

6TH EDITION OF
GLOBAL CONFERENCE ON

SURGERY AND ANAESTHESIA

GLOBAL PERSPECTIVES ON **SURGICAL
AND ANAESTHETIC** ADVANCES

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IN-PERSON

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6th Edition of Global Conference on
**Surgery and
Anaesthesia**

SEPTEMBER
15-17
2025

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Keynote Speakers



Claudio Bencini

Medicea Medica srl, Italy



Darwin Eton

Vasogenesis Inc., United States



Gamal Al-Saied

Al-Azhar University Hospitals, Egypt



Jose Luis Braga De Aquino

Pontifical Catholic University of Campinas, Brazil



Michael Karsy

University of Michigan, United States



Nagy Habib

Imperial College London, United Kingdom

Keynote Speakers



*Thank You
All...*



Welcome Message

Welcome to the 6th Edition of the Global Conference on Surgery and Anesthesia (GCSA2025), to be held in London, UK September 15 to 17, 2025. The Magnus Group LLC once again is bringing together scientists, industry experts, and clinicians to foster international collaboration.

As a vascular surgeon, I recognize that the published outcomes of traditional vascular invasive procedures often fall short in comparison to the perfection of Mother Nature. We each originate from 2 cells. We are born with miles of vascularity. Hemorrhage does not occur as vessels grow to match our stature. Nature knows how to engineer vessels. Unfortunately, as vascular disease advances, neovascularization often becomes impaired. Our novel approach is to improve the biology of the ischemic environment so neovascularization can proceed as Nature intended. Proteomic and cytometry data support hemodynamic, angiographic, and clinical evidence of restored neovascularization in patients so treated.

Restoring natural processes through tissue engineering and regenerative medicine will be the platform for disease management in the future. This meeting provides a valuable gateway for synergistic investigation to expedite reaching this endpoint.

Darwin Eton
MD FACS DFSVS



Welcome Message

Hello distinguished colleagues, and partners in care,

It's a privilege to welcome you to this important gathering—a true multidisciplinary meeting. We are joined not only by physicians, nurses, and allied health professionals, but by researchers, technologists, administrators, and advocates—each of you bringing a unique lens to the shared mission of improving health outcomes.

Today, we find ourselves at a crossroads in healthcare. On one hand, we are in a golden age of discovery—biomedical knowledge is advancing at an astonishing rate. Treatments that were once unimaginable are now within reach. Medical devices and digital technologies are transforming how we diagnose, treat, and monitor disease. The science is moving fast—and so are the expectations.

But on the other hand, we face mounting challenges: persistent barriers to care, growing health disparities, and an ever-widening gap between innovation and implementation. Many of our patients still struggle to access even the most basic services. Healthcare systems are stretched. And clinicians across specialties are navigating growing complexity with fewer resources and higher demands.

The solution to these challenges doesn't lie in any one specialty, sector, or system. It lies in how we come together.

Multispecialty collaboration is not just a strategic advantage—it is a clinical imperative. Because no single field holds all the answers. When we connect disciplines—when surgery meets oncology, when primary care speaks to public health, when clinical experience informs health policy—we begin to build solutions that are holistic, sustainable, and human-centered.

This conference is a powerful reminder of what's possible when we remove professional silos and focus on shared goals: equitable access, evidence-based innovation, and patient-centered care.

So let's make the most of our time together. Let's question assumptions, challenge convention, and embrace the hard conversations. Most importantly, let's strengthen the partnerships that will carry us forward—not just for the sake of progress, but for the patients and communities who depend on our unity.

Michael Karsy, MD, PhD, MSc, FAANS, FCNS

Assistant Clinical Professor of Neurosurgery



ABOUT MAGNUS GROUP

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

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

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



ABOUT GCSA 2025

We are ecstatic to extend a warm welcome to the **6th Edition of the Global Conference on Surgery and Anaesthesia (GCSA 2025)**, scheduled to take place in **London, UK, and virtually from September 15–17, 2025**. This hybrid gathering will bring together surgeons, anaesthesiologists, researchers, and healthcare innovators from across the globe to share expertise, exchange best practices, and explore the latest advances in surgical and anaesthetic care.

With the theme **Global Perspectives on Surgical and Anaesthetic Advances**, the conference emphasizes innovation, emerging technologies, and patient-centered care—prioritizing outcomes that enhance the safety, comfort, and overall experience of patients—while promoting multidisciplinary collaboration across the surgical and anaesthetic fields. This conference reflects the diverse scientific and clinical contributions of our participants, covering a wide spectrum of topics ranging from minimally invasive and robotic surgery to perioperative medicine, complex interventions, reconstructive procedures, and advances in operative training.

We hope GCSA 2025 serves not only as a platform for learning but also as an inspiration for collaboration, future research, and stronger professional connections, all working toward the shared goal of advancing surgical and anaesthetic excellence worldwide.

As we gather in this vibrant exchange of ideas and experiences, we encourage you to engage actively, challenge assumptions, and envision new possibilities in surgical and anaesthetic science. May this event empower you with knowledge, spark innovative thinking, and reinforce our shared commitment to improving patient outcomes across borders.

Thank you for being a part of GCSA 2025 — where global expertise meets transformative progress.

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**KEYNOTE
PRESENTATIONS**

Biography

Claudio Bencini M.D., F.I.C.S., F.B.H.S.

Medicea Medica srl, Fauglia, Italy

Innovative medical device to easily control stool emission in colostomates

Stoma surgery is a mutilating procedure that requires the formation of an opening between the intestine or ureters and the abdominal wall and in most cases is permanent. Patients must apply a stoma bag for the collection of urine and/or feces. The author has designed an innovative soft and permanent one-piece inflatable device to restore colostomy continence in the most natural way possible, avoiding surgical procedures and implantation in the peristomal tissues, and reversible at will at any time and in any bathroom. The device could improve the quality of life of patients by overcoming the drawbacks of colostomy bags and continence devices already on the market and is the result of more than forty years of research and an initial development of a previous rigid model handmade one at a time tailored for patients who participated in a previous study. It is now possible to produce a soft and deformable one-piece model and deformable enough to follow the body's movement without causing discomfort. It is therefore possible today to start industrial production because elastomeric materials and new technologies are available for molding liquid silicone in forms containing complex cavities hosting internal devices for the control and deodorization of gas emission when the prosthesis is in use. The device likely represents a milestone in stoma continence, as it intends to provide reversible stoma continence; easy to handle by the patient himself; allowing the use of normal toilets. The colostomy becomes invisible under any clothing even on naked patients, since it can be colored as desired. It will be used for no more than 28 days, only during the day, since at night a colostomy bag can be used thus favoring the emission of feces during sleep



Dr. Bencini graduated as MD in 1980 at Pisa University Dept. of Surgery of Professor M. Selli obtaining University Specialization in General Surgery in 1985, then joined the Chest Surgery Dept. of Professor A. E. Paletto obtaining University Specialization in 1988, and obtained the University Specialization in Vascular Surgery in Firenze of Professor D. Bertini. He has been accredited to IRCAD of Professor Jaques Marescaux in Strasbourg on 1991. He was a Consultant in Libya, England, Poland, as well as War Surgeon in Iraq. Since 1980, he has been committed to improving the quality of life of colostomy patients.

and therefore limiting the need for evacuation during daytime activities. In deflated form, it can be easily inserted and extracted from the stoma. Made of soft silicone elastomer, it is resistant to acids, prevents colonization by bacteria and resists commonly used sanitizing treatments. It consists of a dome-shaped disk flattened on the outside of the stoma resting on the skin, with a stem with an elastic balloon inflatable by means of lateral deformation that allows a final toroidal shape applied to the end of the stem. The device in question is also environmentally friendly. Since colostomy bags used by colostomy patients can be more than one per day, no less than thirty bags full of feces must be disposed of in the waste. The device in question instead lasts 28 days and the single specimen, once rinsed, can be disposed of in household waste.

Biography

Darwin Eton MD, FACS, DFSVS

Chief Science and Medical Officer Vasogenesis Inc, 32 Marshal St., Boston MA 02446 USA

Cell therapy for chronic ischemia

Background/Objective: In the presence of arterial occlusive disease, Neo Vascularization (NV) is a natural process that strives to preserve tissue perfusion through growth of collateral arteries (arteriogenesis) and growth of capillaries, arterioles, and venules (angiogenesis). Endothelial shear stress initiates arteriogenesis, while hypoxia stimulates angiogenesis. NV becomes impaired as vascular disease progresses, leading to Chronic Limb-Threatening Ischemia (CLTI). Symptoms include forefoot ischemic rest pain, ulceration, and/or gangrene. Standard of care includes invasive revascularization by surgery or catheter-based interventions. Significant procedural risks, variable durability, and high cost have spurred efforts to develop an effective, durable, low-risk, home-based, inexpensive revascularization option. Phase II clinical trials attempting to orchestrate cellular or molecular aspects of NV have not yielded a solution to promoting this complex process.

A novel approach has since been tested clinically that sought to restore innate NV by overcoming obstacles that arise due to the multilevel arterial occlusive disease and progenitor cell deficits. These obstacles include attenuated endothelial shear stress precluding endothelial activation, an unhealthy biosynthetic environment in the ischemic tissue, and the diminished number and function of salutary progenitor cells. The outpatient cell therapy uses a programmed Pneumatic Compression Pump (PCP) and Filgrastim (FDA approved for stem cell mobilization). In the first patients so treated, there was abatement of ischemic rest pain and healing of forefoot ischemic wounds. Hemodynamics improved (increase in ankle brachial index, development of photoplethysmographic pulsatility in the forefoot



Dr. Eton served as Professor of Vascular Surgery at University of Chicago, and Visiting Professor at University of Illinois at Chicago. Prior appointments included Professor and Chief of Vascular Surgery at the University of Miami Miller School of Medicine, and Associate Professor at the University of Southern California where he was awarded the 1998 Outstanding Physician of the Year Award. He earned his MD at NYU School of Medicine, and his ScB and ScM from MIT. He is a Distinguished Fellow of the Society of Vascular Surgery. Dr. Eton now serves as the Principal Scientist of Vasogenesis Inc, Boston, MA. This company was formed around his pioneering approach to the management of chronic ischemia. The cell therapy project was the winner of the 2016 Cures Within Reach Inc Competition.

and toes). Angiography showed corkscrew collateral growth and improved contrast transit. Surprisingly, segmental recanalization of previously occluded infrageniculate arteries was also observed. Lysis of chronic thrombus was suspected. Molecular evidence for fibrinolysis and neovascularization was sought.

Methods: CLTI patients were treated with PCP alone (N=19), or with filgrastim (10mcg/kg every 72 hours SQ) and PCP (N=8 and N=6, at two institutions). ELISA was used to measure the plasma concentration of plasmin and of Fibrin Degradation Products (FDP), and the serum concentration of proteins associated with neovascularization (VEGF, HGF, MMP-9, Angiopoietin, PDGF et al). In the PCP-alone group, blood was sampled on day 1 (baseline) and after 30 days of daily PCP. In the filgrastim and PCP group, blood was drawn on day 1, and 1 day after the 5th and the 10th filgrastim doses. Each blood draw occurred before and after 2 h of supervised PCP.

Results: In patients who received filgrastim the expected significant increase in the circulating progenitor cell count was accompanied by a mean 6 fold increase in the absolute neutrophil count. Significant ($p<0.01$) PCP independent increases in the plasma concentration of plasmin (>10-fold) and FDP (>5-fold) were observed 1 day after both the 5th and the 10th Filgrastim doses, compared to Day 1. Significant ($p<0.05$) increases in the concentration of pro-angiogenic proteins were also observed. Filgrastim at this novel dosimetry induced fibrinolysis without causing acute hemorrhage, in addition to inducing a pro-angiogenic milieu conducive to NV.

Conclusion: These results substantiate recent reports that the fibrinolytic and angiogenic capacity of endothelial cells can be promoted by G-CSF, and that the significant G-CSF induced neutrophilia may also significantly enhance these effects in the context of ischemia. Further research is needed to clarify mechanism. Additionally, further clinical testing is warranted at this novel dosimetry in CLTI, as well as in other chronically ischemic tissue beds.

Keywords: Neutrophilia, Neutrophil, Angiogenesis, Arteriogenesis, Filgrastim, Neupogen, Granulocyte-Colony Stimulating Factor, G-Csf, Fibrinolysis, Thrombosis, Neovascularization, Plasmin, Hepatocyte Growth Factor, Vegf, Artassist Device, Ischemia, Vascular Disease, Vegf-165b, Mmp-9, Hematopoietic Stem And Progenitor Cell, Endothelial Progenitor Cell, Hematopoietic Stem Cell, Hematopoietic Progenitor Cell.

Biography

Gamal Al-Saied

Professor of Pediatric Surgery, Al-Azhar University, Cairo, Egypt

Giant anterior sacral meningocele masquerading as cystic sacrococcygeal teratoma in a neonate: A diagnostic pitfall and literature review

Background: A giant anterior sacral meningocele is a very rare swelling in the sacrococcygeal region and is difficult to diagnose preoperatively, as it does not usually present as an exophytic swelling. The aim is to present a newborn with a giant anterior sacral meningocele masquerading as cystic sacrococcygeal teratoma.

Case scenario: A full-term male neonate (3.5 kg) presented with a giant, cystic sacrococcygeal swelling displacing the anus anteriorly. Imaging studies (CT and MRI) showed no spinal canal communication or sacral defect. MRI favored a diagnosis of cystic sacrococcygeal teratoma. Surgical excision and anorectoplasty were performed via the posterior sagittal approach. Intraoperatively, the cyst contained clear fluid, lacked a defined wall, and histopathology did not confirm teratoma. The postoperative course was uneventful, and the patient was discharged on the 6th postoperative day.

Conclusion: Anterior sacral meningocele can present as a cystic swelling that closely mimics sacrococcygeal teratoma, making preoperative diagnosis difficult. If not correctly identified and repaired properly during surgery, recurrence may occur. A high index of suspicion and meticulous intraoperative assessment are essential for optimal management.

Keywords: Anterior Sacral Meningocele, Sacrococcygeal Teratoma, Neonatal Cystic Mass, Diagnostic Pitfall, Posterior Sagittal Approach.



Professor Dr. Gamal Al-Saied is a distinguished Egyptian pediatric surgeon and academic affiliated with Al-Azhar University in Cairo, Egypt. He has made significant contributions to pediatric surgery through clinical practice, research, and academic leadership. He graduated from Al-Azhar University with a Bachelor's degree in Medicine and Surgery, earning high honors and ranking 9th among the top 10 graduates of his class. He completed his Master's degree (MSc) in Pediatric Surgery in 1991 and obtained his Doctorate (MD) in Pediatric Surgery in 1998. His academic career at Al-Azhar University progressed from demonstrator to assistant lecturer, lecturer, assistant professor, and ultimately to full professor in 2009. He holds several prestigious certifications, including the Fellowship of the European Board of Pediatric Surgery (FEBPS), awarded in Glasgow, Scotland; the Fellowship of the American College of Surgeons (FACS); and the Membership of the Royal College of Physicians and Surgeons of Glasgow (MRCPS). He has an extensive research portfolio, with 37 international publications in

pediatric surgery journals and a chapter in the textbook Current Concepts of Urethroplasty. He has supervised numerous Master's and Doctorate theses and serves as Editor-in-Chief for two international pediatric surgery journals, as well as an editor for thirteen others. His research interests include complex pediatric and neonatal surgical conditions. Leadership and Conference Participation Beyond academia, he is actively involved in the global pediatric surgery community. He has been invited as a speaker and chairperson at various international conferences, including the Global Conference on Surgery and Anaesthesia and the Pediatrics and Neonatology Conference Online Presence he maintains a professional profile on ResearchGate, where he shares his publications and connects with the research community.

Biography

Jose Luis Braga De Aquino

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

Advanced esophageal cancer palliative surgical therapy using isoperistaltic gastric tube

Although malignant neoplasms of the esophagus remain a very common disease, their diagnosis might often come late. This issue combined with excessive weight loss due to dysphagia and the association with cardiopulmonary diseases resulting from excessive tobacco use, makes patients with this neoplasm difficult to manage clinically, which explains why 50% of patients require palliative treatment. The ideal scenario would be the performance of procedures that provided an adequate quality of life and satisfactorily restored swallowing, without the need for further hospitalizations and with lower rates of complications. Thus the aims to describe indications and results of palliative methods and especially diversion surgeries, discussed with emphasis on the technique of the Isoperistaltic Greater Curvature Gastric Tube (IGCGT), which was performed at the Surgery Department of Medical School, Pontifical Catholic University of Campinas, Brazil. 143 patients with unresectable squamous cell carcinoma of the esophagus (stage T4b) were evaluated at this facility, but they all had clinical conditions to undergo IGCGT. In the early postoperative evaluation, 64 patients (44.7%) presented systemic complications, with pulmonary infection being the most frequent; 51 patients (35.6%) presented local complications, with cervical esophagogastric anastomotic leak being the most frequent. Thirteen patients (9.1%) died as a result of post operative complications. Out of 112 patients who were adequately followed up, 91 (81.2%) achieved good palliation with this procedure, as they had adequate restoration of swallowing function. Chemorradiation was performed after the IGCGT transposition in 82 patients, with a median survival of 3 years in 63 patients (76.8%).



Jose L. B. de Aquino was born in Campinas, Brazil, graduated in Medicine in 1978 from the Faculty of Medicine of Sao Jose do Rio Preto, SP. He completed his training in General Surgery for 4 years at the Faculty of Medicine of the Pontifical Catholic University of Campinas, having obtained a Master's degree in Surgery in 1990 and a Doctorate in Surgery in 1996, both from the State University of Campinas (UNICAMP). He is Professor of Surgical Clinic at the Faculty of Medicine of PUC, working with Head and Neck Surgery, Thoracic Surgery, Digestive and Esophageal Diseases. Leader of one of the PUC Research Groups DIAGNOSTIC AND CLINICAL SURGERY TREATMENT with a multidisciplinary focus with the clinical, surgical and nutritional areas. He is a Professor of the Postgraduate Course in Health Sciences at PUC, Editor-in-Chief of the Revista de Ciências Médicas at PUC; Associate editor of the Revista do Colégio Brasileiro de Cirurgias. Author and co-author of 212 articles published in national and international magazines and winner of several awards for works presented in Congresses.

With the results, it is possible to conclude that despite showing non-negligible morbidity, IGCGT can be performed quickly and safely, especially after the advent of mechanical suturing, offering adequate palliation and survival rate. In addition, it has the advantage of simultaneously providing good drainage of the esophagus and stomach, thus avoiding potential esophageal mucocele.

Biography

Michael Karsy MD, PhD

Department of Neurosurgery, University of Michigan, Ann Arbor

Multidisciplinary management of complex skull base pathologies – What's in store for the future?

Management of skull base pathologies remains a highly technical and multidisciplinary endeavor. These conditions are often rare, complex, and anatomically challenging, with limited high-quality, prospective studies available to guide evidence-based treatment. This scarcity of robust data, combined with the nuanced nature of each pathology, contributes to significant variability in clinical decision-making and outcomes across institutions.

To address these limitations and foster collaboration across specialties, the Registry of Adenomas of the Pituitary and Related Disorders (RAPID) was established as the first multispecialty, multi-institutional, prospective registry focused on the management of skull base pathologies. Currently, the registry includes 24 high-volume academic centers across the United States, bringing together expertise from neurosurgery, endocrinology, otolaryngology, radiation oncology, and neuro-ophthalmology. Its goal is to harmonize data collection, support longitudinal outcome tracking, and facilitate large-scale, collaborative research efforts.

To date, over a dozen studies utilizing RAPID data have addressed management strategies and outcomes in patients with Cushing's disease and craniopharyngiomas, providing valuable insights into surgical approaches, perioperative management, and long-term endocrinologic and neurologic outcomes. Ongoing efforts aim to expand the scope of the registry to include additional skull base pathologies such as other functional and non-functioning



Michael Karsy completed residency at the University of Utah in 2020 and a fellowship in minimally invasive and open skull base surgery at Thomas Jefferson University Hospital in 2021. He is an Assistant Professor of Neurosurgery, Neurooncology and Skull Base at the University of Utah. His research interest is on surgical outcomes, translational research, and implementing surgical techniques from the lab to the operating room. He has published over 130 peer-reviewed papers on various neurosurgical and neurooncology topics, provided numerous regional and national lectures on neurooncology, as well as edited a textbook on surgical subspecialty education for medical students and residents.

pituitary adenomas RAPID represents a major step toward addressing these gaps, offering a framework for collaboration and evidence generation that will ultimately improve patient care and outcomes.

Biography

Professor Nagy Habib*, Dr. Khalfan Al Hinai, Dr. Loay Tawfik

Department of Surgery and Oncology Imperial College NHS Trust, London, UK

Evolution of surgical oncology

Progress in medicine, anaesthesia and surgical techniques have reduced significantly immediate and early surgical mortality. On the other hand, intra-operative and post-operative survival have been limited in some cancers such as liver and pancreatic cancer. There has been no significant improvement in survival in pancreatic cancer outcome in the last 5 decades. This presentation will discuss current research that hopefully will make a difference.

This will include: Neoadjuvant immunological approach, intraductal and endo-vascular RF ablation as well as post-operative cancer vaccines.



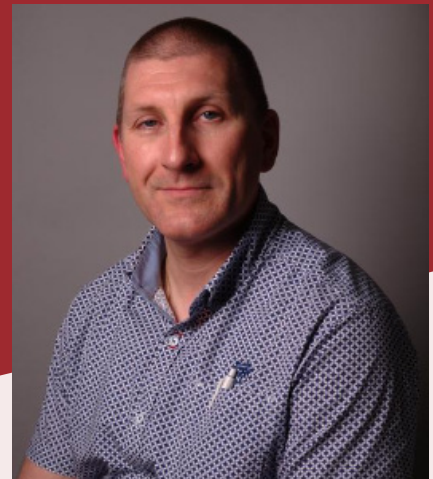
Nagy is a founder and Head of R&D of MiNA Therapeutics. For over three decades Nagy has been at the forefront of clinical research and clinical practice in cancer. He pioneered the first clinical trial in the use of adenovirus and plasmid for the treatment of liver cancer, as well as the use of plasmid gene therapy in hydrodynamic gene delivery. Currently, he is driving the development of an saRNA drug (a new class of medicines) which is currently being trialed in patients with liver cancer in eight UK centres, and sites in Singapore and Taiwan (OUTREACH study, ClinicalTrials.gov ID NCT02716012) and in a second trial in patients with solid tumours (TIMEPOINT study, ClinicalTrials.gov ID NCT 04105335) in the UK, USA, Europe, Singapore and Taiwan. He has published widely in gene therapy, stem cell therapy, oligonucleotides, endoscopy and surgery. Previously Nagy was founder and Chairman of EMcision Limited (acquired by Boston Scientific Inc in 2018). Nagy is Lead Clinician and Head of the Department of HPB Surgery at Imperial College London.

Biography

Ricky Rasschaert

Department of Neurosurgery AZ Rivierenland
Antwerp, Belgium

Department of Rehabilitation Sciences,
University of Leuven, Belgium



Dr. Ricky Rasschaert is neurosurgeon and spine surgeon at the AZ Rivierenland in Antwerp, Belgium. The use of minimally invasive techniques and spinal reconstructive surgery are his main interests. He is a member of several Neurosurgical and Spine societies and has a teaching position at Odisee, University of applied Sciences. He does research involving the treatment of Tarlov cysts, the link with cerebrospinal fluid and small fiber neuropathy. Other research projects involve hemostats and partners in other projects. As head of the Neurosurgery Department and member of the OR committee he is also involved in hospital management and governance. As a medico-legal expert the management of complications and the impact on the health care professionals as well as the patient is a side interest.

The coincidence between spinal perineural cysts, increased intracranial pressure and the appearance of small fiber neuropathy. Exploring the relationship and (surgical) lessons to be learned

Tarlov cysts remain a topic of controversy, from the first publication of Tarlov in 1938 and even now a myriad of treatments have 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.

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 Acetamolozone. Even small cysts seems to react positively on these diagnostic tests.

Although the Tarlov cysts may not cause radicular pain in the corresponding dermatomes directly, individuals with Tarlov cysts frequently report a range of symptoms that have previously been linked to symptomatic Tarlov cysts, including bladder, bowel, sphincter, and sexual symptoms,

as well as local pain. Additionally, seemingly unrelated symptoms, such as headaches, fatigue, cognitive difficulties, neuropathic pain localized in other parts of the body, and autonomic dysfunctions, are commonly reported. These symptoms may be associated with elevated cerebrospinal fluid pressure within the nerve root sheath. Elevated pulsatile cerebrospinal fluid pressure underlies the formation of Tarlov cysts at the dorsal root ganglion and may gradually contribute to small-fiber dysfunction by irritating, compressing and damaging small nerve fibers within the dorsal root ganglion.

As several studies show radiculopathy and axial pain as a general finding in idiopathic intracranial hypertension an idiopathic cerebrospinal pressuredysregulation syndrome might be proposed as a common denominator. In our presentation we will show our own results together with a literature study leading to the new insights as described above.

Biography

Sagar Aravind Jawale

Jawale Hospital, India

My innovations in hypospadias surgery

Introduction: Last 20 years I performed 1978 cases of hypospadias surgeries and made various innovations in the technique of surgery. Most innovations are reported for the first time in medical literature.

Materials and Methods: 1) 718 cases done with continuous interlocking stitches instead of simple and every 5 Th stitch a knot is taken. They are water tight and knot prevents unwinding of complete suture line. 2) 1568 cases, IV amino acid solution was given which supplies essential amino acids which led to much better healing. 3) Glutaraldehyde Albumin induced laser tissue welding in 318 cases which reinforces skin suture line making it waterproof. 4) 13 hypospadias fistulae closed without surgery by above technique. 5) Methylene blue dye induced laser tissue welding in 58 cases, stopped bleeding which did not with cautery. 6) Urethral pull up operation on 135 cases, free of complications such as fistula, meatal stenosis, meatal regression and residual chordee and one that does not require Dartos flap and suprapubic diversion 7) Modified urethral pull up operation on 78 cases with urethra pulled through Glans Tunnel. 8) Appendicular Mucosal Tube Implant with Dartos Wrap Operation in 23 cases of bad quality urethral plate. 9) Extended Urethral Plate Mobilization and reimplantation surgery in proximal hypospadias with severe chordee in 108 cases. Urethral plate lifted, chordee released and proximal mobilization till bulbar urethra. 10) Implanting delipated full thickness graft from inguinal area in stage 1 cases with bad quality urethral plates in proximal hypospadias. 11) Suprapubic diversion even in distal hypospadias cases as collagen is laid down in 3 weeks. 12) Low dose oral steroids in 38 cases for severe post op pain and in urethral stenosis requiring repetitive dilatations.



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 Finseth 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.

Discussion: With techniques described conventionally, success rate could not cross 60%. All above innovations improved success rate from 60 to 99%.

Results: Results were much better and statistically significant compared to control group.

Conclusion: We need constant modifications in conventional techniques of hypospadias surgery for better results.

