



7TH EDITION OF GLOBAL CONFERENCE ON
**SURGERY AND
ANAESTHESIA**

Delta Hotels Heathrow Windsor
Ditton Rd, Langley, Slough SL3 8PT,
United Kingdom

7TH EDITION OF
GLOBAL CONFERENCE
**SURGERY AND
ANAESTHESIA**

HYBRID EVENT
24-26
SEPTEMBER 2026

BOOK OF
ABSTRACTS



Index

Index

Keynote Speakers	4
Welcome Messages	6
About Magnus Group	16
About GCSA 2026	17
About CPD Accreditation	18
Table of Contents	9
Keynote Presentations	19
Oral Presentations	31
Poster Presentations	147

Keynote Speakers

Keynote Speakers



Ricky Rasschaert

AZ Rivierenland, Belgium



Jose Luis Braga De Aquino

Pontifical Catholic University - Campus,
Brazil



Ashfaq Chandio

Manchester University NHS Foundation
Trust, United Kingdom



Ajit Naniksingh Kukreja

Ratandeep - Dr Kukreja's Laser Piles Clinic,
India



Sagar Aravind Jawale

Jawale Hospital, India



Gamal Al Saied

Al-Azhar University, Egypt

Keynote Speakers



Osman Ahmed

Al Khor Anesthesia HMC, Qatar

Welcome Message



Gamal Al-Saied

Al-Azhar University, Egypt

Dear professors and colleagues

On behalf of the all scientific committee, it's our distinct honor to extend our a heartfelt invitation to you to join us at the upcoming 7th edition of the Global conference on Surgery and Anaesthesia 2026. This conference stands as a remarkable and unparalleled for all attendees to engage, exchange knowledge and delve into the latest scientific breakthroughs in the realms of surgery and Anesthesia. There will be a session in Pediatric surgery. Your presence and participation would not only enrich this event but also contribute to the collective pursuit of the excellence in medical science. We look forward to welcoming you to this exceptional gathering, where the future in surgery and Anesthesia takes center stage.

Welcome Message



Ricky Rasschaert

AZ Rivierenland, Belgium

Dear friends and colleagues, It is with great pleasure to welcome you to the 2026 Global Congress on Surgery and Anesthesia in the vivid capital city of London. Once again as I read through the abstracts and the different subjects I can assure you the meeting programme is truly educational and most certainly worthy of your presence. The programme is diverse, but that makes it even more interesting with the potential of looking outside of our own narrow field. I hope to meet you all in London!



Welcome Message

Dr. Sagar Jawale

Paediatric and neonatal surgeon, India

Dear Distinguished Delegates, Speakers, Researchers, and Healthcare Professionals,

It is my great pleasure to welcome you to the **7th Edition of the Global Conference on Surgery and Anaesthesia (GCSA 2026)**. This conference brings together leading surgeons, anaesthesiologists, researchers, academicians, and healthcare innovators from across the globe to share knowledge, exchange ideas, and foster meaningful collaborations.

As surgery and anaesthesia continue to evolve through technological advances, artificial intelligence, robotics, and evidence-based practice, GCSA 2026 provides an outstanding platform to discuss the latest innovations, emerging techniques, and future challenges in patient care. The scientific program has been carefully designed to inspire learning, encourage interdisciplinary dialogue, and promote excellence in clinical practice and research.

I extend my sincere gratitude to our speakers, delegates, sponsors, scientific committee, and organizing team for their valuable contributions. I wish you a rewarding conference filled with insightful discussions, new collaborations, and lasting professional connections.

Welcome to GCSA 2026, and I wish you every success.

Table of Contents



Title: Idiopathic renal infarction in a young adult with isolated nicotine vaping exposure after extensive exclusion of conventional thrombotic causes <i>A B Azharul Islam, University Hospital Birmingham NHS Trust, United Kingdom</i>	32
Title: Xanthogranulomatous pyelonephritis mimicking locally advanced renal cell carcinoma <i>A B Azharul Islam, University Hospital Birmingham NHS Trust, United Kingdom</i>	34
Title: Improving T&O team confidence in using Cerner following transition from paper-based records: A closed-loop two-cycle audit <i>Abd AlRahman AlMeshali, Princess Alexandra Hospital NHS Trust, United Kingdom</i>	36
Title: Intrapericardial incarceration of preperitoneal fat after subxiphoid pericardial window <i>Abraham Garcia Reyes, Universidad Autonoma del Estado de Mexico, Mexico</i>	38
Title: Assessment and decision-making in complex limb fracture management: Limb salvage versus primary amputation <i>Adele Zacken, Royal London Hospital, United Kingdom</i>	40
Title: Negative appendectomy rates in the department of general surgery, Galway University Hospital, Republic of Ireland, 2025: A retrospective chart review <i>Afiq Rafidzy Bin Anwar Samhari, Galway University Hospital, Ireland</i>	42
Title: An avoidable delay: Audit of the neurosurgical referral pathway for head injury in Galway University Hospital <i>Afiq Rafidzy Bin Anwar Samhari, Galway University Hospital, Ireland</i>	44
Title: Isolated gallbladder injury following blunt abdominal trauma: A rare surgical presentation <i>Afua Timah Agyei, Medway Maritime Hospital, United Kingdom</i>	148
Title: ERAS compliance in elective colorectal surgery: Assessment, protocol development, and impact on post-operative outcomes. A closed-loop audit <i>Ahmed Elbioumy, Mid Cheshire Hospitals NHS Trust, United Kingdom</i>	46

Table of Contents

Title: Improving follow-up and post-operative care in patients with acute pilonidal and perianal disease: A closed-loop clinical audit Ahmed Elbioumy, Mid Cheshire Hospitals NHS Trust, United Kingdom	48
Title: From STUMBL to standard: Improving rib fracture management through guideline adherence in an acute surgical unit Aimee Bardon, Ulster Hospital, United Kingdom	50
Title: Artificial intelligence in colorectal surgery: From preoperative planning to intraoperative navigation Ajit Naniksingh Kukreja, Ratandeep - Dr Kukreja's Laser Piles Clinic, India	20
Title: Improving pharmacological DVT prophylaxis compliance using an electronic alert system in an acute surgical ward; A quality improvement project Akash Singh Sachdev, NHS Lanarkshire, United Kingdom	52
Title: Sentinel lymph node biopsy for breast cancer in low-resource settings: The role of superparamagnetic iron oxide tracers Alice Honigmann, University of Oxford Medical School, United Kingdom	54
Title: Tracheostomy practices in a District General Hospital ITU: An audit against NCEPOD standards Anthony Aldcroft, Dartford and Gravesham NHS Trust, United Kingdom	56
Title: Dermatofibrosarcomaprotuberans: A case series and review of clinical management from a tertiary care center Archita Jain, JSS Medical College, India	58
Title: Outcomes of rectal biopsy in the investigation of Hirschsprung's disease: A six-year two-cycle departmental audit Arian Rahim, Royal Alexandra Children's Hospital, United Kingdom	59
Title: Ciprofloxacin ear drops associated acute bursitis: A case report Arqam Shariq Syed, Aintree University Hospital NHS Trust, United Kingdom	150
Title: Innovation in general surgery Ashfaq Chandio, Manchester University NHS Foundation Trust, United Kingdom	22
Title: Defining the ideal umbilicus - A structured review of aesthetic preferences in plastic surgery Atharv Patil, Bedford Hospital, United Kingdom	61
Title: The rhinologist as developer: A practical framework for prompt engineering and app creation in clinical practice Ayan Ibrat, Gloucestershire Hospitals NHS Trust, United Kingdom	62
Title: When acute abdomen crosses the diaphragm: An incarcerated adult Bochdalek hernia Ayesha Nadeem, King's Mill Hospital, United Kingdom	64

Table of Contents

Title: Behind the knee lies a threat: A case report of popliteal artery aneurysm Ayesha Nadeem, King's Mill Hospital, United Kingdom	66
Title: Optimising NELA risk stratification through enhanced accuracy in ASA grading Caitlin McLaughlin, Medway NHS Foundation Trust, United Kingdom	152
Title: Enhancing foundation doctor confidence in acute surgical management through a structured simulation programme Caitlin McLaughlin, Medway NHS Foundation Trust, United Kingdom	154
Title: Renal autotransplantation for a hypervascular renal tumour in a solitary kidney: Ex vivo bench surgery to preserve renal function Christos Costa, Oxford University Hospitals NHS Foundation Trust, United Kingdom	68
Title: Impact of frailty in patients undergoing continuous-flow left ventricular assist device therapy: A systematic review and meta-analysis Christos Costa, Oxford University Hospitals NHS Foundation Trust, United Kingdom	70
Title: A planned robotic-assisted retroperitoneal lymph node dissection for symptomatic unicentric Castleman's disease: A case report Daniel Andreyev, Nottingham University Hospitals, United Kingdom	72
Title: How to keep your resident doctors happy: A departmental improvement project Daniel Andreyev, Nottingham University Hospitals, United Kingdom	73
Title: Anaesthetic management of splenectomy across diverse clinical scenarios: A case series of four patients Dennis Shadokpam, Sree Balaji Medical College and Hospital, India	156
Title: Transrectal excision of a foreign body lodged in the retrorectal space in a pediatric patient Devki B Patel, Texas Tech Health Sciences School of Medicine, United States	158
Title: Compliance with surgical antibiotic prophylaxis guidelines in bowel resection surgery: A retrospective audit Di Yuan, Mater Hospital Brisbane, Australia	160
Title: Unusual cause of small bowel obstructions in infants: A warning letter to parents Gamal Al Saied, Al-Azhar University, Egypt	24
Title: Mapping pediatric general surgery training in low-and middle-income countries: A scoping review Habba Mahal, University of Alberta, Canada	74
Title: Benchmarking paediatric appendicitis care against GIRFT standards: A single-centre audit Ishan Singh, Norfolk and Norwich University Hospital, United Kingdom	76

Table of Contents

Title: Digital replantation in hours versus out of hours: A retrospective review of outcomes Ivy Kuo, Portsmouth Hospitals University Trust, United Kingdom	80
Title: Mycotic multilobed lumbar artery pseudoaneurysm resulting from epidural and psoas abscess embolized with NBCA glue: A case report Ivy Kuo, Portsmouth Hospitals University Trust, United Kingdom	78
Title: BiZact versus bipolar diathermy and intracapsular coblation for tonsillectomy: A UK cohort study of 1,267 patients Jane Mendonca, Chelsea and Westminster NHS Foundation Trust, United Kingdom	82
Title: The sustainability literacy gap: A multi-centre analysis of resident doctor perceptions and barriers to green surgery Jane Mendonca, Chelsea and Westminster NHS Foundation Trust, United Kingdom	83
Title: Analysis of morbidity of salvage esophagectomy in advanced esophageal cancer Jose Luis Braga De Aquino, Pontifical Catholic University - Campus, Brazil	25
Title: Critical analysis of surgical treatment of relapse advanced esophageal achalasia Jose Luis Braga De Aquino, Pontifical Catholic University - Campus, Brazil	85
Title: Evolution of hand surgery over four decades: Experience from the Pulvertaft Hand Centre Joseph Norvill, Royal Derby Hospital, United Kingdom	87
Title: Normative scaphoid height-to-length ratio on computed tomography imaging: A new definition for scaphoid malunion? Joseph Norvill, Royal Derby Hospital, United Kingdom	89
Title: The educational value of 3D printed models in surgical airway skills teaching for medical students Katherine Birt, Swansea University, United Kingdom	91
Title: Does cross-sectional imaging of isolated greater trochanter fractures influence management and clinical outcomes? A 19-year single-centre case-control study Kieran Dey, Nottingham University Hospitals NHS Trust, United Kingdom	93
Title: Improving the dietary guidance in patients with a newly-formed ileostomy in a District General Hospital in the UK Matteo Moro, University Hospitals Sussex NHS Foundation Trust, United Kingdom	95
Title: Utilizing a 3D printed laparoscopic Nissen fundoplication model to shorten a resident's learning curve Muhammd Osama Wali Zada, Hangzhou Medical College, China	162

Table of Contents

Title: Pre-operative iron deficiency anaemia in colorectal cancer surgery: A missed opportunity for optimisation Murray James MacKay, NHS Lothian, United Kingdom	97
Title: Association of alpha-fetoprotein levels with tumour size and aetiological factors in hepatocellular carcinoma: A cross-sectional analysis Nayab Ahsan, University Hospitals Sussex, United Kingdom	99
Title: Perioperative nutritional optimisation within enhanced recovery pathways: Impact on postoperative morbidity and length of stay following elective abdominal surgery Nayab Ahsan, University Hospitals Sussex, United Kingdom	101
Title: Compliance of surgical operative notes to Royal College of Surgeons' Good Surgical Practice standards in Ealing Hospital Nida Selina Sultani, London North West Trust, United Kingdom	164
Title: Appropriateness of microbiological pus swabs following incision and drainage of cutaneous abscesses: A closed-loop audit of antimicrobial stewardship Noor Alshamlan, Mersey and West Lancashire Teaching Hospitals NHS Trust, United Kingdom	103
Title: Compliance with the Liverpool Head Injury Tomography (HIT) Score in neuro-surgical referral decisions for patients admitted under general surgery: A closed-loop audit Noor Alshamlan, Mersey and West Lancashire Teaching Hospitals NHS Trust, United Kingdom	105
Title: From assessment to action: Evaluating and improving adherence to the Enhanced Recovery After Surgery (ERAS) protocol in elective colorectal patients Olympia Hadjicosta, Imperial College Healthcare NHS Trust, United Kingdom	107
Title: The utility of AI in ultrasound guided regional anesthesia Osman Ahmed, Al Khor Anesthesia HMC, Qatar	26
Title: Transition in surgical management of benign prostatic hyperplasia in a tertiary centre: From TURP to contemporary minimally invasive and laser therapies Pranavi Challapalli, Royal Liverpool University Hospital, United Kingdom	109
Title: Utility value of colonoscopy in octonagenarians Pranavi Challapalli, Royal Liverpool University Hospital, United Kingdom	111
Title: Blood pressure management during endovascular thrombectomy after the 2026 AHA/ASA stroke guideline: Implications for anesthetic practice; A narrative review Rajesh Veeramachaneni, Rand Memorial Hospital, Bahamas	113
Title: Anal squamous cell carcinoma in Lancashire and South Cumbria: Regional epidemiology and alignment with current screening recommendations Rana Mohamed, Lancashire Teaching Hospitals NHS Foundation Trust, United Kingdom	115

Table of Contents

Title: A comprehensive review of operative considerations, surgical techniques, outcomes, and future perspectives in total knee arthroplasty Rana Muhammad Ali, The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, United Kingdom	117
Title: Are we assessing and documenting mortality risk scores for patients undergoing emergency laparotomy? A clinical audit Rana Muhammad Ali, The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, United Kingdom	119
Title: Inferior rectal nerve block for proctological surgery: A technical note Rawan Al Dehailan, Oxford University NHS Foundation Trust, United Kingdom	121
Title: When things go wrong! From victim to liability and the case of AI Ricky Rasschaert, AZ Rivierenland, Belgium	28
Title: Very late isolated bladder recurrence of testicular seminoma 16 years after orchidectomy: A rare case report Saad Masood, York Hospital, United Kingdom	123
Title: Omental pouch and intrapancreatic stem cell therapy for type 1 diabetes Sagar Aravind Jawale, Jawale Hospital, India	29
Title: Glycaemic variability and all-cause mortality in adult patients with sepsis: A systematic review and critical appraisal Sanjali Anil Chu Ahuja, Queen Mary University of London, United Kingdom	125
Title: Lung-protective ventilation compliance in mechanically ventilated ICU patients at a tertiary care hospital : A single-centre clinical audit Sanjay Pulpandi, Aberdeen Royal Infirmary, United Kingdom	127
Title: Ambulatory EMSU ultrasound audit Sarah Stevenson, Antrim Area Hospital, United Kingdom	129
Title: Appendicitis biomarker review Sarah Stevenson, Antrim Area Hospital, United Kingdom	131
Title: Incarcerated pre-sternal epigastric hernia causing closed-loop large bowel obstruction Sarah Stevenson, Antrim Area Hospital, United Kingdom	133
Title: Guiding selective neck dissection: Pattern of nodal spread and imaging accuracy in head and neck SCC Sheung Hang Mak, Hywel Dda University Health Board, United Kingdom	135
Title: A case of progressive bilateral candidal endogenous endophthalmitis Sri Harsha Dintakurti, Royal Gwent Hospital, United Kingdom	137

Table of Contents

Title: Does senior surgical review prevent negative appendicectomy? Stewart Chikukuza, Great Western Hospital NHS Foundation Trust, United Kingdom	141
Title: Macroscopic assessment of acute appendicitis versus histopathological diagnosis: A clinical audit of diagnostic concordance Stewart Chikukuza, Great Western Hospital NHS Foundation Trust, United Kingdom	139
Title: Large unclassified hepatocellular adenoma with spontaneous haemorrhage and necrosis in a young woman: Surgical management and post-operative surveillance challenges Sukanya Lakshmi Mahendran, Medway Maritime NHS Trust, United Kingdom	143
Title: Assessment of head elevation in ventilated patients Varunaen Udayachandran, Princess Alexandra Hospital NHS Trust, United Kingdom	145

About Magnus Group



Magnus Group, a distinguished scientific event organizer, has been at the forefront of fostering knowledge exchange and collaboration since its inception in 2015. With a steadfast commitment to the ethos of Share, receive, grow, Magnus Group has successfully organized over 200 conferences spanning diverse fields, including Healthcare, Medical, Pharmaceuticals, Chemistry, Nursing, Agriculture, and Plant Sciences.

The core philosophy of Magnus Group revolves around creating dynamic platforms that facilitate the exchange of cutting-edge research, insights, and innovations within the global scientific community. By bringing together experts, scholars, and professionals from various disciplines, Magnus Group cultivates an environment conducive to intellectual discourse, networking, and interdisciplinary collaboration.

Magnus Group's unwavering dedication to organizing impactful scientific events has positioned it as a key player in the global scientific community. By adhering to the motto of Share, receive, grow, Magnus Group continues to contribute significantly to the advancement of knowledge and the development of innovative solutions in various scientific domains

About GCSA 2026



It is our great pleasure to welcome you to the **7th Edition of the Global Conference on Surgery and Anaesthesia (GCSA 2026)**, taking place **September 24–26, 2026, in London, UK, and virtually**. This hybrid conference brings together surgeons, anaesthesiologists, researchers, clinicians, academics, and healthcare professionals from around the world to exchange knowledge, share clinical experiences, and explore emerging developments across surgery and anaesthesia.

Under the theme **Advancing Surgery & Anaesthesia: Safety, Quality, Outcomes**, GCSA 2026 provides a platform for discussing new approaches, evolving technologies, and evidence-based practices that are shaping the future of patient care. The scientific program encompasses a broad range of topics, including **minimally invasive and robotic surgery, surgical innovation, perioperative and critical care, anaesthesia, complex surgical interventions, reconstructive and regenerative approaches, surgical education, and patient safety and outcomes**.

GCSA 2026 aims to foster meaningful scientific exchange and multidisciplinary collaboration, connecting professionals from different specialties and regions to discuss challenges, share practical insights, and identify opportunities for future research and clinical advancement.

Beyond the scientific sessions, the conference offers an opportunity to build professional connections, exchange perspectives, and encourage collaborations that extend beyond the event. We invite all participants to engage actively in discussions, share their experiences, and contribute to the collective advancement of surgical and anaesthetic practice.

We hope your participation in **GCSA 2026** will be both informative and inspiring, providing valuable knowledge, new perspectives, and opportunities for professional growth. Together, let us continue working toward safer, more effective, and patient-centered surgical and anaesthetic care worldwide.

Thank you for being part of GCSA 2026 — where global expertise, innovation, and collaboration come together to shape the future of surgery and anaesthesia.

About CPD Accreditation

About

Continuing Professional Development (CPD) credits are valuable for GCSA 2026 attendees as they provide recognition and validation of their ongoing learning and professional development. The number of CPD credits that can be earned is typically based on the number of sessions attended. All the participants have an opportunity to avail 1 CPD credit for each hour of Attendance.

Some benefits of CPD credits include:

Career advancement: CPD credits demonstrate a commitment to ongoing learning and professional development, which can enhance one's reputation and increase chances of career advancement.

Maintenance of professional credentials: Many professions require a minimum number of CPD credits to maintain their certification or license.

Increased knowledge: Attending GCSA 2026 and earning CPD credits can help attendees stay current with the latest developments and advancements in their field.

Networking opportunities: This Conference provide opportunities for attendees to network with peers and experts, expanding their professional network and building relationships with potential collaborators.

7TH EDITION OF

GLOBAL CONFERENCE

SURGERY AND ANAESTHESIA

HYBRID EVENT
24-26
SEPTEMBER 2026

KEYNOTE PRESENTATIONS





Ajit Nanik Singh Kukreja

Ratandeep – Dr Kukreja's Laser Piles Clinic, Ahmedabad, India

Biography: Ajit Nanik Singh Kukreja is a Consultant Laparoscopy Gastrointestinal & Anorectal Surgeon at Ratandeep Surgical Hospital & Endoscopy Clinic, in exclusive anorectal practice for the last 36 years. Kukreja has organized workshops where around 500+ surgeons across Asia received hands-on training in hemorrhoidal artery ligation, rectoanal repair, and lasers in anorectal surgery, and has been faculty to multiple national and international conferences. Kukreja is author of the Amazon bestseller Anorectal Surgery Made Easy – with two interactive DVD ROMs and a contributor to multiple

chapters in international authors' books, received the best paper award for Anal tonometry – a newer diagnostic aid in anorectal disorders at GUJSURGCON 2005, and is an Elsevier- and Publons-certified peer reviewer for international journals. Research includes DG-RAR for the treatment of symptomatic grade III and grade IV hemorrhoids: a 12-month multi-center, prospective observational study, published in European Surgery in February 2013. Kukreja has contributed to the Association of Colon & Rectal Surgeons of India practice parameters for the management of hemorrhoids, served as organizing committee member for numerous conferences and workshops, organizing chairman of AAS Proctocon 2022 held in Ahmedabad on 13th November 2022, and program director to ACRSICON 2025, and is an Executive Committee Member of the Association of Colon & Rectal Surgeons of India (2023–2025).

Artificial intelligence in colorectal surgery: From preoperative planning to intraoperative navigation

Artificial intelligence is increasingly influencing colorectal surgery by supporting more accurate diagnosis, individualized operative planning, real-time decision-making, and postoperative risk prediction. This keynote address will examine how AI is being integrated across the surgical pathway, with particular emphasis on its transition from preoperative assessment to intraoperative navigation.

Preoperatively, AI-assisted imaging can facilitate tumor detection, staging, anatomical segmentation, assessment of vascular structures, and prediction of lymph-node involvement. Machine-learning models may also support patient selection, anticipate technical difficulty, and estimate the likelihood of conversion, anastomotic leakage, postoperative complications, and oncological outcomes. By combining radiological, pathological, clinical, and genomic data, these systems may enable more personalized treatment strategies and improve multidisciplinary decision-making.

Intraoperatively, computer vision and advanced image-analysis technologies are creating new opportunities for surgical navigation. Potential applications include recognition of operative phases, identification of critical anatomical landmarks, delineation of dissection planes, assessment of tissue perfusion using fluorescence imaging, and real-time alerts during laparoscopic and robotic procedures. Integration with augmented reality, robotic platforms, and digitally connected operating rooms may further enhance precision, standardization, training, and patient safety.

However, the adoption of AI in colorectal surgery also presents important challenges. Algorithmic bias, variable data quality, limited external validation, lack of interpretability, cybersecurity concerns, regulatory uncertainty, and medico-legal accountability must be addressed before widespread clinical implementation. Surgeons must remain central to the design, evaluation, and governance of these technologies.

AI should not be viewed as a replacement for surgical expertise, but as a tool that augments clinical judgment and technical performance. This keynote will highlight current innovations, practical limitations, and future directions, emphasizing the need for robust evidence, ethical oversight, multidisciplinary collaboration, and surgeon-led implementation.



Ashfaq Chandio

Manchester University NHS Foundation Trust,
United Kingdom

Biography: Ashfaq Chandio is a surgeon specialising in General and Colorectal Surgery with extensive clinical and academic experience within the United Kingdom and Ireland, currently associated with Manchester University NHS Foundation Trust, one of the largest teaching hospital organisations in the United Kingdom. Chandio graduated in medicine from Chandka Medical College Larkana, Pakistan, and subsequently pursued postgraduate surgical training across Ireland and the United Kingdom, gaining broad multidisciplinary surgical experience including colorectal surgery,

general surgery, urology, vascular surgery, emergency surgery, and breast and endocrine surgery. Chandio holds the Fellowship of the Royal College of Surgeons in Ireland (FRCSI) and dual European Board of Surgery (FEBS) certifications in General Surgery and Coloproctology, and has completed a Diploma in Laparoscopic Surgery in France. Chandio has worked across multiple NHS organisations including Hywel Dda University Health Board, London North West University Healthcare NHS Trust (Northwick Park Hospital), and NHS Grampian, and while working in Scotland also served as Honorary Senior Lecturer at the University of Aberdeen. Clinical interests include colorectal disease, laparoscopic and minimally invasive surgery, multidisciplinary colorectal care, and surgical service development, and Chandio has contributed to service innovation including work related to Colon Capsule Endoscopy at Dr Gray's Hospital. Chandio maintains a strong commitment to surgical education and professional training, having taught and supervised medical students, International Medical Graduates, foundation doctors, surgical trainees, and advanced nurse practitioners, and has served as faculty for surgical training programmes delivered through the Royal College of Surgeons of England, including Basic Surgical Skills (BSS), START Surgery, and CCrISP. Chandio has also contributed to MRCS examination preparation programmes, participated in peer-reviewed publications and national and international scientific presentations, and reflects a continuing commitment to clinical excellence, surgical education, multidisciplinary collaboration, and mentorship.

Innovation in general surgery

Background: Innovation has always been central to the evolution of general surgery, driving safer techniques, better outcomes, and more efficient patient care. From antisepsis and anaesthesia to robotics and artificial intelligence, the specialty has consistently adapted to meet new challenges and opportunities.

Objective: This presentation explores key technological and systemic innovations transforming modern general surgery and highlights their impact on surgical practice, education, and patient outcomes.

Methods: A comprehensive review of current advances was undertaken, focusing on minimally invasive and robotic platforms, artificial intelligence–assisted decision-making, 3D printing, augmented reality, and enhanced recovery protocols. The analysis also considers the ethical, educational, and economic implications of integrating such innovations into daily practice.

Results: Innovations such as robotic-assisted surgery have enhanced precision and ergonomics, while AI and data analytics now contribute to preoperative planning and postoperative outcome prediction. 3D modelling and augmented reality have improved pre-surgical visualization, and enhanced recovery pathways have optimized perioperative care. Together, these developments have shortened hospital stays, reduced complications, and improved patient satisfaction.

Conclusion: Innovation in general surgery extends beyond technology — it encompasses system redesign, multidisciplinary collaboration, and the commitment to continuous improvement. The future surgeon must embrace digital tools, evidence-based protocols, and patient-centred thinking to deliver safer, smarter, and more personalized care.

Keywords: General Surgery, Innovation, Robotics, Artificial Intelligence, 3D Printing, Augmented Reality, ERAS, Surgical Education.



Gamal Al-Saied

Al-Azhar University, Cairo, Egypt

Biography: Gamal Al-Saied is a distinguished Egyptian pediatric surgeon and academic affiliated with Al-Azhar University in Cairo, Egypt. Al-Saied earned a medical degree from Al-Azhar University with honors, ranking 9th in the class, and advanced training included an MSc in Pediatric Surgery (1991) and an MD in Pediatric Surgery (1998), progressing through academic ranks to become a full professor in 2009. Professional credentials include Fellowship of the European Board of Pediatric Surgery, Fellowship of the American College of Surgeons, and Membership of the Royal College of Physicians and

Surgeons of Glasgow. Al-Saied's scholarly work encompasses 37 international publications in pediatric surgery and a textbook chapter on urethroplasty, and Al-Saied serves as Editor-in-Chief for two international pediatric surgery journals and editor for thirteen others. Research focuses on complex pediatric and neonatal surgical conditions, and Al-Saied has supervised numerous graduate theses.

