PSA 2021 ASC

Virtual
05 07 August, 21

BEGA VALLEY

RECENT ADVANCES AND CONTROVERSIES IN GENERAL SURGERY

05-07 AUGUST, 2021
VIRTUAL

SCIENTIFIC CONVENORS

Dr Sandra Krishnan FRACS & Dr Adrian Fernandez FRACS
CONSULTANT GENERAL SURGEONS, BEGA

WELCOME,

"Everybody has a plan until they get punched in the mouth." Mike Tyson

Well, it's safe to say that we got our nose bloodied too. Our best laid plans, now more than two years in the making, had come undone by an invisible and formidable opponent. In the initial days, there was always a glimmer of hope though, somewhere deep in our recesses (really deep), that despite the chaos around us, we could remain in the eye of the hurricane for just long enough and come away unscathed. Unfortunately, it was not to be. We were disappointed, but only for the briefest of moments. We regrouped, marshalled our resources and worked at a furious speed to come up with a game plan. And so, ladies and gents, with the overwhelming support of our faculty and delegates, we take great pleasure in welcoming you to the ***56th Provincial Surgeons of Australia 2021 Virtual Annual Scientific Conference*** in Bega, NSW. This, of course, is a state of mind as we embrace a completely virtual approach to bring together the surgical fraternity from all corners of the country.

Drawing from our theme of ***'Controversies and Recent Advances,'*** we have structured an exciting program geared towards the surgeon working in regional Australia. The sessions cover the breadth of general surgery by experts in their respective fields that include Quality, Education and the various clinical subspecialties. We will also take a deep dive by way of two Masterclasses on ***Sentinel Node Biopsy for Melanoma*** and ***Laparoscopic Transcystic Common Bile Duct Exploration***.

We are delighted to have **Dr Gordon McFarlane**, our international speaker who is an experienced general surgeon (and 'Viking!') working in rural Scotland. He recently chaired the report prepared for the RCSEd on the provision of care in rural surgery and will provide insight on the pivotal areas of standards, training, maintenance of skills, recruitment and retention.

We intend for the sessions to be thought-provoking and anticipate that certain parts will stimulate robust discussion. Bega, as many of you are aware, is famous for its dairy industry. Cows abound but we assure you though that there will be no 'bulldust.' So with our lips cut and nose bloodied, we may also end up with a black eye but what's life without a few challenges eh?

See you on the other side (of your screen)!

Dr Sandra Krishnan FRACS & Dr Adrian Fernandez FRACS
CONSULTANT GENERAL SURGEONS, BEGA
PSA ASC SCIENTIFIC CONVENORS

PHOTOGRAPHY CREDIT: DAVID ROGERS PHOTOGRAPHY
WALLAGOOT LAKE. SAPPHIRE COAST.

Scientific Convenor

Dr Sandra Krishnan FRACS MBBS

Dr Sandra Krishnan is a teaching surgeon. A Surgical Oncologist, Breast and General Surgeon who practices at the Sydney Adventist Hospital, Calvary Bruce Private Hospital and South East Regional Hospital, an Educator and Mentor.

She is a Clinical Senior Lecturer at ANU Medical School and a RACS Senior EMST Instructor who teaches and trains juniors both in person and online. She is a Non Executive Director of the Board for So Brave, Australia's Young Women's Breast Cancer Charity, which focusses on raising awareness that young women get breast cancer too, raise funds for research and empower young women.

My mantra "Do It Lovingly." I believe if anything is worth doing, do it with all your heart.

Scientific Convenor

Dr Adrian Fernandez FRACS

Dr. Adrian Fernandez is a General and Colorectal Surgeon in the Far South Coast, NSW. He completed colorectal fellowships in Newcastle and Sydney prior to moving to the coast where he has lived and worked for more than 10 years. He is passionate about surgical education and training and is keenly developing an academic component to his practice. He supervises SET trainees, JMOs and medical students and is a mentor for the inaugural Mentoring Australasian Surgical Students (MASS) program in 2021.

He firmly believes that regional Australia offers the perfect environment to balance the rigours of surgery and personal life. Outside work he has two great loves - his family and long suffering football club (in equal measure!)

International Guest Speaker

Gordon A McFarlane ChM FRCS(Ed)

Gordon McFarlane is a Consultant Surgeon in Lerwick, Shetland Islands. He graduated from Aberdeen University and continued training in General Surgery in Aberdeen and Inverness, obtaining an FRCS in 1989. After a further 6 month post in Inverness as an orthopaedic registrar, he worked for 9 years as a surgeon in Chogoria, Kenya, a 300 bed rural church hospital. While there he undertook a ChM thesis on H. Pylori and gastric cancer.

On returning to UK, he spent 4 years on the West of Scotland Training Rotation in General Surgery, the last year of which was as a Rural Surgical Trainee with the North of Scotland Deanery. He was appointed to Gilbert Bain Hospital, Shetland in 2004. He is a Fellow of the College of Surgeons of East Central and Southern Africa, and a member of the Viking Surgeons Association. He maintains an interest in rural surgical training and surgery in Africa. He is a Deacon in one of the churches in Lerwick, enjoys cycling and squash, and occasional sea kayaking.

