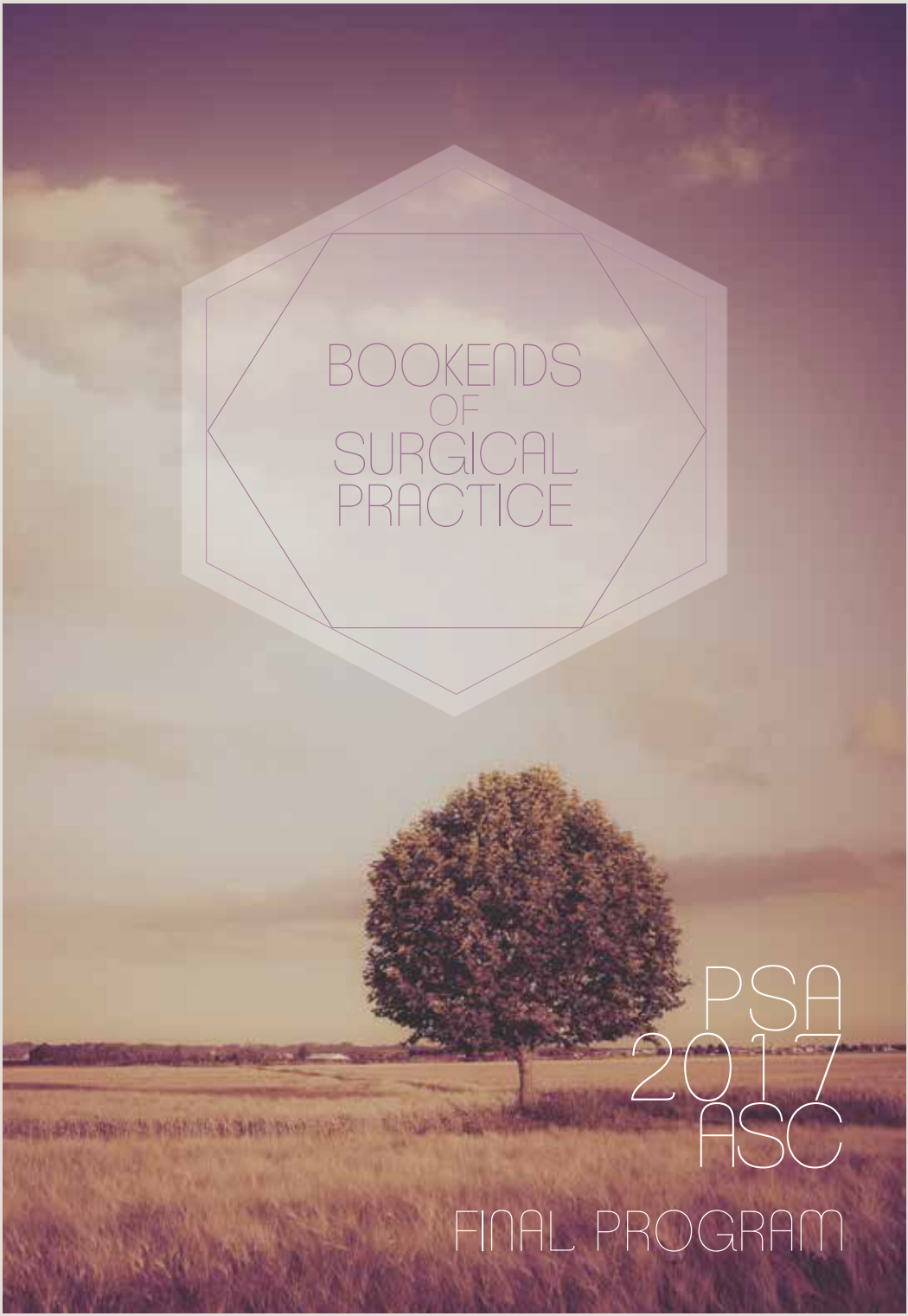

BOOKENDS
OF
SURGICAL
PRACTICE
PSA
2017
ASC
FINAL PROGRAM

PROVINCIAL SURGEONS OF AUSTRALIA 2017 ANNUAL SCIENTIFIC CONFERENCE

BOOKENDS OF SURGICAL PRACTICE

19-21 OCTOBER, 2017
ARMIDALE, NSW

ORGANISING COMMITTEE

SCIENTIFIC CONVENOR
ASSOC PROF GRAHAM STEWART FRACS

PSA PRESIDENT & TREASURER
DR TOM BOWLES FRACS

PSA SECRETARY
MR JACK MONK FRACS

PSA 2017 ASC

ARMIDALE

DEAR COLLEAGUES,

On behalf of the Provincial Surgeons of Australia, it is with pleasure that we welcome you to the *53rd PSA 2017 Annual Scientific Conference - Bookends of Surgical Practice*, being held at the Michael Hoskins Creative Arts Centre, Armidale, NSW, from Thursday 19 - Saturday 21 October, 2017.

We are pleased to present to you a scientific program that highlights important areas of Rural Surgery, as well as some key topics on Rural Surgery in Papua New Guinea from our Pacific Colleagues. Presenting the program over three days is a cohort of national and international experts including Dr Noah Tapaua - General & Cardiothoracic Surgeon from Port Moresby - we are extremely thankful for their contributions.

We are thrilled to welcome you to the beautiful New England region - an area of natural beauty, arts and culture, and we look forward to you experiencing a handful of carefully selected social events and activities across the three days. Kicking the PSA ASC off is the Welcome Reception at the beautiful Petersons, followed by the PSA Spit Roast at the historical Booloominbah House, and then finishing off with the Gala Dinner in the Jackson Woolshed which is part of Saumarez Homestead. For partners and friends, we hope you will enjoy the Associates Program which includes a number of fun and interesting activities.

Thank you for coming to Armidale; we hope you enjoy your time here.

Yours sincerely,

Assoc Prof Graham Stewart, FRACS
Scientific Convenor

We would like to acknowledge and pay respect to the traditional owners of the land on which we will meet — the Anaiwan Tribe. It is upon their ancestral lands that we come together.

JIM PRYOR BEGONIA PRIZE

Jim Pryor was a distinguished General Surgeon in the City of Ballarat from 1963 to 2002.

Jim attended the inaugural PSA ASC in Shepparton in 1965. He became the prime mover in structuring the PSA and insisted on high standards for papers and the conduct of meetings.

An eminent knowledge of surgery together with his enthusiasm and abundance of humour was a golden strand running through all meetings he attended (and as I recall, he did not miss one).

Jim was the first Foundation Fellow in Rural Surgery at the RACS ASC in Canberra in 1992. His interest and expertise in medical work led to his appointment as the Inaugural Chairman of the Medico-Legal Section of the RACS in 1998.

The Jim Pryor Begonia Prize, as a part of PSA Annual Scientific Conferences, is a fitting memorial to Jim's contributions to country surgery.

Jim Pryor conceived the Begonia Prize session of the PSA Annual Meeting to enable surgeons to exchange views about procedures large or small, instruments they had found useful or techniques which they found worked. The presentations had to be brief and Jim instructed the Judge (usually an invited visiting Lecturer) to award extra points for originality.

Country Surgeons adopting these new ideas in their day to day practice found them extremely useful and worthwhile.

No other forum at any other Surgical Meeting compares with this format and it epitomises the true spirit of PSA meetings (no bullshit!).

PETER MACNEIL, FRACS, 2005

PSA 2017 ASC

ARMIDALE

HISTORICAL LISTING

YEAR	DESTINATION	PRESIDENT
1965	Shepparton	WG Ferguson
1966	Albury	R W A Bottoms
1967	Canberra	R W A Bottoms
1968	Ballarat	G Heap
1969	Wagga Wagga	J Pryor
1970	Warrnambool	P Macneil
1971	Griffith	A Cole
1972	Mt Gambier	J Binks
1973	Shepparton	E Shaw
1974	Dubbo	P King
1975	Dandenong	J Beith
1976	Whyalla	G Trigg
1977	Wollongong	G Markey
1978	Portland	H Chesterfield-Evans
1979	Bega	W Davey
1980	Naracoorte	J Smith
1981	Traralgon	J McKee
1982	Canberra	F Keiller
1983	Horsham	E Fleming
1984	Mt Gambier	E Brownstein
1985	Singleton	M Landy
1986	Sale	N Miles
1987	Tamworth	H Huygens
1988	Hamilton	J Fisher
1989	Cairns *Silver Jubilee*	B Aarons
1990	Berri	R Arnot
1991	Murwillumbah	J Nettleford
1992	Alice Springs	G Fowkes
1993	Mildura	C Butcher
1994	Geraldton	N Fox
1995	Moe	D Dring
1996	Port Lincoln	D Birks
1997	Ballina	J Fletcher
1998	Kingaroy	J Graham
1999	Wangaratta	P Benjamin
2000	Bunbury	R Fraser
2001	Orange	D Adamthwaite
2002	Hamilton Island	S Porges
2003	Devonport	C Fitzgerald
2004	Coffs Harbour	F Konetschnik
2005	Shepparton	A Warrier
2006	Kalgoorlie	I Gunn
2007	Whyalla	M McGushin
2008	Wagga Wagga	M Damp
2009	Alice Springs	B Kirkby
2010	Broome	J Jacob
2011	Bendigo	A Thompson
2012	Mt Gambier	M Oliver
2013	Queenstown	W Wichmann
2014	Darwin	G Cooper
2015	Lismore	M Thomas, S Weidlich
2016	Albany	S Butchers
2017	Armidale	T Bowles

SNAP SHOT

WEDNESDAY 18 OCTOBER

- Workshop | Foundation Skills for Surgical Educators
- Welcome Reception - Petersons Winery & Guesthouse

THURSDAY 19 OCTOBER

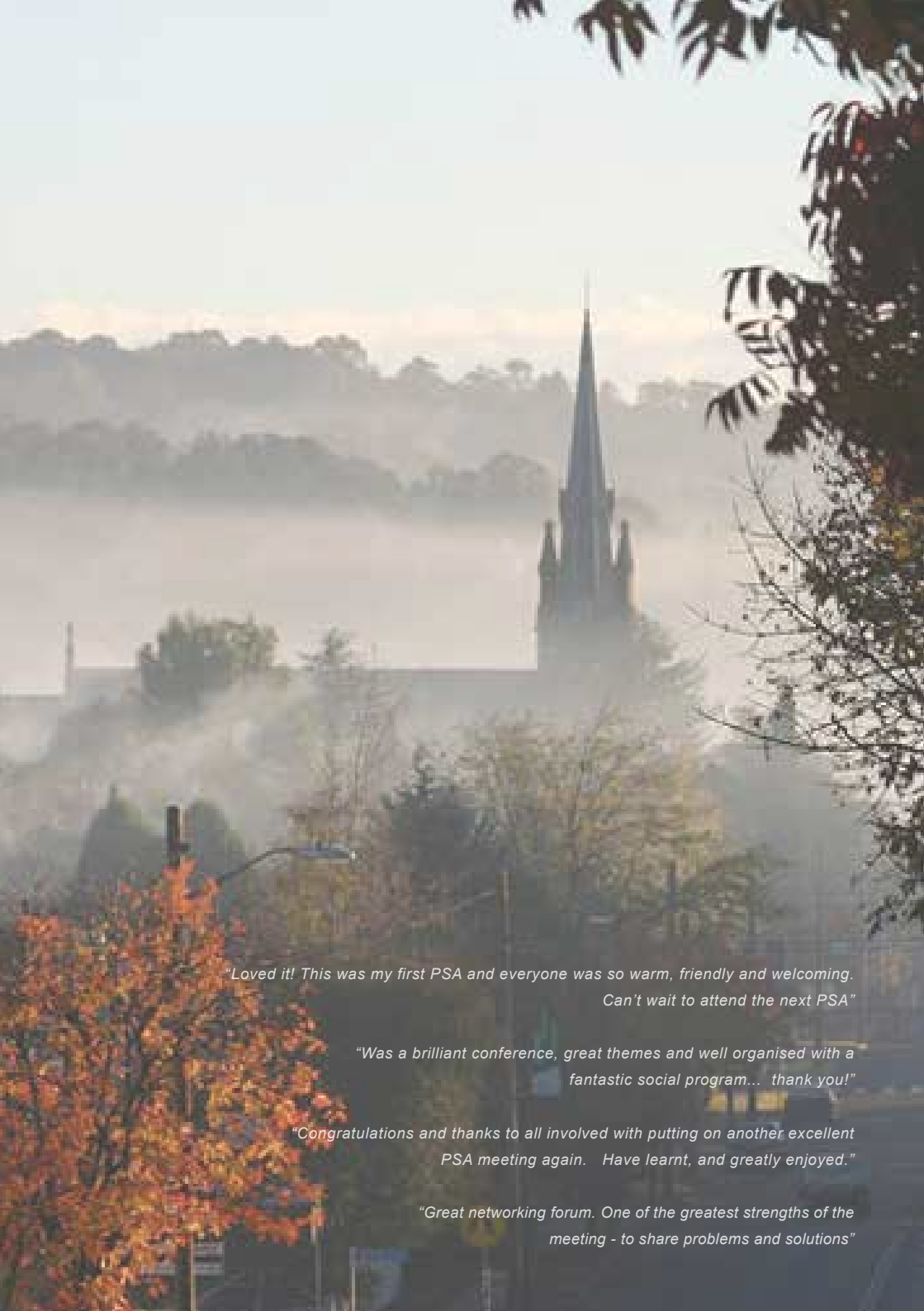
- Scientific Program Day 1 - Full Day
- Laparoscopic Skills Simulation Sessions - Lunch Break Only
- Associate's Program Day 1 - Saumarez Homestead
- PSA Spit Roast - Booloominbah House

FRIDAY 20 OCTOBER

- Scientific Program Day 2 - Full Day
- Breakfast Session - Private Practice: Maximising Your Earnings
- Laparoscopic Skills Simulation Sessions - Lunch Break Only
- Associate's Program Day 2 - Textiles Art Class
- Gala Dinner - Jackson Centre Woolshed at Saumarez Homestead

SATURDAY 21 OCTOBER

- Scientific Program Day 3 - Half Day
- Associate's Program Day 2 - Walcha/Quilt Show
- PSA Picnic - Petersons Winery & Guesthouse



"Loved it! This was my first PSA and everyone was so warm, friendly and welcoming. Can't wait to attend the next PSA"

"Was a brilliant conference, great themes and well organised with a fantastic social program... thank you!"

