

GCSA 2019

GLOBAL CONFERENCE ON
SURGERY AND **ANAESTHESIA**

Theme:

Pioneering Advances in Surgical and Anaesthesia Research

Millennium Airport Hotel Dubai, Casablanca St. Al Garhoud,
P.O.Box 13018, Dubai, UAE



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DUBAI **UAE**

EXHIBITORS



Global Conference on

SURGERY AND
ANAESTHESIA

Theme:
*Pioneering Advances in Surgical and
Anaesthesia Research*

OCTOBER 21-23, 2019
DUBAI, UAE

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Na Homolce Hospital, Czech Republic



Ramanathan Kasivisvanathan

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Clive A. L. Thomas

Linstead Hospital West Indies



Soojin Park

Asan Medical Center Korea

Thank You
All...

Welcome Message



Dear friends and colleagues,

It is with pleasure that I would like to warmly welcome you to the Global Congress on Surgery and Anesthesia 2019 in wonderful Dubai.

During this week many different specialties are joining here to share their excellent clinical work, innovation and future proceedings.

The world of health care is rapidly changing, not only with new technology but also, the integration of mobile apps, for fast interaction with patients, technical investigations and follow up seems unstoppable. We are quickly evolving into a new era of medicine, even more patient centered and tailored to the individual. As health care becomes more complex and multifaceted it is of the utmost importance to interact with all colleagues as one treatment might influence the other.

With my background in spine surgery I am convinced that new technology will provide new ways of treatment and medicine is changing at a fast pace. We do have to remain careful however not to shift too fast and only implement emerging technology after adequate research.

The best is yet to come!

Ricky Rasschaert
ZNA Middelheim, Belgium

Welcome Message



Welcome Message

Dear Participants of GCSA 2019. It is a pleasure for me to welcome you to the Global Conference on Surgery and Anaesthesia in Dubai. This conference brings together people from different fields and various viewpoints, interested in the areas of advances in surgery and anesthesia. In a world of changing climate –as well as changing perception of information –it is the responsibility of all of us to uncover and evaluate the advances in these areas.

GCSA 2019 gives us the opportunity of learning and sharing knowledge and with my own focus in maternal and child health many other topics will be presented and should lead to inspiring discussions. Mutual collaborations will be initiated at the conference, and this will pave the way to future scientific progress.



Situated in the city of Dubai, GCSA will stimulate scientific exchange between the participants by the lively atmosphere of this exciting city. Being an organizing committee member I look forward to meeting you in Dubai.

T. P. Chiang
Theresa P. Chiang

Canada China Child Health Foundation
Canada

Keynote Speakers



Theresa P. Chiang
Canada China Child Health
Foundation, Canada



Andy Higgs
Warrington Hospitals NHS FT,
UK



Ricky Rasschaert
ZNA Middelhim
Belgium



Kuriakose Joshi George
Salford Royal NHS Foundation
Trust, UK



Matthew S Broadhurst
Queensland Voice Centre
Australia



Basil J. Ammori
King Hussein Cancer Center
Jordan



Ramanathan Kasivisvanathan
The Royal Marsden NHS Foundation
Trust, UK



Sagar Jawale
Jawale Institute of Pediatric
Surgery, India



Osman Ahmed
Mrh Tullamore
Ireland



About MAGNUS GROUP

Magnus Group (MG) is initiated to meet a need and to pursue collective goals of the scientific community specifically focusing in the field of Sciences, Engineering and technology to endorse exchanging of the ideas & knowledge which facilitate the collaboration between the scientists, academicians and researchers of same field or interdisciplinary research. Magnus group is proficient in organizing conferences, meetings, seminars and workshops with the ingenious and peerless speakers throughout the world providing you and your organization with broad range of networking opportunities to globalize your research and create your own identity. Our conference and workshops can be well titled as 'ocean of knowledge' where you can sail your boat and pick the pearls, leading the way for innovative research and strategies empowering the strength by overwhelming the complications associated with in the respective fields.

Participation from 90 different countries and 1090 different Universities have contributed to the success of our conferences. Our first International Conference was organized on Oncology and Radiology (ICOR) in Dubai, UAE. Our conferences usually run for 2-3 days completely covering Keynote & Oral sessions along with workshops and poster presentations. Our organization runs promptly with dedicated and proficient employees' managing different conferences throughout the world, without compromising service and quality.

About GCSA 2019

GCSA 2019 is designed for those surgeons passionate about connecting with brilliant minds, learning about ground-breaking advances and building a successful practice. Our goal is for you to return home with renewed passion, enhanced skills, and ideas for practice growth.

The Theme of the conference is "Pioneering Advances in Surgical and Anaesthesia Research" which provides a fresh and diverse educational programme packed full with renowned scientific speakers, expert panels, concurrent sessions and skills-based workshops, poster session, the conference will keep you up to date with the latest scientific research, innovations and clinical skills that you can take back to your workplace.



ABOUT EXHIBITOR



High tech medical device company, Engineered, produced, sterilized, and controlled all in Italy. Our vision is to introduce new technology & improve the actual, we strongly support the better product make better Life. We are providing the right products for each market with highest technology. Customer talk we listen and we provide custom made products. We support our partners with sales and marketing organization that will help the local distributor to educate the end user.

ABOUT EXHIBITOR



Operation Smile has provided hundreds of thousands of safe surgeries for those born with cleft lip and cleft palate. With more than three decades of expertise, Operation Smile creates solutions that deliver free surgery to people where it's needed most. As one of the largest medical volunteer-based nonprofits, Operation Smile has mobilized thousands of medical volunteers from a wide range of medical specialties from more than 80 countries. Operation Smile engages public-private partnerships to advance health care delivery, train local medical professionals to provide surgical care for patients in their communities, donate crucial medical equipment and supplies, and increase access to surgical care so that everyone living with cleft is treated. Visit [HYPERLINK "http://www.operationsmile.org/"](http://www.operationsmile.org/) operationsmile.org, find us on Facebook or follow us on Instagram and Twitter

DAY 1

KEYNOTE FORUM

GLOBAL CONFERENCE ON

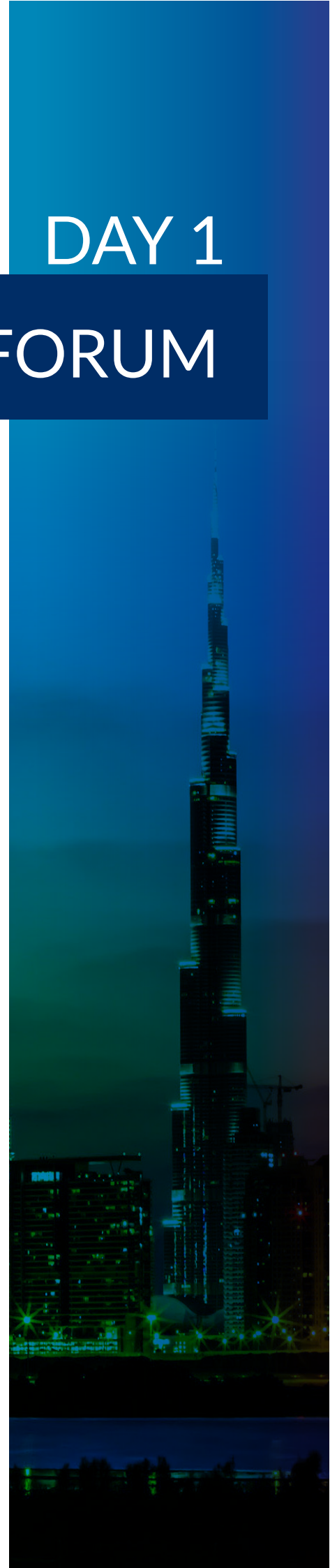
SURGERY AND ANAESTHESIA

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Biography

BSc, DDS, Doctorate in Dental medicine(Dalhousie University Canada), Master of Science (Epidemiology) Harvard University, Post doctorate studies at the Massachusetts Institute of Technology(MIT) Cambridge Mass, Teaching Fellow in Pediatric Dentistry, Harvard School of Dental Medicine/Boston Children's Hospital American pediatric dentistry Fellow. China's consultant in Preventive Dentistry Steering Committee. Honorary president of China's Nanjing Stomatology hospital, Nanjing Medical University, Emeritus of the University of B.C, Honorary professor/consultant of the Beijing children's Hospital, Beijing Institute of Pediatrics, Harbin Children's Hospital ;Guangzhou Maternal and Child Health Institute & children's Hospital, Tianjin children's Hospital, Children's Hospital of Dalian, Nanjing Maternal and Child Health hospital, Maternal and Child Health hospital of Wuhan, Suzhou health College. Chongqing Medical University children's Hospital. Winner of Lewis Perinbam Award for International Development from WUSC

Oral surgical role in cleft lip/palate management

Dr. T.P. Chiang

Canada China Child Health Foundation, Canada

Cleft lip and palate is a common congenital maxillofacial deformity. There is serious tissue defects with loss of maxillary bone segment and tissue displacement involved, affecting both appearance and function. This deformity causes major challenges because of associated problems, i.e. feeding, conduct disorder, high treatment cost, ear infection, hearing loss, language difficulty. The prevalence of cleft lip/palate is extremely high.

With the advancement of science and technology, new surgical techniques and treatments greatly improve the effectiveness of treatment of cleft lip/palate. The current approach to cleft lip and palate treatment include restoration of physical appearance and function, psychological problem, and changes in growth and development. Optimal management utilizing an integrated and collaborative/multidisciplinary approach is particularly important and this collaborative team involves: anesthesiologist, pediatric dentist, orthodontist, speech pathologist, audiologist, feeding nurse, pediatrician, otolaryngologist and the surgical team involve the plastic and oral maxillofacial surgeon.

Cleft lip and palate sequential treatment approaches different growth stages with different therapeutic targets. Neonatal period pursue physical appearance/ functionality; prepubertal period guide dental arch form development and completion of alveolar bone graft; puberty aims at the improvement of function; orthognathic surgery repair takes place following growth and development completion. Following are the roles of Maxillofacial surgeon in the treatment of cleft patients: Performs secondary alveolar bone grafts, combines effort with the orthodontist to correct facial skeletal deformities, augments bone and places implants with the prosthodontist.

This program was initially introduced to China in 1999 through multiple exchange programs with Canada and the US starting at the Guangzhou Children's Hospital. Later this was followed by Harbin Children's hospital, Qinghai Children's Hospital, Beijing Children's Hospital and the Chongqing University Children's Hospital. Up to now there has been an impressive treatment load of over 10,000 children at the Guangzhou maternal child health center /Children's hospital alone.



Biography

Dr. Higgs studied Medicine at Liverpool University Medical School, UK and graduated MB ChB in 1989. He then trained in Anesthesia & Intensive Care Medicine in Northern England and Melbourne, Australia. He was awarded his Fellowship of the Royal College of Anaesthetists in 1995 and Fellowship of the Faculty of Intensive Care. He is a Consultant in Anesthesia & ICM and has an interest in airway management, co-authoring the world's 1st guideline on tracheal intubation and the leading the group producing the UK's 1st national multi-disciplinary intubation guideline (above).

Tracheal intubation in critically ill adults. The 2018 national airway guideline from the difficult airway society, intensive care society, faculty of intensive care medicine & the royal college of anesthetists

Dr Andy Higgs

Warrington Hospitals NHS FT, United Kingdom

The 4th National Audit Project of the Royal College of Anaesthetists assessed major complications arising from airway management in the UK over a 12 month period and demonstrated that tracheal intubation in the ICU and Emergency Department was associated with exceptionally high levels of death and significant morbidity, compared to that in the OR. This is mirrored by experience throughout the world. In response to this, the Difficult Airway Society and Royal College, together with the 2 UK Intensive Care stakeholders (Intensive Care Society & Faculty of Intensive Care Medicine) commissioned a guideline to address this problem. This Working Party studied this issue for just over 3 years and published the guideline in January 2018.

The reasons for this high rate of complications are discussed and a systematic approach to avoiding these are covered.

It includes assessment of the airway and the implications for potentially complicated airway management, optimal use of newer technologies like video-laryngoscopy and best practice for maintaining oxygenation during the intubation attempt.

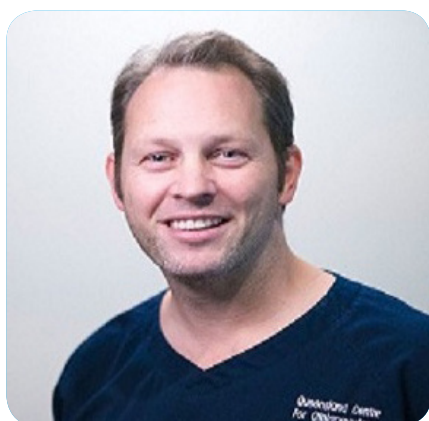
Human Factors are a major element in minimising death and other serious complications, and this is addressed in detail.

A new intubation algorithm was developed which includes elements of the Vortex Approach, together with how best to acutely rescue difficult or failing airway management in critically ill adults. Optimal techniques for emergency surgical access to the airway are also covered.

The specific area of tracheal intubation in the critically ill obese patient is described, together with burns and those with potential cervical spinal trauma. This has been very well received and adopted as the standard in 20 countries in Latin America.

Audience Take Away:

- Explain the high incidence of death and severe morbidity associated with efforts to intubate patients in ICU and in the ED
- I will outline evidence-based approaches to minimizing this high complication rate
- I will discuss how to optimize the airway team's success
- I will underline how the latest equipment can be best used to minimize avoidable deaths and critical incidents



Biography

Dr Matthew Broadhurst is a fellowship trained laryngeal and upper airway surgeon specializing in laryngeal surgery, voice restoration and obstructive sleep apnea. He returned to Brisbane, Australia from Boston, Massachusetts in 2007 having worked for 2 years at Harvard Medical School and Massachusetts General Hospital. He was the first fellowship trained laryngeal surgeon in Australia and now has a large tertiary referral practice in voice and larynx disorders and sleep apnea. In his practice, he utilizes state of the art techniques in surgery to the airway and is actively involved in clinical research and education both nationally and internationally. His areas of special interest and research include KTP laser for dysplasia and glottic cancer, short and long term management of vocal fold paralysis, phonotraumatic lesions in professional voice users and laryngeal papilloma.

Oncologic efficacy of KTP laser in early glottic cancer

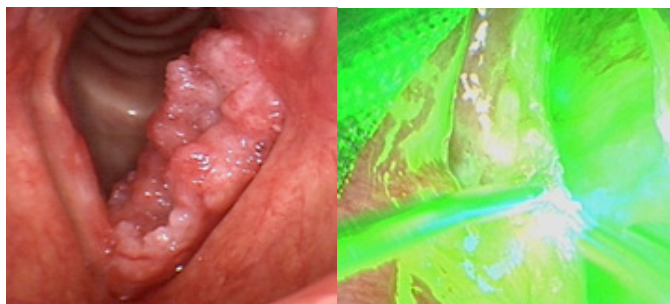
Dr Matthew S Broadhurst, MBBS, FRACS (ENT)

Queensland Voice Centre, Australia

Early glottic cancer (T1,T2) is typically managed by curative-intent radiotherapy or CO2 laser resection. Disease control rates and voice outcomes are comparable. KTP laser treatment of early glottic cancer has shown promise with similar control rates in limited studies. This study presents the largest series outside its conception in Boston, USA.

Methodology: A retrospective chart review analyzed treatment outcome of consecutive patients with early glottic cancer (T1-2 NOMO). Pre-treatment videostroboscopy and voice handicap index were compared 2 years following treatment. Recurrence, progression to radiation or open surgery and mortality were recorded.

Results: For 61 patients (average age 61 years, 59 males) 34=T1a, 15=T1b, 9=T2a and 3=T2b. Three had prior irradiation and were excluded. Four patients had recurrence(6.9%):two CIS(treated with repeat KTP laser surgery), two SCC(one recurrence progressed to open partial resection and chemo radiotherapy with subsequent total laryngectomy for a non-functioning cancer-free larynx, one recurrence progressed to total laryngectomy within 1 year, and then chemotherapy for extensive loco-regional recurrence 3 months later. Primary KTP laser treatment provided 100% disease-free survival at 2 years, larynx preservation of 96.5% and post-surgery radiation at 2%. Radiotherapy was preserved as a future option in 98% of patients (100% in T1, 91.6% of T2). The cure rate was 96.5 % (2 year minimum follow-up).



Conclusion: This study provides further data supporting oncological efficacy of KTP laser treatment in early glottic cancer. Recurrence and salvage total laryngectomy rates are low with the former often amenable to repeat KTP laser treatment. There is minimal requirement for post-surgery radiation allowing its preservation as a future treatment in 98%.

Audience Take Away:

- A novel neuroimaging technique
- Dopamine neurotransmission and its influence on addiction
- Help audience use a novel technique to study the brain mechanism of addiction



Biography

Dr. Basil Ammori graduated with MB ChB degree from Baghdad University, Iraq in 1986. He undertook his surgical training in the UK, completed an MD degree from Leeds University and his CCST in 2000, and became a Consultant Laparoscopic, Bariatric and Hepatopancreatobiliary Surgeon in Manchester, UK 2000-2017. He joined King Hussein Cancer Center in Jordan as a Gastrointestinal Surgeon in November 2017. He was granted a Hunterian Professorship by the Royal College of Surgeons of England in 2000 and appointed as Honorary Professor of Surgery at Manchester University, UK in 2011. He has over 170 publications in peer-reviewed medical journals.