Guest Speakers

Dr Emilia Dauway MD, FACS, FRACS

Dr. Emilia Dauway completed a surgical oncology/breast fellowship at Moffitt Cancer Centre in the United States. She was first in the world to use radioactive seeds in the breast to localise non-palpable breast cancers and the first in Australia to use magnetic seeds instead of radioactive seeds. She is the co-inventor for Radio-guided seed localization of imaged lesions and the former Chief of Breast Surgery at Scott and White in Texas. She is currently a consultant general surgeon specializing in oncoplastic breast surgery at the Hervey Bay Hospital and St. Stephens Private Hospital, in Hervey Bay, Queensland.

Emilia's interests involve developing novel techniques to improve localization of non-palpable lesions in surgery and reducing disparities in health care access in regional remote areas. She was recognized as "Inspirational Women of the Year" in 2019 for her holistic approach to surgery and her work with regional women through the non-profit RESTORE More.

Guest Speakers

Lorane Gaborit

Lorane Gaborit is a third-year medical student currently undertaking a rural clinical year in Goulburn NSW, and a member of the Trials and Audits in Surgery by Medical Students in Australia and New Zealand (TASMAN) Projects team.

Lorane is passionate about health equity, with a particular interest in rural and remote health and Aboriginal and Torres Strait Islander health. Lorane was a recipient of the Tuckwell Scholarship, graduating with a Bachelor of Development Studies in 2019, and is the inaugural recipient of the Bill Nicholes "Willigobung" Scholarship for Medicine.

A/Prof T. Michael Hughes MBBS (HonsI) USyd., FRACS

Michael is the founder and Clinical Director of Northern Surgical Oncology (NSO). He is a Surgical Oncologist (a surgeon specialising in the management of tumours both benign and malignant) with over 30 years' experience, having trained as a general surgeon then pursued post-fellowship training in surgical oncology. His expertise includes the management of breast cancer as well as benign breast disease, melanoma as well as advanced and rare non-melanoma skin cancers, soft tissue tumours benign and sarcoma, salivary gland tumours and lymph node malignancy (neck, axilla and groin).

Guest Speakers

Michael is committed to providing the highest quality care to his patients. Michael ensures that the care given to his patients is the best and safest possible through his significant involvement in research, education, leadership and quality management systems at NSO, the Sydney Adventist Hospital (SAH) and more broadly. In addition to his medical practice Michael has number of significant leadership roles including – the Clinical Lead of the ANU SAH Clinical School Project having been the Head of the Sydney Adventist Hospital Clinical School, the University of Sydney; the Clinical Director of Surgical Services and a member of the Medical Advisory Committee at SAH; Chairman of the SAH Breast Cancer and Surgical Oncology/Head and Neck MDTs; Chairman of the Section of Surgical Oncology of the Royal Australasian College of Surgeons; committee member on a number of state and national advisory groups.

Dr James Kollias FRACS

James Kollias is a Breast and Endocrine Surgeon having previously served as research fellow at the Nottingham Breast Unit and as a senior surgical consultant Royal Adelaide Hospital. He is currently a senior VMO at BreastScreen SA. He is a senior lecturer in Surgery at the University of Adelaide, having published over 120 manuscripts in scientific journals. He has been involved on numerous advisory groups for Cancer Australia, Chairman of the RACS Breast Section, Founding President of BreastSurgANZ and Chairman of BreastSurgANZ Breast Quality Audit.

James' major interests include clinical audit and standards, surgical training and oncoplastic breast surgery.

Guest Speakers

Dr Soundappan Sannappa Venkatraman FRACS

Dr.Soundappan is Paediatric Surgeon working at the Children's Hospital at Westmead. He is also a Senior Lecturer in Paediatric Surgery at University of Sydney. He is currently head of Trauma at Children's Hospital at Westmead.

He graduated from Madras Medical College India in 1989. He completed his General surgery training from RNT Medical College, India and completed Paediatric Surgery Training from the Institute of Child Health and Hospital for Children, Chennai, India. He moved to Sydney, Australia in 2002 and obtained his fellowship in Paediatric Surgery in 2008.
He has over 30 publications in peer reviewed journals. He has many local, regional and international presentations and has invited speaker at national and international conferences. He is an EMST instructor. He has been invited examiner for Paediatric Fellowship exams, Univeristy of Malaysia.
His interests are Paediatric trauma, Hirschsprung's disease, Anorectal anomalies, Minimally invasive surgery and Point of care ultrasound.
He recently completed his PhD on Surgeon Performed Ultrasound in Paediatric Surgery.

Guest Speakers

A/Prof Robyn Saw FRACS MS MBBS

A/Prof Robyn Saw is a Melanoma and Surgical Oncologist working at Royal Prince Alfred Hospital Sydney (Head of Department) and affiliated with Melanoma Institute Australia.

As well as her clinical responsibilities, she is actively involved in melanoma research and leads major research projects on surgical aspects, quality of life and survivorship. Translation of research into clinical benefit for patients is the focus of her research activity. She also has a strong focus on consumer engagement, coordinating the development of Early-Stage and Stage III melanoma booklets.

Robyn is passionate about improvement of clinical care through education of students, trainees and clinicians.

Guest Speakers

A/Prof Kellee Slater MBBS (Hon) FRACS FACS

Associate Professor Kellee Slater is a General Surgeon at The Princess Alexandra Hospital and Greenslopes Private Hospital. She is a Hepatobiliary specialist and is a member of the Queensland Liver Transplant Service. Her other special interest is abdominal wall reconstruction and hernia repair and is a world leader in this field.