"Congratulations and thanks to all involved with putting on another excellent PSA meeting again. Have learnt, and greatly enjoyed."

"Great networking forum. One of the greatest strengths of the meeting - to share problems and solutions"

PARTICIPATING EXHIBITORS

ONE
- APPLIED MEDICAL

TWO
- AVANT MUTUAL

THREE
- BONGIORNO NATIONAL NETWORK

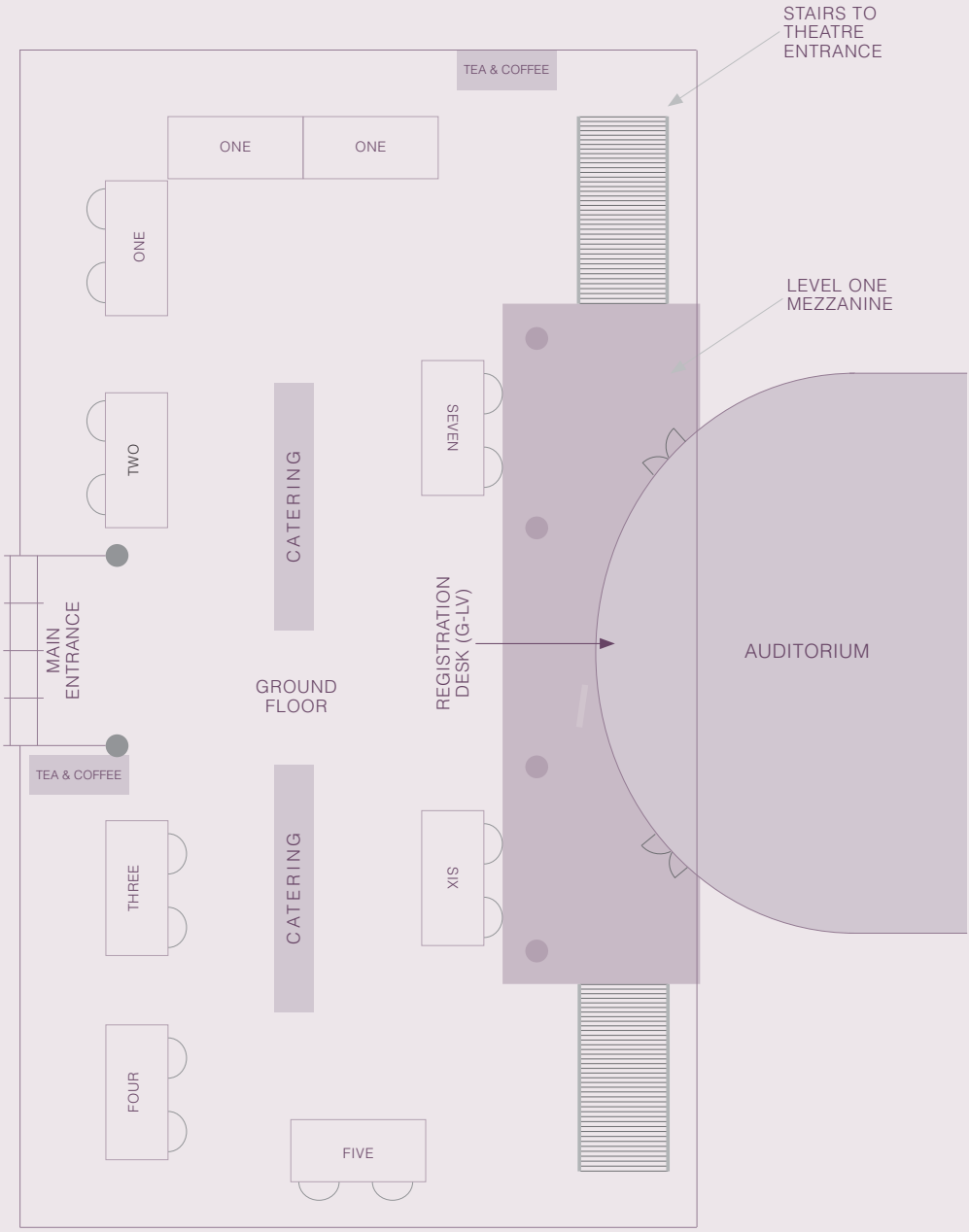
FOUR
- RACS

FIVE
- RYMED

SIX
- ASPEN MEDICAL

SEVEN
- BD

EXHIBITION FLOOR PLAN



PLEASE NOTE FLOOR PLAN IS NOT TO SCALE
EXHIBITION FLOOR PLAN IS SUBJECT TO CHANGE WITHOUT NOTICE

WORKSHOPS

MAXIMISING YOUR EARNINGS WHILE IN PRIVATE PRACTICE

KEEP YOUR FINANCES IN LINE, FROM BEGINNING TO END

FRIDAY 20 OCTOBER, 2017
07:00-08:30
TAS Hoskins Centre
$FREE including breakfast

As a hard-working surgeon, the world of finance can sometimes feel like an overwhelming, never-ending stack of decisions, with nothing more than good fortune keeping everything in line. But what happens when things start to domino?

Money management is an undeniably important part of your surgical career. While in private practice, it's vital to remember that the financial decisions you make today will impact how you are rewarded now and into the future.

Regardless of where you are in your surgical career, this wealth management workshop is a not-to-be-missed event.

The Bongiorno National Network will be covering key areas that will help to ensure you're making the right financial decisions to protect yourself in the years to come.

TO REGISTER

Please visit the on site Registration Desk to enquire after places.

bongiornonationalnetwork

vic bongiorno group nsw bongiorno & partners qld wallis sa bartons wa smith coffey

PSA 2017 ASC
ARMIDALE

WORKSHOPS

FOUNDATION SKILLS FOR SURGICAL EDUCATORS

PRESENTED BY THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

WEDNESDAY 18 OCTOBER, 2017
Armidale Bowling Club - Tops Function Room
08:45 - 16:30
$FREE Registration

The Foundation Skills for Surgical Educators - *aimed at Fellows, IMGs and Senior SET Trainees* - is an introductory course to expand knowledge and skills in surgical teaching and education.

The aim of the course is to establish a basic standard expected of RACS surgical educators and will further educate in teaching and learning concepts. Participants will look at how these concepts can be applied into their own teaching context and will have the opportunity to reflect on their own personal strengths and weaknesses as an educator.

With the release of the RACS Action Plan: Building Respect, Improving Patient Safety, the Foundation Skills for Surgical Educators course is now MANDATORY for Surgeons who are involved in the training and assessment of RACS SET Trainees.

The course will cover such topics as:

- Understanding myself as a teacher
- Planning a learning process
- Understanding and supporting learning
- Recognising teaching and learning opportunities
- Feedback
- Assessment

REGISTRATION

Please visit SURGEONS.ORG to register for this course

WORKSHOPS

LAPAROSCOPIC SKILLS SIMULATION SESSIONS

THURSDAY 19 & FRIDAY 20 OCTOBER, 2017
During the lunch breaks only
TAS Hoskins Centre
$FREE

Please note that these sessions will be offered during the 60 minute lunch breaks on the Thursday and Friday, in the exhibition area. You do not need to pre-register - places will be allocated on a first-come, first served manner.

Applied Medical will host Laparoscopic Skills Simulation sessions during the lunchbreaks of the PSA 2017 ASC. Delegates will be invited to attend these sessions on the Thursday and Friday, with Faculty who will mentor them through laparoscopic skills training utilizing the Simsei® laparoscopic training system.

Participants can practice laparoscopic fundamentals, such as intracorporeal suturing, or more advanced procedural simulation with lifelike tissue models for appendicectomy and cholecystectomy training.

ABOUT APPLIED MEDICAL

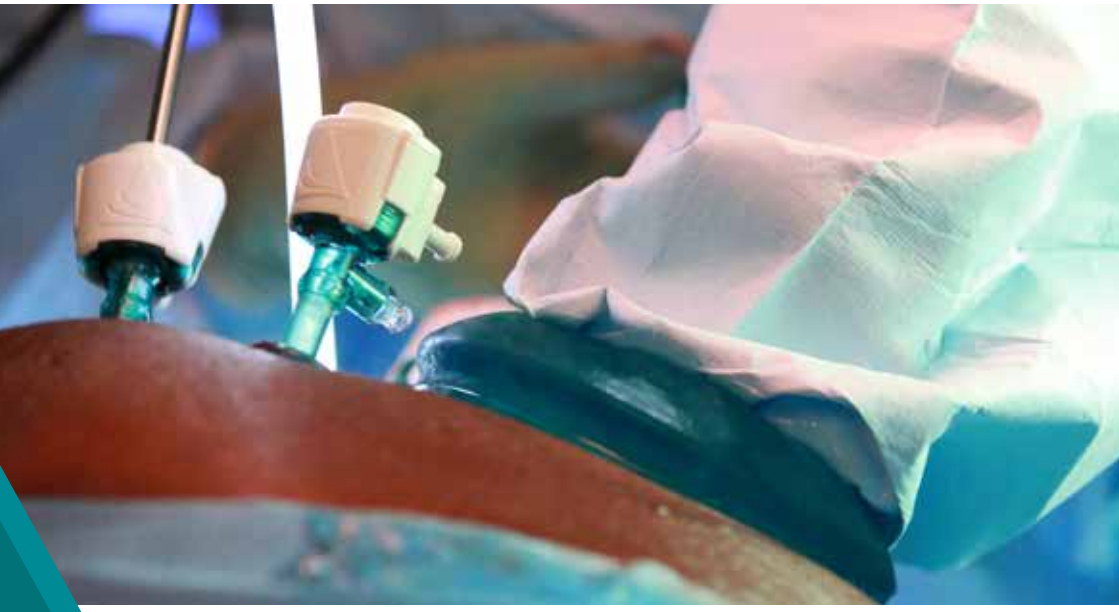
Applied Medical, a new generation medical device company, is committed to advancing surgery by offering breakthrough technologies, clinical solutions and sophisticated training, including GelPort® laparoscopic system. Dedicated to improving hospital and patient outcomes, Applied is committed to being a part of the overall solution to reduce surgical site infection (SSI) through research, education and awareness of the Alexis® O wound protector/retractor.

Applied Medical understands that learning is a lifelong endeavour and is committed to supporting education through training forums including minimally invasive surgery workshops, as well as hands-on Simsei® laparoscopic trainer events to enhance dexterity and technical skills.

For more information on our educational programs please visit WWW.APPLIED MEDICAL.COM or call New Zealand 0800 644 344 / Australia 1800 666 272.

Applied Medical
A New Generation Medical Device Company

GelPort®
Laparoscopic System



UTILITY AND SHORT-TERM OUTCOMES OF HAND-ASSISTED LAPAROSCOPIC COLORECTAL SURGERY: A SINGLE INSTITUTION EXPERIENCE IN 1103 PATIENTS

September 2011 - Diseases of the Colon & Rectum

"Hand-assisted laparoscopic colorectal resection can be performed for numerous indications. It preserves nearly all the benefits of laparoscopic colectomy reported in the literature. With experience, it is associated with significantly reduced operative times. Wider adoption of hand-assisted laparoscopic colorectal surgery would increase the number of patients benefiting from minimal access colorectal surgery."

Cima, Robert R., Pendlimari, R., Holubar, S., et al. Utility and Short-Term Outcomes of Hand-Assisted Laparoscopic Colorectal Surgery: A Single Institution Experience in 1103 Patients. Diseases of the Colon & Rectum. 2011; 54 (9): 1076-1081.

To learn more, please visit us at **www.appliedmedical.com**
or by calling **Australia 1800 666 272** | **New Zealand 0800 644 344**

Applied Medical

SCIENTIFIC CONVENOR

ASSOC PROF GRAHAM STEWART FRACS

CONSULTANT GENERAL AND TRANSPLANT SURGEON

ARMIDALE

Assoc Prof Graham Stewart is a General and Transplant Surgeon based in Armidale.

He provides surgical services as a senior visiting medical officer at the Armidale Hospital, and is Associate Professor of Surgery as well as Medical Director of the Simulation Centre, at the School of Rural Medicine - University of New England.

Graham is affiliated with the Royal Australasian College of Surgeons, and is an Executive Member of the RACS NSW Regional Committee.