Unusual cause of small bowel obstructions in infants: A warning letter to parents

Foreign-body ingestion is a common problem in the pediatric age group, as infants and young children naturally explore their surroundings by placing objects in their mouths. Among the hazardous items they may encounter are decorative crystal gel balls, which have the ability to absorb water and enlarge dramatically once inside the gastrointestinal tract. This expansion can lead to serious complications. Herein, we present three infants who developed small-bowel obstruction following the ingestion of these crystal balls, highlighting the potentially severe consequences of exposure to such materials. These cases emphasize the importance of rapid medical attention, as certain foreign bodies require urgent intervention. When ingestion of a crystal gel ball is identified early, immediate endoscopic retrieval is advisable to prevent further swelling and obstruction. Raising parental awareness is essential, and public education through media outlets plays a vital role in discouraging the presence of decorative gel balls in households and environments accessible to children, thereby reducing the likelihood of accidental ingestion and its associated risks.



Jose Luis Braga De Aquino

Hospital and Maternity Celso Pierro, Medical School,
Pontifical Catholic University of Campinas, Brazil

Biography: Jose L. B. de Aquino was born in Campinas, Brazil, and graduated in Medicine in 1978 from the Faculty of Medicine of Sao Jose do Rio Preto, SP. De Aquino completed training in General Surgery for 4 years at the Faculty of Medicine of the Pontifical Catholic University of Campinas, having obtained a Master's degree in Surgery in 1990 and a Doctorate in Surgery in 1996, both from the State University of Campinas (UNICAMP). De Aquino is Professor of Surgical Clinic at the Faculty of Medicine of PUC, working with Head and Neck Surgery, Thoracic Surgery, Digestive and Esophageal Diseases, and leads one

of the PUC Research Groups, DIAGNOSTIC AND CLINICAL SURGERY TREATMENT, with a multidisciplinary focus spanning the clinical, surgical and nutritional areas. De Aquino is a Professor of the Postgraduate Course in Health Sciences at PUC, Editor-in-Chief of the Revista de Ciências Médicas at PUC, and Associate Editor of the Revista do Colégio Brasileiro de Cirurgiões, and is author and co-author of 217 articles published in national and international magazines and winner of several awards for works presented in Congresses.

Analysis of morbidity of salvage esophagectomy in advanced esophageal cancer

Even though the esophageal cancer has innumerable treatment options, its prognosis is still unsettled. Because esophagectomy is rarely curative, others therapies, such as chemoradiation emerging in advanced disease followed or not surgery. The salvage esophagectomy is an alternative for those patients with recurrent disease. Thus the intend is show the results of the salvage esophagectomy in patients with esophageal cancer who had previously undergone chemoradiation and discussion about the morbidity of this surgical technique. Too, its show the our experience in 72 patients with unresectable esophageal carcinoma were treated with chemoradiation followed by salvage esophagectomy. Patients was evaluated with regard post-operative complications and disease free survival. The major complications was leak at the level of the anastomotic esophagogastric cervical, present in 16 patients (22,2%) and pulmonary infection in 23 patients (31,9%). In 53 patients that were available for a five years follow-up a rate of 43,3% (23 patients) of disease free survival. Thus with the results its conclude that the salvage esophagectomy seems to be valuable in cases without any other therapeutic options.



Osman Ahmed

Al Khor Anesthesia HMC, Qatar

Biography: Dr. Osman Ahmed is an assistant professor of Anesthesiology at CMED Qatar University and Al Khor Hospital HMC, a fellow of the College of Anesthesiologists in Ireland, who completed a fellowship program in ultrasound-guided regional anesthesia at Cork University Hospital. Ahmed subsequently collaborated with professors at University College Cork, completing an MD research program in 2017 focused on simulation training. Ahmed's current research interests center on virtual reality applications in procedural skills training, curriculum development, and assessment tool validation.

The utility of AI in ultrasound guided regional anesthesia

Regional Anesthesia (RA) is increasingly used in anesthesia practice. Ultrasound has been used to facilitate the performance of the regional blocks. The use of ultrasound for nerve localization increases success and reduces complication rate.

Ultrasound technology has increasingly gained popularity among practitioners due to its portability, and the ability to track the performance of the procedure in real-time. Other benefits of ultrasound use in regional anesthesia include direct visualization of nerves, blood vessels, muscles, bones, tendons and the local anesthetic spread during injection and as such minimizes the rate of possible complications like inadvertent intravascular injections and unintended intraneuronal injection of local anesthetics.

The use of ultrasound technology in regional anesthesia like other image guided procedures is challenging. It is associated with several technical difficulties, which are especially prevalent in trainees and less experienced proceduralists. The performance of a block can then be complicated with loss of coordination between hand, needle and probe. Performance also requires intense mental work in terms of real time image interpretation and to guide the needle under ultrasound guidance towards the intended target.

Artificial Intelligence (AI) is a field of computer science which uses techniques that enable computers to undertake tasks associated with human intelligence. AI solutions might be useful for practitioners in anatomical landmark identification and, reducing or avoiding possible complications such as injury to the nerve, artery, vein, and other vital structures, as

well as local anesthetic systemic toxicity. AI-guided solutions can improve the optimization and interpretation of the sonographic image, visualization of needle advancement and injection of local anesthetic. The big question is what is the evidence supporting the use of artificial intelligence for ultrasound scanning in regional anesthesia? and whether it improves performance and subsequently translate into favorable patient's outcomes. Training skills pertinent to ultrasound guided regional anesthesia is another area that AI may prove helpful however its utility and limitation should be carefully evaluated before a conclusion could ever be drawn.



Ricky Rasschaert

AZ Rivierenland, Bornem, Belgium

Biography: Dr. Ricky Rasschaert is a neurosurgeon and spine surgeon at the AZ Rivierenland in Antwerp, Belgium. The use of minimally invasive techniques and spinal reconstructive surgery are Rasschaert's main interests. Rasschaert is a member of several neurosurgical and spine societies and has a teaching position at Odisee, University of Applied Sciences. Rasschaert conducts research involving the treatment of Tarlov cysts, the link with cerebrospinal fluid and small fibre neuropathy; other research projects involve haemostats and partnerships in further projects.

As head of the Neurosurgery Department and member of the OR committee, Rasschaert is also involved in hospital management and governance. As a medico-legal expert, the management of complications and the impact on healthcare professionals as well as the patient is a side interest.

When things go wrong! From victim to liability and the case of AI

As surgeons we all have to deal with complications and sometimes errors. In neurosurgery this can be devastating for the patients with a lifelong deficit or even resulting in the decease of the patient. These unforeseen events cause a lot of (emotional) stress and should be handled carefully. The patient and his family are certainly the first victims and optimal management of aftercare and communication is of the utmost importance. However often the second victim tends to be forgotten: the treating physician who is responsible for the adverse event is also going through an emotional process and should be supported as well. Unfortunately the institutions are often not supportive and still search for a scapegoat. Peer support programmes have already shown their meaningful impact in helping these second victims.

The risk of litigation is another impacting factor which is more prominent in some countries compared to others. I will present shortly different approaches with the financial and emotional impact.

To finish the presentation we cannot omit the evolution of AI and its impact on our daily functioning, but who takes the responsibility and what are the risk? A story untold...



Sagar Jawale

Jawale Hospital, Jalgaon, India

Biography: Dr. Sagar Arvind Jawale is an Indian paediatric and neonatal surgeon, scientist, innovator, and founder of Vigyan Yog Foundation. With over 25 years of clinical and research experience, Jawale has developed more than 100 medical innovations, secured 50 patent registrations, and received 12 Indian patents. Jawale's work focuses on affordable healthcare technologies, paediatric surgery, stem cell therapy, biomedical devices, and indigenous medical equipment under the Make in India initiative. Jawale has authored 22 scientific publications, delivered over 30 national and international

presentations, and received 18 awards, and also researches yoga, consciousness, and scientific approaches to spiritual development.

Omental pouch and intrapancreatic stem cell therapy for type 1 diabetes

Background: Type 1 Diabetes Mellitus (T1DM) is a chronic autoimmune disorder characterized by destruction of pancreatic β -cells, resulting in lifelong dependence on exogenous insulin. Although insulin therapy and islet cell transplantation remain the standard treatment options, both have important limitations related to lifelong treatment, cost, donor availability, and limited long-term efficacy. This presentation describes two novel autologous stem cell-based therapeutic approaches developed for T1DM: the Omental Pouch Stem Cell Operation for children below 10 years of age and Intrapancreatic Stem Cell Transplantation for patients above 10 years of age.

Methods: Adult autologous stem cells were obtained either from omental adipose tissue through enzymatic collagenase digestion or from bone marrow using density-gradient centrifugation. In the omental pouch technique, stem cells were distributed into a surgically created omental pouch, the peritoneal cavity, and intravenously. Twenty-one insulin-dependent children aged 2.5–10 years underwent this procedure and were compared with 26 conventionally treated controls. In the intrapancreatic technique, performed in 23 insulin-dependent patients aged 10–56 years, stem cells were infused directly into the pancreatic artery and distal splenic artery using interventional radiology to maximize pancreatic stem cell delivery. Patients were evaluated at three-month intervals using fasting and postprandial blood glucose, HbA1c, Anti-GAD antibody titres, C-peptide levels, and insulin requirements.

Results: In the omental pouch group, improvement became evident after approximately three months. At one-year follow-up, 14.3% of patients became insulin independent, while the remaining patients experienced an approximately 50% reduction in insulin requirement together with substantial improvement in blood glucose control. Anti-GAD antibody titres decreased by 50–75%, suggesting partial reversal of autoimmunity, while C-peptide levels increased by approximately 50%, indicating improved endogenous insulin secretion. No therapy-related mortality was reported.

Among patients undergoing intrapancreatic stem cell transplantation, 30.4% achieved insulin independence after one year, whereas the remaining patients demonstrated approximately 50% reduction in insulin requirement with improved glycaemic control. Similar reductions in Anti-GAD antibody titres and increases in C-peptide levels were observed. Direct arterial delivery was proposed to increase pancreatic stem cell concentration substantially compared with conventional intravenous administration. In both studies, control groups showed no patients achieving insulin independence and demonstrated comparatively poorer metabolic outcomes during follow-up.

Discussion: These approaches are based on the regenerative and immunomodulatory properties of adult stem cells. The omentum provides a vascularized, relatively immune-privileged environment that may support stem cell survival and differentiation, while direct arterial infusion increases stem cell delivery to pancreatic tissue. The proposed mechanisms include regeneration of β -cells, stimulation of endogenous repair through growth factors and cytokines, and partial reversal of autoimmune activity. The reported procedures were designed as cost-effective alternatives, with treatment costs substantially lower than conventional cell-based therapies.

Conclusion: The presented clinical experience suggests that autologous stem cell therapy delivered through either an omental pouch or direct intrapancreatic infusion may improve glycaemic control, reduce insulin dependence, and partially reverse autoimmune markers in selected patients with Type 1 diabetes. The author concludes that these techniques appear affordable, safe, and promising; however, larger controlled clinical studies with longer follow-up are required to establish their efficacy, long-term safety, reproducibility, and role in routine clinical practice.

7TH EDITION OF
GLOBAL CONFERENCE
**SURGERY AND
ANAESTHESIA**

HYBRID EVENT
24-26
SEPTEMBER 2026

ORAL
PRESENTATIONS



A B Azharul Islam

University Hospital Birmingham NHS Trust, Birmingham,
United Kingdom

Idiopathic renal infarction in a young adult with isolated nicotine vaping exposure after extensive exclusion of conventional thrombotic causes

Background: Renal infarction is a rare and frequently overlooked clinical entity, often presenting with non-specific abdominal symptoms that mimic more common intra-abdominal pathology, resulting in delayed recognition. The condition is typically associated with cardioembolic disease, inherited or acquired thrombophilia, vasculitis, and vascular abnormalities. Cases occurring in young adults without identifiable risk factors are uncommon and present a diagnostic challenge. Electronic cigarette use has recently emerged as a potential contributor to endothelial dysfunction, oxidative stress, and platelet activation, although evidence linking vaping to clinically significant arterial thrombotic events remains limited.

Case Presentation: A 26-year-old man with a background history of asthma presented with acute abdominal pain, initially central in distribution before localising to the right flank and right iliac fossa, associated with repeated episodes of vomiting. He denied urinary symptoms, trauma, previous thrombotic events, or significant urological history. Initial biochemical investigations demonstrated a markedly elevated lactate dehydrogenase level (1755 U/L), elevated inflammatory markers (CRP 92 mg/L), and preserved renal function (creatinine 109 $\mu\text{mol/L}$; eGFR 77–80 mL/min/1.73 m²). Contrast-enhanced CT imaging identified a right upper-pole partial renal infarction without evidence of renal artery stenosis or major vascular abnormality. Comprehensive investigations were initiated to evaluate underlying causes, including thrombophilia screening, antiphospholipid antibody testing, vasculitis screening, homocysteine levels, JAK2 mutation analysis, paroxysmal nocturnal haemoglobinuria screening, and genetic assessment. No conventional thrombotic or vascular aetiology was identified during evaluation. Social history was notable for regular nicotine-containing electronic cigarette use (approximately 5–6 inhalations ten times daily), representing the only identifiable potential prothrombotic exposure.

Discussion: Idiopathic renal infarction in young patients remains uncommon and necessitates systematic investigation to exclude embolic, vascular, autoimmune, and hypercoagulable causes. Experimental and epidemiological studies increasingly suggest nicotine-containing

vaping may induce endothelial injury and a prothrombotic state through platelet activation and vascular dysfunction. Although a causal relationship cannot be inferred from a single case, the absence of alternative risk factors raises the possibility of an association warranting further investigation.

Conclusion: This case emphasises the importance of considering renal infarction in young patients presenting with acute abdominal or flank pain and disproportionately elevated LDH levels. It additionally highlights nicotine vaping as a possible emerging thrombotic exposure requiring further study.

Keywords: Renal Infarction, Electronic Cigarette, Nicotine Vaping, Arterial Thrombosis, Hypercoagulable State, Acute Flank Pain.

A B Azharul Islam

University Hospital Birmingham NHS Trust, Birmingham,
United Kingdom

Xanthogranulomatous pyelonephritis mimicking locally advanced renal cell carcinoma

Introduction: Xantho Granulomatous Pyelonephritis (XGP) is an uncommon inflammatory renal condition associated with urinary obstruction, infection and calculi. Focal XGP may resemble Renal Cell Carcinoma (RCC), particularly when typical radiological features are absent. We report a case in which XGP presented as an enhancing renal mass with renal vein thrombosis and paracaval lymphadenopathy.

Case Presentation: A 75-year-old patient presented with right flank pain, fever and vomiting. Investigations demonstrated leukocytosis, renal impairment and right hydronephrosis secondary to an upper ureteric calculus. The collecting system was initially decompressed by percutaneous nephrostomy, followed by percutaneous nephrolithotomy. After improvement in renal function, contrast-enhanced CT demonstrated a 49 × 35 × 43 mm right renal mass. The lesion enhanced from 33 HU to 118 HU and contained non-enhancing areas. Renal vein thrombosis and multiple paracaval lymph nodes were also present. The imaging findings were considered suspicious for RCC, with a radiological stage of T3aN2M0. The patient underwent laparoscopic radical nephrectomy. Histopathology demonstrated renal parenchyma extensively infiltrated by foamy macrophages and inflammatory cells, consistent with XGP. No malignancy was identified. Postoperative recovery was uncomplicated.

Discussion: The combination of a strongly enhancing renal mass, renal vein thrombosis and regional lymphadenopathy favoured RCC on preoperative imaging. However, the preceding obstructing calculus, hydronephrosis and infection were also compatible with XGP. This case demonstrates the difficulty of distinguishing focal XGP from renal malignancy when the usual CT appearance is absent. The distinction has practical implications. When imaging cannot

exclude malignancy, nephrectomy may be required both for definitive treatment and diagnosis. Histopathological examination remains decisive in such cases.

Conclusion: Focal XGP can closely resemble locally advanced RCC. In a renal mass occurring alongside calculi, obstruction or infection, XGP should remain in the differential diagnosis even when CT demonstrates marked enhancement, venous thrombosis or regional lymphadenopathy.

Keywords: Xanthogranulomatous Pyelonephritis, Renal Cell Carcinoma, Renal Mass, Renal Vein Thrombosis, Nephrectomy.



Abd AlRahman AlMeshali

Department of Trauma, and Orthopaedics Surgery, Princess Alexandra Hospital NHS Trust, Hamstel Road, CM20 1QX, Harlow, Essex, UK

Improving T&O team confidence in using Cerner following transition from paper-based records: A closed-loop two-cycle audit

Background: Princess Alexandra Hospital NHS Trust introduced Cerner, replacing previous systems for clinical documentation, prescribing and outpatient services. Variable staff fluency and system dysfunctionality during this transition risked delays, near misses and misses compromising patient safety within the Trauma & Orthopaedics (T&O) team.

Aim: To assess T&O team members' confidence in performing role-specific tasks on Cerner, identify training gaps and system faults, implement a targeted intervention, and re-evaluate confidence following this intervention.

Method: A role-specific questionnaire (three sections: registrars/consultants; SHOs/FY1s/FY2s; trauma co-ordinators) rated confidence (1–5 Likert scale) across tasks including requesting procedures/investigations, documenting operative notes, clerking and ward-round notes, generating patient lists, and booking outpatient follow-ups. Cycle 1 (n=19) identified confidence gaps and system faults, which informed a concise step-by-step quick-reference guide circulated to all team members, alongside feedback to the IT department. Cycle 2 (n=15) re-surveyed the same domains post-intervention.

Results: Cycle 1 showed low-to-moderate confidence across most tasks, notably OP follow-up clinic booking among SHOs/FY1s/FY2s (0% rating $\geq 4/5$) and biopsy/sample-request confidence among registrars/consultants (11.1% rating $\geq 4/5$). Following the intervention, high-confidence ratings ($\geq 4/5$) rose across nearly all tasks and grades: OP follow-up booking confidence among SHOs/FY1s/FY2s rose from 0% to 75%, investigation-requesting confidence from 63.6% to 100%, operative note documentation confidence among registrars/

consultants from 44.4% to 100%, and OP clinic management confidence from 33.3% to 80%. Free-text feedback consistently described the guide as helpful and confidence-building.

Conclusion: A brief, role-tailored quick-reference guide combined with structured IT feedback produced a substantial, measurable improvement in self-reported staff confidence using Cerner across all T&O grades. This low-cost, scalable intervention supports patient safety during electronic-record transitions and should be sustained via a shared-drive FAQ resource, ongoing IT liaison, and Datix reporting of any system-related safety incidents. Limitations include reliance on self-reported (rather than observed) competence and a smaller respondent pool at re-audit (n=15 vs n=19).

Biography

Dr Abd AlRahman AlMeshali is a trust grade resident doctor working at ST1 level in the Department of Acute Medicine at Princess Alexandra Hospital NHS Trust, on a fixed-term 12-month contract. He completed A-levels in Maths, Chemistry and Biology at Oxford (2017–2018), before studying Medicine (MBChB) at Buckingham Medical School (2019–2023). He undertook Foundation Training at Princess Alexandra Hospital (2023–2025), rotating through Colorectal Surgery, Ortho-geriatrics, Acute Medicine, Trauma & Orthopaedics, Emergency Medicine, and General Practice. Since completing Foundation Training, he has worked ~0.6–0.7 FTE as a locum across A&E, Acute Medicine, and T&O, alongside his current substantive post.



Abraham Garcia Reyes*, Adriana Nieves Valerdi, Aphil MJ Montiel H, Aly M. Emeterio Hernández, Daniel A. Tenorio G.

Universidad Autonoma del Estado de Mexico, Mexico

Intrapericardial incarceration of preperitoneal fat after subxiphoid pericardial window

Intrapericardial incarceration of preperitoneal fat is an exceptionally rare complication of subxiphoid pericardial window creation. We report a 70-year-old Hispanic Mexican woman with morbid obesity (BMI 45 kg/m²), hypertension, type 2 diabetes, and hypothyroidism who developed recurrent pericardial effusion after COVID-19 infection and laparoscopic cholecystectomy. A subxiphoid pericardial window was performed, but nine months later she presented with positional dyspnea, dizziness, and hypotension. Transthoracic echocardiography was unremarkable, yet noncontrast chest computed tomography revealed a 3 cm defect in the central tendon of the diaphragm through which an 11 × 7 × 4 cm fat mass herniated into the pericardial sac, compressing the right cardiac chambers. Urgent median sternotomy permitted safe reduction of the incarcerated preperitoneal fat and primary closure of the diaphragmatic defect with interrupted 10 polyglactin (Vicryl) sutures, without mesh reinforcement. The postoperative course was uneventful; at four-year follow-up the patient remained asymptomatic (NYHA I) with no recurrence. This case underscores that transthoracic echocardiography may miss extrinsic intrapericardial masses and that cross-sectional imaging is essential for diagnosis when patients with prior pericardial peritoneal communication develop unexplained positional cardiopulmonary symptoms. The pathophysiology likely involves iatrogenic creation of a diaphragmatic communication allowing gradual herniation of preperitoneal fat under increased intraabdominal pressure, resulting in dynamic cardiac compression. Surgical management should be individualized; median sternotomy provided optimal exposure for reduction and direct primary repair, offering durable long term outcomes for small, well defined defects. The report complies with the SCARE 2025 checklist, emphasizing transparent case reporting and ethical standards. This case adds to the limited literature on intrapericardial diaphragmatic hernias, highlighting a novel mechanism of obstruction and a successful operative strategy that may guide future management of similar iatrogenic complications.

Biography

Dr. Abraham García Reyes is a general surgery resident and assistant professor of general surgery residency at UAEMEX, IMMS Bienestar, Hospital General Atizapán, Dr. Salvador González Herrejón, and earned a medical degree from UNAM and is currently an endoscopy resident candidate. Training and research focus on endoscopic, laparoscopic, and robot-assisted surgery. Dr García Reyes Abraham is committed to advancing minimally invasive surgical techniques and contributes to surgical education through teaching and clinical work.



Adele Zacken^{1*}, Kayaththery Varathan¹, Tasmia Islam¹, Yasmin Sheikey², Diana Sabbagh²

¹Royal London Hospital, UK

²Newham General Hospital, UK

Assessment and decision-making in complex limb fracture management: Limb salvage versus primary amputation

Complex limb injuries present a major challenge in trauma and orthopaedic practice due to the extent of damage involving bone, soft tissue, nerves, and vascular structures. These injuries create a critical decision point between limb salvage and primary amputation, both of which have significant implications for patient outcomes and quality of life.

A narrative review of the literature was undertaken to examine current approaches to assessment and management. Studies evaluating clinical assessment strategies, injury severity scoring systems, and treatment outcomes were analysed. Commonly used scoring systems include the Mangled Extremity Severity Score (MESS), Mangled Extremity Syndrome Index (MESI), Predictive Salvage Index (PSI), Limb Salvage Index (LSI), and the Ganga Hospital Open Injury Severity Score (GHOISS). Key studies comparing outcomes following limb salvage and amputation were also reviewed.

The evidence highlights the importance of structured trauma assessment, particularly early identification of vascular injury, in determining limb viability. While scoring systems provide useful frameworks for evaluating injury severity, their ability to predict long-term functional outcomes is limited. Advances in orthoplastic surgery, microsurgical reconstruction, and trauma care have improved limb salvage success. However, salvage often involves prolonged recovery, multiple procedures, and higher complication rates.

Importantly, studies such as the Lower Extremity Assessment Project demonstrate that long-term functional outcomes following limb salvage and primary amputation are often comparable. Therefore, management should rely on clinical judgement, multidisciplinary input, and patient-centred decision-making. Scoring systems should support, but not dictate, treatment decisions, with priority given to functional outcomes and overall quality of life.

Biography

Zacken is a resident doctor currently undertaking a Master's degree in Trauma and Orthopaedic Sciences while working in a Major Trauma Centre in London. Zacken's clinical and academic interests focus on the management of complex limb injuries, with a particular emphasis on limb reconstruction, and Zacken is committed to improving patient outcomes through evidence-based practice and surgical innovation. In addition to clinical work, Zacken is actively involved in quality improvement projects aimed at enhancing patient care and service delivery. Zacken aims to pursue a career in trauma and orthopaedics, specialising in limb reconstruction and complex injury management.



Maha Shehab, Afiq Rafidzy Bin Anwar Samhari*, Muhammad Azam Arif

Department of General Surgery, Galway University Hospital, Republic of Ireland

Negative appendectomy rates in the Department of General Surgery, Galway University Hospital, Republic of Ireland, 2025: A retrospective chart review

Introduction: Acute appendicitis is one of the most common surgical emergencies, but diagnostic uncertainty can lead to removal of a histologically non-inflamed appendix. The Negative Appendectomy Rate (NAR) is therefore used as a surgical quality indicator. This study aimed to determine the NAR in the Department of General Surgery at Galway University Hospital (GUH) during 2025 and identify associated clinical and radiological predictors.

Methods: A retrospective cohort study was performed using 2025 surgical handover sheets. Electronic health records, radiology reports, histology and laboratory results were reviewed. Demographic data, inflammatory markers, preoperative imaging, operative findings and appendicular histology were collected. Statistical analysis was performed using IBM SPSS Statistics.

Results: Among 509 admissions with suspected appendicitis, 335 patients (65.8%) underwent appendectomy. Histology confirmed appendicitis in 300 patients (89.6%), while 35 patients had no histological evidence of appendicitis, giving an NAR of 10.4%. Fourteen patients had no appendicular pathology, giving a true NAR of 4.2%; alternative findings included lymphoid hyperplasia, Enterobius vermicularis and malignancy. Female sex was significantly more common in the negative appendectomy group (62.9% vs 43.3%, $p=0.028$). Inflammatory markers were lower in the negative group, including WBC (10.0 vs $14.5 \times 10^9/L$, $p<0.001$), CRP (22.1 vs 47.2 mg/L, $p=0.002$), neutrophil count (6.8 vs $11.4 \times 10^9/L$, $p<0.001$) and leukocyte shift (22.9% vs 66.3% , $p<0.001$). Ultrasound was more frequently used in the negative group (57.1% vs 32.3% , $p=0.004$), with equivocal ultrasound findings also more common (65.0% vs 34.0% , $p=0.033$). CT was performed in 31.4% of the negative group, and 72.7% of these scans were reported positive despite negative histology.

Conclusion: GUH demonstrated an NAR of 10.4% and a true NAR of 4.2%, comparing favourably with reported Irish benchmarks. Lower inflammatory markers, female sex and equivocal imaging were associated with negative appendicectomy. Structured use of clinical scoring, appropriate preoperative imaging and continued prospective audit may help further reduce unnecessary appendicectomy.

Biography

Afiq Rafidzy Bin Anwar Samhari is a General Surgery Registrar in Upper Gastrointestinal Surgery at University Hospital Galway. Anwar Samhari holds an MCh from the Royal College of Surgeons in Ireland and MRCS (Edinburgh). Anwar Samhari clinical interests include upper gastrointestinal surgery, abdominal wall reconstruction and minimally invasive surgery. Anwar Samhari has a strong interest in surgical research, audit and quality improvement, with several peer-reviewed publications and national and international presentations. Anwar Samhari conceived the 2025 Galway negative appendicectomy rate audit, focusing on diagnostic accuracy and strategies to reduce unnecessary surgery.



Chelsea Rampersad, Afiq Rafidzy
Bin Anwar Samhari*, Deeksha
Sammy, Muhammad Azam Arif

Department of General Surgery, Galway University Hospital,
Republic of Ireland

An avoidable delay: Audit of the neurosurgical referral pathway for head injury in Galway University Hospital

Introduction: Head injuries are a common Emergency Department (ED) presentation and may require urgent CT brain imaging and timely specialist neurosurgical input. At Galway University Hospital (GUH), the current adult head injury pathway involves ED assessment, referral to the General Surgical team for repeat review, and subsequent discussion with Beaumont neurosurgery. Most comparator Irish hospitals identified in this audit use direct ED-to-neurosurgery referral, meaning the GUH pathway contains an additional intermediary step.