Kellee trained in Queensland and did her Solid Organ Transplantation Fellowship in Colorado, in the United States.

From 2017-2019 she was the Chair of the Australian Board in General Surgery responsible for training of General surgeons in Australia. She is the Vice President of General Surgeons Australia.

In 2014 Kellee released her first book called "How to Do A Liver Transplant – stories of my surgical life" and was the winner of Queensland Book of the Year. She also runs a successful You Tube Channel – The Surgeon Not the Surfer.

Kellee had been married for 28 years and is a mother of four.

Guest Speakers

A/Prof Michael Suen FRACS MBBS MS (Colorectal)(Syd)

Dr Michael Suen is a specialist colorectal surgeon and a member of the Colorectal Surgical Society of Australia and New Zealand (CSSANZ). His areas of expertise include management of colorectal cancer using minimally invasive (laparoscopic) techniques, surgical management of inflammatory bowel disease, complex proctology conditions, defeacatory disorders and anal incontinence.

Soon after he accomplished the colorectal training, Dr Suen was appointed by the Colorectal Unit at Concord Repatriation General Hospital. He has led the unit in advocating and establishing bowel cancer prehabilitation program, and Enhanced Recovery After Surgery Program (ERAS) in which he believes bowel cancer management involves multidisciplinary approach for treating the diseases and patient's quality of life after recovery. Dr Suen is pioneered in complex proctology conditions by using modern minimally invasive procedures such as Haemorrhoidal Artery Ligation- Rectal Anal Repair (HAL-RAR), Video-Assisted Anal Fistula Treatment + Over The Scope Clip (VAAFT + OTSC) to name a few. Adding to his skills in pelvic floor specialty, the comprehensive anorectal physiology assessment assists him to make an accurate diagnosis for all the defecatory disorders and anal incontinence.

He has special research interests in: (1) New surgical techniques in the management of complex fistula in ano; (2) Perioperative care in bowel cancer resection patients, with the establishment of the Enhance Recovery After Surgery (ERAS) program and the Prehabiliation preoperative program; (3) Management of bowel dysfunction (Anterior Resection Syndrome) after bowel resection for colorectal cancer.

VIRTUAL SCIENTIFIC PROGRAM

DAY ONE, THURSDAY 05 AUGUST

SESSION 01 - WELCOME CHAIR: DR ADRIAN FERNANDEZ

Time	Session	Speaker
8:45	Welcome to the PSA	Mr Bruce Stewart - President
8:50	Official Opening by Scientific Convenors	Dr Sandra Krishnan Dr Adrian Fernandez
8:55	The General Surgeon in Bega: Then and now	Dr John McKee & Dr Sandra Krishnan
9:15	Southern LHD	A/Prof Allen-John Collins
9:25	Saftey and wellbeing of surgeons and pilots during COVID: Are we really that similar?	Dr Sue Velovski, CPT Stuart James, Mr Anthony Lock DSM

10:10-10:40 - MORNING TEA

SESSION 02 - GENERAL SURGERY | CHAIR: DR ANITA JACOMBS

Time	Session	Speaker
10:40	Acute pancreatitis	A/Prof Sivakumar Gananadha
10:55	SSI	Dr Stephen Smith
11:10	Laparoscopic TEP inguinal hernia- tips and tricks	A/Prof Douglas Fenton-Lee
11:25	Umbilical Hernia Repair - Can it be The Start of a Much Larger Abdominal Wall Problem?	A/Prof Kellee Slater
11:40	Women in surgery	Dr Deepali Poels
11:55	***Q+A***	***Panel***
12:10	*FREE PAPER: Quality Assurance in Melanoma Sentinel Node Biopsy in the ACT*	*Dr Lauren Turner*
12:17	*FREE PAPER: Skills of the aspiring surgeon: A Needs Assessment*	*Dr Isaac Ealing*
12:24	*FREE PAPER: Taree Hospital Right Hemicolectomy Incisional Approach Review*	*Brent Gilbert*

12:35-13:30 - LUNCH

13:00 TRAINEES WITH RURAL COACH CHAIR - DR DAMIAN FRY

VIRTUAL SCIENTIFIC PROGRAM

DAY ONE CONTINUED

SESSION 03 - QUALITY IN SURGERY. CHAIR: DR EMILIA DAUWAY

13:30	RACS Rural Health Equity Strategy	Dr Kerin Fielding
13:55	Rural Surgery Fellowship	Dr Sally Butchers
14:10	COVID-19: Victoria's response	Prof David Watters
14:30	NSQIP: Reducing complications and improving quality of care in rural hospitals	Dr Shehnarz Salindera
14:45	Life of a Viking Surgeon	Dr Gordon McFarlane
15:15	***Q+A***	***Panel***

15:30-16:00 - AFTERNOON TEA

SESSION 04 - RESEARCH

16:00	*FREE PAPER: 3D Printing: Making Surgery Accessible*	*Dr Amos Nepacina Liew*
16:07	*FREE PAPER: The Role of ICG in left sided colorectal anastomosis*	*Dr Raziqah Ramli*
16:14	*FREE PAPER: Emergency resuscitative thoracotomies at an Australian trauma centre- Surviving against the odds*	*Dr Arushi Singh*
16:21	*FREE PAPER: Investigations and time trends in loop ileostomy reversals following anterior resections*	*Dr Danielle Taylor*
16:28	*FREE PAPER: Spontaneous Gas Gangrene and occult malignancy - case report, review of associated malignancies*	*Dr James Kovacic*