PSA 2017 ASC

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INTERNATIONAL GUEST SPEAKER

DR NOAH TAPAUA

CONSULTANT GENERAL AND CARDIOTHORACIC SURGEON

PORT MORESBY GENERAL HOSPITAL, PAPUA NEW GUINEA

Noah Tapaua is a consultant General Surgeon and Cardiothoracic surgeon at the Port Moresby General Hospital, Papua New Guinea. He is also an Honorary Senior Clinical Lecturer at the University of Papua New Guinea Medical School and Surgical Co-ordinator for the Surgical Division at the Port Moresby General Hospital.

He qualified as a General Surgeon in 2003 and worked in two provincial hospitals in PNG before qualifying as a cardiothoracic surgeon in 2010 at the University of Papua New Guinea. He then worked as a Fellow in Cardiothoracic surgery for two years at the Geelong Cardiothoracic unit, Melbourne, Australia and another two years at the Singapore National Heart Centre, Singapore and returned to PNG in 2015.

He is currently a chairman of the PNG Operation Open Heart Foundation and an active member for the organizing committee for the annual international cardiac visits to PNG since 2006. He was awarded the gold medal award in 2006 for the work with the PNG Operation Open Heart Foundation and the Queen's Diamond Jubilee Award in 2012 for services to the community. After returning from the Fellows attachment in Singapore National Heart Centre, he has established a PNG National Pacemaker program and is currently coordinating the full establishment of a local cardiothoracic unit in PNG. His other clinical interests are Minimally Invasive Thoracic Surgery and Upper GIT surgery.

Dr Tapaua is a member for the PNG Medical Board Pre-registration Committee and an active member of the PNG Surgeon's Association, the PNG National Doctor's Association, and the Pacific Island Surgeon's Association.

Proudly Sponsored By:

INTERNATIONAL GUEST CONVENOR

DR KENNEDY JAMES

CONSULTANT GENERAL SURGEON

MILNE BAY PROVINCIAL HEALTH AUTHORITY, MILNE BAY PROVINCE, PNG

Dr Kennedy James is a General Surgeon based at the Alotau Provincial Hospital. During his surgical training at Port Moresby Hospital, Kennedy was awarded the Best Clinical Performance student by the India Association of PNG.

Kennedy has also completed his Masters in Medicine (MMED –GENERAL SURGERY) at the University of Papua New Guinea.

PSA 2017 ASC

ARMIDALE

INTERNATIONAL GUEST SPEAKER

PROF IKAU KEVAU OL

CONSULTANT ORTHOPAEDIC & TRAUMA SURGEON

PORT MORESBY GENERAL HOSPITAL, PAPUA NEW GUINEA

Professor Ikau Kevau was appointed Head of Surgery for School of Medicine & Health Science, University of Papua New Guinea in February 2000 and has remained since. He took over from Professor David Watters who was the former Head & Professor from February 1992 to December 1999. He is an Orthopaedic Surgeon who did his early training in Orthopaedics and Trauma in Milton Keynes for two years in England after attaining his Masters in General Surgery from University of Papua in 1991. In 1997, he moved to Royal Newcastle Hospital and John Hunters Hospital in NSW to undergo further training in Orthopaedics and Trauma with a specific interest in Arthroplasty and Spinal surgery. Returning to PNG from overseas training and experience with all the major skills he acquired in Hip and Knee Arthroplasty surgery, he was greatly handicapped as essential equipments for these modern major undertakings were unavailable in Papua New Guinea.

During the last 17 years as the Academic head, he has led and orchestrated the training of various cadres of surgical trainees to date since the departure of Prof Watters. His collaborative associations with international organizations such as Royal Australasian College of Surgeons, Australian Orthopaedics Association, former mentors and colleagues from his training institutions in England and Australia, has had a major impact and enormous tangible benefits to the quality and competence of PNG surgical trainees of general and subspecialist surgeons that we have to date.

He participated in numerous General surgical and orthopaedics educational forums and workshop locally and abroad. He presented more than 36 papers both in the country and at international conferences. He was past President of Papua New Guinea Surgeons Association (PNGSA) and past Vice-President of Pacific Island Surgeons Association (PISA). He established orthopaedics and trauma unit and services at Port Moresby General Hospital in 1994 soon after his return from England and has been an Orthopaedic Surgeon and trainer for the past 23 years.

NATIONAL GUEST SPEAKER

DR JOHN BARKER MBBS (Syd), MAppSci (Syd), BSc (Hons) (UTS)

CONSULTANT GENERAL SURGEON

ARMIDALE, NSW

Dr John Barker completed medical school at Sydney University where he spent a year in western New South Wales through the Dubbo Clinical School.

He completed his General Surgical training through the Newcastle network, spending time on the Central Coast and throughout the Hunter region. He is currently the Surgical Fellow at Armidale Rural Referral Hospital. He has a teaching role with the University of Newcastle/ University of New England Joint Medical Program. He has been involved with the Army Reserve for over twenty years, and has been deployed to the Middle East.

John has clinical interests in Emergency and Trauma Surgery, and socially is a keen boardgamer.

PSA 2017 ASC

ARMIDALE

NATIONAL GUEST SPEAKER

MR PETER FRANCIS BURKE MBBS FRCS FRACS FACEM DHMSA FAMA

CONSULTANT GENERAL SURGEON

LA TROBE, VIC

Mr Peter Burke graduated from the University of Melbourne in 1969, and, gaining his FRACS, elected to work in the N.H.S. Whilst in England he obtained the FRCS (Eng.) and pursued an interest in medical history, the DHMSA.

On his return to Melbourne and St Vincent's Hospital, in 1979, he accepted the position of Director of Casualty: subsequently he played an active role in the development of the Australasian College for Emergency Medicine.

He then began his active service of the RACS, particularly with the Archives Committee, where he was Secretary for 17 years, the Victorian Road Trauma Committee, the National Road Trauma Committee, and the Library Committee, amongst others. Peter was appointed as spokesperson for the first RACS Younger Fellows Course in 1982. Following participation in the First EMST course held in Australia, he was awarded a RACS Travelling Fellowship to study Trauma Centres in Europe and the USA.

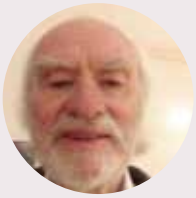
From 1987 he worked as a consultant General Surgeon in Victoria's Latrobe Valley in both public and private practice, always associated with the PSA, being particularly involved in the 1995 Moe Conference.

At the Darwin PSA meeting in 2015 Peter delivered the opening address, "PSA Golden Jubilee' 1965-2014", the definitive history of the first 50 years of the PSA.

Currently, he is the ANZ JSurg. Specialty Editor in Surgical History, writing also for 'Surgical News', and heavily involved in teaching of graduate medical students at the Monash University School of Rural Health.

NATIONAL GUEST SPEAKER

DR PETER HUGHES AO FRACS



CONSULTANT UROLOGIST

CANBERRA, ACT

Peter Hughes was born in Wagga Wagga. He did Medicine at Sydney University, and while there served as Secretary of the National Union of Australian University Students. He did his intern year in Newcastle-on-Hunter, then went to England for six years, where he trained in general surgery and then Urology. Peter and his wife Ellen settled in Canberra in 1962, where he practiced as a Urologist until 2008.

Peter has stood twice for federal parliament, as a Liberal Party candidate, unsuccessfully. He was actively involved in medical industrial action in 1984, 1987 and 1993.

In 2014 he was awarded the Medal of the Order of Australia, for services to Medicine and the community.

PSA 2017 ASC

ARMIDALE

NATIONAL GUEST SPEAKER

MR BRIAN KIRKBY FRACS

CONSULTANT GENERAL SURGEON

LAUNCESTON, TAS

Mr Brian Kirkby was born in Adelaide the eldest of three children, and attended both public and private schools before undertaking my medical degree at the University of Adelaide. He graduated in 1993 following which he relocated to Tasmania to study General Surgery. He became a Fellow of the Royal Australasian College of Surgeons in 2000.

Brian has been a General Surgeon with a vascular interest in a consultant practice for 17 years. During this time he broadened his horizons by gaining an honours law degree - graduating in 2011 and winning the Northern Territory Supreme Court Medal in the same year. Brian is currently the Director of Surgery at the Launceston General Hospital. In addition he holds several senior positions in the RACS including Chair of Tasmanian State Committee, Deputy Chair of Rural Surgical Section and member of the Board in General Surgery.

His interests include competitive motor racing, fishing, Australian Rules football, farming, cattle rearing, grazing and breeding and music - piano in particular. He has been a consultant surgeon with the Royal Australian Army in East Timor, and from 2010 until now, a volunteer for Disaster Relief with AUSMAT.

Brian is married with two children.

NATIONAL GUEST SPEAKER

DR BASAVARAJ MUNDASAD MBBS, MS, MRCSEd, FRCS Gen Surg, FRACS

CONSULTANT GENERAL SURGEON - COLORECTAL

ARMIDALE, NSW

Dr Basavaraj Mundasad graduated with a MBBS from Jawaharlal Nehru Medical College Belgaum, India in 1995. He then completed his post-graduate surgical training from the same institute in 1999 and obtained MRCSEd from The Royal College Of Surgeons Edinburgh, UK in 2001.

Basavaraj completed his higher surgical training in Northern Ireland and Scotland, followed by the exit exam to obtain FRCS General Surgery in 2009. He then worked as a Consultant General and Colorectal Surgeon.

In 2013, Basavaraj moved to Australia and has been providing surgical services to Armidale and the surrounding communities since. He successfully completed his Australian Fellowship in 2015.

PSA 2017 ASC

ARMIDALE

NATIONAL GUEST SPEAKER

PROFESSOR DAVID WATTERS OBE, FRCSEd, FRACS

CONSULTANT GENERAL SURGEON - COLORECTAL & ENDOCRINE

GEELONG, VIC

Prof David Watters is a Past President of RACS (May 2015-May 2016) who since 2000 has been Professor of Surgery for Barwon Health in Geelong, initially with Melbourne (2000-2010), and then Deakin University (2011-). He is a general surgeon with interests in general, colorectal and endocrine surgery. He is actively engaged in advocating for global surgery, having spent almost 20 years in developing countries including Papua New Guinea, Hong Kong, Zambia and South Africa. He is an Edinburgh University graduate, and in addition to the FRACS, a fellow of the Edinburgh, Hong Kong, and East Central and Southern Africa Colleges of Surgeons. His research interests include history of surgery, surgical audit and performance, colorectal outcomes, perioperative mortality and global health. He has over 150 peer reviewed publications and 6 books including Stitches in Time - Two centuries of Surgery in Papua New Guinea (Xlibris, 2012) and the recently published Anzac Surgeons of Gallipoli (RACS 2015). Deakin University appointed an Alfred Deakin Professor (August 2016) In recognition of his contribution to surgery and surgical training in PNG he was awarded the OBE (2012), Rotary's Paul Harris Fellowship (2000) and life membership of the PNG Medical Society (2017). In September 2017 he gave the Guthrie Lecture to the British Society of the History of Medicine on "Daring to Dream of Equal opportunity in Medicine". He has been twice ASC Foundation Visitor in Rural Surgery (1996 and 2004). He first attended the PSA in Mildura in 1993.

NATIONAL GUEST SPEAKER

MR MATTHIAS WICHMANN FRACS

CONSULTANT GENERAL SURGEON

MOUNT GAMBIER, SA

Matthias Wichmann was born in 1968 in Münster (Germany), is married and has three children.

In 1994 he graduated from the University of Würzburg (Germany). Between 1994 and 1996 he worked as a Trauma and Shock Research Fellow at the Michigan State University (East Lansing MI, USA) as well as at the Brown University (Providence RI, USA). Matthias received his surgical training at the University of Munich (LMU) in Germany from 1996 and subsequently worked as a Consultant General Surgeon at the LMU until 2006. Matthias has an academic position with the LMU and is sub-specialized in 'Visceral Surgery'. In 2006 Matthias and his family made the decision to move to Australia to find a better 'work-life-balance'. Since early 2006 Matthias works as a Consultant General Surgeon in Mount Gambier (SA) and was awarded FRACS in May 2007. He has academic appointments with the University of Adelaide as well as Flinders University.

Matthias is Co-Editor of three surgical textbooks (Basic Surgery, Rural Surgery, Palliative Surgery; all published with Springer Publishing). Currently he works on 'Gastroenterology for General Surgeons' to be published in 2018 by Springer. Matthias authored more than 70 peer reviewed original publications and book chapters.

Matthias' current academic interests are: colorectal cancer surgery, outcomes in rural surgery, multidisciplinary cancer care, and emergency surgery. Away from work Matthias spends as much time as possible with his family and in the garden.

PSA 2017 ASC

ARMIDALE

NATIONAL GUEST SPEAKER

PROF CHRISTOPHER YOUNG MBBS, MA, FRACS, FACS

CONSULTANT COLORECTAL SURGEON

SYDNEY, NSW

Professor Christopher Young is a Colorectal Surgeon and Head of the Department of Colorectal Surgery at Royal Prince Alfred Hospital.

He is Executive Director of Surgical Education at the RPA Institute of Academic Surgery, a member of the Australia and New Zealand Training Board in Colon and Rectal Surgery, and Deputy-Chairman RACS ANZ Scholarship and Grant Committee. He is past Chairman of the RACS Board In General Surgery. Christopher's interests include surgical education and decision making. His interests as a colorectal surgeon include the management of colon and rectal cancer, inflammatory bowel disease and pelvic floor dysfunction.

