

Western Surgical Association

# 2013 ANNUAL SCIENTIFIC SESSION

Saturday through Tuesday November 2–5, 2013 The Grand America Hotel Salt Lake City, Utah

and

Transactions of the 2012 Annual Meeting The Broadmoor Resort Colorado Springs, Colorado

## LOCATION

#### The Grand America Hotel

Salt Lake City, Utah

### REGISTRATION

Sat, Nov 2	3:00pm - 6:00pm
Sun, Nov 3	7:00am - 12 Noon
Mon, Nov 4	7:00am - 5:00pm
Tue, Nov 5	7:30am - 12 Noon

## SCIENTIFIC SESSIONS

Sun, Nov 3	7:30am - 12 Noon
Mon, Nov 4	7:30am - 12 Noon —and— 1:30pm - 4:00pm
Tues, Nov 5	8:00am - 12 Noon

### **MEETING OBJECTIVES**

- 1. Delineate the importance of new diagnostic and therapeutic modalities in surgery.
- 2. Prioritize treatment of surgical diseases with new operative and non-operative technologies and treatment options.
- 3. Elucidate the outcome of new surgical procedures.

### **ACCREDITATION STATEMENT**

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the American College of Surgeons and the Western Surgical Association. The American College Surgeons is accredited by the ACCME to provide continuing medical education for physicians.

### AMA PRA CATEGORY 1 CREDITS<sup>™</sup>

The American College of Surgeons designates this live activity for a maximum of 13.75 *AMA PRA Category 1 Credits*<sup>™</sup>. Physicians should only claim the credit commensurate with the extent of their participation in the activity.

Of the AMA PRA Category 1 Credits<sup>™</sup> listed above, a maximum of 10 credits meet the requirements for Self-Assessment.



American College of Surgeons Division of Education

### **DISCLOSURE INFORMATION**

In compliance with ACCME Accreditation Criteria, the American College of Surgeons, as the accredited provider of this activity, must ensure that anyone in a position to control the content of the educational activity has disclosed all relevant financial relationships with any commercial interest. All reported conflicts are managed by a designated official to ensure a bias-free presentation. Please see the insert to this program for the complete disclosure list.

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## ELECTED TO MEMBERSHIP AT THE ANNUAL MEETING NOVEMBER 2012

### The Western Surgical Association Welcomes its New Members and their Spouses

**Adela Casas-Melley, M.D.** Sioux Falls, SD

**Eugene Choi, M.D.** Chicago, IL

**Andrew Chontos, M.D.** Sioux Falls, SD

Rami Dakkuri, M.D. Santa Cruz, CA

**Jonathan D'Cunha, M.D.** Pittsburgh, PA

**Carl Doerhoff, M.D.** Jefferson City, MO

George Fuhrman, M.D. New Orleans, LA

**Steven Johnson, M.D.** Phoenix, AZ

**Paul Kuo, M.D.** Maywood, IL **John Mansour, M.D.** Dallas, TX

**Terri Marty, M.D.** Fort Collins, CO

Keith Paley, M.D. Owatonna, MN

Bashar Safar, M.D. St. Louis, MO

John Santaniello, M.D. Hines, IL

Geoffrey Silver, M.D. Hines, IL

**Thavam Thambi-Pillai, M.D.** Sioux Falls, SD

Michael Ujiki, M.D. Evanston, IL

Katharine Yao, M.D. Evanston, IL

# WESTERN SURGICAL ASSOCIATION MISSION STATEMENT

The Western Surgical Association is dedicated to the cultivation, promotion, and diffusion of the art and science of surgery, to the sponsorship and maintenance of the highest standards of practice and to the delivery of the best possible care for the public. The goal of our continuing medical education effort is to provide information to the practicing surgeon that will enhance his/her knowledge regarding new diagnostic modalities and therapeutic maneuvers. The scope of our activities is meant to encompass the breadth of general surgery, including the primary and secondary components and is intended for our members and guests who are surgeons in academic and private practice. Our activities will focus on recent advances in basic science applicable to surgical practice, new developments in technology, issues in pre- and post-operative care; assessment of diagnostic accuracy and surgical outcomes; and critical analysis of the information provided.