The role of laparoscopic metabolic surgery in treating type-2 diabetes: An evidence update

Basil J Ammori

King Hussein Cancer Centre, Jordan

Type-2 diabetes (T2D) is one of the most important and frequent comorbidities associated with morbid obesity, and both conditions are increasing in prevalence worldwide. Whilst the medical therapy for T2D continues to evolve and expand, the role of laparoscopic metabolic surgery in treating patients with T2D is increasing. We present an updated evidence-based practice that defines the role of laparoscopic metabolic surgery in the management of morbidly obese patients with T2D and compare its outcomes with that of contemporary best medical practice. The repertoire of surgical procedures includes gastric bypass, sleeve gastrectomy, duodenal switch and others; the pathophysiology behind their glycaemic control is discussed. The choice of surgical procedure is investigated based on the current evidence. In addition, the impact of surgery on long-term mortality and its role in preventing the onset of T2D in the morbidly obese subject is discussed.

Audience Take Away:

- Appreciate the role of metabolic surgery in managing patients with uncontrolled type-2 diabetes
- Appreciate the selection criteria for the laparoscopic metabolic surgery in diabetic subjects
- Appreciate the basis for best choice of surgical procedure
- Appreciate the role of metabolic surgery in long-term prevention of onset of type-2 diabetes in morbidly obese subjects

DAY 1

SPEAKERS

GLOBAL CONFERENCE ON

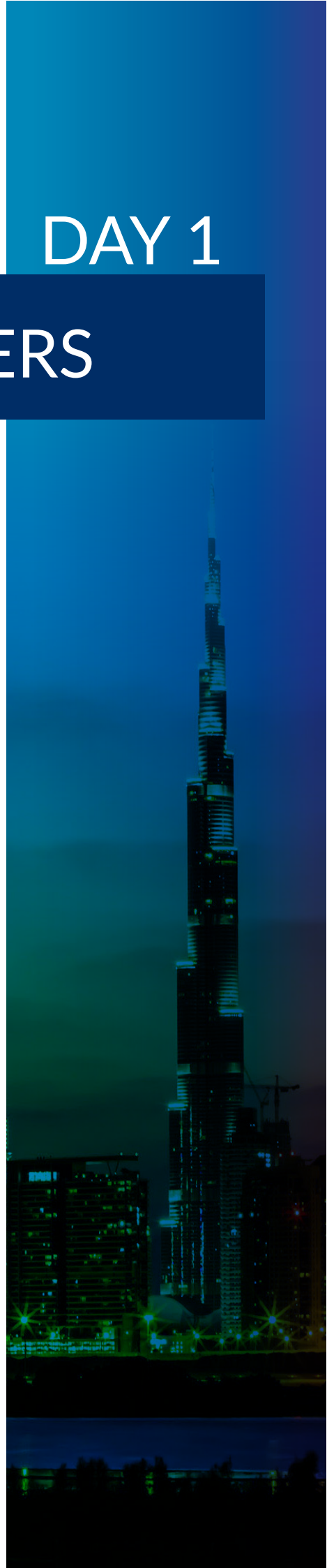
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One Lung Ventilation in Children - techniques and management

Dinesh K Choudhry MD; FRCA (Eng.)

Pediatric Anesthesiologist and Director of Pain Service
Department of Anesthesiology & Perioperative Medicine
Nemours A.I.DuPont Hospital for Children, Wilmington, DE
Professor of Anesthesiology & Pediatrics
Sidney Kimmel Medical College at Thomas Jefferson University

Thoracic surgery is being performed in increasing spectrum of pediatric patients. Over the years, indications for video assisted thoroscopic surgery (VATS) has increased exponentially and one lung ventilation (OLV) is frequently performed to facilitate surgical exposure or to isolate diseased lung from healthy lung to prevent soiling. OLV refers to mechanical separation of two lungs to accomplish ventilation of only one lung while the surgical lung is allowed to passively deflate. My goal in the presentation would be talk about:

- Physiology of OLV in children
- Various devices available for OLV in infants and children
- Pros and cons of various techniques
- Various strategies to optimize oxygenation

Audience Take Away:

- The audience will learn various devices that are available to accomplish OLV in infants and children
- Pros and cons of these devices
- Various measures that can be adopted to minimize the likelihood of hypoxia during OLV in children

Biography

Professor of Anesthesiology and Pediatrics; Sidney Kimmel Medical College at Thomas Jefferson University. Pediatric Anesthesiologist and Director of Pain Service at Department of Anesthesiology & Perioperative Medicine, at Nemours A.I.DuPont Hospital for Children, Wilmington, DE. Have several publications in the field of pediatric anesthesiology in various indexed journals.

Training:

MD Anaesthesiology All India Institute of Medical Sciences, Delhi, India

F.R.C.A. (England) - worked in the United Kingdom for five years

F.F.A.R.C.S.I. (Ireland)

Certification - American Board of Anesthesiology

Certification – American Board of Pediatric Anesthesiology

Robotic-assisted 3-hole Esophagectomy for Cancer

Olusola Oduntan, MD, FACS
University of Florida, USA

Esophageal cancer is the sixth leading cause of cancer death worldwide. Esophagectomy remains the standard for the long-term survival of patients with early stage and advanced esophageal cancer, and improved perioperative care and advanced surgical techniques have contributed to reduced postoperative morbidity. However, despite these advances, esophagectomy continues to be associated with significant morbidity and mortality.

Minimally invasive esophageal surgery has been increasingly used in patients undergoing surgery for esophageal cancer. Potential advantages include the decreased postoperative pain, lower postoperative wound infection, decreased pulmonary complications, and decreased length of hospitalization.

Robotic esophagectomy is an increasingly used minimally invasive modality. Patients who are candidates for traditional, open esophagectomy are typically also candidates for robotic esophagectomy. Knowledge of and training on the robotic platform is critical for success.

Robotic-assisted 3-hole esophagectomy with anastomosis in the neck is a safe and feasible method of minimally-invasive esophagectomy. In this video presentation, we describe our technical approach to a robotic-assisted 3-hole esophagectomy describing the thoracic and abdominal phases of the operation, and the anastomosis on the left side of the neck. We also review the most recent clinical outcomes of this approach and make comparisons with other techniques. Advantages and disadvantages to robotic esophagectomy are discussed.

Minimally invasive and uterus-preserving techniques in pelvic floor surgery

Pawel Szymanowski MD, PhD

Department of Gynecology and Urogynecology, AFM Krakow University, Krakow, Poland

More than 30% of women in the western world suffer from different urogynecological diseases like urinary incontinence and pelvic organ prolapse (POP). In cases of POP the most commonly used operative procedure is still a hysterectomy with anterior and posterior colporrhaphy even though the uterus is not the cause of the prolapse. Instead POP is a result of different defects of fascia and ligaments in the pelvic floor. These defects should be accurately detected and taken into account when planning operative treatment. There are plenty of minimally invasive laparoscopic methods dedicated to these defects such as: laparoscopic hystero-, colpo-, cervicosacropepy, pectopexy, laparoscopic lateral repair and laparoscopic colporrhaphy. The use of minimally invasive methods in pelvic floor repair is less of a burden for the patients and reduces the hospitalization time and recurrence rates immensely.

Audience Take Away:

- Hysterectomy is not the treatment of choice in cases of POP
- There are different minimally invasive operative methods in pelvic floor repair which specifically target various pelvic floor defects
- Pelvic floor surgery should often be performed by an interdisciplinary team of gynecologists, urologists and colorectal surgeons

Biography

Pawel Szymanowski graduated medicine from the Medical School of Hannover and then did a specialization in gynecology and obstetrics in Germany where he worked for 15 years. He has been the head of department since 2006. His main focus over the years and still to today is urogynecology. In 2013 he moved to Poland where he has continued his work in urogynecology and operative gynecology. He is currently the head of the Department of Gynecology and Urogynecology at Andrzej Frycz Modrzewski Krakow University. In May 2017 he became the President of the Polish Urogynecological Association.

Use of blood tests and ABG in the diagnosis of acute mesenteric ischemia

Daneshmand A¹*, Parys S¹, Rao S¹, Sieunarine K², Watanabe Y¹

¹Department of General Surgery, Royal Perth Hospital, Perth, Australia

²Department of Vascular Surgery, Royal Perth Hospital, Perth, Australia

Aim: To investigate the usefulness of commonly used blood tests and Arterial Blood Gas results in the diagnosis of Acute Mesenteric Ischemia

Methods: All patients with acute mesenteric ischemia (AMI) who presented to a single tertiary hospital in Perth, Western Australia over a 10-year period were analyzed. Blood test results including White Cell count (WBC), CRP and hemoglobin (Hb) levels were investigated. From the ABG, patients' pH, Base excess (BE) and Lactate level were investigated. A control group was created using patients with other severe acute intra-abdominal pathologies including bowel obstruction, diverticulitis, inflammatory bowel disease and severe pancreatitis. The blood test results were compared using ANOVA analysis

Results: A total of 68 patients with AMI were identified, Male to female 1:1, average age 67 (range 33-94) and compared to 39 patients in the control group: male to female 1.6:1, average age 69 (range 25- 96). While patients' comorbidities of hypertension, ischemic heart disease, atrial fibrillation, diabetes and COAD were comparable, the prevalence of peripheral vascular disease was significantly higher in patients with AMI ($p=0.001$). Only lactate levels were statistically different between the groups: 4.2 vs 2.3 mmol/L ($p=0.014$), however, all other blood tests, did not show a meaningful difference: WCC 20.7 vs. 12.8 $\times 10^9/L$, Hb 106 vs. 117 g/L, CRP 121 vs. 127 mg/L, pH 7.32 vs. 7.35 and BE -3.1 vs. -3.8 mEq/L. Further analysis of the lactate levels revealed high variation (0.5 to 19). Histogram analysis showed that the majority of patients (42 of 68) had only mildly elevated lactate levels (0.5 to 4.1 mmol/L), a further 11 patients had lactates of 4.1-7.7 mmol/L and only a minority of patients had lactate levels > 7.7 mmol/L.

Conclusion: Overall, the commonly used blood investigations cannot distinguish between acute mesenteric ischemia and other serious intra-abdominal pathologies. Only lactate is shown to be of statistical use. However, due to large variation in lactate levels, it remains an unreliable investigation for the diagnosis of AMI.

Audience Take Away:

- How to use widely available blood tests to diagnose mesenteric ischemia. The early diagnosis of acute mesenteric ischemia is critical to patient survival. The diagnosis is difficult to make clinically. While imaging provides additional information, it is not always available or not available in a timely manner. The possibility of using simple blood tests to diagnose mesenteric ischemia quickly will help surgeons to manage patients appropriately.
- Our research affirms previous studies that Arterial Blood Gas Lactate level is useful in the diagnosis of mesenteric ischemia. However, other biochemical markers are of limited value.
- Further clinical based research should be performed on different biochemical markers.

Biography

Dr. Daneshmand (M.D., MSc) is a Surgical Registrar working in a Tertiary Hospital in Perth, Australia. He has published and presented widely in the fields of both General and Vascular surgery.

Using of new double invaginated end to end pancreatojejunostomy with transanastomotic stenting and external pancreatic duct drainage: Preliminary report

Prof.M. Kiladze*, Prof.M. Mizandari, Assoc.Prof.G.Chiqobava, O.Kepuladze M.D

1Javakhishvili TSU, Clinic GIDMEDI, Tbilisi, Georgia

Pancreatoduodenectomy (PD) is the most invasive and complex operative procedure of GI tract surgery most commonly performed for the pancreatic head and periampullary area malignancy with morbidity rate 40-50% and mortality on average 5%. Following the PD the pancreatic anastomosis, which is the most important component of reconstruction, carries the highest risk of leak and cause of morbidity and mortality. The incidence of postoperative pancreatic fistula (POPF) rate is estimated to be 5% to 30% and so, the pancreatic anastomosis is still Achilles heel of pancreatic surgery and achieving a zero percent of POPF rate remains a dream of every pancreatic surgeon. More than 80 different methods of pancreatocenteric reconstruction have been proposed, illustrating the complexity of surgical techniques as well as the absence of the ideal pancreatic anastomosis.

METHODS: Our data from 2013 to 2017 include the last series of 29 cases of PD for 14 pancreatic and 15 ampullary tumors. There were 12 females and 17 males (average age 57, range 43-78 years). The standard classic Whipple procedure was performed at 18 cases and modified pylorus-preserving variant (ppPD) – in 11 cases. 28 cases of pancreatojejunostomy and 1 pancreaticogastrostomy were created. Percutaneous biliary drainage procedure was performed at 18 and dual decompression with the pancreatic duct – at 6 cases. In 23 cases the biliary drainage was used as transanastomotic stent during hepaticojejunostomy and in 5 cases the pancreatic duct drainage was also used as transanastomotic stent at our method of performing the double invaginated pancreatojejunostomy.

RESULTS: There was no operative mortality in our series of PD. Three patients developed surgical site infection, 2 - dehiscence of abdominal wound closure and 3 patients experienced pancreatic leak and abscess, which required interventional radiologic and intensive care management. Two patients required reinterventional surgical procedure: 1 case of necrohaemorrhagic pancreatitis and 1 - of erosive bleeding and 5 patients died at follow up period (6 months – 3 years). The main operative time was 5 hours and the median length of stay was 12 days overall. There was no postoperative pancreatic fistula in our last series of PD, where preoperative biliary and pancreatic duct drainage and our modified double invaginated pancreatojejunostomy was performed. The transanastomotic biliary and pancreatic catheters were removed 3-4 weeks after surgery when control X-ray examination revealed complete capacity and leak resistance of both anastomoses without any contrast extravasation.

CONCLUSIONS: Based on our limited experience we can conclude, that preoperative percutaneous biliary and pancreatic drainage is feasible, safe, effective and realistic minimally invasive procedure. External biliary and pancreatic duct drainage with a stents can effectively reduce the POPF and overall morbidity rates in patients undergoing pancreatoduodenectomy. Our preliminary results of using the double invaginated pancreatojejunostomy with transanastomotic stent and external pancreatic duct drainage are very encouraging and indicate that this technique is less complicated and time consuming, very safe, simple, easy to perform and also applicable almost to all situations.

Audience Take Away:

- The audience will be able to use our practical recommendations for optimization of perioperative management for favorable at pancreatoduodenectomy. By using our new method of double invaginated pancreatojejunostomy with transanastomotic stent and external pancreatic duct drainage they will effectively reduce the POPF and overall morbidity rates in patients undergoing pancreatoduodenectomy.

Biography

Merab Kiladze M.D., Ph.D is heading Department of Surgery at Javakhishvili Tbilisi State University and at Georgia-Israel Joint Clinic Gidmedi. He graduated from Tbilisi State Medical Institute, Faculty of General Medicine. Dr. Kiladze accomplished his research and clinical fellowships at the Mayo Clinic, Rochester, USA and National Centers of Surgery and Oncology, Moscow, Russia. Dr. Merab Kiladze is Immediate Past President of Mukhadze Society of Surgeons of Georgia, Fellow of American College of Surgeons, International College of Surgeons and Member of Editorial Board of the Journal Ann. Ital. Chir. (Bologna, Italy). He is also Member of European Association for Endoscopic Surgery and European Society of Surgery. In 1997 he was awarded with a Medal of Honor and in 2001 with a Order of Honor by the President of Georgia. In 1999 he was awarded with 2000 Millennium Medal of Honor (ABI, USA). Dr. Merab Kiladze is an expert in general surgery Ministry of Labor, Health and Social Affairs of Georgia and Honorary Citizen of Batumi (Georgia).

Pelvic sheet wrap and initial management of unstable fractures

Ameen I. Ramzy, MD, MBA, FACS.

Former Trauma Level 1 Medical Director, Legacy Emanuel Medical Center, Portland, Oregon, USA
Former Maryland State EMS Director and Medical Director, Baltimore, Maryland, USA.

Pelvic fractures resulting from high-energy mechanisms can be deadly. Internal bleeding from pelvic fractures can be both arterial and venous. Bleeding into the retroperitoneal space, which is large enough to hold the patient's entire blood volume, can result in fatal hemorrhage. EMS and initial hospital recognition of unstable pelvic fractures and their stabilization, as well as an understanding of the potential intervention, can improve patient survival.

In some series, pelvic fractures have shown a 10% mortality, which has been 37% for patients greater than 60 years old. If a patient is conscious and is able to convey pelvic pain, that should raise the suspicion of a pelvic fracture. Proper and careful compression of the pelvis can help determine pain and instability. Correct placement of a pelvic sheet wrap or pelvic binder can help with pain and hypotension. Definitive care of pelvic fractures can involve surgery and control of bleeding with interventional angiography, but the initial assessment and intervention can make an important clinical difference.

Audience Take Away:

- A pelvic fracture can result in major blood loss, so early assessment and intervention are essential
- The correct location for assessment of pelvic stability or instability, and the correct location for pelvic compression are essential
- If one individual finds pelvic instability, the examination should not be repeated by another person
- The correct placement for pelvic compression, and the correct amount of compression, are both important

Biography

Dr. Ramzy did undergraduate study at Northwestern University near Chicago, Illinois. He graduated from the University of Nebraska School of Medicine in 1975, and then did a General Surgery Residency. In Baltimore, Maryland, he trained in Trauma Fellowship and went on staff as a Trauma Surgeon. He also became both State EMS Director and Medical Director at the Maryland Institute for Emergency Medical Services System. He later provided surgery and critical care at the Legacy Emanuel Medical Center in Portland, Oregon, and became the Trauma Medical Director of the Level 1 Trauma Center. In his career, he published in the Journal of Trauma and made over 200 presentations in EMS and Trauma.

What's the best non-mesh continence surgery for my patients?

Professor Mohamed Abdel-fattah

Clinical Chair in Gynaecology – University of Aberdeen, UK

Urinary incontinence (UI) is a common and debilitating condition among women (1). In 2000, the MRC Incontinence Study showed that 34% of women (~6million) in the UK over 40 years of age have clinically significant UI with 2.7% (~0.33 million) reporting UI as socially disabling (2). This prevalence is set to increase knowing the ageing population in the western world.