His specialty training to be a colorectal surgeon included fellowships in Sydney, Australia at RPA and Concord Hospitals, at Royal Adelaide Hospital, and at the Cleveland Clinic, Ohio, USA.

Christopher operates at Royal Prince Alfred Hospital and Chris O'Brien Lifehouse.

SCIENTIFIC PROGRAM I DAY ONE -THURSDAY 19 OCTOBER

SURGERY AND POLITICS		
08:30	Welcome to PSA	Tom Bowles
08:40	Official opening	Graham Stewart
09:00	Introduction to Armidale and New England	John Flynn
09:30	Surgery and politics	Peter Hughes
09:55	Sir Earle Page-Rural Surgeon and Prime Minister	Peter Burke
10:20	*Discussion*	*Panel*
10:30 - 11:00	**MORNING TEA WITH INDUSTRY**	
RESEARCH AND INNOVATION/DEVELOPMENT IN RURAL SURGICAL PRACTICE		
11:00	The Mt Gambier experience	Matthias Wichmann
11:20	ERAS principles in a rural setting	David Rowe
11:40	Are we as scientific as we think?	Robin Diebold
11:55	The introduction of laparoscopic colectomy to a regional centre	Basavaraj Mundasad
12:15	Faecal occult blood: Colonoscopy + gastrectomy	Peter Cheng
12:25	Proposal for a Rural Surgical Research Network	Graham Stewart
FREE PAPERS | TRAINEE/IMG - SIX MINUTES + TWO MINUTE Q&A		
12:35	*The Effectiveness of TEMS (Transanal Endoscopic Microsurgery) in a Regional Area*	*Jennifer Chang*
12:43	*The rise & fall of childhood urinary tract stones (CHUTS) in the Top End of Australia*	*Aqiq Tulip Chowdhury*
12:51	*Should BMI determine on whom we operate in rural Victoria?*	*Jessie Cole*
12:59	*Laparoscopic Cholecystectomy: Rural versus Metropolitan Training Opportunities*	*Dane Cole-Clark*
13:10- 14:05	*Trainees Session with Rural Coach*	*Tony Heinz*
13:10 - 14:05	**LUNCH WITH INDUSTRY**	

SCIENTIFIC PROGRAM DAY ONE CONTINUED

SURGERY IN PAPUA NEW GUINEA		
14:05	Surgical training: Where are we heading?	Ikau Kevau
14:20	Cardiothoracic surgery in PNG	Noah Tapaua
14:40	Lower lip cancers in Milne Bay	Kennedy James
15:00	How Papua New Guinea can contribute towards advocacy for surgery within the Global Health agenda	David Watters
15:20	Orthopaedic visit to Rabaul: Bush knives to volcanoes	Robin Diebold
15:40	*Discussion*	*Panel*
15:45 - 16:15	**AFTERNOON TEA WITH INDUSTRY**	
JIM PRYOR BEGONIA PRIZE		
16:15	Jim Pryor Begonia Prize presentations	
17:00 - 17:30	**PSA ANNUAL GENERAL MEETING**	
17:30	DAY ONE PROGRAM CLOSE	
19:00	PSA DINNER	

SCIENTIFIC PROGRAM | DAY TWO - FRIDAY 20 OCTOBER

FREE PAPERS | JDOCS - SIX MINUTES + TWO MINUTE Q&A		
08:30	*Audit of Emergency Subtotal Cholecystectomy*	*Andrew Awad*
08:38	*Identifying premature departure from hospital as a performance indicator of Indigenous healthcare.*	*Joshua Baker*
08:46	*The role of culture and sensitivity in the management of sacrococcygeal pilonidal abscesses*	*Chao Cheng*
08:54	*Management of the acute scrotum in children: a 14-year review.*	*Jeremy Granger*
09:02	*Improving management of oesophageal varices in the Northern Territory*	*Damien Harris*
09:10	*Life or limb: a 10 year vascular trauma study in Alice Springs*	*Mathew Jacob*
09:18	*Bariatric Complications Managed in a Rural Setting*	*Ashley Jenkin*
09:26	*Seeing is believing: Extra-peritoneal wound protectors for improved exposure in open hernia repair*	*Joshua Lawson*
09:34	*Index cholecystectomy in a rural hospital: It can be done.*	*Jay Maloney*
09:42	*Lack of health care for Surgical trainees, a compression study*	*Ali Mohtashami*
09:50	Medical students' perspectives on the benefits and challenges of rural based medical training and prospects for practice and specialisation in rural areas post- graduation	Digby Allen
10:00	Diverticular disease	Christopher Young
10:20	RACS President's Address	John Batten
10:30 - 11:00	**MORNING TEA WITH INDUSTRY**	
CONTROVERSIES IN SURGICAL RURAL PRACTICE 1		
Emergency Vascular Surgical Skills in the Country:		
11:00	• Shunts and other vascular damage control measures	-
11:15	• Why rural surgeons can't get vascular training: Rural view	Brian Kirkby
Blood Products in a Rural Setting:		
11:30	• The problem	David Rowe
11:45	• Blood donor panels	-
12:00	• Frozen blood products	-

SCIENTIFIC PROGRAM DAY TWO CONTINUED

12:15	Peritonectomy and HIPEC: What rural surgeons need to know	David Morris
12:35	How can surgeons use reports on clinical variance to inform their practice?	David Watters
12:55	*Discussion*	
13:00 - 14:00	*Trainees with Keynote Speaker*	*Christopher Young*
13:00 - 14:00	**LUNCH WITH INDUSTRY**	
CONTROVERSIES IN SURGICAL RURAL PRACTICE 2		
14:00	Appendiceal cancer	David Morris
14:15	Disasters in the operating theatre	Christopher Young
14:30	Quality, safety and manpower: Professionalism and cultural change	Brian Kirkby
14:45	Principles for extending scope of practice in rural and regional surgery	David Watters
15:00	An anaesthetist's view of rural manpower issues	David Rowe
15:15	Surgical burnout	John Barker
15:30	Country... City... United or divided?	Christopher Young
15:45 - 16:15	**AFTERNOON TEA WITH INDUSTRY**	
FREE PAPERS | JDOCS/TRAINEE-IMG - SIX MINUTES + TWO MINUTE Q&A		
16:15	*Evaluation of patients presenting with colonic bleed in a regional hospital: Transfer & intervention*	*Duncan Self*
16:23	*Diagnostic performance of the LRINEC score applied to a cluster of necrotizing fasciitis*	*Renishka Sellayah*
16:31	*Predictors of severity in acute diverticulitis*	*Matthew Trinder*
16:39	*Large abdominal hernia repair: a series of component separation and negative pressure therapy*	*Edward Yang*
16:47	*Axillary management in sentinel node positive breast cancer in a metropolitan and regional centre*	*Kimberley Heron*
16:55	*The cost-effectiveness of parathyroid hormone testing post total thyroidectomy*	*Dina Saks*
17:10	DAY TWO PROGRAM CLOSE	
18:30	PSA 2017 ASC GALA DINNER	

SCIENTIFIC PROGRAM | DAY THREE - SATURDAY 21 OCTOBER

SESSION ONE		
09:00	Ablative surgery in the chest and abdomen	David Morris
09:20	Workshop for rural surgical research	Matthias Wichmann
FREE PAPERS | TRAINEE + FELLOWS		
10:15	*A Regional Experience with Umbilical Hernia Repair*	*Scott Whiting*
10:23	*Blast Injuries*	*Samsher Ali*
10:33	*The third way*	*Neil Geddes*
10:43	*Cuban-trained interns: Do they create difficulties for the medical workforce of Vanuatu?*	*John Graham*
10:53	*RACS Morbidity Audit and Logbook Tool (MALT) Peer Review Tools - A Boon for Provincial Surgeons.*	*Mark Stewart*
11:05 - 11:30	**MORNING TEA WITH INDUSTRY**	
SESSION TWO		
11:30	A woman in rural surgical practice: Tailoring to needs and how I do it	Melinda van Oosterum
11:50	A Queensland's flying surgeon	John Kyngdon
12:10	If you are a doctor that can code, you have made it!	Kenneth Gilpin
12:30	KEYNOTE: Surgical life in PNG: What rural surgery can do in PNG - Rural perspective	Noah Tapaua
12:55	*Awards and presentations*	
13:00	**PSA 2017 ASC CLOSE**	
13:15	**PSA PICNIC LUNCH**	

ARMIDALE

1000 metres above sea level,
surrounded by rich history
and stunning natural beauty...
Wilderness, breathtaking views
four distinct seasons...

SOCIAL EVENTS

WELCOME RECEPTION | WEDNESDAY 18 OCTOBER

PETERSONS WINERY & GUESTHOUSE

19:00 - 22:00

Smart Casual Dress

TRANSFERS: Transfers will depart the TAS Hoskins Centre, Armidale at 18:40.

Return transfers will depart Petersons at 22:00

Join us as we welcome the 53rd PSA ASC in casual style at the elegant Petersons Winery and Guesthouse.

The historic homestead, originally named 'Palmerston', was built in 1911 and it has been lovingly restored in line with traditional architecture. Enjoy old-world refinement in the Great Hall, or catch the last of the sunset on the Homestead's front veranda and lawns, all while enjoying first class local produce and wines produced on the estate.

INCLUSIONS

- Canapes
- Beverages
- Transfers

TICKETS

Please visit the on-site registration desk for ticket enquiries

PSA 2017 ASC

ARMIDALE

SOCIAL EVENTS

PSA DINNER | THURSDAY 19 OCTOBER

BOOLOOMINBAH HOUSE
19:00 - 22:00
Smart Casual Dress
TRANSFERS: Transfers will depart the TAS Hoskins Centre, Armidale at 18:40. Return transfers will depart Booloominbah at 22:30

This year enjoy a casual evening at Booloominbah House - a grand country gentleman's homestead designed by Horbury Huntone. Enjoy welcome drinks with friends and colleagues before enjoying a spit roast and buffet on the lawn, designed to showcase the local produce at its best.

October is the perfect time to visit Armidale, where the days are warm and the evenings balmy - ideal weather to enjoy an outdoor evening event.

Please note, should weather be unfavourable, the dinner will be moved to the Brasserie located within Booloominbah House.

INCLUSIONS

- Pre-dinner drinks
- Spit roast + buffet dinner and dessert
- Beverages
- Return transfers

TICKETS

Please visit the on-site registration desk for ticket enquiries

SOCIAL EVENTS

PSA GALA DINNER | FRIDAY 20 OCTOBER

SAUMAREZ HOMESTEAD - THE JACKSON BARN

19:00 - 23:30

Smart Casual Dress

TRANSFERS: Transfers will depart the TAS Hoskins Centre, Armidale at 18:30. Return transfers will depart Saumarez at 23:30

See out the week in rustic, country style at the Saumarez Homestead's Jackson Barn, for the last official social event of the PSA 2017 ASC.

Located in the Homestead, the barn, previously horse stables, will provide you with a unique and quintessentially country space to wine and dine and converse with friends as you celebrate the 53rd PSA ASC. The barn overlooks sheep fields, and will provide some spectacular views as the sun sets.

INCLUSIONS

Pre-dinner drinks
Three-course dinner & beverages
Entertainment
Return transfers

TICKETS

Please visit the on-site registration desk for ticket enquiries

PSA 2017 ASC

ARMIDALE

SOCIAL EVENTS

PSA PICNIC LUNCH | SATURDAY 21 OCTOBER

PETERSONS CELLAR DOOR, ARMIDALE
13:15 - 16:00
Casual Dress
TRANSFERS: Transfers will depart the TAS Hoskins Centre, Armidale at 13:15.
Return transfers will depart Petersons at 22:00

We return to where we began, at Petersons Winery Armidale, this time at the Cellar Door and gardens - the perfect space for a casual picnic lunch and celebration to mark the conclusion of the PSA 2017 ASC.

The Cellar Door, located in the restored horse stables, and the surrounding gardens and lawn is where you will be able to unwind and enjoy Petersons award-winning cool climate wine varieties as well as a gourmet picnic lunch.

INCLUSIONS

- Lunch
- Beverages
- Return Transportation

TICKETS

Please see the on-site registration desk for ticket enquiries

PSA 2018 ASC Bundaberg.

THE YOUNG REGIONAL SURGEON

25-27 OCT 2018

PSA 2017 ASC

ARMIDALE

ASSOCIATES' PROGRAM

SAUMAREZ HOMESTEAD | THURSDAY 19 OCTOBER

SAUMAREZ HOMESTEAD & PICNIC

10:30 - 15:30

TRANSFERS: Transfers will depart the TAS Hoskins Centre, Armidale at 10:15.

Return transfers will depart Saumarez at 15:30

Start your day at Saumarez Homestead on a guided tour of the historic property including award-winning gardens.

The two storey, 30 room Edwardian mansion is the jewel of the New England region. Wander through its rooms and the farm buildings to be transported back to 19th century pastoral life.

Your guided tour will take you through the White family's 30 room Edwardian mansion complete with original furnishings. Stroll through Mary White's garden, with its Doris Jocelyn Brown-style cottage garden, the picking garden, and the heritage rose garden, followed by a picnic lunch on the lawns.