Biography

Dr. Sujeet Rai MD

Additional Professor, Department of Anaesthesia & Critical Care, Dr Ram Manohar Lohia Institute of Medical Sciences, Lucknow, Uttar Pradesh, India

Utility of near-infrared spectroscopy in monitoring renal perfusion following adult kidney transplantation

Background: Near-Infrared Spectroscopy (NIRS) is a continuous, real-time method for evaluating Regional Oxygen Saturation (rSO_2) that can detect early declines in renal tissue oxygenation. This study aims to assess the effectiveness of NIRS in monitoring the perfusion of transplanted kidneys in the postoperative period.

Methods: In this prospective observational study, 21 End-Stage Renal Disease (ESRD) patients undergoing living donor renal transplantation were enrolled. Immediately after transplantation, a NIRS monitor was placed on the skin over the upper pole of the kidney, allowing for continuous rSO_2 (renal saturation) monitoring. Measurements of rSO_2 , Mean Arterial Pressure (MAP), and urine output were recorded at baseline. Every 30 minutes for the first 24 hours, followed by hourly intervals until 48 hours, and then every eight hours until 120 hours. Creatinine and arterial lactate levels were measured at baseline and every 24 hours. Patients were followed for five days, with renal perfusion assessed using rSO_2 trends and correlations between rSO_2 values, urine output, and serum creatinine levels.



Dr. Sujeet Rai is an Additional Professor in the Department of Anaesthesia and Critical Care at Dr. Ram Manohar Lohia Institute of Medical Sciences, Lucknow. He completed his MBBS at King George Medical University, Lucknow, in 2006 and obtained his MD in Anaesthesiology from GSVM Medical College, Kanpur, in 2009. Dr. Rai has a strong academic and research background, with four national and 24 international publications, five book chapters, and one edited book to his credit. He has successfully completed six research projects and supervised eight postgraduate theses. His work reflects a commitment to advancing clinical practice and medical education in anesthesia.

Results: Our findings indicated that rSO_2 levels increased over time, signaling improved kidney perfusion following transplantation. Consistently, a significant negative correlation was found between rSO_2 and serum creatinine levels. A negative correlation was also observed between mean rSO_2 and urine output, which was statistically significant at all time points except 48 hours.

Conclusion: NIRS monitoring is an efficient, noninvasive, and valuable tool for assessing renal perfusion in patients after renal transplantation. It allows for the early detection of complications during the postoperative period. The continuous nature of this monitoring method provides real-time insights into renal oxygen saturation, facilitating the early identification of impaired blood flow in renal allografts and potentially leading to timely interventions that increase the success rates of salvage attempts.

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ORAL PRESENTATIONS



Abdelfatah Elsenosy

Frimley Park Hospital, United Kingdom

Effectiveness of regional vs general anaesthesia in total knee replacement outcomes: A systematic review and meta-analysis

Background: Total Knee Replacement (TKR) is a common procedure for advanced knee osteoarthritis. The choice of anaesthesia—Regional Anaesthesia (RA) versus General Anaesthesia (GA)—can influence perioperative outcomes. This systematic review and meta-analysis aimed to compare the effectiveness of RA and GA in TKR.

Methods: We systematically searched PubMed, Embase, Scopus, Web of Science, and Cochrane Library from inception to May 2025 for studies comparing RA and GA in TKR. Eligible studies included adult patients and reported at least one of the following outcomes: blood transfusion, complication rates, or hospital length of stay. A random-effects meta-analysis was performed to pool data.

Results: Nine retrospective cohort studies encompassing 522,080 TKR procedures were included. RA significantly reduced the odds of perioperative blood transfusion (OR=0.58, 95% CI 0.44–0.77, $p=0.0001$), 30-day postoperative complications (OR=0.59, 95% CI 0.39–0.88, $p=0.01$), and hospital length of stay (SMD=−0.09, 95% CI −0.14 to −0.04, $p=0.0009$). No study found RA to be inferior to GA. Heterogeneity was high across outcomes, but the direction of effect consistently favored RA.

Conclusion: Regional anaesthesia is associated with better short-term outcomes than general anaesthesia in total knee replacement, including fewer complications, lower transfusion rates, and shorter hospital stays. These findings support the preferential use of RA, particularly in high-risk patients, while considering individual patient factors.

Keywords: Total Knee Replacement, Regional Anaesthesia, General Anaesthesia, Blood Transfusion, Postoperative Complications, Length of Stay, Meta-Analysis.

Biography

Elsenosy is a Trauma & Orthopaedics Specialist Registrar with over nine years of experience, including five years in the NHS. He holds a Master's degree in Orthopaedics and a Postgraduate Certificate in Medical Education. He has published multiple papers in peer-reviewed journals and is actively involved in research, national audits, and surgical education.



Abdelfatah Elsenosy

Frimley Park Hospital, United Kingdom

Early versus delayed weight-bearing following tibial plateau fracture surgery: A systematic review and meta-analysis

Tibial plateau fractures are complex injuries affecting the knee's load-bearing surface, commonly requiring surgical fixation. Traditional rehabilitation protocols favor Delayed Weight-Bearing (DWB) to avoid complications, while recent evidence suggests Early Weight-Bearing (EWB) may enhance functional recovery without increasing risk. This systematic review and meta-analysis aimed to compare outcomes between early and delayed weight-bearing following surgical treatment of tibial plateau and shaft fractures. A comprehensive search across multiple databases identified 10 eligible studies comparing EWB versus DWB in adult patients. Data on postoperative pain, healing time, delayed union, non-union, and functional outcomes were extracted. Meta-analyses were conducted using RevMan 5.4, and methodological quality was assessed using the Downs and Black checklist. Across 940 patients, early weight-bearing was not associated with increased pain, delayed union, or non-union. Meta-analysis showed no statistically significant differences in VAS pain scores (SMD=0.06; $p=0.89$), time to union (SMD=-0.45; $p=0.32$), delayed union (OR=0.40; $p=0.25$), or non-union (OR=0.14; $p=0.10$). Studies reported earlier recovery, improved range of motion, and similar complication rates in EWB groups. Early weight-bearing after tibial fracture fixation is safe and may accelerate functional recovery without increasing risk. However, heterogeneity in fracture types and protocols highlights the need for individualized strategies and further high-quality research.

Biography

Elsenosy is a Trauma & Orthopaedics Specialist Registrar with over nine years of experience, including five years in the NHS. He holds a Master's degree in Orthopaedics and a Postgraduate Certificate in Medical Education. He has published multiple papers in peer-reviewed journals and is actively involved in research, national audits, and surgical education.



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Anatomical variations in morphometric measurements of the coracoid process in a cross section of the Sudanese population: Evaluation using chest computed tomography

Introduction: The coracoid process is integral to the functionality of the scapula, serving as a crucial attachment point for several muscles involved in shoulder movement and stability. In pathologies and fractures of the coracoid process, understanding the morphometric variations is essential for devising optimal surgical strategies. Given the substantial lack of relevant data, this study aimed to analyze the morphometric variations in the dimensions of the coracoid process among the Sudanese population and evaluate the differences in the measurements in relation to gender.

Methods: The study was performed on 100 images of human scapulae (50 males and 50 females). The radiographs and reports were acquired from the Radiology Department at Almoalim Medical City, Khartoum, Sudan. CT scan images were uploaded to medical imaging software (PaxeraViewer version 1.0.1.9, PaxeraHealth, Newton, MA, USA). Quantitative measurements of linear parameters were calculated via this software, and data was analysed using SPSS Statistics version 23 (IBM Corp. Released 2015. IBM SPSS Statistics for Windows, Version 23.0. Armonk, NY: IBM Corp.).

Results: Our study revealed that the mean measurements of the coracoid process dimensions were as follows: the length 39 ± 2.7 mm, the tip thickness 10.8 ± 1.8 mm, the base height 13 ± 1.1 mm, and the base width 22.2 ± 1.6 mm. Gender-based comparisons showed a trend towards larger parameters in males compared to females. Significant variations in the length ($p=0.03$) and base height ($p=0.002$) of the coracoid process were noted.

Conclusion: This study demonstrated variations in coracoid process dimensions among the Sudanese population, emphasizing gender influence. Moreover, comparisons to earlier research highlighted discrepancies across different ethnicities. Further investigation with a greater number of cases from a prospective viewpoint is needed for more compound insight into this issue.

Biography

Mr. Abdelrahman completed his undergraduate medical education at the University of Khartoum, Sudan, graduating in 2020. He went on to earn a master's degree in human clinical Anatomy from the National University, Sudan. Throughout his academic and early professional career, he actively participated in various research projects across medical and anatomical sciences. Following completion of his General Medical Council (GMC) registration, he began his clinical career in Trauma and Orthopaedics at Betsi Cadwaladr University Health Board in North Wales.

Ahmed Ibrahim

Hywel Dda ENT, United Kingdom

Outpatient biopsy of upper aerodigestive tract lesion: Has it made a difference to the patient pathway?

Introduction/Aim: This retrospective audit evaluated the impact of Local Anaesthetic (LA) biopsies of upper aerodigestive tract lesions on diagnostic adequacy and patient pathway outcomes.

Methods: A 12-month review of 47 patients undergoing LA biopsies for suspected head and neck lesions was performed. Diagnostic adequacy, patient cohort, and the need for conversion to General Anaesthetic (GA) were analysed.

Results: LA biopsies yielded adequate histology in all cases (100%). Two patients required GA for diagnosis due to clinical suspicion. Thirty biopsies were performed using a side-channelled video scope, including 13 incidental findings detected during PET scans for cancer workup. Seventeen tonsil biopsies were undertaken using snare forceps.

Conclusion: LA biopsies are diagnostically robust, without compromising histological accuracy. Early diagnosis reduces patient anxiety and shortens waiting times for definitive management.

Recommendation: Experience of the surgeon, careful patient selection, and ongoing service evaluation will further improve patient outcomes and experience.

Biography

Dr. Ahmed Emad Basheir Ibrahim is an ENT clinician at Hywel Dda University Health Board, NHS Wales. His clinical interests include head and neck oncology and service development in diagnostic pathways. He has a growing portfolio in surgical research and audit, with a focus on improving patient outcomes and streamlining care.



Wickman E*, Hutchinson SR, Wickman AM*

Alta Orthopaedics, 510 Castillo Street, Suite 203, Santa Barbara, CA 93101, USA

Insights on kyphoplasty: A retrospective analysis of intraoperative variables and patient demographics

Study Design: Single Surgeon Observation Study: 77 Patients with VCF undergoing kyphoplasty over 18 months.

Objective: To highlight the relationships between age, sex, and spinal levels treated by kyphoplasty with balloon pressure, volume, and cement volume.

Summary of Background Data: Vertebral compression fractures are common fragility fracture, comprising significant health care costs. Kyphoplasty is an accepted treatment option, however details of procedural aspects are less well established.

Methods: Kyphoplasty balloon pressure/volume, and cement volume were recorded. The inclusion criteria included acute/subacute osteoporotic fracture; exclusion criteria included non-osteoporotic fractures and previous surgery.

Results: A total of 141 levels were included in this study (54 thoracic, 87 lumbar). There were 77 patients; 61% female, 39% male. There was a statistically significant relationship between age and region (T vs. L spine) ($p=.013$). Mean inflation pressure was 152.5 PSI for thoracic spine and 147.5 PSI for lumbar spine. There was a significant correlation between age and mean pressure ($p=0.0014$). There was a statistically significant relationship between anatomic spinal groups and pressure ($p=0.044$). The mean balloon volume was 2.42 cc for the thoracic spine and 2.89 cc for the lumbar spine. Statistically significant relationships were identified between balloon volume and level ($p=0.014$) and age ($p=0.003$). No statistically significant correlation was found between balloon volume and sex. The mean cement volume was 2.27 cc for thoracic spine and 2.92 cc for lumbar spine. Cement volume demonstrated a significant relationship with spinal level ($p<.001$), sex ($p=0.0255$) and age ($p=0.034$). Advanced age and males required higher cement volumes ($p<.0001$).

Conclusion: Age, sex, and spinal level significantly influence kyphoplasty components. Both thoracic and lumbar fractures have different procedural requirements, with greater lumbar spine demands. Variations in sex and age emphasize the importance of personalized surgical planning.

Biography

Dr. Wickman completed her Bachelor of Arts at Brown University in Providence, RI in 1999. She then went onto receive her MD at Loyola University Medical Center in Maywood, IL 2005, and completed her orthopaedic residency there in 2010. She was a Spine Surgery Fellow at New York University/ Hospital for Joint Disease in 2010-2011. She has been in private practice in Santa Barbara, CA since then.



Andrew Wanees

The Royal Devon and Exeter University, United Kingdom

Reinforcement of the esophageal hiatus using ligamentum teres during sleeve gastrectomy: Outcomes regarding gastroesophageal reflux disease and hiatal hernia

Background: Laparoscopic Sleeve Gastrectomy (LSG) is a surgery that involves the removal of 75–80% of the stomach. It offers benefits like less postoperative pain and better recovery compared to open surgery, but it also carries the risk of developing Gastro Esophageal Reflux Disease (GERD) and hiatus hernia.

Patients and Methods: This retrospective study included a group of patients who underwent LSG, divided into two groups: Group A, which contained 30 patients who received LSG without Ligamentum Teres Reinforcement (LTR), and Group B, with 30 patients, who underwent LSG with the additional LTR procedure.

Results: Group B experienced significantly fewer reflux symptoms during follow-up at 3, 9, and 18 months ($p < 0.05$). Additionally, Group B had a lower incidence of endoscopic reflux at 6 and 18 months (3.3% vs. 26.7% and 6.7% vs. 30.0%). Hiatus hernia size was significantly smaller in Group B (1.2 cm vs. 2.5 cm, $p < 0.001$).

Conclusion: Incorporating LTR during LSG may reduce postoperative GERD. The small sample size and retrospective design suggest the need for larger studies to confirm LTR's long-term benefits as an adjunctive technique in bariatric surgery.

Biography

Andrew Wanees is an experienced surgical doctor with over seven years of postgraduate training in General and Upper Gastrointestinal Surgery. He holds Full GMC Registration, MRCS qualification, and a Master's degree in General Surgery, and is currently preparing for the FRCS examination. His clinical focus includes Bariatric Surgery, Upper GI malignancies, and emergency surgical care. He gained significant operative experience in both open and laparoscopic procedures, managing a wide range of bariatric and metabolic conditions including obesity-related complications, hiatal hernias, and complex revisional surgeries. He has a strong academic background, with multiple peer-reviewed publications on GERD, hiatus hernia repair, and bariatric surgical outcomes. He also completed the Harvard Medical School Clinical Scholars Research Training Program, enhancing his expertise in clinical research and evidence-based practice. He is Passionate about teaching, he holds a Train the Trainer certificate and has participated in undergraduate medical education and mentoring of junior doctors. His commitment to quality improvement is evident through his leadership in clinical audits targeting peri-operative safety and enhanced recovery. He is dedicated to advancing patient care through clinical excellence, research, and innovation, embodying the core values of the NHS.



Andrew Wanees

The Royal Devon and Exeter University, United Kingdom

Advancements and challenges in the application of artificial intelligence in surgical arena: A literature review

This literature review delves into the transformative potential of Artificial Intelligence (AI) in the field of surgery, exploring its evolution, applications, and technological advancements. AI, with its ability to mimic human intelligence, presents a paradigm shift in surgical practices. The review critically analyzes a broad range of research, encompassing machine learning, deep learning, natural language processing, and their diverse applications in preoperative planning, surgical simulation, intraoperative guidance, and postoperative analysis. Ethical, legal, and regulatory considerations, as well as challenges and future directions, are also explored. The study underscores AI's ability to revolutionize surgical visualization and its role in shaping the future of healthcare.

Keywords: AI and Machine Learning, Artificial Intelligence, Artificial Intelligence and Robotics In Healthcare, Artificial Intelligence Education, Robotic-Assisted Surgery.

Biography

Andrew Wanees is an experienced surgical doctor with over seven years of postgraduate training in General and Upper Gastrointestinal Surgery. He holds Full GMC Registration, MRCS qualification, and a Master's degree in General Surgery, and is currently preparing for the FRCS examination. His clinical focus includes Bariatric Surgery, Upper GI malignancies, and emergency surgical care. He gained significant operative experience in both open and laparoscopic procedures, managing a wide range of bariatric and metabolic conditions including obesity-related complications, hiatal hernias, and complex revisional surgeries. He has a strong academic background, with multiple peer-reviewed publications on GERD, hiatus hernia repair, and bariatric surgical outcomes. He also completed the Harvard Medical School Clinical Scholars Research Training Program, enhancing his expertise in clinical research and evidence-based practice. He is Passionate about teaching, he holds a Train the Trainer certificate and has participated in undergraduate medical education and mentoring of junior doctors. His commitment to quality improvement is evident through his leadership in clinical audits targeting peri-operative safety and enhanced recovery. He is dedicated to advancing patient care through clinical excellence, research, and innovation, embodying the core values of the NHS.



Biplab Mishra*, Devendra G. Parikh

HCG AASTHA Cancer Centre, Ahmedabad, Gujarat, India

Urogenital outcomes following laparoscopic and robotic assisted rectal cancer resection-A prospective longitudinal study

Purpose: Urological and sexual dysfunction are recognised risks of rectal cancer surgery; however, there is limited evidence regarding urogenital function comparing robotic to laparoscopic techniques. The aim of this study was to assess the urogenital functional outcomes of patients undergoing laparoscopic and robotic rectal cancer surgery.

Methods: Urological and sexual functions were assessed using gender-specific validated standardized questionnaires. Urinary and erectile function were evaluated using the International Prostatic Symptom Score (IPSS) and the five-item version of the International Index of Erectile Function (IIEF-5) scale and female sexual function by Female Sexual Function Index (FSFI). A total of 62 patients of whom 21(Female 4, Male 17) underwent laparoscopic and 41 (Female 10, Male 21) robotic surgery. Data were prospectively collected from the two groups at baseline, 3, and 6 months after surgery and compared.

Results: The mean IPSS score was similar between the two groups at baseline and 3 months, but it was lower in the robotic arm at 6 months (laparoscopic- 7.39 ± 4.27 , robotic- 6.48 ± 4.33 $p=0.43$) though not significant. The interval decreases in scores at 6 months favoured the robotic arm (laparoscopic- 2.07 ± 3.82 , robotic- 1.33 ± 3.25 $p=0.45$). The mean baseline IIEF-5 score was slightly better in the robotic cohort (laparoscopic- 22.58 ± 2.93 , robotic- 23.62 ± 1.8 $p=0.25$). The interval decrease in IIEF-5 scores at 6 months was higher in the laparoscopic group than in the robotic group at 6 months (laparoscopic= -4.65 ± 4.82 , robotic= -5 ± 4.76 $p=0.83$). The mean FSFI score at baseline was better in the robotic group, but the interval decrease was similar between both the groups (laparoscopic= -1.38 ± 1.12 , robotic= -1.2 ± 1.13 $p=0.85$).

Conclusion: Evaluating quality of life and functional outcomes can help patients and surgeons make decisions by giving them a thorough grasp of the results of surgical techniques, such as robotic or laparoscopic procedures. In conclusion, the postoperative sexual and urinary functions were comparable between patients who underwent laparoscopic and those who underwent robotic rectal surgery, although there was trend towards laparoscopic approach in male urinary function and towards robotic for better recovery of male and female sexual function in this non-randomized comparison. Age, RT, stoma, lower rectal tumour and APR negatively correlated with urogenital function. Therefore, while we consider this study to be a significant step in comparing the relative efficacy of RTME and LTME as treatment options for clinically localized rectal cancer, larger, well-designed comparisons based on randomized

controlled trials are necessary to more definitively assess RTME against alternative treatment modalities.

Biography

Dr. Biplab Mishra studied MBBS at the Berhampur University, Odisha, India and completed post-graduation in M.S General surgery from Utkal university, Odisha, India in 2019. He received his Dr. NB surgical oncology degree from National board of examinations in 2025 and now a consultant at GI, HPB and Thoracic department of HCG AASTHA Cancer centre, Gujarat, India. He has presented at many national and international conferences including last ASCO, 2024.



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Utilisation of intraoperative cell salvage: A single-centre retrospective analysis of use patterns and blood volume returns

Aims: Intraoperative Cell Salvage (ICS) is a strategy for optimisation of patient blood volume. There are however, associated risks such as contamination and embolism as well as an associated cost of materials and staff members. As such, guidelines recommend use of ICS based on expected blood loss between more than 500mL. This study reviews use patterns of ICS across all non-cardiac surgical specialties at a single centre in Australia.

Methodology: Non-cardiac ICS from 2022-2024 was reviewed to identify indications and patterns of use. Blood volume returns were analysed to identify cases that met recommended guidelines. This was cross-referenced against the Massive Transfusion Protocol (MTP) used to identify surgical procedures that may benefit from ICS.

Results: ICS was utilised across 168 procedures by seven surgical specialties. The most common use cases were in general surgery, vascular surgery and obstetrics. The mean blood returns per specialty varied significantly from 157mL (95%CI 92-223mL) in orthopaedic surgery to 1000mL (95%CI 651-1347mL) in vascular surgery. A total of 26% of procedures returned no blood and 70% returned <500mL. The most common procedures to return no blood were lower-uterine caesarean section (42%) and total hip replacement (32%). On review of 62 open surgical MTP activations, only 14 also utilised ICS concurrently. The most common MTP activation that did not utilise cell salvage was trauma laparotomy.

Conclusion: This review notes that blood returns in the majority of ICS cases fell below 500mL and suggests more judicious use of ICS, especially for procedures with commonly low blood return. Furthermore, cases that often require MTP activation such as trauma laparotomy may benefit from more routine ICS use.

Biography

Dr. Connor completed his medical degree in Tasmania (Australia) in 2021 and began working as a doctor at the Royal Hobart Hospital across various roles before pursuing Vascular Surgery as a surgical registrar. During this time, he has published research in multiple peer-reviewed journals across areas of vascular surgery, artificial intelligence and genomics. He completed a Master of Surgery at the University of Sydney and continues to work at the Royal Hobart Hospital as a Vascular Surgery registrar whilst enjoying mountain biking and exploring the nature-filled environment of Tasmania.



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Patterns of anaesthesia choice during endovascular aortic aneurysm repair: 15-year trends at a regional vascular centre in Australia

Aims: Endovascular Aortic Aneurysm Repair (EVAR) has become an increasingly adopted intervention for aortic aneurysms in both elective and emergency settings. A recent systematic review comparing General Anaesthesia (GA) vs Local Anaesthesia (LA) for EVAR demonstrated a significant benefit in LA across multiple outcomes including lower in-hospital stay as well as lower rates of myocardial infarction, pneumonia and mortality. With Enhanced Recovery After Surgery (ERAS) generating a significant amount of research interest in recent years, the use of LA in EVAR may be an appropriate strategy for implementation to optimise ERAS protocols. We sought to explore anaesthesia trends within a regional centre that provides vascular surgery care for Tasmania in relation to the use of GA and LA.

Methodology: A 15-year retrospective analysis of all EVARs performed within Tasmania was performed. General patient demographics were extracted including age, sex and key comorbidities (ischaemic heart disease, hypertension, diabetes, chronic kidney disease and smoking status). The primary data points of interest included year of procedure, indication for EVAR, comorbidities and anaesthetic choice (GA vs LA/regional). A sub-analysis of GA vs LA was performed in relation to indications, cases per year and length of stay in order to identify usage patterns of LA in EVAR.

Results: A total of 385 EVARs were performed across the 15-year period by a total of seven vascular surgeons. Of these, Abdominal Aortic Aneurysms (AAA) were the most common type of aneurysm (90.6%), followed by thoracic aortic aneurysms (4.7%), common iliac aneurysm (3.1%), and branched/fenestrated thoracoabdominal aortic aneurysms (1.5%). The significant majority of patients were male (83.9%) with a mean age of 73.7 (range 22-94). Patients had a broad range of comorbidities with most common being hypertension (76.3%), and ischaemic heart disease (46.5%). The most common indication for EVAR was elective aneurysm (78.6%), followed by symptomatic/ruptured aortic aneurysms (18.4%) and mycotic aneurysms (2.6%). GA was used in the vast majority of cases (91.7%) compared to LA with no increased use of LA use across years. Of the 32 LA cases, 24 were utilised in ruptured/symptomatic aortic aneurysms with only 8 being elective aneurysms. When looking at length of stay of elective EVARs, all LA cases (8/8) were discharged on day-one postoperatively, compared to only 46.7% of GA cases. A further 42.9% of GA EVARs were discharged on days two to five postoperatively.

Conclusion: In conclusion, this analysis has shown that there remains little uptake of the use of LA for elective EVAR with the most common use-case continuing to be in symptomatic/ruptured aortic aneurysm cases. There are many reasons that GA may be preferred in elective EVAR (surgeon preference, patient preference, ease of ventilatory pause for angiograms), however, in light of recent evidence in literature and patterns of recovery in our retrospective review, this review suggests that LA-based EVAR may be an effective way to enhance recovery after surgery in EVAR.

Biography

Dr. Connor completed his medical degree in Tasmania (Australia) in 2021 and began working as a doctor at the Royal Hobart Hospital across various roles before pursuing Vascular Surgery as a surgical registrar. During this time, he has published research in multiple peer-reviewed journals across areas of vascular surgery, artificial intelligence and genomics. He completed a Master of Surgery at the University of Sydney and continues to work at the Royal Hobart Hospital as a Vascular Surgery registrar whilst enjoying mountain biking and exploring the nature-filled environment of Tasmania.



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Evaluating thyroidectomies performed at a single NHS trust; Outcomes and considerations

Background: Around 22,000 thyroidectomies are performed annually in England. Common indications include FNA result (38%), compressive symptoms (24%) and thyrotoxicosis (19%). Recognised complications include pain, bleeding (re-operation), infection, Vocal Cord Palsy (VCP) and voice change, and long-term calcium replacement.

Aim: To compare the outcomes of thyroidectomies performed within a single centre against the BAETS guidelines.

Method: A retrospective case note review of all thyroid surgeries performed by ENT surgeons within a single centre between 01/01/23 and 31/12/23 was performed.

Results: 62 thyroid surgeries were performed on 49 women and 8 men. 89% of the cases were primary surgeries. Commonest indications were compressive symptoms (35%) and FNA result (31%). Pre and post-operative laryngoscopy was performed in 71% and 89% of cases respectively, adjusted calcium was checked within 12 hours post-operatively in 100% of total and completion thyroidectomies and in 12 patients post-hemithyroidectomy. Post-operative bleeding requiring re-operation occurred in 1.8% and post-operative wound infection in 5.3%. Long-term calcium supplementation was required in 3 patients, 4.8%. Post-operative VCP occurred in 1 patient at 12 months follow-up.

Conclusions: Comparatively, peri-operative laryngoscopy was above the national standard, however post-operative VCP at 12 months was below and long-term hypocalcaemia was higher (4.8% c.f 3.7%). Notwithstanding a smaller data set, valuable learning points remain: All patients should have peri-operative laryngoscopy recorded as VCP may occur in 2.4% of patients pre-operatively and 2.7% post-operatively. Education on avoidance of unnecessary investigation post-hemithyroidectomy may improve patient experience. Implementation of a pre-operative vitamin-D check and post-operative 6-week thyroid function check may improve clinical management and outcomes.