# WESTERN SURGICAL ASSOCIATION 121<sup>st</sup> Scientific Session

# FUTURE MEETINGS

November 8–11, 2014

Miramonte Resort and Spa Indian Wells, California

November 7–10, 2015

Meritage Resort and Spa Napa Valley, California

## OFFICERS - 2013

**PRESIDENT** Clive Grant Rochester, Minnesota

1<sup>ST</sup> **VICE PRESIDENT** Norman Estes Peoria, Illinois

**2<sup>ND</sup> VICE PRESIDENT** Thomas Stellato South Euclid, Ohio **SECRETARY** R. James Valentine Dallas, Texas

**TREASURER** Mark Talamonti Evanston, Illinois

**RECORDER** Kelly McMasters Louisville, Kentucky

# EXECUTIVE COMMITTEE

**PRESIDENT** Clive Grant Rochester, Minnesota

**SECRETARY** R. James Valentine Dallas, Texas

**TREASURER** Mark Talamonti Evanston, Illinois

**RECORDER** Kelly McMasters Louisville, Kentucky

IMMEDIATE PAST PRESIDENT Raymond Joehl Phoenix, Arizona

**PAST PRESIDENT** Gregory J. Jurkovich Denver, Colorado

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PAST PRESIDENT Michael Farnell Rochester, Minnesota

DISTRICT REPRESENTATIVE Donald Low Seattle, Washington

**DISTRICT REPRESENTATIVE** Randall Smith Temple, Texas

**DISTRICT REPRESENTATIVE** Karen Borman Abington, Pennsylvania

DISTRICT REPRESENTATIVE Margo Shoup Warrenville, Illinois

# OTHER REPRESENTATIVES

#### BOARD OF GOVERNORS, AMERICAN COLLEGE OF SURGEONS

Karen J. Brasel Milwaukee, Wisconsin

#### AMERICAN BOARD OF SURGERY

Gregory J. Jurkovich Denver, Colorado

#### ADVISORY COUNCIL ON SURGERY, AMERICAN COLLEGE OF SURGEONS

Thomas A. Broughan Falls Church, Virginia

#### **MEMBERSHIP COMMITTEE - 2013**

Jason Fleming – *Chair* Katherine Liu Anees Chagpar Mark Faries Donald Low Randal Smith Clive Grant, *Ex-Officio* R. James Valentine, *Ex-Officio* Mark Talamonti, *Ex-Officio* 

#### PROGRAM COMMITTEE - 2013

Mitchell Posner – *Chair* Amalia Cochran Mark Talamini Peter Rhee Karen Borman Margo Shoup Clive Grant, *Ex-Officio* R. James Valentine, *Ex-Officio* Kelly McMasters, *Ex-Officio* 