INCLUSIONS

- Saumarez Homestead and gardens guided tour
- Picnic lunch
- Return transfers

TICKETS

Please see the on-site registration desk for ticket enquiries

ASSOCIATES' PROGRAM

TEXTILES ART CLASS | FRIDAY 20 OCTOBER

COLOUR MY WORLD TEXTILES CLASS - *Presented by Jan Clark*
Go Create! New England - Kentucky
08:45 - 16:00
TRANSFERS: Transfers will depart the TAS Hoskins Centre, Armidale at 08:00. Return transfers will depart Kentucky at 16:00

Spend the day with award-winning artist and illustrator Jan Clark at Go Create! New England - a textile and art retreat situated in beautiful pastoral country in the New England Tablelands.

The class will explore conventional and unconventional ways to produce unique fabrics for practical and/or decorative use. You will explore various surface printing techniques including Jan's 'no rules' printing, monoprinting, painting with acrylics, foiling, pencils, crayons and pastels.

INCLUSIONS

- Textiles art class
- Long table lunch
- Return transfers

TICKETS

Please see the on-site registration desk for ticket enquiries

PSA 2017 ASC

ARMIDALE

ASSOCIATES' PROGRAM

WALCHA QUILT EXHIBITION & HIGH TEA | SATURDAY 21 OCTOBER

THE WOOLSHED @ LANGFORD HOUSE, WALCHA

08:30 - 13:00

TRANSFERS: Transfers will depart the TAS Hoskins Centre, Armidale at 08:30. Return transfers will depart Walcha at 12:30

Spend a lovely morning getting to know Walcha during the annual Walcha Mountain Festival.

The day includes a visit to the historic Langford House and the Woolshed, which will house an extensive quilting exhibition, followed by a morning high tea on the Langford House veranda or in the gardens.

Time permitting, take a wander around Walcha and take in some of the other festivities before making your way back to Petersons for the PSA picnic (or drop off in Armidale if required).

INCLUSIONS

- Admission to Langford House
- Admission to the Woolshed and quilting exhibition
- Morning high tea
- Return transfers

TICKETS

Please see the on site registration desk for ticket enquiries

ARMIDALE POST OFFICE

PSA 2017 ASC

ARMIDALE

GENERAL INFORMATION

VENUE

THE THEATRE

The Michael Hoskins Creative Arts Centre
The Armidale School
Barney Street
NEWLING NSW 2350

REGISTRATION DESK

The registration desk, located in the Auditorium Foyer, will operate as follows:

- Wednesday 18 October 1600 - 1800
- Thursday 19 October 0700 - 1800
- Friday 20 October 0730 - 1730
- Saturday 21 October 0830 - 1300

CME ACTIVITY

The PSA 2017 ASC has been approved as an appropriate educational event in the RACS CPD Program. Fellows who participate can claim one point per hour in Maintenance of Knowledge & Skills, to a maximum of 16.5 points.

INTENTION TO PHOTOGRAPH

Please note that photographs will be taken throughout the ASC and may be reproduced for promotion of future PSA ASCs.

DIETARY REQUIREMENTS

Please note that the assigned caterer is responsible for all catering at the ASC and GSA does not inspect or control food preparation areas or attempt to monitor ingredients used throughout the conference. It is advisable that you contact the venue directly for particular dietary requirements that may be of concern. GSA will endeavour to communicate all dietary requirements that we are made aware of no later than 48 hours out from the event. GSA accepts no responsibility in ensuring that the venue acknowledges your dietary requirements or that these requirements can be met. Additionally GSA accepts no responsibility for any failure to adequately provide your special dietary requirements or any consequential damage resulting from such failure.

ABSTRACTS

Abstracts are listed in order of presentation date and time

SURGERY AND POLITICS - *PETER HUGHES*

Surgery, and Medicine as a whole, have always been political, particularly because of cost, and the question of availability to the general populace. This has resulted in doctors often being involved in political action, even extending to industrial action, which has occurred in Australia, Canada and Belgium. In 1949 the profession as a whole campaigned vigorously, and effectively, against the attempt by the Chifley Labor government to restrict the dispensing of free medicines to those prescribed on government prescription forms, which forms could be withdrawn from an individual doctor at any time. The challenge to the Pharmaceutical Benefits Act in the High Court was successful.

Industrial action by doctors was taken in NSW and ACT in 1984 and continued in NSW in 1985, against Labor's amendments to Section 17 of the Health Insurance Act. Industrial action by doctors was also taken in the ACT in 1987 and 1993, over the terms and condition of VMO contracts.

In 1965 Dr Bill Ferguson and Peter Hughes circulated most of the regional surgeons in Victoria and NSW, inviting them to meet in Shepparton. The meeting was held in November, 1965, and the Provincial Surgeons Association started.

In 1965 the Board of Canberra Hospital, the only hospital in Canberra, announced its plans to move to a salaried medical staffing system. Peter Hughes called a meeting of private practitioners, who resolved to encourage someone to build a private hospital in Canberra. Eventually the doctors decided to build a non-profit private hospital themselves, and this was done. The John James Memorial Private Hospital opened in 1970, and gradually expanded to 130 beds.

SIR EARLE PAGE-RURAL SURGEON AND PRIME MINISTER - *PETER BURKE*

In recounting the life of a great man, it is always a relief to work with primary sources. In the case of Sir Earle Page, through his autobiography 'Truant Surgeon', we are provided with a detailed and full account of his life and times.

Page died on December 20, 1961, while his manuscript was being prepared for publication; it was his intention to follow that work with an illustrated account on the possibilities of Australian water development entitled, 'Missed Opportunities- Turning Water into Gold'.

He dedicated his memoirs 'by special permission' to Sir Winston Churchill, K.G., O.M., C.H.
Writing in the Foreword, Lord Beaverbrook, noted his relationship with Page as follows:

"*What a magnificent impression he made on me! Courageous, confident and with a point of view clear-cut and expressed with vigour. He was completely Australian in his approach to the anxious problems of those days (1941-2), and at the same time broadly imperial in outlook".*

"He always reminded me of Abraham Lincoln".

Born at Grafton and named for the town, Earle Christmas Grafton Page had a lifelong affection for the noble Clarence river, noting in his autobiography how the circumstances of his birth "left an indelible impression which not only coloured my whole outlook but guided the course of my political career. Over the years I have always turned to the Clarence for peace and inspiration".

From our perspective today, Sir Earle Page had two basic facets to his life; a political facet and a personal facet.

His political career commenced at the age of 39 in 1919; he helped to found the Australian Parliamentary Country Party and was its leader for 19 years. Though only Prime Minister for nineteen days, he frequently held the power to make or break prime ministers and was closely associated, as ally or opponent, with Hughes, Bruce, Scullin, Lyons, Menzies, and Curtin.

He also worked with Churchill, Beaverbrook, and other wartime leaders when he was Australia's envoy to the British War Cabinet in the early 1940's.

Being essentially apolitical, we will gloss over that aspect of his life and concentrate more on the years prior to his entering political life: his upbringing in the Clarence River district of Grafton, his university days, his adventures as a country doctor and a pioneer in both medicine and motoring, his war service and his activities as a landowner and pastoralist.

THE MOUNT GAMBIER EXPERIENCE - *MATTHIAS WICHMANN*

Mount Gambier is a rural center on the border between South Australia and Victoria and is SA's second biggest town with a population of approximately 35000. Since 2006 surgical services in Mount Gambier have been provided by up to 4 General Surgeons with support from The Queen Elizabeth Hospital in Adelaide.

This presentation will illustrate the benefits of a close working relationship between a large metropolitan hospital and a rural center ("Hub and Spoke"). It will also address the importance of academic surgery for the provision of high level patient care. Examples of this relationship between academic interests and improvement of patient care are the introduction of:

- A prospective Colorectal Cancer Database
- A multidisciplinary Cancer Care Team

The Mount Gambier experience also demonstrates that moving away from metropolitan surgery into the rural environment does not mean a move away from academic interests.
Rural Surgery is a lifestyle choice and the Mount Gambier experience makes it very attractive.

THE INTRODUCTION OF LAPAROSCOPIC COLECTOMY TO A RURAL CENTRE, EXPERIENCES OVER THE FIRST 2 YEARS - *BASAVARAJ MUNDASAD*

BACKGROUND
Laparoscopic hemicolectomies have been shown to have reduced morbidity, analgesia requirements and hospital length of stays, as compared to open procedures. Long-term outcomes have also been validated to show non-inferiority for cancer remission and survival using the laparoscopic approach.
Our hospital is a 64 bed rural referral centre, 4hrs from the tertiary referral hospital, and is laparoscopically capable with a 5 bed high-dependency unit. Thus the introduction of laparoscopic hemicolectomies would provide a better service to our patient population whilst simultaneously reducing burden on our referral hospital.

METHODS
One of the staff surgeons at our centre is a colorectal specialist, with prior experience in laparoscopic hemicolectomies. External auditing, with initial supervision on site by a colorectal surgeon from our referral hospital was used to upskill and accredit the allied health, nursing and medical staff. Patients with BMI ≥35, ASA >3, extensive previous abdominal surgery or surgeon preference were excluded and referred to a larger centre due to limited post-operative support in our hospital. The introduction of laparoscopic hemicolectomies was done in conjunction with an enhanced recovery after surgery (ERAS) protocol that consisted of minimising fasting and catabolic states, minimising opioid use post-operatively and early mobilisation to achieve improved morbidity and length of stay outcomes.

RESULTS
Over the first 24 months, 20 laparoscopic hemicolectomies were performed, 16 for cancer and 4 for benign pathologies. A total of 8 right hemicolectomies, 11 left/sigmoid colectomies and 1 transverse colectomies made up the case mix. Our conversion to open rate was 20%, with all specimens retrieved with clear margins and a median lymph node count of 15, for the cancer cases. Our mean length of stay was 4.5 days (SD 1.7). A single readmission within 30 days of discharge for adhesive small bowel obstruction, that was managed non-operatively, gave a readmission rate of 5%. These are all comparable to current literature, particularly the two largest prospective trials published to date (COST and COLOR).

CONCLUSION
Initial data shows that it is safe and feasible to perform laparoscopic hemicolectomies at a rural hospital. With support from our referral hospital, the introduction of an ERAS protocol and laparoscopic hemicolectomies will improve accessibility, technical quality, cost-effectiveness for our rural patient population whilst reducing social strains for patients, transport costs and service strain to our referral hospital.

THE EFFECTIVENESS OF TEMS (TRANSANAL ENDOSCOPIC MICROSURGERY) IN A REGIONAL AREA - *JENNIFER CHANG*

PURPOSE OF STUDY:
TEMS (Transanal Endoscopic Microsurgery) is a minimally invasive technique used in the management of selected rectal neoplasms. It has become commonplace in specialist units in Australia, but is less accessible to patients in regional areas. This study investigates the effectiveness of TEMS in a regional setting.

METHODS:
A prospective TEMS database was maintained between 2006 and 2015 in a regional area. TEMS was offered as a curative treatment for benign lesions, and as a compromise or palliative treatment for malignant lesions where co-morbidities made this a preferred alternative to major surgery. A retrospective review was performed to determine the outcome of these cases if TEMS was not available, to compare TEMS with standard best practice. Outcome measures included the number of major abdominal operations and stomas avoided, length of hospital stay, complications, recurrence, the number of primary cases with unsuspected malignancy, and further procedures required.

RESULTS:
Of the 136 TEMS cases, 16 patients avoided major surgery for malignancy. The median length of hospital stay was 1 day. Complications included perforation (0.7%), rectal bleeding (7%), urinary retention (3%), and temporary faecal incontinence (2%). There was no associated mortality.

CONCLUSIONS:
TEMS can be safely and effectively introduced to a regional setting. It has beneficial outcomes for patients and should be made available where possible.

THE RISE & FALL OF CHILDHOOD URINARY TRACT STONES (CHUTS) IN THE TOP END OF AUSTRALIA - *AQIQ TULIP CHOWDHURY*

BACKGROUND:
The epidemiology of urinary tract stones occurring in children living in the remote areas of Australia appears to be unique. The predominant urate stone are found in anatomically normal urinary tract in children living in areas away from major settlement. The geographic distribution is likely a proxy for lifestyle and cultural factors rather than macro environment or genetic predispositions. And the incidence seems to be at a decline in our recent experience at RDH.

METHODS:
Identification of paediatric patients using ICD codes from RDH database and then retrospective data collection using paper-based and electronic hospital records of the identified episodes. Data collected were basic demographics, details of presentation, characteristics of stone, management & follow-up.

RESULTS:
Our previous unpublished data from RDH showed 60 children with CHUTS between June 1990 & June 2002. All of whom were of Aboriginal origin with male predominance. The number reduced drastically in subsequent years. Between July 2002 and December 2016 only 16 paediatric patients were found to have urinary tract stones and with 2 exception all were of Aboriginal origin mainly from remote locations.

CONCLUSION:
Our hypothesis that the incidence of CHUTS has significantly decreased in the recent years, have been proven. But now the bigger question is whether lifestyle and nutritional factors seen significant improvement during the same timeframe to explain the decline in what presumed to be a disease related to malnutrition.

SHOULD BMI DETERMINE ON WHOM WE OPERATE IN RURAL VICTORIA? - *JESSIE COLE*

Adults in regional and remote Australia are more likely to be overweight or obese than their city counterparts[1]. There is a perceived risk that bigger patients equal more complications, however new research is challenging this notion[2, 3].