QUICK SHOT POSTERS - TWO MINUTES EACH

16:35	Orange Base Hospital Emergency Laparotomy Audit	Dr Lashnika Bandaranayake
16:37	Laparoscopic Versus Open Hartmann's Reversal in Patients Undergone Hartmann's Procedure	Dr Alyssa Chong
16:39	Transanal Minimally Invasive Surgery (TAMIS): Long term outcomes in a regional centre	Dr Laura Deveson
16:41	Implant-Based Breast Recon: The Role of NSQIP	Dr Neesa Fadee
16:43	Laparoscopic Colectomy Audit - introduction in a rural referral hospital in NSW	Dr Lillian Fitzpatrick
16:45	Predictive risk factors for recurrence of colorectal cancer	Dr Jonathan Holt
16:47	Endoscopic pilonidal sinus treatment (EPSiT): the future of pilonidal sinus surgery?	Dr Trudy Hong

VIRTUAL SCIENTIFIC PROGRAM

DAY ONE CONTINUED

QUICK SHOT POSTERS CONTINUED		
16:49	Radiological staging in breast cancer - are we over servicing?	Dr Yegi Kim
16:51	Factors associated with polypectomy versus surgical resection of malignant colorectal polyps	Dr Christine Li
16:53	Value of CEA as a surveillance tool after resected early colorectal cancer	Dr Yuchen Luo
16:55	Full Thickness Skin Grafts: A New Spin on an Old Classic	Dr Rory Marples
16:57	General Surgery Transfers Out of Far West NSW: The 'Little Brother' Perspective	Dr Nithya Niranjan
16:59	Mesh related complications in paraoesophageal hernia repair	Dr Natalie Quarmby
17:01	Feasibility of MagSeed Localization for Non-palpable Breast Lesions in Queensland Munasinghe Silva	Dr Munasinghe Silva
17:03	Reconstruction with Biodegradable Temporising Matrix (BTM) following necrotising fasciitis in Darwin	Dr Cherry Talavera
17:05	The risk of advanced colorectal neoplasia in Australasian populations with Sessile Serrated Lesions	Dr Daniel Tani
17:07	Effect of prehabilitation on post-operative function in bowel resection patients-systematic review	Mr Joshua Teo Teo
17:09	Does ERCP confer benefit to palliative cancer patients	Dr Phyu Cin Thant
17:11	The Impact of COVID-19 on Major Trauma Presentations in Rural Area	Dr Yuen Ting Wong

17:15 - VIRTUAL WELCOME DRINKS & GROUP PHOTOS
Delegates, faculty, and guests, please stay online for group zoom photos and BYO virtual drinks

17:45 DAY ONE PROGRAM CLOSE

VIRTUAL SCIENTIFIC PROGRAM

DAY TWO, FRIDAY 06 AUGUST

SESSION 01 - COLORECTAL. CHAIR: DR ADRIAN FERNANDEZ

9:00	ERAS Laparoscopic Bowel Resection in the Regional Hospital	Dr Ned Abraham
9:15	Modern management of diverticulitis	Dr Nimalan Pathma-Nathan
9:30	Colon CA and microbiome	Dr Michelle Tan
9:45	Prehabilitation	Dr Shanthan Ganesh
10:00	Surgical Management of Early Rectal Cancer: Is there a role for local excision?	Dr Kirk Austin
10:15	**Q+A**	***PANEL***

10:30-11:00 - MORNING TEA

SESSION 02 - BREAST + ENDOCRINE. CHAIRS: DR SANDRA KRISHNAN, DR ERICK FUENTES

11:00	Parathyroid surgery in a regional setting	A/Prof Allen-John Collins
11:20	Approaches to a difficult thyroid	A/Prof Navin Niles
11:35	How I do it: Avoidance of breast deformities in breast conserving surgery	Dr James Kollias
12:50	The Future of Magnetics: Exploring Innovative Techniques in Localization of Non-Palpable Breast Lesions	Dr Emilia Dauway
12:05	Radiotherapy for breast cancers	Dr LeeNa Chong
12:20	**Q+A**	***Panel***

12:35-13:30 - LUNCH

****TRIVIA****

SESSION 03 - MELANOMA + SARCOMA. CHAIR: MR BRUCE ASHFORD

13:30	Sarcoma: What every surgeon should know	A/Prof Michael Hughes
13:45	Melanoma update	A/Prof Robyn Saw
14:00	Metastatic cSCC	Mr Bruce Ashford
14:15	**Q+A**	***Panel***

VIRTUAL SCIENTIFIC PROGRAM

DAY TWO CONTINUED

SESSION 03 CONTINUED

14:20	KEYNOTE: The Provision of Surgical Services in a Rural Setting	Dr Gordon McFarlane
14:50	*KEYNOTE Q+A*	Dr Gordon McFarlane
14:55	*FREE PAPER: The introduction of surgical stabilisation of rib fractures to a regional trauma service*	*Dr Lauren Daneel*
15:03	*FREE PAPER: South Australian Rural Endoscopy and Colonoscopy Audit*	*Dr Matthew Watson*
	15:11-15:30 - MORNING TEA	

SESSION 04 - SNB FOR MELANOMA TWILIGHT MASTERCLASS
CHAIR: DR REBECCA READ

Presented in conjunction with:

Proudly supported by:

15:30	When and how to discuss sentinel node assessment for melanoma Robyn Saw	Prof Robyn Saw
15:45	Lymphatic mapping tips and tricks	Dr Kevin London
16:05	The sentinel node biopsy procedure... or not	Prof Robyn Saw
16:25	Performing, interpreting and reporting melanoma sentinel node pathology	Dr Robert Dawson
16:45	What next ?	Prof Robyn Saw
17:00	***DAY TWO PROGRAM CLOSE***	
17:00	*PSA ANNUAL GENERAL MEETING*	

VIRTUAL SCIENTIFIC PROGRAM

DAY THREE, SATURDAY 07 AUGUST

MASTERCLASS: COMMON BILE DUCT. CHAIR: GRACE LIM

Masterclass proudly supported by:

MASTERCLASS: COMMON BILE DUCT *Laparoscopic transcyctic common bile duct exploration: The why and the how*		
08:00-09:00	1. A perspective on why primary surgical treatment should be considered 2. The results of the Northern Health group 3. The technique we use for laparoscopic transcystic CBD exploration.	Dr David Bird Dr Roger Hodgson
09:00-09:15 - SHORT BREAK		

SESSION 01 - GENERAL SURGERY POTPOURRI/EDUCATION CHAIR: DR GRACE LIM

9:15	Paediatric surgery for General Surgeons	Dr Soundappan Sannappa Venkatraman
9:30	Common Urology Issues in a Regional Centre	Dr Chi Can Huynh
9:45	The surgeon and social media	Dr Imogen Patterson
10:00	Surgical training during COVID-19: A registrar's perspective	Dr Joseph Xavier
10:15	Increasing the representation of rural surgery in research: An opportunity for a collaborative model	Dr Lorane Gaborit
10:30	Surgical education for medical students: Past, present, future	Dr Sandra Krishnan & Dr Chloe Campbell
10:45	Expert Commentary from two Educators	Prof Zsuzoska Kecskes & Prof Amanda Barnard
11:00-11:30 - MORNING TEA		

VIRTUAL SCIENTIFIC PROGRAM

DAY THREE, SATURDAY 07 AUGUST

SESSION 02 - HOW I DO IT. CHAIR: DR ERICK FUENTES

Time	Session	Speaker
11:30	FREE PAPER: *The short-term outcomes of colorectal surgery on anxiety and depression*	Dr Phillip Chia
11:40	FREE PAPER: *14-Year Experience of Oesophageal Cancer Treatment from a Single Centre*	Dr Devesh Kaushal
11:50	How to get started in oncoplastic surgery	Dr James Kollias
12:05	Autologous fat grafting in breast surgery: How and why I do it	A/Prof Cindy Mak
12:20	TAMIS: How to get started	Dr Grace Lim
12:35	Laser/ RF Haemorrhoids	Dr Naseem Mirbagheri
12:50	VAAFT and OTSC Proctology Clip: Another over-promised technique for anal fistula repair?	A/Prof Michael Suen
13:05	**Q+A**	***Panel***
13:15	AWARDS + CLOSE OF PROGRAM	

~ 13:30 PSA 2021 ASC END ~

PHOTOGRAPHY CREDIT: DAVID ROGERS PHOTOGRAPHY
GILLARDS BEACH. SAPPHIRE COAST.

Abstracts

Quality Assurance in Melanoma Sentinel Node Biopsy in the ACT - **Dr Lauren Turner**

PURPOSE: Sentinel node biopsy (SNB) for melanoma identifies subclinical lymph node metastases and stratifies patients for adjuvant treatment. Oncological quality assurance is essential; SNB can be evaluated by rates of positiveness, completeness and false negatives (FN). We investigated quality of SNB at two Canberra Hospitals.

METHODOLOGY: A retrospective audit of 133 consecutive patients booked for wide local excision and SNB for melanoma. Clinical, radiological and surgical data were reviewed. Complete SNB was defined as excision of all nodes identified on preoperative lymphoscintigraphy; incomplete SNB as excision of fewer lymph nodes. FN rate was defined as regional recurrence after negative SNB. Follow up was 24 months.

RESULTS: Mean Breslow thickness was 2.32mm (0.5-21.0mm). SNB was not performed in 14 patients. Sentinel node metastases were identified in 10.9% (13/119). Sentinel nodes were identified in the axilla (53.8%; 64/119), groin (26.9%; 32/119) and neck (23.5%; 28/119). Overall complete and incomplete SNB rates were 81.5% (96/119) and 19.3% (23/119). Rate of incomplete SNB did not vary with region. The incidence of FN SNB was 0.84% (1/119), with one case occurring in the groin with a time to recurrence of 345 days. Calculated FN rate was 7.14% at two years.

CONCLUSION: SNBs were positive in fewer patients than in major trials. The rate of incomplete SNB was similar to those reported (17.7-40%). Our FN rate was on the lower end of the literature (0-34.0%) however, may increase over time. Taken together, these results are reassuring in demonstrating the quality of SNB procedures in the ACT.

Skills for the Aspiring Surgeon - A Needs Assessment - **Dr Isaac Ealing**

PURPOSE: With increased duration of unaccredited training years, there is a greater demand and opportunity for unaccredited trainees develop competency in general and subspecialty surgical skills. It is unclear which competencies trainees should prioritise in pre-SET. This paper looks at the current gaps in pre-SET surgical training and define which general and specific surgical skills trainees should focus on developing.