#### LOCAL ARRANGEMENTS CHAIRMAN – 2013

Leigh Neumayer and Amalia Cochran Salt Lake City, Utah



# Schedule of Events

# SCHEDULE OF EVENTS

### **FRIDAY, NOVEMBER 1**

4:30pm – 5:30pm Advisory Nominating Committee Divide

6:00pm – 9:30pm Executive Committee Dinner (invitation only) Off Property

### **SATURDAY, NOVEMBER 2**

8:00am – 12noon **Executive Committee Meeting** Milano

3:00pm – 6:00pm **WSA Registration Open** Imperial Ballroom Reg Deck

*3:00pm – 5:00pm* **Exhibitor Setup** Imperial Ballroom B

*5:30pm – 6:30pm* **New Member Reception** Vienna

*6:30pm* – 8:30pm **Welcome Reception** Grand Salon

### **SUNDAY, NOVEMBER 3**

7:00am – 8:00am **Continental Breakfast for Physicians** Imperial Ballroom B

7:00am – 12noon **WSA Registration Open** Imperial Ballroom Reg Deck

*7:00am – 12noon* **Exhibits Open** Imperial Ballroom B

8:00am – 10:00am **Spouse/Guest Hospitality and Breakfast** Vienna

*7:30am – 10:00am* **Scientific Session I** Imperial Ballroom A

10:00am – 10:15am Beverage Break Imperial Ballroom B

10:15am – 11:15am Scientific Session I continued Imperial Ballroom A

11:15am – 12noon Presidential Address: Dr. Clive S. Grant Imperial Ballroom A

12:30pm – 5:00pm Optional Tour: Salt Lake City Grand Tour

### SUNDAY, NOVEMBER 3 continued

1:30pm – 4:30pm Optional Tour: Utah Olympic Park Tour

Afternoon **Open** 

### **MONDAY, NOVEMBER 4**

7:00am – 8:00am **Continental Breakfast for Physicians** Imperial Ballroom B

7:00am – 5:00pm **WSA Registration Open** Imperial Ballroom Reg Deck

*7:30am – 1:30pm* **Exhibits Open** Imperial Ballroom B

*7:30am – 12noon* Scientific Session II Imperial Ballroom A

8:00am – 10:00am **Spouse/Guest Hospitality and Breakfast** Vienna

10:00am – 11:30am Spouse/Guest Program: Style Seminar and Lunch at Nordstrom City Creek Center

10:30am – 10:45am Beverage Break Imperial Ballroom B

### MONDAY, NOVEMBER 4 continued

12noon – 1:30pm NEW Video Session (Boxed Lunch Included) Imperial Ballroom A

12:15pm – 1:15pm **Western Surgical Women in Surgery Lunch** Garden Café

*1:30pm – 4:00pm* Scientific Session III Imperial Ballroom A

*1:30pm – 2:30pm* **Special Discussion** Imperial Ballroom A

*1:30pm* **Exhibit Teardown** Imperial Ballroom B

*3:00pm – 3:15pm* **Beverage Break** Imperial Ballroom B

*4:00pm – 5:00pm* Annual Business Meeting Imperial Ballroom A

*7:00pm – 8:00pm* **Presidents Reception** Grand Salon Foyer

8:00pm – 11:00pm **President's Dinner Dance** Grand Salon

### **TUESDAY, NOVEMBER 5**

7:30am – 8:00am Continental Breakfast for Physicians and Spouses Imperial Ballroom B

7:30am – 12noon **WSA Registration Open** Imperial Ballroom Reg Deck

8:00am –12noon Scientific Session IV Imperial Ballroom A

9:20am – 9:40am Beverage Break

Imperial Ballroom B

12:00noon Meeting Concludes



# Scientific Program

## SCIENTIFIC PROGRAM

#### FIRST SCIENTIFIC SESSION

*Sunday, November 3, 2013 – 7:30am – 12Noon* Moderator: Dr. Clive S. Grant

> The Surgical Olympics: Identifying What Day 1 Interns Know And How Much They Can Be Expected To Learn In 6 Months Of Training Raaj Ruparel, Yazan AlJamal, Siddhant Yadav, David Farley Mayo Clinic

#### Prognostic Effect Of Ultra-Staging Node Negative (Pn0) Colon Cancer Without Adjuvant Chemotherapy: Prospective Nci Clinical Trial 5RO1CA090848

Alexander Stojadinovic, Mladjan Protic, Aviram Nissan, Zev Wainberg, Scott R. Steele, David Chen, Nir Wasserberg, Dan Seror, Sarah Morgenstern, Itzhak Avital, Anton Bilchik

John Wayne Cancer Institute & University of California - Santa Monica

#### Metformin And Sorafenib Have Synergistic Effects On Liver Cancer Cells But Variable Effects On Stem-Like Liver Cancer Cells

Hong-Wu Xin, Chenwi M. Ambe, Tyler C. Miller, Jin-Qiu Chen, Gordon W. Wiegand, Andrew J. Anderson, Satyajit Ray, John E. Mullinax, Danielle M. Hari, Tomotake Koizumi, Jessica D. Godbout, Paul K. Goldsmith, Alexander Stojadinovic, Snorri Thorgeirsson, Udo Rudlof, Itzhak Avital Sponsor: Scott Steele Bon Secours Cancer Institute

1. Validating Trauma Specific Frailty Index For Geriatric Trauma Patients: A Prospective Analysis

Viraj Pandit, Bellal Joseph, Hassan Aziz, Julie Wynne, Bardiya Zangbar, Narong Kulvatunyou, Terence O'Keeffe, Andrew Tang, Gary Vercruysse, Mindy J. Fain, Randall S. Friese, *Peter Rhee* The University of Arizona **Invited Discussant: Christopher Brandy, Chico, California** 

 Changing Surgical Trends In Young Patients With Early Stage Breast Cancer, 2003-2010: A Report From The National Cancer Data Base Catherine Pesce, Tomasz Czechura, David J. Winchester, David P. Winchester, Katharine Yao, NorthShore University HealthSystem Invited Discussant: Nora Hansen, Chicago, Illinois