SUI is the most common type of UI accounting for almost 50% of cases. (3) It is defined as involuntary leakage of urine on effort, sneezing or coughing. Mixed UI (MUI) is the second most common type and is often SUI predominant (i.e. women also describe concomitant urgency and/or urgency incontinence but SUI are their predominant bothersome symptoms) (3). Initial management includes conservative therapy such as specialist physiotherapy for pelvic floor muscle training. When conservative therapy fails, in about one-third of cases, surgery is the next option (3). Current data suggests the lifetime risk for women in the UK to undergo surgery for SUI is 10% (4).

Since 2014, surgical practice in the UK has significantly changed and synthetic mid-ureteral slings (mesh) have been largely replaced with other surgical procedures. The recent NICE guideline (NG123) recommends the following surgical options: Autologous fascial sling, Burch colposuspension, mid-urethral sling (mesh) and urethral bulking.

In this talk we will discuss the operative steps and evidence behind non mesh surgical options.

Audience Take Away:

- The audience will watch short videos for the operative steps and evidence behind non mesh surgical options
- The audience will be able to reflect on their own surgical practice and use this talk as a first step in ensuring they are providing their patients with appropriate surgical options

Biography

Professor Mohamed Abdel-fattah (MAF) is a Clinical Chair in Gynaecology and Co-Director Aberdeen Centre For Women's Health Research – University of Aberdeen. He has published many articles in peer reviewed journals some of which are considered bench marking in the field. MAF has secured over £9 million for funding his research being the Chief Investigator on a number of nationwide multicenter randomised trials. MAF is also honorary Consultant Gynaecologist and Subspecialist Urogynaecologist. He runs the tertiary Urogynaecology referrals dealing with complex medical and surgical cases of female urinary incontinence and pelvic organ prolapse in North East of Scotland. For his full profile and competing interests, please visit <https://www.abdn.ac.uk/iahs/research/obsgynae/profiles/m.abdelfattah>

Does pre-operative urodynamic lead to better outcomes in management of urinary incontinence in women? A linked systematic review and meta-analysis

Alyaa Mostafa

University of Aberdeen, UK

The use of preoperative urodynamics as a standard investigation for urinary incontinence (UI) has long been a subject of debate, with a lack of robust evidence to demonstrate improved patients' outcomes. We aim to compare the clinical and cost effectiveness of urodynamics vs clinical evaluation only prior to the treatment of UI.

We conducted three linked systematic reviews and meta-analyses of randomised controlled trials (RCTs) comparing urodynamics as part of assessment vs clinical evaluation only in women prior to 1) non-surgical treatment of UI, 2a) surgical treatment stress urinary incontinence (SUI) and 2b) invasive treatment for overactive bladder (OAB). Women with severe pelvic organ prolapse, incontinence caused by neurological disease and previous incontinent surgery were excluded. Primary outcomes were patient-reported and objective success post-treatment. Secondary outcomes were adverse events, quality of life, sexual function and health economic measures. We searched MEDLINE, EMBASE, Cochrane Central Register of Controlled Trials for each category, last updated on January 2019. Study selection, risk of bias assessment and data extraction were performed independently by two reviewers. The random effects model was used to assess risk ratio and mean difference with 95% confidence interval. Statistical heterogeneity was assessed by I² statistics and the quality of evidence by the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) approach.

Four RCTs compared urodynamics versus clinical assessment only prior to non-surgical management of UI. Treatment consisted of pelvic floor muscle training, with or without pharmacological therapy. Meta-analysis of 150 women showed no evidence of significant difference in the patient-reported and objective success rates between groups ($P=0.520$, RR: 0.91, 95% CI 0.69-1.2, low quality of evidence and $P=0.470$, RR: 0.87, 95% CI 0.59-1.28, very low quality of evidence respectively). Seven RCTs were identified for surgical management of SUI. The majority of women underwent mid-urethral tape procedures (retropubic or transobturator approach). Meta-analysis of 1,149 women showed no evidence of significant difference in patient-reported ($P=0.850$, RR:1.01, 95%CI 0.88-1.16, $I^2 = 53\%$, low quality of evidence) and objective success ($P=0.630$, RR:1.02, 95% CI 0.95-1.08, $I^2 = 28\%$, moderate quality of evidence) between groups. There was no significant difference in incidence of voiding dysfunction, de novo urgency urinary tract infection between groups. No RCTs were identified for invasive management of OAB.

In conclusion, limited evidence shows that routine urodynamics prior to non-surgical management of UI or surgical management of SUI is not associated with improved treatment outcomes, when compared to clinical assessment only. Well-designed clinical trials are needed to evaluate the clinical and cost-effectiveness of routine urodynamics prior to surgical management of SUI and OAB.

Three-dimensional reconstruction in liver surgery: A feasible reality in clinical practice

Banchini Filippo*, Romboli Andrea, Delfanti Rocco, Capelli Patrizio

Department of General Surgery, Guglielmo da Saliceto Hospital, Piacenza, Italy

Three-dimensional reconstruction of CT and MRI is now becoming a frequent option to visualize clinical images with direct volume rendering software. Unfortunately, this kind of rendering doesn't allow the reconstruction of a single organ to manipulate it in clinical practice. On the other hand, further evolution of this technology have proposed augmented reality systems. However, the deformation and displacement of the organs as observed during a surgical intervention remain a problem for their applicability. For this reason three-dimensional reconstruction of radiologic images remains a challenge for many surgeons due to the relative lack of widespread utilization as well as the availability of relevant resource materials. The main question remains how to apply the three-dimensional reconstruction in clinical practice with low cost or free software. There is no doubt about the various advantages that may be obtained following its use, particularly in liver surgery. Its utilization allows a new way of surgical thinking in term of planning the intervention, in comprehension of complex liver anatomy and its intraparenchymal variation, in improving comprehension of intraoperative ultrasound, in planning the preferable section plan employing intraparenchymal structures as landmark for resection, in facilitating intraoperative decision making and sharing intuitive understanding in the surgical staff. We present some examples of its usage, starting from manipulation and editing of three-dimensional reconstruction to its application during intervention, demonstrating how this technology could be easily available in daily practice.

Audience Take Away:

- The aim of the presentation is to show how to use in daily practice a simple software to generate and use three-dimensional reconstruction from image selection to reconstruction edit till intraoperative usage. This will create a new way of thinking in term of use medical image, in preparing and planning liver surgery, in facilitate teaching and easy learning. The image manipulation is very usable and could be applied also in others situation as pancreatic surgery, lung surgery and more demonstrating how this technology must to be spread and shared. In conclusion this provide a practical solution in visualizing and studying anatomical variation using them in an easier and intuitive way for planning surgery and teaching.

Biography

Dr Banchini graduated as Medical Doctor in 1998 at Parma University in Italy. He was as observer at Cabrini Medical Center (Mont Sinai Medical School affiliated) in New York in 1998. During his residency in General Surgery he worked in Paris at Saint Antoine Hospital and Cochin Hospital. Since 2004 he has worked as a Surgeon at Guglielmo da Saliceto Hospital in Piacenza Italy, where he deals with surgical oncology in particular colorectal and liver surgery as well as emergency surgery. In 2010 he graduated in Paris University XI at Poul Brousse Hospital with a University Diploma in hepatobiliary and pancreatic surgery. He takes a master of the latter at IGoMilsAccademy in laparoscopic liver surgery in 2017, and subsequently frequented the Heidelberg University Hospital (Germany) as an observer in order to advance his knowledge of pancreatic surgery. He is currently responsible for the management of colorectal cancer patients and is the referent surgeon for oncologic surgery in his hospital.

Making our hospitals safer for surgical patients; Using improvement science, health services research and machine learning in acute urological surgery

Tony Tien*, James Green

Whipps Cross University Hospital, Barts Health Trust, London, United Kingdom

Patient safety is a serious worldwide public health concern. Adverse events in the United Kingdom (UK) is estimated by the Department of Health to occur in 10% of hospital admissions, which is over 850 000 per year. The cost to the health service is estimated at £2 billion per year. In the UK, serious incidents (SIs) and never events include wrong site surgery, retained foreign objects post procedure, wrong implant/prosthesis and wrong route administration of medication. Fortunately, all serious incidents are reported in a systematic detailed manner and stored in the Strategic Executive Information System (StEIS). This repository, managed by National Health Service (NHS) Improvement, holds an enormous amount of data spanning the whole of the UK, over many years.

This data is currently not being systematically reviewed to improve patient care, however we will describe how this data can be used to prioritise Health Service Research by using it to identify; patterns, comparative information, trends and hot spots on a national level and we will explain a methodology that can be used in countries with similar types of centralised databases. The aim is to allow changes applicable nationally to be designed and prioritised for the highest impact on patient safety. After implementing change, the longitudinal rate and contributing factors of serious incidents can be used to assess improvement using improvement science research and the StEIS database.

We will use a detailed example of this, as proof of concept, where our team in London have used this repository and mined the data to evaluate one of the common acute paediatric emergency surgical conditions. As result over 1000 patients in the UK were discovered with SIs relating to this condition during a 4-5 year period. These SI reports then underwent thematic analysis with the aim of feeding into a 'logic model' and pragmatic trial evaluation of the impact quality improvement intervention can make on safer care outcomes in this condition.

We will describe the methodology to process a high volume of information within the database using machine learning. Machine learning or artificial intelligence is based on data pattern analysis and is capable of processing overwhelming amounts of complex data. This can be applied to SIs reported in StEIS and be a huge leap forward for improvement research. It will identify common themes and enable us to strategically make changes to enhance patient safety within our nation's Health Service.

Audience Take Away:

- The presenter will describe the methodology of using machine learning to identify areas for improvement science research using pooled national data.
- The delegates will understand how to use high volumes of national data effectively in a simple illustrative example, being undertaken and presented in the UK.
- The delegates will understand how centralised routinely collected data can be used to create and monitor interventions to improve patient safety over long periods of time.
- This presentation will allow researchers to identify priority areas within their health system that will then attract research funding.

Biography

Mr Tony Tien studied Medicine at Imperial College London and graduated in 2015. He became a member of the Royal College of Surgeons England in 2017. He has completed his Core Surgical Training in the United Kingdom and is now working as a Research Fellow with Professor James Green at Whipps Cross University Hospital. He has multiple publications and has presented internationally.

Preperitoneal laparoscopic lateral repair operation in pelvic organ prolapse – A novel approach

Wioletta Katarzyna Szepieniec MD

Department of Gynecology and Urogynecology, AFM Krakow University, Krakow, Poland

Introduction and methods: The aim of this study is to show a novel approach of the repair of the lateral paravaginal defect causing the cystocele. The extraperitoneal (preperitoneal) approach has its advantages and can be used in patients with comorbidities and in obese patients. The main advantage of this procedure is omitting of the pneumoperitoneum and of the Trendelenburg position during the operation. The avoiding of peritoneal adhesions is also important.

Results: This study presents the first results of this novel approach on 27 patients. All of the patients have a cystocele POP Q 2 and 59% of them concomitant stress urinary incontinence due to lateral defect of the vesico-vaginal fascia. Mean operation time was 80 minutes. After the operation by all of the patients was achieved the reduction of the cystocele to POP Q I or 0. Follow-up after 6 months revealed only 1 recurrence of the cystocele. Quality of life was controlled with PIFQ Questionnaire and revealed a statistical improvement from average 6,8 point before operation to average 0,7 points after ($p < 0,05$).

Conclusion: Preperitoneal laparoscopic lateral defect repair is a relatively fast operation. It is feasible also for obese women and for patients with cardiac risk, because of the omitted Trendelenburg position and pneumoperitoneum. Postoperative can be achieved a very satisfied effect with the reduction of patient's complaints and reduction of the cystocele.

Audience Take Away:

- There are different minimally invasive approaches in treatment of cystocele with lateral defect
- Preperitoneal laparoscopic lateral repair is an possible alternative also for patients with anesthesiological risk profile
- This operation can become an alternative for cyctocele repair using alloplastic materials

Biography

Wioletta K. Szepieniec graduated medicine from the Jagiellonian University in Krakow and did her specialization in gynecology and obstetrics in Germany where she worked for 10 years. Her main focus over the years and still to today is urogynecology but also breast surgery and aesthetic gynecology. In 2014 she moved to Poland where she has continued her work in urogynecology and operative gynecology. She is currently senior doctor of the Department of Gynecology and Urogynecology at Andrzej Frycz Modrzewski Krakow University.

Histone deacetylase 2 (HDAC-2) expression in human breast cancer and its association with clinicopathological factors and patients' survival

Konstantinos Kontzoglou^{1*}, Christos Damaskos¹, Nikolaos Garmpis¹, Anna Garmpi²

¹Second Department of Propedeutic Surgery, Laiko General Hospital, Medical School, National and Kapodistrian University of Athens, Athens, Greece.

² Internal Medicine Department, Laiko General Hospital, Medical School, National and Kapodistrian University of Athens, Athens, Greece

There is strong association with malignancy and histone deacetylases (HDAC) in humans. The histone deacetylase inhibitors (HDACI) are now tested as antitumor agents in various clinical trials. The aim of this study is to assess the clinical importance of HDAC-2 in breast cancer.

Materials and Methods: 118 breast cancer specimens were obtained from patients and were examined immunohistochemically. A statistical analysis was conducted in order to examine the relation between HDAC-2 and clinicopathological features and survival of the patients.

Results: Higher levels of HDAC-2 expression were related to lobular histological type of cancer ($p=0.004$), grade III and stage III ($p<0.001$). In addition, the progression free survival and overall survival were shorter and negatively related to the over-expression of HDAC-2 respectively [HR: 3.32 (1.57-7.01), $p=0.002$], [HR: 2.56 (1.31-4.99), $p=0.006$]. Other factors correlated with worse survival were histological types different to ductal or lobular and stage of the disease ($p<0.001$).

Conclusion: This study showed a possible relationship between HDAC-2 and breast cancer. Further studies need to be conducted in order to examine the value of HDAC-2 as a predictive tumor marker and therapeutic target against breast cancer.

Biography

Konstantinos Kontzoglou has completed his PhD from Medical School of National and Kapodistrian University of Athens. He is a Professor of Surgery in Medical School of National and Kapodistrian University of Athens. He is a Surgeon in Laiko General Hospital of Athens, Greece. He has published more than 100 papers (published and accepted for publication) and has been serving as an editorial board member of repute journals. He participates with presentations in medical congresses.

Laparoscopic excision of deep infiltrating endometriosis involving the rectovaginal space and bowel

Dr Marlain Mubarak¹, Dr Firas Younis², Dr Rachana Shukla³, Dr Vyomesh Buch⁴, Dr Yasser Jassem⁵, Dr Raad Nasser⁶

¹Department of Obstetrics and Gynaecology, Canadian specialist Hospital, Dubai, UAE, ²Department of Colorectal Surgery Organisation Luton & Dunstable University Hospital, Luton, United Kingdom

³Department of Radiology, Organisation Luton & Dunstable University Hospital, Luton, United Kingdom

⁴Department of Radiology, Canadian specialist Hospital, Dubai, UAE

⁵Department of Urology, Canadian specialist Hospital, Dubai, UAE

⁶Department of Anesthesia, Canadian specialist Hospital, Dubai, UAE

Endometriosis affects 1 in 10 women in the childbearing age. It causes period pain which can be debilitating and can cause infertility. Severe endometriosis found in 5 – 37% of women. Severe endometriosis diagnosis established in the presence of DIE involving uterus, rectovaginal septum, ureters and bowels.

Laparoscopic surgery is associated with a high risk of complications requiring specialist multidisciplinary team approach, compromising of expert gynaecologist, colorectal surgeon, urologist and radiologist. In the United Kingdom the British Society of Gynaecology Endoscopy (BSGE) accredits and monitors recognised centres of care.

The Luton University Hospital was accredited by BSGE since 2014 as a specialist centre. In 2018 we established a BSGE accredited centre at Canadian Specialist Hospital. We introduced MRI ENZIAN classification in 2015 to assess the location, size and depth of DIE prior to surgery.

Methods and population: In total 76 women had Laparoscopic surgery in the 2 centres. All performed by the same specialist surgical team. 14 cases were operated on at the Canadian Specialist Hospital from 2018 up to February 2019. 62 cases between 2014 and 2017 at Luton & Dunstable University Hospital. We introduced MRI ENZIAN classification in 2015 as part of preoperative assessment. All women completed BSGE pelvic pain questionnaire prior to surgery.

Second analysis performed to correlate MRI ENZIAN classification with surgical ENZIAN classifications. We analysed the data of 26 patients between January 2015 and February 2017. MRI reported by one radiologist, all cases managed laparoscopically by one Gynaecologist. Age range of patients 22 – 48 years (mean 36.4 years, SD 9.7 years).

Results: 76 women completed their pre-operative BSGE pain questionnaire. Length of follow up depends on date of surgery. At 3, 6 and 12 months post-operatively, women reported no symptoms of pre-menstrual pain, dyspareunia or dyschezia. At 24 months post-operatively women reported no symptoms of non-cyclical pain, dyspareunia or dyschezia. All women reported significant improvement in their pain symptoms at 6, 12 and 24 hours post-operatively. There were no conversions to laparotomy. Three complications were reported; one ureteric injury, one bowel leakage and one developed clot in the ureters which resolved with conservative management.

For the 2ry analysis, there was statistically significant correlation between MRI ENZIAN classification and surgical findings (P 0.01). MRI identified 92 lesions; 86 of these were confirmed and excised laparoscopically (95%). Histology confirmed endometriosis in all 86 lesions. MRI also identified DIE on the caecum & appendix in 1 out of 3 cases. Excellent radio-surgical correlation for recto-sigmoid DIE, identifying 15 out of 17 lesions (88%). MRI identified all the rectovaginal lesions and 46 out of 51 uterosacral lesions (90%).

Conclusion: Management of DIE is complex requiring a multidisciplinary team approach, surgical management of DIE should be considered in women who experience symptoms associated with DIE as it has been shown to significantly improve endometriosis-associated pain and improve quality of life. It is however, not without complications, especially when colorectal surgery is required, intra-operative complication rates have been reported as 2.1% and post-operatively complication rates as 13.9%. Our data shows good outcome and low complication rate at 3.9%.

