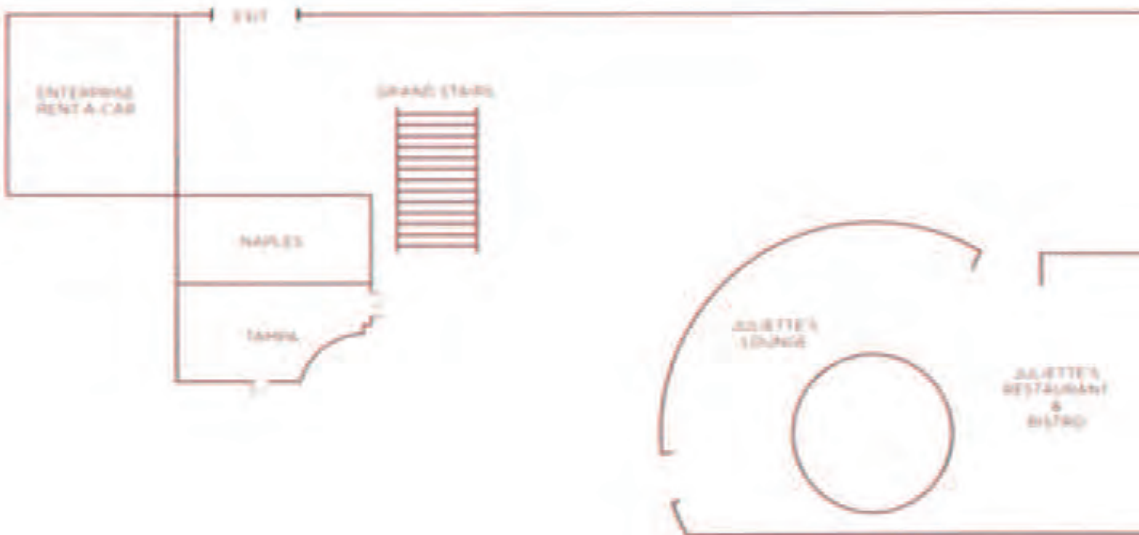
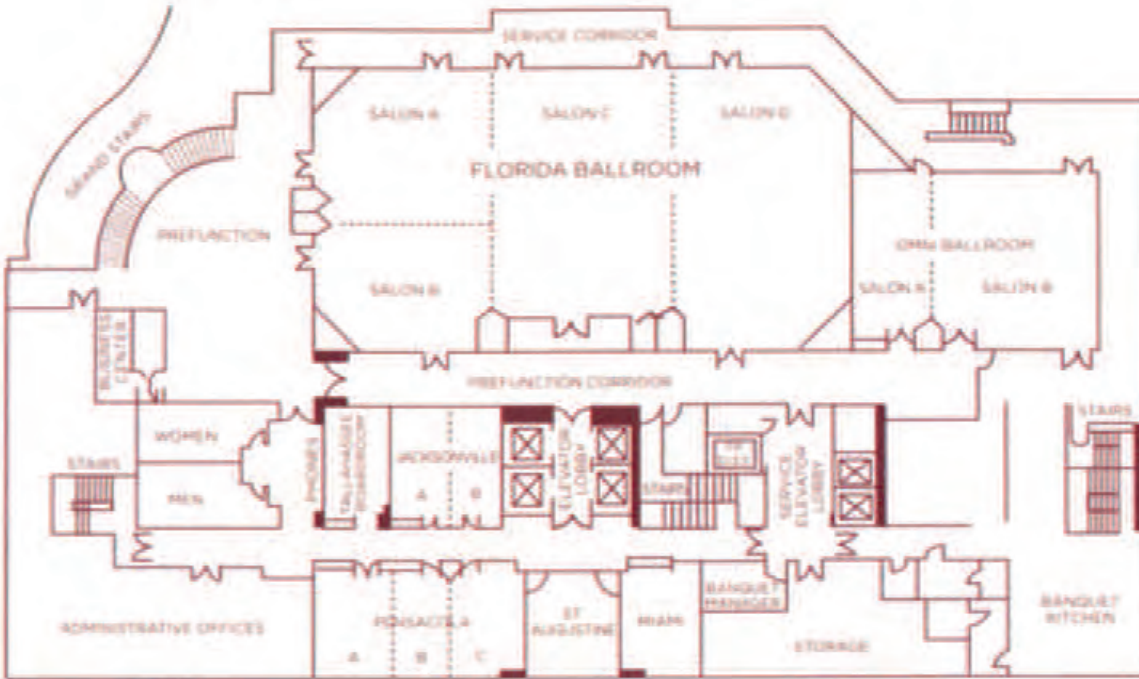
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Jacksonville Floor Plans



Schedule at a Glance

WEDNESDAY

JUNE 5

7:00-8:30AM
Officer Breakfast
OMNI BALLROOM A

8:00-4:00PM
Meeting Registration
PREFUNCTION

8:00-8:30AM
Endowment Fund, Board
of Trustees Meeting
PENSACOLA ROOM

8:30-12:30PM
US Section Standing
Committee Meetings
PENSACOLA ROOM

12:30-1:30PM
Officer Luncheon
ATRIUM

1:30-3:00PM
Board of Regents Meeting
OMNI BALLROOM A&B

2:00-3:00 PM
Alliance Board of Directors
& General Membership
Meeting
JACKSONVILLE ROOM