Biography

Divine Adegbe is a core surgical doctor (ENT theme) within the NHS, graduated from University College London Medical School with a Bachelor of Medicine, Bachelor of Surgery degree and an intercalated Bachelor of Science degree in Anatomy. She has received several awards during her medical journey in recognition of her outstanding academic achievement and leadership skills, including a Dean's merit award for academic excellence, HSBC's Future Leader award, The Akindolie Medical Scholarship, and she was shortlisted as a Rising Star in Healthcare. She is dedicated to teaching and has taught at almost every stage of her career so far with a desire to make the Medicine pathway simpler and more accessible to all. Passionate about research, she has undertaken research in a wide range of topics from stem cell research to Cardiology, Surgery, and Education, and has been able to publish in reputable journals and present her research at national and international conferences. She is actively engaged with her community, having led community initiatives for young girls and young people.



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The financial and environmental cost of anaesthetic emergency drugs: Comparing ampoules with prefilled syringes, a second cycle quality improvement project

Anaesthetic emergency drugs are essential for safe practice; however, many prepared drugs remain unused and are disposed of daily. Prefilled Syringes (PFS) may reduce medication errors and waste although are associated with increased costs. Cycle 1 of our project found 48.1% of prepared emergency drugs were wasted producing 3,372kgCO₂e a year. Substituting PFS for metaraminol, ephedrine, and atropine, predicted a 22% saving annually. Cycle 2 was undertaken following substitution to assess real-world outcomes.

Methods: A survey was distributed to nine theatres at Queen Elizabeth the Queen Mother (QEQM) hospital examining the use and waste of emergency drugs. Anaesthetic teams were encouraged to complete these throughout February 2024 and 2025 for cycles 1 and 2 respectively. Annualised use and waste of drugs were estimated with costs of ampoules, PFS, equipment, and sharps bin disposal, provided by hospital pharmacy, suppliers, and facilities teams. Ampoules and equipment were weighed and kgCO₂e (CO₂ equivalent) estimated using emission factors per NHS spend and waste incineration.

Results: Cycle 2 provided 87 surveys representing 270 cases. 82.5% fewer emergency drugs were wasted with a waste reduction of 48.1% to 8.4% contributed to by greater utilisation percentages for PFS. The annualised cost of waste reduced by 91.1% from £23,348 to £2,080. Weight of waste reduced by 93.0% from 196.8kg to 13.8kg contributing to a 91.3% reduction in kgCO₂e from 3,372 to 294kgCO₂e. The cost-analysis of replacing metaraminol, ephedrine, and atropine ampoules with PFS using local tariffs estimated a 31.6% saving of £14,042.

Discussion: PFS for metaraminol, ephedrine, and atropine, are estimated to have saved 31.6% at one hospital site, predominantly through producing less waste. This exceeded expectations of 22%, partially contributed to by a change in practice with less emergency drugs such as glycopyrrrolate being routinely prepared. Limitations included self-reported data, relying on NHS-specific conversion factors, generalisability between hospitals, and lacking the human cost of potential medication errors. Despite these limitations, PFS are highly likely to provide a cost, environmental, and safety benefit to patients, the trust, and planet.

Biography

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The impact of gender on carotid revascularization outcomes: A comprehensive review

Background: Carotid revascularization procedures, including Carotid End Arterectomy (CEA) and Carotid Artery Stenting (CAS) both transvervical and transfemoral, are commonly performed to reduce stroke risk in patients with symptomatic or asymptomatic carotid stenosis. Despite their widespread use, evidence regarding gender differences in clinical outcomes following these interventions remains inconsistent. Understanding these differences is crucial for improving individualized patient care and optimizing treatment strategies.

Objective: This literature review aims to synthesize and analyze existing studies on gender differences in outcomes following carotid revascularization, including perioperative complications, stroke prevention, restenosis rates, and long-term survival.

Methods: A comprehensive review of studies published between 2000 and 2023 was conducted using major medical databases such as PubMed, Scopus, and Cochrane. Studies assessing gender-based differences in perioperative morbidity and mortality, stroke recurrence, long-term survival, and procedural complications following CEA or CAS were included. Data were analyzed for trends in gender disparities across different clinical outcomes.

Results: The review revealed that female patients tend to experience higher rates of perioperative complications, including wound infections, myocardial infarction, and postoperative hemorrhage, compared to males. However, long-term stroke prevention outcomes were generally similar between genders, with both groups showing significant reductions in stroke risk following carotid revascularization. Studies on restenosis rates yielded mixed results.

Conclusion: Gender differences in outcomes following carotid revascularization are evident, with female patients at higher risk for perioperative complications, yet achieving similar long-term stroke prevention benefits as male patients. While gender-related factors like comorbidities and anatomical differences may contribute to these outcomes, more focused research is needed to clarify the underlying mechanisms and improve personalized management strategies for both genders.

Keywords: Gender Differences, Carotid Revascularization, Carotid Endarterectomy, Carotid Artery Stenting, Perioperative Complications, Stroke Prevention, Restenosis, Long-Term Survival.



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T1 & T2 squamous cell carcinoma of the oral cavity- A detailed study

Introduction: Squamous cell carcinoma is the most common oral cancer, representing up to 84.97% of all malignant neoplasms of the oral cavity. The GLOBOCAN 2020, documented 377,713 new cancer cases and 177,757 deaths worldwide. Surgical therapy is the prime treatment option for squamous cell carcinoma, while radiotherapy and chemotherapy are adjuvant therapy depending upon the stage and histopathological characteristics. The purpose of this study was to evaluate the neck node status, patterns of neck metastasis, distribution of patients according to T (T1 & T2) stage and its management.

Methodology: 55 histopathologically proven cases of oral squamous cell carcinoma were included in our study. T1 and T2 lesions of oral squamous cell carcinoma cases were considered. Recurrent cases and prior treatment of oral cancer by chemotherapy and radiotherapy were excluded. All the patients involved in the study underwent tumor resection with neck dissection.

Results: A total of 55 patients were staged as per TNM criteria (AJCC 8th edition). The most common oral squamous cell carcinoma site was the tongue (n=26) followed by the buccal mucosa (n=21) and 2 patients each in lower alveolus, palate, lip and RMT region. Thirty two (58.18%) patients were pathologically node-negative (pN0) and twenty three (41.82%) patients were Pathologically Node-Positive (pN+). Three (05.45%) patients were pathologically node-positive with extranodal extension (pN+/ENE+). In pathologically node-positive patients N1 category was the highest followed by N2 category and N3 category. The percentage of T1 and T2 lesions were 21.82% and 78.18% respectively. The lymph node positivity was highest in T2 followed by T1. Final histopathological stage grouping revealed early stage disease in 32 patients and advanced stage disease in 23 patients. 25, 27 and 03 patients were treated by surgery alone, surgery with postoperative radiotherapy and surgery with postoperative CTRT respectively.

Conclusion: This study concluded that 41.82% of the patients were Pathologically Node-Positive (pN+) and nearly 06% of the patients were Pathologically Node-Positive with Extranodal Extension (pN+/ENE+). Histopathology reports demonstrated the most of the patients had well-differentiated squamous cell carcinoma. Early stage patients were treated primarily by surgery alone and stage III and IV (advanced stage) patients were treated with combination therapy.

Biography

Dr. Gaurav Vishal is an Oral and Maxillofacial Surgeon (M.D.S), Fellowship in Oral Oncology and Reconstructive Surgery. He completed M.D.S- Oral and Maxillofacial Surgery from Institute of Dental Sciences, Bareilly, India in 2020, Observership in Head and Neck Surgical Oncology from Mahavir Cancer Sansthan, Patna and Fellowship in Oral Oncology and Reconstructive Surgery from Rohilkhand Medical College and hospital, Bareilly, India in 2021. He has received the Emerging Oncosurgeon Award by HPP Cancer Hospital & Research Institute, with collaboration of Indian Medical Association, Lucknow (Oncological CME was organized in Lucknow), India. He has participated in various International conferences as a Speaker and Moderator. He is an expert in the field of Head & Neck Oncology, Reconstructive Surgery, Facial Trauma, Maxillofacial Pathology, Tobacco Cessation and Basal Implantology. He has several International and National Publications to his credit.



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Adequacy of ankle radiographs lateral views in a trauma unit: A quality improvement project

Introduction: Ankle injuries are among the most common presentations in an acute orthopedic setting. Appropriate radiographic analysis of the ankle is of paramount importance from a diagnostic perspective. According to the British Orthopedic Association Standard for Trauma guidelines, radiographs should be centered on the ankle and include a true lateral for proper assessment. We assessed the adequacy of the true lateral radiograph films at our hospital in a closed loop audit.

Methods: To ascertain the adequacy of lateral views ankle radiographs taken in an acute setting in accordance with the standards for them being true lateral. Data was collected retrospectively for patients with ankle xrays done for suspected fractures, and the adequacy of the lateral radiograph was assessed on 4 parameters, namely; Criteria 1 (distal fibula should be superimposed by posterior aspect of distal tibia), Criteria 2 (talar domes should be superimposed), Criteria 3 (joint space between distal tibia and talus should be open and uniform), Criteria 4 (lateral ankle radiograph should include lower third of tibia and fibula, talus, base of 5th metatarsal and calcaneus). 2 cycles were conducted against these standards. Following the first cycle, gaps in practice were identified and an educational session was undertaken along with display of posters in clinical areas to improve awareness. A subsequent cycle was undertaken to evaluate effectiveness of aforementioned interventions. Target compliance was set to 100%. Patients <12 yrs, open fractures or those in casts or with previous ankle surgery met the exclusion criteria. The adequacy of radiographs against set standards was reviewed by a senior orthopedic registrar.

Results: 100 patient records were analyzed during the first and second cycles. For the first cycle, the compliance to each criterion was as follows; criteria 1 (83%), criteria 2 (61%), criteria 3 (69%) and criteria 4 (99%). Following the interventions after first cycle, a repeat cycle was conducted with similar number of patient records, which yielded the following results; criteria 1 (95%), criteria 2 (85%), criteria 3 (92%) and criteria 4 (99%).

Conclusion: Appropriateness of ankle radiographs, especially the true lateral view is an important diagnostic tool for the orthopedic doctor. Our quality improvement project demonstrates that simple educational measures to increase awareness amongst involved team members can significantly improve quality of radiographs.

Biography

Georgios Kouklidis completed his MBBS at the Aristotle University of Thessaloniki, Greece, and undertook his foundation training in the UK (2020–2022). He obtained membership of the Royal College of Surgeons in 2024 and is currently working as a Specialty Registrar in the Trauma and Orthopaedics Department at University Hospitals Dorset. He has published and presented multiple papers at national and international conferences, including eFORT and ESGO, over the past two years.



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PICO (closed incision negative pressure wound therapy) dressing use as post-op prophylaxis for preventing surgical site infections in spinal surgery; a retrospective single center study

Introduction: Surgical Site Infections (SSI) are among one of the dreaded complications of spinal surgery. These typically develop within the first 30 days following surgery. Negative Pressure Wound Therapy (NPWT) has been employed for the management of open wounds and soft tissue injury. There has been a recent trend towards use of closed incision Negative Pressure Wound Therapy (ciNPWT), such as PICO. There are only a few studies evaluating prophylactic use of ciNPWT in Spinal Surgery. The aim of this study was to evaluate whether prophylactic use of PICO dressings can reduce SSI incidence and complications in Spinal Surgery.

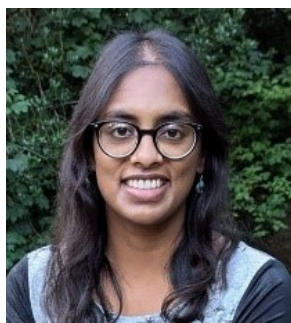
Methods: Data was collected retrospectively for patients undergoing spinal surgery, with a PICO dressing used for closed surgical incisions, from February 2021 to October 2022. Each patient was followed up for 30 days. The results were compared with local hospital infection control statistics for previous years.

Results: A total of 50 patients underwent spinal surgery with PICO dressings. None developed a seroma or wound dehiscence. 2/50 (4.0%) patients developed SSIs (1 superficial, 1 deep). These were managed conservatively without a return to theatre. The average SSI incidence in the prior years was 1.15%, with 77.3% of cases requiring return to theatre. The use of PICO dressings did not significantly change the SSI incidence rate ($p=0.087$) or the rate of return to theatre for SSI ($p=0.48$).

Conclusion: Our study reflects that there is no difference in the incidence rates for surgical site infections for patients who have PICO dressings versus those having standard occlusive dressings as post-operative closed surgical incision site wound closure following spinal surgery. For those who do develop surgical site infections, there was no difference in the rates of return to theatres among the two patient populations.

Biography

Georgios Kouklidis completed his MBBS at the Aristotle University of Thessaloniki, Greece, and undertook his foundation training in the UK (2020–2022). He obtained membership of the Royal College of Surgeons in 2024 and is currently working as a Specialty Registrar in the Trauma and Orthopaedics Department at University Hospitals Dorset. He has published and presented multiple papers at national and international conferences, including eFORT and ESGO, over the past two years.



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The STROCCS 2024 guideline: Strengthening the reporting of cohort, cross-sectional, and case-control studies in surgery

Introduction: First released in 2017, the STROCCS guidelines have become integral for promoting high-quality reporting of observational research in surgery. However, regular updates are essential to ensure they remain relevant and of value to surgeons. Building on the 2021 updates, the authors have developed the STROCCS 2024 guidelines. This timely revision aims to address residual reporting gaps, assimilate recent advances, and further strengthen observational study quality across all surgical disciplines.

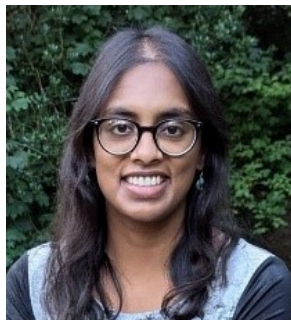
Methods: A core steering committee compiled proposed changes to update the STROCCS 2021 guidelines based on identified gaps in prior iterations. An expert panel of surgical research leaders then evaluated the proposed changes for inclusion. A Delphi consensus exercise was used. Proposals that scored between 7-9 on a nine-point Likert agreement scale, by ≥70% of Delphi participants, were integrated into the STROCCS 2024 checklist.

Results: In total, 46 of 56 invited participants (82%) completed the Delphi survey and hence participated in the development of STROCCS 2024. All suggested amendments met the criteria for inclusion, indicating a high level of agreement among the Delphi group. All proposed items were therefore integrated into the final revised checklist.

Conclusion: The authors present the updated STROCCS 2024 guidelines, which have been developed through expert consensus to further enhance the transparency and reporting quality of observational research in surgery.

Biography

Dr. Ginimol Mathew graduated from University College London with MBBS BSc in 2020. Subsequently, she worked as an academic foundation doctor at York and received a PG Cert in Health Research and Statistics from University of York in 2023. Currently, she is working as an Internal Medicine Trainee at Royal Free London NHS Foundation Trust. She has more than 20 PubMed indexed publications with over 10000 citations.



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Preferred Reporting of Case Series in Surgery (PROCESS) 2023 guidelines

Introduction: The Preferred Reporting of Case Series in Surgery (PROCESS) guidelines were developed in 2016 in order to improve the reporting quality of surgical case series. Since its inception, it has been updated twice, in 2018 and 2020, and has been cited over 1000 times. PROCESS guidelines have enjoyed great acceptance within the surgical research community. Our aim is to update the PROCESS guidelines in order to maintain its applicability in the field of surgical research.

Methods: A PROCESS 2023 steering group was created. By working in collaboration, members of this group came up with proposals to update the PROCESS 2020 guidelines. These proposals were presented to an expert panel of researchers, who in turn scrutinised these proposals and decided whether they should become part of PROCESS 2023 guidelines or not, through a Delphi consensus exercise.

Results: A total of 38 people participated in the development of PROCESS 2023 guidelines. The majority of items received a score between 7 and 9 from greater than 70% of the participants, indicating consensus with the proposed changes to those items. However, two items (3c and 6a) received a score between 7 and 9 from less than 70% of the participants, indicating a lack of consensus with the proposed changes to those items. Those items will remain unchanged.

Discussion: The updated PROCESS 2023 guidelines are presented with an aim to continue improving the reporting quality of case series in surgery.

Biography

Dr. Ginimol Mathew graduated from University College London with MBBS BSc in 2020. Subsequently, she worked as an academic foundation doctor at York and received a PG Cert in Health Research and Statistics from University of York in 2023. Currently, she is working as an Internal Medicine Trainee at Royal Free London NHS Foundation Trust. She has more than 20 PubMed indexed publications with over 10000 citations.



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Comparison of frequency of seroma formation in laparoscopic para umbilical hernia repair with and without primary closure of defect

Objective: To compare the frequency of seroma formation in laparoscopic para-umbilical hernia repair with and without primary closure of defect.

Method: The randomised parallel group study was conducted at the Department of Surgery, Bahawal Victoria Hospital, Bahawalpur, Pakistan, from October 1, 2019, to May 31, 2020, and comprised patients of both genders age 25-65 years diagnosed as a case of para-umbilical hernia. The patients were randomised into group A which subsequently had laparoscopic primary repair of defect with non-absorbable suture prior to mesh placement, and group B which had laparoscopic repair without primary closure of the defect. Case sheets of patients were prepared for age, gender, duration of disease, operating time, body mass index and the presence or absence of seroma formation. Data was analysed using SPSS 20.

Results: Of the 100 patients, 35(35%) were males and 65(65%) were females with male-to-female ratio of 1:1.9, and an overall mean age of 43.92 ± 10.77 years. Both groups had 50(50%) patients each. Post-operative seroma formation was noted in 1(2%) group A patient and 12(24%) group B patients ($p=0.001$).

Conclusion: Primary closure of the fascial defect in laparoscopic para-umbilical hernia repair resulted in decreased frequency of post-operative seroma formation.

Keywords: Paraumbilical Hernia, Seroma, Laparoscopic Paraumbilical Hernia Repair.



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Re-audit of extended thromboprophylaxis following abdominal and pelvic cancer surgery: Closing the gap in compliance

Background: Extended Venous Thromboembolism (VTE) prophylaxis — typically Low Molecular Weight Heparin (LMWH) for up to 4 weeks after major abdominal or pelvic cancer surgery — is supported by randomized controlled trials showing reduced postoperative VTE rates without a significant increase in bleeding risk. Major guidelines, including NICE and ASCO, recommend extended prophylaxis for high-risk cancer surgery patients. Despite this, real-world audits have demonstrated variable compliance across institutions. This re-audit aimed to assess current adherence to NHS Tayside guidelines following implementation of targeted quality improvement measures.

Methods: A retrospective review was conducted of all patients undergoing major abdominal or pelvic cancer surgery between January and March 2024. Data were extracted from electronic patient records regarding prescription and administration of extended VTE prophylaxis. Compliance was assessed against NHS Tayside guidelines and compared with the previous audit cycle. The first audit cycle highlighted gaps in prescribing extended prophylaxis at discharge. In response, a series of targeted interventions were implemented, including delivering educational lectures during junior doctor induction, placing posters in the prescribing room to highlight protocol requirements, adding electronic prescribing reminders, and holding multidisciplinary meetings with pharmacists to reinforce discharge prescription checks.

Results: Eighty-two patients were included.

- **Compliance rate:** 66/82 patients (80.5%) received extended VTE prophylaxis.
- **Non-compliance:** 16/82 patients (19.5%) did not receive the recommended prophylaxis.

This represents an improvement from the prior audit but full adherence was not achieved. Barriers included omission at discharge prescribing, patient refusal, and clinical contraindications.

Conclusions: Implementation of targeted recommendations has improved compliance with extended VTE prophylaxis in abdominal and pelvic cancer surgery, but gaps remain. Strategies such as electronic prescribing prompts, discharge checklist integration, and staff education may further improve adherence. Continued monitoring is necessary to maintain progress.

Keywords: VTE Prophylaxis, Abdominal Surgery, Pelvic Surgery, Cancer, Audit, Quality Improvement, Re-Audit

Biography

Hesham Mahmoud is a Clinical Fellow in General Surgery at Royal Sussex County Hospital, with over three years of surgical experience across General and Vascular Surgery. He graduated from Cairo University with a Very Good degree and is a Member of the Royal College of Surgeons of England. He has led and contributed to several quality improvement and audit projects, including extended venous thromboprophylaxis, lower GI bleeding pathways, and bladder cancer referrals. He has presented his work at departmental and clinical effectiveness meetings and is preparing abstracts for national conferences. His clinical interests lie in General Surgery, particularly Colorectal surgery. He is passionate about medical education, audit, and research, and is working towards Specialty Training in General Surgery in the UK.

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Annular pancreas and current approaches to surgical management

Annular pancreas is an uncommon but well documented anatomical variant. Annular pancreas has a strong embryological basis, likely resulting from errors in rotation of the ventral duct of the embryological pancreas. Despite a low prevalence, annular pancreas is associated with surgical pathology that requires urgent intervention. In neonates and adults, duodenal obstruction can pose a life-threatening risk, and prolonged inflammation of related structures in adults can result in pancreatitis, cholangitis, and ultimately pancreaticobiliary malignancy. Currently, in cases of duodenal obstruction, bypass surgery has garnered favour over resection, whereas in cases of recurrent pancreatitis and cholangitis, endoscopic Retrograde Cholangiopancreatography (ERCP) is preferred. Further longitudinal investigation of the risk of developing foregut malignancy with bypass as opposed to resection would be beneficial in informing guidelines for surgical management.

Biography

Dr. Gregory completed his MBBS and Grad Dip Surg Anat through James Cook University in 2022. He then commenced clinical practice throughout various hospitals in South East Queensland. He completed a Master of Surgery degree through The University of Sydney in 2025, and continues as an associate lecturer in anatomy at James Cook University, and as a clinical tutor at the University of Queensland clinical schools.



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Embryology of the non-recurrent laryngeal nerve and advancements in detection prior to surgery

The Non-Recurrent Laryngeal Nerve (NRLN) is an uncommon anatomical variant of the Recurrent Laryngeal Nerve (RLN). A right-sided NRLN is exceedingly more common than a left-sided NRLN, and almost all are associated with abnormalities of the aortic arch, especially a right Aberrant Subclavian Artery (ASCA). The NRLN has a strong embryological basis, resulting from the premature obliteration of the right fourth aortic arch. Absence of this structure during longitudinal development allows the laryngeal nerve to migrate superiorly, ultimately branching from the cervical vagus nerve without entering the mediastinum. Despite a low prevalence, the presence of a NRLN is associated with a six to eight-fold increase in iatrogenic injury during surgeries of the thyroid, parathyroid and carotid structures. Pre-operative ultrasound for identification of an ASCA and thus the presence of a NRLN has demonstrated a clinically-significant reduction in the risk of laryngeal nerve damage Intra-Operatively. Intraoperative Nerve Monitoring (IONM) has also been shown as an effective alternative approach for detection of a NRLN intra-operatively. Further prospective studies exploring the effectiveness of these strategies in identifying a NRLN would be beneficial.

Biography

Dr. Gregory completed his MBBS and GradDipSurgAnat through James Cook University in 2022. He then commenced clinical practice throughout various hospitals in South East Queensland. He completed a Master of Surgery degree through The University of Sydney in 2025, and continues as an associate lecturer in anatomy at James Cook University, and as a clinical tutor at the University of Queensland clinical schools.

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Barn theatres: A novel learning environment for orthopaedic surgeons

Introduction: The evolving landscape of surgical education has led to the exploration of alternative models for training environments, including the implementation of Barn-Integrated Operating Rooms (BOR). Early evidence suggests BOR improve theatre efficiency whilst maintaining low levels of surgical site infection. Whilst BOR are increasingly utilised as an education tool, there remains paucity of data detailing its effects on surgical learning outcomes and skill acquisition. This study aims to identify, analyse and discuss the current concerns, benefits, and training experience of surgeons and theatre staff operating in this novel learning environment.

Methods: Prospective cohort study, using a mixed qualitative, quantitative methodology. Theatre staff, current and aspiring orthopaedic surgeon satisfaction and perceptions of the educational environment were assessed via a pilot tested questionnaire.

Results: BOR were preferred to the Conventional Operating Room (COR) environment by 81.5% (44/54) of respondents. Per operating session, 78.3% (36/46) of surgeons, including consultants, attended an adjacent theatre within the BOR for a learning opportunity, at least once. Furthermore, 67.4% of surgeons agree that the BOR facilitates a superior environment for supervision. Reflexive thematic analyses of free text answers elicit themes of increased accountability, supervision and improved communications. One third (18/54) of respondents were concerned that infection rates may be higher in the BOR, in addition to having concerns regarding increased ionisation risk between theatres. 46% of participants had concern regarding noise pollution in-between theatres.

Conclusion: BOR are a promising alternative to a traditional theatre learning environment, fostering increased supervision and frequency of learning encounters for surgeons of all grades. With well-defined local protocols, the BOR can facilitate shared decision making and improve interdisciplinary communication. Multidisciplinary team perceptions regarding noise pollution, radiation and infection risk are topical, under-recognised, and indicate that more research is required in this field.

Keywords: Barn Integrated Operating Rooms, Orthopaedic Training.

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Comparing outcomes for Open, Laparoscopic and Robotic colorectal resections; A single center retrospective cohort study

Introduction: Recent years have seen advances in Minimally Invasive Surgery (MIS) to colorectal surgery, including Laparoscopic and Robotic. Apart from shorter length of stay for Robotic assisted surgeries, most studies do not demonstrate a clear advantage of one MIS technique over the other. We evaluated patient outcomes for these surgical modalities and present our findings.

Objective: We studied a case series of patients undergoing open, laparoscopic, and robotic colorectal surgery in the past year, to study the safety and effectiveness between these techniques.

Methods: A list of patients who underwent elective colorectal resections by either open, laparoscopic or robotic approach, between 1/1/2021 and 31/12/2021 was obtained. Emergency colorectal procedures were not included. Measured outcomes were: conversion to open surgery, anastomotic leak rate, return to theatre, length of hospital stay, and mortality within 30 and 90 days of surgery.

Results: A total of 174 colorectal resections were performed in 2021 (104 laparoscopic, 49 open, and 21 robotic). Conversion rates for laparoscopic and robotic surgery were 20% and 0%, respectively. Overall, the indication for resection included 151/174 (87%) malignant cases. A total of 156 resections ended up with a primary anastomosis, with 16 leaks (8 open, 8 laparoscopic, 0 robotic) with 3 (2 open, 1 laparoscopic) requiring a return to theatre. Median length of stay was 8, 6, and 4 days for open, laparoscopic and robotic surgery, respectively. 30 day mortality was 1/174 (1 laparoscopic) while 90 day mortality was 3/174 (1 laparoscopic, 2 open).

Conclusion: Our experience shows that Robotic surgery confers better overall outcomes when compared to open and laparoscopic surgery for elective colorectal resections, with much lower rates of complications, median length of hospital stays and overall mortality.

Keywords: Colorectal Surgery, Robotic Surgery, Robot Assisted Surgery, Minimally Invasive Surgery (MIS).



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Hypertension as a novel predictive marker for symptomatic cholelithiasis in post-bariatric patients: Coincidence or causation?

Introduction: As obesity is well known to be associated with gallstone pathology, new advances have shown the role hypertension may play in predicting the occurrence of the latter. This study analyzes the correlation between symptomatic cholelithiasis post-bariatric surgery and hypertension.