Audience Take Away:

- Awareness of the incident and diagnosis of severe endometriosis as women can present to surgical, Gynaecologist or Urology team with symptoms and complications as result of severe endometriosis which is a poorly diagnosed disease Will present 2 min surgical videos to increase understanding of surgery. Improving awareness, use of appropriate diagnostic tools and refereeing women to expert in the disease improve patient outcome

Biography

Dr Marlain Mubarak completed postgraduate training at the Oxford Deanery UK, obtaining Level 2 Laparoscopic surgery in 2004. Following that did spend a year working with Endometriosis team at Oxford Radcliff Hospital as a senior registrar. Worked as a consultant Lead for Colposcopy and Diagnostic Oncology at Luton & Dunstable University Hospital, UK. Between 2010 until moved to Dubai in November 2017. In 2014 facilitated the development of BSGE accredited endometriosis centre and in 2018 at the in 2016 on Endometriosis. Canadian Specialist Hospital. She has special interest in research and finished an MSC in Experimental Therapeutics at Oxford University

Principles and practice of collaborative surgical procedures at oncogynecology

Ts. Gatenadze* M.D, Ph.D., Prof. M.Kiladze, Prof.D.Gagua, Assoc.Prof.G.Chiqobava

Maritime Hospital, Gagua Clinic, JSC "GIDMEDI" Batumi/Tbilisi, Georgia

Background: We describe our experience of treatment of benign and malignant gynecologic pathology with make an emphasis on combined and simultaneous surgical procedures and collaborative team approach for optimization of the clinical outcomes of specialized care cases. Recently the combination of gynecologic and different surgical procedures is become more common in various institutions, but there are still some controversial questions concerning classification, terminology, proper definition and clinical assessment of traumatism of performed surgical procedures.

Methods: A retrospective review of 1327 patients of gynecologic surgery at 2012-2015 is analyzed. Analyzed data included: indications for surgery, initial treatment, pre-operative status, extent of the procedure, operative time, blood loss, infusions and complications.

Results: Of 1327 patients, the median age was 51 years (range: 27-76). Benign gynecologic pathology was diagnosed at 1114 (83%) and correspondingly gynecologic malignancies at 221 (17%) with I-II stage of disease in 70% and III-IV stage – at 30% of all cases. Recurrent tumors was revealed at 18 cases: cervical stump tumors – 10 cases and another 8 cases with following localization: retroperitoneum – 3, omentum – 3, abdominal wall/bladder – 1, mesentery/sigmoid colon – 1. Concomitant surgical pathology was revealed at 95 of all cases and the most often were found: abdominal adhesions – 33, hernias – 18 and cholecystolithiasis – 16. There was no operative mortality in the immediate post-operative period, 16 deaths occurred at follow up period (6 months – 2 years). The overall prevalence of composite 30 day major postoperative complications was 4,3% (57 cases).

Conclusions: Based on our experience and appropriate anatomico-surgical landmarks we propose a new more optimal classification of abdominal hysterectomies. Our results suggest that joint surgical treatment is the best approach in repeated surgery and advanced cases to achieve the surgical adequacy. Thus, collaborative surgical management is feasible and realistic approach for optimization of clinical outcomes of treatment.

Audience Take Away:

- The audience will be able to use our practical recommendations for optimization of perioperative management for gynecologic recurrences
- By using our approach they will effectively reduce the overall morbidity and mortality rates in patients undergoing reoperations at gynecological surgery

Biography

Dr. Tsismar Gatenadze graduated medicine from Tbilisi State Medical University (Tbilisi, Georgia) with Honors Diploma in 1999. She completed the specialization and postgraduate training at the St. Petersburg (Russia) Mechnikov Medical Academy, Obstetrics-Gynecology Department in 1999-2001 and at the St. Petersburg (Russia) Petrov Research Institute, Oncogynecology Course in 2001-2002. She received the Academic Title of Ph.D. in Medicine after successfully completed the Research Fellowship Course in 2010. In 2018-2019 she completed the Visiting Professorship Programme at Sheba and Haifa Medical Centers (Israel). Her main focus over the years is oncogynecology and also plastic and aesthetic gynecology. She is Member of European Society of Medical Oncology and currently is a senior doctor of the Department of Gynecology at Batumi Medical Center (Georgia).

Thoracoscopic surgery in children- Rare cases managed successfully

Dr Amit Raut

Ashoka Medicover Hospitals, India

Here I would be presenting unusual or rare cases of pediatric patients having various thoracic problems like thoracic masses, mediastinal masses, empyema, lung cyts etc which were managed successfully in paediatric patients including in neonates by means of VATS i.e video-assisted thoracoscopic surgery. I would be presenting details of cases with their complexities like masses adherent to heart, compressing heart others compressing bronchus, esophagus, aorta etc with thoracoscopic procedure details for such cases. This will include patient positions in each cases, approach, ports sites, hospital stay etc with their ultimate outcomes.

Audience Take Away:

- They will learn newer surgical technique or approaches for thoracic problems in paediatric patients which are more simple, safer and easier
- As VATS technique is safe, efficient, more rewarding with better cosmesis is fruitful from patient point of view also
- Yes, definitely, these techniques can be used by faculty to expand their research and teaching
- It will also make performing persons job more efficient and rewarding

Biography

MBBS, DNB-Paed-Surgeon, DEBPS-Paed-Surgeon, FIAGES, FMAS, Consultant Paediatric & Neonatal Surgeon, Paediatric Urologist, Paediatric Minimally Invasive Surgeon, Paediatric Trauma Specialist.

Awards:

1. Award by National Level, Education & Research Foundation for Hospitals for Publication in International Indexed Journal about 'Innovative Surgical Technique 2016'.
2. Award for Presentation - 1st prize -- Single incision Laparoscopic Gastric Pull-up - 1st to be Published in literature. -- At Paediatric Endoscopic Surgeons of India 2014 National meet.
3. Award for Best Paper Presentation 1st prize for --Follow up study of PSARP cases in last four years-MCAIPSCON, Jan 2012
4. Award in Quiz at IAPSCON 2011 at Chennai.
5. Prize in Meet the Professor Session-Neonatal Surgery at IAPSCON 2011 at Chennai.
6. Award for Best Paper Presentation 1st prize for --Follow up study of esophageal replacement case At IAPSCON, Jan 2011
7. Award for Best Paper Presentation 2nd prize for-- Follow up study of Use of bisected Appendix simultaneously, MCAIPSCON, Feb 2010,
8. Award for Best Paper Presentation 3rd Prize -- Modified technique of use of Bisected Appendix for Incontinence in same patient, at Decn Surgical Society Meet, Miraj, July 08.
9. Award for Best Paper Presentation for --Fetus in Fetu at IV th Annual Conference, Pune, Feb 07 10. Award of Appreciation by Indian Academy of Paediatrics, 2018

Member of Professional Organization's:

Life Member, Indian Association of Paediatric Surgeons (IAPS)
Life Member, Paediatric Endoscopy Surgeons of India (PESI)
Life Member, Paediatric Urology Chapter of IAPS
Member of European Paediatric Surgery Association (EUPSA)
Life Member of Indian Association of Gastro-intestinal Endoscopic Surgeons (IAGES)
Life Member of Association of Surgeons of India (ASI)
Member of Association of Minimal Access Surgeons of India
Associate Member of Indian Academy of Paediatrics (IAP)

Publications:

Total 5 publications in International/Indexed Journals regarding rare cases managed successfully and regarding newer surgical techniques.

DAY 2

KEYNOTE FORUM

GLOBAL CONFERENCE ON

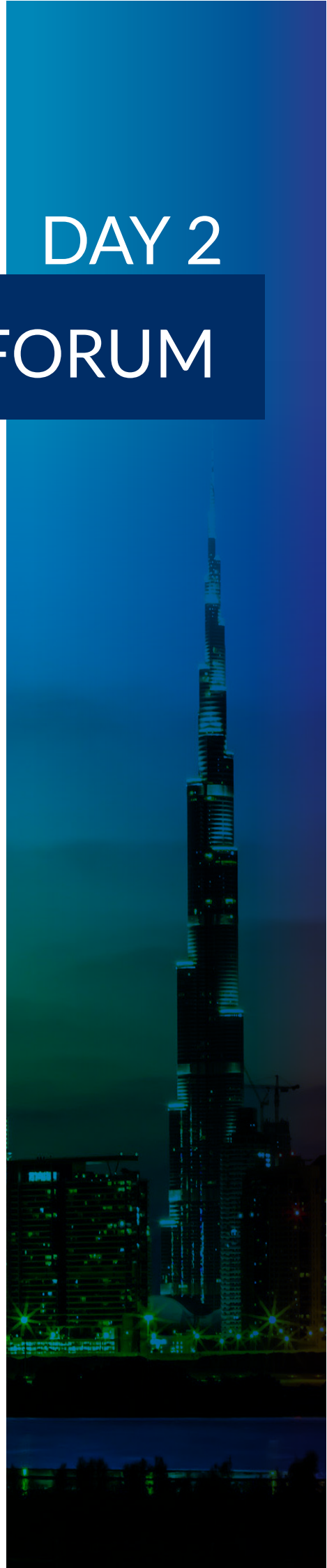
SURGERY AND ANAESTHESIA

OCTOBER

21-23, 2019

DUBAI, UAE

GCSA 2019





Biography

Mr. Joshi George did his medical schooling in India and then trained in trauma in Belfast. He gained his MD in Neurotrauma from the university of London. He gained his FRCS(Neuro. Surg) from Birmingham and the Royal College of Physicians and Surgeons of Glasgow. He subsequently gained a Fellowship of the European Board of Neurological Surgery from St. Augustin, Germany. He then went to Canada and completed his Fellowship in Spine Surgery at the University of Toronto. He is a consultant Neurosurgeon at Salford Royal Foundation Trust in Manchester, U.K. and is the Clinical Lead for Neurosurgery in Manchester. He is the specialist surgeon for Neurofibromatosis at the National Complex NF1 Service based in Manchester.

Advances in neurosurgery

K. Joshi George

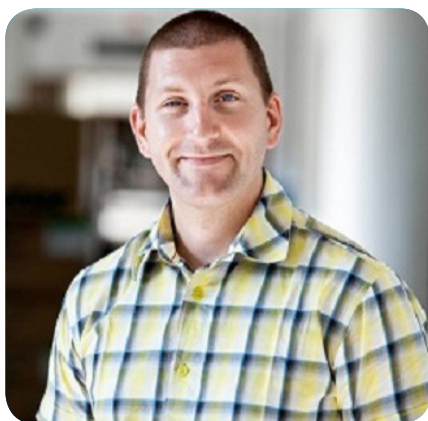
Salford Royal Foundation Trust, U.K

Neurosurgery has made great advances in recent years as a result of a greater understanding from research of neurological conditions and technological breakthroughs which have expanded the scope of surgery.

Deep brain stimulation, neuromodulation, role of stereotactic radiosurgery and proton beam therapy, robotic surgery, endoscopic surgery, endovascular techniques and advances in the treatment of brain and spine tumours are some of the topics which will be covered.

Audience Take Away:

- A better understanding of what neurosurgeons do
- What is possible now for treating patients with neurosurgical conditions
- Areas for collaboration.



Biography

Dr. Ricky Rasschaert is a neurosurgeon and spine surgeon at the ZNA Middelheim Hospital, the largest non-academic teaching hospital in Antwerp. The use of minimally invasive techniques and spinal reconstructive surgery is his main interest.

He is member of several Neurosurgical and Spine societies and elected as an IM board representative for the EANS. He also has teaching positions and does research involving the treatment of Tarlov cysts and on neuromonitoring in spine surgery cases. There also is an active participation in the Spine Tango project, an international registry for spine surgery with the intention of improving quality of given care. Other interests are department and hospital management as well as medico-legal expertise.

Dr. Rasschaert is co-founder of the SpineCare@CURE project, trying to improve Neurosurgical care in sub Saharan Africa.

Tarlov cysts and the idiopathic cerebrospinal pressure dysregulation syndrome

Ricky Rasschaert, MD

Department of Neurosurgery, ZNA Middelheim, Lindendreef 1, 2020 Antwerp, Belgium

Tarlov cysts remain a topic of controversy, from the first publication of Tarlov in 1938 and even now a myriad of treatments has been proposed for larger sacral cysts. For several reasons which will be discussed, Tarlov cysts have the tendency to be regarded as incidental findings. However, with a comprehensive history taking and perineal nerve conduction studies we might be able to distinguish better the symptomatic perineural cysts from the truly incidental finding (unpublished data).

As these cysts are being considered as dilations of the nerve root sleeve the hydrostatic pressure together with pulsatile/dynamic features are coined to be the generators of the cysts and growth mechanism. An increase in intracranial pressure has been measured in our case series and with positive effects on the symptoms with CSF evacuation and Acetazolomide. Even small cysts seem to react positively on these diagnostic tests.

As several studies show radiculopathy and axial pain as a general finding in idiopathic intracranial hypertension an idiopathic cerebrospinal pressure dysregulation syndrome might be proposed as a common denominator, for example in chronic fatigue syndrome and fibromyalgia.

Audience Take Away:

- How an incidental finding of sacral cysts evolved to an important cause of back pain and nerve root related symptoms
- A potential missing link between fibromyalgia, chronic fatigue syndrome and idiopathic intracranial hypertension



Biography

Dr. Sagar Jawale is a pediatric surgeon turned into a scientist. He has about 75 inventions in medical sciences till date, 25 of his inventions are reported for the first time in the history of medical sciences. He has developed 17 new operations and 12 new therapies in medicine which are under trial. He has been awarded with 2 international awards such as Antia Fineth innovation award 2017 and Siemens GAPIO innovation award in medicine 2018. He has invitations from all over the world for the demonstration of his inventions and as a keynote speaker on various topics.

My 75 inventions to make healthcare affordable to every one

Dr. Sagar Jawale

Jawale Institute of Pediatric Surgery, India.

Most of the advanced therapies in Medical Sciences are just a dream to 99.9 % of people as they cannot afford them. To bring this dream into a reality I decided to do research myself and reduced the cost of costly equipment in Medicine and Surgery about hundred times. The entire research was funded with my own money. 40 patents have been registered for these inventions in Mumbai office. This project is likely to have a huge positive impact on public health and going to revolutionize healthcare in India and other third world countries. I founded a research foundation called Vigyan Yog Foundation a no profit organization which dedicates itself for research in medical sciences. The foundation does research and the commercial activities are seen by another company I set named Vigyan Yog. Following of his inventions are for the first time in history of medicine. Flexible and rigid video laparoscopes, Flexible video laparoscope with 30, 45 and 60 degree mirror attachments, rigid ventilating video bronchoscope with forceps, Rigid ventilating video bronchoscope without forceps, adult rigid video cystoscope 24F, semi flexible thin video nephroscope, Rigid video nephroscope for PCNL, wireless laparoscopy and endoscopy device, laser tissue welding device, life force meter, Rigid video esophagoscope, Rigid video sigmoidoscope, Rigid video hysteroscope, Intravaginal video colposcope, Peritoneal laparoscopic microscope, Rigid video neuroscope, etc. These are produced at a record low cost of USD 150 each.

Other inventions which are first made in India are, articulating video laparoscope, 3D laparoscopy system, Capsule endoscopy device, VR magnifying loops, hydrophobic nano silicone coating, world's smallest video camera, video laryngoscope, laser lithotripter and laser cautery, Transcranial magnetic stimulation device(TMS), transcranial direct current stimulation device(tDCS), Intranasal laser therapy device, Machines for bronchial thermoplasty and Stretta procedure, Urodynamics and uroflowmetry device, CO2 incubator, Portable and commercial O2 concentrators, Central vacuum machine, Digital Stethoscope, Pathology video microscope, Ophthalmic video microscope, Microscope for microvascular surgery, USB Spectrometer, muscle stimulator, nerve stimulator, Hemodialysis machine, Partial ECMO machine, Harmonic scalpel and ultrasonic lithotripter and led light cord, 24 hour PH monitoring. I also set up stem cell laboratory and tissue culture laboratory at record low cost of USD 500. I have set up Gene therapy facility with American multinational Thermo Fischer Scientific for Crispr Cas9 Genome editing to be done in India for USD 1000 instead of USD one million in USA. The 8 mm rigid video laparoscope and 5 Megapixel laparoscopic cameras are commercialized for USD 300 each which is going to revolutionize laparoscopy in rural India.

My future innovations are hands Free Robotic Camera Holder, Da Vinci Laparoscopic Robot like system, Cochlear Implant, Artificial Urethral Sphincter, A Digital Radiography system, Electron Microscope, A Laser Microscope with one million times magnification, Alternatives

to antibiotics and antivirals, Tissue nano Transfection(TNT), Usb Pocket Ultrasound Machine, Cardiac catheterization Monitor ,Portable MRI scanner, ESWL Machine, Gamma Camera(scintillation Camera), Positron emission Tomography, Terahertz camera Imaging System, Terahertz Tomography.

Audience Take Away:

I propose to demonstrate my innovations in front of the audience. They can directly handle the instruments and learn from the activity. Since 25 of my innovations are unique and reported for the first time in medical literature, the audience are not likely to see them anywhere else. Audience can buy certain commercialized innovations and will be a practical solution to many problems. A limited hand on training is possible for some innovations. Most of my innovations are not available in any world market at present. Hence the presentation will be a unique experience.



Biography

Dr Ramanathan (Nathan for short) Kasivisvanathan is the Head of the Department of Anaesthesia and Perioperative Medicine at the Royal Marsden, an international cancer centre based in London. He has a strong interest in perioperative medicine and has a diverse range of research interests being published in numerous areas of perioperative medicine including High Risk Patient; Blood transfusion, Analgesia for major surgery.