- 3. Tep Inguinal Hernia Repair: Are Patient Outcomes Based On Annual Surgeon Volume? Yazan N. AlJamal, Benjamin Zendejas, Shahzad M. Ali, Stephanie F. Heller, Michael L. Kendrick, *David R. Farley* Mayo Clinic Invited Discussant: David Sheldon, Kalispell, Montana
- 4. Workplace Satisfaction And Retention Of Surgical Specialists In Academic Medicine In The United States: Analysis Of Critical Factors Philip Wai, David M. Radosevich, Valerie Dandar, Linda Brubaker, Ann Steinecke, *Paul Kuo*, Loyola University Medical Center Invited Discussant: Jonathan D'Cunha, Pittsburgh, Pennsylvania
- 5. Diagnostic Value Of Epigenetic Chromatin Conformation Changes Identified In Peripheral Blood To Differentiate Early Stage Melanoma From Healthy Volunteers

*James W Jakub\**, Travis Grotz, Antoni Ribas, Phillip Jordan, Ewan Hunter, Mark Pittelkow, Roger S. Lo, Bartosz Chmielowski, Elizabeth Seja, Aroul Ramadass, Alexandre Akoulitchev, Svetomir Markovic Mayo Clinic

Invited Discussant: Mark Faries, Santa Monica, California

#### INTRODUCTION OF NEW MEMBERS

#### PRESENTATION OF "J. BRADLEY AUST AWARD" FOR BEST PAPER BY A NEW MEMBER

#### RECIPIENT OF "J. BRADLEY AUST AWARD" 2012 – Thomas A. Aloia, MD

.....INTERMISSION.....

#### Moderator: Dr. Norman Estes

 A Prospective Three Year Study of Repeat Head Computed Tomography In Traumatic Brain Injury Bellal Joseph, Ammar Hashmi, Viraj Pandit, Narong Kulvatunyou, Hassan Aziz, Terence O'Keeffe, Andrew Tang, Julie Wynne, Gary Vercruysse, Lynn Gries, Randall S. Friese, *Peter Rhee* The University of Arizona Invited Discussant: Gregory J. Jurkovich, Denver, Colorado

- 7. Concomitant Cholecystectomy Should Be Routinely Performed With Laparoscopic Roux-En-Y Gastric Bypass Anna Weiss, Tazo Inui, Alisa Coker, Ralitza Parina, Garth Jacobsen, Mark Talamini, Santiago Horgan, Bryan Sandler University of California San Diego Invited Discussant: James Madura, II, Scottsdale, Arizona
- Adrenalectomy Outcomes Are Superior With The Participation Of Fellows Carolyn D. Seib, David Yu Greenblatt, Michael J. Campbell, Wen T. Shen, Jessica E. Gosnell, Orlo H. Clark, *Quan-Yang Duh* University of California San Francisco Invited Discussant: Samuel Snyder, Temple, Texas

#### PRESIDENTIAL ADDRESS Dr. Clive S. Grant "4-Part Harmony: From Hand Crank to Hash Tags"

#### SECOND SCIENTIFIC SESSION

*Monday, November 4, 2013 – 7:300am – 12noon* Moderator: Dr. Clive S. Grant

> Vocal (Voice Outcomes Appraisal, Longitudinal) Trial: A Prospective Longitudinal Multimodal Evaluation Comparing Voice Outcomes In Patients Undergoing Total Thyroidectomy, Partial Thyroidectomy, And Non-Neck Surgery

Diego A. Vicente, Nancy P. Solomon, Itzhak Avital, Leonard R. Henry, Robin S. Howard, George L. Coppit, Craig D. Shriver, Chester C. Buckenmaier, Steven K. Libutti, Ashok R. Shaha, Alexander Stojadinovic Sponsor: Scott Steele Walter Reed National Military Medical Center

Impact Of Maximum Cytoreduction Plus Regional Chemotherapy On Outcome Of Gastric Cancer Patients With Peritoneal Carcinomatosis Udo Rudloff, Russell C. Langan, John E. Mullinax, Seth M. Steinberg, Tatiana Beresnev, Carole C. Webb, Melissa Walker, Mary Ann Toomey, David Schrump, Prakash Pandalai, Alexander Stojadinovic, Itzhak Avital Sponsor: Scott Steele National Cancer Institute, Surgery Branch