Aim: To quantify delays at each stage of the GUH neurosurgical referral pathway and assess whether direct ED-to-Beaumont referral for selected isolated head injury patients could streamline care.

Methods: A retrospective chart review was conducted from January 2024 to July 2025. Adult patients presenting with mechanical head injury who underwent CT brain and required neurosurgical referral/discussion through the current GUH pathway were included. Of 193 patients identified, 64 were excluded because of age under 18 years, non-mechanical mechanism, or incomplete data, leaving 129 patients for analysis. Documented time intervals were extracted from ED doctor assessment to CT brain, CT to surgical referral, surgical referral to surgical review, and surgical review to Beaumont discussion. The primary outcome was total time from ED doctor assessment to Beaumont neurosurgical discussion.

Results: Mean time from ED assessment to CT brain was 2 h 40 min, CT to surgical referral 1 h 36 min, surgical referral to surgical review 1 h 36 min, and surgical review to Beaumont discussion 1 h 25 min. The total mean pathway duration was 7 h 17 min. The clearest pathway-dependent delay was the 1 h 36 min wait for surgical review; the combined post-surgical-referral interval was approximately 3 hours. Contributing factors included surgical SHO availability, duplication

of assessment, referral documentation, handover gaps, and callback/logistical delays. In several cases, Beaumont referral was initiated using the ED assessment and verbal handover before formal surgical review.

Conclusion: The current GUH pathway is associated with prolonged time to neurosurgical discussion. Direct ED-to-Beaumont referral for selected isolated head injury patients, with surgical input retained for complex trauma or when specifically required, may reduce avoidable delay. Formal pathway revision and prospective re-audit with balancing measures are recommended.

Biography

Afiq Rafidzy Bin Anwar Samhari is a General Surgery Registrar in Upper Gastrointestinal Surgery at University Hospital Galway. Anwar Samhari holds an MCh from the Royal College of Surgeons in Ireland and MRCS (Edinburgh). Anwar Samhari clinical interests include upper gastrointestinal surgery, abdominal wall reconstruction and minimally invasive surgery. Anwar Samhari has a strong interest in surgical research, audit and quality improvement, with several peer-reviewed publications and national and international presentations. Anwar Samhari conceived the 2025 Galway negative appendicectomy rate audit, focusing on diagnostic accuracy and strategies to reduce unnecessary surgery.

Ahmed Elbioumy^{1*}, Noor Alshamlan, Shopon Saha³

¹Department of General Surgery, Leighton Hospital, Mid Cheshire Hospitals NHS Foundation Trust, UK

²Core Surgical Trainee, North West Deanery, Health Education England, UK

³Consultant General and Laparoscopic GI Surgeon, Clinical Audit Lead for General Surgery, Countess of Chester Hospital NHS Foundation Trust, UK

ERAS compliance in elective colorectal surgery: Assessment, protocol development, and impact on post-operative outcomes. A closed-loop audit

Background: Enhanced Recovery After Surgery (ERAS) is an evidence-based, multimodal perioperative care pathway proven to reduce complications, shorten hospital stays, and improve patient experience following colorectal surgery. Despite the strength of the evidence, compliance with ERAS principles varies considerably across clinical teams and settings. Incomplete adherence has direct financial consequences: each postoperative complication following colorectal surgery adds substantial cost to an already resource-pressured NHS. We undertook a closed-loop audit to assess compliance with ERAS Society guidelines at our unit, identify knowledge gaps, implement a targeted intervention, and measure the impact through a re-audit.

Methods: The initial cycle was a retrospective audit of 61 patients who underwent elective colorectal resection at Countess of Chester Hospital between June and December 2024. Compliance with 22 ERAS data points was assessed across the perioperative pathway using EPR records, operative notes, anaesthetic charts, and discharge summaries, benchmarked against ERAS Society guidelines. A staff knowledge quiz was administered to 34 multidisciplinary team members to identify educational gaps. Findings were presented at a departmental Morbidity and Mortality meeting in August 2025. Following discussion, a standardised, locally applicable ERAS protocol was developed and formally agreed at departmental level, with dissemination to surgical wards and the intensive therapy unit. A daily ward round checklist was also introduced to embed ERAS principles into routine post-operative care. A retrospective re-audit of 36 patients treated between September and December 2025 was then conducted using identical methodology.

Results: The baseline audit showed variable compliance. Opioid-sparing analgesia was used in 63.9 percent of patients, early mobilisation in 68.9 percent, and abdominal drains were avoided in only 39.3 percent. The overall post-operative complication rate was 41 percent (25/61), with a 30-day readmission rate of 18 percent and a mean length of stay of 10 days. The staff knowledge quiz identified key gaps in drain use (70.6%), antibiotic timing (76.5%), and pre-operative fasting guidance (85.3%). Following implementation of the standardised ERAS protocol and targeted education, the re-audit demonstrated marked improvements. Opioid-

sparing analgesia increased to 91.7 percent (from 63.9%), early mobilisation within 24 hours to 83.3 percent (from 68.9%), and early oral intake reached 100 percent (from 91.8%). Pre-operative education was documented in 100 percent of patients. Most significantly, the post-operative complication rate fell from 41 percent to 16.7 percent (6/36), representing a reduction of more than half. The 30-day readmission rate remained comparable at 19.4 percent, reflecting the multifactorial nature of readmission.

Conclusions: Development and implementation of a standardised, locally agreed ERAS protocol, supported by targeted staff education and a structured ward round checklist, led to significant and sustained improvements in ERAS compliance across the perioperative pathway. The reduction in post-operative complications from 41 percent to 16.7 percent is clinically meaningful and carries direct cost implications: with each complication-related extended stay costing the NHS thousands of pounds, preventing complications in this cohort alone represents substantial savings in direct healthcare costs, reduced critical care utilisation, and improved bed availability. This project demonstrates how structured quality improvement work, combining data-driven identification of gaps with multidisciplinary engagement and protocol standardisation, can translate evidence into measurable improvements in patient outcomes. The framework is practical and replicable across other surgical units aiming to optimise ERAS delivery.

Keywords: ERAS, Colorectal Surgery, Quality Improvement, Clinical Audit, Protocol, Post-Operative Complications, NHS, Perioperative Care.

Biography

Ahmed Elbioumy is a Core Surgical Trainee (CT2) in General Surgery at Leighton Hospital, Mid Cheshire Hospitals NHS Foundation Trust. Elbioumy holds MRCS from the Royal College of Surgeons of England and an MBBCh from Mansoura University, Egypt, graduating with Excellent Honours, and serves as Associate Principal Investigator on the RESPOND multicentre RCT and as a Management Group Member of the PANDORA National Audit. Elbioumy has publications in the British Journal of Surgery, ANZ Journal of Surgery, and Obesity Surgery, and has presented at national and international surgical meetings including ASGBI 2026.

Ahmed Elbioumy^{1*}, Noor Alshamlan, Kamran Qurashi¹

¹Department of General Surgery, Northwick Park Hospital, London North West University Healthcare NHS Trust, London, UK

²Core Surgical Trainee, North West Deanery, Health Education England, UK

Improving follow-up and post-operative care in patients with acute pilonidal and perianal disease: A closed-loop clinical audit

Background: Pilonidal sinus disease recurs in roughly 15 to 40 percent of patients after incision and drainage, with recurrence rates varying by surgical technique. Each emergency admission costs the NHS approximately £1,081 per episode, with the wider socio-economic burden estimated at £8,791 per patient when lost working days are included, amounting to an estimated £96.7 million annually across England. NICE guidance mandates same-day incision and drainage, outpatient review within six to eight weeks, and patient education on perianal hygiene and hair removal to reduce recurrence. Working in a busy emergency general surgery unit seeing a high volume of these presentations, we identified that post-operative documentation and follow-up arrangements were falling short of these standards, prompting a two-cycle closed-loop audit.

Methods: The first cycle was a retrospective review of 37 patients who underwent incision and drainage for acute pilonidal or perianal abscess at Northwick Park Hospital between November 2021 and January 2022. Admission clerking sheets, operative notes, discharge summaries, and outpatient records were reviewed and benchmarked against NICE standards. On the basis of the results, we introduced targeted changes: a purpose-built clerking proforma, staff education at a clinical governance meeting, printed patient information leaflets for every admission, and a clear process for booking outpatient appointments directly from the Surgical Assessment Unit. A second cycle, a mixed retrospective and prospective review of 51 patients seen between May and July 2022, was then conducted using the same data collection approach.

Results: The first cycle revealed significant shortfalls. Follow-up was documented in operative notes for only 51 percent of patients and in discharge summaries for 49 percent. Outpatient clinic appointments were booked for just 35 percent of patients. Clerking sheets recorded prior presentation history in none of the cases, and not a single patient received recurrence-prevention advice. The overall RAG rating was Amber. Following the changes, the second cycle showed clear improvements across all measures. Follow-up documentation in operative notes rose to 88.2 percent (from 51 percent) and in discharge summaries to 90.1 percent (from

49 percent). Outpatient clinic appointments increased to 60 percent (from 35 percent). All clerking sheets captured prior presentation history, and every patient received recurrence-prevention advice and a printed information leaflet. Same-day incision and drainage was achieved in 74.5 percent of patients. The RAG rating improved to Green.

Conclusions: Introducing a structured set of practical changes including a disease-specific clerking proforma, staff education, and routine patient information led to meaningful and sustained improvements in the management of acute pilonidal and perianal disease, bringing practice in line with NICE standards across all measured outcomes. Given recurrence rates of 15 to 40 percent with simple incision and drainage alone, ensuring every patient receives proper follow-up and recurrence prevention advice has direct financial implications. Across our combined cohort of 88 patients, preventing a conservative 15 percent recurrence rate represents approximately 13 avoided emergency re-admissions, equating to a saving of roughly £14,000 in direct NHS costs for this cohort alone. Scaled to national volumes of around 11,000 acute admissions per year, this framework could translate into substantial NHS savings. Closed-loop audit proved an effective tool for identifying gaps in care and confirming that change made a real difference. The approach is straightforward to replicate and could benefit other busy emergency surgical units managing this patient group.

Keywords: Pilonidal Disease, Perianal Abscess, Clinical Audit, Quality Improvement, NICE Guidelines, Follow-Up, NHS Costs.

Biography

Ahmed Elbioumy is a Core Surgical Trainee (CT2) in General Surgery at Leighton Hospital, Mid Cheshire Hospitals NHS Foundation Trust. Elbioumy holds MRCS from the Royal College of Surgeons of England and an MBBCh from Mansoura University, Egypt, graduating with Excellent Honours, and serves as Associate Principal Investigator on the RESPOND multicentre RCT and as a Management Group Member of the PANDORA National Audit. Elbioumy has publications in the British Journal of Surgery, ANZ Journal of Surgery, and Obesity Surgery, and has presented at national and international surgical meetings including ASGBI 2026.



Aimee Bardon

Ulster Hospital Dundonald, United Kingdom

From STUMBL to standard: Improving rib fracture management through guideline adherence in an acute surgical unit

Background: Blunt chest wall trauma is a common presentation to an acute surgical take, accounting for up to 10–15% of emergency department attendances globally, with rib fractures present in the majority of cases. These injuries are associated with significant morbidity due to impaired ventilation, ineffective cough, and risk of pulmonary complications. Evidence-based guidelines, including the Northern Ireland Major Trauma Network (NIMTN) Clinical Practice Guideline 26, recommend early multimodal analgesia, physiotherapy, and use of risk stratification tools such as the STUMBL score to guide management.

Aim: To evaluate compliance with NIMTN rib fracture management guidelines and assess documentation and utilisation of the STUMBL score on admission in an acute surgical unit.

Methods: A two-cycle retrospective audit was conducted. Cycle 1 included patients admitted between September–October 2025, followed by an intervention comprising formal teaching and implementation of a rib fracture electronic order set. Cycle 2 included patients from November–December 2025. Data were collected from admission documentation, electronic prescribing records, and patient notes, focusing on STUMBL score use, adherence to guideline-recommended therapies, and early physiotherapy involvement.

Results: A total of 25 patients were included (13 in Cycle 1, 12 in Cycle 2), with a mean age of 65 years. STUMBL score documentation improved from 15% (2/13) in Cycle 1 to 75% (9/12) in Cycle 2. Compliance with guideline-recommended prescribing improved significantly, with 83% (10/12) of patients in Cycle 2 receiving >50% of recommended interventions compared to 38% (5/13) in Cycle 1. Full compliance was achieved in 50% of Cycle 2 patients. Early physiotherapy review within 24 hours remained high in both cycles (77% vs 83%). There was no change in the use of Erector Spinae Plane (ESP) blocks. Length of stay remained similar between cycles.

Conclusion: Targeted interventions, including education and electronic order set implementation, significantly improved adherence to rib fracture management guidelines and use of the STUMBL score. Despite improved prescribing practices, uptake of regional anaesthesia remained unchanged, highlighting an area for further improvement. Future work should focus on linking guideline adherence to patient outcomes, including respiratory complications and critical care admission.

Biography

A. Bardon is a Core Surgical Trainee (CT2) with a strong interest in emergency general surgery, and urology. Bardon is currently working within an acute general surgery unit, actively involved in the management of high-acuity patients and quality improvement initiatives aimed at enhancing patient care and outcomes.



Akash Singh Sachdev

University Hospital Monklands, NHS Lanarkshire, United Kingdom

Improving pharmacological DVT prophylaxis compliance using an electronic alert system in an acute surgical ward; A quality improvement project

Background: Venous Thrombo Embolism (VTE) is a major cause of preventable hospital mortality. National guidance mandates universal VTE risk assessment and timely administration of pharmacological prophylaxis for eligible inpatients. Despite this, early prescribing is inconsistently achieved in acute surgical environments due to workload and communication barriers and multiple human factors.

Aim: To achieve $\geq 90\%$ compliance with timely pharmacological DVT prophylaxis (within 14 hours of admission) in surgical inpatients by introducing an automated electronic alert system.

Methods: This quality improvement project analysed all new adult admissions into Ward 4 (General Surgery) in a period of 4 months. Baseline compliance from the data before the implementation of the alert system was 84.8%. The intervention consisted of a daily HEPMA electronic alert, emailed at 8am every morning, listing patients not yet prescribed Enoxaparin, prompting review on morning ward rounds. Data were captured for: VTE risk assessment completion, eligibility, prescribing accuracy, dose appropriateness, timeliness of administration, and final compliance.

Results: Across 55 patients in Cycle 2:

- 100% completed VTE risk assessments
- 100% of eligible patients were prescribed pharmacological prophylaxis
- 100% of alerts successfully triggered
- 94.5% (52/55) received prophylaxis within 14 hours of admission

- 96.4% (53/55) met full final compliance criteria
- Dose adjustments for renal impairment or high weight were correct in 98% of cases

Only three patients fell outside the 14-hour window: one due to delayed correction of an initial underdose, one awaiting confirmation of eligibility, and one administered after email prompting.

Conclusion: The introduction of an automated electronic alert system substantially improved the timeliness and completeness of pharmacological DVT prophylaxis, raising overall compliance from 84.8% to 96.4%. The system ensures reliable daily identification of at-risk patients and offers a scalable, low-burden intervention suitable for wider adoption across NHS Lanarkshire surgical wards.

Biography

Sachdev is a Foundation Year 1 resident doctor based at University Hospital Monklands in the greater Glasgow and Clyde region. Sachdev completed medical school training at the University of Dundee and is keen on the urology speciality, and is very keen on learning more about surgery as a whole to be the best doctor possible.



Alice Honigmann^{1*}, Sarah Davidson²

¹Oxford University Medical School, United Kingdom

²Nuffield Department of Surgical Sciences, Oxford, United Kingdom

Sentinel lymph node biopsy for breast cancer in low-resource settings: The role of superparamagnetic iron oxide tracers

Sentinel Lymph Node Biopsy (SLNB) is the standard technique for axillary staging in early breast cancer, allowing accurate nodal assessment while avoiding the morbidity associated with full axillary clearance. However, the conventional SLNB approach, which relies on radioactive tracers in combination with blue dye, is often difficult to implement in Low Resource Settings (LRS). This is due to limited access to nuclear medicine facilities, regulatory restrictions surrounding radioactive materials, and shortages of trained personnel.

Superparamagnetic Iron Oxide (SPIO) tracers offer a radiation-free alternative, enabling sentinel lymph node detection using a handheld magnetic probe. This educational poster provides an overview of the principles of SPIO-guided SLNB, compares it with standard radiocolloid-based techniques, and explores its potential role in improving access to breast cancer surgery in LRS.

Compared to radioactive tracers, SPIO offers several practical advantages, including elimination of the need for nuclear infrastructure, simplified storage and handling requirements, and reduced regulatory burden. Additionally, SPIO allows greater flexibility in timing of tracer administration, with injection possible from minutes up to several days prior to surgery. Evidence from clinical studies suggests that SPIO provides detection rates comparable to conventional techniques, while potentially reducing indirect system costs.

Despite these advantages, SLNB remains underutilised in LRS. Survey data indicate that only a minority of eligible patients in these settings undergo SLNB, largely due to lack of access to radiocolloid tracers, inadequate infrastructure, and workforce limitations. Additional barriers to widespread SPIO adoption include limited validation in diverse resource-constrained

contexts, upfront equipment costs, and the need for training and integration into existing surgical pathways.

Addressing these challenges will require further prospective studies, economic evaluations, and coordinated policy efforts aligned with global initiatives such as the Global Breast Cancer Initiative and national surgical planning frameworks. SPIO-guided SLNB represents a promising strategy to expand access to effective axillary staging in resource-limited environments, with potential to improve surgical outcomes and reduce global disparities in breast cancer care.

Biography

Honigmann is a fifth-year medical student studying at the University of Oxford, currently completing clinical rotations in hospitals in the Thames Valley area, and has a particular interest in global surgery and medical development.

Anthony Aldcroft

Darent Valley Hospital, Dartford, United Kingdom

Tracheostomy practices in a District General Hospital ITU: An audit against NCEPOD standards

Objective: A tracheostomy is a surgically created airway in which a stoma is formed, and a tracheostomy tube is inserted to establish a secure airway. Common indications include upper airway obstruction, prolonged mechanical ventilation, and airway protection. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) produced a review entitled *On the Right Trach?*, critiquing and recommending guidance on the care pathway for tracheostomies. We conducted an audit of our practices to determine whether any changes to our tracheostomy procedure and pathway were necessary.

Methods: A retrospective study was conducted on all tracheostomies performed in the Intensive Therapy Unit (ITU) within Darent Valley Hospital from January 2023 to February 2024, assessing adherence to 12 of the *On the Right Trach?* recommendations. Data from 31 patients were collected by reviewing case notes from our intranet portal. The recommendations against which we compared our patients' care pathways included correct documentation and coding, presence of consent forms, use of a Local Safety Standards for Invasive Procedures (LocSSIP) checklist, use of capnography and endoscopy, whether extubation trials were conducted and documented, correct discharge documentation, and whether Speech and Language Therapy (SALT) referrals were made under the correct indications.

Results: 33 patients underwent a tracheostomy in Darent Valley Hospital ITU from January 2023 to February 2024, excluding repatriations. All 33 patients had their tracheostomies recorded and coded as an operative procedure; however, an additional 3 patients were incorrectly coded as having a tracheostomy, and only 31 of the 33 had notes available for review. The following results relate to these 31 patients. 26 (83.9%) had the reason for their tracheostomy documented. 28 (90.3%) had their consent discussion documented, with 17 (54.8%) having had a Consent Form 4 completed. Regarding the procedure itself, all patients had a LocSSIP checklist used, and all patients had capnography used, though only 20 (64.5%) had endoscopy. 13 (41.9%) underwent a trial of extubation during their admission; of the 18 who did not have a trial of extubation, only 6 (33.3%) had documentation explaining why. All patients who required a SALT referral ($n=21$), i.e., those with dysphagia, had a SALT referral made. However, only 7 of the 21 (33.3%) had their referrals made the next working day. The mean time between sedation being turned off and the SALT referral being made was 5.86 days.

Conclusions: Our retrospective study revealed relatively good overall adherence to the recommendations assessed. However, compliance with these guidelines was notably reduced in areas relating to documentation. It should be noted that lack of documentation does not equate to lack of practice. Furthermore, there was no assessment of the causation or clinical outcomes of non-adherence. Therefore, to mitigate potential poor clinical outcomes, our recommendations included the implementation of a tracheostomy passport as an essential piece of documentation for consent, tracheostomy procedure details, tracheostomy tube details, extubation trials, swallowing assessments, and SALT referrals. This tracheostomy passport has been in use since October 2025, and following its use for 12 months, a re-audit will be conducted to assess its effects.

Archita Jain

JSS Medical College, Mysuru, India

Dermatofibrosarcoma protuberans: A case series and review of clinical management from a tertiary care center

Dermatofibrosarcoma Protuberans (DFSP) was first described by Darier and Ferrand in 1924 and was named by Hoffmann in 1925. In this clinical series of patients with dermatofibrosarcoma protuberans, data was retrieved, collected and analysed from JSS Hospital (2023–2026). The case series there were 3 males and 1 female, in the age range of 60–70 years, had commonly presented with malignant soft tissue sarcomas and local recurrence. A male predominance is there, and patients were from a low socioeconomic status. The duration of symptoms varied from 4 to 8 years, and underwent wide local excision. The clinical and morphological characteristics and treatment of DFSP were evaluated.

Keywords: Sarcoma, Wide Local Excision, Malignant.



Arian Rahim*, Tom Khan-White, Tanya Gupta

Royal Alexandra Children's Hospital, University Hospital
Sussex NHS Foundation Trust, United Kingdom

Outcomes of rectal biopsy in the investigation of Hirschsprung's disease: A six-year two-cycle departmental audit

Background: Rectal biopsy is the gold-standard investigation for Hirschsprung's Disease (HSCR), with Suction Rectal Biopsy (SRB) preferred in infants and Open/Strip Biopsy (O/S) more commonly used in older children or following inadequate SRB. Optimising biopsy yield, minimising complications and avoiding unnecessary procedures are key to timely diagnosis and efficient use of paediatric surgical resources.

Aim: To evaluate and compare outcomes of rectal biopsies for suspected HSCR over two consecutive three-year audit cycles (May 2018–December 2021 and January 2022–September 2025) in a tertiary paediatric surgical centre, focusing on indications, diagnostic yield, failure and complication rates for SRB and O/S, and to assess the impact on practice and resource use.

Methods: A retrospective review was conducted of all rectal biopsies (SRB and O/S) for suspected HSCR over six years. Data was extracted from electronic and paper records on age, sex, indications, associated anomalies, biopsy type, adequacy, complications and histopathological diagnosis. All specimens were processed locally and reported with histology and immunohistochemistry at a specialist centre. Outcomes were analysed by biopsy type and audit cycle, and benchmarked against NICE guidance and published literature.

Results: In the first cycle, 157 analysed patients underwent 70 SRBs and 98 O/S biopsies; SRB median age was 30 days and O/S 4 years. SRB had a 14% initial inadequacy rate and an overall complication rate of 19%, predominantly due to repeat procedures and one self-limiting post-biopsy bleed, while 14% of SRBs were positive for HSCR with 90% diagnosed within the first month of life. O/S in this cycle had a 4% repeat rate, 1% HSCR diagnosis and 4% complication

rate. In the second cycle, 184 patients underwent 195 biopsies (79 SRB, 116 O/S), with SRB performed at a mean age of around 3 months and O/S at 4 years 10 months. Overall failure and complication rates fell to 6.7% and 8.2% respectively, with SRB failure and complication rates improving to 10.1% and 12.7% and O/S rates to 4.3% and 5.2%; 15 biopsies (8.2%) were diagnostic for HSCR. Between cycles, workload increased from 3.7 to 4.3 biopsies per month, while SRB failure (18% to 10.1%) and overall complication rates (17–19% to 8.2%) reduced.

Conclusions: Over six years, rectal biopsy for suspected HSCR in our unit has achieved acceptable diagnostic yield with improving safety and technical performance, particularly for SRB, despite rising case volumes. Earlier practice was characterised by higher SRB failure and complication rates and substantial numbers of potentially inappropriate strip biopsies with significant financial cost. The more recent cycle demonstrates reduced failure and complication rates and a clearer focus on appropriate indications, supporting SRB as the primary modality in infancy and O/S as a targeted adjunct. Departmental changes now include planned adoption of manometry-guided suction and a formal SRB protocol, alongside stricter adherence to NICE criteria for O/S, aiming to further reduce inadequate sampling, unnecessary procedures and delays to definitive surgery.

Biography

Arian Rahim is a Core Surgical Trainee with a strong academic and educational interest alongside clinical training. Rahim has presented research at national and international meetings, including work exploring workforce diversity and retention within medical training. Alongside clinical practice, Rahim holds a Postgraduate Certificate in Medical Education and has designed structured teaching programmes for medical students and junior doctors. Rahim's current interests include surgical training, equity in healthcare, and quality improvement, with a long-term aim of pursuing higher surgical training while maintaining active involvement in research and medical education.

Atharv Patil*, Sandip Hindocha

Bedford Hospital, United Kingdom

Defining the ideal umbilicus- A structured review of aesthetic preferences in plastic surgery

Background/Aims: The umbilicus is a central feature of abdominal aesthetics and an important consideration in procedures such as abdominoplasty and umbilicoplasty. Despite its clinical relevance, there is no universally accepted definition of the ideal umbilicus. This review aims to identify and synthesise key anatomical and aesthetic characteristics associated with an attractive umbilicus.

Methods: A structured literature review was conducted using PubMed. Search terms included umbilicoplasty, ideal umbilicus, and aesthetic. Studies were included if they assessed aesthetic characteristics such as shape, size, or position. Nine studies meeting predefined inclusion criteria were analysed qualitatively.

Results: A consistent preference for an oval-shaped umbilicus was identified across multiple studies. Superior hooding was commonly associated with higher aesthetic ratings. Gender differences were noted, with vertical orientation favoured in females and horizontal orientation more frequently observed in males. Smaller umbilici were consistently rated as more attractive, typically measuring less than 1.5 to 2 cm in width. In terms of position, the ratio between the xiphoid process to umbilicus and umbilicus to lower abdominal crease was most commonly reported between 1.5 to 2 to 1. Variability in study design and measurement techniques limited direct comparison.

Conclusion: Current literature suggests that an ideal umbilicus is small, oval, and often demonstrates superior hooding, with a positional ratio of approximately 1.5 to 2 to 1. Variation exists across gender and ethnicity. A simplified aesthetic framework is proposed to support surgical planning. Further research using standardised methodologies is required to establish consensus.

Biography

Atharv Patil is an FY2 doctor at Oxford University Hospitals NHS Foundation Trust, and a graduate of the University of Leicester. Patil has a developing interest in surgery and academic medicine, with experience across a range of teaching, research, and quality improvement projects.



Ayan Ibrat

Gloucestershire Hospitals NHS Trust, United Kingdom

The rhinologist as developer: A practical framework for prompt engineering and app creation in clinical practice

Objectives: Generative AI and Large Language Models (LLMs) have lowered the technical barrier for software creation, yet a gap remains between potential and practical application for surgeons. We aim to bridge this gap by defining a structured Prompt Engineering Framework specifically for Rhinologists. Our objective is to demonstrate how clinicians can utilize specific prompting strategies to build NHS-compliant, effectively functioning medical software without prior coding experience.

Methods: We performed a literature review of current prompt engineering methodologies (e.g., Chain-of-Thought, Few-Shot prompting) with experiential data derived from the development of 'Sniffinsticksonline'—a fully functional clinical web app built using natural language. We deconstructed the development process into an iterative workflow, analysing the specific prompt structures required to overcome common AI pitfalls such as logic errors (hallucinations) and security compliance issues.