Age is just a number: Identification and optimizing the high risk surgical patient

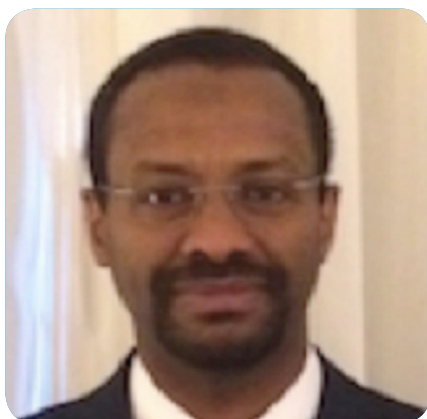
Dr Ramanathan Kasivisvanathan

The Royal Marsden NHS Foundation Trust, UK

The High Risk Surgical patient consumes a significant proportion of surgical and perioperative resources. High risk patients underpin the concept of perioperative medicine. The first part of this talk discusses identification of such patients. The second part talks about evidence based strategies to optimize such patients to potentially improve surgical outcomes .

Audience Take Away:

- Old age doesn't necessarily equal high risk
- Frailty is a good predictor of poor outcome
- Having a perioperative strategy to deal with high risk patients is key for surgical units
- Prehabilitation, and Iron Therapy are two preoptimizing strategies



Biography

Dr. Osman Ahmed is a consultant Anesthesiologist at Midland Regional Hospital-Tullamore and a fellow of the College of Anesthesiologists, Ireland (FCARCSI, CST). He completed subspecialty fellowship in ultrasound-guided regional anesthesia at Cork University Hospital. He then joined a research group at University College Cork, Ireland, completed a two-year research program and received his MD degree in 2017. Dr. Ahmed's MD thesis is Procedural skills of ultrasound-guided axillary brachial plexus blockade, a novel form of metric-based simulation training and assessment. His research focuses on the use of simulation in healthcare for procedural skills training, curriculum development and validation of assessment tools.

Proficiency-based progression as a paradigm shift in peripheral nerve blocks training

Dr. Osman Ahmed

MRH-Tullamore and University College, Ireland

Currently, procedural skills in medicine are widely taught by means of an apprenticeship model, whereby trainees perform procedures under a graded level of supervision during clinical practice on live patients. Due to a variable and unpredictable clinical workload especially with the introduction of work-time directives, the trainee may have limited opportunity for repeated 'hands on' practice to acquire and maintain skills during clinical practice. Increasing patient expectation and high profile error cases compounds the problem even more. The current shift towards outcome-based training may require the trainee to achieve a level of competency before graduating from training program and performing procedures on patients. Competence is the minimal level of skill, knowledge and/or expertise derived through training and experience, required to safely and proficiently perform a task or procedure. Outcome-based training entitles that progression on the training program is determined on trainee's objectively assessed performance. Simulation could be part of a solution to such a problem as it provides realistic situations where trainees can rehearse procedural skills in a relaxed environment without endangering patients. Deliberate practice with feedback in a simulated environment has been reported to accelerate the rate of skill acquisition and facilitate the transfer to clinical practice. The advent of newer skills set such as laparoscopic surgery and ultrasound-guided peripheral nerve blocks pose a daunting challenge to training bodies in the current atmosphere of medical education. A paradigm shift is the introduction of proficiency-based progression (PBP) training (Gallagher et. al.) where trainee must achieve a proficiency benchmark before being permitted progression through training. This approach involves a procedure specific task characterization undertaken by those experts to the procedure of interest. Performance metrics and errors are first identified and defined for a reference procedure in an objective manner. Subsequently a validation process (face, content and construct) must be achieved for the set of metrics and errors. The final component of this approach is the design of a specific metric-based curriculum, establishing a benchmark of performance and deployment of the validated assessment tool.

Audience Take Away:

- Currently there are many challenges to medical training such as reduced training time, increasing patient expectations and high profile error cases
- Training is moving from the traditional apprenticeship model (time-based) to one of competence (outcome)-based training
- Simulation-based training facilitates trainees to rehearse procedural skills in a relaxed environment without endangering patients
- In Proficiency based progression trainee must achieve a level of proficiency before being permitted progression in training program. This must be done on trainee's objectively assessed performance
- Clinical educators may apply this method to their own institutional training programs and then compare outcomes results to traditional apprenticeship training

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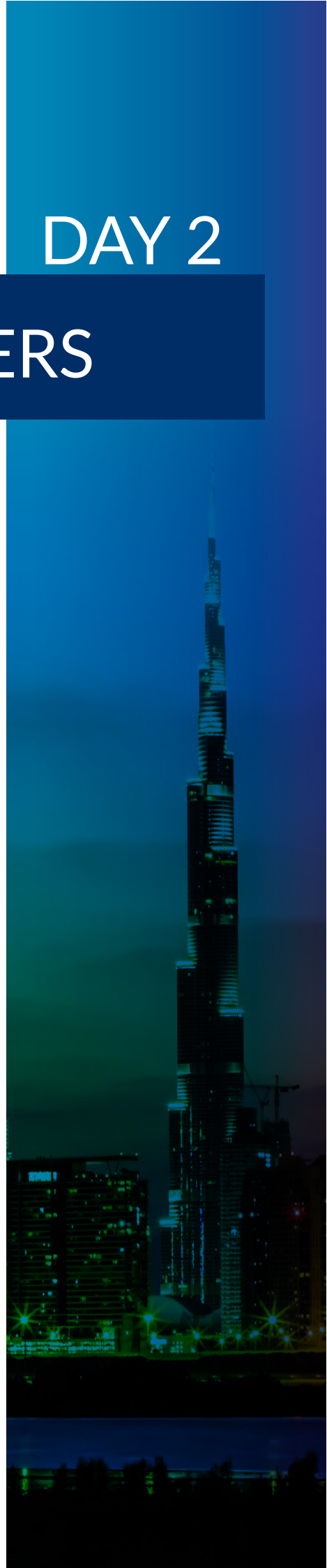
SURGERY AND ANAESTHESIA

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The role of laparoscopic approach to pancreatic resections: An evidence update

Basil J Ammori

Department of Surgery, King Hussein Cancer Center, Amman, Jordan

The laparoscopic approach to gastrointestinal cancer resections offers advantages in terms of postoperative hospital stay, return of bowel function and intensive care and hospital stays. Though laparoscopic pancreatic resections are technically demanding, they are gaining increasing acceptance in specialised units. We appraise case-matched comparative studies, randomised studies and meta-analyses that compared laparoscopic with open pancreatic resections (pancreaticoduodenectomy, distal pancreatectomy) and present an evidence-based update to guide practice.

The data suggest that whilst laparoscopic resections in experienced hands require significantly longer operating time than open resections, they are associated with benefits, particularly significant reductions in intensive care and hospital stay and more rapid functional recovery. The laparoscopic approach to pancreatic resections is becoming the gold standard approach in selected patients and in experienced hands within high volume units.

Audience Take Away:

- Appreciate the established and controversial indications for laparoscopic pancreatic resections
- Apply the selection criteria for the laparoscopic approach to pancreatic resections
- Develop an updated understanding of the pros and cons of laparoscopic versus open approaches to pancreatic resections
- Benefit from video presentation of the surgical technique to laparoscopic pancreatic resections

Biography

Dr. Basil Ammori graduated with MB ChB degree from Baghdad University, Iraq in 1986. He undertook his surgical training in the UK, completed an MD degree from Leeds University and his CCST in 2000, and became a Consultant Laparoscopic, Bariatric and Hepatopancreatobiliary Surgeon in Manchester, UK 2000-2017. He joined King Hussein Cancer Center in Jordan as a Gastrointestinal Surgeon in November 2017. He was granted a Hunterian Professorship by the Royal College of Surgeons of England in 2000 and appointed as Honorary Professor of Surgery at Manchester University, UK in 2011. He has over 170 publications in peer-reviewed medical journals.

Improving global mortality and outcomes in neck of femur fracture management

Abdus Samee Wasim¹*, Muaaz Tahir², Umar Hanif³

¹Birmingham Orthopaedic Training Programme, Dudley NHS Foundation Trust, Birmingham, West Midlands, UK,

²Birmingham Orthopaedic Training Programme, University Hospital Coventry & Warwickshire, Birmingham, West Midlands, UK

³Birmingham Core Surgical Training Programme, Good Hope Hospital, Birmingham, West Midlands, UK

Globally, neck of femur fractures (NOFF) are one of the most devastating injuries to the elderly population with a recognised 1 year mortality of 30% and 30 day mortality of 10%. In the UK alone, the reported annual health and social care cost is £2 billion and rising. The UK National Hip Fracture Database (NHFD) has reported annually since 2010, auditing practices within all national centres to improve on these outcomes. In collaboration with the British Orthopaedic Association (BOA), they have provided and updated national guidelines outlining a gold standard evidence based approach to managing all NOFF patients. This represents an exemplar of the effectiveness of NOFF care on a national scale by enabling clinical teams to monitor their performance against agreed clinical standards.

Key changes included financial incentives for hospitals achieving best practice criteria including: surgery within 36 hours of triage, prompt orthogeriatric review peri-operatively within 72 hours, pre and post operative delirium assessment, nutrition optimisation and specialist falls assessment with view to bone protection medication. 2017 data indicates the UK achieved these criteria in 59.7% of all NOFF patients. A further review noted correlation between early geriatric review and increased median time per patient was associated with a relative reduction in mortality of 3.4%. This represents an absolute reduction of 0.3% since the programme's inception.

The National Institute for Clinical Excellence (NICE) also produced guidelines with key criteria and patient based indications for total hip replacement (THR) or hemiarthroplasty for intra-capsular fractures. This has streamlined the approach for such fracture patterns in the UK ensuring decisions are evidence based and that appropriate patients who would benefit from a THR are ascertained. Latest data from 2018 informs us that 31.4% of eligible patients are now having a THR. Current evidence base also suggests cemented arthroplasty to be superior to uncemented due to reduced risk of prosthetic complications including: peri-prosthetic fracture, aseptic loosening, dislocation as well as post op thigh pain. Improving data notes 89.2% to have had cemented arthroplasty.

Overall the UK orthopaedic model provides an example that others can follow to audit and reduce varying practice in NOFF care with the goal of globally improving outcomes of mortality and morbidity within this vulnerable cohort of patients.

Audience Take Away:

- How we can improve international outcomes including mortality for neck of femur fracture patients using an evidence based approach via standardised guidelines
- The value of a holistic approach including orthogeriatricians in optimising and managing neck of femur fracture patients
- How operative strategies have changed for various neck of femur fracture patterns including considering patient based factors

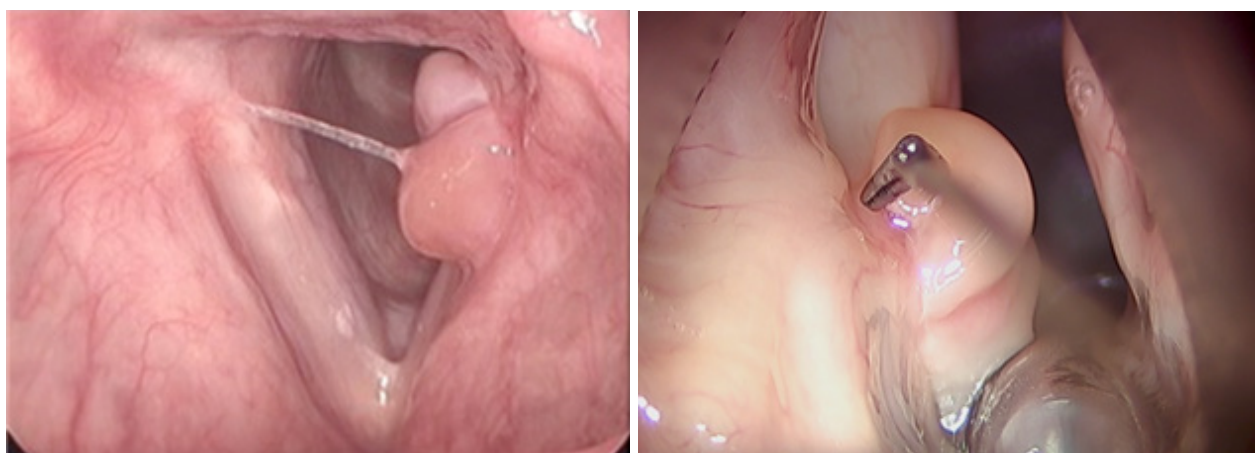
Biography

Mr Wasim studied sciences at the Queen Elizabeth's School London, United Kingdom developing an appetite for surgery at an early stage. He continued at Bart's & the London School of Medicine, the oldest medical school in the world, graduating in 2014 with an MBBS (distinction) and BSc (Hons) in experimental pathology carrying out research at the Blizard Institute, London. He completed junior surgical training in Birmingham, achieving MRCS (England) and secured a trauma & orthopaedic specialty job on the prestigious Birmingham orthopaedic training programme. He has a keen interest in research and surgical education delivering multiple UK national training courses.

Refining the role of Coblation technology in the larynx.

Dr Matthew S Broadhurst, MBBS, FRACS(ENT)
Queensland Voice Centre, Australia

Coblation technology offers the ability to ablate or remove soft tissue and cartilage from the larynx through the creation of a low temperature plasma field. Surrounding thermal injury is minimal but achieving precision can be a challenge. Given the delicate layered microstructure of the vocal folds, new technology needs to be used with caution to avoid irreversible injury and permanent hoarseness. With a number of years fine tuning the application of this technology by the author, helpful guidelines have been established to maximise efficacy and safety in treating laryngeal pathology.



Methodology: Consecutive patients presenting to a single surgeon from July 2013 to June 2018 with varying laryngeal pathology were included. All patients had pre and post-surgery high-definition videostroboscopy and voice handicap index (VHI) scores recorded. Minimum patient follow-up was 4 months. Outcome measures were disease resolution, recurrence, revision surgery, changes in the VHI and post-surgery videostroboscopy. Conditions treated included vocal process granuloma, false cord resection, debulking of papilloma, stenosis resection, suture lateralisation and other laryngeal granulation.

Results: Fifty five patients were included, complete data was available on 52 patients. (final results pending). The VHI was elevated pre-surgery and lowered in some post-surgery(results pending). There were two recurrences The use of Bioglue as a novel technique improved outcomes.

Conclusion: Careful application of Coblation technology in the larynx provides safety and efficacy on treatment certain laryngeal pathology. The techniques are relatively simple to acquire and the technology is reliable in reproducing results. Awareness of the delicate layered microstructure of the vocal folds and the possibility of irreversible damage and hoarseness should always guide application of new technology to maximize outcomes.

Biography

Dr Matthew Broadhurst is a fellowship trained laryngeal and upper airway surgeon specialising in laryngeal surgery, voice restoration and obstructive sleep apnoea. He returned to Brisbane, Australia from Boston, Massachusetts in 2007 having worked for 2 years at Harvard Medical School and Massachusetts General Hospital. He was the first fellowship trained laryngeal surgeon in Australia and now has a large tertiary referral practice in voice and larynx disorders and sleep apnoea. In his practice, he utilises state of the art techniques in surgery to the airway and is actively involved in clinical research and education both nationally and internationally. His areas of special interest and research include KTP laser for dysplasia and glottic cancer, short and long term management of vocal fold paralysis, phonotraumatic lesions in professional voice users and laryngeal papilloma.

Da vinci robotic vascular surgery

Petr Štádler

Department of Vascular and Robotic Surgery, Na Homolce Hospital, Prague, Czech Republic

Introduction

The da Vinci system has been used by a variety of disciplines for laparoscopic procedures but the use of robots in vascular surgery is still relatively unknown. The feasibility of laparoscopic aortic surgery with robotic assistance has been sufficiently demonstrated. Our clinical experience with robot-assisted vascular surgery performed using the da Vinci system is herein described.

Methods

Between November 2005 and September 2018, we performed 437 robot-assisted vascular procedures. 291 patients were prospectively evaluated for occlusive diseases, 111 patients for abdominal aortic aneurysm, 5 for a common iliac artery aneurysm, 9 for a splenic artery aneurysm, 1 for a internal mammary artery aneurysm, 8 for median arcuate ligament release, 8 for endoleak type II treatment post EVAR, 2 for renal artery reconstruction and two cases were inoperable. 5 hybrid procedures in study were performed.

Results

417 cases (96%) were successfully completed robotically, 1 patient's surgery (0,25%) was discontinued during laparoscopy due to heavy aortic calcification. In 16 patients (3,7%) conversion was necessary. The thirty-day mortality rate was 0,5% (2 patients), and early non-lethal postoperative complications were observed in 7 patients (1,6%).

Conclusion

Our experience with robot-assisted laparoscopic surgery has demonstrated the feasibility of this technique for occlusive diseases, aneurysms, endoleak II treatment post EVAR, for median arcuate ligament release and hybrid procedures.