METHODOLOGY: We conducted semi-structured interviews with experts in general and subspecialty surgery fields, to assess their expectations of pre-SET surgical trainees. Expert surgeons were asked to rate the importance of the RACS list of Essential Skills. An additional list of skill-based competencies was developed based on the surgeon's expectations of trainees.

RESULTS: 18 interviews were conducted at a large metropolitan hospital. Barriers to training identified lack of feedback mechanism; reduced operative experience; poor organisational skills; no professional development programs. Competency was deemed inadequate for: Insertion ofintercostal catheter; application of plaster backslab; pleural/peritoneal tap; removal of foreign body from eye/ear/ nose; epistaxis control; Emergency management of miscarriage; abdominal sepsis

Abstracts

and closed head wounds. Significant variability amongst surgical subspecialties was observed. Utilising simulation in training was perceived as a good method of bridging the gap in competence and clinical experience.

CONCLUSIONS: We found that interest in simulation training is nearly universal. Surgeons believe this can improve competency for pre-SET trainees. There is a need to revise the 'essential skills'expected of pre-SET trainees, particularly for surgical subspecialties. Whilst, an opportunity exists to design relevant and useful training programs for pre-SET surgical trainees.

A Regional Hospital Comparison of Midline and Transverse Incision Approaches for Open Right Hemicolectomies and Impact on Post-operative Outcomes. - **Dr Brent Gilbert**

PURPOSE: Open right hemicolectomies are performed via open midline (MIA) or transverse incision approaches (TIA). The approach remains controversial; however presumed benefits using TIA include improved operative field visualization, less postoperative pain and improved post-operative respiratory function. There is, however, little Australian data regarding this. The objective was to compare length of stay (LOS), postoperative complications and opiate use for each approach in an Australian population.

METHODS: Retrospective review of right hemicolectomies at a single site over 5 years was performed for 4 different experienced surgeons (3x = MIA, 1x=TIA). Post-operative complications, LOS, patient controlled analgesia (PCA) use and discharge analgesia was recorded. Data was collated and analysed in Excel (Microsoft Corp.®).

RESULTS: 92 right hemicolectomies were performed (TIA = 45 vs. MIA=47). LOS was significantly shorter in TIA versus MIA (μ=7.3 vs μ=9.6 days, $p<0.05$). PCA usage was statistically prolonged in MIA versus TIA (μ=1.9 vs μ=0.93 days, $p<0.05$) and chi-square analysis showed a significant association between opiates on discharge and MIA [X2 (1, N = 90) = 5.8, $p<0.05$]. Post-operative complications occurred more often in MIA (MIA = 29 vs TIA = 16) with higher Clavien Dindo (CD) Scores (CD Score > 3: MIA = 61% vs TIA = 33%).

CONCLUSION: This retrospective review indicates significant advantages in LOS, opiate use and complication rate associated with TIA over MIA. This indicates patient and economic advantages of TIA over MIA. This study did not, however, consider long term complication including hernias between TIA and MIA.

3D Printing: Making Surgery Accessible - **Dr Amos Nepacina Liew**

The advancement of 3-Dimensional (3D) printing technology has made the design and production of items increasingly ubiquitous amongst the public. This technology is increasingly being used widely in various medical fields. With its increasing cost efficiency and accessibility, it is the author's perspective that 3D technology can improve accessibility to surgical procedures in low- and medium-income countries (LMIC) by providing proceduralists the basic equipment required to perform routine operations.

Abstracts

The role of Indocyanine Green (ICG) dye affecting surgical strategy and anastomotic leak in left-sided colonic anastomosis – a systematic review – ***Dr Raziqah Ramli***

PURPOSE: To review the role of Indocyanine Green (ICG) dye affecting surgical strategy and anastomotic leak in left-sided colonic anastomosis in current literature. ICG is more beneficial in left-sided resection to assess for perfusion than the right side due to nature of blood supply to the area. Current literature has shown the use of ICG in colorectal anastomosis has led to change in site of resection and reduced rates of anastomotic leak post-operatively. There has not been a systematic review on left-sided colorectal anastomosis based on the most recent studies.

METHODOLOGY: A literature review was performed in MEDLINE, EMBASE, PubMed and Cochrane Library from inception till 7 May 2021, using the terms "indocyanine green" and "colonic anastomosis". PRISMA guideline method was used to exclude articles. All articles were critically appraised by 2 independent reviewers. Studies that 1) focused on other uses of ICG not relating to left-sided resection; 2) did not specify outcomes such as change of resection site and anastomotic leak rate specific to left sided colorectal anastomoses; 3) studies with no control groups were excluded. Statistical analysis was done via SPSS.

RESULTS: 14 studies were included in this review. The mean change in surgical strategy in the ICG groups was 14.68% (±6.84), with mean anastomotic leak rates in the ICG groups was 4.63% (±3.58, p=0.000), while the mean rate in the control group was 9.95% (±6.67, p=0.001).

CONCLUSION: There is a reduction of anastomotic leaks associated with the use of ICG for left-sided colonic anastomosis.

Emergency resuscitative thoracotomies at an Australian trauma centre: Surviving against the odds! ***Dr Arushi Singh***

PURPOSE: Retrospective study examining incidence and outcomes of emergency resuscitative thoracotomies (ERT) performed in an Australian Level -1Trauma centre. Most of the available literature is American while reports from Australia are sparse. We report our experiences of ERT performed in patients retrieved to our centre.