3:00-5:00PM
Executive Council &
House of Delegates
Joint Meeting
OMNI BALLROOM A&B

7:00-8:00 PM
Welcome Reception
PENSACOLA ROOM

THURSDAY

JUNE 6

7:00-4:00PM
Meeting Registration
PREFUNCTION

7:00-8:30AM
Continental Breakfast
FLORIDA BALLROOM SALON C

8:00-8:50AM
Opening Ceremony and
Special Lecture
FLORIDA BALLROOM SALON A-B

8:50-10:20 AM
MANAGEMENT OF
PORTAL HYPERTENSION
FLORIDA BALLROOM SALON A-B

10:30-NOON
Late Complications
Following Repair of
Congenital Malformations
FLORIDA BALLROOM SALON A-B

NOON-1:30 PM
LUNCH PRESENTATION
FLORIDA BALLROOM SALON C

1:30-2:00 PM
DR. ARNO A. ROSCHER
ENDOWED LECTURE
FLORIDA BALLROOM SALON A-B

2:00-3:30 PM
Vascular Surgery & the
Diabetic Foot
FLORIDA BALLROOM SALON A-B

2:00-3:45 PM
JACKSONVILLE "TOP TO BOT-
TOM" WALKING TOUR
MEET AT REGISTRATION DESK

3:30-3:45 PM
Integrative Multi-Disc.
Management of
Peripancreatic Fluid
FLORIDA BALLROOM SALON A-B

4:00-5:30 PM
Min. Invasive Bariatric Sur-
gery Technical Options
FLORIDA BALLROOM SALON A-B

FRIDAY

JUNE 7

7:00-4:00PM
Meeting Registration
PREFUNCTION

7:00-8:30AM
Continental Breakfast
FLORIDA BALLROOM SALON C

8:00-9:45AM
ANNUAL RESEARCH
SCHOLARSHIP COMPETITION
FLORIDA BALLROOM SALON A-B

9:00-3:00PM
ST. AUGUSTINE TOUR
MEET AT REGISTRATION DESK

9:00-3:00PM
NEUROSURGICAL AND
ORTHOPAEDIC PLATFORM
PRESENTATIONS
OMNI BALLROOM A&B

10:00-NOON
ANNUAL INTERACTIVE
ETHICS SESSION
FLORIDA BALLROOM SALON A-B

NOON-1:30PM
LUNCH PRESENTATION
FLORIDA BALLROOM SALON C

1:30-2:00PM
KEYNOTE LECTURE
FLORIDA BALLROOM SALON A-B

2:00-3:30PM
Integrative Multi-Disc.
Management of
Peripancreatic Fluid
FLORIDA BALLROOM SALON A-B

2:00-5:00PM
Seeing & Sticking with Sound
PENSACOLA ROOM

3:00-5:00PM
AANOS BOARD OF
DIRECTORS MEETING
JACKSONVILLE ROOM

3:45-5:15PM
Management of Mediastinal
Pathology
FLORIDA BALLROOM SALON A-B

7:00PM
4th Annual AANOS
Fundraising Event and
Awards Dinner
PENSACOLA ROOM

SATURDAY

JUNE 8

7:00-4:00PM
Meeting Registration
PREFUNCTION

7:00-8:30AM
Continental Breakfast
FLORIDA BALLROOM SALON C

8:00-9:45AM
CHALLENGES FOR THE ACUTE
CARE SURGEON
FLORIDA BALLROOM SALON A-B

9:00-NOON
CHALLENGES IN ABDOMINAL
WALL RECONSTRUCTION
TAMPA ROOM

9:00-NOON
NEUROSURGICAL AND
ORTHOPAEDIC PLATFORM
PRESENTATIONS
OMNI BALLROOM A&B

10:00-NOON
ROBOTIC SURGERY & OTHER
TECHNOLOGY ADVANCEMENTS
FLORIDA BALLROOM SALON A-B

NOON-1:30PM
LUNCH PRESENTATION
FLORIDA BALLROOM SALON C

1:30-2:30PM
HONORED LECTURES
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2:30 -3:45PM
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MILLENNIUM
FLORIDA BALLROOM SALON A-B

3:45-5:15PM
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FLORIDA BALLROOM SALON A-B

6:30PM
US Section Convocation
& Awards Ceremony
FLORIDA BALLROOM SALON D

7:30PM
New Fellows Reception
PREFUNCTION

8:30PM
Gala Dinner
FLORIDA BALLROOM SALON A-B

EXHIBIT SHOW

Representatives from several companies will be present in Florida Ballroom Salon D Thursday-Friday from 8:00-4:00pm, and Saturday from 8:00- Noon. Please take a moment to visit these individuals whose support enhances our meeting.