Sutureless circumcision using iso-amyl cyanoacrylate - Innovative surgical technique

Dr Amit Raut, DNB(Paed-Surgery), DEBPS (PaedSurg) Europe, FMAS, FIAGES

Saafalya Childrens Hospitals, Nashik, Maharashtra, India

There are different techniques of performing circumcision however in any case requires suturing of wound edges to complete the procedure. Wound closure techniques have evolved from the earliest development of non-absorbable suturing materials to advanced modalities like synthetic absorbable sutures, staples and tissue adhesives. Here we have used iso-amyl cyanoacrylate as adhesive for approximation of wound edges playing a role of sutures and also have done comparative analysis of sutureless circumcision using iso-amyl cyanoacrylate to approximate wound edges with conventional use of absorbable suture material for approximation of wound edges in paediatric patients. We have innovated a newer surgical technique with help of this iso-amyl cyanoacrylate. Use of this adhesive was thought in view of sutureless procedure and to study its safety, efficacy, functional outcome and cosmesis. The two most common complications of circumcision are bleeding and wound infection. The cyanoacrylate tissue glue has been claimed to have the advantages of being hemostatic, bacteriostatic and easy to use. The use of cyanoacrylate as tissue adhesive as an alternative to sutures has invoked curiosity and interest in the field of cosmesis and wound healing. Compared to other cyanoacrylates, Iso amyl 2-cyanoacrylate has unique properties having faster tissue bonding capacity and curing, than octyl cyanoacrylate. Iso amyl 2-cyanoacrylate is superior to N-butyl cyanoacrylate since it does not get brittle and fracture on long lacerations. Its fast polymerization, immediate hemostasis, excellent tensile strength, biocompatibility, ease of application, and bacteriostatic properties make it very effective and useful in closing surgical or wound incisions. Our study shows use of iso-amyl 2 cyanoacrylate as tissue adhesive instead of conventional absorbable interrupted suturing technique for paediatric circumcisions in 364 patients total in which comparative study of Sutureless versus Sutured Circumcision has been done. Our results show that when iso-amyl cyanoacrylate is used for paediatric circumcisions there are less chances of bleeding, infection, lesser degree and incidence of swelling, above all there is less post-operative pain, hence lesser use of analgesics in our paediatric patients. Also wound healing was found to be better and with best final cosmesis in follow-up period as compared to sutured group patients. Our results show that iso-amyl cyanoacrylate is comparatively safe, efficient, has better functional outcome and good cosmesis when used as adhesive for wound edges of paediatric circumcisions.

Audience Take Away:

- They will learn newer surgical technique of circumcision which is more simple, safer and easier
- As this technique is safe, efficient, more rewarding with better cosmesis is fruitful from patient point of view also
- Also this technique does not involve use of sutures for surgery so no worry or no problems related to sutures like suture tracks, infections, pain, bleeding, edema nor any other problems post-operatively
- Yes, definitely, this newer technique can be used by faculty to expand their research and teaching
- It will also make performing persons job more efficient and rewarding

Biography

Amit Raut is currently acting as a pediatric surgeon in Saafalya Childrens Hospitals, Nashik, Maharashtra, India

THRIVEing children: A major advancement using 'tubeless' anesthesia (thrive) for delivering pediatric endoscopy under general anesthesia

Dr Aynkaran Dharmarajah

St. Mark's Hospital, London North West University Healthcare NHS Trust, London, UK

Transnasal Humidified Rapid-Insufflation Ventilatory Exchange (THRIVE) is increasingly used in a range of settings in anaesthesia. It has been shown that THRIVE extends the safe apnoea time in children¹, and it is used well in paediatric resuscitation. At our quaternary referral centre we propose a further application of THRIVE to help provide anaesthesia without intubation, yet oxygenate paediatric patients undergoing upper gastrointestinal tract endoscopy.

Established practice for paediatric oesophagogastrroduodenoscopy (OGD) is tracheal intubation and ventilation under general anaesthetic or sedation. Our technique uses THRIVE combined with sedation without intubation. Patients are consented for anaesthetic. IV access, AAGBI monitoring is applied in the anaesthetic room and the child sedated with 1 mcg/kg fentanyl and 1-2 mg midazolam. The awake patient is taken into theatre where an OptiFlow™ nasal set (small) is applied. Initial flow rate is set at 20-30L/min humidified oxygen and the patient preoxygenated for at least 3 minutes in a 30 degree ramped position. Following WHO Time Out the patient is moved to the left lateral position, and given an induction dose of propofol which renders them apnoeic. The oxygen flow rate increases to 40-50L/min and a jaw thrust is maintained during the procedure. The child is closely monitored for respiratory effort and desaturation. They remain unresponsive to endoscopic oesophageal intubation. The OGD takes 5-10 minutes by which time, or soon after, spontaneous breathing returns.

The patient remains in the left lateral position until recovery. Desaturation has never been observed with the use of this technique, and children have tolerated it well.

We compared two groups of ASA 1-2 paediatric patients undergoing OGD: one using THRIVE (age 11-16 years); and one in which patients were intubated due to video capsule deployment (age 4-17 years). To account for the different procedures, the anaesthetic time before and after the procedure itself was calculated from the electronic theatre log. In both groups 6 patients also had a colonoscopy. Despite the small sample, both the pre and post-procedure anaesthetic time were significantly lower in the THRIVE group ($p < 0.05$). There was no significant difference in recovery time between groups ($p > 0.05$) (see Table 1). Neither group exhibited desaturation during the procedure, however there was an episode of laryngospasm in one patient in the intubated group.

	THRIVE group (n=12)	Intubation group (n=12)
Mean pre-procedure anaesthetic time (mins)	9.67	19.00
Mean post-procedure anaesthetic time (mins)	4.36	9.50
Mean time in recovery (mins)	39.50	34.83
Desaturation ($SpO_2 \leq 94\%$)	Nil	Nil
Adverse events	1 patient: transient post-procedure bradycardia	1 patient: laryngospasm and vomit on extubation

In conclusion we propose 'tubeless' anaesthesia using THRIVE in combination with intravenous anaesthesia as a potentially safe, efficient and less invasive method of providing anaesthesia for paediatric endoscopy in low-risk children. Since this data was collected we have continued to use this technique with encouraging outcomes. In suitable candidates who are assessed to have low risk of airway compromise it provides a viable alternative to tracheal intubation, avoiding risks associated with instrumenting the airway and the use of muscle relaxant. There is also significantly less time taken to administer anaesthesia, increasing theatre utilization and the number of patients that can be treated.

1. Humphreys S, Lee-Archer P, Reyne G, Long D, Willims T, Schibler A, Transnasal humidified rapid-insufflation ventilatory exchange (THRIVE) in children: a randomized controlled trial. Br J Anaesth 2017; 118: 232-238

Audience Take Away:

- The audience will be able to take this technique back to their department and in conjunction with their anaesthetic team, deliver a novel method of anesthesia that enhances patient care, and also increases theatre utilization and the

number of patients treated. Anecdotally patients report a better and quicker recovery once on the ward.

- This is a novel method, so the talk will show them how to deliver this within their hospital. The other benefits are as above. In addition this has been used for adults endoscopy with similar success.

Biography

Dr. Dharmarajah graduated from his medical training at the Imperial School of Medicine, London in 2001. He started his anesthesia training in London on the St. Bartholomew's & Royal London rotation, completing his higher training at the Imperial school of Anesthesia. He additionally undertook a part time Masters in Medical & Surgical Education from Imperial College receiving a Merit in 2012. He has been a Consultant Anaesthetist since 2011 having worked at St. Mary's Hospital, Paddington, University College Hospital, London, and now at St. Mark's hospital, London. He has contributed significantly to patient safety and education, and now has an additional role working as an academic educationalist at Imperial College.

Telling difficult news

Ameen I. Ramzy, MD, MBA, FACS

Formerly at Legacy Emanuel Medical Center 1, Medical Director, Legacy Emanuel Medical Centre, Portland, Oregon, USA
Former Maryland State EMS Director and Medical Director, Baltimore, Maryland, USA

Telling happy news is fun and usually easy. Telling difficult news is not fun and never easy but in some ways is more important, both for the one who says it and the one who is meant to hear it. How difficult news is told makes all the difference as to whether and how it is heard. Difficult news is not synonymous solely with bad news, a subtle distinction that has to be understood. In the trauma surgery where I worked and in other medical services with emergencies, telling someone a loved one is likely to survive an unexpected event is still telling difficult news.

Difficult news is told not only by health care providers. In a country with a population of 300 million, it can be expected that 2 million people will lose their lives in one year, and the 8 million people in their immediate families will receive and convey this difficult news to other family members.

Telling someone that a loved one has died is obviously bad news. Telling someone that a loved one has had a close brush with death, but is expected to live may seem at first to be good news. In reality, however, this is still very difficult news. Even if the prognosis is favorable (which is hard to predict with absolute certainty), there are many losses of time and control that are not easy to measure, but are still very real and daunting. For someone who has had a heart attack or an injury, there is a sense of both uncertainty and loss of control. Virtually any conversation in an Emergency Department or an Intensive Care Unit can involve difficult news.

Audience Take Away:

- There is a specific three-step approach to deal with some of the most uncertain and difficult situations. Additionally, there is hope for increased sensitivity as to the situations of a family's fear and uncertainty.

Biography

Dr. Ramzy did undergraduate study at Northwestern University near Chicago, Illinois. He graduated from the University of Nebraska School of Medicine in 1975, and then did a General Surgery Residency. In Baltimore, Maryland, he trained in Trauma Fellowship and went on staff as a Trauma Surgeon. He also became both State EMS Director and Medical Director at the Maryland Institute for Emergency Medical Services System. He later provided surgery and critical care at the Legacy Emanuel Medical Center in Portland, Oregon, and became the Trauma Medical Director of the Level 1 Trauma Center. In his career, he published in the Journal of Trauma and made over 200 presentations in EMS and Trauma.

Primary hepatocellular carcinoma

Dr. Clive Thomas* FRCS, FICS, FACS, Dr. G. Smith FRCS, Dr. C. Morris MDDM and Dr. J. Thame

Association of Surgeons in Jamaica, West Indies

Comparing the aetiologies and presentations of two cases in Jamaica, West Indies in the Caribbean. The goal of this lecture is to outline the various predisposing factors on the onset of the disease process following several years of exposure to the infective process. We will expose the investigative options to confirm the disease and staging and pre-operative evaluation.

Audience Take Away:

- How to appreciate the various approaches to surgically and oncologically successfully excise the tumour with negative margins
- Describe the procedures and maneuvers to achieve haemostasis and reduce blood loss
- The overall planning and execution of the peri-operative management of these cases
- To achieve a cure by surgical and oncological means and therapy to improve the outcome and prognosis of this potentially lethal disease

Biography

Dr. Thomas gained his MBBS at the University of the West Indies, Jamaica in 1981. Between 1989 and 1999 he became a Fellow Royal College of Surgeons, Fellow American College of Surgeons and Fellow International College of Surgeons. Between 2005 and 2007 he performed the first Laparoscopic Nissen's Fundoplication and Hiatus Hernia Repair and the Laparoscopic Bariatric Sleeve Gastrectomy, in Jamaica. He wrote several academic papers for publishing, served as President of the Association of Surgeons in Jamaica and has presented at academic conferences locally and internationally. He's currently a Consultant, Laparoscopic General Surgeon with over 33 years of experience in Public Hospitals and private practice.

Diagnosis and management of bone tumours of the lesser trochanter

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²Department of Orthopaedics, Royal Orthopaedic Hospital, Birmingham, UK

³Department of Orthopaedic Oncology, Royal Orthopaedic Hospital, Birmingham, UK

⁴Department of Musculoskeletal Radiology, Royal Orthopaedic Hospital, Birmingham, UK

Introduction: Primary bone tumours of the lesser trochanter (LT) are rare and the literature describing them is sparse. We describe the largest series of LT tumours reviewing the demographics, diagnosis and management.

Methods: A retrospective search of prospectively maintained radiology and oncology databases was performed to identify bone tumours of the LT diagnosed between 2007 and 2018. Metastatic lesions were excluded. All cases were re-reviewed by a senior Consultant Radiologist and all case of benign isolated tumours of the LT were included.

Results: 23 cases of isolated LT tumours were identified. There were 15 males and 8 females. Median age of our cohort was 32 (14 - 63) years. Most (n=19, 82.6%) cases had classic radiological (Radiographic, MR Imaging and CT) features and therefore did not undergo biopsy. 4 patients had equivocal radiological investigations that required biopsy to confirm the diagnosis. MR imaging was the most commonly used imaging modality for diagnosis (n=17, 73.9%)

There was a broad range of tumour subtypes, and osteochondroma (n=17, 73.9%) the most frequently diagnosed. Surgical excision was performed in 4 patients (all osteochondromas) and 4 patients underwent therapeutic radiological guided hip injections for symptomatic relief. The remaining cases were managed conservatively. Where they were identified incidentally, no intervention was required.

Conclusion: We report the largest case series of isolated primary bone tumours of the LT. All isolated primary bone tumours of LT are benign. Osteochondroma is the most common. The diagnosis can be made with on radiological investigations in most patients.

Audience Take Away:

- The epidemiology of tumors of the LT; prevalence and demographics
- The diagnosis of Tumors of the LT which are considered rare and often missed
- The dilemma in the surgical management of these cases, due to the anatomical location of the LT

Biography

Mr Wasim studied sciences at the Queen Elizabeth's School London, United Kingdom developing an appetite for surgery at an early stage. He continued at Bart's & the London School of Medicine, the oldest medical school in the world, graduating in 2014 with an MBBS (distinction) and BSc (Hons) in experimental pathology carrying out research at the Blizard Institute, London. He completed junior surgical training in Birmingham, achieving MRCS (England) and secured a trauma & orthopaedic specialty job on the prestigious Birmingham orthopaedic training programme. He has a keen interest in research and surgical education delivering multiple UK national training courses.

Our experience with own new method of implant placement: Dual plane subfascial

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Background: Breast augmentation is the one of the most frequently performed aesthetic surgical procedures in the world. The most important preoperative decisions with influence on the final appearance of the augmented breast are the breast implant pocket choice and selection of the most appropriate implant. Described pocket locations are subglandular, subfascial, partial retropectoral, total submuscular and dual plane.

Objectives: We introduced new method of pocket forming/location for implant placement, which is combination of Tebbett's dual-plane 2 or 3 and Graf's subfascial.

Material and Methods: Between January 2016 and April 2019, 36 patients were operated using dual plane subfascial breast augmentation. Pinch test in medial pole less than 2,0 cm and in upper pole less than 2,5 cm are indications for this technique. In our modification, dissected flap in front of the muscle is fasciocutaneous and it provides better coverage especially in thin patient with small amount of subcutaneous fat.

Results: Hematoma and infection didn't occur in any patient from our study. In two patients occur a capsular contracture gradus I/II without the need for reoperation. Palpability of implants is recorded in three patients.

Conclusion: Dual plane subfascial is good option in primary and secondary breast augmentation with a well set indication especially in the breasts with the upper pinch test less than 20 mm.

Key words: dual plane subfascial, implant placement, new method.

Audience Take Away:

- The audience would learn the new method of implant placement for breast augmentation
- The learned facts and methods will be easily applicable in the daily practice
- Presented facts will provide a practical solution to a problem that could be very difficult solved without this method(s)

Biography

Specialist in General Surgery and Plastic, Reconstructive and Aesthetic Surgery. Reuf Karabeg was born in Bugojno

In 2000, he was appointed Head of the Fist Surgery Department at the Clinic for Plastic and Reconstructive Surgery at the Clinical Center in Sarajevo

In 2009 - Appointed Head of the Clinic for Plastic and Reconstructive Surgery at the Clinical Center of the University of Sarajevo. Elected President of the Balkan Association of Plastic, Reconstructive and Aesthetic Surgeons for the period 2009-2011. Elected President of the Organizing Committee of the 7th Balkan Congress of the Association of Plastic, Reconstructive and Aesthetic Surgeons to be held in September 2011 in Sarajevo.

In 2013 - Elected as the first president of the Association / Association of Plastic, Reconstructive and Aesthetic Surgeons / Surgeons in BiH, which office he still holds today. (Biography updated July 2015).

In 2014 - Assistant Professor Reuf Karabeg, PhD, was promoted to academic title Associate Professor at the Faculty of Medicine in Sarajevo, course SURGERY, PLASTIC AND RECONSTRUCTIVE SURGERY.

December 2014. The book Fundamentals of Plastic, Reconstructive and Aesthetic Surgery, published by the Faculty of Medicine, University of Sarajevo, has been promoted. The book was written by, along with Professor Reuf Karabeg, as author and editor, 22 more prominent experts from Croatia, Serbia, Slovenia, BiH and the USA. It is the first textbook for students of medicine and dentistry, but also a manual for specialists in related specialties. 2011th to 2015th participates as part of the team and head of the Clinic for Reconstructive and Plastic Surgery of the University Clinical Center Sarajevo for five years in the humanitarian campaign of Euromelanom BiH, an action of free examinations and surgeries, which are held in BiH and 30 countries of Europe.

September 2015 Dubrovnik-Croatia. As Vice President of Congress and a member of the Organizing Committee of the 2nd Congress of Fellows of Science and the Xth Jubilee Croatian Congress of Plastic, Reconstructive and Aesthetic Circuits, he will be present and present 2 papers (one in aesthetic surgery and one in tumor-melanoma surgery) as an invited lecturer.

Professor Reuf Karabeg has published over 63 papers in reference journals and / or presented at congresses worldwide

2016 got employed at the Karabeg Surgical Clinic;

He has published in referenced journals and/or presented at congresses over 75 papers all over the world.

Intensive care doctors preferences for arterial oxygen tension levels in mechanically ventilated patients

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Oxygen is liberally administered in intensive care units (ICUs). Nevertheless, ICU doctors' preferences for supplementing oxygen are inadequately described. The aim was to identify ICU doctors' preferences for arterial oxygenation levels in mechanically ventilated adult ICU patients.

In April to August 2016, an online multiple-choice 17-part-questionnaire was distributed to 1080 ICU doctors in seven Northern European countries. Repeated reminder e-mails were sent. The study ended in October 2016.

The response rate was 63%. When evaluating oxygenation 52% of respondents rated arterial oxygen tension (PaO₂) the most important parameter; 24% a combination of PaO₂ and arterial oxygen saturation (SaO₂); and 23% preferred

SaO₂. Increasing, decreasing or not changing a default fraction of inspired oxygen of 0.50 showed preferences for a PaO₂ around 8 kPa in patients with chronic obstructive pulmonary disease, a PaO₂ around 10 kPa in patients with healthy lungs, acute respiratory distress syndrome or sepsis, and a PaO₂ around 12 kPa in patients with cardiac or cerebral ischemia. Eighty per cent would accept a PaO₂ of 8 kPa or lower and 77% would accept a PaO₂ of 12 kPa or higher in a clinical trial of oxygenation targets.