Methods: Our study applied a retrospective cohort design, where 3000 Lebanese patients who underwent bariatric surgery, were selected from a single center, at Al Zahraa University Hospital from the years 2008 till 2018. 485 patients have been documented to have hypertension. Chi-square testing was employed to correlate symptomatic cholelithiasis incidence with subsequent cholecystectomy with hypertension status.

Discussion: Our data showed a significant association between hypertension and symptomatic gallstones ($p=0.021$). While causation cannot be concluded, this possible interaction may stem from common metabolic pathways regarding bile composition and cholesterol homeostasis. Our findings shed light on the added value of emphasizing hypertension as a variable in risk models. Such an emphasis in the management of bariatric cases may bring some surgical scenarios as better and safer options such as concomitant cholecystectomy during bariatric or redo surgeries.

Conclusion: Hypertension may sometimes be overlooked as a potential marker for the risk of gallstone occurrences post bariatric surgery. This study opens the door for further investigations as more data and evidences is required to properly decorticate the intensity of the association or causation between hypertension and gallstone formations, especially with bariatric surgeries, which may be seen as a synergistic component to the occurrence of cholelithiasis.

Biography

Dr. Jaafar AL Shami is a Senior Clinical Fellow in the General Surgery Department at King's College Hospital, London. He is a member of the Royal College of Surgeons of England. Dr. AL Shami finished his MD and General Surgery Diploma at the Lebanese University, Lebanon. He was a general surgery consultant at the Central Military Hospital, Beirut, Lebanon. He is a Clinical Instructor of General Surgery at Faculty of Medicine-Balamand University, Lebanon. He is an instructor of BSS, CSES, Core Lap and SSSHP course in the Royal College of Surgeons, RCS faculty, and an examiner at King's College University.



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Laparoscopic resection of cecal duplication cyst in a 28 years old male

Introduction: Cecal duplication cyst is a congenital anomaly that is rarely observed in adults. It has diverse clinical presentation with different treatment approaches. This article sheds light on a case of cecal duplication cyst in an adult patient where it was laparoscopic surgically resected.

Case Report: This is a case of 28 years old male patient presenting with one week history of right lower quadrant pain with no other associated symptoms. Radiology report mentioned a diagnosis of an epiploic appendagitis or cecal diverticulitis, for which a medical treatment of antibiotics and pain killer was started. 10 days later, a control CT scan of the abdomen and pelvis with IV and PO contrast was done showing increase in the size of the cystic mass with excessive fatty stranding. Since the patient was still in pain and no amelioration based on the clinical and radiological findings, decision was taken to go for diagnostic laparoscopy. The pathology report showed a non-communicating cystic duplication cyst of the cecum.

Discussion: Enteric duplication cyst is rare congenital anomaly. They can be found anywhere in gastrointestinal tract with the small intestine being most commonly involved mainly in its distal part. In our case, the patient was a male aged 28 years, thus considered out of the common age and gender group of this presentation. Presenting feature may differ depending on site, size and morphology of CDC. Duplication cysts may have malignant transformation, and cases of adenocarcinoma from cyst wall have been reported.

Conclusion: Duplication cyst is a rare finding in the pathologies of the gastrointestinal tract, and is even rarer when occurring in adults and affecting the cecum. This is a study showing this unique presentation, which was treated laparoscopically.

Biography

Dr. Jaafar AL Shami is a Senior Clinical Fellow in the General Surgery Department at King's College Hospital, London. He is a member of the Royal College of Surgeons of England. Dr. AL Shami finished his MD and General Surgery Diploma at the Lebanese University, Lebanon. He was a general surgery consultant at the Central Military Hospital, Beirut, Lebanon. He is a Clinical Instructor of General Surgery at Faculty of Medicine-Balamand University, Lebanon. He is an instructor of BSS, CSES, Core Lap and SSSHP course in the Royal College of Surgeons, RCS faculty, and an examiner at King's College University.

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Scarless thyroidectomy through the Transoral Endoscopic Vestibular Approach (TOETVA): A systematic review of clinical outcomes and global relevance in low-resource settings

Background: Transoral Endoscopic Thyroidectomy Vestibular Approach (TOETVA) is a scarless, minimally invasive technique avoiding visible neck incisions. It may improve surgical access in low-resource settings where aesthetic concerns, stigma, or limited wound care impact treatment uptake. This systematic review evaluates global clinical outcomes, complications, and the potential role of TOETVA in resource-constrained healthcare systems.

Methods: We systematically searched major databases to May 2025. From 1,986 records, 112 studies involving over 6,000 adults undergoing TOETVA were included. Study designs included RCTs, cohort studies, and case series. Outcomes analysed included nerve injury, hypoparathyroidism, infection, operative time, hospital stay, and cosmetic satisfaction. Thematic relevance to surgical delivery in low-resource settings was also explored.

Results: Transient recurrent laryngeal nerve injury occurred in 0–20%, permanent injury in up to 1.5%. Transient mental nerve symptoms were common but usually mild and self-limiting. Conversion to open surgery and infections were rare (<3%). Operative times averaged 110–210 minutes, improving with experience. Hospital stays were short (1–5 days). Patient satisfaction with cosmetic outcomes was consistently high.

Discussion and importance to the field: TOETVA provides a safe, cosmetically favourable surgical option that could reduce barriers to care in low-resource settings. Minimising visible scars may improve acceptability and uptake of surgery. Challenges remain around affordability, training, and infrastructure. This review highlights TOETVA's global potential and the importance of adapting surgical innovations to suit varied resource environments.

Biography

Miss Patel has completed her Core Surgical Training in the Thames Valley region, with a strong interest in Otolaryngology. She has completed her MRCS (ENT) and is pursuing a career in Otolaryngology within the NHS.

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Transoral endoscopic vestibular approach for parathyroid surgery: A systematic review of clinical outcomes and safety

Background: The Transoral Endoscopic Parathyroidectomy Vestibular Approach (TOEPVA) is a scarless, minimally invasive technique for parathyroid surgery, mostly indicated in primary hyperparathyroidism. Building on transoral thyroid surgery, TOEPVA offers direct midline access without visible scarring. Despite advantages, concerns remain regarding safety, learning curve, and effectiveness in gland localisation and excision. This review evaluates current evidence on TOEPVA outcomes and limitations.

Method: A search of major databases through May 2025 identified 255 studies, with eleven included from international centres of 280 adults undergoing TOEPVA. These comprised case series, retrospective cohorts, and comparative studies. Two independent reviewers screened and analysed data. Key outcomes included cure rates, Recurrent Laryngeal Nerve (RLN) palsy, hypocalcaemia and cosmetic satisfaction. Operative time, hospital stay, and technical challenges were assessed. Systematic reviews were examined separately for context.

Results: Cure rates were uniformly high (>95%) with a 1% open conversion rate. There were no reports of permanent RLN palsy; transient palsy in up to 9%. Hypocalcaemia rates varied but similar to conventional surgery. Operative times (40-260 min) decreased with experience. Hospital stays were brief (1–3 days), and cosmetic satisfaction was excellent. Patient selection and surgeon training were emphasised.

Conclusion: TOEPVA is a promising scarless technique for select patients with hyperparathyroidism, delivering high cure rates and excellent cosmetic outcomes with a safety profile comparable to other approaches when performed by experienced surgeons. Wider adoption requires standardised protocols, training pathways, and further multicentre studies to optimise outcomes.

Biography

Miss Patel has completed her Core Surgical Training in the Thames Valley region, with a strong interest in Otolaryngology. She has completed her MRCS (ENT) and is pursuing a career in Otolaryngology within the NHS.

Dr. Jeevitha Channappa*, Alison Fernandes

Ashford and St Peter's NHS Trust, UK

Escape the operating room: A gamified experience for surgical decision-making

Introduction: Escape rooms are an innovative and increasingly utilized tool in medical education, offering a dynamic and interactive alternative to traditional didactic teaching. By embedding critical thinking, decision-making under pressure, and teamwork into a time-bound, story-driven challenge, escape rooms simulate the high-stakes environment of clinical practice. This study explores the use of a surgically themed educational escape room to enhance medical student engagement, consolidate learning, and evaluate preparedness for clinical placements. It investigates whether this format can serve both as a formative learning experience and as a potential tool for assessment.

Methods: A surgical escape room was developed and piloted at St Peter's Hospital for penultimate-year medical students from St George's University. Learning objectives were explicitly aligned with the GMC outcomes and mapped to the surgical undergraduate curriculum. The game's challenges were rooted in real-life scenarios frequently encountered during placements and incorporated core clinical skills previously taught during the students' five-week placement.

The escape room comprised a sequence of interlinked tasks embedded within a narrative arc. Activities included: structured A-E assessment with sepsis 6 initiation, differential diagnosis-matching using a Jenga-style puzzle, surgical incision recognition, suturing techniques, CT interpretation, nasogastric tube insertion, and SBAR handover simulation. A pilot run was conducted by the Simulation Lead and Clinical Teaching Fellow (CTF) to optimize delivery. In April 2025, nine sessions were conducted and video recorded for ethnographic analysis. Informed consent was obtained from all participants. Following the session, participants completed structured Likert-scale questionnaires and open-ended feedback forms. Thematic analysis was applied to qualitative responses and observational data.

Results: All 26 participants were penultimate-year medical students, most of whom had no prior exposure to gamified learning in medical education. Quantitative data demonstrated universally positive feedback, with Likert scale scores ranging from 4.4 to 5.0 across all domains. Participants strongly agreed that the escape room improved their clinical reasoning, communication, and

teamwork. Thematic analysis revealed high engagement, appreciation of the realism and challenge, and recognition of the activity's educational value. Students particularly valued the integration of clinical content with decision-making under pressure. No negative feedback was recorded, and several participants recommended extending the duration of the session.

Discussion: Educational escape rooms represent a promising pedagogical approach in undergraduate surgical education. Their immersive and interactive nature promotes deep engagement, contextual learning, and reinforcement of essential non-technical skills. This study supports the inclusion of escape-room-based simulations as a complementary tool to traditional clinical teaching, with potential applications in both formative assessment and curriculum delivery to better prepare students for real-world surgical practice.

Biography

Jeevitha Channappa is a clinical teaching fellow for undergraduate surgery working in Ashford and St Peter's NHS Trust, with a strong interest in pursuing a career in Upper Gastrointestinal surgery. She holds a Postgraduate Certification in Medical Education from University of Warwick and is passionate about combining clinical practice with teaching and surgical training.

Dr. Jeevitha Channappa*, Esther Louise

Ashford and St Peter's NHS Trust, UK

Port to practice: Simulation-driven laparoscopic skills for aspiring surgeons

Introduction: Laparoscopic surgery is an essential component of modern surgical practice. However, current formal laparoscopic skills training is often limited to trainees at the ST3 level and above. This project aimed to address this gap by introducing a structured, registrar-led laparoscopic skills course for medical students and junior doctors with an interest in surgery, in alignment with Royal College of Surgeons (RCS) guidelines.

Methods: A five-day hands-on laparoscopic training course was conducted using box trainers and the VirtaMed LaparoS™ virtual reality simulator. The curriculum was designed according to RCS-recommended competencies and was conducted once a week over course of 5 weeks, included key skills such as port insertion, camera navigation, instrument handling, and basic procedural steps in laparoscopic appendicectomy and cholecystectomy. A total of 15 participants, comprising final-year medical students and foundation year doctors, were enrolled. Feedback was collected via anonymized pre- and post-course questionnaires assessing confidence, knowledge, and satisfaction.

Results: All 15 participants completed the course. Pre-course assessments revealed limited prior exposure to laparoscopic techniques. Post-course feedback indicated significant improvement in confidence and perceived competence in essential laparoscopic skills. Participants rated the course highly, with 100% expressing that such training should be included earlier in surgical education. Qualitative feedback highlighted the value of early exposure and the structured approach to technical skill development.

Discussion: This pilot course successfully demonstrated the feasibility and impact of early laparoscopic training for junior trainees and medical students. By aligning with RCS guidelines and utilizing a combination of simulation modalities, the course filled a crucial gap in early surgical education. The overwhelmingly positive feedback supports wider implementation of similar initiatives, promoting preparedness and engagement in surgical careers from an earlier stage.

Learning Points: Early exposure to laparoscopic skills significantly enhances confidence and perceived competence among junior trainees and medical students. Structured, simulation-based training—aligned with Royal College of Surgeons (RCS) guidelines—is both feasible and well-received at the undergraduate and foundation levels.

Biography

Jeevitha Channappa is a clinical teaching fellow for undergraduate surgery working in Ashford and St Peter's NHS Trust, with a strong interest in pursuing a career in Upper Gastrointestinal surgery. She holds a Postgraduate Certification in Medical Education from University of Warwick and is passionate about combining clinical practice with teaching and surgical training.



Jimena Alvarez del Castillo Gonzalez*, Anisha Sukha, Asmaa Ghazi, Yara Lima de Mendonça, Nico-Karlo Plete, Shahnawaz Rasheed, Shengyang Qiu

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Strategies to identify and raise awareness of alcohol consumption in oncological patients before major cancer surgery. The importance of prompt counselling provided by healthcare providers

Introduction: Healthcare professionals play a crucial role in patient education, as they are often seen as a reliable source of information and counselling. Research has suggested that providing structured guidance when modifying a behavioural practice can increase acceptance and adherence. Certain habits, such as alcohol consumption, are associated with an increased risk of perioperative and postoperative complications, making this a key aspect to address as part of a patient's optimization.

This project aims to optimise preoperative patients by targeting modifiable risk factors.

Objectives: To analyze the screening methods for alcohol intake, the role of health care providers in raising awareness about alcohol cessation and the acceptance of referral to support services among preoperative oncological patients as a key component of adherence to the NICE clinical guidelines.

Materials and Methods: A retrospective analysis was conducted on patients who underwent pre-assessment for cancer-related procedures or surgery in June 2025 at a single centre in London, United Kingdom. Alcohol consumption status (including units and type of alcohol) and referral to a community-based quitting program were identified from their electronic records.

An optimization protocol was then developed incorporating the AUDIT-C (alcohol use disorder identification test consumption) questionnaire to raise awareness, provide counselling, and facilitate referral of these patients to specialized alcohol cessation programs before surgery. This protocol, titled "Alcohol Cessation Pathway" was implemented during the first week of July 2025, across all pre-assessment units, including day-case surgery, pre-surgical assessment department, and endoscopy department within the hospital.

Data collected included patients with active alcohol consumption, including the number of units consumed weekly, type of alcohol, and the frequency of intake. In addition, the type of cancer this group of patients had and the proportion of patients who were provided with information and who accepted referral was assessed.

Results: Prior to protocol implementation, 58 patients with a median age of 64 years old were evaluated in the pre-assessment units. Of these, 31 patients (53%) screened positive for alcohol consumption, with four male patients (12.9%) and one female patient (3.22%) identified as being at higher risk of alcohol use disorder. The most preferred drink was wine, followed by beer. Although verbal counselling may have been provided, documentation within the pre-assessment notes did not record risk level and referral to community alcohol cessation services.

After implementation of the “Alcohol Cessation Pathway”, 49 patients were evaluated, of whom 23 patients (46%) screened positive for alcohol consumption. Within this group, 2 male patients (8.6%) and 1 female patient (4.3%) reported alcohol intake at a level indicating increased risk for harmful use. All patients received counselling from healthcare professionals, and 2 patients (8.6%) accepted information regarding referral to their local NHS alcohol support service.

Among the patients who were considered at higher risk, the most common cancer type was urological, followed by breast, colorectal, sarcoma and gastric cancers.

Conclusions: Preoperative assessment represents a key stage in patient preparation for surgery, where the role of healthcare professionals in counselling is essential to raise awareness of alcohol consumption. Providing appropriate information and facilitating access to quitting support services can positively influence the reduction of alcohol consumption prior to surgery and reduce withdrawal symptoms during their hospital stay among oncological patients.

Biography

Dr. Jimena Alvarez del C. completed her medical training in Mexico, where she subsequently worked as a GP, in the A&E department, and in the intensive care unit during the COVID-19 pandemic. She was later awarded an academic scholarship for Master's degree in Global Public Health and Nutrition in the UK. In August 2022, she decided to specialize in surgery, gaining experience at The Royal Marsden Hospital in Endoscopy and Upper and Lower GI Surgery, at St Mary's Hospital in Vascular Surgery, and at Charing Cross Hospital in General Surgery. She is currently working as a surgical clinical fellow in Plastic Surgery.



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Preoperative identification and implementation of smoking cessation strategies in oncological patients: The role of healthcare providers

Introduction: The preoperative period represents a key opportunity to identify modifiable risk factors in oncological patients and to implement strategies that optimize outcomes before major surgery. Smoking cessation prior to surgery has been shown to reduce perioperative stress, maintain postoperative physiological stability, and accelerate recovery, while lowering morbidity and mortality.

To support pre-surgical assessment, NICE guidelines and ERAS protocols recommend the use of screening tools to identify smokers and implement targeted cessation interventions. Evidence indicates that counselling and guidance provided by healthcare professionals during the cessation process have a significant positive impact and enhance treatment adherence. This project aims to optimize preoperative patients by targeting modifiable risk factors.

Objectives: To evaluate whether preoperative oncological patients who are smokers were counselled and referred for smoking cessation support as part of the NICE clinical guideline NG209 (Tobacco: preventing uptake, promoting quitting and treating dependence). Additionally, to propose strategies to improve the referral pathway for community-based services.

Materials and Methods: A retrospective analysis was conducted of patients who underwent colorectal cancer surgery at a single centre in June 2025. Smoking status and referral for cessation were identified from preoperative assessment records. Based on these findings, a structured “Smoking Cessation Pathway” was subsequently developed to provide a standardized, user-friendly process for patient identification, counselling, and referral. The pathway algorithm was implemented during the first week in July 2025 across all pre-assessment units, including day-case surgery, the pre-surgical assessment clinic, and the endoscopy department. Outcomes measured included the prevalence of active smokers, provision of smoking cessation advice, and acceptance of referral to support services.

Results: Before implementation, 58 patients with a median age of 64 years old were evaluated preoperatively, of whom 9 patient (15%) were active smokers. Patients referred having a smoking history of over 45 years, consuming on average between a quarter and half a pack of cigarettes per day. Although verbal counselling may have been provided, documentation within the pre-assessment notes did not record this or referral to community smoking cessation services.

Following implementation of the “Smoking Cessation Pathway”, 49 patients were assessed, with 7 patients (14%) identified as active smokers. All received smoking cessation counselling, and of this group, 3 patients (6%) accepted referral to the NHS Better Health Stop Smoking Service.

Among the patients who were active smokers, the most common cancer type was gastrointestinal, followed by colorectal and urological.

Conclusion: The preoperative setting represents a crucial opportunity to identify modifiable risk factors and implement strategies to optimize patients before surgery. During this stage, healthcare professionals play a fundamental role in delivering smoking cessation advice and facilitating referral to structured support services.

Biography

Dr. Jimena Alvarez del C. completed her medical training in Mexico, where she subsequently worked as a GP, in the A&E department, and in the intensive care unit during the COVID-19 pandemic. She was later awarded an academic scholarship for Master's degree in Global Public Health and Nutrition in the UK. In August 2022, she decided to specialize in surgery, gaining experience at The Royal Marsden Hospital in Endoscopy and Upper and Lower GI Surgery, at St Mary's Hospital in Vascular Surgery, and at Charing Cross Hospital in General Surgery. She is currently working as a surgical clinical fellow in Plastic Surgery.



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Evidenced based diagnostic protocol and management for pain in right iliac fossa

Right iliac fossa pain is most common clinical presentation encountered in surgical opd. Usually during evaluation, diagnosis is uncertain in some cases and patient suffers a lot. Clinical symptoms usually not involved during evaluation of patient this also makes diagnosis more difficult. Be very cautious during clinical evaluation then precede biochemical and radiological investigation. Even CT scan is still unclear about the diagnosis and till date no definite diagnostic protocol has made. This is still very challenging for any surgeons. Keeping in mind various differential diagnosis according to age and sex and clinical knowledge that supported by investigation required to find out definitive diagnosis.

Biography

Dr. Jitendra Kumar Saroj, general and laparoscopic surgeon, has completed his MBBS & MS from King George's Medical university Lucknow, India. Where he serves as a senior resident after completing his MS degree. Now he is associate professor in department of general surgery in Venkateshwara Institute of Medical Sciences, India. He has been awarded fellowship FAIS from Association of Surgeons of India (ASI) and FAIGES from Indian Association of Gastrointestinal Endo-Surgeons (IAGES). Recently he got prestigious fellowship FACS from American College of Surgeons (ACS). He has been published many original article, case report, book chapter, in reputed journal.



John R. Bach MD

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Tracheostomy-free total ventilatory support

Introduction: Home mechanical ventilation became possible once electricity became widely available. From 1930 through 1952, it was via negative pressure body ventilators. Subsequently, it became possible via tracheostomy (TVS) or up to Continuous Noninvasive Ventilatory Support (CNVS) for those offered it and who refused tracheotomies.

Methods: Candidates for definitive noninvasive management of Ventilatory Pump Failure (VPF) have very involved families and absence of severe upper motor neuron disease that tends to close the upper airway and render mechanically assisted cough flows ineffective. Interventions for definitive, up to Continuous Noninvasive positive pressure Ventilatory Support (CNVS), include NVS via oral, nasal, and oronasal interfaces up to 24 hours a day, and intermittent abdominal pressure ventilator. These permit extubation and trach tube decannulations of ventilator unweanable (vital capacity as low as 0 ml) patients who satisfy specific criteria. An oximetry, NVS, Mechanical In-Exsufflation (MIE) protocol is used to clear the airways (essentially noninvasive airway suctioning) to avoid intubations and for successful extubations and decannulations of even ventilatory unweanable patients. NVS settings are about 20 cm H₂O Pressure Support (PS) by bi-level or pressure assist ventilation, by volume targeted bi-level, or preferably by volume preset ventilation over a range of 650 to 1500 ml. This range permits optimal rest, support, lung expansion, and tidal volume variation.

Results: In 1993 257 VPF patients were published who left Iron Lungs in 1954 in favor of up to CNVS via mouthpiece,??? None were known to have died from respiratory causes. Several continue to use mouthpiece CNVS today, now for 70 years. The same center has 20 patients with Spinal Muscular Atrophy type 1 (SMA1), nasal CNVS dependent from as young as 3 months of age, with only trace residual ocular movements, now between 20 and 30 years of age, all with 0 ml of VC. Over 270 consecutive intubated, ventilator unweanable VPF patients, including with SMA1, satisfying specific criteria were extubated, and over 100 decannulated of trach tubes, despite having no ventilator free breathing ability.

Conclusion: Considering that tracheotomy tubes increase ventilator dependence and hinder weaning, cause morbidity and mortality, enormous expense for nursing care, and are not desired by patients who can use NVS and MIE in the community, it became evident that no one needs a trach tube for only being too weak to breathe.

Biography

Dr. John R. Bach is a Professor of Physical Medicine and Rehabilitation and a Professor of Neurology at Rutgers University in New Jersey, USA. He has over 300 peer-reviewed publications and 13 books with some translated into 4 languages and has lectured on noninvasive management of ventilatory pump failure in over 40 countries. He has directed the Howard Rusk Ventilator Unit and Kessler Institute Ventilator Units and received many awards including the Newark Beth Israel Health Care Foundation Humanism in Medicine Award.



Jose Luis Braga De Aquino

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

Surgical treatment of advanced esophageal achalasia

Endoscopic and/or laparoscopic myotomy has shown positive results in non-advanced esophageal achalasia due to the development of this surgical technique currently. For the most advanced stages of the disease, esophagectomy seems to be the most indicated procedure due to the involvement of the entire esophagus, which prompted PINOTTI (PINOTTI,1976,1977) to disseminate the transmediastinal esophagectomy technique in the 1970s with the advantage of avoiding thoracotomy. Nevertheless, several series demonstrated that this technique was not exempt from complications, one of which could lead to massive hemopneumothorax with potential fatal evolution due to injury to the tracheobronchial tree and vessels due to periesophagitis that may be present with consequent adherence of the esophagus to these noble organs of the mediastinum. Because of this, AQUINO (AQUINO, 1996) in the 1990s introduced the Esophageal Mucosectomy (EM) technique with preservation of the esophageal muscle tunic at the level of the mediastinum as well as the transposition of the stomach to the cervical region inside this tunic for the reconstruction of the digestive transit. The greatest advantage of this procedure is to avoid transgression of the mediastinum and consequently the potential pleuromediastinal complications. To date, 136 patients with advanced esophageal achalasia have undergone this procedure, having as early postoperative complications (up to 30 PO days): dehiscence of the cervical esophagogastric anastomosis-19p (13.9%), with good outcome, pleural effusion-13p (9.3%), with good evolution; pulmonary infection-6p (4.4%) with good evolution; death from cardiovascular event-2p (1.4%). A late evaluation using the ECKARDT score was performed in 65 patients up to 5 years after surgery, demonstrating positive results in 59p (90.7%), with a score up to 3. Thus, it is possible to conclude that there are advantages in EM due to the low incidence of immediate postoperative complications with good resolution and in the long term due to the absence of symptoms in most patients.

Biography

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

with a multidisciplinary focus with the clinical, surgical and nutritional areas. He is a Professor of the Postgraduate Course in Health Sciences at PUC, Editor-in-Chief of the Revista de Ciências Médicas at PUC; Associate editor of the Revista do Colégio Brasileiro de Cirurgiões. Author and co-author of 212 articles published in national and international magazines and winner of several awards for works presented in Congresses.



Lee Karen*, Pattullo Champika, Vujcich Elizabeth, Rotherham Joann

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Royal Brisbane and Women's Hospital (RBWH), Metro North Health, Brisbane, QLD, Australia

Evaluating discharge opioid prescribing practices in elective surgical patients: A retrospective audit from a specialist rehabilitation and surgical service centre

Purpose of Study: While opioids remain essential for acute postoperative pain management, inappropriate prescribing—especially at hospital discharge—contributes significantly to ongoing opioid use, dependency, and diversion. National guidelines such as the Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard emphasise minimal effective dosing, short durations, multimodal strategies, and deprescribing plans. This audit investigates current opioid prescribing patterns at discharge for elective surgical patients and evaluates adherence to best practice principles.

Methods: A retrospective audit was conducted on all adult patients admitted to STARS surgical wards 6B and 6C following elective surgery between October 1, 2024, and January 1, 2025, with at least one overnight stay. Patients already on opioids pre-operatively or discharged directly from PACU were excluded. Data extracted from iEMR included demographics, procedure type, opioid and simple analgesia use during admission, discharge opioid prescription details (including type, quantity, duration, indication) and discharge simple analgesia details. Simple descriptive statistics were used to summarise findings.

Results: 580 patients met inclusion criteria. Orthopaedics accounted for the highest proportion of opioid discharges. Oxycodone was the predominant opioid prescribed both during admission and at discharge. A substantial number of discharge prescriptions aligned with manufacturer box sizes (e.g., 5 or 10 tablets), with limited tailoring to patient-specific needs. Only a minority of patients were documented as receiving counselling on opioid use or weaning strategies. Use of simple analgesia was universal during admission but underrepresented at discharge. Multimodal analgesia uptake and alignment with national guidelines were variable.