This audit of patients at Colac Area Health, a small hospital in South West Victoria, came about after a draft proposal of a "capability framework" that excluded patients from having elective surgery based on their Body Mass Index (BMI). This proposal was rejected by clinicians, as BMI is not a good measure of surgical and anaesthetic risk and would unnecessarily exclude patients from having routine procedures performed locally. Through this study we aim to show that, in Colac, increased BMI does not significantly increase complication rate or length of stay. We propose that there are more effective means of determining surgical risk based on clinical judgement and by overall assessment of a patient's health and co-morbidities.

1. National Health and Medical Research Council (2013) Clinical practice guidelines for the management of overweight and obesity in adults, adolescents and children in Australia. Melbourne: National Health and Medical Research Council.
2. Ryan, T., Gosal, P., Seal, A., McGirr, J. and Williams, N. (2017), Association of waist circumference with outcomes in an acute general surgical unit. ANZ Journal of Surgery, 87: 453–456. doi:10.1111/ans.13962
3. STARsurg Collaborative. (2016) Multicentre prospective cohort study of body mass index and postoperative complications following gastrointestinal surgery. The British Journal of Surgery, 103(9):1157-72. doi: 10.1002/bjs.10203. Epub 2016 Jun 20.

LAPAROSCOPIC CHOLECYSTECTOMY: RURAL VS METROPOLITAN TRAINING OPPORTUNITIES - *DANE COLE-CLARK*

INTRODUCTION:
Laparoscopic Cholecystectomy is one of the more common 'major' cases frequently conducted by surgical trainees. There are multiple opportunities to undertake intra-operative training for the procedure within a rural and metropolitan settings either as an elective or emergency procedure.

AIM:
To determine differences in intra-operative training opportunities within rural and metropolitan settings for Laparoscopic Cholecystectomy.

METHOD:
Research will obtain data from Registrar GSA Logbooks from the current 5 Surgical Trainees at Lismore Base Hospital and 5 Surgical Trainees at Royal North Shore Hospital for Term 1 2017. Data will be collected on total number of Laparoscopic Cholecystectomy cases conducted, insurance status, level of involvement as per RACS logbook pilot scheme (Primary (>75%), Partial Primary (25-75%), Assistant) and emergency vs elective status. Data will also include differential based upon SET level of training, term allocation and hospital.

RESULTS:
It is anticipated that:
- Similar number of Laparoscopic Cholecystectomies are conducted within both settings
- More senior surgical trainees have a greater involvement in the procedure
- Surgical trainees have a greater involvement within a rural setting and are more likely to assist a consultant directly where less fellows are available

SURGICAL TRAINING; WHERE ARE WE HEADING? - *IKAU KEVAU*

1. The beginning of surgical practices dates back to 1940s while training of national surgeons began only in the mid-1970s in Papua New Guinea. Papua New Guinea did not have any local surgeons until 1979 when the first two national Surgeons qualified after 4 years of training. The surgical services, overwhelmed with varied and interesting surgical pathologies, were all treated by a very few dedicated expatriate surgeons in the country, who were young surgeons learning themselves to do things guided by literature. To date, most provinces now have a surgeon or more rendering surgical services in the provincial hospitals throughout PNG. Surgical Division of University of PNG runs an excellent training program to train its own surgeons to cater for the ever-increasing surgical demand in the country. The population of PNG is now almost 7 million with 850 tribes and different languages, 22 provinces, annual growth rate of 2.8%. The life expectancy is 60.4 male and 68 females. Majority of the population live in the rural areas which constitute 85% of the nation's population.

Historically, we have trained 102 General Surgeons and 20 subspecialists in various specialty areas; 7 Orthopaedic surgeons and 2 trainees, 3 Head, Neck and Plastic surgeons and 1 trainee, 2 Neurosurgeons and 1 trainee, 4 Paediatric Surgeons, 2 Cardiothoracic Surgeons and 2 trainees and 3 Urologists. Our surgical audits are presented weekly and they portray a true reflection of the rising incidences of some of the surgical pathologies eg trauma and emerging surgical diseases.

Training of a surgeon is a very expensive exercise and developing a pathway for a surgeon in his bid to execute and improve his hard-learned skills on patients on a daily basis is vehemently not an easy task. A Surgeon use his head and two hands and needs tools to work with. The challenges we face are enormous as the demands are maximal with the unexpected population increase, uncontrolled urban drift due to the recent mineral and gas boom. Pathologies are interesting and in galore, however incentives are poor, system support is abysmal and abstruse. Equipments and tools which a surgeon needs are not handy and lack a "replacement mechanism or system" in place. At the end of the day, the poor surgeon calls it the day in a state of tedium. From the practice standpoint, decision making is a major challenge in our setting where resources are poor, facilities are not readily available therefore paving a way for improvisation.

Training young surgeons towards 2030 is a difficult undertaking, however, we have succeeded and the future looks bright in terms of providing specialist manpower and service delivery. The support from the RACS in terms of funding, provision of teaching and continued medical education support is well appreciated and we welcome this to continue. Funding from our nation's budget to improve services is the major call to improve our service provision.

THE ROLE OF SURGERY AND ORAL METHOTREXATE TREATMENT (MXT) ON LOWER LIP SQUAMOUS CELL CARCINOMA (SCC) IN MILNE BAY PROVINCE AND NATIONAL CAPITAL DISTRICT, PAPUA NEW GUINEA - *KENNEDY JAMES*

This cohort study was undertaken over 54 months to observe the effectiveness of primary surgery and long term oral MXT treatment on lower lip SCC in Milne Bay Province and National Capital District, Papua New Guinea.

The current standard treatment for lower lip SCC depends on the stage of the disease; stage 1 is treated with either surgery or radiotherapy only, while stages 2 and 3 are treated with surgery followed by chemotherapy and radiotherapy, and stage 4 is metastatic disease and is treated with palliative chemotherapy and radiotherapy (1). Due to limited treatment options available in Papua New Guinea for cancer patients, this study was conducted with the primary aim of finding an alternative, affordable and effective treatment option for lower lip SCC in PNG. There were 20 patients recruited in the study with histologically confirmed SCC of lower lip. They had primary surgeries which involve selective neck dissection (SND) for positive neck 8 (40%), tumour resection and reconstruction 20 (100%), and once the wounds healed well they were commenced on long term oral MXT treatment for a maximum of 24 months. The follow up period was for approximately 54 months and the primary outcomes measured were; local recurrence 0 (0%), neck metastasis 0 (0%), distant metastasis 0 (0%), and mortality 0 (0%). In conclusion, even though acknowledging the small number of subjects recruited, this cohort study does give some hope to health care practitioners including surgeons in PNG that lower lip SCC can be alternatively treated with surgery and MXT when there are no other treatment modalities available in their health facility.

AN AUDIT OF EMERGENCY SUBTOTAL CHOLECYSTECTOMY - *ANDREW AWAD*

PURPOSE
This study examines the value and peri-operative complications of subtotal cholecystectomy (SC) for a difficult operation where the structures of the Calot's triangle are difficult to identify.

METHODOLOGY
The records of all patients presenting to Geelong Hospital requiring emergency cholecystectomy between January 2008 and December 2015 were examined. We examined the incidence of re-admission, perioperative complications and subsequent episodes of pancreatitis or cholecystitis in those who had a SC.

RESULTS
1046 patients who underwent emergency cholecystectomy were included, 40/1046 had a SC. The procedure was completed laparoscopically in 67.5% (27/40), converted to open in 25% (10/40) and performed via an open approach in 7.5% (3/40). Intraoperative cholangiogram was performed in 57.5% (23/40), with three of these unsuccessful. Bile leak occurred in 20% (8/40) and bile duct injury in 2.5% (1/40). Postoperative endoscopic retrograde cholangiopancreatography was required in 10% (4/40). 15% (6/40) were readmitted for treatment of biliary pathology. There were no cases of pancreatitis, recurrent cholecystitis or deaths in the patients examined. A recent meta-analysis showed comparable data; laparoscopic accounting for 72.9%, bile duct injury (0.08%) and readmissions (1.8%)1.

CONCLUSION
The results of our study suggests that SC is adequate for control of gallstone disease when cholecystectomy is difficult. We found a low incidence of re-admissions and post-operative biliary complications. Further evidence should be gathered on how these results compare to complete cholecystectomy at our institution.

IDENTIFYING RATES OF PREMATURE DEPARTURE FROM HOSPITAL AS A PERFORMANCE INDICATOR OF GOOD INDIGENOUS HEALTHCARE AND ENGAGEMENT. - *JOSHUA BAKER*

The population northern Top End of Australia is unique, it is diverse and many Indigenous patients come from remote and isolated communities and the traditional model of hospital based healthcare is unfamiliar and daunting to many. Frequently Indigenous patients and medical professionals caring for them face communication and cultural barriers on a daily basis. It has been anecdotally observed that there is a disproportionately higher rate of Aboriginal patients who leave hospital prior to being deemed ready for discharge often for unknown reasons, this is known throughout the Top End Medical Service as having ‘Taking [ones] Own Leave’ (TOL).

PURPOSE:
To determine the rates of Indigenous patients who take their own leave in comparison to the non-Indigenous population and explore whether this rate may be a useful measurement as a quality and performance indicator of good Indigenous healthcare and the level of engagement with medical professionals.

METHODOLOGY:
A retrospective audit was performed of Surgical Acute Care Unit admissions during a one-year period and a comparison was made between Aboriginal and non-Aboriginal patients regarding rates of patients taking their own leave during the length of their admission.

RESULTS:
Our results demonstrate that there significantly higher rates of TOL in Indigenous patients, identifying Indigenous males aged 40-44 as being at the highest risk. In some cases 3 or 4 times the rate of TOL in some months that were observed.

CONCLUSION:
Due to various cultural factors this observed difference in TOL rate may never reach zero however it should be the aim of the Top End Medical Service to aim to minimise this difference as much possible through the institution of purpose designed measures. One such This rate may be used in the future as a tool to measure effectiveness of interventions intended to improve patient compliance, retention and engagement in healthcare settings.

THE ROLE OF CULTURE AND SENSITIVITY IN THE MANAGEMENT OF SACROCOCCYGEAL PILONIDAL ABSCESSES - *CHAO CHENG*

PURPOSE
Current practice for patients who present to hospitals with acute sacrococcygeal pilonidal abscess is operative management. Wound swabs are routinely taken in the peri-operatively and antibiotics are initiated empirically pending culture and sensitivity results. Our aim of the study is to evaluate whether the results of wound swabs change post-operative antibiotic therapy for these patients, and to identify the common microorganisms.

METHODOLOGY
This is a retrospective study which includes patients presented to the Northern Hospital, Victoria with acute sacrococcygeal pilonidal abscess from 1st January 2013 to 30th June 2016. Data was collected using hospital electronic medical records. Patients who had wound swabs taken were identified and their post-operative management analysed.

RESULTS
There were 297 presentations identified within the study period. Two hundreds and twenty-four cases (224 out of 297, 75.4%) had wound swab taken, out of which 130 (130/297, 43.8%) cases were followed up in outpatient clinic and one case (1/130, 0.8%) had a subsequent change in antibiotics based on the wound swab result. Common microorganisms grown were mixed anaerobes (127/224, 56.7%) and skin flora (41/224, 18.3%). There were 6 representations within 6 weeks period post-discharge, five of which had wound swab taken during their initial presentation and none grew multi-drug resistant microorganisms.

CONCLUSION
Majority of the patients who presented for treatment of acute sacrococcygeal pilonidal abscess had wound swabs taken peri-operatively. Results of wound swabs did not change post-operative management and particularly antibiotic therapy in nearly all of our study population. The most common microorganisms cultured was mixed anaerobes.

MANAGEMENT OF THE ACUTE SCROTUM IN CHILDREN: A 14 YEAR REVIEW
- *JEREMY GRANGER*

INTRODUCTION
The acute scrotum represents a surgical emergency and timely clinical assessment with the appropriate management is paramount to ensure the safety of the testicle.

AIM
The primary aim of our retrospective study was to determine if our findings corresponded with the current literature in terms of pathology causing acute scrotal pain. Secondary outcome measures included 1) the effectiveness of the various surgical approaches. 2) The number of patients who underwent diagnostic imaging prior to surgery.

MATERIALS AND METHODS
We retrospectively reviewed all clinical data of emergency scrotal exploration performed for acute scrotal pain at single tertiary children's hospital over a 14-year period.

RESULTS
1156 cases of scrotal exploration were considered. The most common cause of acute scrotum was torsion of a testicular appendage (45%). Other causes included spermatic cord torsion (20%), "no identifiable pathology" (23%), and "other pathology" (12%). A bimodal peak in incidence of spermatic cord torsion was observed in patients under the age of 1 and over the age of 12.
Jaboulay procedure was used as the method of orchidopexy in 42% of cases with the remainder being some variation of fixation suture to the tunica albuginea.

CONCLUSION
The causative pathologies for the acute scrotum in our institution are in keeping with those found in the current literature. Imaging is rarely helpful in the acute setting. While there is disagreement on which orchidopexy procedure is superior in preventing subsequent spermatic cord torsion, Jaboulay fixation is just as effective when compared to other methods of orchidopexy.

IMPROVING MANAGEMENT OF OESOPHAGEAL VARICES IN CHRONIC LIVER DISEASE PATIENTS IN THE NORTHERN TERRITORY - *DAMIEN HARRIS*

BACKGROUND:
Spontaneous haemorrhage from oesophageal varices is a common (12% per year) complication of liver cirrhosis that can be highly lethal with a six week mortality of 15-35%.
To help reduce the risk of variceal bleeding, screening endoscopy upon diagnosis of liver cirrhosis is recommended with serial surveillance endoscopy thereafter. In the Top End, the management of oesophageal varices faces a number of social, physical and cultural barriers.