Results: We present a validated, three-stage Clinician-to-Code workflow:

Contextual Architecture: How to structure initial system prompts to define clinical parameters and safety constraints.

Iterative Refinement: Demonstratable success using Chain-of-Thought prompting (asking the LLM to explain its reasoning step-by-step) to debug complex clinical logic, significantly increasing code accuracy.

Cross-Verification: The utility of using multiple LLMs to audit code for NHS digital compliance. This workflow was successfully used to build 'Sniffinsticksonline', which achieved superior usability scores compared to the legacy OLAF system in subsequent validation trials.

Conclusions: Proficiency in prompt engineering is emerging as a critical competency for clinical innovators. We conclude that by applying this structured framework, Rhinologists can rapidly prototype and deploy digital solutions, removing the dependency on external developers. 'Sniffinsticksonline' serves as a proof-of-concept, demonstrating that clinician-led, AI-architected software is not only feasible but can outperform existing solutions.

Biography

Ayan Ibrat is a third-year medical student at the University of Bristol with a strong academic foundation and a passion for patient-centred care. Ibrat has developed a particular interest in ENT surgery, valuing its combination of clinical precision, procedural skill, and quality-of-life improvements for patients. Throughout medical studies, Ibrat has pursued clinical exposure, independent learning, and engagement with relevant research and surgical practice, and is motivated and detail-oriented, with a commitment to developing clinical and surgical expertise.



Ayesha Nadeem

Department of General Surgery, King's Mill Hospital,
Sherwood Forest Hospitals NHS Foundation Trust, United
Kingdom

When acute abdomen crosses the diaphragm: An incarcerated adult Bochdalek hernia

Background: Bochdalek hernias are congenital posterolateral diaphragmatic defects that usually present in infancy. Adult presentations are rare and may first manifest with bowel obstruction, strangulation, or ischaemia. Early diagnosis is essential to reduce morbidity and mortality.

Case Presentation: A middle-aged male patient presented to the emergency department with sudden-onset severe generalised abdominal pain that radiated to the back, associated with multiple episodes of vomiting. Examination demonstrated diffuse abdominal tenderness with guarding and rigidity, raising concern for an acute surgical abdomen. Initial investigations revealed raised WCC of $25.9 \times 10^9/L$, lactate of 4.5 mmol/L and a normal CRP. The patient's past medical history included HIV infection, hepatitis C, and a learning disability.

The patient's urgent CT abdomen and pelvis demonstrated a large posterior defect in the left hemidiaphragm, with herniation of most of the spleen, splenic flexure of the colon, and multiple jejunal loops into the left hemithorax, consistent with a left-sided Bochdalek hernia. Mesenteric vascular congestion and poor enhancement of the herniated small bowel suggested incarceration. A subsequent CT thorax excluded pneumoperitoneum while confirming mediastinal shift and a left sided pleural effusion.

Management and Outcome: The patient underwent urgent surgical assessment for an incarcerated Bochdalek hernia with suspected bowel compromise. The patient was transferred urgently to a tertiary centre for an emergency laparotomy. The patient's colon, spleen, and most of the small bowel were found within the left hemithorax through an approximately 4 cm posterolateral diaphragmatic defect. Small bowel ischaemia was noted; however, it was deemed viable. The diaphragm was closed using loop PDS sutures and clips.

A left sided intercostal drain was inserted for the pleural effusion, and a rectus sheath catheter was also inserted. Postoperatively, patient was sent to HDU to recover, where the patient had NG insertion and sips only for the first 48 hours. The patient continued to recover.

Discussion: Adult Bochdalek hernias are rare and often mimic more common causes of acute abdomen, resulting in delayed diagnosis. This case demonstrates the importance of recognising features of bowel compromise on the CT scans, facilitating urgent transfer and surgical intervention before irreversible bowel necrosis develops, which was successfully done for this patient.

Conclusion: Although rare, Bochdalek hernia should be considered in adults presenting with acute abdominal pain. Early CT diagnosis and prompt surgical management are essential to prevent bowel necrosis and optimise patient outcomes.

Biography

Dr Ayesha Nadeem is a Foundation Year 2 Doctor working in General Surgery at King's Mill Hospital, Sherwood Forest Hospitals Trust. Nadeem graduated from Aston University in Birmingham with an MBChB degree and a Postgraduate Certificate in Leadership. Dr Nadeem is passionate about pursuing higher surgical training and getting involved in medical education, and has contributed to two surgical quality improvement projects and designed and organised a general surgery teaching programme for junior doctors. Nadeem is preparing to present this work at a conference and aspires to continue advancing in clinical practice, research, and education.



Ayesha Nadeem

Department of General Surgery, King's Mill Hospital,
Sherwood Forest Hospitals NHS Foundation Trust, United
Kingdom

Behind the knee lies a threat: A case report of popliteal artery aneurysm

Background: A popliteal artery aneurysm is the most common type of peripheral artery aneurysm, that can lead to limb threatening ischaemia. Early recognition is essential; however, diagnosis may be delayed when presentations mimic more common conditions.

Case Presentation: A male patient in his seventies presented with unilateral left leg swelling following a fall, against a background of recurrent multifactorial falls. The initial clinical impression favoured traumatic soft tissue injury; however, subtle discolouration of the left toes raised concern for an underlying vascular pathology. Doppler ultrasonography, initially requested to exclude deep vein thrombosis, instead demonstrated left sided acute limb ischaemia, secondary to popliteal aneurysm with thrombus.

The patient had multiple cardiovascular comorbidities, including chronic kidney disease stage 4, previous repaired aortic dissection, hypertension, and prior transient ischaemic attack, placing him at high vascular risk.

Management and Outcome: Urgent vascular intervention was undertaken, including attempted femoral bypass and popliteal aneurysm decompression. Despite surgical management, due to the extent of irreversible ischaemia, an above knee amputation became necessary.

The postoperative care was further complicated by acute kidney injury superimposed on chronic kidney disease, requiring multidisciplinary management and rehabilitation input (amputation therapy team). This is essential in the management as major limb amputation affects not only physical function but also a patient's psychological wellbeing, social participation, and overall quality of life.

Discussion: This case highlights a diagnostic challenge in which a limb-threatening vascular emergency masqueraded as a common post-traumatic presentation. The presence of unilateral leg swelling may point towards a more common diagnoses such as deep vein thrombosis or soft tissue injury, while subtle signs of distal ischaemia can be overlooked. Delayed recognition of thrombosed popliteal artery aneurysms is associated with significantly worse limb salvage outcomes.

Conclusion: Popliteal artery aneurysm should remain an important differential diagnosis in patients presenting with unilateral leg swelling, particularly when accompanied by signs of distal ischaemia. This case reinforces the importance of early recognition and urgent vascular assessment in symptomatic popliteal artery aneurysms to minimise ischaemia and limb compromise.

Biography

Dr Ayesha Nadeem is a Foundation Year 2 Doctor working in General Surgery at King's Mill Hospital, Sherwood Forest Hospitals Trust. Nadeem graduated from Aston University in Birmingham with an MBChB degree and a Postgraduate Certificate in Leadership. Dr Nadeem is passionate about pursuing higher surgical training and getting involved in medical education, and has contributed to two surgical quality improvement projects and designed and organised a general surgery teaching programme for junior doctors. Nadeem is preparing to present this work at a conference and aspires to continue advancing in clinical practice, research, and education.



Christos Costa^{1*}, Mark Sullivan²

¹Department of Surgery, Oxford University Hospitals NHS Foundation Trust, Oxford, UK

²Department of Urology, Churchill Hospital, Oxford University Hospitals NHS Foundation Trust, Oxford, UK

Renal autotransplantation for a hypervascular renal tumour in a solitary kidney: Ex vivo bench surgery to preserve renal function

Introduction: Managing complex renal tumours in a solitary functioning kidney represents a major surgical challenge, where oncological control must be balanced against avoidance of dialysis. In highly vascular or centrally located tumours, conventional nephron-sparing surgery may be unsafe due to haemorrhage risk and prolonged warm ischaemia. Ex vivo bench tumour excision with renal autotransplantation offers a nephron-preserving alternative in selected cases but is rarely performed outside specialist centres.

Case Presentation: A man in his mid-sixties with a solitary left kidney following prior donation presented with visible haematuria and urinary retention. Imaging demonstrated a hypervascular lower-pole renal mass with arteriovenous shunting and hydronephrosis. Repeated embolisation failed to fully devascularise the lesion, and biopsy was limited by bleeding risk. Multidisciplinary review concluded that in-situ partial nephrectomy carried unacceptable risk of catastrophic haemorrhage and renal failure, while radical nephrectomy would result in dialysis dependence. The patient therefore underwent laparoscopic nephrectomy, EX Vivo bench tumour excision under cold ischaemia, and renal autotransplantation into the right iliac fossa.

Results: Surgery was technically demanding due to prior embolisation, dense fibrosis and distorted hilar anatomy. Warm ischaemia time was approximately five minutes and cold ischaemia just under six hours. Immediate graft reperfusion and urine production were achieved. Postoperative complications included pulmonary embolism, infected urinoma requiring drainage, and urinary tract infection, all managed successfully without graft loss.

Renal function stabilised at creatinine $\sim 150 \mu\text{mol/L}$ (eGFR 40–45 mL/min/1.73 m²), avoiding dialysis. At 20-month follow-up, imaging demonstrated no recurrence and preserved graft function.

Conclusion: Ex vivo bench surgery with renal autotransplantation can provide definitive oncological management while preserving renal function in carefully selected patients with solitary kidneys. Although associated with significant morbidity, this approach remains a valuable nephron-preserving strategy when conventional surgery is not feasible.

Biography

Dr Christos Costa MBBS, MSc, MRCS is a surgical trainee at Oxford University Hospitals NHS Foundation Trust. Costa completed a Specialised Foundation Programme in cardiothoracic surgery at Imperial College Healthcare NHS Trust and graduated from Barts and The London School of Medicine and Dentistry with triple distinction. Costa's academic interests include surgical innovation, clinical outcomes research, and medical education. Costa has published multiple papers in high-impact peer-reviewed journals and has presented work at national and international conferences. Alongside clinical training, Costa remains actively involved in teaching, mentorship, and collaborative research aimed at advancing evidence-based surgical practice and improving patient outcomes.



Christos Costa^{1*}, Arian Arjomandi Rad², Prakash P. Punjabi³

¹Department of Surgery, Oxford University Hospitals NHS Foundation Trust, Oxford, UK

²Department of Cardiothoracic Surgery, Oxford University Hospitals NHS Foundation Trust, Oxford, UK

³Department of Cardiothoracic Surgery, Imperial College Healthcare NHS Foundation Trust, London, UK

Impact of frailty in patients undergoing continuous-flow left ventricular assist device therapy: A systematic review and meta-analysis

Background/Introduction: Frailty, characterised by reduced physiological reserve and increased vulnerability, is common in end-stage heart failure. Continuous-flow Left Ventricular Assist Devices (LVADs) improve outcomes, but the impact of frailty on clinical outcomes remains unclear.

Purpose: To evaluate the effect of frailty on clinical outcomes following LVAD implantation.

Methods: A systematic review and meta-analysis were conducted according to PRISMA guidelines. PubMed, Cochrane, EMBASE, MEDLINE and Google Scholar were searched up to September 2023. Studies comparing frail versus non-frail patients undergoing LVAD implantation were included. Outcomes included mortality, hospital length of stay, intubation duration, bleeding, infection and readmission. Data were analysed using Mantel–Haenszel random-effects models with heterogeneity assessed using the I^2 statistic.

Results: Fifteen studies involving 3,458 patients were included. Frailty was associated with higher long-term mortality (OR 2.12; 95% CI 1.17–3.83; $p=0.01$), but not short-term mortality (OR 1.61; 95% CI 0.71–3.65; $p=0.26$), hospital length of stay (MD 1.93; 95% CI –9.83 to 13.68; $p=0.75$), or intubation duration (MD 34.28; 95% CI –1.15 to 69.71; $p=0.06$). No significant differences were found in bleeding (OR 1.76; $p=0.19$), infection (OR 0.44; $p=0.26$), or readmission (OR 1.07; $p=0.68$).

Conclusions: Frailty is associated with increased long-term mortality after LVAD implantation but not short-term outcomes or perioperative complications. These findings support improved risk stratification and targeted frailty-focused interventions.

Biography

Dr Christos Costa MBBS, MSc, MRCS is a surgical trainee at Oxford University Hospitals NHS Foundation Trust. Costa completed a Specialised Foundation Programme in cardiothoracic surgery at Imperial College Healthcare NHS Trust and graduated from Barts and The London School of Medicine and Dentistry with triple distinction. Costa's academic interests include surgical innovation, clinical outcomes research, and medical education. Costa has published multiple papers in high-impact peer-reviewed journals and has presented work at national and international conferences. Alongside clinical training, Costa remains actively involved in teaching, mentorship, and collaborative research aimed at advancing evidence-based surgical practice and improving patient outcomes.

Daniel Andreyev*, Alex Nesbitt, Clara Cerrato, David Bratt

Nottingham City Hospital, Nottingham University Hospitals Trust, Nottingham, United Kingdom

A planned robotic-assisted retroperitoneal lymph node dissection for symptomatic unicentric Castleman's disease: A case report

Castleman's disease is a rare, benign, lymphoproliferative disorder effecting 1 in 100,000. It is characterised into multicentric or unicentric disease. Unicentric disease is typified by compressive symptoms with a midline mass often misdiagnosed as malignancy. Gold-standard management is surgical resection. Our case is a 73-year-old, found to have a 5.8x5cm para-aortic mass with unicentric disease on biopsy. We describe the first case to use robotic assistance, with indocyanine green stain instilled via ureteric catheter for ureteric identification, to successfully resect the lesion with confirmed diagnosis pre-operatively of Castleman's disease. The patient recovered quickly without complication and is now symptom free.

Keywords: Unicentric Castleman's Disease, Retroperitoneal Dissection, Robotic Surgery, Para-Aortic Mass.

Daniel Andreyev

Nottingham City Hospital, Nottingham University Hospitals Trust, Nottingham, United Kingdom

How to keep your resident doctors happy; A departmental improvement project

Introduction: Urology is a challenging specialty for Foundation Year 1 (FY1) doctors, as it is often under-represented in undergraduate curricula and has limited overlap with other disciplines. At our tertiary centre, many FY1s reported difficulty adapting to the pace and demands of the urology department. This project aimed to improve self-assessed preparedness by developing an Electronic Handbook (E-Handbook) outlining common urological presentations, their management, and unit-specific operational practices.

Methods: A baseline questionnaire was distributed to FY1s who had already completed a urology rotation to assess experiences prior to the intervention (Cohort A). Using survey findings and feedback from outgoing FY1s, an E-Handbook was developed and approved by consultants. The handbook was circulated to incoming FY1s (Cohort B) two weeks before their rotation, followed by a post-rotation survey assessing preparedness, confidence, and ease of transition.

Results: Before implementation, 80% of Cohort A felt departmental induction could be strengthened and that a handbook would have supported their transition. The mean preparedness score was 1.8 out of 5. After introduction of the E-Handbook, 100% of FY1s reported it was useful and aided rapid adaptation to ward responsibilities. Doctors described clearer understanding of role expectations, increased confidence in clinical decision-making, and improved awareness of escalation pathways. The mean preparedness score increased to 4.7 out of 5, and respondents provided constructive suggestions for future revisions.

Conclusions: Introducing a structured, department-specific handbook significantly improved preparedness and facilitated faster integration into clinical duties. This low-cost intervention enhanced confidence, clarified expectations, and improved overall satisfaction with the rotation.



Habba Mahal^{1*}, Camelia Ursu², Hasnaien Ahmed³

¹Faculty of Medicine & Dentistry, University of Alberta, Canada

²Cumming School of Medicine, University of Calgary, Canada

³Department of Surgery, University of Alberta, Canada

Mapping pediatric general surgery training in low- and middle-income countries: A scoping review

Children in low- and middle-income countries experience a substantial disparity in access to essential pediatric surgical care. Estimates suggest that up to 85 percent of children will require at least one surgical intervention before the age of 15. However, the availability of trained pediatric surgeons remains critically limited. In sub Saharan Africa, approximately 100 pediatric surgeons currently serve more than 300 million children, and this number is expected to approach 500 million by 2050. These demographic projections underscore an urgent need to strengthen the pediatric surgical workforce. Building capacity requires not only expansion of training programs but also a clear understanding of which educational models are effective, contextually feasible, and scalable within resource constrained settings.

Purpose: The objective of this scoping review is to map the existing literature describing pediatric general surgery training in low- and middle-income countries and to identify the barriers, facilitators, and educational strategies reported in the global literature. By synthesizing these findings, the review aims to highlight approaches that can support the development of equitable and sustainable pediatric surgical training programs, both internationally and within underserved regions of high-income countries.

Methods: A scoping review methodology was applied, incorporating seven electronic databases and grey literature sources. A total of 6,213 records were identified. After sequential screening of titles, abstracts, and full texts, 50 studies were included. Data extraction focused on training modalities, instructional approaches, evaluation methods, contextual barriers, and enabling factors. Studies were examined across geographic regions and classified by the structure and reported outcomes of the training initiatives.

Results: The educational initiatives identified in the literature demonstrated considerable variation in structure and delivery. Examples included low bandwidth videoconferencing initiatives used for case-based instruction in South Africa, DVD based seminar programs implemented across East and Central Africa, simulation-based modules introduced in Kenya and Nigeria, regional training hubs developed in Tanzania, and the early adoption of competency based pediatric surgery curricula in Pakistan and India. Many programs reported high acceptability, perceived gains in trainee knowledge and confidence, and strengthened collaboration. However, objective assessments of skill acquisition and long-term clinical outcomes were seldom reported. Significant barriers included limited faculty availability, lack of infrastructure, insufficient access to simulation equipment, absence of standardized curricula, and competing clinical responsibilities. Facilitators included blended and asynchronous learning models, regional and international partnerships, structured mentorship, and institutional support for protected teaching time.

Conclusion: The findings of this review demonstrate that context specific and adaptable educational models can meaningfully contribute to the development of pediatric surgical capacity in low resource environments. Strengthening the global pediatric surgical workforce may require standardized evaluation frameworks, regionally coordinated training networks, and investment in sustainable and flexible learning infrastructures. Lessons derived from these international initiatives may also inform strategies for improving pediatric surgical access in remote and underserved areas of Canada and other high-income countries.

Biography

Habba Mahal (BSc, MSc, MD in progress) is a third-year medical student at the University of Alberta with a special interest in global surgery, pediatric surgical education, and health-systems equity. Her passions include surgical workforce development in low-resource international contexts and underserved Canadian settings to create equitable, context-appropriate training models that improve access to safe surgical care for children worldwide. Outside of medicine, she loves exploring the outdoors, travelling, and crafting. When she's not in the hospital, you can often find her in a café with a matcha latte and a new crochet project or a good book.



Ishan Singh

Norfolk and Norwich University Hospital, United Kingdom

Benchmarking paediatric appendicitis care against GIRFT standards: A single-centre audit

Aim: To assess compliance with Getting It Right First Time (GIRFT) best-practice standards for paediatric appendicitis at Norfolk and Norwich University Hospital and compare local negative appendicectomy and readmission rates with national benchmarks.

Methods: A six-month retrospective audit was undertaken of children aged 0–16 years undergoing appendicectomy. Compliance was assessed against 17 GIRFT-derived standards covering clinical assessment, analgesia, imaging, multidisciplinary review, timing of surgery, antimicrobial stewardship, intraoperative sampling and postoperative outcomes. A separate three-year appendicectomy dataset was analysed to evaluate appendicitis related readmission. Local negative appendicectomy and readmission proportions were compared with published national benchmark rates using two-sided exact binomial tests. Statistical significance was defined as $p < 0.05$.

Results: Fifty-three appendicectomies were included in the six-month audit, with full compliance achieved for 15 of 17 standards. No appendicitis related readmissions occurred in this cohort (0/53). Across the separate three-year dataset, 8/275 patients were readmitted (2.9%), compared with the national benchmark of 9.7% ($p < 0.05$). The negative appendicectomy rate was 1/53 (1.9%), compared with the national average of 6.1% ($p > 0.05$). Areas requiring improvement were compliance with recommendations regarding peritoneal swab sampling and appendicectomy within 24 hours of admission.

Conclusion: Compliance with GIRFT paediatric appendicitis standards was high, with local negative appendicectomy and readmission rates below national benchmarks. Improvement measures should focus on timely surgery and appropriate peritoneal swab use. Following departmental education and pathway reinforcement, re-audit is planned to assess compliance with all 17 standards and complete the audit cycle.

Biography

Ishan Singh is a Core Surgical Trainee (CT1) at Norfolk and Norwich University Hospital with a career interest in Otolaryngology (ENT). Singh graduated from the University of Buckingham in 2023 and has completed MRCS Part A, with Part B planned. Alongside clinical training, Singh has led quality improvement projects, published research in surgical and ENT journals, and presented nationally at the Association of Surgeons in Training (ASiT) Conference. Singh is the founder of the national FY1 Essentials teaching programme and is actively involved in surgical education, research, and leadership, with aspirations to pursue higher surgical training in ENT.



Ivy Kuo*, Eleanor Boden,
Prashant Ravindran Menon

Portsmouth Hospitals University Trust, Portsmouth,
United Kingdom

Mycotic multilobed lumbar artery pseudoaneurysm resulting from epidural and psoas abscess embolized with NBCA glue: A case report

Background: Lumbar artery pseudoaneurysm is a rare vascular pathology, with infective (mycotic) cases exceptionally uncommon. Only three cases of infective lumbar artery pseudoaneurysm have previously been reported. We describe a unique case of multilobed mycotic lumbar artery pseudoaneurysm associated with epidural and psoas abscesses, managed successfully with endovascular embolisation using n-butyl cyanoacrylate (NBCA) glue.

Case Presentation: A 47-year-old man with a history of intravenous drug use presented with sepsis, progressive back pain, and pyrexia. Imaging demonstrated epidural and right psoas abscesses with methicillin-sensitive *Staphylococcus aureus* bacteraemia. Despite intravenous antibiotics, interval CT mesenteric angiography demonstrated enlargement of the psoas abscess and development of two multilobed pseudoaneurysms arising from the right L4 lumbar artery, alongside a right iliac vein thrombus. Endovascular embolisation was performed via left common femoral artery access using a microcatheter technique. NBCA glue diluted 1:3 with lipiodol was injected to occlude the pseudoaneurysm sac and outflow vessels.

Results: Angiography confirmed complete exclusion of the pseudoaneurysm with preservation of the proximal parent vessel. No residual filling was identified post-embolisation. The patient subsequently improved clinically, inflammatory markers normalised, and antimicrobial therapy was de-escalated. Anticoagulation was commenced safely following haemorrhage control. At three-week follow-up, the patient remained clinically well without evidence of recurrent bleeding.

Conclusion: Infective lumbar artery pseudoaneurysm should be considered in patients with psoas or epidural abscesses who deteriorate clinically, develop enlarging collections, or demonstrate falling haemoglobin despite antimicrobial therapy. This case represents the first reported use of NBCA glue for treatment of a mycotic lumbar artery pseudoaneurysm and highlights its utility in infected, friable vascular lesions where permanent intravascular hardware may be undesirable.

Implications: Early vascular imaging and consideration of endovascular management are important in complex spinal and psoas infections.

Biography

Ivy Kuo earned a Bachelor of Science in Molecular, Cell, Developmental Biology at the University of California, Los Angeles (UCLA) before moving to the UK for a BMBS at the University of Southampton. Kuo completed foundation training and a junior clinical fellow year in Trauma and Orthopaedics at the Orthoplastics centre for Wessex, Salisbury District Hospital, from 2021–2024, then completed core surgical training from 2024–2026, gaining membership of the Royal College of Surgeons of Edinburgh in 2025, and is now working as a specialty registrar in Trauma and Orthopaedics at Portsmouth Hospitals University Trust.



James Holland, Ivy Kuo*,
Malin White, Kim Borsky, Francisco
Moura, Remy Rees-Goddard,
Caroline McGuinness

Portsmouth Hospitals University Trust, United Kingdom

Digital replantation in hours versus out of hours: A retrospective review of outcomes

Introduction: The British Society for Surgery of the Hand's (BSSH) Getting It Right First Time (GIRFT) guidelines recommend that surgery for traumatic amputations of the digits is ideally performed during normal working hours, even if this results in a delay of up to 24 hours.

Objective: To compare current practice against the BSSH GIRFT guideline regarding the timing of digital replantation and to compare the success rate of replantation performed within working hours (same or next day) and outside of working hours.

Materials and methods: A single-centre retrospective analysis of two years of digital replantation was performed. A comparison was made between the success rate of those operated within and outside of normal working hours. Secondary outcomes included operating time, rate of revision surgery, rate of interposition vein grafting, and the effect of the mechanism of injury on success rate.

Results: A total of 32 digital replantation attempts were included in 21 patients. 71.9% of cases (n=23) were performed within normal working hours, demonstrating good compliance with GIRFT guidelines. The success rate of digital replantation attempts was 68.8% overall (n=22). The success rate of same-day in-hours replantation was 66.7% (n=6), 78.6% (n=11) for next-day in-hours replantation, and 55.6% (n=5) for digital replantation attempts made out of hours. Revision surgery was required in 28.13% of all replant attempts (n=9). 55.56% (n=5) of cases requiring revision were ultimately successful. The rate of vein graft use was highest in cases taking place same-day in-hours (75%; n=3) and lowest in cases same-day out-of-hours (22%; n=2). The average operating time per digit was 5.5 hours for same-day in-hours cases, 4.8 hours for next-day in-hours cases, and 7.1 hours for out-of-hours cases.

Conclusion: Digital replantation during normal working hours was associated with a higher success rate, although no statistically significant difference was observed between timing groups due to the sample size. Replantation during normal working hours was associated with shorter operating time per digit and a lower revision rate, although statistical testing was not performed. Further research is required as digital replantation cases are relatively rare.

Biography

Ivy Kuo earned a Bachelor of Science in Molecular, Cell, Developmental Biology at the University of California, Los Angeles (UCLA) before moving to the UK for a BMBS at the University of Southampton. Kuo completed foundation training and a junior clinical fellow year in Trauma and Orthopaedics at the Orthoplastics centre for Wessex, Salisbury District Hospital, from 2021–2024, then completed core surgical training from 2024–2026, gaining membership of the Royal College of Surgeons of Edinburgh in 2025, and is now working as a specialty registrar in Trauma and Orthopaedics at Portsmouth Hospitals University Trust.

Jane Mendonca*, Lindsey Young, Zohaib Siddiqui,
Ankur Patel, Graeme Crossland

Chelsea and Westminster NHS Foundation Trust, United Kingdom

BiZact versus bipolar diathermy and intracapsular coblation for tonsillectomy: A UK cohort study of 1,267 patients

Introduction: BiZact (Medtronic) is an electrothermal device used in a small number of UK centres. This study presents the first large-series UK comparative analysis of BiZact, bipolar diathermy and intracapsular coblation across adult and paediatric cohorts.

Methods: Retrospective cohort study of 1,267 elective tonsillectomies at a single NHS centre (May 2024–November 2025). Primary outcomes: secondary haemorrhage, post-operative pain-driven re-attendance and all-cause hospital readmission.

Results: In 283 adult tonsillectomies (BiZact n=98, bipolar n=185), no BiZact patient required return to theatre versus 4.9% bipolar ($p=0.030$). All-cause readmission was lower with BiZact (14.3% vs 27.0%, $p=0.039$). Pain outcomes were identical (OR 1.07, $p=1.000$). BiZact operative time was consistent regardless of surgeon seniority ($p=0.479$), in contrast to bipolar diathermy where trainee operators took significantly longer than consultants (24.5 vs 41.0 minutes; $p<0.001$). In 984 paediatric tonsillectomies (BiZact n=184, bipolar n=362, coblation n=438), haemorrhage rates were equivalent across all three devices (4.9%, 5.8%, 5.7%; all $p>0.80$). Coblation demonstrated significantly lower post-operative pain-related events than BiZact and bipolar (2.7% vs 7.6% and 6.9%; $p=0.013$), persisting after adjustment for surgeon grade and post-operative analgesia prescribing.