9. Prct Comparing Standard Oral Analgesia With Multi-Modal Targeted Operative And Port-Site Local Anesthesia For Post-Operative Pain Management

Mladjan Protic, Radovan Veljkovic, Anton J. Bilchik, Ana Popovic, Aviram Nissan, MD; Bjoern Bruecher, Martin Daumer, Itzhak Avital, Alexander Stojadinovic Sponsor: Scott Steele Walter Reed National Military Medical Center **Invited Discussant: Margo Shoup, Warrenville, Illinois** 

10. A Twenty Year Experience Of Hepatic Resection For Melanoma: Is There An Expanding Role? Mark Faries, Anna Leung, Donald Morton, Danielle M. Hari, Ji H. Lee, Anton Bilchik

John Wayne Cancer Institute and Saint Johns Health Center Invited Discussant: Thomas Aloia, Houston, Texas

#### 11. Do Trauma Stomas Ever Get Reversed?

Laura Godat, Leslie Kobayashi, David Chang, *Raul Coimbra* University of California San Diego **Invited Discussant: John Santaniello, Hines, Illinois** 

12. Direct Peritoneal Resuscitation Improves Mortality, Liver Blood Flow, And Fluid Balance In A Rat Model Of Acute Brain Death Jason W. Smith, Paul J. Matheson, Cameron A. Ghazi, Brandon C. Cain, Cynthia D. Downard, R. Neal Garrison, *J. David Richardson* University of Louisville Invited Discussant: Alan Hemming, San Diego, California

#### 13. Endovascular Management Of Popliteal Aneurysms Kim Nguyen, M. Ashraf Mansour, Michelle C. Kosovec, Jason D. Slaikeu, Christopher M. Chambers, Robert F. Cuff Michigan State University Invited Discussant: Howard Saylor, III, Edina, Minnesota

14. The Validation of Predictive Scoring Models in Primary Hyperparathyroidism to Differentiate Single-Gland from Multigland Disease Sapna Nagar, Omran Embia, Edwin L. Kaplan, *Peter Angelos*, Raymon H. Grogan University of Chicago Invited Discussant: Shelby Holt, Dallas, Texas

#### .....INTERMISSION.....

#### 10:20am – 12Noon Moderator: Dr. Clive S. Grant

- 15. Single Staged Resection Combined With Microwave Ablation (Mw) For The Treatment Of Bilobar Colorectal Cancer Metastases: Results From 201 Consecutive Patients: Superior To Two-Stage Hepatectomy Prejesh Philips, Ryan T Groeschl, Erin M Hanna, Ryan Z Swan, David Sindram, John B Martinie, David A Lannitti, Mark Bloomston, Carl Schmidt, T Clark Gamblin, *Robert CG Martin* University of Louisville Invited Discussant: William Chapman, St. Louis, Missouri
- 16. Success & Sustainability: An Acute Care Surgery Model In A Community Hospital Setting Michael Shay O'Mara, Lynette A. Scherer, David H. Wisner, Leon J. Owens Mercy San Juan Medical Center Invited Discussant: Tom Cogbill, LaCrosse, Wisconsin
- 17. Laparoscopic Gastric Ischemic Preconditioning Improves Functional Outcomes After Esophagectomy

Sabha Ganai, Mark S. Talamonti, John Howington, Ki-Wan Kim, John Linn, *Michael B. Ujiki* NorthShore University HealthSystem **Invited Discussant: Robert Martin, II, Louisville, Kentucky** 

- 18. Identification Of High Risk Population Of Patients Undergoing Endarterectomy For Asymptomatic Carotid Stenosis Tiffany Y. Wu, Gabriel Akopian, Steven G. Katz Huntington Hospital Invited Discussant: Bruce Gewertz, Los Angeles, California
- 19. Is A Low Readmission Rate Indicative Of A Good Hospital Ralitza Parina, David Chang, *Mark Talamini* University of California, San Diego Invited Discussant: Leigh Neumeyer, Salt Lake City, Utah

.....INTERMISSION.....