METHOD:
A retrospective analysis was conducted on patients that had Endoscopic Band Ligation (EBL) during an emergency admission between 2010 and 2015. For each patient a review of surveillance endoscopies, mortality, missed opportunities to screen for varices, compliance of follow-up and acute presentations requiring banding was also determined.

RESULTS:
81 patients and 128 acute admissions requiring EBL were reviewed. 39 persons (48%) died within the study period. Thirty three percent of patients were not known to have cirrhosis on first presentation and in this group 2/3 had at least one emergency department presentation in the preceding year. Only 30% had repeat surveillance scope within 6 weeks and 25% represented again with acute bleed requiring EBL. Median follow up was 3.8 years.

CONCLUSION:
One of the greatest challenges to managing many of these patients relates to compliance with follow up. Thus, it may be appropriate in some patients, to implement strategies where screening and surveillance is conducted opportunistically on presentation to the Emergency Department.

LIFE AND LIMB: A 10-YEAR VASCULAR TRAUMA STUDY IN ALICE SPRINGS - *MATHEW JACOB*

At one point of time Alice springs held the title of 'Stab capital of the world' and to this day Vascular injuries poses significant challenges in Alice Springs. This is a retrospective study of 294 vascular injuries over a period of 2007-2017, which analyses the mechanism, presentations, surgical approaches, and outcomes of vascular trauma in Alice Springs.

Unfortunately our study shows an overrepresentation of indigenous people in this study with 216 cases (73.5%). Stab injuries and contact with glass and sharp objects account for the majority of cases at 144 (48.5%). Alcohol related violence still accounts for a large portion of presentations with 82 patients intoxicated at the time of admission. Upper limb vessels were injured in 161 (54.7%) followed by lower limb vessels at 85 presentations. There were 46 radial, 32 ulnar,13 brachial, 14 femoral and 13 popliteal artery injuries. Repair methods included, direct anastomosis, patch angioplasty, end to end anastomosis and bypass graft with vein or prosthetic grafts. Fasciotomy was also conducted in established cases of ischemia. In most extremity vascular injuries pre-operative angiogram was not necessary. 237 patients were discharged home, 39 patients took own leave, there were 7 deaths and 27 cases where RFDS was used to transfer patients for further management at a tertiary center.

Successful treatment of vascular injuries is life and limb saving in the outback; training in the management of vascular trauma surgery for general surgical trainees is vital to optimize the care of patients in remote and rural Australia.

BARIATRIC COMPLICATIONS MANAGED IN A RURAL SETTING - *ASHLEY JENKIN*

PURPOSE
Medical tourism is frequently seen in regional settings in Australia, and presents a unique issue in patient management. While bariatric surgery has been touted to have very low complication rates, it is possible that this distinct subset of patients has been underestimated in previous reviews.

METHODOLOGY
A qualitative retrospective review of adult patients admitted to the General Surgical Unit at Mackay Base Hospital with complications of previous bariatric surgery performed elsewhere.

RESULTS
17 patients, predominantly women, were admitted with short and long-term complications following bariatric procedures to Mackay Base Hospital from January 2016 to June 2017. Eight patients were seen following gastric banding, seven following gastric sleeve, one after gastric bypass, and one with both gastric band and sleeve gastrectomy. Presentations to our facility ranged from six days to 15 years post-operatively. Delayed complications were more common in the setting of a gastric band. Early complications, such as leak and vomiting, were more likely following sleeve gastrectomy. The most common presenting complaints were pain and vomiting (8/15). Eight patients required operative management. Six patients underwent gastric band removal, and two patients required washout and transfer to tertiary centres.

CONCLUSION
Bariatric surgical complications may be under-represented due to medical tourism from regional areas- an interesting dilemma for the rural General Surgeon. Training, resources, and dedicated referral pathways should be developed to assist in the care of these patients in regional settings.

SEEING IS BELIEVING: EXTRA-PERITONEAL WOUND PROTECTORS FOR IMPROVED EXPOSURE IN OPEN HERNIA REPAIR - *JOSHUA LAWSON*

Achieving adequate surgical exposure is a fundamental principle of good surgical practice. Traditionally in the extra- peritoneal repair of ventral and open inguinal hernias this has been accomplished with the aid of self-retaining retractors or by extending the incision length. We propose that through the use of disposable wound protectors, surgical exposure may be improved for a given incision length in the extra-peritoneal repair of ventral and open inguinal hernias, compared to traditional methods. Using an animal tissue model, we compared the surgical exposure achieved with disposable wound protectors (Alexistm) versus surgical exposure achieved with a Mollison self – retainer.

Our results demonstrate that the use of disposable wound protectors provide superior surgical exposure for a given incision length ($p<0.0001$) compared to traditional techniques in extra-peritoneal open hernia repair. Use of wound protectors reduced the depth to the operative site by an average of 12.5 – 15%. In addition disposable wound protectors may provide added benefit with a reduction in post-operative wound and mesh infections.

INDEX CHOLECYSTECTOMY IN A RURAL HOSPITAL: IT CAN BE DONE. - *JAY MALONEY*

INTRODUCTION:
Index cholecystectomy (IC) refers to an operation during a patient's first hospital admission with symptomatic gallstone (GS) disease. There are proven reductions in GS related complications while awaiting elective surgery 1, 2. Despite this, IC has not been universally adopted, particularly in smaller centres where logistics can present a barrier.

AIMS:
We aim to describe the introduction of routine IC at Hastings Hospital and examine the effects in terms of waiting time until surgery; GS-related re-presentations; complications while awaiting surgery; operative complications and overall hospital stay.

METHODS:
Data was collected on all patients who underwent cholecystectomy in the year following the introduction of IC (2015/2016). The results were compared to identical data from the year 2009/2010.

RESULTS:
A total of 259 cholecystectomies were performed over the 2015/2016 study period compared with 186 in the 2009/2010 study period. The IC rate rose from 9.89% in 2009 to 75.4% in 2015 ($p<0.001$). For patients who did not receive index cholecystectomy, there were an additional 64 Emergency Department (ED) presentations and 37 admissions in 2009, compared with 45 ED presentations and 14 admissions in 2015. The incidence of gallstone pancreatitis whilst waiting for surgery, fell in 2015 compared to 2009 from six cases to one ($p=0.046$). The operative complications were similar in both groups. Total hospital stay was also similar.

CONCLUSION:
Our study shows that it is possible to perform IC in a rural setting reducing complications of waiting and in particular, rates of GS-related pancreatitis were significantly reduced. It can be done safely with an accommodating acute on-call system.

HEALTH CARE NEGLECT AMONGST HEALTH CARE PROFESSIONALS, A COMPARISON STUDY AMONG IN A REGIONAL HOSPITAL - *ALI MOHTASHAMI*

BACKGROUND
Health care professionals (HCP) are often meticulous in caring for their patients however many admit to neglecting their own health. Recent suicides of HCP have highlighted this concern and indicated a culture of circumventing appropriate medical services. Whilst HCP may have access to support and appropriate care it is unclear whether these are being appropriately utilised. The aim of the study is to determine the extent of health self-neglect amongst HCP, barriers to seeking medical services and potential improvements.

METHOD
An online survey was distributed to cross section of HCP including junior and senior doctors, medical

students and allied health professionals at a regional hospital in NSW. A series of questions were asked regarding health care status. Comparisons were made between types of health professional.

RESULTS
58% of respondents felt they had recently neglected their health. 53.85% of doctors were unable to visit their GP when needed, 69% had self-diagnosed and 23 % presented to ED instead. 61.54% reported that they were asked by other colleagues to prescribe them medications.

CONCLUSIONS
Many HCP do not present to their GP on time. There are often difficulties in accessing quality health care such as scheduling issues, lack of appointments and concerns about confidentiality of health care information. HCP often ignore their own health issues; recognising this problem and discussing it openly would be the first step to improving health advocacy.

BURNOUT IN AUSTRALIAN SURGEONS AND TRAINEES - *JOHN BARKER*

This talk will provide an overview of burnout amongst surgeons, with specific reference to Australian surgeons and trainees. Burnout is a state of exhaustion characterised by depersonalisation. It is recognised in surgeons and can have negative effects on individuals, patients, and organisations. This study used an anonymous, cross-sectional survey to assess Australian surgeons and trainees. The Maslach Burnout Inventory (MBI) score was used to categorise respondents' risks for emotional exhaustion, depersonalisation, and a lack of personal accomplishment. Averaged scores were compared across demographic groups to identify factors associated with burnout. Gender, age, role and a variety of workplace factors were assessed variables.

RESULTS
215 valid survey responses were received. 55% of respondents were at high risk of emotional exhaustion. 33% of respondents were at high risk of depersonalisation. 99% of respondents were in the low risk category for a lack of personal accomplishment. Female respondents were at higher risk of emotional exhaustion than male respondents ($p=0.0004$). Respondents aged under 50 were at higher risk of emotional exhaustion and depersonalisation than older respondents ($p<0.0001$). Fellows were at lower risk of emotional exhaustion and depersonalisation than trainees ($p<0.0001$), and senior fellows (>10 years since Fellowship) were at lower risk of depersonalisation than junior fellows (0-10 years since Fellowship) ($p=0.0006$).

CONCLUSION
This survey is the first Australian study to assess burnout across trainees, fellows, and all surgical specialties. Significant proportions of respondents were at risk for emotional exhaustion and depersonalisation, and this correlated with female gender, lower age and lower experience. These identified predictor variables allow individuals and organisations to better manage risk from burnout.

EVALUATION OF PATIENTS PRESENTING WITH COLONIC BLEED IN A REGIONAL HOSPITAL: TRANSFER & INTERVENTION - *DUNCAN SELF*

BACKGROUND
Highly selective mesenteric angio-embolization is an important strategy in management of acute colonic bleeding. Due to the requirement for specialised Interventional Radiology, many hospitals (both regional and central) rely on transfer for this service. Costs for this patient group are significant, particularly in rural and remote areas.

AIM
This study will evaluate management outcomes for patients presenting with acute colonic bleeding to a health service without access to on-site interventional angiography.

METHODS
All presentations to Central Coast Local Health District (CCLHD) with colonic bleeding from June 2013-June 2017 were included.

A guideline for transfer of patients with contrast extravasation (blush) on CT mesenteric angiogram (CTMA) from CCLHD to Royal North Shore Hospital (RNSH) had been established prior to the study period. Primary outcomes include patient transfer rates and attempted and successful embolization.
Patient demographics, comorbidities, bleeding site, anticoagulant and reversal agent usage, transfusion requirements, other interventions and mortality data were collected on all patients.

RESULTS
84 of 265 patients investigated with CTMA had a blush. 51 patients were transferred to RNSH, including four without a blush on CTMA. 35 patients proceeded to angiography (21 had active bleeding identified and 19 were successfully embolized). There was no mortality or significant procedure-related morbidity.

SUMMARY
A protocol of selective transfer for colonic bleeding based on CTMA is a safe and effective strategy for centres without access to onsite interventional angiography Intervention rates according to patient demographics and clinical factors will be reported and discussed.

DIAGNOSTIC PERFORMANCE OF THE LRINEC SCORE APPLIED TO A CLUSTER OF NECROTIZING FASCIITIS AT A NON-TROPICAL HOSPITAL - *RENISHKA SELLAYAH*

BACKGROUND:
Necrotising fasciitis (NF) is a rare, rapidly progressing soft tissue infection. A high index of clinical suspicion is key to establishing an early diagnosis to facilitate prompt treatment. The Laboratory Risk Indicator for Necrotising Fasciitis (LRINEC) score, based on routine blood tests, can facilitate early diagnosis.

METHODS:
A retrospective review of the medical records was conducted to identify adult patients with a diagnosis of NF during the period January 2014 to August 2016. Patients included had either a clinical, intraoperative or histological diagnosis of NF and were treated primarily at our institution. Control patients in a ratio of 2:1, matched on age and gender, were identified from the same time period with a diagnosis of simple cellulitis or abscess. Blood tests on admission were used to calculate the LRINEC score. A diagnostic performance analysis of the LRINEC score was conducted.

RESULTS:
24 patients with NF were identified and matched to 48 controls. The sensitivity and specificity of the LRINEC score, when abnormal was defined as ≥ 6, was 58% and 79% respectively. The area under the curve (AUC) was 0.83 (95% CI: 0.72 – 0.91) while the false positive rate was 0.40 (95% CI: 0.20 – 0.81) at 90% sensitivity. The sodium level and CRP components of LRINEC were most predictive of NF with AUC's both 0.79. Creatinine level did not predict NF (AUC = 0.52).

CONCLUSION:
The LRINEC score has reasonable diagnostic performance overall but an unacceptably low sensitivity at the previously validated cutoff of 6. Clinical features remain the cornerstone of early diagnosis.

PREDICTORS OF SEVERITY IN ACUTE DIVERTICULITIS - *MATTHEW TRINDER*

BACKGROUND
The management of acute complicated diverticulitis has shifted from operative intervention to a more conservative approach due to increased access to computed tomography (CT) to assist in assigning disease severity. Recent studies have shown that first episode of diverticulitis, comorbidities (Charlson score >3), and high CRP on admission were considered predictors for severe diverticulitis. Our aim was to assess the predictors of complicated diverticulitis in our patient population.