Conclusions: BiZact is associated with lower return to theatre and readmission rates than bipolar diathermy in adults, with grade-independent operative time suggesting a shallower learning curve. Paediatric haemorrhage outcomes are equivalent across devices. Coblation retains a pain advantage in children. These findings have implications for surgical training and device selection across ENT departments.

Biography

Jane is a postgraduate medical education fellow in North West London with an interest in surgical education. She is pursuing a career in otolaryngology and her other interests include environmental sustainability in surgery and clinical leadership in healthcare.

Jane Mendonca*, Ashish Shrestha

Chelsea and Westminster NHS Foundation Trust, United Kingdom

The sustainability literacy gap: A multi-centre analysis of resident doctor perceptions and barriers to green surgery

Introduction: Despite initiatives such as the Green Theatre Checklist and Green Surgery Report, adoption of sustainable practices in surgery is limited, due to low stakeholder engagement. Existing literature has focused primarily on consultant perspectives. As future key stakeholders, this study aimed to evaluate resident doctors' perceptions of sustainability in surgery.

Methods: A validated questionnaire was distributed to resident doctors across general surgery, ENT, trauma and orthopaedics, and plastic surgery in four NHS hospitals within the Kent, Surrey, and Sussex Deanery. Data included 5-point Likert scale responses and categorical questions assessing awareness, attitudes and priorities.

Results: Of the 69 responses received, 68.1% were junior residents (foundation, core trainees and SHO grade) and 31.9% were senior residents. General surgery was most represented (50.7%), followed by ENT (21.7%). 84% of participants reported strong concern about climate change and 92% acknowledged the environmental impact of surgery. However, an attitude-behaviour gap was seen, with more respondents reporting sustainable changes in their personal life than at work (66.7% vs 42.0%). Additionally, 84.1% were unaware of NHS sustainability targets and 81.2% did not receive any formal sustainability training. Seniority did not significantly improve target awareness ($p=0.83$), indicating a deficit across training grades. When weighed against sustainability, 76.8% viewed sustainability as equal to, or more important than, financial cost and 63.8% were willing to accept a longer operative time to achieve a more sustainable procedure. The top perceived barriers to sustainable practice were the time and effort required (79.7%), financial cost (76.8%), and organisational factors (69.6%).

Conclusions: Resident doctors are highly motivated to engage with sustainable surgery but are hindered by a significant literacy gap. Sustainability must be formally integrated into the resident doctor surgical curriculum to overcome the primary organisational and awareness-based barriers identified.

Biography

Jane is a postgraduate medical education fellow in North West London with an interest in surgical education. She is pursuing a career in otolaryngology and her other interests include environmental sustainability in surgery and clinical leadership in healthcare.



Jose Luis Braga De Aquino

Hospital and Maternity Celso Pierro, Medical School,
Pontifical Catholic University of Campinas, Brazil

Critical analysis of surgical treatment of relapse advanced esophageal achalasia

Endoscopic and/or laparoscopic myotomy has shown positive results in non-advanced esophageal achalasia due to the development of this surgical technique currently. For the most advanced stages of the disease, esophagectomy seems to be the most indicated procedure due to the involvement of the entire esophagus, which prompted Pinotti to disseminate the transmediastinal esophagectomy technique in the 1970s with the advantage of avoiding thoracotomy. Nevertheless, several series demonstrated that this technique was not exempt from complications, one of which could lead to massive hemopneumothorax with potential fatal evolution due to injury to the tracheobronchial tree and vessels due to periesophagitis that may be present with consequent adherence of the esophagus to these noble organs of the mediastinum. Because of this, Aquino in the 1990s introduced the Esophageal Mucosectomy (EM) technique with preservation of the esophageal muscle tunic at the level of the mediastinum as well as the transposition of the stomach to the cervical region inside this tunic for the reconstruction of the digestive transit. The greatest advantage of this procedure is to avoid transgression of the mediastinum and consequently the potential pleuromediastinal complications. To date, 137 patients with advanced esophageal achalasia have undergone this procedure, with 47 patients has a relapse achalasia after myotomy. having as early postoperative complications (up to 30 PO days): dehiscence of the cervical esophagogastric anastomosis -6p (12.7%), with good outcome, pleural effusion- 3p (6.3%), with good evolution; pulmonary infection- 2p (4.2%) with good evolution; no death post operative. A late evaluation using the Eckardt score was performed in 40 patients up to 5 years after surgery, demonstrating positive results in 37p (92.5%), with a score up to 3. Thus, it is possible to conclude that there are advantages in EM due to the low incidence of immediate postoperative complications with good resolution and in the long term due to the absence of symptoms in most patients.

Biography

Jose L. B. de Aquino was born in Campinas, Brazil, and graduated in Medicine in 1978 from the Faculty of Medicine of Sao Jose do Rio Preto, SP. De Aquino completed training in General Surgery for 4 years at the Faculty of Medicine of the Pontifical Catholic University of Campinas, having obtained a Master's degree in Surgery in 1990 and a Doctorate in Surgery in 1996, both from the State University of Campinas (UNICAMP). De Aquino is Professor of Surgical Clinic at the Faculty of Medicine of PUC, working with Head and Neck Surgery, Thoracic Surgery, Digestive and Esophageal Diseases, and leads one of the PUC Research Groups, DIAGNOSTIC AND CLINICAL SURGERY TREATMENT, with a multidisciplinary focus spanning the clinical, surgical and nutritional areas. De Aquino is a Professor of the Postgraduate Course in Health Sciences at PUC, Editor-in-Chief of the Revista de Ciências Médicas at PUC, and Associate Editor of the Revista do Colégio Brasileiro de Cirurgiões, and is author and co-author of 217 articles published in national and international magazines and winner of several awards for works presented in Congresses.



**Joseph Norvill*, Dwiti Jatin Ponda,
Kevin Farrell, Anna Selby, Carlos
Heras-Palou, Nick Johnson**

Pulvertaft Hand Centre, Royal Derby Hospital, Derby, UK

Evolution of hand surgery over four decades: Experience from the Pulvertaft Hand Centre

Introduction: Prevalence of common hand conditions is increasing. Hand injuries account for ~20% of attendances to the UK emergency department. We aimed to analyse temporal trends in hand surgery over a 40-year period at the Pulvertaft Hand Centre.

Methods: We conducted a retrospective review of prospectively recorded procedure documentation at a specialist tertiary hand centre. Data were collected for trauma and elective hand procedures for two weeks per year from 1985–2024. We analysed trends in patient demographics, acuity, date of surgery and procedure type. Subgroup analyses of Dupuytren's and thumb carpometacarpal joint (CMCJ) procedures were performed.

Results: 3851 procedures were recorded. Most procedures were elective (n=2767; 72%) compared with trauma (n=1084; 28%). Mean patient age increased by ~11 years. Hand surgery activity grew across all five-year intervals with the exception of 2020–2024. There was a ~13-fold increase in trauma procedures (n=8 [1985–1989]; n=103 [2020–2024]). Highest procedure volume (n=305) was reported in 2015–2019. Nerve, vessel, and tendon repairs (n=339) was the most common trauma procedure. There was a 1.3-fold increase in elective procedures (n=121 [1985–1989]; n=158 [2020–2024]). Highest procedure volume (n=578) was reported in 2010–2014. Nerve procedures (n=891) was the most common elective procedure. Number of Dupuytren's (n=351) and thumb CMCJ (n=149) procedures increased.

Conclusion: Volume and complexity of hand surgery has risen greatly. Increasing service demand coincides with an older patient population and a shift toward more complex and reconstructive procedures. Our findings should prompt discussion on how best to meet the evolving challenges of hand surgery.

Biography

Joe is a Core Surgical Trainee (CT2) in Trauma and Orthopaedics at the University Hospitals of Derby and Burton NHS Foundation Trust. He has a particular interest in upper limb surgery, alongside clinical education and research. Joe has been involved in a range of research, audit and quality improvement projects including work in hand surgery, scaphoid morphology, theatre sustainability and surgical safety. He is currently undertaking a Postgraduate Certificate in Medical Education with the University of Warwick. Alongside his training, Joe works as an Immediate Care Doctor with Nottingham Rugby supporting the medical management of professional rugby players.



Joseph Norvill^{1*}, Smeer Aggarwal²,
Joseph Dias³, Nicholas Johnson¹

¹The Pulvertaft Hand Centre, Royal Derby Hospital, Derby, UK

²Department of Radiology, Royal Derby Hospital, Derby, UK

³Leicester Hand Unit, Royal Leicester Infirmary, Leicester, UK

Normative scaphoid height-to-length ratio on computed tomography imaging: A new definition for scaphoid malunion?

Introduction: Scaphoid height-to-length (H/L) ratio is an established quantitative measurement of scaphoid deformity. There is no consensus for normal Computed Tomography (CT)-based H/L ratio for healthy scaphoids, including for age and gender. Our study aimed to establish normative CT-based reference values for scaphoid H/L ratio and define upper thresholds of normal morphology to propose a new definition of scaphoid malunion.

Methods: We performed a retrospective single-centre study of healthy scaphoids imaged by CT from May 2024 to May 2025. Non-healthy scaphoids were excluded based on pre-defined criteria. Sagittal CT reconstructions were used to measure scaphoid height (H) and length (L), from which H/L ratio was determined. Descriptive statistics were calculated. Subgroup analyses based on age (<50 vs. ≥50 years) and gender (male vs. female) and combined age and gender (male <50 years, male ≥50 years, female <50 years old, female ≥50 years) were performed.

Results: A total of 195 scaphoid CT images were reviewed; 96 were excluded due to pathology (n=62), previous scaphoid surgery (n=19), carpal bone instability (n=7), and inadequate imaging (n=8). Final analysis included 99 scaphoids from 97 patients. Majority of patients were female (n=53; 54%) and <50 years old (n=59; 60%). Mean patient age was 43 years (range, 12–79 years). Mean H/L ratio was 0.60 (95% normal range, 0.53–0.68) with a 99th percentile of 0.67. Scaphoid H/L ratio was consistent across all subgroups. Mean H/L ratio by gender (male, 0.61 [95% normal range, 0.53–0.69]; female, 0.60 [95% normal range, 0.52–0.68]) and age (<50 years, 0.60

[95% normal range, 0.52–0.67]; ≥ 50 years, 0.61 [95% normal range, 0.53–0.69]) were calculated. 99th percentile values by gender (male, 0.68; female, 0.67) and age (<50 years, 0.67; ≥ 50 years, 0.67) were calculated. Combined gender and age analyses demonstrated consistent mean H/L ratio and 99th percentile values.

Conclusion: Our study established normative CT-based scaphoid H/L ratios derived from healthy scaphoids across age and gender subgroups. We propose a H/L ratio >0.7 as the definition for scaphoid malunion. Its use may support in objective diagnosis of suspected scaphoid malunion and inform surgical management.

Biography

Joe is a Core Surgical Trainee (CT2) in Trauma and Orthopaedics at the University Hospitals of Derby and Burton NHS Foundation Trust. He has a particular interest in upper limb surgery, alongside clinical education and research. Joe has been involved in a range of research, audit and quality improvement projects including work in hand surgery, scaphoid morphology, theatre sustainability and surgical safety. He is currently undertaking a Postgraduate Certificate in Medical Education with the University of Warwick. Alongside his training, Joe works as an Immediate Care Doctor with Nottingham Rugby supporting the medical management of professional rugby players.



**Katherine Birt^{1*}, William Spencer¹,
Charlotte Arnold², Chris Summers¹**

¹Swansea University Medical School, Swansea University,
Swansea, UK

²Imperial College Healthcare NHS Trust, London, UK

The educational value of 3D printed models in surgical airway skills teaching for medical students

Introduction: Using 3D models to help with surgical skill acquisition has been shown to improve both confidence and technical skills. However, surgical education has historically utilised animal tissues or human cadaveric specimens, both of which are associated with high financial cost and limited accessibility due to specialist facilities. This research evaluated the use of three-dimensional (3D) printed airway models as an accessible alternative for teaching surgical airway management to postgraduate medical students.

Methodology: A multidisciplinary team (MDT) of ear, nose and throat (ENT) surgeons and anaesthetists (n=9) delivered a practical workshop to 20 postgraduate medical students (n=20). Students were taught how to perform surgical airway procedures, including tracheostomy and emergency cricothyrotomy, using 3D-printed airway models. Students received hands-on practice on the models in a small group setting, under clinician guidance. To assess the value of the 3D models, pre- and post-workshop surveys were utilised, including qualitative and quantitative components. Questions were designed to assess changes in students' knowledge and confidence of surgical airway management, as well as their perceptions of the models themselves.

Results: Overall 100% of participants rated the course as excellent (n=20). The data indicates that medical student knowledge of surgical airways improved; for example the number of students correctly able to identify signs of early airway obstruction increased from 40% pre course to 85% post course. Similarly, confidence levels in airway management increased substantially: prior to the course 95% of attendees rated feeling either 'unsure', 'low confidence' or 'not at all confident'; whereas 90% felt 'confident' following the course. Regarding the 3D printed models, 85% of delegates 'strongly agreed' that the models helped them achieve their learning goals and allowed them to perform key steps in performing tracheostomy and cricothyroidotomy.

In addition to the quantitative data collected, thematic analysis was performed on qualitative responses: students highlighted the value of hands-on experience, a lack of previous exposure to airway management through their training, and a wish for further teaching in a 'workshop/MDT' style. In addition, clinician feedback was collected and with 100% of clinicians agreeing that it was beneficial having both ENT and Anaesthetics present. 100% of clinicians also 'agreed' or 'strongly agreed' that the models allowed them to demonstrate the key stages in a tracheostomy and cricothyroidotomy.

Discussion: Overall, this initial workshop supports the educational value of 3D printed models within surgical airway teaching. The model is comparatively much cheaper and easily reproducible compared to current alternatives. In addition it provides opportunity for students to fine-tune their skills in a realistic and stress-free environment. Drawbacks include clinician feedback surrounding realism of tissue feel with the 3D materials used, which the authors aim to improve. In addition this study supports airway workshops with a multidisciplinary faculty, which was perceived favourably by both clinicians and students. Future aims include validation of the models with further workshops and a larger dataset. In addition models could be used to teach resident doctors in specialities such as A&E, ENT and Anaesthetics.

Biography

Katherine Birt is a 4th year Graduate Entry Medicine Student at Swansea University, UK, with a previous degree in Biomedical Sciences (BSc) from Cardiff University, UK. Birt has a keen interest in surgery and aims to pursue this as a career. Whilst at medical school, Birt has led student medical societies, developing opportunities for students to gain hands-on experience when learning surgical skills.



Kieran Dey

Nottingham University Hospitals NHS Trust, United Kingdom

Does cross-sectional imaging of isolated greater trochanter fractures influence management and clinical outcomes? A 19-year single-centre case-control study

Background: Isolated Greater Trochanter Fractures (GTFs) are an uncommon presentation of hip fracture, representing approximately 2% of all hip fractures. Historically managed non-operatively, recent evidence using cross-sectional imaging has challenged this approach by showing a high rate of occult Intertrochanteric (IT) extension. However, whether identifying such extension materially influences management and clinical outcomes in routine practice remains unclear.

Aims: To review whether cross-sectional imaging of isolated GTFs influences treatment decisions and clinical outcomes at a high-volume major trauma centre over a 19-year period.

Methods: This case-control study was carried out using the local hip fracture database at a major trauma centre. Patients who received cross-sectional imaging were matched against those who did not. Patient demographics, imaging modality, presence of IT extension, operative intervention, weight-bearing status, length of stay (LOS), repeat admissions, and mortality were recorded.

Results: One hundred and forty patients were identified (82 female, 58 male). Cross-sectional imaging was obtained in 111 patients (79.3%): 70 CT only, 39 MRI only, and 3 both. IT extension was identified in 31 of 111 scanned patients (27.9%). MRI detected IT extension in 59.0% of MRI-only cases (23/39) compared with 8.6% on CT alone (6/70). Only one patient (0.7%) underwent primary operative intervention, for a subtrochanteric extension identified on MRI. All remaining patients were managed non-operatively with full weight-bearing as tolerated. There was no significant difference in LOS or mortality between scanned and unscanned patients, nor between those with and without IT extension on imaging.

Conclusion: Whilst MRI significantly increases detection of occult IT extension compared to CT, identification did not alter operative management in our cohort. Clinical outcomes were not significantly different regardless of imaging or extension status. These results question the requirement for mandatory cross-sectional imaging of all GTFs and suggest that non-operative management with full weight-bearing is safe in the majority. A prospective multicentre study would be effective to define the role of MRI in this fracture pattern.

Keywords: Greater Trochanter Fracture, Intertrochanteric Extension, Cross-Sectional Imaging, MRI, Occult Hip Fracture, Non-Operative Management.

Biography

Kieran Dey is a Core Surgical Trainee in the East Midlands, currently aiming for higher surgical training in Trauma & Orthopaedics.



Matteo Moro

University Hospitals Sussex NHS Foundation Trust, United Kingdom

Improving the dietary guidance in patients with a newly-formed ileostomy in a District General Hospital in the UK

Background: Ileostomy formation is a common operation in the UK amongst certain patient groups including inflammatory bowel disease, colon cancers and other colorectal diseases. In certain UK centres, there is no written dietary guidance given to patients discharged with a newly-formed ileostomy, with patients often reporting uncertainty about adequate nutritional intake and recognising stoma complications. I describe a Quality Improvement Project (QIP), used to create a standardised written reference on dietary guidance for patients with a newly-formed ileostomy on discharge.

Methods: An initial qualitative questionnaire was carried out on 40 patients with a newly-formed ileostomy to establish baseline patient knowledge on dietary requirements and stoma complications. These findings suggested a lack of education and recognition of complications amongst this cohort. Collaboration with dieticians and stoma nurses led to the formation of a dietary reference sheet for this cohort of patients. A further post-change qualitative questionnaire was carried to assess the effect of the changes implemented.

Results: Baseline research suggested a lack of knowledge in ileostomy care, dietary and nutritional requirements and variation in clinician guidance within the same centre. After implementation of a dietary reference sheet in this cohort, a post-change qualitative questionnaire was carried out. In this cohort of patients, our findings demonstrated a 60% increase in confidence in recognising suitable food choices, an 80% increase in confidence in recognising suitable beverage choices, and a 60% increase in knowledge surrounding common stoma complications post-operatively. In this cohort, 34 out of 40 patients supported written guidance on dietary and nutritional requirements.

Conclusions: In patients with a newly formed ileostomy secondary to colorectal disease, standardisation of written dietary guidance created by local clinicians in collaboration with dieticians and stoma nurses demonstrated a significant improvement in patient confidence regarding meal choice, navigating common post-operative complications and overall contributed to patient safety. This QIP was beneficial in reducing variability in clinician advice, reducing patient knowledge gaps, empowering patients on the self management of stoma care and recognising complications.

There is evidence to suggest a knowledge gap on dietary and nutrition related subjects amongst allied health professionals, clinicians, and within the medical school curriculum. Through the creation of a dietary reference sheet, this reinforced education and guidance amongst resident doctors and reduced their knowledge gaps, and allowed for consistent advice to patients. Therefore, this QIP helped further clinician education, and fostered multidisciplinary team involvement in improving patient care.

Overall, the created dietary reference leaflet was integrated into the standard discharge pathway for all patients with a new stoma. There is a plan to re-assess knowledge at future intervals to see if there evidence of sustained knowledge, and if any further changes can be implemented to improve patient knowledge, safety and outcomes.

Biography

Matteo Moro is a current Foundation Year 2 (FY2) doctor at the University Hospitals Sussex NHS Foundation Trust, undertaking clinical rotations in Psychiatry, Stroke Medicine, and Orthopaedics. Moro previously completed Foundation Year 1 training at William Harvey Hospital in Ashford, Kent, with experience in Acute Medicine, General Surgery, and Cardiology. Moro's clinical interests focus on enhancing patient care during recovery periods post-surgery, and Moro advocates for accessible patient information to promote engagement in treatment decisions. Moro is committed to combining academic rigor with clinical practice, integrating research and education into medical care delivery to improve patient outcomes.

**Murray MacKay*,
Peter Vaughan-Shaw**

Colorectal Surgery, NHS Lothian, Edinburgh, United Kingdom

Pre-operative iron deficiency anaemia in colorectal cancer surgery: A missed opportunity for optimisation

Background: Anaemia prior to surgery for colorectal cancer is associated with increased morbidity and mortality. A significant proportion of patients will have anaemia secondary to iron deficiency, a symptom of colorectal cancer. National Institute of Health and Care Excellence (NICE) guidelines recommend that anaemic patients should undergo iron studies pre-operatively to ensure timely pre-operative optimisation.

Aim: To assess the adherence to NICE guidelines in the investigation and management of pre-operative iron deficiency anaemia in patients undergoing elective colorectal cancer surgery.

Methods: A retrospective review of all patients who underwent elective operations for colorectal cancer in a tertiary centre in the 6 months prior to March 2026. Patient records were analysed for the presence of pre-operative anaemia, investigation for iron deficiency anaemia and whether patients received oral or intravenous treatment for iron deficiency anaemia. Anaemia was defined using NICE criteria (men Hb <130 and females <120). Exclusion criteria included patients with appendiceal tumours, who received adjuvant chemotherapy, or patients having operations for recurrent disease. Findings were then presented at a departmental meeting and a standardised approach to the recording is being implemented in colorectal cancer clinics.

Results: A total of 105 patients were identified, 61 male and 44 female; the incidence of anaemia was 41% (n=43/105). 56% (n=24) of anaemic patients had pre-operative iron studies performed, while 9% (n=4) had iron studies performed post-operatively. Iron deficiency anaemia was identified in 80% (n=22/28) of patients who had it recorded. Overall, 90% (n=20) of iron-deficient patients received treatment. Treatment rates were higher in patients identified pre-operatively (94%, n=17/18) compared to those identified post-operatively (75%, n=3/4). A larger cohort is required to determine statistical significance.

Conclusion: While treatment of iron deficiency anaemia is appropriately initiated when identified, pre-operative investigations remain sub-optimal. A substantial proportion of anaemic patients do not undergo iron studies prior to surgery, representing a missed opportunity for optimisation of a potentially reversible condition. Education sessions with colorectal cancer nurses and the introduction of a standardised anaemia protocol will be

implemented in the unit, in order to improve identification of iron deficiency anaemia. Further analysis will evaluate whether pre-operative optimisation of anaemia improves haemoglobin levels and peri-operative outcomes.

Biography

Murray MacKay is currently a Foundation Year 2 doctor in Edinburgh, with a keen interest in surgery, and will begin Core Surgical Training in the South-East Region of Scotland in August, rotating through General Surgery and Urology. MacKay has a keen interest in quality improvement, teaching and research, and is keen to pursue a career in Urology, having found the specialty highly rewarding, with great technical skill involved, while working in the job as a junior doctor.



Muhammad U. Bukhari¹,
Nayab Ahsan^{2*}, Aurang Zaib¹

¹Internal Medicine, Dow University of Health Sciences / Civil
Hospital Karachi, Pakistan

²University Hospitals Sussex, United Kingdom

Association of alpha-fetoprotein levels with tumour size and aetiological factors in hepatocellular carcinoma: A cross-sectional analysis

Background: Alpha-fetoprotein (AFP) remains the most widely used biomarker in hepatocellular carcinoma (HCC) for diagnosis, disease monitoring, and prognostic assessment. However, AFP expression varies across tumour burden and underlying disease aetiology, which may influence its clinical utility.

Aim: To evaluate the association of serum AFP levels with tumour size and aetiological factors in patients with hepatocellular carcinoma.

Methods: This cross-sectional study was conducted at Dow University of Health Sciences / Civil Hospital Karachi between October 2017 and April 2018. A total of 94 patients with newly diagnosed hepatocellular carcinoma were included using non-probability consecutive sampling. Demographic characteristics, tumour size, and aetiological factors were recorded. Serum AFP levels were measured and stratified according to age, gender, tumour size, and underlying aetiology. Statistical analysis was performed using independent t-tests and ANOVA, with $p \leq 0.05$ considered significant.

Results: The mean age of the patients was 49.33 ± 15.86 years, with a nearly equal gender distribution (47.9% male, 52.1% female). The mean AFP level was 1356.06 ± 898.36 ng/mL. Hepatitis B was the most common underlying cause (36.2%), followed by hepatitis C (27.7%). AFP levels were significantly higher in patients younger than 45 years compared to those older than 45 years (1621.78 ± 948.66 vs 1112.04 ± 740.22 ng/mL; $p=0.005$). Tumour size demonstrated a significant association with AFP levels ($p=0.001$), with larger tumours showing higher AFP expression. Alcoholism ($p<0.001$) and obesity ($p<0.001$) were also associated with significantly elevated AFP levels.

Conclusion: Serum AFP levels in hepatocellular carcinoma are significantly influenced by tumour size, age, and certain underlying aetiologies. These findings support the role of AFP as a marker of tumour burden and disease characterisation, particularly in resource-limited settings where access to advanced imaging may be restricted.

Biography

Nayab Ahsan is a GMC-registered doctor currently working as a Trust Doctor (CT1/2 equivalent) in Trauma & Orthopaedics at University Hospitals Sussex NHS Foundation Trust, UK. She holds MRCS (UK), ALS and ATLS qualifications, with a strong academic and clinical interest in General Surgery, particularly Hepatobiliary and Transplant Surgery, alongside academic research in hepatobiliary oncology.



Nayab Ahsan^{1*}, Rana Basit Ali Rajput², Sana Akhtar Ansari³, Muhammad Yaqoob Hassan⁴, Muhammad Arslan Riaz⁵, Hafiz Muhammad Shoaib⁶, Khushnood Ali⁴

¹University Hospitals Sussex, United Kingdom

²Wythenshawe Hospital, Manchester University NHS Foundation Trust, United Kingdom

³Faisalabad Medical University, Faisalabad, Pakistan

⁴Shaikh Zayed Hospital, Lahore, Pakistan

⁵Punjab Institute of Cardiology, Lahore, Pakistan

⁶Children Hospital Lahore, Pakistan

Perioperative nutritional optimisation within enhanced recovery pathways: Impact on postoperative morbidity and length of stay following elective abdominal surgery

Background: Enhanced Recovery After Surgery (ERAS) pathways emphasise early feeding and mobilisation to improve postoperative recovery; however, perioperative protein optimisation remains inconsistently implemented despite its potential impact on outcomes.

Objective: To evaluate the influence of perioperative protein supplementation on length of hospital stay and postoperative complication rates in patients undergoing elective abdominal surgery.

Methods: This observational cohort study included a total of 265 adult patients undergoing elective abdominal surgery, categorized into protein supplementation (n=132) and non-supplementation (n=133) groups. Patients in the supplementation group received a high-protein oral nutritional formula targeting approximately 1.2–1.5 g/kg/day, initiated 5–7 days preoperatively where feasible and continued for at least five postoperative days or until discharge. Postoperative complications, wound healing status, and length of hospital stay were compared.

Results: Patients receiving protein supplementation had a significantly shorter hospital stay compared with those without supplementation (4.8 ± 1.9 vs. 6.2 ± 2.4 days, $p=0.001$). Overall postoperative complications were lower in the supplementation group (18.2% vs. 33.8%, $p=0.004$). Infectious complications were also reduced (9.8% vs. 20.3%, $p=0.018$), including surgical site infections (5.3% vs. 12.0%, $p=0.047$). Optimal wound healing by postoperative day three was more frequent among supplemented patients (84.9% vs. 63.1%, $p<0.001$).

Conclusion: Perioperative protein supplementation was associated with shorter hospital stays, fewer postoperative complications, and improved early wound healing among patients undergoing elective abdominal surgery. Incorporating structured perioperative nutritional optimization into ERAS pathways may represent a practical strategy to improve surgical recovery.