Conclusions: This audit highlights significant variation in discharge opioid prescribing practices and limited documentation of deprescribing or education strategies. The findings suggest a need for enhanced opioid stewardship at discharge, including personalised analgesic plans, improved documentation, and better implementation of national standards. Future efforts should focus on multidisciplinary interventions to support safer, more consistent prescribing practices

Biography

Karen Lee is a PGY2 doctor at Royal Brisbane women's hospital with clinical and research interests in anaesthesia, perioperative medicine, and opioid stewardship. She is passionate about evidence-based practice and quality improvement, with aspirations to pursue dual training in anaesthetics and intensive care.



**Lara Nassar*, Kyleen Kiew, Orestis Argyriou,
Aws Al-Mukhtar, Miqdad Qandeel, Manuela Alexa,
Mohamed Ibrahim**

Emergency General Surgery, London North West University Healthcare NHS Trust,
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From table to template: Standardizing appendicectomy documentation to enhance compliance with national standards

Background: Laparoscopic appendicectomy is among the most commonly performed emergency general surgical procedures and is often documented by junior surgeons. High-quality operation note documentation is essential to guide multidisciplinary care, facilitate communication and support clinical governance. National standards from Get It Right First Time (GIRFT), the Royal College of Surgeons (RCS), and the Association of Surgeons of Great Britain and Ireland (ASGBI) provide benchmarks for documentation quality.

Aim: To assess and improve the quality of laparoscopic appendicectomy operation note documentation in our general surgery department.

Methods: Operation notes for all laparoscopic appendicectomies performed between August and October 2024 were retrospectively reviewed. Notes were evaluated against documentation standards recommended by GIRFT, RCS, and the ASGBI, focusing on pre-operative, intra-operative and post-operative documentation domains. Following baseline audit, targeted interventions were implemented, including the introduction of a standardised operation note template, dissemination of educational posters, and focused teaching sessions for junior doctors. A re-audit was conducted on operation notes from April and May 2025 to assess improvement.

Results: Documentation compliance improved across all assessed domains following interventions. Pre-operative documentation increased from 60% to 67%, intra-operative documentation from 54% to 66%, and post-operative plan documentation from 40% to 50%. Despite improvements, post-operative plan documentation remained the least compliant domain.

Conclusion: Targeted, multidisciplinary interventions led to measurable improvements in the quality of laparoscopic appendicectomy operation notes. Ongoing education and reinforcement, particularly focused on post-operative planning documentation, are necessary to achieve full adherence to national documentation standards. These strategies represent scalable methods for improving surgical documentation quality and patient care continuity in emergency general surgery.

Biography

Dr. Lara Nassar studied Medicine at The University of Nottingham where she completed a Bachelor of Medical Sciences (BMedSci) and a Bachelor of Medicine and Surgery (BMBS) in 2021. She completed a PGCert in medical education during foundation training. After spending a year working in surgical oncology in colorectal and sarcoma surgery at The Royal Marsden in London, she started her core surgical training. She is currently completing her first year of core training in the Emergency General Surgery Department at Northwick Park Hospital. She engages in audit, quality improvement and research and presents at national and international conferences.



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Championing change: Enhancing NELA case ascertainment through team ownership

Background: The National Emergency Laparotomy Audit (NELA) is a UK-wide quality improvement initiative, established in 2012, aimed at reducing morbidity and mortality for patients undergoing emergency laparotomy through comparison against national standards and feedback. Complete case documentation is essential to ensure accurate audit data, drive quality improvement, and meet national standards. The most recent NELA report recorded a national case ascertainment rate of 72.1%, below the target of 100%.

Aim: To assess and improve compliance with NELA documentation for all eligible emergency laparotomy cases in our emergency general surgery department

Methods: All emergency laparotomies performed were identified from a prospectively maintained departmental database. Each case was categorized as complete (fully submitted NELA record), incomplete (partially entered) or not started (no entry). The audit standard was 100% eligible case submission. Baseline data were collected in July 2024. Interventions included appointing NELA champions responsible for monitoring monthly compliance and sending reminders to clinicians, delivering targeted educational sessions, and disseminating informative posters. Compliance was re-audited in October and November 2024.

Results: An average of 11 emergency laparotomies were performed per month. At baseline (July), 11% of NELA records were complete, 11% incomplete and 78% not started. Post-intervention, complete records rose to 50% in October and 80% in November. Records not started decreased to 30% in October and 10% in November. This represents a 69-percentage point increase in complete records post-intervention.

Conclusion: Targeted team-based interventions, including local ownership and continuous education, resulted in a substantial and sustained improvement in NELA case ascertainment. These measures enhanced quality of national audit data, potentially driving improved patient outcomes. The approach is low-cost, adaptable to other surgical departments nationally, and effectively engages junior surgical teams in national audit efforts.

Biography

Dr. Lara Nassar studied Medicine at The University of Nottingham where she completed a Bachelor of Medical Sciences (BMedSci) and a Bachelor of Medicine and Surgery (BMBS) in 2021. She completed a PGCert in medical education during foundation training. After spending a year working in surgical oncology in colorectal and sarcoma surgery at The Royal Marsden in London, she started her core surgical training. She is currently completing her first year of core training in the Emergency General Surgery Department at Northwick Park Hospital. She engages in audit, quality improvement and research and presents at national and international conferences.

Dr. Lucie Ayliffe-Daly

Royal Brisbane and Womens Hospital Burns Unit, Brisbane, QLD, Australia

Improving VTE prophylaxis compliance in burn patients

Patients with burn injuries are at increased risk for Venous Thrombo Embolism (VTE) and often require higher doses of prophylactic anticoagulation. Despite this, there is no universal guideline for VTE prophylaxis in this population, leading to significant practice variation. At the Royal Brisbane and Women's Hospital (RBWH) Burns Centre, local guidelines recommend twice-daily dosing of Enoxaparin for high-risk patients, with dose adjustments based on body weight. However, adherence to these guidelines has been inconsistent.

A retrospective audit of patient records from January 1 to March 1, 2025, was conducted to evaluate current practice. Of 57 charts reviewed, 42 met inclusion criteria. While 95.2% of patients received some form of VTE prophylaxis, only 10.5% were prescribed the recommended twice-daily dosing. Notably, none of the six patients weighing over 100kg received appropriately adjusted doses, highlighting substantial non-compliance with local protocols.

In response, a revised VTE prophylaxis guideline was developed in collaboration with the Head of Department and Ward Pharmacist. This updated protocol included weight- and BMI-based dosing adjustments and recommendations for anti-Xa level monitoring. It was disseminated to staff via an educational session and a visual summary poster on March 9, 2025. A re-audit conducted one month post-implementation demonstrated 100% compliance (31/31 patients).

This quality improvement initiative successfully standardized VTE prophylaxis practices in burn patients, significantly improving adherence to local guidelines and promoting safer, evidence-based care.

Biography

Dr. Lucie Ayliffe-Daly completed her degree in medical sciences and post-graduate degree in medicine at the University of Oxford, graduating as BMBCCh in 2023. She completed a year of research with the Oxford department of Molecular Neuroscience in 2020. She worked as an FY1 doctor in Somerset NHS Trust, and is completing her FY2 year abroad in the Royal Brisbane and Womens Hospital, Brisbane, Australia. She is currently an Associate Lecturer for the University of Queensland.



Dr. Mahmoud Elhefnawy

Department of Anaesthesia, NHS University Hospitals of Liverpool Group, Liverpool, UK

Anaphylaxis to indocyanine green during robotic anterior resection: A case report and review of perioperative management

Indocyanine Green (ICG) is widely used intraoperatively for tissue perfusion and vascular assessment. While generally considered safe, rare hypersensitivity reactions, including anaphylaxis, can occur. We report the case of a 58-year-old male undergoing elective robotic anterior resection for rectal adenocarcinoma. Following intravenous ICG administration to assess bowel perfusion, the patient developed sudden hypotension, tachycardia, generalized erythema, and bronchospasm. Immediate management included cessation of ICG, intravenous epinephrine, aggressive fluid resuscitation, corticosteroids, antihistamines, and advanced airway support. Hemodynamic stability was achieved within 20 minutes, and the surgery was successfully completed with adjusted anaesthetic management.

This case emphasizes the importance of early recognition and rapid intervention in ICG-related anaphylaxis. It also highlights the need for thorough preoperative risk assessment and strategies for intraoperative monitoring and management of rare hypersensitivity reactions. Sharing such cases contributes to increasing awareness among anesthesiologists and surgical teams using ICG across colorectal and other major surgeries.

Biography

Dr. Mahmoud Elhefnawy is a Locum Anaesthetic Consultant at NHS University Hospitals of Liverpool Group, with expertise in perioperative anaesthesia, obstetric anaesthesia, and major general surgery. He holds an MSc in Anaesthesia and Surgical Intensive Care, FRCA, and EDAIC. As Pain Lead at Liverpool Women's Hospital, he oversees the development and implementation of evidence-based pain management protocols. Dr. Elhefnawy manages a wide range of surgical subspecialties, including colorectal, urology, obstetrics, Gynaecology oncology, robotic, and hepatobiliary surgery. He has presented in perioperative medicine, pain management, and obstetric anaesthesia, advancing patient care across multiple NHS trusts.



Dr. Manoj Tripathi

Department of Anaesthesia & Critical Care, Dr. Ram Manohar Lohia Institute of Medical Sciences, Lucknow, UP, India

Effect of renal transplantation on severe TR and severe PAH in a patient with end stage renal disease

Statement of the Problem: End-Stage Renal Disease (ESRD) is strongly associated with an elevated incidence of Pulmonary Arterial Hypertension (PAH), which significantly contributes to increased mortality, morbidity. PAH resulting from aetiologies other than left-sided heart disease, such as idiopathic PAH and PAH secondary to Chronic Kidney Disease (CKD), can lead to the development of Tricuspid Regurgitation (TR) due to increased Right Ventricular (RV) afterload, RV dilation, and dysfunction.

Methodology: We present a case of a patient with severe PAH and TR who was scheduled for a living donor renal transplantation. A 21-year-old male, weighing 54 kg with ESRD with systemic hypertension belonging to NYHA grade IV was scheduled for renal transplantation. He was on maintenance hemodialysis twice a week through left Arteriovenous Fistula (AV) since 2018 having history of orthopnea and PND. We had monitored this patient with Flo Trac monitor. We assessed SV, Stroke Volume Variation (SVV), SVR, CO, Cardiac Index (CI) and CVP, to evaluate hemodynamic stability and guide appropriate treatment to augment vascular volume, fluid administration, reduce anesthetic administration or use of vasopressors or inotropes.

Findings: The focus of this report is on the importance of meticulous anaesthetic management and the impact of renal transplantation on the improvement of PAH and severe TR. After successful renal transplantation, on postoperative day 1, symptoms of fluid overload subsided. On postoperative day 3, PASP came down to 54 mmHg from 84 mm Hg preoperatively and TR becomes moderate on Echocardiographic findings. Finally at postoperative day 10, PASP comes down to 40 mm HG and TR became of mild state.

Conclusion: By this report we can conclude that in ESRD patients with severe PAH and severe TR, renal transplantation can revert the altered pathophysiology that causes PAH and TR.

Biography

Dr. Manoj Tripathi, Professor (Junior) at Dr. Ram Manohar Lohia Institute of Medical Sciences, Lucknow, completed his MBBS and MD (Anesthesia & Critical Care) from KGMU and PDCC (Neuroanesthesia) from SGPGI. With prior experience as a Senior Resident, he joined the institute in 2016. He has 34 research publications, 6 book chapters, and has edited one book. Actively involved in both funded and non-funded research, Dr. Tripathi is committed to advancing anesthesia and critical care medicine.



Dr. Marcos Leal Brioschi

Chairman, American Academy of Thermology, Phoenix, Arizona, United States
Researcher, Harvard T.H. Chan School of Public Health, Boston, Massachusetts, United States

AI-assisted infrared vision robotics for postoperative assessment

(Tele rounding)

This session will explore the integration of AI-driven infrared imaging and robotics to revolutionize postoperative care through telerounding. Dr. Brioschi will demonstrate how robotic-assisted thermal analysis can help identify complications at an early stage, improving patient outcomes and streamlining remote monitoring. The presentation will highlight recent advancements in AI algorithms and infrared technology, showcasing how these innovations have enhanced precision medicine and surgical recovery. With real-world case studies, Dr. Brioschi will discuss the potential for these systems to reduce hospital readmissions, improve care efficiency, and set new standards for post-surgical assessment in a global healthcare landscape.

Biography

Dr. Marcos Leal Brioschi is a recognized leader in the field of medical thermography and AI-assisted imaging techniques. As Chairman of the American Academy of Thermology and a researcher at Harvard T.H. Chan School of Public Health, Dr. Brioschi has contributed extensively to advancing infrared technology in clinical and surgical settings. His ground breaking work in postoperative thermal imaging has been published widely, and he has presented at numerous international conferences. Dr. Brioschi's expertise in merging AI and infrared vision technologies continues to shape the future of precision medicine and postoperative care.



Marina Temelkovska Stevanovska

University Clinic Mother Teresa Skopje, Republic of North Macedonia

University Ss. Cyril and Methodius, Faculty of Medicine, Skopje, Republic of North Macedonia

Ultrasound guided peripheral nerve block for upper limb surgery: Case report

Introduction: The supraclavicular block is a regional anesthetic technique used as a sole type of anesthesia for upper limb surgery (mid-humerus through the hand), adjunct to general anesthesia or used for postoperative pain control. This block is an excellent alternative to general anesthesia in patients with cardiac and pulmonary comorbidities, for upper limb surgery.

Case study: A 66-year-old male AA was admitted to the clinic for orthopedic diseases in Skopje for surgical treatment of a fracture of the proximal part of the upper limb. After the performed anesthesiological examination, it was determined that the patient had wheezing and crepitations in the distal parts of the lungs, cardiomyopathy and ischemic heart disease previously untreated and diabetes mellitus type II. The patient was scheduled for open fixation of the fracture. The choice for perioperative management was the performance of a supraclavicular brachial plexus block, as the most non-invasive technique, taking into account the patient's health condition. Intraoperatively, the patient was stable with normal vital parameters. After 2 days of treatment, he was discharged from the clinic and in stable condition.

Discussion: Peripheral nerve blocks are from significant interest not only for anesthesiologists but also for surgeons, considering the benefit to the patient, especially good pain relief and thus patient satisfaction with the type of anesthesia and surgical intervention, as well as the possibility of early discharge from the hospital. 14 It can be performed as a bilateral continuous technique for bilateral interventions on the both upper limbs. 15,23 Peripheral nerve blocks are particularly suitable and safe for outpatient interventions such as shoulder and knee arthroscopy, hand contractures and other short interventions 19 and especially for the patients with severe heart and lung conditions.

Conclusion: Pulmonary and cardiac preoperative comorbidity, especially if previously untreated, represent a high risk for peri- and postoperative complications. Peripheral nerve block, in our case supraclavicular brachial plexus block, proved to be a safe choice for the type of anesthesia for upper limb surgery, without the occurrence of postoperative complications. 16,17,18

Keywords: Peripheral Nerve Blocks, Supraclavicular Block, Fracture of Upper Arm, Anesthesia, Postoperative Complications.

Biography

Dr. Marina Temelkovska Stevanovska has completed her PhD at the age of 46 years in the University Clinic for Anesthesia, Reanimation and Intensive Care, Mother Theresa, Medical Faculty, Ss' Cyril and Methodius University, Skopje, R. North Macedonia and postdoctoral studies in the same University Clinic. She has worked as an Assistant Professor for 10 years and has published more than 20 papers in reputed journals and presentations in many anesthesiology meetings. In mean time she worked as an Anesthesiologist for three years in Clinical Hospital Acibadem Sistina and from June 2020 - 2022, works as a Consultant Anesthesiologist in City General Hospital 8th which was COVID Center at that time and has experience from 1½ year as an anesthesiologist in University Clinic Cardio surgery. She is working in University Clinic for Traumatology and Orthopedic diseases over 20 Years as an anesthesiologist and has participated on many meetings and workshops for regional anesthesia and peripheral nerve blocks in the country and abroad. She is a member of Board of directors of Macedonian Society for Anesthesiology and Intensive Care – ZLARIL, Macedonian Medical society – MLD, Macedonian Doctor's Chamber – LKM and European Society for Regional Anesthesia – ESRA.



**Marten AttaAlla*, Hawazen Al-Herbawi,
Ahmad B. Maswadeh**

Department of Cardiothoracic Surgery, St. Bartholomew's Hospital, London, UK

Post-operative pain management in thoracic surgery patients

Aim of the study: Effective post-operative pain management is critical for optimizing recovery and reducing complications in thoracic surgery patients. This study aimed to enhance pain control strategies by implementing a multimodal analgesia protocol and educational interventions, in accordance with Enhanced Recovery After Surgery (ERAS) guidelines.

Methods: A retrospective analysis of current pain management practices was conducted in patients undergoing open, robotic-assisted, and Video-Assisted Thoracic Surgery (VATS) at St Bartholomew's Hospital. Data on patient-reported pain scores, analgesic use, and post-operative recovery, including Length of Hospital Stay (LOS) and complication rates, were collected.

Based on the findings, targeted interventions were implemented to improve analgesia and raise awareness among healthcare providers and patients. These included:

- **Standardized Multimodal Analgesia Protocol:** Developed in accordance with the Enhanced Recovery After Surgery (ERAS) guidelines and in collaboration with the acute pain team, incorporating opioid-sparing strategies with regional anesthesia, non-opioid analgesics, and adjunct medications.
- **Educational Sessions:** Conducted for surgeons, anesthesiologists, and nursing staff to reinforce best practices in pain management.
- **Clinical Reminders:** Informational flyers displayed in clinical areas to prompt appropriate post-operative analgesic prescribing.
- **Patient-Centered Education:** Patients were encouraged to actively request pain relief when needed, fostering shared decision-making in pain management.
- **Nursing-Led Interventions:** Nurses were instructed to routinely assess and remind patients of available analgesic options, ensuring proactive pain control.

Results: Following implementation, post-operative outcomes showed measurable improvements. Patients reported lower pain scores, indicating better pain control. Additionally, there was a reduction in opioid consumption, leading to fewer opioid-related side effects. The incidence of post-operative complications, such as respiratory issues due to inadequate pain relief, also declined. Most notably, the average Length of Hospital Stay (LOS) was reduced, reflecting enhanced recovery and overall patient well-being.

Conclusion: A structured, multimodal approach to post-operative pain management, incorporating standardized analgesia ARCHIVO findings underscore the importance of continuous quality improvement strategies in perioperative care. Future efforts should focus on sustaining these improvements, further refining analgesia protocols, and expanding patient and provider education to ensure optimal pain management and recovery.

Biography

Dr. Marten AttaAlla, M.D., pursued his medical education at Charles University, graduating among the top 10 students of his cohort. Following his graduation, he conducted research at the prestigious Mayo Clinic in Rochester, USA, where he contributed to groundbreaking work in the cardiovascular disease laboratory under the mentorship of Dr. Jordan Miller. His research focused on the role of the SIRT6 gene in aortic valve disease, utilizing genetically modified murine models to elucidate its pathophysiological mechanisms. Dr. AttaAlla has presented his findings at international conferences and maintains an active research collaboration with the Mayo Clinic. He subsequently undertook a clinical fellowship in cardiothoracic surgery at St. Bartholomew's Hospital in London, the largest cardiothoracic center in Europe. In parallel with his clinical training, he has successfully completed the MRCS Part A examination, continues to contribute to the scientific literature through ongoing research publications, and is actively involved in medical education, mentoring and teaching future physicians.



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How common is the uncommon? Vascular trauma amidst access gaps and trauma care disparities in global surgery

Introduction: Extremity vascular injuries are best addressed timely and are associated with a high morbidity and mortality.

This is a retrospective study from a developing world's level 1 public trauma center and vascular surgery referral centre which caters to a multi provincial population scattered over more than 100,000 square miles.

We frequently encounter delays in presentation owing to poor referral services and prolonged travel times between the hospital and place of injury. All these incidents contribute to a higher rate of limb loss and mortality, especially in the young population who are the most frequent victims of such injuries.

We aim to quantify the magnitude of extremity vascular trauma and report its demography alongside our center's post intervention outcomes and limb salvage rates. This is a call for strengthened trauma systems and improving country-wide access to vascular surgery services.

Methodology: We conducted a retrospective review of all patients admitted with a vascular injury of the upper or lower extremity to our department from January to December 2023. Eligible participants were included from our online database and the details of their demography, time since presentation, operative findings and outcomes of limb salvageability and mortality were recorded. Data was entered and analyzed via SPSS v.23 and a p value of <0.05 was considered significant.

Results: We included 254 cases of extremity vascular trauma. The mean age was 29.46 (13.03) years and 94% were males. 45% of patients presented from outside the city and the median time elapsed since injury was 12.5 (133) hours. The most common mechanisms of injury were firearms (49.6%) followed by road traffic accidents (17.7%) and glass cut injuries (7.5%). The lower limb was involved more frequently (67.7%) than the upper limb (32.3%). Concomitant bony and venous injuries were encountered in 35.4% and 30.7% cases respectively.

Arterial repair via native venous graft was undertaken in 51.6% cases, with ligation being performed in 25.6% and a primary amputation done in 12.6% of the patients. Additionally, 6.7% of patients required a secondary amputation.

Limb salvage rate was 80.3% overall, 92% for the upper and 66% for lower extremities. The highest rate of limb loss was associated with injury to the popliteal artery (up to 50%). Age, gender, mechanism of injury, and coexisting orthopedic or venous injuries had no statistically significant impact on limb salvage. However, a lower arrival hemoglobin was significantly associated with limb loss. ($p=0.028$)

Discussion: Extremity vascular trauma presents a significant healthcare concern with a high morbidity in young people. This needs to be addressed at multiple levels amid policy makers and government institutes, and prehospital trauma care and vascular surgery services should be expanded throughout the province. This will enable us to timely salvage limbs and also share the net burden of trauma on a single center.

In many cases, the critical salvage window even before reaching a vascular service. An important point to highlight here is that the provided data is an under-representation of the amputation rates as many non salvageable limbs are amputated at local levels without making it to our vascular service. Strengthening regional trauma networks and investing in training, pre hospital care, and transport is, therefore, a public health imperative.

Biography

Miss Siddiqui is a resident doctor working in MidYorkshire NHS trust in the division of surgery with an interest in general and vascular surgery. She graduated from Dow University of Health Sciences Pakistan as the best graduate of her batch in 2022. Her previous work experience comes from a high-volume trauma center and vascular surgery service in Pakistan where she has been actively involved in research.



M. Castagna*, L. Tenang, K. Dharmajan, S. Byalpudi, K. Boyle

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The use of ReSPECT forms peri-operatively to document the wishes of patients with a clinical frailty score of 5 or more, in case of clinical deterioration

Introduction: Frail individuals are making up an increasing proportion of our patients. Research shows that a Clinical Frailty Score (CFS) of 5 or more greatly increases the risk of 90-day mortality post-operatively; with those with a CFS of 7 having nearly 25x the risk of those with a CFS of 1. Highlighting the importance of a clear escalation plan for this cohort of patients in the post-operative period. The resuscitation council UK and British geriatric society also provide guidance on the importance of care plans for these patients.

Method: An observational study across a period of 6 weeks. Collating data from clinical notes and electronic data sources. Data collected included: Frailty score, age, operation performed, SORT score, ReSPECT form/discussion documentation, and complications that occurred in the 30 days post-operatively. Inclusion criteria: CFS of 5-7 and undergoing surgical intervention.

Results: A total of 46 patients met the criteria for inclusion within the timeframe, with only 12 (26%) of the patients having a valid ReSPECT form documented. 83% of the patients with a ReSPECT form were documented as DNACPR or 'ward-based ceiling of care'. Whilst 21 patients (46%) experienced post-operative complications (including sepsis, ICU readmissions and death). 5 out of the 46 patients died within 2 weeks of their surgery, only 1 of which had a valid ReSPECT form; 3/5 of those patients underwent 'simple' hernia repairs without bowel resection, none of which had a valid ReSPECT form in place.

Conclusions: Patients with a CFS of 5 or above are increasingly vulnerable to sudden postoperative deterioration, regardless of the surgical risk or high standard of care they receive. 83% of the patients with a ReSPECT form in place were not suitable for, or did not wish for, CPR. We can therefore infer this would likely be the case for many of our patients. Thus, we can use this study to implement changes to practice, such as ensuring our patients at risk of deterioration are given the chance to voice their wishes. We can introduce this as part of the routine consent process for our frail patients, improving their care, preventing unnecessary/unwanted CPR and ensuring clear communication to our staff (especially those working out of hours with limited knowledge of our patients). A secondary outcome was also identified in this project; the mortality rates for seemingly low-risk operations were higher than expected (namely hernia repairs). This suggests that we may be underestimating the risk of these procedures in frail patients and has highlighted this as an area for future projects to investigate.

Biography

Dr. Molly Castagna studied Medicine (MBChB) at the University of Leicester and graduated in 2024 with honours. She continued her career in Leicester, beginning her foundation training at Leicester Royal Infirmary. During her time working within the general surgical department, she sought out opportunities to develop her basic surgical skills and independently initiated this project, with the intention of improving patient care. Molly is keen to pursue a career in surgery and is currently exploring her interest in paediatric surgery.

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Exploring surgical oncology-based comparative and systematic analysis of the diagnostic potential of various novel biomarkers in head and neck squamous cell carcinoma

Head and Neck Squamous Cell Carcinoma (HNSCC) is a widespread malignancy and has high morbidity and mortality rates. Identifying reliable biomarkers can help in improvement of diagnosis, prognosis, and treatment response. This systematic review aimed to evaluate the diagnostic potential of various novel biomarkers against HNSCC. A comprehensive search was taken place using PubMed, Scopus, Web of Science, and Google scholar that covered range of studies published from 2019 to 2025. The search focused on biomarkers that related to HNSCC and its correlation with clinical outcomes such as survival rates and treatment response. Studies were selected on the basis of predefined eligibility criteria and included observational and experimental study designs. Data extraction was performed by two independent reviewers. Study quality was assessed using the Newcastle-Ottawa Scale and the Cochrane Risk of Bias Tool for respective study designs. The quality of the evidence was evaluated using the GRADE approach. A total of 12 studies were included in this review after full screening process. The studies evaluated several biomarkers that indicated towards significant correlations between certain biomarkers and HNSCC prognosis. Elevated levels of expression of specific biomarkers were associated with poor survival outcomes, while others showed promise in the prediction of recurrence and treatment efficacy. The review highlighted the effectiveness of novel biomarkers for improving the HNSCC management. However, further validation of these findings and establish biomarkers for clinical use.

Keywords: Genetic Biomarkers, Head and Neck Neoplasms, Squamous Cell Neoplasm, Surgical Oncology, Tumor Micro Environment (TME)



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Thirty day perioperative outcome of segment 3 bypass surgery for malignant hilar biliary obstruction: Multicenter cross sectional retrospective study, Ethiopia, 2025

Background: Segment 3 bypass surgery, which was once the most commonly done procedure, is the construction of biliary enteric anastomosis between segment 3 intrahepatic bile duct and proximal jejunum. Mostly it is done as palliative treatment for Malignant Hilar Biliary Obstruction (MHBO). This procedure has been done worldwide starting from the early 20th century but rarely being done nowadays. The 30-day perioperative mortality of this procedure falls in the range between 0-31%. There is no study in Ethiopia, to the best of author knowledge, assessing clinical profile and 30-day perioperative outcome of segment III bypass surgery.