METHODOLOGY: Retrospective study examining all patients who had an ERT at St George Hospital from Jan 2009 to Jan 2021. Data was extracted using both the institutional trauma registry and electronic medical records, including injury profile, demographics and outcomes. Location where thoracotomy was performed (en-route/ emergency department/OT), time from injury to thoracotomy, presence of other injuries were also analysed. Possible predictors of mortality versus survival were examined. Comparison of groups was done by descriptive statistics.

RESULTS: We examined the 50 patient who were retrieved direct from scene of injury, of which 10 (20%) were female and 40 (80%) were male. Median age was 44.2 (17-90) years. 28 had ERT for blunt trauma and 22 for penetrating trauma. Overall

64% (32) of patients survived. 63% (14) of penetrating injury patients survived. This is double the survival statistics from literature for ERT. CONCLUSION: Interestingly in this study, ERT conferred good outcome with survival in two of every three procedures. Performing ERT in severely injured patients appears to be justified, even in blunt trauma. Survival was associated with procedure being performed within 30 min of arrival and in OT. Mortality was associated with ERT performed in setting of cardiac arrest.

Investigations and time trends in loop ileostomy reversals following anterior resections: a single Australian institution seven-years' experience. **Dr Danielle Taylor**

PURPOSE: Currently no consensus exists regarding what pre-reversal investigations are required to assess integrity of the rectal anastomosis. The objective of this study was to compare pre-reversal assessments of anastomotic integrity and to evaluate trends that might have influenced timings for reversal.

METHODOLOGY: From a prospectively maintained database, patients with colorectal cancer resections between March 2012 to October 2019 were identified. Patient characteristics, pre-reversal contrast enema and flexible sigmoidoscopy findings were recorded, and management of complications were recorded. Time-to-ileostomy reversal and time series for trends were analysed.

RESULTS: There were 154 patients included. Pre-reversal contrast enema or sigmoidoscopy detected a possible stricture or leak at the rectal anastomotic site in 11% (15 of 132) and 15% (18 of 112) respectively. When both modalities were used there was concordance of 86.1% and a positive likelihood ratio of 5.73. Of 125 (81.2%) ileostomies reversed, the median time-to-reversal was 11.99 months; time series analysis over the 7-year period showed no significant trend for average patientdays from booking to reversal (P = 0.60). Cox regression modelling did not identify any influential risk factors for the times taken to reversal.

CONCLUSION: This study supports the use of both contrast enema and flexible sigmoidoscopy in the assessment of rectal anastomosis integrity. Most patients with complications can have their ileostomies reversed. Patients who have adjuvant chemotherapy have a prolonged time to reversal.

Spontaneous Gas Gangrene and occult malignancy - case report, review of associated malignancies - **Dr James Kovacic**

PURPOSE: We present a remarkable case of survivorship in a 59 year-old male patient with spontaneous gas gangrene (SGG) underpinning time-critical decision-making, multidisciplinary approach and search for occult malignancy. Gas gangrene or myonecrosis, has historically been a disease of trauma, we reviewed spontaneous causes in the literature.

METHODOLOGY: A literature review of SGG with occult malignancies was undertaken through searching Embase and Medline database.

RESULTS: Cases of spontaneous gas gangrene without history of trauma are rare, making up approximately 16% of presentations. The disease is largely caused by the Clostridial species of gram-positive, anaerobic, spore-forming rods. Whilst in traumatic presentations Clostridium Perfringes predominates, in cases such as ours of spontaneous gas gangrene, Clostridium Septicum is the most frequent causative organism. First cultured in 1877 by Joubert and Pasteur, the bacterium causes disease by forming multiple exotoxins leading to haemolysis and myonecrosis. Aetiology within the literature has been well described. Larson et al. identified 50% of such cases being associated with occult malignancy - 70% had colorectal carcinoma, 24% had a haematological malignancy, and 6% had gallbladder carcinoma. Theories of pathogenesis associated with lymphoma-related cases include neutropaenic enterocolitis, colonic lymphomatous involvement of the gastrointestinal tract, as well as an impaired immune system. Mortality rates of spontaneous gas gangrene vary widely within the literature between 50-100%.

CONCLUSION: SGG is a rapidly progressive form of clostridial infection which can be associated with occult malignancies. Awareness of this condition not only allows appropriate management, but should also prompt a search for underlying malignancies.

The introduction of surgical stabilisation of rib fractures to a regional trauma service.

Dr Lauren Daneel

PURPOSE: Chest wall trauma is a significant cause of morbidity and mortality. Recently, positive evidence has mounted in support of surgical stabilisation of rib fractures (SSRF) with advances in ribspecific locking plates. The set-up of a regional trauma unit without on-site cardiothoracic support is novel territory, endeavouring to reduce the need for tertiary centre transfer. The aim of this study was to evaluate the implementation of this new trauma service.

METHODOLOGY: This is a retrospective analysis of all adult patients with blunt thoracic trauma who underwent SSRF between January 2020 to May 2021. The medical records of all patients included were reviewed. The section of patients for SSRF adhered to the 2020 Chest Wall Injury Society Guidelines.