Biography

Nayab Ahsan is a GMC-registered doctor currently working as a Trust Doctor (CT1/2 equivalent) in Trauma & Orthopaedics at University Hospitals Sussex NHS Foundation Trust, UK. She holds MRCS (UK), ALS and ATLS qualifications, with a strong academic and clinical interest in General Surgery, particularly Hepatobiliary and Transplant Surgery, alongside academic research in hepatobiliary oncology.

Noor Alshamlan^{1*}, Ahmed Asaad², Ahmed Elbioumy¹

¹Mersey and West Lancashire Teaching Hospitals NHS Trust, UK

²Southport and Ormskirk District General Hospital, UK

Appropriateness of microbiological pus swabs following incision and drainage of cutaneous abscesses: A closed-loop audit of antimicrobial stewardship

Introduction: Incision and drainage is the definitive treatment for most cutaneous abscesses, and the majority of patients are discharged without antibiotics. No NICE guideline specifically addresses swabbing of primary cutaneous abscesses. We therefore applied the antimicrobial-stewardship concept of NICE NG125 which promotes targeted microbiological sampling to guide, rather than routinely accompany, treatment to rationalise swab-taking in this setting. On this basis, culture was considered indicated only in selected cases: systemic features of infection, severe or complex local infection, recurrence, treatment failure, or immunocompromise. Routine swabbing of uncomplicated abscesses rarely alters management and incurs avoidable laboratory cost.

Aims: To assess whether pus swabs taken at abscess drainage were clinically indicated under stewardship-based criteria, and whether their results influenced management, against a standard of 100% appropriate use.

Methods: A retrospective audit was conducted at a single hospital over 3 months. Consecutive patients undergoing incision and drainage of a cutaneous abscess were identified. Applying the NG125-derived stewardship criteria, each case was assessed for the presence of an accepted indication for swabbing, whether a swab was taken, the result, and any consequent change in management (antibiotic initiation/change or microbiology input). Patients not undergoing drainage were excluded.

Results: Fifty-one patients were included (median age 48 years; range 17–93); the commonest sites were perianal and pilonidal. A swab was taken in 33 patients (65%), the majority of whom had no accepted indication. Overall, only 20 of 51 patients (39%) were managed appropriately (swab correctly taken or correctly omitted). Among patients swabbed without indication, the result changed management in only one case, and 26 of 31 (84%) had no change to treatment irrespective of the result. No patient required an antibiotic change on the basis of swab sensitivities alone.

Conclusion: Most pus swabs were taken without an accepted indication and did not influence management, representing avoidable laboratory cost and workload contrary to antimicrobial-stewardship principles. Applying the stewardship concept of NG125 provided a practical framework to rationalise sampling. A combined intervention of departmental teaching and an integrated swab-indication prompt within the operative and discharge pathway was introduced. A second cycle is currently underway and will additionally involve the microbiology team to further strengthen swab rationalisation, with its impact to be assessed.

Biography

Alshamlan is a first-year Core Surgical Trainee in the North West of England, training on a vascular-themed pathway and intending to apply for vascular surgery (ST3) this year. Alshamlan is keen on improving the quality of care and service provided to patients, is currently involved in several quality improvement projects and audits, and is aiming to develop a research portfolio.

Noor Alshamlan^{1*}, Ahmed Asaad², Ahmed Elbioumy¹

¹Mersey and West Lancashire Teaching Hospitals NHS Trust, UK

²Southport and Ormskirk District General Hospital, UK

Compliance with the Liverpool Head Injury Tomography (HIT) score in neurosurgical referral decisions for patients admitted under general surgery: A closed-loop audit

Introduction: The Liverpool Head Injury Tomography (HIT) score is a validated tool that stratifies patients with CT-confirmed traumatic brain injury by their need for neurosurgical intervention, supporting the decision to refer to neurosurgery (HIT >2) or manage locally with neuro-observation (HIT <3). Accurate application reduces both missed referrals of high-risk patients and unnecessary referrals that burden neurosurgical services and delay care. This audit assessed local concordance between HIT score and referral practice in patients admitted under general surgery, and whether low-score patients could be safely managed locally.

Aims: To evaluate whether neurosurgical referral decisions for patients with traumatic intracranial findings on CT were concordant with the HIT score (against a standard of 100% appropriate management), and to assess whether patients with low HIT scores were safely managed locally without complications requiring transfer.

Methods: A retrospective audit was conducted at a single district general hospital over 3 months. Consecutive patients with head injury and acute traumatic findings on CT who were admitted under general surgery for local management were identified. For each patient, the HIT score was calculated from radiological findings, and the resulting recommendation (refer if >2 ; local management if <3) was compared with the actual referral decision. Outcomes of patients with low HIT scores were reviewed to identify any deterioration or complication requiring subsequent neurosurgical transfer.

Results: Thirty-one patients were included. Fifteen (48%) had a HIT score >2 , indicating a need for neurosurgical referral; 14 of these (93%) were appropriately referred. Of the 16 patients with a HIT score <3 suitable for local management, 7 (47%) were referred to neurosurgery despite not meeting the threshold. Overall, 23 of 31 patients (74%) were managed in concordance with the HIT score, the predominant deviation being over-referral of low-risk patients rather than failure to refer high-risk patients. No patient with a low HIT score deteriorated or required transfer to neurosurgery, supporting the safety of local management in this group.

Conclusion: Compliance with referring high-risk patients was good, and low-score patients were safely managed locally, supporting use of the HIT score to guide referral. However, a substantial proportion of low-risk patients were referred unnecessarily, representing avoidable neurosurgical workload. A combined intervention of departmental teaching and an integrated HIT score prompt within the CT reporting and referral pathway was introduced to improve appropriate use of the score. A second cycle is currently underway to assess its impact.

Biography

Alshamlan is a first-year Core Surgical Trainee in the North West of England, training on a vascular-themed pathway and intending to apply for vascular surgery (ST3) this year. Alshamlan is keen on improving the quality of care and service provided to patients, is currently involved in several quality improvement projects and audits, and is aiming to develop a research portfolio.



Olympia Hadjicosta*, Andrew Bernstein, George Reese

Charing Cross Hospital, Imperial College Healthcare NHS Trust, London, UK

From assessment to action: Evaluating and improving adherence to the Enhanced Recovery After Surgery (ERAS) protocol in elective colorectal patients

Background: Enhanced Recovery After Surgery (ERAS) is an evidence-based, multidisciplinary perioperative care pathway that optimises recovery following colorectal surgery by reducing surgical stress, postoperative complications, and length of hospital stay. Adherence to ERAS recommendations is associated with improved clinical outcomes; however, compliance with individual protocol elements varies in routine practice. This audit evaluated adherence to the local ERAS protocol, based on ERAS Society recommendations, among patients undergoing elective colorectal surgery at a tertiary colorectal centre and identified areas for quality improvement.

Methods: A two-cycle audit was conducted with elective colorectal patients admitted to a single tertiary center. The first cycle (July–August 2024) included all patients undergoing colorectal surgery, and the second cycle (September–October 2024) followed a similar cohort. Interventions in the first cycle included redesigning the ERAS protocol poster and distributing it throughout key hospital areas. Additionally, a weekly email reminder was sent to the colorectal team, emphasizing the importance of referring patients to the ERAS pathway. In the second cycle, adherence to the ERAS protocol was reassessed with a focus on the effectiveness of these interventions.

Results: In the first cycle, 77% of patients were referred to the ERAS nurse on the operative note, and 62% were reviewed by the ERAS nurse on the ward. However, only 60% of these patients were seen within 24 hours post-operatively. On post-operative day 1, 77% of patients progressed to free fluids, and 50% were discharged by day 5. In the second cycle, 70% of

patients were referred to the ERAS nurse, and 65% were reviewed on the ward, with 80% seen within 24 hours. Additionally, 65% of patients progressed to free fluids by day 1, and 50% were discharged by day 5.

Discussion: This audit identified several gaps in the implementation of the ERAS protocol, particularly regarding timely referrals and reviews by the ERAS nurse. The findings highlight the need for consistent adherence to the protocol to optimize postoperative care. As a result of the audit, a significant change was made: all elective colorectal patients are now automatically considered for the ERAS pathway, unless contraindicated. This ensures that each patient is reviewed by the ERAS team, thereby improving protocol compliance and care continuity.

Conclusion: Implementing the revised ERAS pathway, with a default referral for all elective colorectal patients, will enhance adherence to protocol guidelines. Regular review by the ERAS team promotes early mobilization, fluid management, and pain control, reducing postoperative complications and length of stay, and ultimately improving patient recovery and satisfaction.

Biography

Olympia Hadjicosta is completing Core Surgical Training at Imperial College Healthcare NHS Trust. Hadjicosta graduated from Barts and The London School of Medicine and Dentistry and holds a Master's degree in Laparoscopic Surgery and Surgical Skills. Hadjicosta's clinical and research interests include minimally invasive surgery, general surgery, and Enhanced Recovery After Surgery (ERAS), with a particular focus on perioperative optimisation and quality improvement. Hadjicosta aspires to pursue higher surgical training in general and transplant surgery while continuing to contribute to clinical research and innovation.



Pranavi Challapalli*, Ahmed Badr, Rauf Abdul, Matthew Liew, Christianna Taddeo, Noor El Bassam, Matthew McClafferty, Ming Xiu Chai

Royal Liverpool University Hospital, Liverpool,
United Kingdom

Transition in surgical management of benign prostatic hyperplasia in a tertiary centre: From TURP to contemporary minimally invasive and laser therapies

Introduction: Transurethral resection of the prostate (TURP) has been the gold standard surgical treatment for Benign Prostatic Hyperplasia (BPH). However, Minimally Invasive Surgical Therapies (MIST) and laser-based approaches are increasingly adopted. We evaluated the evolution of BPH surgical practice at our tertiary centre and compared perioperative outcomes.

Materials and Methods: A retrospective review was performed of 296 patients between September 2023 and April 2026. Procedures included TURP (193), UroLift (28), iTIND (10), Rezūm (27), and HoLEP (38). Total institutional procedural volume during this period was TURP (410), HoLEP (72), iTIND (16), Rezūm (35), and UroLift (32). Outcomes included length of stay (LOS), complications, symptom outcomes, and reintervention.

Results: A progressive shift away from TURP toward MIST and laser therapies was observed. Day-case management was achieved in all iTIND and Rezūm cases and 96.4% of UroLift procedures. HoLEP achieved comparable LOS despite treating significantly larger prostates than TURP (mean 121.4 cc vs 56.7 cc); 73% of HoLEP patients were discharged on postoperative day 1 compared with 51.8% following TURP. Functional outcomes improved markedly following HoLEP (IPSS 22.5 → 4.5; QoL 4.47 → 1.23), compared with after TURP (IPSS 20.3 → 14). TURP showed higher perioperative morbidity, including urosepsis (4.1%), haematuria (4.7%), and TWOC failure (19.7%), compared with HoLEP (2.6%). Reintervention rates within one year were highest in UroLift (14.3%) and Rezūm (7.4%), compared to TURP (0.5%), HoLEP (2.6%) and iTIND (0%). Urinary incontinence occurred in 7.3% of TURP patients and 10.2% of HoLEP patients (when performed by multiple training surgeons) and 2% with a single main surgeon, compared to UroLift (3.6%), iTIND (10%), and Rezūm (0%).

Conclusion: Our institutional experience demonstrates a shift toward MIST and laser-based surgery. While MIST offers excellent recovery profiles, HoLEP delivered durable functional improvement and favourable perioperative outcomes in a more complex patient population, supporting its expanding role in contemporary BPH management.

Biography

Pranavi is a Core Surgical Trainee at the Royal Liverpool University Hospital, with a keen interest in pursuing a career in Urology. She is currently gaining valuable clinical and surgical experience within the Urology Department, working alongside consultants across a range of urological conditions and procedures. She is passionate about research and is actively involved in projects aimed at improving patient outcomes and advancing surgical practice within the field. Her dedication to combining clinical training with academic development reflects her commitment to becoming a skilled and well-rounded urological surgeon.



Pranavi Challapalli*, Krishnan Gokul, Dmitri Artioukh

Royal Liverpool University Hospital,
General Surgery, Liverpool, United Kingdom

Utility value of colonoscopy in octonanogenarians

Aim: To evaluate the rationale and effectiveness of colonoscopy in patients aged over 80 years during a one-year period at Southport Hospital, which serves a predominantly geriatric population. Current protocol-driven diagnostic pathways frequently result in direct triaging to endoscopy, potentially bypassing comprehensive assessment of biological age, procedural feasibility, and overall risk–benefit balance.

Methods: A retrospective audit was conducted involving 105 patients aged over 80 who underwent colonoscopy between January and December 2021. Data were collected using a structured audit proforma, encompassing pre-, intra-, and post-procedural variables, and were obtained from hospital endoscopy and clinical records.

Results: Pre-procedural demographics identified anaemia (31%) and change in bowel habit (26%) as the most common indications. The overall completion rate was 73%. Diagnostic findings included diverticulosis (52%), polyps (9%), colitis (3%), and malignancy (15%). Factors contributing to incomplete procedures and reduced diagnostic yield included patient discomfort, colonic angulation, inadequate bowel preparation, as well as the impact of polypharmacy and multiple comorbidities.

Conclusion: The findings suggest that a more selective, targeted approach to endoscopy in this age group may be preferable to its routine use as a first-line investigation, in order to optimise diagnostic yield and procedural efficacy.

Biography

Pranavi is a Core Surgical Trainee at the Royal Liverpool University Hospital, with a keen interest in pursuing a career in Urology. She is currently gaining valuable clinical and surgical

experience within the Urology Department, working alongside consultants across a range of urological conditions and procedures. she is passionate about research and is actively involved in projects aimed at improving patient outcomes and advancing surgical practice within the field. Her dedication to combining clinical training with academic development reflects her commitment to becoming a skilled and well-rounded urological surgeon.



**Rajesh Veeramachaneni^{1*},
Kalyani Gadidesi², Revathi Lokala¹**

¹Rand Memorial Hospital, PHA, The Bahamas

²District Hospital Ballari, Karnataka, India

Blood pressure management during endovascular thrombectomy after the 2026 AHA/ASA stroke guideline: Implications for anesthetic practice; A narrative review

Introduction: Blood Pressure (BP) management during endovascular thrombectomy (EVT) remains one of the most debated aspects of acute ischemic stroke care. While the 2026 American Heart Association/American Stroke Association (AHA/ASA) guideline advises against routine intensive Systolic Blood Pressure (SBP) reduction below 140 mmHg following successful EVT, it provides limited guidance regarding intraprocedural hemodynamic management during general anesthesia. Because anesthesiologists directly influence cerebral perfusion throughout induction, thrombectomy, reperfusion, and emergence, understanding how contemporary stroke evidence translates into perioperative practice is essential. This review evaluates current evidence and proposes a practical framework for phase-specific BP management during EVT.

Methodology: A narrative review of contemporary literature was conducted using randomized controlled trials, systematic reviews, anesthesia-specific studies, and international guideline recommendations published through July 2026. Major post-EVT BP trials including BP-TARGET, ENCHANTED2/MT, BEST-II, OPTIMAL-BP, and the 2026 HOPE trials were critically reviewed alongside evidence comparing general anesthesia with procedural sedation. Studies evaluating intraprocedural hypotension, cerebral autoregulation, collateral perfusion, BP variability, and ongoing clinical investigations such as the MASTERSTROKE trial were also analyzed to determine their implications for anesthetic management.

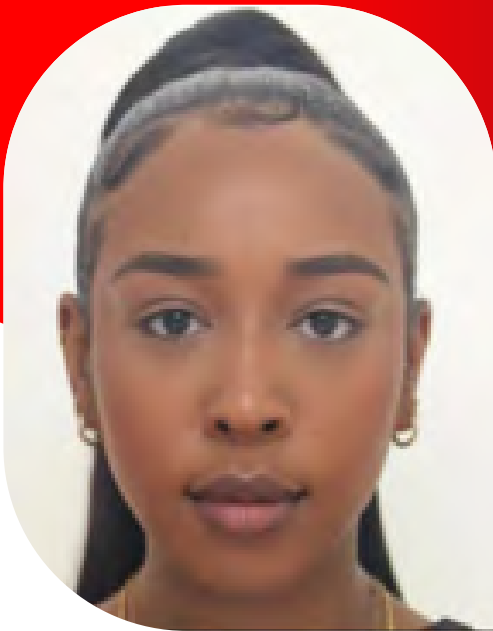
Results and Discussion: Recent randomized evidence consistently demonstrates that routine intensive post-reperfusion SBP reduction below 140 mmHg does not improve neurological outcomes and may worsen functional recovery. The HOPE trial further suggests that

individualized BP targets based on angiographic reperfusion status may improve outcomes compared with a uniform treatment strategy. In contrast, evidence addressing intraprocedural BP management remains limited. Observational studies indicate that sustained hypotension during vessel occlusion may compromise collateral-dependent cerebral perfusion and is associated with poorer neurological outcomes. Randomized anesthesia trials, however, demonstrate that protocolized general anesthesia achieves outcomes comparable to procedural sedation when treatment delays are minimized, and meticulous hemodynamic control is maintained. Collectively, these findings support shifting the focus from selecting an anesthetic technique to optimizing hemodynamic stability throughout each procedural phase. A phase-specific approach that avoids substantial hypotension before reperfusion, minimizes BP variability during thrombectomy, avoids indiscriminate aggressive BP reduction after reperfusion, and tailors management according to reperfusion status appears physiologically and clinically justified.

Conclusion: Contemporary evidence supports individualized rather than uniform BP management during EVT. Although the 2026 AHA/ASA guideline provides important recommendations for post-reperfusion care, significant uncertainty remains regarding optimal intraprocedural BP targets during general anesthesia. Until results from anesthesia-specific trials become available, anesthesiologists should prioritize preservation of collateral perfusion before reperfusion, prevention of marked BP variability, and individualized post-reperfusion management based on clinical and procedural context. These principles may improve multidisciplinary stroke care while informing future evidence-based anesthetic protocols.

Biography

Dr. Rajesh Veeramachaneni is an anesthesiologist with clinical experience in anesthesiology, critical care, and perioperative medicine, and has worked in both academic and tertiary care hospitals, being actively involved in resident education, quality improvement initiatives, and multidisciplinary patient care. Veeramachaneni's research interests include perioperative optimization, critical care, cardiovascular medicine, artificial intelligence in healthcare, and patient safety. Dr. Veeramachaneni has authored and co-authored peer-reviewed publications and has presented research at national and international scientific meetings, and is committed to advancing evidence-based perioperative care through clinical research, innovation, and collaboration. Current work focuses on improving perioperative outcomes using digital health technologies, AI-assisted clinical decision support, and quality improvement strategies to enhance patient-centered care.



Rana Mohamed*, Edward Parkin, Peter Mitchell

Lancashire Teaching Hospitals NHS Foundation Trust,
Preston, United Kingdom

Anal squamous cell carcinoma in Lancashire and South Cumbria: Regional epidemiology and alignment with current screening recommendations

Aim: Anal Squamous Cell Carcinoma (ASCC) is uncommon but has an increasing incidence. The 2024 International Anal Neoplasia Society (IANS) consensus guidelines for ASCC screening prioritise high-risk groups, primarily individuals with HIV, men who have sex with men (MSM) and transgender women. Our aim was to assess patients newly diagnosed with ASCC in Lancashire and South Cumbria in relation to screening recommendations.

Method: A retrospective study was performed on all new cases of ASCC across a regional cancer network diagnosed between 01.01.2024 and 31.12.2024. Cases were identified from regional MDT records. Demographic and clinical variables were extracted from electronic patient records. Socioeconomic deprivation was assessed using the 2019 Index of Multiple Deprivation (IMD) tool.

Results: During the 12-month period there were 66 new cases of ASCC: 68% were female, and the median age was 62.5 years. Chemoradiotherapy was the first-line treatment in 67% and 73% were Stage 3 or above. Only 10.6% were HIV-positive MSM, there were no cases of transgender women, and 1.5% had a history of other HPV-related malignancy. IMD data showed that 24% lived within IMD decile 1 (top 10% of most deprived neighbourhoods in England) and 48% lived within IMD decile 3.

Conclusions: Although IANS consensus guidelines appropriately target groups with higher incidence of ASCC, the burden of disease in our study lies outside the targeted populations. Implementation of such guidelines would have minimal impact for the vast majority of ASCC in our study group, where social deprivation is a clear risk factor.

Biography

Rana Mohamed is a Foundation Doctor currently working at East Suffolk and North Essex Foundation Trust. Academic and clinical interests include general surgery and surgical oncology, with a particular focus on improving patient care through evidence-based practice. Mohamed is actively involved in clinical research and quality improvement and aspires to pursue a career in colorectal surgery while contributing to advances in surgical research and education.



Rana Muhammad Ali

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, United Kingdom

A comprehensive review of operative considerations, surgical techniques, outcomes, and future perspectives in total knee arthroplasty

Objectives: Total Knee Arthroplasty (TKA) remains the gold-standard surgical treatment for end-stage knee osteoarthritis (OA). With TKA numbers rising, this review summarises its development, implant options, perioperative care and the technologies likely to shape its future.

Methods: We carried out a narrative review using PubMed, MEDLINE and Google Scholar. We included randomised controlled trials, clinical trials, meta-analyses and systematic reviews published in English over the past 15 years in human subjects aged 45 and over. Key comparisons were cemented versus cementless fixation, mobile versus fixed bearing, posterior-stabilised versus ultra-congruent design, and single-radius versus multi-radius femoral design, alongside alignment strategies, preoperative optimisation, robotic and sensor-assisted surgery, rehabilitation and complications.

Results: Cemented fixation remains standard, though cementless TKA may give comparable results in selected younger patients. Mobile-bearing and newer medial-pivot designs may offer small functional gains, without consistent improvement in revision rates or implant survival. Robotic and sensor-assisted systems improve implant positioning, alignment and soft-tissue balancing, and may aid early recovery, cut alignment errors and reduce blood loss, but these gains have not reliably translated into better long-term function, complications or survival. Preoperative optimisation, patient education and rehabilitation remain key to recovery, and an early functional advantage is often seen with minimally invasive approaches. AI-assisted planning, outpatient arthroplasty and patient-specific 3D-printed implants show promise but are limited by cost, access and a lack of long-term validation.

Conclusion: TKA continues to deliver excellent results while evolving through better technique, implant design and perioperative care. Current innovations improve precision and some short-term outcomes, but their long-term clinical value and cost-effectiveness stay uncertain. More multicentre studies with standardised outcomes and longer follow-up are needed before wider adoption.

Biography

Rana Ali is a Clinical Fellow at The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust in the United Kingdom. Ali is a Member of the Royal College of Surgeons of Edinburgh (MRCSEd) and holds an MBBS and BSc from Pakistan, with a keen interest in surgery, clinical research, and medical education. Ali is committed to delivering high-quality patient care while contributing to academic and professional development through research and conference presentations.



Rana Muhammad Ali

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, United Kingdom

Are we assessing and documenting mortality risk scores for patients undergoing emergency laparotomy? A clinical audit

Background: Emergency laparotomy is associated with significant morbidity and mortality. Emergency laparotomy is a common procedure, with 30,000–50,000 performed annually in the UK. The 30-day postoperative mortality rate is 8.1%. Assessing mortality risk before surgery is important for informed consent, peri-operative planning and identifying patients who may need a higher level of care. This audit aimed to assess how consistently mortality risk scores were being calculated, documented and discussed with patients undergoing emergency laparotomy.

Method: We carried out a retrospective audit over a six-month period. Patients who underwent emergency laparotomy were identified using the electronic theatre management system. Medical records and consent forms of 45 patients were reviewed to see whether mortality risk scores had been calculated, discussed with the patient and documented in both the clinical notes and consent form. Compliance was assessed against National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations, with a target of 100%. Patients undergoing laparoscopic procedures or laparotomy for gynaecological indications were excluded.

Results: Thirty-four patients were included. Mortality risk scores had been calculated and documented in only 6/34 patients (17.6%). Only 2/34 patients (5.9%) were fully compliant, with both NELA and P-POSSUM scores calculated, documented in the medical record and consent form, and discussed with the patient. A further 4/34 patients (11.8%) showed partial compliance, either because only one score had been calculated or because documentation was incomplete.

Recommendations: Overall compliance with recommended pre-operative mortality risk assessment and documentation was low. Suggested changes included increasing staff awareness through education and displaying posters, discussing compliance regularly at clinical governance meetings, and adding dedicated mortality risk sections to clerking and emergency theatre booking documentation. A re-audit following these changes would assess whether compliance has improved and complete the audit cycle.

Biography

Rana Ali is a Clinical Fellow at The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust in the United Kingdom. Ali is a Member of the Royal College of Surgeons of Edinburgh (MRCSEd) and holds an MBBS and BSc from Pakistan, with a keen interest in surgery, clinical research, and medical education. Ali is committed to delivering high-quality patient care while contributing to academic and professional development through research and conference presentations.



Rawan Al Dehailan*, Ian Lindsey, Chris Cunningham

Oxford University Hospital NHS Foundation Trust, Oxford, United Kingdom

Inferior rectal nerve block for proctological surgery: A technical note

Background: Day-case proctological surgery is commonly performed under general anaesthesia, which can be cumbersome and inefficient for often short-duration procedures, with prolonged recovery and excessive resource use. The inferior rectal nerve block provides anatomically targeted anaesthesia to the perianal region while avoiding anaesthetising a large area of sensory distribution. It allows for faster recovery, quicker patient turnover, avoids general anaesthetic risks and provides adequate analgesia. This is a new technique currently in use at Oxford University Hospitals for day-case proctological surgery.

Technique: Inferior rectal nerve block can be performed under titrated intravenous sedation administered by an anaesthetist, using agents such as propofol in combination with fentanyl, prior to block administration. A combination of lidocaine 1% (20mls) and bupivacaine 0.5% (20mls) is used to provide both short and long-acting anaesthesia to make a total of 40mls. Following sedation, the patient is positioned in either left lateral or lithotomy position and the injection site is identified at the anal verge. The needle is inserted at a 45° angle in the anal verge at 9 o'clock and directed posterior-inferiorly towards the natal cleft. Approximately 15mls of local anaesthetic is injected, followed by partial needle withdrawal and redirection superiorly, maintaining a 45° angle and an additional 5mls is injected to ensure circumferential spread along the inferior rectal nerve trajectory. The technique is repeated on the contralateral side at 3 o'clock to complete a total of 40mls of local anaesthetic infiltration.

Clinical application: Inferior rectal nerve block is suitable for day-case proctological procedures, including polypectomy, skin tag excision, haemorrhoidal artery ligation operation, fissurectomy and examination of the rectum under anaesthesia. In addition, it can provide effective analgesia in acute presentations such as thrombosed haemorrhoids or severe anal fissures.

Benefits: This technique provides effective intra- and post-operative analgesia, supports efficient theatre turnover in the day-case setting and encourages early patient mobilisation and discharge. Additionally, avoiding general anaesthesia minimises airway manipulation and cardiorespiratory depression which enhances patient safety.

Conclusion: Inferior rectal nerve block provides a safe, anatomically precise regional anaesthesia. It is an excellent option for day-case proctology in appropriately selected patients who are suitable for local anaesthesia and have no contraindications to regional techniques.

Biography

Dr Rawan Al Dehailan is a General Surgery-themed Core Surgical Trainee at Oxford University Hospitals NHS Foundation Trust. Al Dehailan graduated from the University of Central Lancashire in 2023 with an MBBS with Honours and was awarded the Dean's Award for Academic Excellence. Al Dehailan held several teaching roles, including Associate Teaching Fellow at John Radcliffe Hospital, and designed a regional surgical teaching programme. Dr Al Dehailan has led multiple trust-wide quality improvement projects and remains actively engaged in surgical research.



Saad Masood

York Hospital, United Kingdom

Very late isolated bladder recurrence of testicular seminoma 16 years after orchidectomy: A rare case report

Background: Very late relapse of testicular seminoma is uncommon, particularly after a prolonged disease-free interval and at an atypical anatomical site. Recurrence involving the urinary bladder is exceptionally rare and may present a significant diagnostic challenge.