Objectives: The objective of this study was to assess thirty-day perioperative outcomes (effectiveness, morbidity, mortality, complication rates) of patients after Segment 3 bypass surgery and its contributing factors after bypass surgery.

Method: Multicenter retrospective cross-sectional study was conducted in Addis Ababa, Ethiopia. Data was collected from medical records of patients with a structured questionnaire and data was entered into SPSS version 27. Descriptive analysis and non-parametric dependent (Wilcoxon) test were done to know the effect of bypass surgery on liver enzymes and serum bilirubin level. Variables with P-value less than 0.05 was used to declare the effect of bypass surgery.

Result: A total of 23 cases were analyzed in the study. The mean age of the patients was 52.87 years. More than half of (56.5%) the cases were males. Hilar cholangiocarcinoma accounts for the majority (78.3%) of causes for hilar biliary obstruction followed by gallbladder cancer. The median duration of surgery was 180.0 (70.0) minutes and the median intraoperative bleeding was around 700.0 (600.0) ml. Three patients (13.0%) patients were died within 30-day of operation and 4 (17.4%) patients developed allover morbidity rate within 30 days of operation. Serum bilirubin and ALP level significantly dropped after the bypass surgery ($z=3.724$ $p<0.001$ and $z=2.659$ $p=0.008$ respectively). Only 1 (4.3) patient developed major complication requiring re operation. The common surgical complications identified were bile leak, surgical site infection, and bleeding.

Conclusion: Segment III bypass surgery gives effective palliation of cholestatic symptoms with acceptable 30-day perioperative mortality and morbidity rate.

Keywords: Segment III Bypass Surgery, Perioperative Outcome, Ethiopia.

Biography

Nebiat Embiale studied medicine at Bahir Dar University and graduated in Doctor of Medicine in 2015 and further attended his specialty training in General surgery again in Bahir Dar University and worked as Assistant professor of General Surgery in Bahir Dar University, Tibebe Ghion Specialized Hospital for 2 years and 6 months. He is currently an attending senior fellow in HPB surgery in Addis Ababa University, Tikur Anbessa Specialized Hospital.

Dr. Niharika Rai*, Mr. Farzan Dholoo, Miss. Kirstin Carswell

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Improving waiting times to laparoscopic cholecystectomy in gallstone pancreatitis patients

Background: Management of Gallstone Pancreatitis includes addressing both the acute episode and the underlying cause. Laparoscopic Cholecystectomy (LC) should ideally be performed either during the index admission or within two weeks, after resolution. Early cholecystectomy reduces recurrence rates of pancreatitis, decreases readmissions, and shortens treatment course. Compliance with the recommended time-frame for LC varies. Delayed diagnosis, logistical issues, and patient factors all contribute to delays in surgery.

Methods: This study aims to assess the extent to which surgical practice complies with guidance, in the management of gallstone pancreatitis. We examined the timing of laparoscopic cholecystectomy in a cohort of patients, evaluating whether it was performed within the recommended window. Factors contributing to delays were identified, improved and then outcomes reassessed.

Results: Three simple interventions aimed at improving service provision, helped to improve compliance from 44 % (cycle 1) to 88 % (cycle 2). In cycle 1, 25% and 19% of patients underwent LC on index admission or within 2 weeks respectively (n=46). In cycle 2, 50% and 33% of patients underwent LC on index admission or within 2 weeks respectively. Patients missing in the outpatient setting also improved from 6, to 2. Readmission rates also significantly dropped in cycle 2 as compared to cycle 1.

Conclusion: The introduction of 3 interventions significantly improved timeframes to LC; 44% to 88%, ensuring timely LC in compliance with guidance. This also has the benefit of reducing readmission rates, reducing pancreatitis recurrence and shortening overall hospital treatment course.

Biography

Dr. Niharika Rai, graduated from London University with a MBBS. She began her career within the Surrey and Sussex NHS Foundation Trust. She has worked within a variety of specialties with a particular interest in Upper Gastro-Intestinal surgery. She has contributed locally to a variety of projects aimed at improving patient flow, reducing readmission rates and improving service provision/flow. She also has a keen interest in teaching; helping to train medical students interested in surgery.



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A comparative analysis of King Vision video laryngoscope with Macintosh and McCoy laryngoscopes in adults undergoing elective surgical procedure

Background: The need to secure a patient's airway is not only of vital importance in any emergency situation but also a routine part of general anaesthesia. The use of the laryngoscope facilitates endotracheal intubation but the force applied by it on the base of the tongue when elevating the epiglottis is the major stimulus for a pressor response. Apart from the traditionally compared Macintosh (Group MT) and McCoy blades (Group MC), the addition of the King Vision Video Laryngoscope (Group KV) and the parameters assessed make this a novel study.

Objectives: To determine the ease of intubation and compare the hemodynamic response with Macintosh, McCoy and King vision video laryngoscope.

Methodology: This study was a prospective analytical study done in Father Muller Medical College. Patients who are going to be intubated are randomized using computer generated randomization tables and are sorted into the three groups depending on the blade used at the time of intubation. The ease of intubation is assessed based on glottic visualization using Cormack-Lehane Grading, number of attempts, lifting force required and need for external manipulation of the larynx. Heart rate and Blood Pressure were recorded preoperatively, prior to and then immediately after laryngoscopy & intubation and thereafter 1, 3, and 5 minutes later to ascertain the hemodynamic response.

Results: 105 individuals were included in our study, 35 patients per group. It was noted that that Group KV had a higher incidence of Cormack Lehane grade 1 view when compared to MC and MT (88.5% VS 57.1% VS 74.3%), lower incidence of increased lifting force required (5.7% VS 20% VS 17.1%) and lowest incidence of need for optimal external manipulation (5.7% VS 25.7% VS 31.4%). It was however noted in our study that in attenuating the hemodynamic response there was no significant benefit of one laryngoscope over the other.

Conclusion: This study demonstrated that the King Vision Video laryngoscope is superior to Macintosh and McCoy blade with regard to ease of intubation, particularly with respect to improvement of the Cormack Lehane grading and a reduced need for external laryngeal manipulation, and that there is no benefit of one blade over the other with regard to hemodynamic parameters.

Biography

Dr. Nikhil Mathew Simon studied his Bachelors of Medicine and Surgery (MBBS) at Father Muller Medical College and graduated in 2018. He continued to pursue his Doctor of Medicine in Anaesthesiology MD at his alma mater and graduated in 2022. He briefly worked at St Marthas Hospital, Bangalore, India in 2022 and St Johns Medical College, Bangalore, India in 2023 before pursuing his Masters of Medicine in Regional Anaesthesia at Edge Hill University at Ormskirk in the United Kingdom. He currently works as Trust Registrar in Anaesthesia and Critical Care at North Cumbria Integrated Care NHS Foundation Trust.



Nirmani Widanage

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Impact of multimodal prehabilitation on functional recovery, hospital stay, and cost-effectiveness in colorectal surgery: A systematic review and meta-analysis of randomized controlled trials

Background: Multimodal prehabilitation aims to optimize patients' physical and psychological readiness for surgery through interventions such as exercise, nutritional support, and psychological counseling. While Enhanced Recovery After Surgery (ERAS) protocols have improved postoperative outcomes in colorectal surgery, the addition of prehabilitation may further enhance functional recovery and reduce complications. This review evaluates the effect of multimodal prehabilitation on functional capacity, hospital stay, and cost-effectiveness in colorectal surgery patients within the context of ERAS-based care.

Methods: A systematic literature search was conducted in PubMed, EMBASE, Cochrane Library, and Scopus over last 10 years for Randomized Controlled Trials (RCTs) comparing multimodal prehabilitation with standard preoperative care in adults undergoing elective colorectal surgery. The primary outcome was postoperative 6-Minute Walk Distance (6MWD), a measure of functional capacity. Secondary outcomes included length of hospital stay and cost-effectiveness. Meta-analysis was conducted using a random-effects model, and results were expressed as Mean Differences (MD) with 95% Confidence Intervals (CI). Risk of bias was assessed using the Cochrane risk of bias 2.0 tool.

Results: Seven RCTs involving 1339 patients were included. Multimodal prehabilitation significantly improved postoperative 6MWD compared to standard care (MD: +35.2 meters, 95% CI: +18.1 to +52.3, $p < 0.001$), indicating enhanced functional recovery. A modest but statistically significant reduction in hospital stay was observed (MD: -1.3 days, 95% CI: -2.4 to -0.2, $p = 0.02$). Three studies included cost-effectiveness analyses, all reporting favorable economic outcomes due to reduced postoperative complications and shorter hospital stays. Heterogeneity was moderate for 6MWD ($I^2 = 48\%$) and high for hospital stay ($I^2 = 71\%$).

Conclusion: Multimodal prehabilitation significantly improves early functional recovery and may reduce hospital stay and healthcare costs in patients undergoing colorectal surgery. When implemented alongside ERAS protocols, prehabilitation appears to offer additional synergistic benefits by enhancing physiological resilience and promoting faster recovery. These findings support integrating structured prehabilitation programs as an adjunct to ERAS pathways in elective colorectal surgical care.

Keywords: Multimodal Prehabilitation, Colorectal Surgery, Eras, 6-Minute Walk Distance, Functional Recovery, Hospital Stay, Cost-Effectiveness, Meta-Analysis.

Biography

Ms. Nirmani Widanage studied Medicine at the Faculty of Medicine Rajarata University of Sri Lanka and graduated as MBBS in 2016. She then joined Ministry of Health Sri Lanka and provided service to the Sri Lankan Healthcare Sector for 7 years working at multiple tertiary care hospitals in Sri Lanka. She received the Membership of Royal College of Surgeons of England in 2023. After one-year she moved to the United Kingdom and started working as a clinical fellow in General Surgery at George Eliot Hospital NHS Trust in Nuneaton.



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Effectiveness of indocyanine green fluorescence angiography in preventing anastomotic leakage in colorectal resections: A systematic review and meta analysis of randomised controlled trials

Background: Anastomotic leakage is a major complication following colorectal resections. Perfusion of bowel ends at the anastomotic site found to be one of the most important modifiable risk factors in preventing anastomotic leakage.

Fluorescence Angiography (FA) using Indocyanine Green (ICG) with Near Infra-Red (NIR) imaging offers real time visualisation of tissue perfusion and has been proposed as a tool to reduce the incidence of anastomotic leakage. Several clinical studies have proven ICG FA to be beneficial in assessment of tissue perfusion, but the strength of high-quality evidence from Randomized Controlled Trials (RCTs) are found to be lacking.

Objective: The systematic review aimed to assess whether ICG FA reduces anastomotic leakage rates in colorectal resections, based only on RCTs including latest available evidence, to evaluate whether outcomes differ between left and right sided resections.

Methods: Systematic research of PubMed, Embase and Cochrane CENTRAL was conducted within last 10 years, identifying RCTs comparing FA with standard intraoperative assessment. The primary outcome was the rate of anastomotic leakage in patients undergoing colorectal resections for benign and malignant conditions. Subgroup analyses were performed for left-and-right sided resections. Risk of bias assessed using the Cochrane Risk of Bias 2.0 tool. Meta analysis was conducted using random-effects model, and heterogeneity was evaluated using I² statistic.

Results: Seven RCTs involving 3,887 patients were included. FA was associated with a statistically significant reduction in the overall anastomotic leakage rate compared to standard assessment, with a combined Odds Ratio (OR) of 0.66 (95% CI:0.53-0.82; p=0.003; I²=0 %), indicating no heterogeneity. Subgroup analyses for left-sided resections demonstrated a more pronounced benefit, with combined OR of 0.59 (95% CI:0.46- 0.75; p=0.002; I²=0%). In contrast, the benefit in right-sided resections was less marked and not statistically significant in most trials.

Conclusion: Indocyanine green fluorescence angiography with near infra-red imaging significantly reduces anastomotic leakage rates in colorectal resections, particularly in left-side. Given its real-time assessment capabilities, safety profile and ease of use, it can be considered as a valuable adjunct to standard surgical techniques. Its selective use in high risk or technically challenging cases may be valuable in intraoperative decision making and postoperative outcomes.

Biography

Ms. Nirmani Widanage studied Medicine at the Faculty of Medicine Rajarata University of Sri Lanka and graduated as MBBS in 2016. She then joined Ministry of Health Sri Lanka and provided service to the Sri Lankan Healthcare Sector for 7 years working at multiple tertiary care hospitals in Sri Lanka. She received the Membership of Royal College of Surgeons of England in 2023. After one-year she moved to the United Kingdom and started working as a clinical fellow in General Surgery at George Eliot Hospital NHS Trust in Nuneaton.



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Reinke's oedema in Africa: A scoping review

Reinke's oedema is a benign pathology of the vocal fold characterised by polypoidal degeneration of its subepithelial space, with resulting dysphonia and in severe cases dyspnoea. It is more common among females and smoking is a strong risk factor. Multiple conditions of the larynx ranging from benign to malignant diseases, which can also present with voice changes and dyspnoea, need to be ruled out when evaluating a patient for Reinke's oedema. The quality of evaluation can be directly influenced by the level of training and experience of the assessor and the diagnostic resources available. This can pose a challenge for the evaluation and management of Reinke's oedema in Africa, as there is a significantly low ENT surgeon-to-patient ratio within the continent, and a lot of health settings are resource-constrained. This review aimed to examine the available literature on the epidemiology, management, and outcomes of Reinke's oedema in Africa.

A literature search on Reinke's oedema was conducted on PubMed, Ovid Online, and African Journal Online, from inception till date. Articles were screened for their relevance to the epidemiology, management, and outcomes of Reinke's oedema in Africa. Results were reported according to the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) extension for scoping reviews. No article satisfied the eligibility criteria used in this review. The dearth of literature from this scoping review could be reflective of the significantly low reach and availability of ENT services in Africa, the low percentage of females who smoke in Africa when compared to other continents, and the relatively rare nature of Reinke's oedema. Our study has established a gap in the literature and highlights a need for further research.

Biography of Dr. Olorunleke Arokoyo

Dr. Olorunleke Arokoyo earned his MB; BS from University of Ibadan, Nigeria. He has a keen interest in otolaryngology, developed with his experience of the specialty as a junior clinical and research fellow with the ENT department at York Hospital, UK.

Biography of Adeleye Collins Tola

Adeleye Collins Tola earned his MB; BS from the University of Lagos, Nigeria. He has a keen interest in gastroenterology, developed with his experience of the specialty as a junior clinical fellow in internal medicine at Doncaster and Bassetlaw Teaching Hospitals, UK.



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Diagnostic accuracy and cure rate of ultrasound and sestamibi in preoperative localisation for patients with primary hyperparathyroidism–A single centre retrospective study

PPrimary hyperparathyroidism is a common endocrine disorder defined by abnormally elevated levels of parathyroid hormone associated with hypercalcemia. It is the number one cause of hypercalcemia in the community,[3] with a prevalence of 0.84% and an incidence of 4 to 6 per 10 000 person years. Solitary adenomas account for the highest cause of primary hyperparathyroidism. Parathyroidectomy is the recommended treatment for symptomatic patients, with contemporary surgical approach and minimally invasive surgery made possible by preoperative imaging. Preoperative imaging has been shown to reduce the burden of treatment in terms of complications, with improved recovery time and cost. Ultrasound and parathyroid scintigraphy are widely used to localise candidate lesions preoperatively as single modality or in combination.

We collect data on 316 patients who underwent parathyroid surgery for suspected primary hyperparathyroidism over 9 years at our single centre and investigate the utility of sestamibi as an adjunct to ultrasound in resulting in cure of primary hyperparathyroidism. Image guided focused parathyroidectomy results in superior cure rates in patients with primary hyperparathyroidism. In the practice of this centre, ultrasound conducted by specialists in the identification of parathyroid candidate lesions has predicted a high rate of all cause cure and cure where histology is concomitant with ultrasound findings. We are unable to show that parathyroid scintigraphy as an adjunct to ultrasound significantly improves cure rates. Patient groups at a high risk of operative failure include those undergoing reoperation, those without positive ultrasound or parathyroidectomy scintigraphy findings and those with concomitant thyroid pathology. In these patients, further imaging with 4dCT might be considered based on early findings where such imaging has delineated candidate lesions in further detail useful in preoperative planning.

Biography

Dr. Olorunleke Arokoyo earned his MB; BS from University of Ibadan, Nigeria. He has a keen interest in otolaryngology, developed with his experience of the specialty as a junior clinical and research fellow with the ENT department at York Hospital, UK.

Rosa D E Bock

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Survival outcomes in patients with sigmoid volvulus

Introduction: This study aimed to assess management pathways and outcomes in Sigmoid Volvulus (SV) in an elderly population with significant morbidity and mortality.

Methods: A retrospective review was performed on patients first admitted with SV between 2019-2023 within a tertiary-level colorectal service. Demographic, management and outcome data were collected including frailty, ASA (American Society of Anaesthesiologists) and National Emergency Laparotomy Audit (NELA) score. Comparative statistics were used to compare baseline demographics between those operated on and those not and to identify factors associated with survival.

Results: A total of 72 patients were included, median age of 78, with 25 undergoing surgery. After index discharge without surgery, 50 patients (88%) were re-admitted with SV at least once, with a total of 212 hospital admissions and 1952 hospital bed days at the end of follow-up. A trend towards lower age, NELA score, ASA score and frailty score was seen in those undergoing surgery, with only 2 deaths observed during post-operative follow-up. In those who were not palliated at first admission but did not undergo surgery at any point, the mortality rate was 42% (n=16, median survival 545 days, median age 79), with causes of death generally reflecting conditions of frailty and not volvulus itself.

Conclusions: This study highlights the substantial burden of sigmoid volvulus in an elderly, frail population, with high recurrence following conservative management. While surgery significantly reduces recurrence, patient selection is critical due to age-related frailty and limited survival benefit. Comprehensive geriatric assessment should guide timely surgical decision-making, ideally following the index episode. Despite good postoperative outcomes, surgical decisions must balance recurrence risk with functional independence and quality of life. Enhanced documentation, multidisciplinary input, and consideration of less invasive alternatives such as percutaneous endoscopic colostomy are essential. Future multicentre studies should prioritise functional and frailty-related outcomes to optimise care pathways.



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Robotic colorectal resections; York teaching hospital experience

The colorectal division in a system of seven hospitals, serving a population of 800,000 over 3,400 square miles, completed the shift to a fully robotic surgical service. The workforce is 10,000 strong and the department has 10 colorectal consultants who perform over 250 laparoscopic resections every year, including segmental colectomies, Abdominoperineal Excisions (APER), Hartmann's maneuvers, and complex combinations of these procedures.

The robotic service began in May 2022 with the goal of achieving full functionality in two years without breaching FT pathway time obligations. By May 2024, a fully operational robotic service was available with trained surgeons, assistants, and theatre personnel. The service now has four robotic colorectal lists and one robotic urology list worked on each week. They included comprehensive robotic courses, simulation training modules, troubleshooting for the theatre teams, and hands-on surgeon proctoring in the training components. This provided for an efficient and seamless transition.

An audit was performed during the period 2022 to 2024 which reviewed robotic and laparoscopic resections done for the colorectal department in York. This included 409 cases with patients average age being 70.2 years (SD=10.7) with range being between 28 to 92 years. Approximately 66.3% of patients had at least one comorbidity. The robotic cohort had a statistically significant incidence of surgical emphysema ($p=0.005$) and chest infection/HAP ($p=0.030$), which was perhaps a consequence of air seal use, although, 90-day mortality rates are still comparable for robotic and laparoscopic groups. Surgical complications were pulmonary embolism, aspiration pneumonia, ischaemic stoma, intraoperative bleeding, and others. Primary preventive approaches, including enhanced thromboprophylaxis, ICG application, and enhanced recovery measures, were done.

The approach toward robotic surgery was gradual and controlled, making patient transitions easier while ensuring high levels of care was maintained through organization and thorough teaching. This achievement proves that there is scope for more widespread use of robotics in colorectal surgery.

Biography

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

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Artificial intelligence in colorectal surgery multidisciplinary team approach – From innovation to application

Objectives: Artificial intelligence (AI) has played a novel role in aiding healthcare system functions and enhancing the patient experience. Multidisciplinary teams (MDT) have become integral to disease and management planning, especially with the rising ageing population and the scarcity of sufficient resources. Our objective is to gather evidence on the impact of AI on colorectal MDT, as well as its drawbacks and merits.

Methods: Electronic searches were performed on PubMed and Cochrane databases, with no date limit. The contemporary and future applications of AI within the surgical practice, including big data analytics and clinical decision-support systems, were included. Search terms were charted to MeSH terms combined using Boolean operations and used as keywords. Papers were selected based on title and abstract.

Results: The integration of AI within the multidisciplinary team (MDT) approach and its potential influence on clinical decision-making from the preoperative phase to the development of tailored treatment algorithms, as well as its support for clinical decision-making, assessment of complication risk, prediction of surgical outcomes and survival, remain relatively obscure. Data on these aspects are limited, and AI's application in colorectal surgery is still emerging.

Conclusions: Divergent conclusions from various studies examining the relationship between MDTs, quality of care, and survival can be attributed to differences in MDT structure, case selection, and diagnoses. An AI-enabled approach can abridge the unmet clinical gap, navigate and explore this terrain, and provide insight into technology-driven advancements where scientific and technology-driven approaches lead clinical practice.



**Dr. Mirza Majid Ali Zaki, Dr. Sana Imtiaz*, Dr. Obiefule
Osuagwu, Dr. Safiah Iqbal, Dr. Jahangir Alam**

Adeenbrookes Hospital, United Kingdom

Use of capnography in theatres recovery

- The use of capnography in anaesthetics is vital to aid in early detection of respiratory and cardiovascular complications. It is essential requirement by AAGBI guidelines to have capnography as part of standard anaesthetic monitoring during transfer of patient
- This is a primary audit, to emphasize the need for capnography during transfer of patients from theatres to recovery, before 22nd August 2024 department did not have portable monitors, almost all patients transferred to recovery were being transferred without essential monitoring exceptions included critically ill patients going to ITU.
- There was also a perceived lack of use of ETCO₂ monitoring during recovery phase.

Aims of the Audit:

- The project's aim was to ensure compliance with AAGBI standards of monitoring during immediate postoperative care.
- To evaluate use of capnography to ensure adequate ventilation in patient that were recovering from GA and had supraglottic airway device in place.

Objectives of Audit:

- In the immediate post-op period, use of capnography was evaluated.
- Staff will be encouraged to use capnography through teaching, training and provision of equipment

Method: The following audit standards criteria were checked by using a proforma,

1. AAGBI Standard Vitals Monitored Including Capnography Used During Transfer From Theatre To Recovery
2. Capnography (ETCO₂ Monitoring) In Recovery
3. If ETCO₂ Was Monitored In Recovery Was It Documented In The Patient Notes

Sample size:

- 30 patients were randomly selected.

Inclusion criteria:

- Any age group or gender
- Patient had GA for procedure
- Transferred to recovery with a SGA in situ

Exclusion criteria:

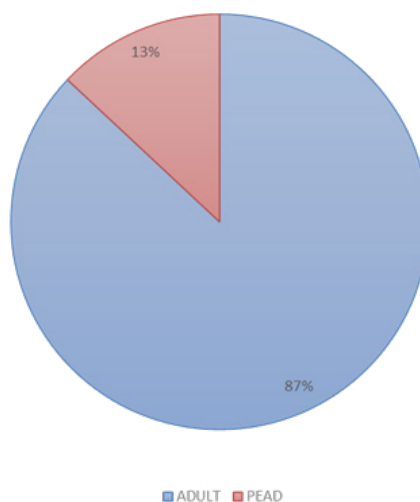
- Patient had RA as only mode of anaesthesia
- Patient had no airway intervention done during conduct of anaesthesia
- Patient came to recovery without SGA or on F.Mask

Data collection:

- All patient data was collected from theatre recovery in PCH.
- Data collected over a period of 2 months.
- Prospective Data collection done

Results

- Adults (Age>16yrs) 27 (87%)
- Paediatric (Age<=16yrs) 4 (13%)
- Total Cases 31
- All received with SGA (LMA, i-gel etc) in situ during transfer

AGE GROUPS

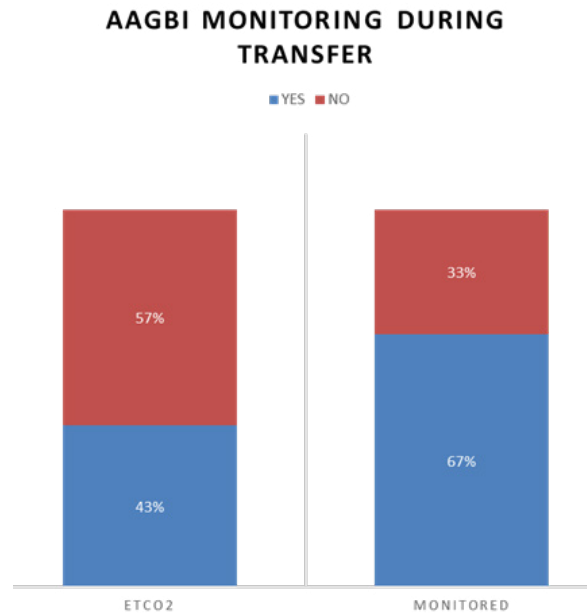
Monitored during transfer 21(67%)

With ETCO2 9(43%)

Without ETCO2 12(57%)

No monitoring during transfer 10(33%)

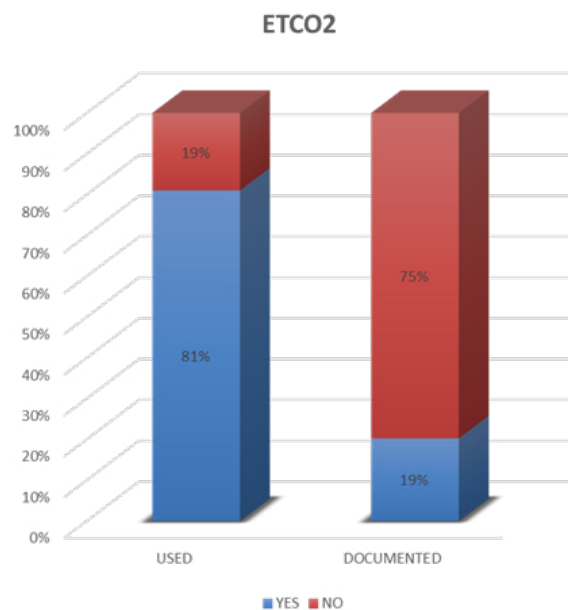
ETCO2 monitored in recovery in 25(81%) cases



Not monitored in 6(19%) cases

5 of which had SGA removed immediately after arriving in recovery

ETCO2 noted and documented in only 6(19%) cases



First audit Cycle**End Tidal CO2**

- Monitored during transfer 21(67%)
- With ETCO2 9(43%)
- Without ETCO2 12(57%)
- No monitoring during transfer 10 (33%)

Re-Audits: To be done in 6 months duration

Recommendations

1. Aim end tidal CO2 monitors to be available in all theatres
2. Encourage doctors, nurses and ODPs education to encourage end tidal CO2 to be used during transfer and monitoring patient in recovery
3. Encourage doctors and nurses to document End Tidal CO2 monitoring in anaesthetic chart.
4. Re audit in 6 months time to evaluate compliance.