RESULTS: 43 patients presented with rib fractures during the review period. Five underwent SSRF including 3 males and 2 females with median age of 67 (53-78). Trauma mechanisms included motorbike accident (3), MVA (1) and fall (1). The median time to operation was 5 days (3-12), with a median length of post-operative chest drain of 4 days (2-7). The median length of hospital stay was 17 days (10-27). One case was complicated by a reaccumulating haemothorax requiring reinsertion of ICC. All patients were followed up within 4-8 weeks of discharge reporting no new complications.

CONCLUSION: This review supports the existing evidence that SSRF is a safe procedure with a low complication risk. Furthermore it demonstrates the effective management in a regional institution within early stages of the service.

Abstracts

South Australian Rural Endoscopy and Colonoscopy Audit - **Dr Matthew Watson**

PURPOSE: Colorectal cancer (CRC) is a major cause of morbidity and mortality in Australia. High quality colonoscopy is vital for the detection and removal of adenomatous polyps and early diagnosis of colorectal cancer. This study evaluates the quality of colonoscopy undertaken in rural and regional South Australia.

METHODOLOGY: Prospective data collection occurred for all endoscopies and colonoscopies performed over a 12 months period (July 2020 to July 2021) at five regional hospitals in South Australia. Data was then compared against benchmark key performance indicators. The outcomes measured include completion rate, adenoma detection rate, serrated polyp detection rate, cancer detection rate and perforation rate. All of these are validated key performance indicators in colonoscopy.

RESULTS - INTERIM*: At the time of interim analysis 2,037 patients were included in the dataset, 1515 of these underwent colonoscopy. Complete colonoscopy was documented in 95.5% of the procedures. The polypectomy rate was 37.8%, with an adenoma detection rate of 27.2% and serrated polyp detection rate of 4.1%. 3 patients sustained a colonoscopy-related perforation.

CONCLUSIONS: The quality of colonoscopy reported in this multi-center rural audit meets benchmark key performance indicators as outlined by national and international groups.

**Please note that data collection is ongoing at the time of submission of this abstract. At the PSA conference we intend to present the final study results. Data collection will conclude in mid-July 2021. The interim results are for the data collection period between 13/7/20 to 31/12/20.*

The short-term outcomes of colorectal surgery on anxiety and depression - **Dr Philip Chia**

PURPOSE: Major colorectal surgery consists of managing three main disease processes: colorectal cancer, inflammatory bowel disease and diverticular disease. These diseases all carry a heavy psychological burden. Despite this, the effect of colorectal surgery on anxiety and depression has been rarely investigated. The primary aim of this study is to assess short-term effects on anxiety and depression of major colorectal surgery. Secondary aims are to determine factors associated with change in anxiety and depression.

METHODOLOGY: All consecutive patients between June 2015 and November 2018 undergoing major colorectal surgery under a single surgeon were invited to enrol. Hospital Anxiety and Depression Scale (HADS) survey was completed during consultation appointments prior to surgery and immediately after surgery. Scores were compared to determine change in levels of anxiety and depression. Regression analysis was performed to determine factors associated with change in HADS scores, factors associated with postoperative anxiety and depression, and factors associated with length of hospital admission.

Abstracts

RESULTS: There was mean decrease of -1.99 ($p<0.001$) in anxiety (HADS-A) score. There was no significant change in depression (HADS-D) score. Multivariate analysis indentified current or prior mental illness and preoperative cases of anxiety or depression were associated with a change in HADS-A and HADS-D score. Independent predictors of postoperative anxiety included stoma formation, history of concurrent mental illness and preoperative anxiety. Independent predictors of length of stay included preoperative HADS-D score, prior neoadjuvant chemoradiotherapy and complications.

CONCLUSION: This study identified that undergoing major colorectal surgery decreases anxiety.

14-Year Experience of Oesophageal Cancer Treatment from a Single Centre - **Dr Devesh Kaushal**

INTRODUCTION: Only 12.6% of people with oesophageal cancer survive over 10 years. Oesophagectomy is the most successful curative option for resectable oesophageal and oesophago-gastric cancers. The role of lymphadenectomy and its impact remains unresolved. This study aims to determine the influence of lymph node resection, chemotherapy regimen, resection margins and tumour type on survival.

METHODS: Patients who underwent oesophagectomy for oesophageal cancer in a tertiary centre in the UK, with or without chemotherapy, were identified from a prospectively maintained database from 2005-2017. We analysed survival by number of lymph nodes resected, number of positive nodes, lymph node ratio, chemotherapy regimen and resection margin positivity.

RESULTS: 130 patients were included in this study, with median follow-up of 93 months (range 24-170 months). The median overall survival was 91 months, and 5- and 10-year survival were 58.1% and 47% respectively. Pathological staging of the cancers revealed that 46.9% of patients had positive nodal disease. Our analysis demonstrated improved survival when ≥24 lymph nodes were removed compared to <24 (5-year survival was 64% and 45% respectively, $p <0.038$). The number of lymph nodes removed was an independent predictor of survival. Shortest survival in patients with an LNR of 10-20% and ≥ 20%. There was no significant difference in survival between different chemotherapeutic regimens.

CONCLUSIONS: This study suggests there is better long-term survival in patients when 24 or more nodes were removed. The number of lymph nodes harvested is an independent and significant predictor of survival in patients undergoing oesophagectomy for operable oesophageal cancer.

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Thank you for joining us – hope you enjoy the program.

See you in person soon.