Case Presentation: A 52-year-old man presented with painless visible haematuria, 16 years after radical inguinal orchidectomy for stage I testicular seminoma. Cross-sectional imaging demonstrated a large infiltrative mass arising from the left posterolateral bladder wall, with extension into the prostate and distal ureter, causing severe hydronephrosis. Serum tumour markers, including alpha-fetoprotein, beta-human chorionic gonadotropin and lactate dehydrogenase, were within normal limits. Transurethral resection of the bladder tumour was performed. Histopathological examination, supported by immunohistochemistry, demonstrated features consistent with classical seminoma. Staging revealed locally advanced disease with regional lymph node involvement but no evidence of distant metastases. The patient was discussed at a multidisciplinary meeting and commenced on systemic platinum-based chemotherapy alongside urinary decompression.

Conclusion: This case highlights the potential for seminoma to relapse after an exceptionally long disease-free interval and at an unusual extragonadal site. Although primary extragonadal germ cell tumours may enter the differential diagnosis, the clinical history and pathological findings support late metastatic recurrence of testicular seminoma. Importantly, normal serum tumour markers do not exclude late relapse. Histopathological confirmation with appropriate immunohistochemistry remains essential when evaluating unusual masses in long-term survivors of testicular germ cell tumours. Awareness of atypical patterns of late recurrence may facilitate earlier diagnosis and appropriate multidisciplinary management.

Biography

Saad Masood completed his MBBS in Pakistan in 2020 and MRCS in 2025. He is working as a Senior House Officer in Surgical Specialities in York Hospital in York and Scarborough Teaching Foundation Trust.

Glycaemic variability and all-cause mortality in adult patients with sepsis: A systematic review and critical appraisal

Background: Sepsis accounts for an estimated 49 million cases and 11 million deaths globally each year, representing approximately one in five of all global fatalities. Identifying modifiable risk factors associated with mortality in septic patients is therefore a clinical and public health priority. Glycaemic Variability (GV), referring to acute fluctuations in blood glucose levels within or between days, has emerged as a potentially important prognostic marker in critically ill patients. Experimental evidence suggests GV may exacerbate oxidative stress and cellular damage more profoundly than sustained hyperglycaemia through overproduction of reactive oxygen species and activation of pro-inflammatory cascades. Despite this, current Surviving Sepsis Campaign guidelines do not address GV as a therapeutic target. This review systematically examined and critically appraised the existing evidence to determine whether high GV correlates with increased all-cause mortality in adult patients with sepsis.

Methods: A systematic review and critical appraisal of all available clinical evidence examining acute GV and all-cause mortality in adult septic patients was conducted. The existing literature was critically evaluated with individual studies appraised using the Newcastle-Ottawa Scale to assess methodological quality. An independent updated literature search was subsequently performed on 1 June 2024 across six databases (PubMed, Embase, Ovid Medline, Web of Science, Cochrane and Scopus) using standardised search terms combining variations of glycaemic variability, sepsis and mortality. Studies with significant methodological concerns or uncertain sepsis classification were excluded following critical appraisal. A forest plot was independently constructed to synthesise findings.

Results: Eleven cohort studies involving over 11,000 adult septic patients were critically appraised. One study was excluded from quantitative synthesis due to significant methodological flaws and uncertainty regarding sepsis classification. Across the remaining studies, a consistent association was identified between high acute GV and increased all-cause mortality, regardless of GV measurement parameter: standard deviation of blood glucose, coefficient of variation, mean amplitude of glycaemic excursion and glycaemic lability index. The updated forest plot, incorporating the largest available cohort to date (n=7,104), yielded a statistically significant pooled effect (OR 1.05, 95% CI 1.02-1.08). Notably, this effect

was attenuated compared to earlier smaller studies, suggesting previous estimates may have overstated the true association. A consistent finding across the majority of studies was that non-diabetic patients demonstrated greater susceptibility to GV-associated mortality than diabetic patients, possibly reflecting adaptation to chronic glucose fluctuations.

Conclusion: This systematic review and critical appraisal confirms a consistent and biologically plausible association between high acute glycaemic variability and increased all-cause mortality in adult septic patients. However, the evidence base remains dominated by retrospective observational studies with significant methodological heterogeneity and effect size attenuates with larger more rigorous studies, warranting cautious interpretation. Large-scale multicentre randomised controlled trials using continuous glucose monitoring and standardised GV protocols are needed to establish causation. If confirmed, GV represents a clinically important and potentially modifiable therapeutic target that should be considered in future sepsis management guidelines, with particular focus on non-diabetic patient subgroups.

Keywords: Glycaemic Variability, Sepsis, Mortality, Critical Care, Intensive Care, Blood Glucose, Dysglycaemia, Systematic Review.

Biography

Ahuja is a FY1 doctor in London, having graduated with an MBBS and MSc in Critical Care from Barts and The London, Queen Mary University of London. Ahuja has research interests in perioperative glucose metabolism and glycaemic variability in critically ill patients, and is an active researcher within the Acute Critical Care Research Team at The Royal London Hospital, including the GlucoVITAL trial, contributing to participant recruitment, data collection and experimental work. Ahuja has presented original research at the BJA Research Forum and has co-authored publications in the British Journal of Anaesthesia and the European Heart Journal.



Sanjay Pulpandi*, Andrew Laurie

Critical Care and Anaesthesia, Aberdeen Royal Infirmary, NHS Grampian, Aberdeen, United Kingdom

Lung-protective ventilation compliance in mechanically ventilated ICU patients at a tertiary care hospital: A single-centre clinical audit

Background: Lung-Protective Ventilation (LPV) reduces ventilator-induced lung injury through limitation of tidal volume and airway pressures. Although LPV is well established in Acute Respiratory Distress Syndrome (ARDS), its principles are increasingly applied to mechanically ventilated critically ill patients more broadly. This audit assessed adherence to LPV principles in a UK intensive care unit and identified areas for improvement, including potential exposure to injurious tidal volumes during spontaneous ventilation.

Methods: A retrospective single-centre audit was conducted in the Critical Care Unit at Aberdeen Royal Infirmary, NHS Grampian. All adults receiving invasive mechanical ventilation between 1 and 31 August 2025 were included. Hourly ventilator data were extracted from the electronic ICU clinical information system (ICCA) for 48 patients. Prespecified LPV criteria included tidal volume ≤ 8 mL/kg Ideal Body Weight (IBW) in non-ARDS patients, plateau pressure ≤ 30 cmH₂O, and driving pressure (plateau pressure minus PEEP) ≤ 15 cmH₂O. Sustained deviation was defined as more than 20% of ventilator-hours above the relevant threshold. Two or more consecutive hours with tidal volume >12 mL/kg IBW were considered a potentially injurious excursion. Spontaneously breathing periods were analysed separately for high tidal-volume exposure and potential Patient Self-Inflicted Lung Injury (P-SILI).

Results: Twelve of 48 patients (25.0%) demonstrated clinically significant deviation from the predefined LPV parameters. The commonest abnormality was elevated driving pressure, with 7 patients (14.6%) spending more than 20% of controlled ventilation time with driving pressure >15 cmH₂O. One patient (2.08%) had plateau pressure >30 cmH₂O for more than 20% of controlled ventilation time, and one experienced consecutive tidal volumes >12 mL/kg IBW.

IBW was not documented in one patient. During spontaneous ventilation, two patients (4.16%) spent more than 20% of ventilated time with tidal volumes >8 mL/kg IBW, and one patient (2.08%) met the exploratory criterion for increased P-SILI risk. Categories were mutually exclusive. No patients with a documented diagnosis of ARDS were identified.

Conclusion: Overall adherence to tidal-volume and plateau-pressure targets was good, while elevated driving pressure represented the principal opportunity for improvement. The audit highlighted the value of routine IBW documentation, regular plateau-pressure assessment, recognition of elevated driving pressure, and closer evaluation of excessive tidal volumes during assisted spontaneous ventilation. Targeted staff education and ventilator monitoring were recommended to strengthen lung-protective practice and reduce potentially avoidable ventilator-induced lung injury.

Biography

Dr Sanjay Pulpandi is a Clinical Fellow at Aberdeen Royal Infirmary, NHS Grampian, with clinical experience across Critical Care, Emergency Medicine and General Medicine. Academic interests include critical care, patient safety and quality improvement. Pulpandi has undertaken clinical audits in lung-protective ventilation, and has contributed to research including a systematic review and meta-analysis presented at the European Renal Association Congress, as well as peer-reviewed publication work.



Sarah Stevenson

Antrim Area Hospital, Bush Road, Northern Ireland,
United Kingdom

Ambulatory EMSU ultrasound audit

An audit was conducted within the Ambulatory General Surgery service to evaluate the appropriateness and efficiency of ultrasound scan requests. Initial review identified significant variation in requesting practices, including inconsistent clinical information, inappropriate indications, duplication of imaging, and limited patient understanding regarding the purpose and timing of scans. These issues contributed to delays in patient flow, increased radiology workload, and occasional tension between surgical and radiology teams due to unclear or low-yield requests.

Baseline data were collected over a defined period and assessed against local and national imaging guidance and accepted standards for ambulatory surgical practice. The audit demonstrated that a considerable proportion of ultrasound requests lacked sufficient clinical justification or failed to meet recommended criteria. In addition, patients frequently reported poor understanding of why scans had been requested and what outcomes to expect, resulting in repeated queries, dissatisfaction, and inefficiencies during follow-up.

To address these concerns, a quality improvement intervention was introduced focusing on two main components: enhanced clinician counselling techniques and the implementation of a QR code-based educational resource for patients. The QR code linked patients to accessible information explaining the role of ultrasound imaging, common indications, preparation requirements, expected timelines, and potential outcomes. Surgical clinicians were also encouraged to adopt a more structured counselling approach during consultations, ensuring patients understood the rationale for imaging and helping clinicians reflect on the appropriateness of requests prior to submission.

Following implementation, re-audit data demonstrated a marked improvement in the quality and appropriateness of ultrasound requests. Requests contained more relevant clinical

information, adhered more consistently to departmental guidance, and showed a reduction in unnecessary or duplicate imaging. The intervention also improved patient engagement and understanding, reducing confusion and improving attendance and preparedness for investigations.

Importantly, the project had a positive impact on interdisciplinary working relationships. Improved request quality and clearer communication enhanced collaboration between the surgical and radiology departments. Feedback from radiology colleagues highlighted greater confidence in the clinical value of requests and reduced frustration associated with incomplete or inappropriate referrals. Surgical teams also reported improved awareness of imaging indications and more efficient patient management within the ambulatory pathway.

Overall, this audit demonstrated that combining digital patient education tools with improved counselling strategies can significantly enhance the efficiency and appropriateness of ultrasound requesting in ambulatory general surgery. The project highlighted the value of simple, low-cost interventions in improving patient care, streamlining workflow, and strengthening interdepartmental collaboration.

Biography

Sarah Stevenson is a second-year Core Surgical Trainee with full MRCS qualification and a strong interest in General Surgery, particularly in the development and optimisation of ambulatory surgical care. She is passionate about improving patient pathways, enhancing clinical efficiency, and promoting high-quality multidisciplinary collaboration. Her work has focused on quality improvement initiatives aimed at streamlining investigations and improving patient understanding through innovative approaches such as digital education tools. She is committed to delivering safe, patient-centred care while continuing to develop her surgical skills, academic interests, and leadership experience within a dynamic clinical environment.



Sarah Stevenson*, B. Cunningham

Antrim Area Hospital, Bush Road, Northern Ireland,
United Kingdom

Appendicitis biomarker review

Acute appendicitis is the leading cause of emergency abdominal surgery worldwide, affecting approximately 7% of the population at some stage of life, with perforation rates reaching up to 20%, underscoring the importance of accurate and timely diagnosis. Traditionally, clinicians have used WBC and CRP to support clinical suspicion. However, both have suboptimal accuracy, especially in distinguishing uncomplicated from complicated appendicitis. CRP, a common marker, exhibits a sensitivity of 46–94% and specificity of 32–84%, with a high negative predictive value that can aid in ruling out severe disease; however, its overall sensitivity and specificity are limited. Similarly, WCC alone shows little predictive value in distinguishing uncomplicated from complicated appendicitis, and elevated levels of WCC and CRP are nonspecific, correlating with various differential diagnoses. Traditional clinical markers such as temperature have also demonstrated limited relevance, especially in children under five, where elevated temperature is not statistically significant between disease severities.

In addition, for certain circumstances we rely on imaging for diagnosis. However, these tools have notable limitations: ultrasound sensitivity is around 71.8% with a specificity of 44.8%, while CT sensitivity ranges from 28% to 95%, and specificity from 71% to 100%. This variability emphasises the need for reliable biomarkers to improve diagnostic accuracy, particularly given that a third of cases present atypically and that older patients often experience more complicated disease courses compounded by co-morbidities.

Ideally we would utilise inexpensive, readily available indices derived from the complete blood count, such as neutrophil-to-lymphocyte ratio (NLR), platelet-to-lymphocyte ratio (PLR), monocyte-to-lymphocyte ratio (MLR), neutrophil-to-platelet ratio (NPR), and Systemic Immune-Inflammation Index (SII). These ratios reflect different aspects of the systemic inflammatory response and have been evaluated across paediatric, adult, and special populations. They are cost-effective, easily accessible, and reproducible, providing objective

measures to improve diagnosis, assess severity, and monitor patients managed conservatively. These biomarkers have the potential to stratify risk effectively, guide management decisions—whether surgical or conservative—and ultimately reduce negative appendectomy rates.

While appendectomy remains the gold standard treatment, accurate diagnosis before surgery continues to challenge clinicians. Misdiagnosis leads either to delayed treatment and perforation or to unnecessary appendectomies, both of which carry morbidity. This review synthesises current evidence on these novel biomarkers, comparing their diagnostic accuracy, strengths, and limitations, while also highlighting gaps in the literature. The overall aim is to enhance diagnostic precision and patient outcomes in appendicitis management.

Biography

Sarah Stevenson is a second-year Core Surgical Trainee with full MRCS qualification and a strong interest in General Surgery, particularly in the development and optimisation of ambulatory surgical care. She is passionate about improving patient pathways, enhancing clinical efficiency, and promoting high-quality multidisciplinary collaboration. Her work has focused on quality improvement initiatives aimed at streamlining investigations and improving patient understanding through innovative approaches such as digital education tools. She is committed to delivering safe, patient-centred care while continuing to develop her surgical skills, academic interests, and leadership experience within a dynamic clinical environment.



Sarah Stevenson*, D. Blades

Antrim Area Hospital, Bush Road, Northern Ireland,
United Kingdom

Incarcerated pre-sternal epigastric hernia causing closed-loop large bowel obstruction

Abstract:

Background:

- Epigastric hernias typically contain fat/omentum
- Rarely migrate into pre-sternal region
- Bowel involvement is rare, large bowel strangulation extremely uncommon
- Emergency laparotomy = higher morbidity / mortality rates, especially in elderly patients

Case:

- 88M frail gentleman with multiple comorbidities
- PC: abdominal pain, distension, nausea, reduced PO intake
- OE: abdominal distension, irreducible epigastric mass

Intra-operative Findings & Management:

- Large bowel herniation via epigastric hernia into pre-sternal region causing closed loop LBO
- Appendicotomy performed to aid decompression and facilitate safe reduction of large bowel from abnormal position avoiding large bowel resection
- Hernia defect repaired - primary suture repair ??mesh

Key Learning Points:

- Interesting case of abnormally located epigastric hernia and use of venting appendicotomy
- Consider use of appendicotomy for decompression in LBO to potentially avoid bowel resection and reduce morbidity in high risk patients

Biography

Sarah Stevenson is a second-year Core Surgical Trainee with full MRCS qualification and a strong interest in General Surgery, particularly in the development and optimisation of ambulatory surgical care. She is passionate about improving patient pathways, enhancing clinical efficiency, and promoting high-quality multidisciplinary collaboration. Her work has focused on quality improvement initiatives aimed at streamlining investigations and improving patient understanding through innovative approaches such as digital education tools. She is committed to delivering safe, patient-centred care while continuing to develop her surgical skills, academic interests, and leadership experience within a dynamic clinical environment.



Sheung Hang Mak*, Dale Isabel Nunes, Georgina Green, Fergus Wood

Department of Ear, Nose and Throat, Glangwili Hospital,
Hywel Dda University Hospital Health Board, Carmarthen,
Wales, UK

Guiding selective neck dissection: Pattern of nodal spread and imaging accuracy in head and neck SCC

Background: Selective neck dissection aims to reduce surgical complications and morbidity while maintaining oncological control of nodal disease in Head and Neck Squamous Cell Carcinoma (HNSCC). However, its success depends on accurate prediction of level-specific nodal disease, typically guided by primary subsite and pre-operative imaging. This study evaluates the pattern of nodal spread and accuracy of pre-operative imaging within a contemporary Welsh cohort.

Methods: A retrospective single-centre cohort study included patients undergoing neck dissection between 2018–2023 in a district general hospital. Of 110 neck dissections identified, 30 were excluded due to absence of malignancy or non-SCC histology. Primary tumour sites were larynx (n=39), oropharynx (n=18), parotid (n=7), unknown primary (n=7), skin (n=3), and hypopharynx (n=2). Patterns of nodal spread were analysed by tumour subsite. Pre-operative imaging and dissected neck levels were compared with histopathological findings to assess diagnostic accuracy and surgical selectivity.

Results: Eighty neck dissections were analysed. Nodal metastases most frequently involved Levels II and III, particularly in oropharyngeal and laryngeal primaries, with lower rates of involvement at Levels I and V. Pre-operative imaging demonstrated limited performance for detecting level-specific nodal disease (sensitivity 50%, specificity 48%, accuracy 49%), with no significant difference between false positive and false negative rates ($p=0.35$).

Levels I, IV and V were often dissected despite low pathological yield (4%, 11%, 5%), paired analysis confirmed a significant excess of dissected levels relative to histopathological positivity ($p<0.001$).

Conclusion: Local pre-operative imaging demonstrates limited reliability for level-specific nodal disease in HNSCC and should not guide selective neck dissection in isolation. Surgical planning should remain primarily subsite driven, with imaging serving as an adjunct to identify high-risk or atypical disease. The observed discrepancy between imaging and pathological findings may contribute to a tendency towards over-dissection in current practice, highlighting an opportunity in the future to refine surgical selectivity with advancements in imaging and pathological risk stratification.

Biography

Dr. Sheung Hang Mak is an ENT clinician working within Hywel Dda University Health Board, NHS Wales. Mak's clinical interests include head and neck oncology, audits, and medical education. Mak has contributed to multiple projects within ENT and is passionate about combining surgical practice, education, and research to improve patient care and safety.

Sri Harsha Dintakurti*, Shoaib Hassan, Rhianon Reynolds

Royal Gwent Hospital, Aneurin Bevan University Health Board, United Kingdom

A case of progressive bilateral candidal endogenous endophthalmitis

Endogenous fungal endophthalmitis can occur secondary to fungaemia with haematogenous seeding of the choroid, most commonly due to *Candida* species. Recognised risk factors include hospitalisation, indwelling intravenous lines, immunosuppression, malignancy, and broad-spectrum antibiotic use. Early ophthalmic assessment is essential in patients with candidaemia who develop visual symptoms.

We report the case of a 77-year-old female who developed candidaemia whilst admitted to intensive care following biliary drain insertion for cholangiocarcinoma. The patient was subsequently referred to our ophthalmology unit with bilateral blurred vision and floaters. Visual acuity was reduced to counting fingers in the right eye and 6/18 in the left. Dilated fundus examination demonstrated a large yellow chorioretinal macular lesion characteristic of candidal chorioretinitis, with mild vitritis in the right eye, and a smaller lesion temporal to the macula in the left eye. A clinical diagnosis of candidal endophthalmitis was made based on the characteristic fundus appearances in the context of recent candidaemia.

The patient was treated with intravenous caspofungin and intravitreal amphotericin. Despite systemic improvement, clearance of candidaemia on blood cultures and initial ocular stability, she developed progressive bilateral vitritis and enlargement of chorioretinal lesions. Repeat intravitreal amphotericin was administered, and systemic therapy continued with oral voriconazole; however, her endophthalmitis continued to progress over a month. Vitreous biopsy did not isolate any candidal growth. The patient was recommended for diagnostic and therapeutic pars-plana vitrectomy.

This case highlights progressive bilateral fungal endophthalmitis as a rare but serious sequela of systemic candidal infection, showing that choroidal seeding may occur following transient candidaemia and progress despite subsequent systemic clearance and intravitreal antifungal therapy. It emphasises the importance of prompt ophthalmic assessment in patients with suspected candidaemia and new visual symptoms, particularly those with malignancy-related immunosuppression, indwelling lines and prolonged hospitalisation.

Biography

Dr Dintakurti studied medicine at Imperial College London with a president's scholarship, graduating in 2023. During medical studies, Dintakurti undertook an intercalated BSc in Medical Sciences with a special interest in Translational Respiratory Medicine, achieving first class honours. Dintakurti is currently undertaking a first year of ophthalmology specialist training in South Wales.

Stewart Chikukuza*, Fahreyar Alam

Great Western Hospital, Swindon SN3 6BB, United Kingdom

Macroscopic assessment of acute appendicitis versus histopathological diagnosis: A clinical audit of diagnostic concordance

Background: Intraoperative macroscopic assessment of the appendix influences surgical decision-making and provides an immediate estimate of disease severity; however, visual assessment may not reliably correspond with definitive histopathology. Misclassification may result in removal of histologically normal appendices or under-recognition of complicated disease. This audit evaluated agreement between intraoperative macroscopic appearance and postoperative histopathological diagnosis in patients undergoing appendicectomy.

Methods: A retrospective clinical audit was undertaken of 120 consecutive appendicectomy cases recorded within a single institutional dataset. Macroscopic operative findings were classified as normal appendix, simple appendicitis, or complex appendicitis (gangrenous or perforated) and compared with definitive histopathology. Three patients without histopathological examination were excluded from pathological comparison. One patient with parasitic pathology was excluded from the three-category concordance analysis, leaving 116 cases. Overall agreement and Cohen's kappa were calculated. Diagnostic performance was additionally assessed for identifying any histological appendicitis and for recognising complex appendicitis.

Results: Among 116 evaluable cases, macroscopic and histopathological classification was identical in 97 (83.6%). Agreement beyond chance was substantial (Cohen's kappa=0.707; linearly weighted kappa=0.743). Fourteen of 15 macroscopically normal appendices were histologically normal, while one demonstrated simple appendicitis. Of 72 appendices classified macroscopically as simple appendicitis, 60 were confirmed as simple disease, four were upgraded histologically to complex appendicitis, and eight were normal. Among 29 macroscopically complex cases, 23 were confirmed as complex and six were downgraded to simple appendicitis. For discrimination of any appendicitis from a normal appendix, macroscopic assessment demonstrated 98.9% sensitivity, 63.6% specificity, 92.1% positive predictive value, 93.3% negative predictive value, and 92.2% overall accuracy. For complex appendicitis, sensitivity was 85.2%, specificity 93.3%, and positive predictive value 79.3%.

Conclusions: Intraoperative macroscopic assessment demonstrated substantial agreement with definitive histopathology and was highly sensitive for the presence of appendicitis. However, specificity was comparatively limited, predominantly because macroscopically inflamed appendices were occasionally histologically normal. Clinically relevant discordance also occurred in grading disease severity, with both under- and over-classification of complex appendicitis. These findings reinforce histopathology as the definitive diagnostic standard and support routine pathological examination following appendicectomy. Standardised intraoperative documentation and prospective re-audit may improve diagnostic consistency and clarify factors associated with macroscopic-histological discordance.

Biography

Stewart Chikukuza is a surgical registrar based at Great Western Hospital, Swindon, United Kingdom, and is the presenting author of this clinical audit examining concordance between intraoperative macroscopic assessment and definitive histopathology in appendicectomy. His work on this project focuses on surgical diagnostic accuracy, clinical audit, and opportunities to improve the quality and consistency of perioperative decision-making.

Does senior surgical review prevent negative appendicectomy?

Background: Negative appendicectomy remains an important quality marker in emergency general surgery. Senior surgical review may improve diagnostic decision-making, although patients with greater diagnostic uncertainty may also be preferentially escalated. We evaluated whether consultant/equivalent review before the decision to operate was associated with a lower Negative Appendicectomy Rate (NAR).

Methods: A retrospective clinical audit of 120 consecutive appendicectomy records from a single institutional dataset was performed. Negative appendicectomy was defined as a histologically normal appendix. Three cases without histopathology and one with parasitic pathology were excluded, leaving 116 evaluable cases. The primary exposure was the most senior surgeon reviewing the patient before the decision to operate: consultant/equivalent versus a doctor with at least three years' experience but not consultant. Proportions, risk ratios, odds ratios and Fisher's exact test were used. Exploratory logistic regression adjusted for age and sex.

Results: Overall, 22/116 appendicectomies were histologically normal, giving an NAR of 19.0%. Among patients reviewed by a consultant/equivalent, 15/70 (21.4%) had a negative appendicectomy compared with 7/46 (15.2%) reviewed by a non-consultant senior surgeon, an absolute difference of 6.2 percentage points. Consultant review was not associated with lower NAR (risk ratio 1.41, 95% CI 0.62–3.19; odds ratio 1.52; Fisher's exact $p=0.474$). In exploratory adjustment, consultant review remained non-protective (adjusted OR 1.14, 95% CI 0.38–3.47; $p=0.816$), while increasing age was associated with lower odds of negative appendicectomy (adjusted OR per year 0.91, 95% CI 0.86–0.96; $p<0.001$). The observed comparison was underpowered, with wide confidence intervals.

Conclusion: In this cohort, consultant/equivalent review before the decision to operate did not reduce negative appendicectomy. The institutional NAR was 19.0%, meeting a commonly used UK audit benchmark of $<20\%$ but leaving scope for improvement. These findings should not be interpreted causally because of limited power and probable confounding by indication. Quality improvement should focus on a standardised diagnostic pathway integrating senior review with imaging, serial assessment and explicit documentation of diagnostic uncertainty, followed by prospective re-audit.

Biography

Stewart Chikukuza is a surgical registrar based at Great Western Hospital, Swindon, United Kingdom, and is the presenting author of this clinical audit examining concordance between intraoperative macroscopic assessment and definitive histopathology in appendicectomy. His work on this project focuses on surgical diagnostic accuracy, clinical audit, and opportunities to improve the quality and consistency of perioperative decision-making.



Sukanya Lakshmi Mahendran*, Afua Agyei, Nabeel Qureshi

Medway Maritime Hospital, Gillingham, Kent, United Kingdom

Large unclassified hepatocellular adenoma with spontaneous haemorrhage and necrosis in a young woman: Surgical management and post-operative surveillance challenges

Hepatocellular Adenomas (HCA) are rare benign liver tumours predominantly affecting young women of reproductive age, strongly associated with Oral Contraceptive Pill (OCP) use. Spontaneous haemorrhage and necrosis are recognised but uncommon complications, occurring in larger lesions. The unclassified subtype of HCA is particularly rare and its clinical behaviour is poorly understood.

Case Presentation: We report a case of a 27-year-old woman who presented acutely on 17th August 2025 with Right Upper Quadrant (RUQ) tenderness, pyrexia, and raised inflammatory markers with deranged liver enzymes. Computed tomography of the abdomen and pelvis (CTAP) revealed a large exophytic solid lesion in segment 6 of the liver with hyperdense areas consistent with internal haemorrhage, without evidence of rupture. The radiological features were suggestive of a benign aetiology, with hepatocellular adenoma considered the most likely diagnosis. The case was discussed with the hepatopancreatobiliary (HPB) team at King's College Hospital (KCH), and the patient was transferred to KCH where she subsequently underwent a right posterior liver sectionectomy of segments 6 and 7.