Intensive care unit doctors preferred PaO₂ to SaO₂ in monitoring oxygen treatment when peripheral oxygen saturation was not included in the question. The identification of PaO₂ as the preferred target and the thorough clarification of preferences are important when ascertaining optimal oxygenation targets. In particular

When designing future clinical trials of higher vs lower oxygenation targets in ICU patients.

Audience Take Away:

- We report the largest multinational survey on ICU doctors' self-reported preferences for targeting oxygenation in mechanically ventilated patients to date
- The majority of doctors preferred PaO₂ to SaO₂ in guiding oxygen supplementation, which enlightens the importance of focusing on also PaO₂ when ascertaining oxygenation guidelines within the ICU population
- The target PaO₂ varied between doctors and between different patient categories and overall preferences may indicate a tendency towards extrapolation of recommendations in-between different patient populations and different settings, which highlights the lack of evidence and underlines the imminent need for clinical trials addressing the optimal oxygenation targets for ICU patients
- The findings of the present survey have important implications for the design of these trials

Biography

I am a consultant anesthetist and intensive care physician, under graduated in Mosul University/Medical College in Iraq in 1996, and Post graduated from Aalborg University Hospital, Northern Jutland Denmark, worked later in Roskilde University Hospital in Zealand / Anesthesia Dept., Denmark since 2013, Consultant at same dept. since 2015. I worked in Dr. Sulaiman Al Habib, DHCC in Dubai since 2017 as Consultant Anesthetist. I have published 4 articles, all peer reviewed in PubMed, and participated with 2 posters in previous anesthesia and ICU related congresses.

Heparin resistance during extracorporeal membrane oxygenation: Dubai hospital experience

Dr Fayaz Mohammed Khazi

Consultant Cardiothoracic Anaesthetist, Department of Cardiothoracic Surgery, Dubai hospital, Dubai Health Authority, UAE

Objective: The management of Heparin resistance in patients undergoing ECMO is still uncertain. We sought to assess the efficacy and safety of Fresh frozen plasma to optimize the anticoagulation in these patients.

We studied 42 adults undergoing VA-ECMO. Heparin infusion was increased incrementally to achieve target ACT in HG group and plasma administered in FFPG group in heparin resistance (HR) patients. Statistical comparison was performed between these two groups and results compared with non-heparin resistance (Non-HR) patients.

Results: Overall 36% survived and 64% suffered bleeding complications. There was no difference in age ($p = 0.118$) or average ECMO duration ($p = 0.393$). The heparin requirement was significantly less in FFPG ($p = 0.008$) and average ACT difference of 159.2 (20.3) was highly significant ($p < 0.001$). Clinically the survival was higher in FFPG (50% vs 10%) without statistical difference ($p = 0.07$) probably due to small sample size. Twenty HR compared to 22 Non-HR patients. The survival rate (41% vs 30%) was not statistically significant ($p = 0.340$). However, more bleeding 80% vs 50% recorded in HR ($p = 0.043$) even though heparin doses between them was not different.

Conclusions: The heparin requirement was high in patients treated with heparin alone. Fresh frozen plasma effectively increased ACT to therapeutic target in HR patients. There was no difference in the heparin dose, significantly higher bleeding complications were recorded in HR patients. Clinically, survival was better in Non-heparin resistance and plasma treated a patient that was not found to be statistically significant.

The heparin requirement was high in patients treated with heparin alone. Fresh frozen plasma effectively increased ACT to therapeutic target in HR patients. There was no difference in the heparin dose, significantly higher bleeding complications were recorded in HR patients. Clinically, survival was better in Non-heparin resistance and plasma treated patients that was not found to be statistically significant.

Audience Take Away:

- During ECMO, AT activity decreases that could be responsible for the development of HR. However, exact incidence, reason and the management of these patients undergoing ECMO is still uncertain. Audience can get a brief clinical background of this phenomenon
- No research has been attempted regarding the use of fresh frozen plasma and heparin resistance in ECMO patients
- This lecture will give an information regarding the patient data collection and usage of statistical analysis in these difficult group of high risk patients
- Lecture can also open up about the possible multicenter trial in a larger group of patients to confirm a clinical benefit of these strategies aimed at treating heparin resistance

Biography

Dr Fayaz Mohammed Khazi has been a consultant Cardiothoracic Anesthetist for 15 years and has worked in various esteemed medical institutions in United Kingdom prior to his current appointment in Dubai Hospital. He is also certified by the European board in Transesophageal echocardiography with extensive experience in perioperative echocardiography. He is also renowned internationally as an expert and investigator for research in ECMO and has delivered various lectures in ELSO meetings as an invited faculty. He has been investigator for various research projects including postoperative pain control, Neurocognitive dysfunction, Histamine release during Cardiopulmonary bypass, Platelet function assessment and bleeding in Cardiac surgery. To his credit, he has several publications in peer reviewed international journals, has given several talks at international meetings and congresses and is an editor/reviewer for four international journals.

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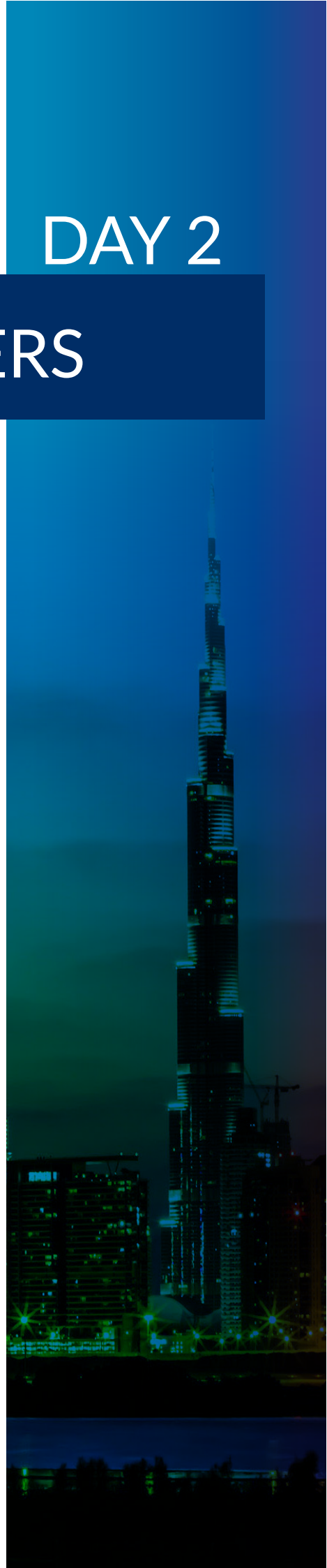
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Analysis of safe surgical practice in a UK based hospital: Adherence to who guidelines during orthopaedic procedures

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Introduction:

The number of surgical procedures being performed annually has consistently increased over the past years worldwide. With the increased demand this puts on surgical services, the surgical profession must ensure that standards are maintained and guidelines followed in order to mitigate risks and prevent adverse harm to patients. Wrong site surgery still remains an occurrence in the surgical profession. 38 Surgical 'Never Events' of which 20 were due to wrong site surgery were identified between April 2016- March 2017 following NHS improvement review. The WHO safety checklist aimed to address and standardise the process of safe surgery. Its currently the Gold standard across the globe, however cases of surgical never events persist. WHO advocates preoperative marking checks be performed at multiple stages prior to surgery: When procedure is scheduled, admission to operation theatre, before patient leaves pre-operative/ anaesthetic area and anytime responsibility of care changes.

Methods:

We investigated local adherence of preoperative guidelines with respect to emergency orthopaedic procedures and perioperative 4-Point patient marking verification checks.

Prospective analysis of 24 cases over a 3 week period in a Trauma theatre. Patients undergoing orthopaedic surgery had their records analysed for presence and accurate completion of 4 part surgical safety preoperative marking checklists.

The 4 Checks were as follows: 1) When patient marked with indelible pen, 2) When leaving ward area, 3) Prior to induction of anaesthesia and 4) During theatre team Time Out procedure

Results:

62% of patients had a surgical preoperative marking checklist filed in their notes with only 54% of cases having the procedure and site written on the checklist.

58% of surgical sites were checked at the first stage with this dropping to 37% at the second stage. Only 8% of cases had preoperative checks carried out at the 3rd stage with 25% of cases being checked during surgical time out

Conclusions:

Results show poor compliance with recommended protocols to prevent wrong site surgery and surgical never events. This places patients at high risk unnecessarily and could have significant litigation costs and issues associated with it. Auditing such processes regularly and providing teaching for relevant healthcare staff remains the cornerstone of optimising safe surgical practice.

Audience Take Away:

- Adherence to established guidelines are essential in preventing surgical never events
- WHO safety guidance advocates checks at a number of stages by a number of people to prevent wrong site surgery
- It is the responsibility of the wider surgical team to ensure risk of harm to patients is minimised

Biography

Mr Wasim studied sciences at the Queen Elizabeth's School London, United Kingdom developing an appetite for surgery at an early stage. He continued at Bart's & the London School of Medicine, the oldest medical school in the world, graduating in 2014 with an MBBS (distinction) and BSc (Hons) in experimental pathology carrying out research at the Blizard Institute, London. He completed junior surgical training in Birmingham, achieving MRCS (England) and secured a trauma & orthopaedic specialty job on the prestigious Birmingham orthopaedic training programme. He has a keen interest in research and surgical education delivering multiple UK national training courses.

Role of endovascular procedures in the management of arterial complications following pancreas transplantation

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³Chirurgische Klinik, Knappschafts Krankenhaus Bochum/Ruhr-Universität, Bochum, Northrhine-Westphalia, Germany

Endovascular medicine is one of the most rapidly expanding fields in medicine today. Vascular complications after pancreatic transplantation carry a high rate of graft loss. It is therefore obvious that efforts have been made to utilise endovascular techniques to treat the challenges of pancreas transplantation.

We reviewed all pancreas transplant procedures in our centre since 1994 (n=556). All endovascular procedures performed for arterial complications related to the pancreas graft were collected. We confined our search to arterial problems since interventions on the venous side were less homogenous and much more diverse. We also did not consider procedures carried out for improvement of inflow in the pelvic vessels or for problems related to PAD because the indication for these intervention does not differ from the indications in not transplanted patients (only with regard to the special emphasis in transplant patients to preserve adequate vessel segments for further transplants).

In our series endovascular techniques were used in the following settings:

- stenosis of the Y-graft: n = 6
- pseudoaneurysm: n = 1
- av fistula: n = 1
- consolidation of the vessel wall after bleeding due to arrosion: n = 7

In all cases the procedure could be carried out successfully thus minimising the need for surgery. The implantation of covered stent grafts following a bleeding episode due to arrosion originating from the pancreas graft seemed also superior to open surgery because we did not observe any episodes of rebleeding. None of the procedures had to be carried out in the first month following transplantation, but were treatment options in the long run (range 41 - 4012 days after the transplant operation).

Pancreas transplantation is an operation not known to many surgeons. So, in an emergency, most surgeons will be confronted with unknown and unexpected problems. This abstract highlights the possible pitfalls of this complex procedure, shows how life threatening situations might be handled and how the evolvement of endovascular medicine contributes to the modern management of these cases.

Biography

Mr. Andreas Wunsch studied Medicine in Aachen (Germany), Hannover (Germany), and London (England). He graduated in 1992 and started his surgical education at Heidelberg University, Germany (Prof. Dr. Herfarth). Later on he continued his training at Mainz University, Germany (Prof. Dr. Otto). Since 2005 he works as a consultant at Bochum University Hospital (Knappschafts Krankenhaus Bochum / Prof. Dr. Viebahn). He obtained board certifications in general, vascular and visceral surgery. He had taken a special interest in liver, pancreas and kidney transplantation and had been the author and coauthor of articles in this field.

The retrospective evaluation of the vocal cord paralysis following a general anesthesia over last 10 years

Dong-Chun Kim*, Seunghee Ki

Inje University, Busan, Korea

Vocal cord paralysis (VCP) is a serious complication after general anesthesia. VCP due to iatrogenic nerve injury is reduced, but VCP due to mechanical damage after general anesthesia is increasing. The purpose of this study is to investigate etiological profile and risk factor for VCP following general anesthesia and consider what the anesthesiologist effort can reduce the incidence of VCP.

This study is a retrospective cohort study. We reviewed the medical record of 322 patients consulted to otolaryngologist due to sore throat, discomfortness of throat, difficulty in swallowing, or voice change after general anesthesia from January 2007 to October 2016. Among them, 197 cases were analyzed to evaluate the etiology of VCP after general anesthesia. The exclusion criteria were as follows; (1) Patient had vocal cord paralysis before the surgery under general anesthesia; (2) Patient who had a possibility of recurrent laryngeal nerve or vagus nerve injury during the surgery; (3) patient who kept tracheal intubation or got ventilatory care after the surgery; (4) The patient who wasn't diagnosed by laryngoscopy; (5) Patient who underwent surgery with a high potential for nerve injury (Thyroidectomy, carotid endarterectomy for stenosis of the carotid artery, cervical spine decompression from anterior approach, open-heart surgery and thorax surgery). The assessment of the relationship between the occurrence of VCP and etiological cause was performed with the correlation analysis and regression analysis.

The average time for patients to see otolaryngologist was 10 days. 28 patients were diagnosed with VCP. Four of them were treated with arytenoid adduction and 9 continued with VCP or symptoms of VCP until the last visit. Five of the other patients recovered spontaneously and the average recovery period was 33 days. Other 169 patients were not diagnosed with VCP, but 27 of them had swelling of vocal cord, vocal cord gap or weakened vocal cord movement and 25 had erosion or contusion on larynx or pharynx. The most common complaints of patients diagnosed with VCP were hoarseness, while the patients with no VCP were the most common complaints of sore throat. Correlation analysis between the hoarseness and VCP revealed Spearman's coefficient rho of 0.381 and p-value of less than 0.001. The factors associated with the development of VCP were height of patient, change of posture during surgery, and operation in sitting position in this study. The results of regression analysis (Odds ratio, 95% CI) of each factors are as follows; height (1.048, 1.001-1.097), posture change (2.652, 1.107-6.354), sitting position (3.007, 1.214-7.447).

To reduce VCP, be careful not to damage the patient (such as arytenoid subluxation or dislocation) when performing airway intubation. In addition, to be careful when changing the posture of the patient during surgery, and to have special vigilance in patients with a high likelihood of vocal fold paralysis.

Audience Take Away:

- This study was initiated by an ENT physician's opinion that a recent increase in patients with VCP or arytenoid dislocation after general anesthesia
- Realized that VCP can occur due to mechanical damage caused by intubation, without iatrogenic nerve injury. And recognized that the number of VCP after general anesthesia is not small
- The results of this study on etiological profiles and risk factors for VCP following general anesthesia can be used to understand what anesthesiologist should pay attention to during anesthesia induction and surgery to reduce VCP
- Furthermore, it raises awareness that prompt treatment (to see otolaryngologist) is needed for patients complaining of hoarseness and sore throat after general anesthesia

Biography

Education:

- 2009-2014 Inje Univ. College of Medicine (M.D.)
- 2016~ Inje Univ. College of Medicine (M.S., Anesthesiology and pain medicine)

Career:

- 2016~ Resident, Department of Anesthesiology and pain medicine, Busan Paik Hospital.

Value of pre-operative imaging of the flexor hallucis longus for achilles tendon transfer surgery

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Introduction: Flexor hallucis longus (FHL) tendon transfer is the method of choice in reconstructing chronic neglected Achilles tendon rupture (ATR). In routine FHL tendon transfer surgery, the FHL is excised at the level of the Master knot of Henry and transferred into a bone tunnel in the calcaneus bone. Using this technique, only the distal FHL tendon is visualised and abnormalities of the FHL muscle belly and proximal tendon may be missed.

Method: In our institution, a tertiary orthopaedic referral centre, we have encountered a varied spectrum of abnormalities involving the FHL on MRI and therefore, the FHL is an important review area for the musculoskeletal radiologist. We decided to specifically analyse fatty infiltration of the FHL and performed a retrospective review of 225 consecutive MR images of ankle performed at our institution during 2017 for ankle pain and analysed the extent of fatty infiltration of the FHL muscle using a modified Goutallier classification.

Results: We performed a retrospective review of 225 consecutive MR images of ankle performed at our institution during 2017 for ankle pain and analysed the extent of fatty infiltration of the FHL muscle using a modified Goutallier classification. The average age of the cohort was of the cohort was 44 years (10-82 years) with a female predominance (130 female and 95 males). 44% of the cohort had normal FHL, 42.7% demonstrated grade 1 fatty atrophy and further small proportion of patients with grade 2 (8.4%), grade 3 (3.1%) and grade 4 (1.8%) fatty atrophy.

Conclusion: Preoperative radiological assessment of the FHL tendon is important to establish that the FHL muscle and tendon are normal and intact and hence suitable for transfer surgery. The FHL is an important review area for the musculoskeletal radiologist and operating surgeon. With our findings, we can also hypothesise that fatty infiltration is a common finding in the FHL muscle. We suggest cross sectional imaging to assess the muscle belly prior to tendon transfer surgery for chronic ATR.

Audience Take Away:

- Provide a pictorial review of the pathology affecting the FHL muscle and tendon
- Discuss the clinical relevance of the FHL tendon in patients with chronic Achilles rupture

Biography

Mr Wasim studied sciences at the Queen Elizabeth's School London, United Kingdom developing an appetite for surgery at an early stage. He continued at Bart's & the London School of Medicine, the oldest medical school in the world, graduating in 2014 with an MBBS (distinction) and BSc (Hons) in experimental pathology carrying out research at the Blizard Institute, London. He completed junior surgical training in Birmingham, achieving MRCS (England) and secured a trauma & orthopaedic specialty job on the prestigious Birmingham orthopaedic training programme. He has a keen interest in research and surgical education delivering multiple UK national training courses.