#### VIDEO SESSION (with boxed lunch) - Moderator: Dr. Mark Talamonti

Michael B. Ujiki, Chicago, Illinois - *Endoscopic Heller Myotomy* James W. Fleshman, Dallas, Texas - *Laparoscopic Low Anterior Resection* Michael Kendrick, Rochester, Minnesota - *Laparoscopic Distal Pancreatectomy* James A. Madura, II, Scottsdale, Arizona - *Laparoscopic Roux-en-y Gastric Bypass* 

OR 12noon – 1:30pm **Lunch Break on own** 

#### THIRD SCIENTIFIC SESSION

*Monday, November 4, 2013 1:30pm – 4:00pm* Moderator: Dr. Tomas A. Stellato

#### SPECIAL DISCUSSION - Moderator: Dr. Raymond J. Joehl

"Adapting to Changes in Financing of Healthcare, Education and Research" Bruce L. Gewertz, Los Angeles, California – *Clinical* Thomas H. Cogbill, LaCrosse, Wisconsin – *Education* James Economou, Los Angeles, California – *Research* 

.....INTERMISSION.....

#### Moderator: Dr. Thomas A. Stellato

- 20. The Addition Of A Deep Inguinal Dissection Does Not Improve Nodal Recurrence Or Survival In Melanoma Michael E Egger, Russell E Brown, Brent A Roach, Amy R Quillo, Robert CG Martin II, Charles R Scoggins, Arnold J Stromberg, *Kelly M. McMasters* University of Louisville Invited Discussant: Jeff Lee, Houston, Texas
- 21. Reinforcement Of The Intestinal Mucus Layer Protects Against Clostridium Difficile Intestinal Injury In Vitro Lawrence N. Diebel, David M. Liberati Wayne State University Invited Discussant: Eugene Choi, Chicago, Illinois

#### 22. Individualized Multimodality Management Of Elderly Patients With Pancreatic Cancer

Amanda B. Cooper, Holly M. Holmes, Jude KA des Bordes, David Fogelman, Shana Palla, Nathan Parker, Jason B. Fleming, Jeffrey E. Lee, Peter W.T. Pisters, Douglas B. Evans, Christopher Crane, Robert A. Wolff, Gauri Varadhachary, *Matthew H.G. Katz* MD Anderson Cancer Center **Invited Discussant: John Mansour, Dallas, Texas** 

4:00pm – 5:00pm Annual Business Meeting (members only)

### FOURTH SCIENTIFIC SESSION

*Tuesday, November 5, 2013 – 8:00am – 11:00am* Moderator: (President Elect)

23. Hormone Receptor Status Does Not Affect Prognosis In Metaplastic Breast Cancer

G. Paul Wright, Marianne K. Melnik, Mathew H. Chung GRMEP/Michigan State University Sponsor: M. Ashraf Mansour Invited Discussant: Katherine Yao, Evanston, Illinois

24. Higher Alcohol Intoxication Is Associated With Less Severe Injuries After Blunt Trauma

Douglas Z Liou, Matthew Bloom, Nicolas Melo, Marko Bukur, Daniel R. Margulies, Ali Salim, Eric J. Ley Cedars-Sinai Medical Center Invited Discussant: Peter Rhee, Tucson, Arizona

25. Non-Operative Management Of Main Pancreatic Duct Involved Intraductal Papillary Mucinous Neoplasm May Be Indicated In Selected Patients Roch AM, DeWitt JM, Al-Haddad MA, Schmidt CMII, Ceppa EP, House MG, Zyromski NJ, Nakeeb A, *Schmidt CM* Indiana University School of Medicine Invited Discussant: Mark Talamonti, Evanston, Illinois

- 26. Fluorescently-Labeled Chimeric Anti-Cea Antibodies Enable Fluorescence-Guided Laparoscopic Surgery Of Pancreatic Cancer Cristina A. Metildi, Sharmeela Kaushal, George A. Luiken, Mark A. Talamini, Robert M. Hoffman, Michael Bouvet University of California San Diego Invited Discussant: Kelly McMasters, Louisville, Kentucky
- 27. Reoperative Surgery: A Critical Risk Factor For Complications Inadequately Captured By Operative Reporting And Coding Of 'Lysis Of Adhesions' *Thomas A. Aloia*, Amanda B. Cooper, Weiming Shi, Jean-Nicolas Vauthey, Jeffrey E. Lee MD Anderson Cancer Center Invited Discussant: Stephen Johnson, Phoenix, Arizona
- 28. Metastatic Lymph Node Ratio Successfully Predicts Prognosis In Western Gastric Cancer Patients Onur Kutlu, Mitch Wachtel, Sharmila Dissanaike Sponsor: Gregory J. Jurkovich Texas Tech University Health Sciences Center Invited Discussant
- 29. Concurrent Beta-Blockers Reduce Mortality Among Patients With Sepsis Irada Ibrahim-zada, Randall S. Friese, John Santoro Jr, Kara Snyde, Peter Rhee University of Arizona Invited Discussant: Will Fry, Roanoke, Virginia