Biography

Sana Imtiaz is a ST4 trainee anaesthetics working at Adeenbrookes hospital, part of east of England deeneary. she is from Pakistan and been working here for 5 years.



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Parastomal hernia repair: A four-year single-centre experience with elective and emergency outcomes

Introduction: Parastomal Hernia (PSH) is a common complication following stoma formation, with surgical repair strategies including open, laparoscopic, and robotic techniques. Despite evolving operative approaches, recurrence and complication rates remain high, particularly in emergency settings.

Methods: We conducted a retrospective observational study of 87 patients who underwent PSH repair between 06/03/2021 and 06/03/2025 at a single UK centre. Data were extracted from the Bluespир theatre system and clinical records. Variables included patient demographics, urgency of surgery, operative approach, theatre duration, hospital stay, complications, and postoperative recurrence. Statistical comparisons were made between elective and emergency procedures, as well as between primary and recurrent repairs.

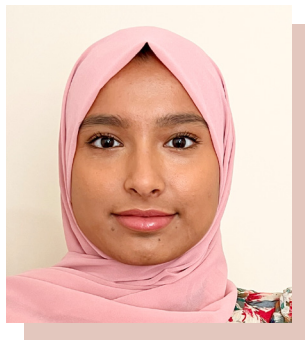
Results: Of the 87 patients, 42 (48.3%) were male, and the median age was 62.1 years. Most repairs were open (78.2%), with fewer laparoscopic (18.4%) and robotic (3.4%) cases. Elective surgeries accounted for 57.5%, and 23% of patients underwent repair of a previously recurrent hernia. Mean operative time was 129.5 minutes, and mean hospital stay was 11.1 days. The overall postoperative recurrence rate was 21.8%. Recurrence rates were 22.1% for open, 25.0% for laparoscopic, and 0% for robotic repairs. Emergency cases had significantly longer hospital stays, and higher complication rates compared to elective procedures ($p < 0.01$).

Conclusion: Elective PSH repair, including via minimally invasive techniques, was associated with favourable outcomes and lower recurrence. Emergency repair remains high-risk, underscoring the importance of early elective referral and optimised surgical planning.

Keywords: Parastomal Hernia, Recurrence, Robotic Surgery, Laparoscopic Repair, Emergency Hernia, Elective Repair.

Biography

Sandeepa Dadigamuwage is a Specialty Registrar in Colorectal Surgery at University Hospitals, Plymouth NHS Trust, United Kingdom. He completed his internship in Medicine and Surgery at Sri Jayewardenepura General Hospital, Sri Lanka, and previously worked as a Resident Doctor and Senior House Officer in Surgery, where he actively contributed to audits and research initiatives. Now in the UK, he is engaged in elective and emergency colorectal surgery, with a strong interest in minimally invasive techniques and surgical innovation. Sandeepa has led multiple retrospective studies, including work on parastomal hernia repairs and antibiotic stewardship. He is passionate about evidence-based practice, education, and presenting research at national and international forums.



Dr. Shifa Bangi*, Dr. Tom Shah, Mr. Tom Pampiglione

Surgical Emergency Unit, John Radcliffe Hospital, Oxford University Hospitals NHS Trust, Oxford, United Kingdom

Improving post-operative analgesia regimens after emergency major abdominal surgery

Background: Effective postoperative pain management is paramount for patient recovery after emergency major abdominal surgery, impacting morbidity, length of stay, and overall outcomes. Variability in analgesic prescribing, potential opioid overuse, and underutilisation of non-opioid analgesics are prevalent issues. A structured, stepwise approach to analgesia is particularly important when patients transition from Patient-Controlled Analgesia (PCA) to regular oral analgesia. This quality improvement project aimed to standardise and optimise postoperative analgesia at the John Radcliffe Hospital's Surgical Emergency Unit (SEU).

Aim: To assess current analgesic practices, implement targeted interventions to align with evidence-based guidelines, and evaluate the impact of these interventions on postoperative pain management following emergency major abdominal surgery.

Methods: A retrospective audit of patients undergoing emergency major abdominal surgery was conducted. Patients were identified using the department's National Emergency Laparotomy Audit registry. Data was collected on surgical, anaesthetic, and patient-related factors influencing postoperative pain, analgesia prescriptions and ward round documentation. Analgesic prescriptions during the first postoperative week were converted to Morphine Milligram Equivalents (MME) for comparative analysis. Key metrics included opioid consumption, non-opioid analgesic usage, documentation quality, and length of stay. Interventions included: (1) educational sessions for junior doctors on multimodal analgesia and guideline adherence, (2) implementation of a standardised analgesic prescription checklist including objective pain score and (3) promotion of a readily accessible electronic powerplan for analgesic prescribing. A post-intervention audit was performed to assess the impact of these changes.

Results: Post-intervention, significant improvements were observed in the documentation of analgesic plans during ward rounds and increased awareness of optimal postoperative analgesic regimens. Over time this has the potential to result in a demonstrable reduction in overall MME consumption and a trend towards decreased length of stay.

Conclusion: This quality improvement project demonstrates that targeted interventions, including education, checklists, and streamlined electronic prescribing, can improve postoperative analgesia following emergency major abdominal surgery. Implementing a standardised, multimodal approach to pain management enhances patient recovery, reduces opioid consumption, and improves clinical outcomes.

Biography

Dr. Shifa Bangi, MBBS BSc Hons, graduated from Imperial College London in 2022 and is currently a Core Surgical Trainee at the Surgical Emergency Unit, John Radcliffe Hospital, Oxford. Her clinical interests centre on general surgery, with a particular focus on Upper GI surgery. Dr. Bangi serves as the Core Surgical Trainee Representative for the Thames Valley region. Furthermore, as Associate Teaching Fellow at Green Templeton College, she delivers and supervises teaching sessions for University of Oxford medical students. Alongside these roles, she is actively engaged in research and will be applying for ST3 General Surgery this year.

Sri Harsha Dintakurti*, Benjamin Chan, Rafael Diaz-Nieto

Department of Hepatobiliary Surgery, Liverpool University Hospitals NHS Foundation Trust, Liverpool, United Kingdom

Rupture of hepatic artery aneurysm presenting into duodenum: A case report

Hepatic artery aneurysms account for one fifth of splanchnic artery aneurysms and are usually asymptomatic until rupture, at which point, mortality reaches 40%. Appropriate identification can crucially inform intervention options such as endovascular repair or surgical resection.

We report a 56-year-old male who presented with melaena and syncope. CT angiography revealed a common hepatic artery aneurysm bleeding into the duodenum, which was initially treated with endovascular hepatic artery embolisation. The patient returned a month later with fever, tachycardia and abdominal pain. Repeat CT angiography showed recurrence of arterio-enteric fistulation and aneurysmal rupture.

Due to this, surgical resection of the aneurysm was performed. The presence of a dominant left hepatic accessory artery averted the need for vascular repair with grafts. Post-operatively, the patient recovered well and currently remains free from complications 11 months on.

We highlight duodenal fistulation as a rare presentation of hepatic artery aneurysm. We further demonstrate that surgical resection of an infected and enterically-fistulating true aneurysm of the common hepatic artery is a viable option for where endovascular intervention is insufficient. This report adds to limited literature on the surgical management options for hepatic artery aneurysms.

Biography

Dr. Dintakurti studied medicine at Imperial College London with a president's scholarship, graduating in 2023. During his medical studies, he undertook an intercalated BSc in Medical Sciences with a special interest in Translational Respiratory Medicine, achieving first class honours. He is currently undertaking his second year of foundation training at Liverpool University Hospitals NHS Trust. He has presented and published his academic work nationally and internationally.

Tanvir Ahmed^{1*}, Professor Juan Valle², Dr. Ganesh Radhakrishna²

¹The Christie NHS Foundation Trust, United Kingdom

²Consultant Medical Oncologist, The Christie NHS Foundation Trust, United Kingdom

Outcomes of patients treated with radiotherapy for pancreatic cancer

Background: Pancreatic cancer is a devastating disease with very poor prognosis. Most patients present with metastases where it is too late for potentially curative surgery. In selected patients where the tumour remains localised, radiotherapy may help reduce progression, improve symptoms, and allow patients time off chemotherapy.

Aims: To assess the proportion of patients completing planned radiotherapy treatment, assess frequency of severe toxicity (grade 3 or 4) post radiotherapy recorded on days 7, 30, and 90. Finally, to determine time to disease progression and overall survival of patients post radiotherapy.

Methods: Sequential patients receiving radiotherapy for pancreatic cancer were identified. All patients from the year 2018 to 2020 were included. Data was then extracted from the Christie Web Portal (CWP) and uploaded into an excel spreadsheet. Results were descriptive, including a Kaplan-Meier curve to estimate progression free survival and overall survival.

Results: A total of 19 patients were identified. Within this group, 68.2% were female with a median age of 69 years (range 36–76). 89.5% of patients completed their full course of planned radiotherapy. Grade 3-4 toxicities were uncommon with only three grade 3 toxicities identified. Median progression free survival was estimated 4.3 months 95% Confidence Interval (CI) [3.9,4.7] and median overall survival was estimated 11.9 months 95% CI [5.8,18.1].

Conclusion: This study showed that most were able to complete the entire course of radiotherapy. Areas of improvement were identified, such as better documentation of toxicity and performance scores. This efficacy data serves as a benchmark for future studies.



Daramola T*, Doleman B, Williams JP

IRIS, School of Medicine, University of Nottingham, Nottingham, UK

Predicting reductions in acute pain and opioid consumption with non-opioid analgesics: A machine learning analysis of randomised controlled trials (OPERA study)

Background: Acute pain is one of the most common complications following surgery and has a detrimental effect on patients' quality of life. It also poses significant healthcare and economic burdens. The role non-opioids play in managing post-surgical pain is increasing, either as a sole agent or in combination with other analgesics. Advances in Machine Learning (ML) presents opportunities to use data from Randomised Controlled Trials (RCTs) in developing algorithms that can guide treatment recommendations. This study is part of a wider systematic review and aims to use ML to develop an algorithm that aims to predict reductions in acute pain and opioid consumption with non-opioid analgesics.

Methods: We included studies in adult patients undergoing a surgical procedure, under general or regional anaesthesia, which evaluated non-opioid analgesia commonly used to treat acute pain. Other procedures, dental surgery and ophthalmic procedures were excluded. The risk of bias was assessed using the Cochrane risk of bias tool version 2 by two study authors (and a third if consensus could not be reached). Predictors include baseline risk (control group mean), age, sex, risk of bias domains, drug within class, route of administration, type of surgery country of origin, year of publication, postoperative doses given, concurrent regional anaesthesia or non-opioids and pre-emptive doses.

Results and Conclusions: We have identified 1375 RCTs for potential inclusion. Data extraction is ongoing. The implications of our results are:

1. Allow clinicians to predict in what clinical circumstances analgesics are more effective
2. Present a method for meta-analyses to present results
3. Demonstrate how the transitivity assumption can be violated in network meta-analyses

Biography

Dr. Daramola completed her undergraduate medical degree at the Brighton and Sussex Medical School, Brighton, United Kingdom. She then went on to complete her NIHR Specialised Foundation Programme (previously known as the Academic Foundation Programme), within the University of Nottingham, in anaesthetics and perioperative medicine in Derby. She also holds a Masters of Public Health (Global Health) with distinction, from the University of Nottingham.

Usman Mateen*, Maaz Yusufi, Paul Froggatt

University Hospital Dorset, Poole, UK

Compliance with national guidelines on antibiotic prescription in acute diverticulitis: A quality improvement project

Introduction: Acute diverticulitis, a common surgical condition, can be classified as uncomplicated or complicated. National guidelines recommend antibiotics only for patients with complicated diverticulitis, immunosuppression, or systemic illness. This quality improvement project assessed compliance with these guidelines, identified gaps in practice, and implemented measures to improve adherence.

Methods: A two-cycle audit was conducted. The first cycle, retrospective in nature, reviewed cases from July to December 2024. Following identification of poor compliance, targeted interventions such as staff education sessions and guidelines posters were introduced. The second cycle was conducted prospectively from February to May 2025. Inclusion criteria were adult patients with CT-confirmed acute diverticulitis. Data were obtained from electronic patient and medication records. The audit standard, based on NICE guidance, required 100% compliance: no antibiotics for uncomplicated, systemically well and not immunocompromised and antibiotics for complicated ones, systemically unwell or immunocompromised.

Results: 43 patients were included in the first cycle (median age 65; gender ratio 1:1). Of the 24 patients with uncomplicated diverticulitis, all were prescribed antibiotics conferring 0% compliance against set standard. The remaining 19 patients with complicated diverticulitis, all received appropriate antibiotics (100% compliance).

35 patients were included in the second cycle. 26/35 had uncomplicated diverticulitis; of these, 8 (31%) required antibiotics due to systemic illness or immunosuppression, 12 (46%) were not given antibiotics as per standard, while 6 (23%) received antibiotics against the standard. Compliance therefore improved from 0 to 77% for managing uncomplicated diverticulitis. All remaining 9/35 patients with complicated diverticulitis received appropriate antibiotics, conferring 100%, as noted during previous cycle.

Conclusion: This project demonstrate that targeted interventions can significantly improve adherence to antibiotic guidelines, enhancing patient care and reducing unnecessary treatment burden.

Biography

Dr. Usman Mateen, currently working as a Junior Clinical Fellow General Surgery at the University Hospital Dorset. Graduated in University Health of Sciences (Continental Medical College, Lahore, Pakistan) in 2015.

Varunaen Udayachandran*, Abdulbari Dkhakhni

General Surgery, London, United Kingdom

Routine operative swab cultures for uncomplicated abscesses – Do they make a difference to the management of patient care?

Introduction: The management of abscesses has long been incision and drainage. Many hospitals still routinely culture the pus intra-operatively and discharge patients with empirical antibiotics.

Method: This retrospective study in a small district general hospital aims to examine whether routine operative swabs of uncomplicated abscesses have an impact on the management and treatment of patients. All patients who were referred to the general surgery team during a three-month period was analysed. The referrals were screened to identify patients who had been diagnosed with a superficial soft tissue abscess and underwent incision and drainage. Body sites that were included in the study included abscesses affecting the axillary wall, breast, abdominal wall, back and perianal regions. Of these abscesses, only 'uncomplicated' cases were chosen, and this was defined as patients presenting to surgery with the abscess affecting the region for the first time. Operation notes and lab requests were then reviewed to see whether Microscopy, Culture, And Sensitivity (MC&S) samples were sent. Patient and clinic notes were also reviewed to identify if MC&S sample results were reviewed post-operatively and whether this affected or altered the management of patient care.

Discussion: It argues that routine swabs for uncomplicated abscesses are not cost-effective, has minimal-to-no effect on patient treatment and management, and does not help to reduce the use of antibiotic therapy and should be avoided in these groups of patients.

Vishnu Prasad

Leighton Hospital, United Kingdom

Retrospective audit on the management of uncomplicated gallstone pancreatitis at MCHFT (Leighton Hospital)

Introduction: Most hospitals in the United Kingdom serving a population of 300,000-400,000 people admit about 100 cases of acute pancreatitis each year. It carries a wide spectrum of disease from mild (80%) to severe (20%) with prolonged hospital stay and risk of death. The commonest causes in western countries are gallstones (50%) and alcohol (25%). Abdominal ultrasonography should be performed to look for gallstones. After the index episode, recurrent gallstone pancreatitis attacks occur in up to 75% of patients with a mortality rate of 15%. Cholecystectomy provides the only definitive therapy, reducing recurrent biliary events to 2%. RCS guidelines state this should happen during the index admission or within 2 weeks of discharge.

Methods: Retrospective audit from January 2024 over 6 months. Relevant notes were sourced. We determined discharge dates, surgical listing means, pre-op assessment and cholecystectomy dates.

Results: There were 38 patients admitted with gallstone pancreatitis over the timeframe. Out of 27 patients who were candidates for surgery, only 1 patient met the national guideline. Mean wait from index discharge to pre-op assessment was 53 days. Mean wait from index discharge to cholecystectomy was 79 days. 7 patients required readmission with Gallstone Pancreatitis or Acute Cholecystitis prior to surgery.

Conclusion: There is a failure to meet national targets due to 2 main reasons. The lack of a dedicated 'Hot gallbladder listing form' and inadequate theatre booking form resulted in 16 out of 21 patients being inappropriately listed. There is an inadequate capacity of pre-op assessment clinics to meet demand.



Zacharias Buttigieg*, Samuel Smith*

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Lincoln, Lincolnshire, United Kingdom



‘Thirst for change’: Improving pre-operative hydration for emergency surgery in a District General Hospital

Historically, patients undergoing emergency surgery are routinely instructed to fast from food for six hours and clear fluids for two hours before arriving to theatre. However, in practice, patients often remain fasted for much longer periods of time, causing unnecessary unpleasant symptoms and patient dissatisfaction. The ‘Sip ‘til Send’ initiative, pioneered by NHS Tayside, permits patients to sip small volumes of clear fluid until they are sent to theatre. This quality improvement project aimed to implement the ‘Sip ‘til Send’ policy at Lincoln County Hospital, a district general hospital in Lincolnshire.

Methods: Following stakeholder engagement and process mapping, we aimed to improve awareness and implementation of the ‘Sip ‘til Send’ policy, thereby enhancing pre-operative hydration and patient experience. Root-cause analysis highlighted key barriers to knowledge and implementation of the policy. Baseline data was collected over four weeks using patient surveys. Interventions included staff education (via email, posters and face-to-face sessions) targeting medical, nursing and catering teams. Post-intervention data was collected using the same survey methodology.

Results: Patient awareness of the ‘Sip ‘til Send’ policy increased from 18% to 90%. Average fasting time for clear fluids reduced from approximately eight hours to one hours and 20 minutes. Hydration variability between patients decreased significantly. Encouragingly, references to ‘Sip ‘til Send’ began appearing in surgical clerking notes, reflecting signs of a positive cultural change

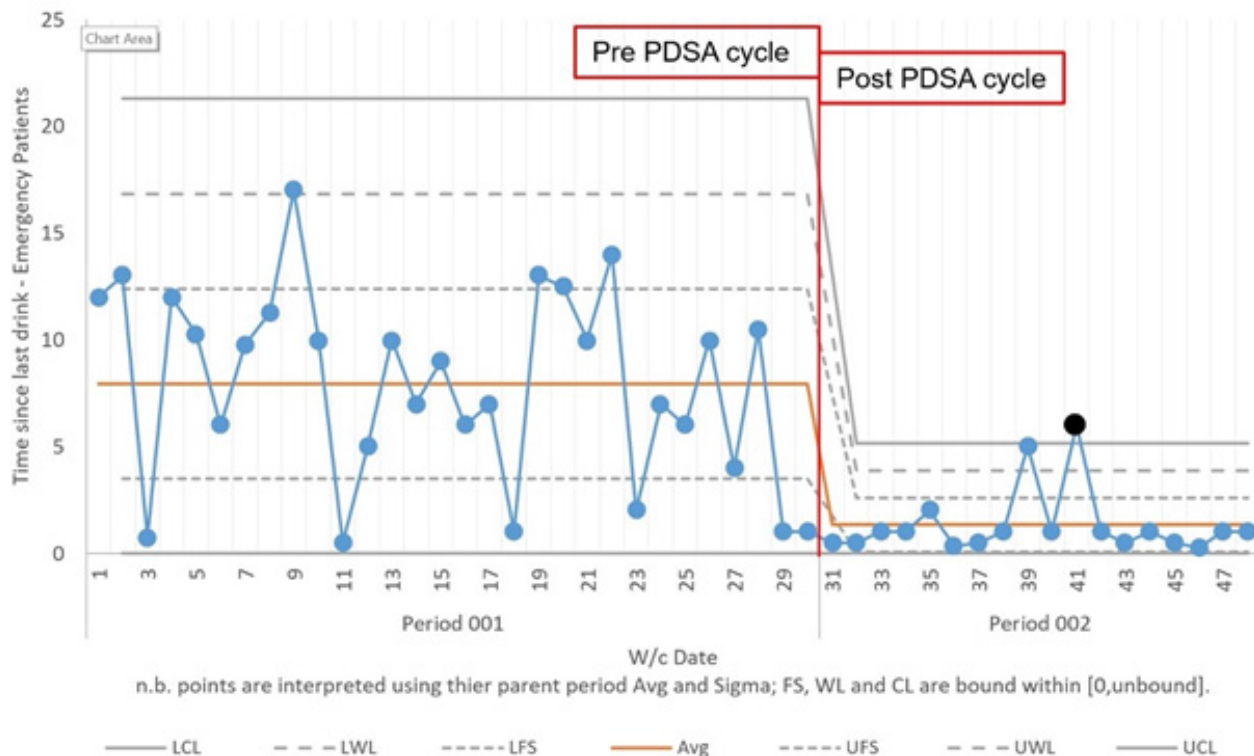


Figure 1–Statistical process control chart for time since last drink of clear fluids pre- and post-PDSA cycle

Discussion: Introducing the ‘Sip ‘til Send’ policy significantly improved patient pre-operative hydration and awareness. These changes likely enhanced overall patient experience and reduced the discomfort associated with prolonged fasting times. Future steps include targeting 100% patient awareness, incorporating the policy into staff induction programmes and embedding prompts in surgical clerking documentation, to ensure lasting policy integration.

Biography of Zacharias Buttigieg

Dr. Buttigieg graduated from the University of Plymouth Peninsula Medical School in 2021 and completed foundation training in the East Midlands. He subsequently worked as a Clinical Fellow in the Intensive Care Unit at Nottingham University Hospitals, a major trauma centre, before starting Core Anaesthetics training at the East Midlands School of Anaesthesia in August 2024. He is currently a Core Level 1 Anaesthetic trainee at United Lincolnshire Hospitals NHS Trust.

Biography of Samuel Smith

Samuel Joseph Smith graduated from the University of Nottingham medical school in 2021 and he completed foundation training in the East Midlands. He subsequently worked as a doctor in Australia before commencing anaesthetics training in the United Kingdom. He is currently a core anaesthetics trainee.

Zhe Shean Lim

St George's University London, United Kingdom

Tranexamic acid use in general surgery — A low hanging fruit

Background: Major intraoperative bleeding remains an important cause of surgical morbidity and mortality. Blood transfusion, though often life-saving, is a limited resource and carries risks including transfusion reactions, infection, and increased length of stay. Tranexamic Acid (TXA) is a low-cost antifibrinolytic that has been shown to reduce bleeding and transfusion requirements in surgery. National guidance, including the Joint Royal Colleges Implementation Group and NICE QS138, recommends administration of 1 g TXA before incision and again after closure for all adult surgical patients at risk of moderate blood loss. Despite these recommendations, TXA use in general surgery is often inconsistent.

Methods: We conducted a retrospective audit of consecutive moderate-risk colorectal operations performed at [SMH and WGH] between 1 September and 31 November 2024. Data were obtained from electronic records. Outcomes included whether TXA was administered correctly (both timing and dose), estimated intraoperative blood loss, and postoperative requirement for blood transfusion or iron replacement. A total of 96 procedures were identified, of which 2 were excluded due to missing records.

Results: Correct TXA administration was documented in only 4/96 (4%) patients, while 13 patients received an incomplete or incorrect regimen. Intraoperative blood loss was generally minimal, although documentation was absent in 31% of cases. One quarter (25%) of patients required postoperative transfusion or iron therapy. Notably, among the 4 patients who received the correct TXA regimen, only 1 required a transfusion. In contrast, patients needing transfusion or iron were predominantly those who had not received TXA or had received it incorrectly.

Conclusion: This audit demonstrates marked underuse of TXA in general surgery, despite clear evidence and national recommendations. A checklist prompt at time of WHO surgical safety sign-in, combined with targeted education of anaesthetic and surgical teams, represents a low-cost and high-yield intervention. Optimising TXA use has the potential to reduce unnecessary transfusions, conserve blood resources, and improve perioperative outcomes.

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**Abbas Merchant*, Haashim Rahman*,
Aaryan Patel**

Lake Erie College of Osteopathic Medicine, Erie, PA, USA



Preoperative implications of GLP-1 receptor agonists on anesthesia outcomes: A systematic review and meta-analysis

Background: Glucagon-Like Peptide-1 Receptor Agonists (GLP-1 RAs) are widely used for treating type 2 diabetes and obesity because they induce benefits like glycemic control and weight reduction. However, their further influence on perioperative anesthesia outcomes, such as gastric emptying, aspiration risk, hemodynamic stability, and glycemic variability, is a serious concern. This systematic review and metaanalysis evaluate the insights regarding the preoperative consequences of GLP-1 RA on anesthesia outcomes, leading to a better guide for perioperative management strategies.

Methods: A systematic literature search was performed across PubMed, Web of Science, Cochrane Library, ClinicalTrials.gov, OpenGrey, and Embase. From the 524 records screened, only six eligible studies met the inclusion criteria and were analyzed. These studies investigated gastric food retention, aspiration risk, perioperative blood pressure changes, glycemic stability, nausea and vomiting, and vasopressor requirements. Statistical analysis was conducted using Open Meta-Analyst and Review Manager 5. The Cochrane Risk of Bias (RoB1) tool was used for Randomized Controlled Trials (Rcts), while the Newcastle Ottawa Scale (NOS) assessed observational study quality.

Results: The use of GLP-1 Receptor Agonists (GLP-1 RAs) significantly increases the risk of gastric Food Retention (OR: 1.39 [1.25-1.56]; $p < 0.00001$; $I^2 = 95\%$), with a 25.69-fold higher risk during elective EGD (OR: 25.69 [7.34-89.99]). Endoscopy discontinuation due to retained gastric contents was 37% more likely (OR: 1.37 [1.23-1.53]; $p < 0.00001$). No significant increase in pulmonary aspiration risk was observed. GLP-1 RA use was associated with a reduction in mean arterial blood pressure (-2.76 mmHg [95% CI: -3.22, -2.30]; $p < 0.00001$; $I^2 = 89\%$), leading to increased intraoperative vasopressor requirements (OR: 1.48 [1.09-1.99]; $p = 0.01$). Perioperative glycemic control improved (mean glucose reduction: -14.93 mg/dL [95% CI: -15.81, 14.05]; $p < 0.00001$). Postoperative nausea and vomiting were more frequent (OR: 1.37 [0.95-1.97]; $p = 0.09$), anesthesia duration extended by 9.86 min (95% CI: 9.12-10.59), and recovery prolonged by 10.01 min (95% CI: 9.42-10.61), with increased ICU admissions (OR: 1.53 [1.01-2.32]; $p = 0.04$). Sensitivity analysis confirmed result robustness.

Conclusions: GLP-1 RAs delay gastric emptying, resulting in extended fasting protocols or gastric ultrasound evaluations concerning the aspiration risk. Their vasodilatory effects may result in hypotension during the perioperative phase, often warranting the use of vasopressors and modification of anesthesia techniques. While they stabilize sugar levels, they may also contribute to Post Operative Nausea and Vomiting (PONV), thereby necessitating modifications in antiemetic guidelines. These observations support the need for personalized perioperative management strategies for users of GLP-1 RAs.