Outcome: Histopathological analysis confirmed a hepatocellular adenoma of unclassified type (105mm in total size) with extensive necrosis and intratumoural haemorrhage, with no evidence of malignancy or beta-catenin activation. The resection margins were tumour free. Post-operative recovery was uneventful. Surveillance MRI with hepatobiliary contrast performed in December 2025 demonstrated multiple bilobar hepatic lesions – the largest in segment 2/3 (7cm) consistent with Focal Nodular Hyperplasia (FNH), with remaining smaller lesions consistent with adenomas. Conservative surveillance is ongoing.

Conclusion: This case highlights the diagnostic and surgical challenges posed by large unclassified HCAs presenting with acute haemorrhage in young women. Multidisciplinary collaboration with specialist HPB centres is essential. Post-operative surveillance with MRI hepatobiliary contrast is critical given the risk of residual and de novo lesions.

Keywords: Hepatocellular Adenoma, Liver Resection, Spontaneous Haemorrhage, Unclassified HCA, Focal Nodular Hyperplasia, Hepatobiliary MRI, Young Women.

Biography

After completing medical training in India, Sukanya Lakshmi Mahendran developed a passion for surgery while working in remote and underserved communities, including the Andaman and Nicobar Islands and Northeast India, where Mahendran witnessed its transformative, permanent impact on patients' lives. Mahendran moved to the UK, joining Medway Maritime NHS Trust in 2022, progressing through CT1 and CT2 equivalent posts, obtaining MRCS, and rising to Trust Grade Surgical Registrar. Mahendran has built a strong clinical and academic foundation, with a long-term goal of specialising in colorectal surgery. In August 2026, Mahendran takes up a Clinical Research Fellowship at Wirral University Teaching Hospital.

Varunaen Udayachandran*, Naureen Mahbub

Princess Alexandra Hospital NHS Trust, Harlow, United Kingdom

Assessment of head elevation in ventilated patients

Background: Ventilator-Associated Pneumonia (VAP) remains an important complication of mechanical ventilation and is associated with increased morbidity, mortality and healthcare utilisation. Head-of-bed (HOB) elevation is a simple, low-cost intervention incorporated into ventilator care bundles to reduce the risk of pulmonary aspiration and subsequent VAP. The Faculty of Intensive Care Medicine (FICM) and Intensive Care Society (ICS) Guidelines for the Provision of Intensive Care Services (GPICS) recommend that, unless clinically contraindicated, ventilated patients should be nursed in a semi-recumbent position at 30–45°. This recommendation is supported by evidence examining semi-recumbent positioning and is incorporated into broader strategies for VAP prevention.

Aim: To assess compliance with the GPICS recommendation for HOB elevation in intubated, mechanically ventilated patients within an intensive care unit (ITU), and to identify potential barriers to achieving the recommended position.

Methods: A prospective clinical audit will be conducted in an adult ITU. Intubated and mechanically ventilated patients will be assessed for HOB elevation during the audit period. The primary outcome will be the proportion of eligible patients positioned at 30–45°. Where the HOB is below 30°, the presence of a documented clinical contraindication will be recorded. Patients for whom semi-recumbent positioning is clinically inappropriate will be excluded from assessment of compliance. Compliance will be compared against the GPICS recommendation, with results presented as the proportion of eligible observations meeting the 30–45° target.

Conclusion: HOB elevation is a simple intervention that can be incorporated into routine care of mechanically ventilated patients. Auditing adherence to the GPICS 30–45° recommendation provides an opportunity to identify variation in practice and support ongoing quality improvement in VAP prevention.

Biography

Varunaen Udayachandran is an ST3 Emergency Medicine trainee with a strong interest in Critical Care, particularly the management of critically ill patients and the interface between

Emergency Medicine and Intensive Care. Udayachandran is keen to pursue a career combining both specialties and hopes to undertake dual training in Emergency Medicine and Intensive Care Medicine, and is enthusiastic about developing experience in Critical Care and contributing to teaching, quality improvement and clinical research.

7TH EDITION OF

GLOBAL CONFERENCE

SURGERY AND ANAESTHESIA

HYBRID EVENT
24-26
SEPTEMBER 2026

POSTER PRESENTATIONS





Afua Timah Agyei*, Sukanya Mahendran, Erol Sarafat, Nabeel Qureshi

Medway Maritime Hospital, Gillingham, Kent, United Kingdom

Isolated gallbladder injury following blunt abdominal trauma: A rare surgical presentation

Background: Isolated gallbladder injury following blunt abdominal trauma is an uncommon and diagnostically challenging condition. Its clinical presentation is frequently nonspecific, mimicking other intra-abdominal pathologies, and necessitates a high index of clinical suspicion, appropriate imaging, and timely surgical input to prevent life-threatening complications.

Case Presentation: We present a case of isolated gallbladder perforation in a male in his late 40s who presented to the Emergency Department following blunt abdominal trauma sustained during a physical assault. On examination, he was haemodynamically stable with right upper quadrant abdominal tenderness. Initial investigations included laboratory blood tests and contrast-enhanced Computed Tomography (CT) of the abdomen and pelvis, which demonstrated free fluid and pericholecystic inflammatory changes consistent with gallbladder injury. No other intra-abdominal injuries were identified on imaging. The patient underwent emergency diagnostic laparoscopy and laparoscopic cholecystectomy within 14 hours of initial presentation. Intraoperative findings confirmed an isolated full-thickness gallbladder perforation at the level of Hartmann's pouch, with no associated injury to surrounding viscera or vascular structures. He made an uneventful postoperative recovery.

Conclusion: Isolated gallbladder injury secondary to blunt trauma is rare, and diagnosis requires clinical vigilance combined with cross-sectional imaging. Early surgical intervention, including laparoscopic cholecystectomy, is both safe and effective. This case contributes to the limited published literature on this injury pattern and highlights the importance of maintaining a broad differential diagnosis in patients presenting with abdominal pain following blunt trauma.

Keywords: Isolated Gallbladder Injury, Blunt Abdominal Trauma, Laparoscopic Cholecystectomy, Gallbladder Perforation, Emergency Surgery.

Biography

Afua T. Agyei is a core surgical trainee in the Kent, Surrey and Sussex Deanery, and completed primary medical education at the Kwame Nkrumah University of Science and Technology, Ghana. After completing foundation year training at 37 Military Hospital and Greater Accra Regional Hospitals, Agyei pursued a Masters in Public Health. Agyei holds memberships of the Royal College of General Practitioners and the Royal College of Surgeons and is passionate about pursuing a career in colorectal surgery, clinical research and teaching.



Arqam Shariq Syed

Aintree University Hospital NHS Trust, Liverpool, United Kingdom

Ciprofloxacin ear drops associated acute bursitis: A case report

Background: Fluoroquinolone antibiotics are associated with serious musculoskeletal adverse effects, most commonly Achilles tendinopathy. Following the 2019 MHRA and European Medicines Agency safety review, and strengthened restrictions issued in January 2024, systemic fluoroquinolones are now reserved for cases where no alternative antibiotic is appropriate. The potential for topical otic fluoroquinolone preparations to precipitate musculoskeletal toxicity remains underappreciated in clinical practice.

Case Presentation: An 18-year-old woman presented to the emergency department with a one-day history of acute left knee swelling, warmth, and pain on weight-bearing without antecedent trauma. Examination revealed periarticular swelling with localised erythema and a preserved range of motion to ninety degrees. Plain radiography demonstrated a small joint effusion with no fracture or erosions. The working diagnosis was acute bursitis. A comprehensive drug history, explicitly including topical preparations, revealed recent use of ciprofloxacin ear drops for otitis externa, which the patient had self-discontinued on noticing knee symptoms. She was treated with flucloxacillin and a non-steroidal anti-inflammatory agent. On follow-up, symptoms had improved significantly following cessation of ciprofloxacin — a dechallenge response supporting a probable adverse drug reaction on the Naranjo scale. A Yellow Card report was submitted to the MHRA and written patient consent for publication was obtained.

Discussion: Fluoroquinolone musculoskeletal toxicity is a class effect involving inhibition of tenocyte proliferation and upregulation of matrix metalloproteinases — processes relevant to both tendinous and bursal tissue. Whilst systemic absorption from otic preparations is generally considered minimal with an intact tympanic membrane, the inflamed and disrupted epithelium of the external auditory canal in acute otitis externa may permit greater systemic

absorption than is typically assumed. The temporal association and dechallenge response in this case support a probable causal relationship.

Conclusion: This case highlights two important clinical messages. First, fluoroquinolone musculoskeletal toxicity should remain on the differential even when the prescribing route is topical. Second, the drug history in any acute soft tissue presentation must explicitly include ear drops, eye drops, and other topical preparations — agents that patients rarely volunteer and clinicians rarely ask about. Suspected adverse drug reactions involving topical fluoroquinolones should be reported via the MHRA Yellow Card scheme to strengthen national pharmacovigilance data.

Biography

Arqam Syed is a salaried GP at Abercromby Family Practice, Liverpool, and a locum GP in Emergency Medicine at Aintree University Hospital NHS Trust. Syed holds MBBS and MRCGP qualifications alongside a Postgraduate Diploma in Clinical Ophthalmology from University College London, serves as an OSCE examiner at the University of Liverpool, and is completing a Master of Public Health in Occupational Health at the University of Manchester. Syed's clinical and research interests span emergency medicine, primary care, ophthalmology, and drug safety, and Syed is a Member of the Royal College of General Practitioners and an Associate Member of the Royal College of Ophthalmologists.



Caitlin McLaughlin*, Mayurey Kalaravy, James Adam, Simon Lascelles

Medway NHS Foundation Trust, United Kingdom

Optimising NELA risk stratification through enhanced accuracy in ASA grading

Background: Accurate ASA (American Society of Anaesthesiologists) grading is essential for perioperative risk assessment, anaesthetic planning, and surgical risk communication. It is also a key input in audit tools such as the National Emergency Laparotomy Audit (NELA) calculator. At a district general hospital, Year 9 NELA data (1 December 2021-31 March 2023) recorded fifteen deaths, identifying it as a potential outlier for 30-day risk-adjusted mortality. Retrospective analysis showed systematic underestimation of ASA grades, resulting in lower NELA scores. This may delay recognition of high-risk patients, affect theatre planning, and compromise postoperative care such as HDU or ICU admission. In emergency cases, anaesthetists may consider the surgeon's NELA estimate, including ASA grade, to support triage decisions. Underestimated risk may delay escalation or result in inappropriate prioritisation. We hypothesised this variability stemmed from inconsistent understanding of ASA criteria among both surgeons and anaesthetists.

Methods: A consultant-led teaching session was delivered to clinicians, covering ASA principles, common grading errors, and the clinical and audit implications of misclassification. Pre-intervention (Cycle 1), clinicians (n=25) completed a questionnaire assigning ASA grades to four anonymised vignettes drawn from the fifteen deaths in the audit cohort. Post-intervention (Cycle 2), the same questionnaire was repeated (n=6) to assess changes in grading accuracy and inter-rater agreement.

Results: Cycle 1 revealed significant inter-rater variability across both groups, with a trend toward underestimating ASA grades. Anaesthetist responses were generally more consistent than surgeons', particularly in straightforward cases.

Following the teaching intervention (Cycle 2), grading accuracy and inter-rater agreement improved in both groups. Clinicians also reported increased confidence in ASA assignment. Feedback highlighted an improved awareness of how ASA grading influences NELA scoring, anaesthetic planning, and patient safety.

Discussion: While ASA grading is inherently subjective, structured multidisciplinary teaching improved clinicians' understanding and reduced variability. This supports more accurate risk stratification, safer perioperative planning, and improved data quality. Anaesthetic-led initiatives can strengthen cross-specialty collaboration and promote shared responsibility for accurate preoperative assessment.

Biography

Dr Caitlin McLaughlin is a Core Surgical Trainee in the Kent, Surrey and Sussex Deanery with a strong interest in colorectal surgery. Alongside clinical training, McLaughlin is passionate about medical education and spent a year working as an Education Fellow, supporting the development and delivery of teaching programmes for healthcare professionals. McLaughlin is committed to promoting collaboration across specialties and departments, recognising the value of strong inter-departmental relationships in improving patient care and professional development.



Caitlin McLaughlin*, Mayurey Kalaravy, James Adam, Simon Lascelles

Medway NHS Foundation Trust, United Kingdom

Enhancing foundation doctor confidence in acute surgical management through a structured simulation programme

Background: UK Foundation doctors rotating through surgical specialities have reported low confidence in assessing and managing acute surgical presentations. High-fidelity simulation provides a safe and supportive environment in which trainees can practise the recognition and management of acute clinical presentations, facilitating the development of clinical reasoning, decision-making and non-technical skills. At Medway Maritime Hospital, a district general hospital in Kent, no structured simulation-based teaching programme existed for Foundation Year 1 (FY1) or Foundation Year 2 (FY2) doctors undertaking a general surgery rotation. This represented an opportunity to provide targeted, specialty-specific training to support trainees in managing common acute surgical presentations.

Aims: To design, implement and evaluate a structured surgical simulation programme for Foundation doctors during their four-month general surgery rotation, assessing its impact on confidence in managing common acute surgical presentations.

Methods: All Foundation doctors rotating through general surgery (n=19; 18 FY1, 1 FY2) attended a high-fidelity simulation programme comprising three scenarios based on common acute surgical presentations: postoperative bleeding, post-ERCP pancreatitis with sepsis, and postoperative deterioration. Scenarios incorporated technical skills (A-E assessment, Sepsis Six and major haemorrhage protocol) and non-technical skills (situational awareness, communication, prioritisation and escalation). Matched pre- and post-course surveys assessed self-reported confidence across seven domains using a 1–10 numerical rating scale: assessment of acutely unwell surgical patients; time-critical decision-making; reviewing patients in A&E and on the wards; accepting and rejecting referrals; and adding

patients to the CEPOD list without senior review. All responses were matched (19/19). Mean scores and percentage change were calculated for each domain. Post-course evaluation assessed scenario realism, course level, faculty facilitation and debriefing, and overall course quality.

Results: Self-reported confidence improved across all seven domains. The greatest relative improvements were observed in adding a patient to the CEPOD list without senior review (2.63 to 4.21; +60.0%), rejecting referrals (2.58 to 4.00; +55.1%), and making time-critical surgical management decisions (4.53 to 6.95; +53.5%). Confidence in assessing acutely unwell surgical patients increased from 5.42 to 7.16 (+32.0%). Mean composite confidence across all seven domains increased from 4.49/10 pre-course to 5.92/10 post-course (+31.8%). Individual confidence increased in 18/19 participants (94.7%), with one participant reporting no change. Course evaluation was strongly positive, with mean ratings of 7.9/10 for scenario realism, 9.0/10 for course level, 9.4/10 for faculty facilitation and debriefing, and 9.6/10 for overall course quality. All participants (19/19; 100%) would recommend the course to colleagues at their level. Free-text feedback highlighted improved escalation skills, clearer application of an A–E assessment and greater confidence in managing acute postoperative deterioration.

Discussion: A structured high-fidelity simulation programme was associated with improved self-reported confidence among Foundation doctors across all assessed domains of acute surgical management. The greatest improvements occurred in areas involving referral decision-making and CEPOD listing, suggesting value in addressing challenging aspects of the Foundation surgical role. Embedding specialty-specific simulation early within the general surgery rotation may enhance trainee confidence and clinical decision-making, with potential benefits for patient safety.

Biography

Caitlin McLaughlin is a Core Surgical Trainee in the Kent, Surrey and Sussex Deanery with a strong interest in colorectal surgery. Alongside clinical training, McLaughlin is passionate about medical education and spent a year working as an Education Fellow, supporting the development and delivery of teaching programmes for healthcare professionals. McLaughlin is committed to promoting collaboration across specialties and departments, recognising the value of strong inter-departmental relationships in improving patient care and professional development.



Dennis Shadokpam*, M.S. Raghuraman

Sree Balaji Medical College and Hospital, Chromepet,
Chennai-600044, India

Anaesthetic management of splenectomy across diverse clinical scenarios: A case series of four patients

Background: Splenectomy is performed for a broad range of emergency and elective conditions, each presenting distinct perioperative challenges. Anaesthetic management must be individualized according to the underlying pathology, physiological derangements, and associated comorbidities. This case series highlights tailored anaesthetic strategies employed in four diverse clinical scenarios.

Methods: Four patients undergoing splenectomy were managed using individualized perioperative anaesthetic protocols. The indications included splenic abscess with sepsis and active pulmonary tuberculosis, hereditary spherocytosis with severe haemolytic anaemia, traumatic splenic rupture with haemorrhagic shock, and immune thrombocytopenia refractory to medical therapy. Preoperative optimization, intraoperative monitoring, anaesthetic techniques, transfusion strategies, and postoperative care were adapted to each patient's clinical condition.

Results: All patients underwent successful splenectomy under general anaesthesia with disease-specific perioperative management. Invasive haemodynamic monitoring and blood component therapy were instituted when indicated. Careful optimization, vigilant monitoring, and multidisciplinary collaboration contributed to favourable intraoperative and postoperative outcomes. No major anaesthetic complications occurred. All patients demonstrated satisfactory recovery with favourable clinical and haematological outcomes during follow-up.

Conclusion: Successful anaesthetic management of splenectomy depends on understanding the underlying disease rather than the surgical procedure alone. Individualized perioperative planning, meticulous physiological optimization, appropriate monitoring, targeted transfusion strategies, and multidisciplinary coordination are essential for ensuring safe outcomes across

diverse clinical scenarios. This case series emphasizes the importance of a pathology-based anaesthetic approach in both elective and emergency splenectomy.

Keywords: Splenectomy, Anaesthesia, Case Series, Hemorrhagic Shock, Thrombocytopenia, Perioperative Management.

Biography

Dr. Dennis Shadokpam is a postgraduate trainee in the Department of Anaesthesiology. Shadokpam has a keen interest in perioperative medicine, regional anaesthesia, trauma anaesthesia, and critical care, is actively involved in clinical research and academic activities, and has presented scientific work at conferences. Shadokpam's research focuses on improving perioperative patient safety and optimizing anaesthetic management in complex surgical cases.



Devki Patel*, Ahmad Zaghal

Texas Tech Health Sciences School of Medicine, USA

Transrectal excision of a foreign body lodged in the retrorectal space in a pediatric patient

Penetrating injuries to the gluteal and perineal regions are uncommon in pediatric patients, and involvement of the presacral (retrorectal) space is particularly rare. Due to its anatomically concealed nature and capacity to accommodate injury with minimal early symptoms, diagnosis and management can be challenging. There is no standardized approach for surgical access or consensus regarding the role of mechanical bowel preparation in cases involving transrectal intervention.

We report the case of an 11-year-old female who sustained a transgluteal impalement injury after accidentally sitting on a sharpened pencil, resulting in a retained fragment within the presacral space. Initial evaluation revealed a hemodynamically stable patient with minimal symptoms despite significant injury. Imaging demonstrated a fractured pencil with one segment lodged deep in the presacral space. A staged surgical approach was employed. The first procedure included examination under anesthesia, flexible sigmoidoscopy confirming an intact rectum, and removal of the externally accessible fragment. Following bowel preparation and continued antibiotic therapy, a second operation was performed using a transrectal approach with posterior rectal wall incision to retrieve the retained fragment. The rectal wall was repaired primarily. The patient had an uncomplicated postoperative course and complete recovery without evidence of infection or functional impairment.

This case highlights the diagnostic and management challenges of presacral foreign bodies in pediatric trauma. The transrectal approach provided direct access to a low-lying presacral object while avoiding more invasive abdominal or posterior approaches. Staging the intervention allowed confirmation of rectal integrity and optimization of surgical conditions with bowel preparation, potentially reducing infectious risk. Given the rarity of such injuries, management must be individualized, with careful consideration of anatomy, injury trajectory, and patient stability.

Transrectal retrieval of presacral foreign bodies is a safe and effective option in select pediatric cases with low-lying pathology and intact rectal wall. A staged approach incorporating initial assessment and delayed definitive management may optimize outcomes. This case underscores the importance of thorough evaluation of seemingly minor penetrating injuries and contributes to the limited literature guiding management of pediatric presacral trauma.

Biography

Devki Patel (BS, MPH in progress, MD in progress) is a first-year medical student at Texas Tech Health Sciences Center School of Medicine in Lubbock, Texas. Patel is interested in going into pediatric surgery and has a passion for ensuring equitable access to healthcare for children. Outside of medicine, Patel's hobbies include baking, boxing, and traveling; when not in school, Patel can often be found at the gym or in a different country.



**Di (Jasmine) Yuan*, Lachlan
Conners, Amelia Tuffley, Vibhu
Goel, Danielle Scott**

Department of Anaesthesia, Mater Hospital Brisbane,
Raymond Terrace, South Brisbane, Queensland, Australia

Compliance with surgical antibiotic prophylaxis guidelines in bowel resection surgery: A retrospective audit

Introduction: Perioperative antibiotic prophylaxis is essential in reducing Surgical Site Infections (SSI) and postoperative morbidity following bowel surgery. Institutional and national guidelines emphasise appropriate antibiotic selection, timing, dosing, and intraoperative redosing. While initial antibiotic administration is often prioritised, compliance with redosing recommendations is less consistently achieved.

Aim: To assess compliance with surgical antibiotic prophylaxis guidelines in patients undergoing bowel resection and to explore associations between antibiotic non-compliance and postoperative outcomes.

Methods: A retrospective observational audit was conducted at Mater Hospital including adult patients who underwent elective or emergency bowel resection between 1 January 2024 and 1 January 2025. Data collected included demographics, comorbidities, surgical characteristics, antibiotic selection, timing relative to incision, dosing, intraoperative redosing, and concordance with institutional and national guidelines. Primary outcomes were SSI and length of stay. Secondary outcomes included Systemic Inflammatory Response Syndrome (SIRS), sepsis or septic shock, ICU admission, Acute Kidney Injury (AKI), unplanned readmission, and mortality.

Results: Sixty-seven patients were included. Intraoperative antibiotics were administered in 97% of cases, with 95% given within 60 minutes prior to incision; most timing breaches occurred in emergency cases (80%). Guideline-compliant antibiotic selection occurred in 87.7% of cases, and initial dosing was appropriate in all patients. Forty-four patients met criteria for intraoperative redosing, of whom 68.2% were appropriately redosed. Overall, only 41.8% of patients received fully guideline-concordant prophylaxis.

The non-compliant cohort demonstrated higher rates of SIRS, sepsis or septic shock, ICU admission, AKI, and mortality. Although SSI appeared higher in patients receiving appropriate dosing and redosing, this group had greater illness severity, including planned ICU admissions. Among patients requiring redosing, no meaningful difference in SSI rates was observed between appropriately and inappropriately redosed groups. SSI occurred more frequently in patients with hospital stay ≥ 15 days, with no infections observed in stays < 7 days.

Conclusion: Compliance with initial antibiotic timing and dosing in bowel resection surgery was high; however, intraoperative redosing compliance was suboptimal. Antibiotic non-compliance was associated with worse clinical outcomes. Targeted quality improvement initiatives focusing on redosing practices may enhance patient safety and postoperative outcomes.

Biography

Dr Di (Jasmine) Yuan is an Intensive Care Principal House Officer (PHO) at Mater Hospital Brisbane with a strong interest in anaesthesia, intensive care, and perioperative medicine. Yuan is actively involved in clinical audits and research focusing on antimicrobial stewardship, perioperative anaemia, and critical care outcomes, and is passionate about medical education and quality improvement initiatives that enhance patient safety and support junior doctor development.



Muhammd Osama Wali Zada

Hangzhou Medical College, China

Utilizing a 3D printed laparoscopic Nissen fundoplication model to shorten a resident's learning curve

Laparoscopic Nissen Fundoplication (LNF) requires extensive training for surgical proficiency, with significant early learning curve complications. A structured training protocol utilizing a 3D-printed anatomical model is described and designed to accelerate the acquisition of advanced laparoscopic skills. The protocol entails the production and assembly of models incorporated into an LNF-specific training curriculum focused on critical components involving advanced suturing skills. The model includes anatomically accurate landmarks, all fabricated using specialized silicon materials. A step-by-step training curriculum is presented, focused on mastering the most challenging components of LNF, including crural closure, mesh suturing, and the fundoplication wrap. Representative results from a pilot participant demonstrate a quantifiable learning curve, with total performance scores improving from 21 to 42 and procedural time decreasing from 95 to 34 min across six sessions, systematically approaching the expert benchmark. The overall efficacy of this training paradigm was validated in a comparative study, where the 3D-printed model trained group demonstrated significantly superior Objective Structured Assessment of Technical Skills (OSATS) scores in the operating room (26.25 ± 1.67 vs. 17.50 ± 2.07) and shorter procedure durations (76.25 ± 2.49 vs. 110.13 ± 3.36 min) compared to a control group, confirming the protocol's positive impact on clinical skills. This validated protocol provides a reproducible method for implementing an effective LNF training program capable of measuring and facilitating progressive skill development.

Biography

Muhammd Osama Wali Zada completed a bachelor degree (MBBS) in China and is pursuing a Master's degree in Basic Medicine at Hangzhou Medical College. Wali Zada's academic

and clinical interests focus on gastrointestinal surgery, Gastroesophageal Reflux Disease (GERD), and medical simulation-based education. Wali Zada actively involved in surgical training research, particularly in the development and application of 3D-printed anatomical models to improve laparoscopic skill acquisition. Wali Zada recent work includes a study on a 3D-printed laparoscopic Nissen fundoplication model designed to shorten the learning curve for surgical trainees. Wali Zada is interested in integrating medical education, surgical innovation, and data-driven approaches to enhance training efficiency and patient outcomes.

**Nida Selina Sultani*, Leonora Michelle de Bruin,
Meera Goutham, Durgesh Raje**
London North West Trust, United Kingdom

Compliance of surgical operative notes to Royal College of Surgeons' Good Surgical Practice standards in Ealing Hospital

Accurate comprehensive operative documentation is essential for patient safety, continuity of care, and medico-legal practice. The Royal College of Surgeons of England (RCSEng) outlines clear guidelines for operative notes. This ensures continuity of care by another doctor and examples but not limiting include operative diagnosis, antibiotic prophylaxis etc. This re-audit evaluated compliance of general surgical operative notes at Ealing Hospital with Royal College of Surgeons of England (RCSEng) Good Surgical Practice standards. Following an initial audit identifying significant documentation gaps, targeted interventions were implemented, including departmental teaching, email reminders, and visual prompts in theatre areas. This re-audit analyses the effects of our implementation.

A re-audit was retrospectively gathered for 100 consecutive operative notes over a 2-week period over 20/09/2024 - 04/10/2024 using Cerner operation notes.

Despite interventions major areas of non-compliance persisted, notably documentation of elective versus emergency status, anticipated blood loss, antibiotic and DVT prophylaxis, and clinician signatures. This is crucial to ensure NICE guidelines are adhered to. Significant reduction was seen with documentation of anticipated blood loss (-33% reduction). Only 13% of documentation highlighted whether it was an elective or emergency operation. Furthermore only 29% of DVT prophylaxis was documented which was an improvement from 1st audit. This is significant given the risk of VTE. Key areas demonstrating partial improvement included identification of prostheses (42% improvement), and recording of the theatre anaesthetist. These findings highlight the ongoing need for structured documentation tools and continued education to improve operative note quality and patient safety.

Biography

Nida Selina Sultani is a Locum F3 doctor working in North West London. Sultani completed a degree in Biomedical Sciences at King's College London, with a focus on pharmacology, before going on to study Medicine at University College London. Sultani's academic interests

lie in patient care and particularly the role of therapeutics in surgical and peri-operative care. Sultani currently works across a range of clinical settings while developing interests in evidence-based practice and multidisciplinary patient care.

WE WISH TO MEET YOU AGAIN AT OUR UPCOMING EVENT

8th Edition of Global Conference on
Surgery and Anaesthesia
September 2027 | Hybrid Event
<https://surgeryconferences.magnusgroup.org/>

Conference Hub



Scan for • Program • Abstract Book
• Zoom Links • Updates

LONDON, UK



Questions? Contact

Phone: +1 (702) 988-2320 | Whatsapp: +1 (640) 666-9566

E-mail: surgery@magnusconference.com