METHODS
We performed a retrospective case series of all patients that were admitted to Royal Perth Hospital (RPH) in 2015 with diverticulitis. Patients with the primary diagnosis of diverticulitis were included in the study. Patients were excluded if they were admitted for an elective procedure. Patients were considered to have complicated diverticulitis if they required operative intervention. Data was collected from the hospital-coding registry and was analysed for demographics, investigations and outcomes.

RESULTS
The total number of patients included in the study was 151. 27 patients required operative intervention, while 124 patients were managed conservatively. There was no difference in the average age of patients 55.7±15.9 vs 59.1±15.3, rate of first presentation 55.5% vs 60.7% or comorbidities. The admission level of CRP was 84.9±63 in the conservative group and 230±126 in the invention group.

CONCLUSION
The CRP level on admission is useful for predicting the severity of acute diverticulitis. Patients with an elevated CRP should be considered for further radiological assessment to exclude complication.

MASSIVE ABDOMINAL HERNIA REPAIR: A CASE SERIES OF COMPONENT SEPARATION WITH ADJUNCTIVE PREVENA® NEGATIVE PRESSURE DRESSINGS - *EDWARD WANG*

INTRODUCTION
Large abdominal incisional hernias present surgeons with a difficult management problem. Elective repair with techniques such as botox injection and component separation is technically challenging and at risk of hernia recurrence. Electing not to repair can also be problematic and complicated eventually by bowel strangulation necessitating emergency repair, a higher risk operation with high rates of wound complications. Prevena® incision management system is a negative pressure dressing for closed wounds that removes exudate, keeps the wound sterile and has been shown to decrease wound infection rates in sternotomy, caesarean section and laparotomy wounds.1,2,3 Experimental models have shown that negative pressure therapy also improve wound healing by stimulating the release of endothelial growth factors and inducing wound matrix remodelling. This study sought to assess the outcomes of emergency and elective incisional hernia repair with the adjunctive use of Prevena® incisional management system.

METHODS
A retrospective case series analysis was completed for all abdominal incisional hernia repairs at Fiona Stanley Hospital. Patients included in the review underwent posterior component separation with retrorectus mesh repair for midline incisional hernias with a minimum of 5cm hernial diameter. Patients with significant ileus were treated with neostigmine infusion. Prevena device issues and patient complications were recorded.

RESULTS
Twenty two patients were identified in the review, with 13 elective repairs and 9 emergency presentations. The only issues with the Prevena dressing encountered were vacuum leak and the small suction canister which needed to be changed frequently...

AXILLARY MANAGEMENT IN SENTINEL NODE POSITIVE BREAST CANCER IN A METROPOLITAN AND REGIONAL CENTRE - *KIMBERLEY HERON*

INTRODUCTION
Sentinel node biopsy (SNB) is standard practice for staging the clinically node negative axilla in breast cancer, conventionally followed by completion axillary clearance (cAC) if positive. There has been a trend in recent literature away from aggressive surgical management of the axilla, with variable uptake of recommendations amongst clinicians and centres. This study aims to compare current management of the sentinel node positive axilla in a regional versus metropolitan centre.

METHOD
A review of all patients undergoing SNB for breast cancer at Eastern Health (EH) and Bendigo Health (BH) over a two year period between May 2013 and 2015 was undertaken. Sentinel node positive patients were identified, and clinicopathological data including rates of cAC were analysed.

RESULTS
Over 24 months 299 SNBs were performed at EH and 133 at BH. Rates of sentinel node positivity were consistent between cohorts, 78 (26%) at EH and 31 (23%) at BH. Rates of cAC in the sentinel node positive group were marginally higher at EH, 52 (67%) compared to 19 (61%) at BH. In those who underwent cAC, the rates of further non sentinel node involvement were similar, 23 (44%) at EH and 8 (42%) at BH.

CONCLUSION
Although there has been significant change in axillary management for breast cancer over recent years this study shows a similar approach to management of the sentinel node positive axilla in both a major metropolitan and regional centre, with similar rates of cAC undertaken over the two year study period.

THE COST-EFFECTIVENESS OF PARATHYROID HORMONE TESTING POST TOTAL THYROIDECTOMY- *DINA SAKS*

Increasing health care costs and bed shortages across hospitals necessitates a change in practice to improve resource utilization. A single measurement of parathyroid hormone (PTH) is effective at predicting post thyroidectomy hypocalcaemia earlier than measurement of serial calcium levels1.

PTH levels therefore facilitate earlier calcium supplementation and possibly shorter length of stay (LOS). This study examines the cost-effectiveness of PTH versus calcium testing.

METHODOLOGY:
Sixty consecutive total thyroidectomies were performed across two hospitals between 2015-2017. Patients underwent either post-operative PTH testing (Group 1 n=26) or serial calcium level monitoring (Group 2 n=34) depending on local institutional guidelines. Primary outcomes were LOS and hypocalcaemia. Cost was calculated as the average cost per bed day and a cost-effectiveness analysis was performed.

RESULTS:
Twenty-four patients (92%) in Group 1 were discharged on the first post-operative day, four with low PTH and early calcium supplementation. 24 patients (70%) in Group 2 were discharged day 2, which was the earliest discharge day in this cohort. Group 1 had 7.7% of patients develop hypocalcaemia, compared to 32% in Group 2. This may be due do earlier supplementation. In both groups extended LOS was largely due to hypocalcaemia (n=2 vs n=5). The average cost savings was $8,207 per patient (95% Uncertainty interval: $5,493 to $11,762).

CONCLUSION:
Measurement of PTH, with early calcium replacement and shorter LOS represents a significant cost saving to the health system. With increasing health care costs, this is a cost- effective way to provide safe, early discharge with significant savings.

A REGIONAL EXPERIENCE WITH UMBILICAL HERNIA REPAIR - *SCOTT WHITING*

INTRODUCTION:
Umbilical hernia account 10-15% of all primary hernia with a reported incisional rate of 5-25% after for laparoscopic trochar placement. Complication rates according QLD hospital state-wide data is approximately 3-9%. Seroma and wound infection can incur significant patient burden due to re-operations, increased LOS, extended dressings and considerable health care cost associated.
Aim: To investigate the outcome of elective umbilical hernia repairs in a regional hospital and determine any pre-disposing factors to their development of complications (for example; obesity, smoking, COPD and diabetes).

METHODS:
We completed a 5 year retrospective study assessing trochar site hernia rate from laparoscopic cholecystectomy and appendicectomy (n=2684) with a minimum 3 year follow up period and a case series of 200 consecutive elective umbilical hernia repair with 12 month follow up period.

RESULTS:
Trochar related hernia requiring repair was unexpectedly low (<0.005%). 3% of patients who underwent a laparoscopic cholecystectomy or appendicectomy in our centre also concomitantly had a hernia repaired at the time of their procedure. Overall, complication rate from elective hernia repairs was five percent.

CONCLUSIONS:
Data review will be extended for a further 3 years and a subset analysis of precipitating factors for hernia complications will be included including costing of complications.

BLAST INJURIES - *SAMSHER ALI*

Until recently, blast related injuries were mostly a battlefield injury, but with the advent of terrorism, we can reasonably expect to be involved in the management of these injuries.

In this presentation, lessons learnt from Afghanistan and Iraq are reviewed with the focus on the mechanics of blast injury patterns and management.

THE THIRD WAY - *NEIL GEDDES*

Uninsured patients have the option of procedures at a private day surgery or going on the waiting list at the public hospital. I have set up and run an operating theatre at the rooms now for fifteen years. The theatre is run as a clean theatre a meditrax sterility identification system, completeness of excision of skin cancers and infection rate are recorded ongoing through a Handy Base program. The range of procedures carried out will be discussed and experience with local anaesthetic techniques included.

In summary I carry out twenty percent of my procedure work in this clinic with results equivalent to other venues that I use. The advantage on costs and lack of delay have more than compensated the cost in setting up and running the facility.

CUBAN-TRAINED INTERNS: DO THEY CREATE DIFFICULTIES FOR THE MEDICAL WORKFORCE OF VANUATU? - *JOHN GRAHAM*

The PSA has been to the forefront in the RACS in its support of surgery in the Pacific countries, especially PNG. Whilst in the past Australia has supported Pacific medicine, in recent years other countries, principally Cuba, have become involved. In 2007-8 many Pacific countries sent students to Cuba to study Medicine and from 2015 they began returning to their home countries.

Medical graduates in Pacific countries have traditionally come from universities in Fiji and PNG and many countries have had internship programs to introduce these graduates to the local scenes. However the large number of Cuban-trained doctors has focused all Pacific countries on the need to either develop or adapt their internship programs to up-skill these graduates from a public health focused undergraduate program to the more clinical diagnostic/therapeutic Western style of Medicine.

This paper will focus on the experience of 29 recent graduates entering the internship program in Vanuatu in 2016-7. Of these, 5 went to medical school in Fiji, 3 in China and 21 in Cuba. The 2 year internship scheme aims to immerse the interns into 60 weeks of medical specialty rotations, 12 weeks of ED/OPD, 12 weeks of surgical subspecialties and the rest in rural practice, into which it is hoped most graduates will move. The experience with this exercise will focus on the difficulties with training this large number of graduates relative to the very limited medical workforce within the country.

THE NEW PEER REVIEW TOOLS IN THE RACS MORBIDITY AUDIT AND LOGBOOK TOOL (MALT) - A BOON FOR THE PROVINCIAL SURGEON. - *MARK STEWART*

Provincial surgeons uphold standards of surgical care for the peoples of regional and remote Australia. However to determine whether what we think is happening really is, and whether performance meets existing standards, we need audit.

Recent MALT improvements directly benefit provincial surgeons. Data comparison is available through audit groups. If no local group exists an audit group can be created including any MALT user, local or remote. Accurate data analysis is now possible, through the new SNOMED procedures. In-built peer-review reports permit basic risk adjustment. Data presentation has been enhanced through detailed reports of the individual compared to the audit group. Outliers are readily identified by the funnel plot reports.

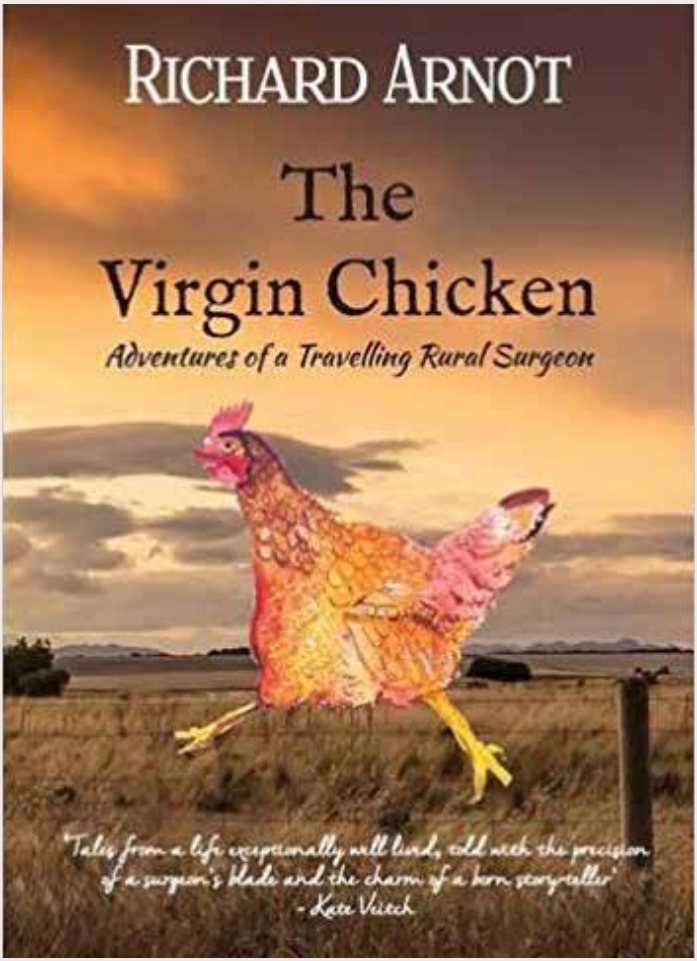
A new Locum Surgeon Report is also available, designed for submission to the College's Locum Evaluation and Peer Review Committee. MALT also offers a suite of new self-audit reports.

Data entry is soon to be facilitated by an offline App for smartphones. Data will be able to be entered offline then uploaded once an internet connection is established.

The General Surgery Unit 2 at the Royal Darwin Hospital has utilised the MALT audit group system, to facilitate their unit audit. Rapidly generated activity reports are reviewed at the weekly unit meetings. Funnel plot reports confirm no outliers in our Unit. Outcome reports have been presented to the Surgical Credentialling Committee.

MALT is a valuable source of information that allows for shared learning and change, and has been used at the Royal Darwin Hospital to contribute to ongoing quality of service.

A NEW BOOK BY RICHARD ARNOT:



The Virgin Chicken

Adventures of a Travelling Rural Surgeon

The Virgin Chicken is a follow-on story from Richard's first book - 'Arabian Nightmare' - and tells the story of Richard when he first came to Australia for what was to be a three-month holiday. Now, after 50 years as a doctor and surgeon, and with more than his fair share of dramatic incidents, international intrigue, medical stories and life experience to draw on, Richard has penned his life story in *The Virgin Chicken* - a must read for any surgeon.

See Richard during the PSA 2017 ASC for book orders.

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