Keywords: GLP-1 Receptor Agonists, Anesthesia Outcomes, Gastric Emptying, Perioperative Glycemic Control, Vasopressor Use, Aspiration Risk.

Biography

Abbas and Haashim are both third year medical students studying in Erie, Pennsylvania. They received their Bachelor of Science degrees in Biology during their undergraduate education at colleges in New York and Maryland, respectively. Currently they are completing their clinical rotations at hospitals in New York in order to prepare for upcoming residencies. In the meantime, they have been independently conducting research and analysis in broad topics across the field of medicine.



Mr. Adnan Higgi*, Dr. Kirsten Arendse, Mr. Nader Naguib

General Surgery at Royal Glamorgan Hospital, Cwm Taf Morgannwg Healthboard, Llantrisant, Wales

Recurrence rates in incisional hernia repair: A retrospective review and service improvement proposal

Objectives: This study aimed to assess recurrence rates in incisional hernia repairs, comparing open and laparoscopic approaches, and to evaluate whether recurrence differed with or without the use of prosthetic mesh. A secondary objective was to explore the potential benefits of establishing an Incisional Hernia Multidisciplinary Team (MDT) and a dedicated theatre list to improve service delivery and patient outcomes within the Healthboard.

Methods: A retrospective cohort study was conducted across two district general hospitals, including 216 patients who underwent incisional hernia repairs between 4th January 2019 and 28th December 2024. Data on patient demographics, hernia type (primary vs. recurrent), surgical approach (open vs. laparoscopic), and mesh usage were collected and analysed.

Results: Of the 216 patients, 80 were male (37%) and 136 female (63%), with 55 recurrent and 161 primary hernias. Most procedures were open repairs (194; 89.8%), while 19 (8.8%) were laparoscopic. Mesh was used in 147 cases (68%) and omitted in 67 (31%).

The overall recurrence rate was 7.9% (17/216), with mesh repairs showing a recurrence rate of 8.2% (12/147) and non-mesh repairs 7.5% (5/67). Open repairs had a recurrence rate of 7.7% (15/194), compared to 15.8% (3/19) for laparoscopic repairs. Elective repairs had a recurrence rate of 8.5% (14/164) versus 7.7% (4/52) for emergency cases.

Conclusions: This study found low overall recurrence rates (7.9%) for incisional hernia repairs. Mesh use did not significantly reduce recurrence compared to non-mesh repairs (8.2% vs. 7.5%). Laparoscopic repairs had a higher recurrence rate (15.8%) than open repairs (7.7%), though the small laparoscopic sample size limits conclusions. Recurrence rates were similar between elective and emergency cases. These findings suggest that recurrence may be influenced more by patient or hernia factors than surgical approach or mesh use. A structured MDT and dedicated theatre list could support improved patient selection, standardised techniques, and better outcomes. Longer term follow up and a prospective study leg could help to further explore the findings of this study and support the implementation of an MDT approach for the management of incisional hernias.

Biography

Mr. Adnan Higgi MBBCh (Hons) 2021, MRCS 2025, MPharm 2014. Graduated with a Masters of Pharmacy degree from Cardiff University in 2014, followed by a medical degree with Honours from Cardiff School of Medicine in 2021. Successfully completed the MRCS in 2025 and currently working as a Core Surgical Trainee at the Royal Glamorgan Hospital in South Wales.



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²Vascular Surgery, The Royal Melbourne Hospital, Melbourne, Victoria, Australia

Acute mesenteric ischaemia: A current Australian perspective

Introduction: Acute Mesenteric Ischaemia (AMI) is a surgical emergency, requiring multidisciplinary collaboration. Prompt diagnosis and treatment is vital yet frequently delayed. Research internationally has considered this and begun to implement clinical guidelines to improve outcomes. This has yet to be considered in an Australian setting, and as such this study aimed to address this though assessing current diagnosis and management within a tertiary hospital from 2020 to 2025.

Methods: A retrospective audit was completed of patients admitted to the Royal Melbourne Hospital general surgical unit with a diagnosis of AMI over the last five years. Demographic data, management information and mortality outcomes were recorded.

Results: 32 patients were managed with a diagnosis of AMI over the five years, with an average of 5.3 patients each year and a median age of 72.5 years (IQR 15.5). 25.8% of patients were transfers, most commonly from regional or rural centres. 62.5% of the patients were male, with the most common recorded comorbidities being hypercholesterolaemia (43.8%) and current smoking status (41.9%). At time of diagnosis, almost all patients had abdominal pain (91.3%) and most demonstrated a metabolic disturbance (lactatemia (77.8%), acidotic (63.0%). 93.7% of patients underwent operative management with vascular surgical involvement in 61.3% of cases. 96.9% required ICU admission, with a median total length of stay of 14 days (IQR 27.8). Mortality was 46.9%.

Conclusion: AMI is a rare, but often fatal diagnosis. International research suggests guidelines improve outcomes and reduces mortality, and this should begin to be considered in an Australian context. This study demonstrates important factors that should be considered in guideline development, which is currently in development stages.

Biography

Dr. Alexandra Jolley studied Medicine at the University of Melbourne, Australia, graduating in 2021. She is currently an unaccredited general surgical registrar at the Royal Melbourne Hospital, Melbourne, Australia. She is currently undertaking her Master of Surgery. She has a particular interest in quality improvement and Trauma Surgery.



Dr. Aneesa Mangalam Lonappan*, Dr. Tara Feeley

Department of Anaesthesia, University Hospital Limerick, Ireland

Anaesthetic management of a patient with myofibrillar myopathy undergoing elective carotid endarterectomy: Risks and strategies

We present the anaesthetic management of a 60-year-old gentleman with myofibrillar myopathy undergoing elective left Carotid Endarterectomy (CEA) following a recent ischaemic event. Myofibrillar myopathies are a heterogeneous group of neuromuscular disorders caused by various genetic mutations leading to progressive skeletal muscle weakness, potential respiratory compromise, and cardiac involvement. These disorders carry significant anaesthetic risk, particularly in the context of major vascular surgery, due to increased susceptibility to perioperative respiratory failure, cardiac arrhythmias, malignant hyperthermia-like reactions, and exaggerated responses to neuromuscular blocking agents.

The patient presented with acute-onset right arm weakness and expressive dysphasia. His MRI brain demonstrated multifocal acute infarcts in the left frontal lobe, and carotid duplex ultrasound revealed 50–69% stenosis of the left internal carotid artery. He was scheduled for an elective left CEA. His past medical history was significant for myofibrillar myopathy with a documented exacerbation following statin therapy. Pulmonary function tests (2023) demonstrated a mild restrictive pattern (FEV₁ 73%, FVC 77%), and his echocardiogram showed normal chamber sizes, preserved left ventricular function (LVEF ≥ 55%), intact interatrial septum, and no evidence of cardiomyopathy or valvular pathology. He reported longstanding dysphagia and adhered to safe swallowing strategies (soft, moist foods) to reduce aspiration risk. Medications included low-dose aspirin, ezetimibe, and pantoprazole.

Neuromuscular disorders present unique hazards for anaesthesia. Patients may have heightened sensitivity to both depolarising and non-depolarising muscle relaxants, prolonged recovery from neuromuscular blockade, and increased risk of postoperative respiratory insufficiency. There is also a recognised risk of anaesthesia-induced rhabdomyolysis and malignant hyperthermia-like reactions, particularly when exposed to volatile anaesthetic agents or depolarising neuromuscular blockers such as suxamethonium.

In this case, the anaesthetic plan was tailored to mitigate these risks. Volatile anaesthetics and suxamethonium were removed from the operating theatre to avoid inadvertent exposure. General anaesthesia was induced and maintained using an Eleveld model Total Intravenous Anaesthesia (TIVA) technique with propofol and remifentanyl, providing stable depth control and reducing the risk of triggering myopathy-related complications. Rocuronium (1.2 mg/kg)

was selected for muscle relaxation due to its predictable pharmacokinetics and availability of rapid reversal agents. Video laryngoscopy facilitated atraumatic intubation.

Intraoperative monitoring included invasive arterial blood pressure and Bispectral Index (BIS). A phenylephrine infusion was titrated to maintain systolic blood pressure within 20% of baseline to ensure adequate cerebral perfusion during carotid cross-clamping. The patient remained haemodynamically stable with no arrhythmias or desaturation episodes. Neuromuscular monitoring guided the timing of reversal, ensuring full spontaneous recovery before extubation.

Postoperative care focused on airway protection, aspiration prevention, and early detection of respiratory compromise. Multimodal, opioid-sparing analgesia minimised respiratory depression risk. The patient was monitored in a high-dependency unit for 24 hours and recovered without complication.

This case underscores the critical importance of detailed preoperative assessment, multidisciplinary planning, avoidance of triggering agents, judicious use of neuromuscular blockade, and meticulous haemodynamic and respiratory management in patients with neuromuscular disease. Even in the absence of overt cardiopulmonary compromise, myofibrillar myopathy confers substantial anaesthetic risk, and careful individualisation of management is essential to optimise outcomes.

Biography

Dr. Aneesa Mangalam Lonappan studied Medicine at University of Galway, Ireland and completed her intern year in University Hospital Limerick. She is currently undertaking her SHO training in University Hospital Limerick and hopes to eventually specialize in paediatric anaesthesia.



Congke Shu*

Department of Orthopaedic and Joint Surgery, Chongqing Orthopedic Hospital of Traditional Chinese Medicine, Chongqing, China

Risk factors for deep venous thrombosis within three months after joint replacement surgery

Objective: To explore the relevant risk factors for Deep Venous Thrombosis (DVT) of lower limb occurring 3 months after joint replacement surgery.

Methods: A retrospective analysis was conducted on the clinical data of 1,782 patients who underwent joint replacement surgery at Chongqing Orthopedic Hospital of Traditional Chinese Medicine, from February 2008 to December 2023. Of these, 1,298 were male and 484 were female, with an average age of 65.4 ± 12.3 years (range, 18-95 years). Fourteen factors associated with DVT occurrence at 3 months were investigated, including age, gender, Body Mass Index (BMI), season of surgery, preoperative coagulation function, type of surgery, selection of minimally invasive approach, occurrence of lower limb venous thrombosis 1 day after surgery, history of previous thrombotic diseases, smoking, tumors, diabetes, hypertension, and heart disease. Independent sample t-tests and chi-square tests were used to analyze the risk factors for DVT occurrence. Indicators with statistically significant differences were included in a binary logistic regression analysis to determine the risk factors for DVT 3 months after surgery. The risk prediction model was established according to the results of logistic regression analysis, and the receiver operating characteristic curve was drawn. The area under the curve of the prediction model was calculated.

Results: A total of 1,782 patients were included. The overall incidence of DVT occurring 3 months after joint replacement surgery was 10.5% (187/1,782). The thrombosis group included 5 symptomatic cases and 182 asymptomatic cases, with 13 proximal and 174 distal cases. DVT was found in the iliac vein (1 case), femoral vein (10 cases), popliteal vein (8 cases), peroneal vein (14 cases), and intramuscular vein (168 cases). Single-factor analysis showed that female gender, increasing age, previous thrombotic disease, hypertension, surgery in autumn, and the occurrence of DVT on the first day after surgery were correlated with DVT occurring 3 months after joint replacement surgery ($P < 0.05$). After excluding the missing data, a total of 1,744 patients were included in the final analysis. DVT occurrence on the first day after surgery [OR=7.498, 95% CI (5.312, 10.584), $P < 0.001$], surgery in autumn [OR=1.834, 95% CI (1.215, 2.769), $P = 0.004$], age [OR=1.024, 95% CI (1.007, 1.042), $P = 0.009$], female gender [OR=1.863, 95% CI (1.184, 2.931), $P = 0.007$], and history of previous thrombotic diseases [OR=0.012, 95% CI (1.136, 2.830), $P = 0.012$] were found to be associated with DVT occurrence at 3 months after surgery. The Area Under the Curve (AUC) for predicting DVT three months after hip or knee arthroplasty was 0.803 [95% CI (0.761, 0.844)].

Conclusion: Advanced age, female gender, history of previous thrombotic diseases, occurrence of DVT on the first day after surgery, and surgery in autumn are risk factors for DVT occurring 3 months after joint replacement surgery.



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Blocked vessels, ticking clock: How imaging saves lives in gut ischemia

Acute Mesenteric Ischemia (AMI) is a life-threatening surgical emergency characterized by sudden interruption of blood flow to the intestines, often resulting in bowel necrosis if not promptly diagnosed and treated. Atrial Fibrillation (AF), a common cardiac arrhythmia, significantly increases the risk of embolic events that can lead to AMI. This retrospective study, conducted between January 2022 and December 2023, analyzed 100 patients aged 50–80 years with AF who presented with AMI confirmed by CT Angiography (CTA). The objective was to evaluate the sensitivity of CTA in diagnosing AMI and to assess surgical outcomes based on the timing of intervention. Inclusion criteria were patients with AF and CTA-confirmed AMI who underwent surgical treatment; patients with chronic ischemia or contraindications to contrast were excluded. CTA demonstrated superior sensitivity in detecting mesenteric arterial occlusions, particularly at the level of the superior mesenteric artery, compared to conventional imaging modalities. Surgical intervention, primarily bowel resection with or without embolectomy, was more successful when performed within 12 hours of symptom onset. Delayed intervention correlated with increased morbidity and mortality. Early CTA (within 6 hours) significantly improved diagnostic accuracy and facilitated timely surgery, leading to better outcomes. The overall 12-month survival rate was 80%, with a recurrence rate of 10%. This study underscores the critical role of CTA in the early diagnosis of AMI in AF patients and highlights the importance of timely radiologic-surgical collaboration. Despite its higher cost, CTA is justified by its diagnostic precision and its ability to guide timely interventions that improve patient survival and reduce complications.

Biography

Dr. Navaneeth completed his MBBS from Rajiv Gandhi university of health sciences in 2017. He completed his MS in General Surgery at Amala institute of medical sciences in 2022. He worked at Department of Surgical Gastroenterology and Urology at Caritas Hospital, Kottayam, India. He is currently working as a Clinical fellow LAS ST3 at Western Health and Social Care trust, Northern Ireland, UK.

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Primary mid-ureter squamous cell carcinoma: A diagnostic conundrum in the absence of traditional risk factors

Upper urinary tract carcinomas are mostly urothelial in origin and squamous cell carcinoma of ureter only constitute 1-1.6% of all urothelial tumors. Risk factors include chronic irritation, urolithiasis and chronic hydronephrosis. Prognosis is poor as 40% of cases present with distant metastasis. Definitive diagnosis is through histology and treatment includes radical nephro-ureterectomy, chemotherapy, radiotherapy or a combination of these treatment. We present a case of 81 year old with local advanced squamous cell carcinoma of ureter but without any traditional risk factors.

Biography

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



**Sandra Lynn Jaya-Bodestyne*, Tan Wei Ching,
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Amniotic fluid embolism – Case series and literature review

Background: Amniotic Fluid Embolism (AFE) is a rare but potentially catastrophic complication of pregnancy. It is characterized by acute cardiovascular collapse, altered mental status, and Disseminated Intravascular Coagulation (DIC) occurring during the peripartum period. Although the incidence is low, it is still one of the leading causes of maternal mortality in developed countries. Early recognition of AFE is critical to a successful outcome. Due to the rarity of this condition, most physicians and institutions have limited experience with the management of amniotic fluid embolism. The aim of this study is to (1) report outcomes of patients with AFE in our centre, (2) describe their critical care management and complications, and (3) review the literature on current AFE management.

Methods: This is a 10-year retrospective case series on women with AFE from 2014 to 2023 at Singapore General Hospital identified by Clark's criteria. Data on patient characteristics, antenatal factors, medical comorbidities, clinical symptoms and signs, treatment, complications and maternal and neonatal outcomes were collected and analysed. Data on clinical characteristics, treatment, complications and outcomes were collected and analysed. A literature review was performed on diagnosis, management, treatment options and outcomes of AFE.

Results: Four cases of AFE were identified. Two met Clark's criteria and presented with cardiac arrest requiring extracorporeal membrane oxygenation, of which one had cognitive and functional impairment. Two patients had atypical AFE, one with Disseminated Intravascular Coagulation (DIC)-type AFE who did not survive, and another who had paradoxical intracranial emboli from a patent foramen ovale, who had a full recovery. All had coagulopathy and postpartum haemorrhage. Other complications included end-organ damage and nosocomial infections. Early recognition and initiation of cardiovascular support is crucial in AFE. The management of AFE is primarily resuscitative and directed towards the maintenance of oxygenation, cardiac output and blood pressure, and aggressive correction of the coagulopathy.

Conclusion: With prompt recognition and treatment of AFE involving a multidisciplinary team, survival and good outcomes are possible.

Biography

Dr. Sandra Lynn Jaya-Bodestyne graduated from Duke-NUS Graduate Medical School in 2018. She is currently a resident in the SingHealth Obstetrics and Gynaecology Residency Program.



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Ischemic bowel: Impact of revascularization on outcomes

Acute Bowel Ischaemia (ABI) is a life-threatening abdominal emergency characterized by sudden interruption of intestinal blood flow, leading to bowel infarction if not rapidly treated. Timely diagnosis and definitive management, particularly revascularization of the affected vasculature, are essential to improving outcomes. European guidelines suggest that damage control surgery be reserved for patients with peritonitis, non-responsive to resuscitation or where bowel viability is indeterminate. In practice, damage control surgery is often first line due to a lack of access to vascular services or difficulty in early diagnosis of ABI. We aimed to study the outcomes of patients who received damage control surgery alone to those who also have revascularisation.

Methods: We performed a retrospective review of patients presenting ABI between 2020 and 2025 to a tertiary level hospital and studied the patient characteristics, intervention, outcomes in those receiving only damage control surgery with those also having revascularisation procedure. The end points included mortality rates, post operative complication rates, number of relook procedures, length bowel resected and representation.

Results: A total of 37 out of 76 patients treated during the study period met the inclusion criteria. Patients who received an Exploratory Laparotomy (EL) only (n=17) and those who received both laparotomy and revascularisation (EL+RE) procedure cohort (n=20) were of similar size but differed in certain sociodemographic characteristics. The average ages of the EL and EL+RE groups were 66.85 and 67.2 years, respectively.

Gender distribution varied between cohorts. In the EL+RE group, males comprised the majority (60%, n=12), whereas in the EL only group, females were more prevalent (52.9%, n=9). Among those the EL+RE group, 45% (n=9) were local patients, while 55% (n=11) were transferred from regional hospitals up to 6 hours away. In contrast, the majority of patients in the EL only group were local (76.4%, n=13). The ASA and POSSUM scores were comparable between the groups. In terms of underlying pathology, 65% (n=13) of patients in the EL+RE group had a thromboembolic event as the primary etiology whereas in the EL group, non-occlusive mesenteric ischemia (n=6, 35.3%) and acute on chronic mesenteric ischemia (n=6, 35.3%) were the predominant pathologies. The average time to surgical review in the EL only group was 20.92 hours (1-504 hours) compared to 24.55hours (1-48hours) in the EL+RA group. The average time till intervention was in the EL only group was 39.43 (1-120 hours) whereas in the EL+RA group it was 44.96 hours till revascularisation (1-432 hours). Mean bowel resection lengths were slightly shorter in the EL+RE group (52.08 cm) compared to the

EL group (56.58 cm). The mean number of re-look operations was similar between the two groups, at 0.5 and 0.48 (SD: 0.95), respectively. Mortality rates were also comparable: 50% (n=10) in the EL+RE group and 47% (n=8) in the EL only group. However, the EL+RE group experienced significantly higher rates of 30-day complications (80%, n=16) and hospital re-presentations (40%, n=8) compared to the EL only group.

Conclusion: ABI is associated with a high mortality rate irrespective of whether a revascularisation was performed or not. Revascularisation may save the amount of bowel resected in non necrotic bowel, however these patients had higher rates of representation and post op complications. Further studies are required to analyse other factors that impact on outcomes such as the time to intervention/revascularisation and time to presentation.

Biography

Tamanna Bakshi studied at the Royal College of Surgeons in Ireland and currently is a General Surgical Registrar at the Canberra Hospital in Canberra Australia. She is currently undertaking her masters of surgery and is interested in colorectal and bowel pathologies.



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Outcomes of short-stay laparoscopic cholecystectomy: A study of safety and efficiency at Trat Hospital, Thailand

Background: Laparoscopic Cholecystectomy (LC) is the standard procedure for treating symptomatic gallstones. The development of an outpatient treatment approach and a short stay model could help reduce hospital stay duration and costs while maintaining safety and efficiency comparable to inpatient treatment.

Objectives: To summarize the outcomes of LC in patients with symptomatic gallstones who underwent treatment at Trat Hospital, and to identify factors affecting the success of short-stay laparoscopic cholecystectomy.

Methods: This retrospective study involved a review of medical records of symptomatic gallstone patients who underwent elective LC at Trat Hospital between October 1, 2021, and September 30, 2024. Descriptive statistics, Chi-square, Fisher's exact test, independent t-test, and Logistic regression were used for analysis.

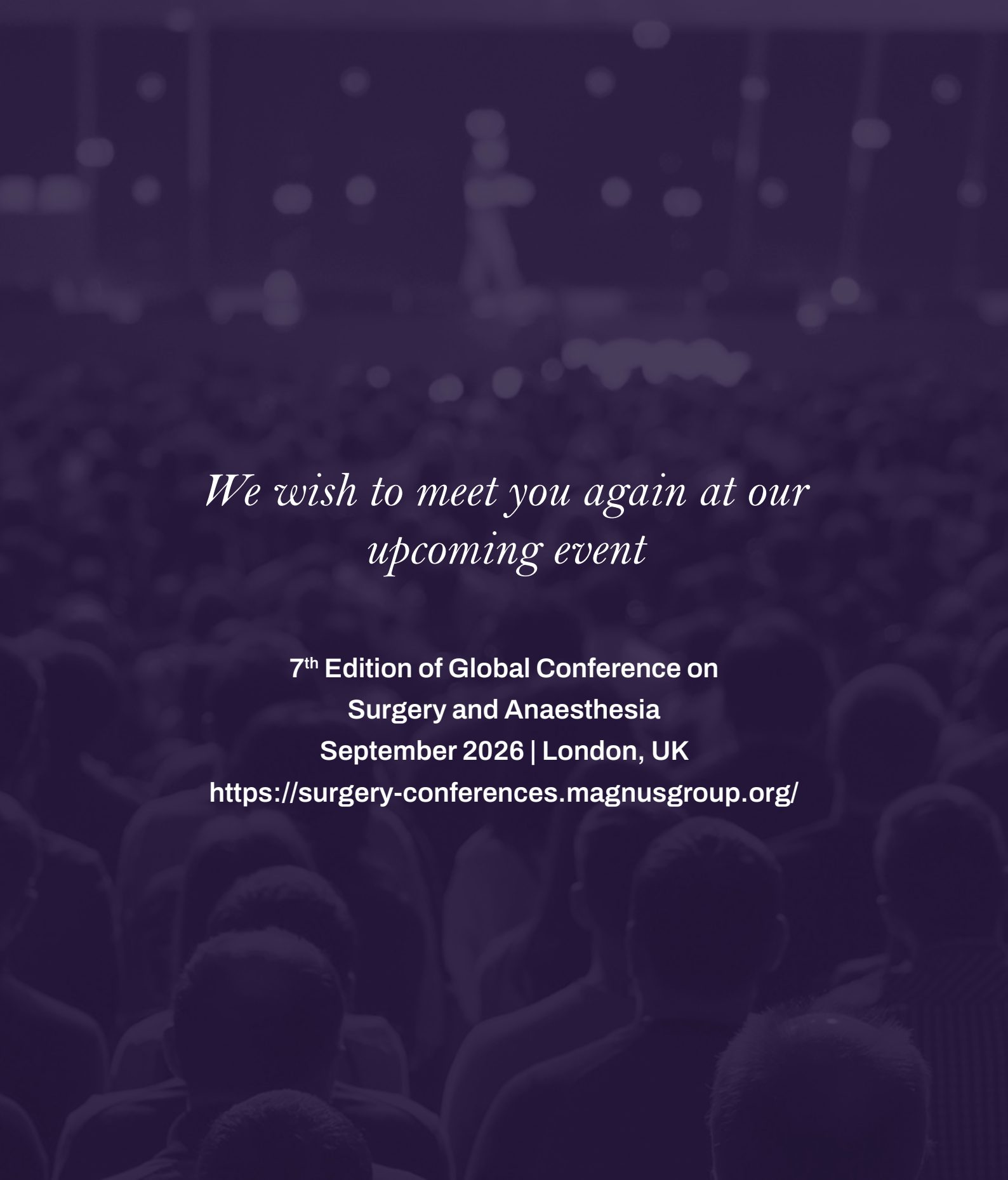
Results: A total of 150 symptomatic gallstone patients who underwent LC were included, with 75 patients in the Short-Stay group and 75 patients in the Inpatient group. Most patients were female (69.3%), with an average age of 51 years. Obesity ($\text{BMI} \geq 25 \text{ kg/m}^2$) was present in 60% of the patients, and the majority had ASA class 2 (80.7%). The most common comorbidities were hypertension (32.7%), dyslipidemia (24%), and diabetes (17.0%). Safety outcomes and surgical complications were similar between the groups, with no readmissions. Efficiency outcomes differed between the two groups, including surgical time (53 minutes vs. 92 minutes; $p < 0.001$), blood loss (9 ml vs. 25 ml; $p < 0.001$), hospital stay duration (1 day vs. 3 days; $p < 0.001$), and treatment costs (15,138 THB vs. 28,451 THB; $p < 0.001$). Logistic regression analysis revealed that for the Short-Stay group, each additional minute of surgery reduced the likelihood of same-day discharge by 6.7% (OR 0.933; 95% CI, 0.878-0.992; $p = 0.027$). Surgery performed after 3:00 PM significantly reduced the chances of same-day discharge (OR 0.001; 95% CI, 0.000-0.031; $p < 0.001$). A history of ERCP was associated with a reduced chance of same-day discharge, though this was not statistically significant ($p = 0.426$).

Conclusions: Short-stay laparoscopic cholecystectomy is as safe as inpatient surgery, reduces hospital stay, and lowers hospital costs. Factors affecting successful recovery and same-day discharge include shorter surgical time and performing surgery before 3:00 PM.

Keywords: Symptomatic Gallstone, Laparoscopic Cholecystectomy, Treatment Outcomes, Short-Stay Laparoscopic Cholecystectomy, Inpatient Laparoscopic Cholecystectomy

Biography

Dr. Thawatchai Trimitwittayakull earned his Doctor of Medicine degree from Chulalongkorn University in 2013 and began his medical career at Trat Hospital, developing clinical skills and experience in patient care. To enhance his expertise, Dr. Thawatchai Trimitwittayakull pursued general surgery training at King Prajadhipok Memorial Hospital, earning Board Certification in Surgery from the Royal College of Surgeons of Thailand in 2020. At Trat Hospital, he has contributed to improving laparoscopic surgery systems and advancing minimally invasive techniques, focusing on patient outcomes and efficiency. Currently, as Chair of the One-Day Surgery and Minimal Invasive Surgery Committee, he is dedicated to implementing innovative techniques and collaborating with multidisciplinary teams to deliver high-quality, patient-centered care.



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