Remote ischaemic preconditioning attenuates kidney injury in patients undergoing surgical lower limb revascularisation

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Introduction: Perioperative acute kidney injury has been found to occur in 12% of patients undergoing lower limb revascularisation. Remote ischaemic preconditioning (RIPC) of short cycles of distant tissue ischaemia followed by reperfusion is a promising technique to reduce tissue damage from ischaemia-reperfusion injury. In a recent meta-analysis, RIPC was shown to reduce kidney injury in patients undergoing cardiac surgery. It has also been found to reduce serum creatinine postoperatively in patients undergoing abdominal aortic aneurysm repair. However, there are many uncertainties regarding clinical benefits from RIPC during vascular surgery. The aim of the current double-blinded, randomised and sham-controlled pilot study was to determine the effect of RIPC in perioperative renal damage in vascular surgery.

Methods: The current study is a part of larger trial assessed the effect of RIPC in vascular surgery. Patients undergoing elective lower limb revascularisation surgery between January 2016 and February 2018, who gave full informed consent, were recruited. Stratified randomisation with a block design was used. Patient, patient's physician and surgical team were blinded to study intervention. Four episodes of 5 minutes of upper limb ischaemia were performed preoperatively. In the sham group, pressure equal to venous pressure was applied instead of ischaemia. Between all episodes, there was a 5-minute period of reperfusion. Blood samples were collected preoperatively and 20–28 hours after surgery for assessment of biomarkers of acute kidney injury. Data were compared by means of t-tests, Wilcoxon's tests or Chi-squared test. The study was approved by the Research Ethics Committee of the University of Tartu and registered in the ClinicalTrials.gov database (NCT02689414).

Results: Twenty-eight patients were enrolled both in the sham and in the RIPC group. The baseline characteristics did not differ between the groups except for gender. The surgery resulted in statistically significant increase of creatinine and trends toward increases in urea, cystatin C and beta-2-microglobulin in the sham group. In the RIPC group, in contrast, significant decline in creatinine and cystatin C together with trends towards reduction in urea and B2M was noted. Changes in creatinine, urea, cystatin C and B2M between the groups were statistically significant.

Conclusion: This pilot study demonstrates that RIPC reduces the levels of biomarkers of acute kidney injury in patients undergoing surgical lower limb revascularisation. This phenomenon may offer renoprotection during vascular surgery.

Audience Take Away:

This pilot study demonstrates that simple non-invasive manipulation - remote ischaemic preconditioning - may offer renoprotection during vascular surgery.

Biography

Dr. Jaak Kals studied Medicine at the Tartu University, Estonia and graduated as MD in 2001. He received PhD degree in 2007 at the same institution and work as staff vascular surgeon at Tartu University Hospital since 2011. He obtained the position of an Associate Professor of Vascular Surgery since 2017. He has published more than 50 research articles in peer-reviewed journals, his H-index is 17.

Pre-operative anaemia (hb<130g/l) is associated with an extended inpatient stay following elective primary hip and knee replacements

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Introduction: NICE guidelines recommend that pre-operative haemoglobin (Hb) should be $\geq 130\text{g/L}$ in patients undergoing elective surgery. At our centre the preoperative Hb cut-off, for patients undergoing elective joint replacement, is $\geq 110\text{g/L}$. We aimed to compare the post-operative length of stay in anaemic (Hb<130g/L) and non-anaemic (Hb $\geq 130\text{g/L}$) patients, undergoing elective primary knee or hip replacement.

Methods: A retrospective review of all patients who had undergone an elective primary knee or hip replacement, over a 6 week period, was carried out. Pre-operative Hb, day 1 post-operative Hb and inpatient length of stay data were all recorded. Patients with no pre-operative Hb available to review were excluded.

Results: A total of 99 patients (35 males, 64 females) were included in this study. 36 patients (3 males, 33 females; median age 70 years (32-89)) were found to be anaemic (Hb <130g/L pre-operatively). 63 patients (32 males, 31 females; median age 69 years (22-93)) were not anaemic pre-operatively.

In the anaemic group, 13 patients underwent primary knee and 23 patients primary hip replacement. The median pre-operative Hb was 120g/L (95-129g/L). The median day 1 post-operative Hb was 104g/L (72-143g/L). No day 1 post-operative Hb was available in 4 patients.

In the non-anaemic group, 26 patients underwent primary knee and 37 primary hip replacement. The median pre-operative Hb was 139g/L (130-169g/L). The median day 1 post-operative Hb was 104g/dL (86-123g/L).

Median inpatient stay was longer in the anaemic group when compared to the non-anaemic group 3 days (1-74) vs. 5.5 days (1-103) (p= 0.08).

Conclusion: Although statistical significance has not been reached in this small study, there is a tendency towards a longer inpatient stay in patients undergoing elective lower limb arthroplasty who have preoperative anaemia (Hb <130g/L). Preoperative optimisation of the patient in general, and haemoglobin in particular, may reduce post-operative inpatient stay

Audience Take Away:

There is a tendency towards a longer inpatient stay in patient undergoing lower limb arthroplasty who have pre-operative anaemia

Our findings may suggest that pre-operative optimization of haemoglobin levels may be associated with a shorter length of inpatient stay

Biography

Mr Wasim studied sciences at the Queen Elizabeth's School London, United Kingdom developing an appetite for surgery at an early stage. He continued at Bart's & the London School of Medicine, the oldest medical school in the world, graduating in 2014 with an MBBS (distinction) and BSc (Hons) in experimental pathology carrying out research at the Blizard Institute, London. He completed junior surgical training in Birmingham, achieving MRCS (England) and secured a trauma & orthopaedic specialty job on the prestigious Birmingham orthopaedic training programme. He has a keen interest in research and surgical education delivering multiple UK national training courses.

Comparison between total intravenous anesthesia and balanced anesthesia on postoperative opioid consumption in patients who underwent laparoscopic-assisted distal gastrectomy

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²Department of Anaesthesiology and Pain Medicine, Eunpyeong St Mary's Hospital, College of Medicine, The catholic University of Korea, Korea

³Department of Anaesthesiology and Pain Medicine, Seoul National University Dental hospital, Seoul, Korea

Introduction: Remifentanyl is the most widely used opioid for total intravenous anesthesia (TIVA) or balanced anesthesia (BA) due to its favorable pharmacological properties. However, opioid-induced hyperalgesia and/or acute tolerance after intraoperative use of remifentanyl have been repeatedly reported. In addition, it is important to effectively control postoperative pain with less opioid. Therefore, we compare TIVA with propofol-remifentanyl and BA with desflurane-remifentanyl on opioid consumption to control postoperative pain in patients underwent laparoscopic-assisted distal gastrectomy with gastroduodenostomy.

Methods: We retrospectively reviewed the electronic medical records of patients underwent laparoscopic-assisted distal gastrectomy with gastroduodenostomy due to early stomach cancer for demographic variables (age, gender, height, weight, and smoking), the duration of general anesthesia, and intraoperatively administered remifentanyl consumption. The primary outcome was postoperative opioid consumption during postoperative day 2. The secondary outcomes were the incidence of any rescue opioid analgesics administered, numeric rating scale, and various adverse effects during postoperative day 2. We divided all data according to 2 patient groups to compare TIVA with propofol-remifentanyl (TIVA group) versus BA with desflurane-remifentanyl (BA group) on the postoperative opioid analgesic consumption in patients.

Results: In total, 114 patients were divided into the TIVA (46 patients) and BA (68 patients) groups. Opioid consumption as a primary outcome was significantly higher in the BA group than in the TIVA group during postoperative day 2 except in the post-anesthesia care unit. The cumulative opioid consumption was significantly higher in the BA than in the TIVA group. The incidence of rescue analgesic at postoperative day 2 was higher in the BA than in the TIVA group. In the TIVA group, remifentanyl consumption was higher, and the duration of general anesthesia was shorter than that in the BA group. No statistically significant differences were observed for other variables.

Conclusion: This study suggests that the maintenance of general anesthesia with TIVA (propofol-remifentanyl) reduces opioid consumption for postoperative pain control compared to BA (desflurane-remifentanyl) in patients undergoing laparoscopic-assisted distal gastrectomy with gastroduodenostomy.

Audience Take Away:

- It provides one option for choosing an anesthetic method
- Postoperative opioid consumption can be reduced by using TIVA
- It makes the audience be interested in the reduction of opioid use
- It would be meaningful to study whether the reduction of postoperative opioid use is related to the overall prognosis of the surgery

Biography

Dr. Sooin Park studied Medicine at the Hanyang University, Republic of Korea and graduated as MD in 2014. Her internship and residency was at Hanyang university hospital at Seoul and she is now in fellowship training course at Asan Medical Center, University of Ulsan College of Medicine

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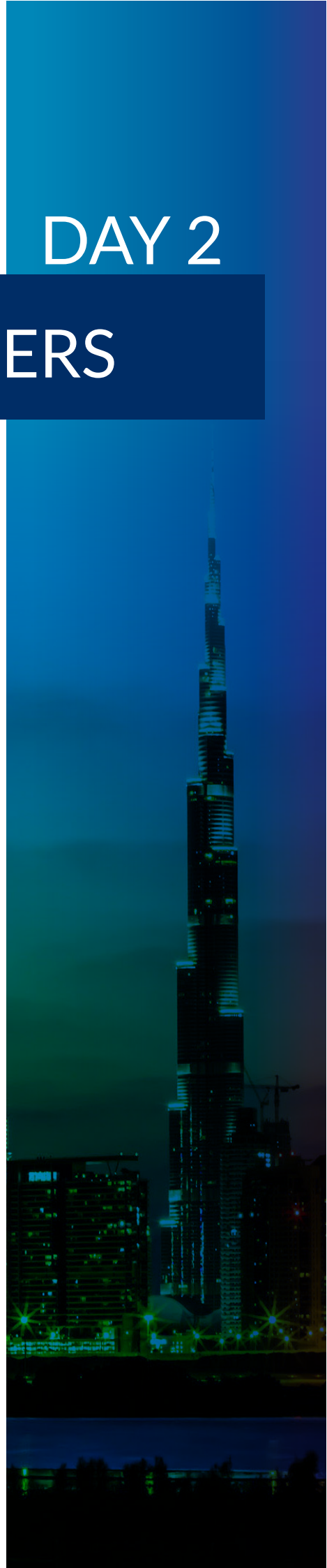
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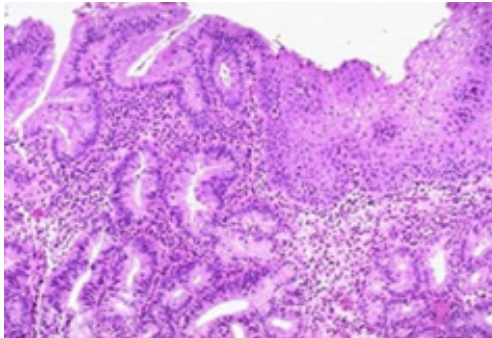
Synchronous primary oesophageal and sigmoid adenocarcinoma

Devisha Raina*, Rasika Hendaheva

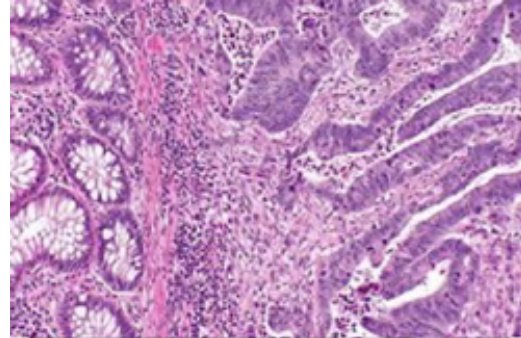
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Introduction: Oesophageal neoplasms manifesting synchronously with other neoplasms of the gastrointestinal tract are a unique challenge for the surgeon contemplating their combined resection. We present a 68 year old patient who had synchronous double primary cancers of the Oesophagus and the Sigmoid colon.

Oesophageal Adenocarcinoma



Colonic Adenocarcinoma



Case Report: A 68 year old man with background of Grover's disease, Diabetes, 15 pack year history of smoking, no previous surgeries, otherwise well and independent, underwent a Colonoscopy and Gastroscopy as a workup for unintentional weight loss of over 7kg in last 6 months. There was no family history of cancer. Upper gastrointestinal endoscopy revealed Severe non-reflux oesophagitis, normal stomach and duodenum (biopsied). He proceeded to have Colonoscopy which identified a frond/villous, fungating and ulcerated non-obstructing medium size mass in Sigmoid colon, biopsies were taken and the area tattooed. Histology confirmed GO junction (40cm) and lower 1/3 Oesophagus (36cm) poorly differentiated adenocarcinoma (primary) with Upper GI origin. Biopsy taken from the Sigmoid colon (25cm) showed a moderately differentiated adenocarcinoma, features consistent with colorectal primary. As a part of staging he had a CT Chest/Abdomen and Pelvis which did not show any evidence of metastatic disease. PET scan demonstrated only mild FDG uptake, no locoregional lymph node or distance metastasis. The patient underwent 2 stage Oesophagectomy with Laparoscopic right posterior-lateral Thoracotomy and later Laparoscopic high Anterior resection.

Histopathological report reconfirmed Oesophageal lesion to be poorly differentiated adenocarcinoma arising on Barrett's with dysplasia, involving adventitial circumferential margin, 1/20 lymph node involved. Stage pT3 pN1 (III B), R1, HER-2: Negative.

High anterior resection specimen showed low grade adenocarcinoma, stage pT2 pN0 I, R0. The patient received Neoadjuvant chemotherapy/radiotherapy to his Oesophagus with routine follow-up at the Upper GI surgical and Colorectal clinic, patient remains asymptomatic and negative for disease relapse on investigations.

Discussion: Synchronous resection of both oesophageal and second primary malignancy may be feasible in a subset of patients. Although isolated cases have been previously reported, the literature on this topic remains rather scarce. Simultaneous resection of oesophageal and extra oesophageal neoplasms can be safely performed [1]. There have been reports that indicated an association between Barrett's metaplasia or adenocarcinoma of the oesophagus and colon carcinoma. [2]. Use of neoadjuvant chemotherapy which showed good response at both the tumour sites as suggested by follow-up PET-CT imaging.

The possibility of synchronous primary neoplasm should be kept in mind while evaluating a case of oesophageal carcinoma.

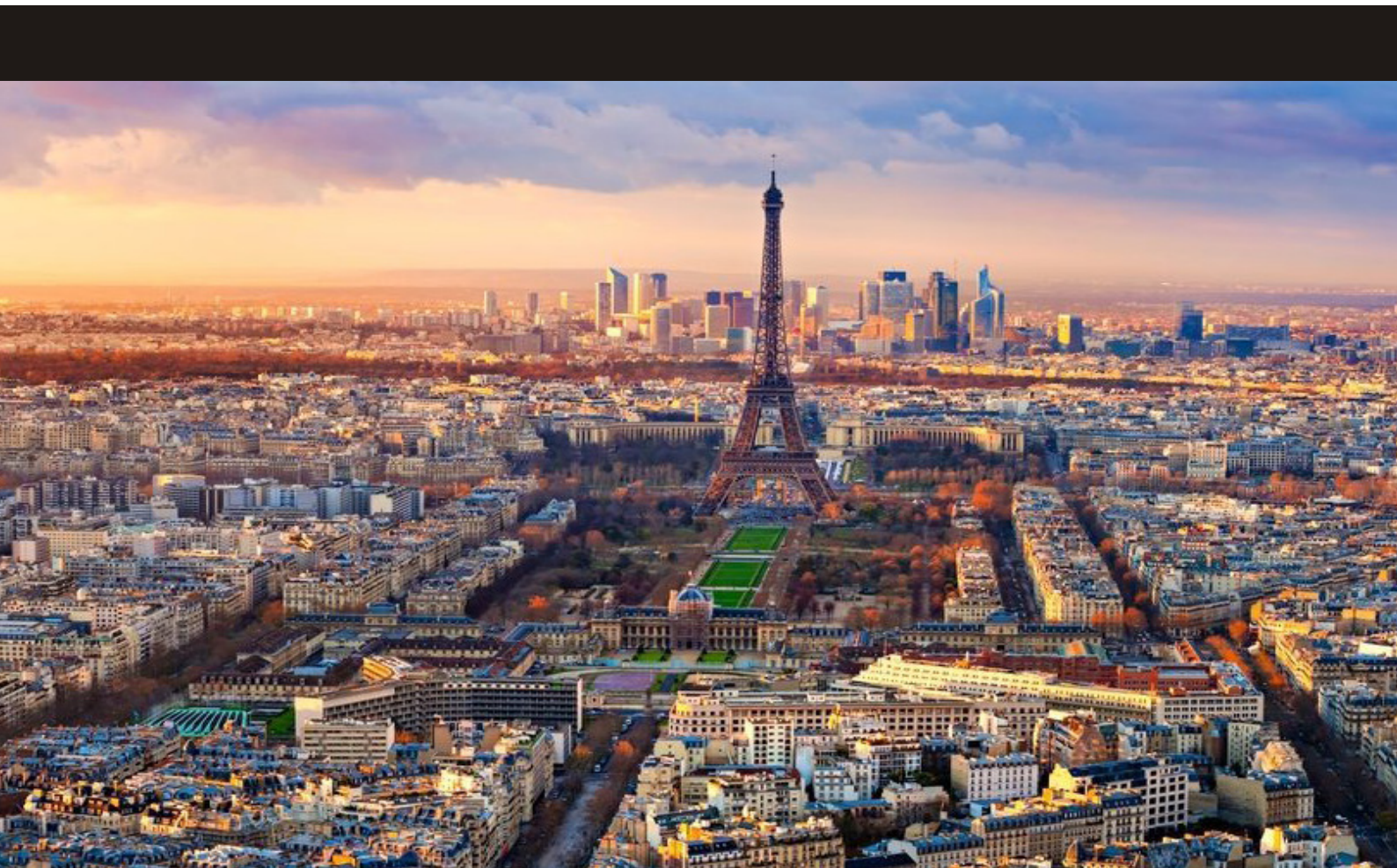
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