Meeting Concludes

Italics indicates a member of the Western Surgical Association \*Indicates a new member 

Indicates Aust Award Candidate

## PAST RECIPIENTS OF THE "J. BRADLEY AUST AWARD"

### FOR BEST PAPER BY A NEW MEMBER

**2012** Thomas A. Aloia Houston, TX

**2011** M.B. Majella Doyle St. Louis, Missouri

**2010** Thomas Robinson Aurora, Colorado

**2009** Karen Borman Abington, Pennsylvania

**2008** Mark B. Faries Santa Monica, California

**2007** Jason B. Fleming Houston, Texas

**2006** Frank R. Arko Dallas, Texas

**2005** Donald E. Low Seattle, Washington **2004** Samuel K. Snyder Temple, Texas

**2003** Nora Hansen Santa Monica, California

**2002** Mark S. Talamonti Chicago, Illinois

**2001** Kelly M. McMasters Louisville, Kentucky

**2000** M. Ashraf Mansour Maywood, Illinois

**1999** William C. Chapman Nashville, Tennessee

**1998** R. Stephen Smith Ranoke, Virginia

<u>Presenting</u> author must be a new WSA member within the past 2 years in order to qualify for the J. Bradley Aust Award.

### THE WESTERN SURGICAL ASSOCIATION WOULD LIKE TO THANK THE FOLLOWING COMPANIES FOR THEIR GENEROUS SUPPORT OF OUR MEETING THROUGH EDUCATIONAL GRANTS:

### **BK Medical**

### Covidien

### W.L. Gore & Associates

### THE WESTERN SURGICAL ASSOCIATION GRATEFULLY ACKNOWLEDGES THE SUPPORT OF THE FOLLOWING EXHIBITING COMPANIES:





# **Abstracts**

Individual abstracts of the papers to be presented at this year's annual meeting appear on the following pages:

### ABSTRACTS

FIRST SCIENTIFIC SESSION Sunday, November 3, 2013 | 7:30am to 12:00 Noon

#### **Quick Shots**

The Surgical Olympics: Identifying What Day 1 Interns Know And How Much They Can Be Expected To Learn In 6 Months Of Training Raaj Ruparel, Yazan AlJamal, Siddhant Yadav, David Farley Mayo Clinic

#### Prognostic Effect Of Ultra-Staging Node Negative (Pn0) Colon Cancer Without Adjuvant Chemotherapy: Prospective Nci Clinical Trial 5RO1CA090848

Alexander Stojadinovic, Mladjan Protic, Aviram Nissan, Zev Wainberg, Scott R. Steele, David Chen, Nir Wasserberg, Dan Seror, Sarah Morgenstern, Itzhak Avital, Anton Bilchik John Wayne Cancer Institute & University of California - Santa Monica

John wayne Cancer Institute & University of Camornia - Santa Monica

#### Metformin And Sorafenib Have Synergistic Effects On Liver Cancer Cells But Variable Effects On Stem-Like Liver Cancer Cells

Hong-Wu Xin, Chenwi M. Ambe, Tyler C. Miller, Jin-Qiu Chen, Gordon W. Wiegand, Andrew J. Anderson, Satyajit Ray, John E. Mullinax, Danielle M. Hari, Tomotake Koizumi, Jessica D. Godbout, Paul K. Goldsmith, Alexander Stojadinovic, Snorri Thorgeirsson, Udo Rudlof, Itzhak Avital Sponsor: Scott Steele Bon Secours Cancer Institute

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NOTES

#### FIRST SCIENTIFIC SESSION Sunday, November 3, 2013 | 7:30am to 12:00 Noon

#### VALIDATING TRAUMA SPECIFIC FRAILTY INDEX FOR GERIATRIC TRAUMA PATIENTS: A PROSPECTIVE ANALYSIS

Viraj Pandit, Bellal Joseph, Hassan Aziz, Julie Wynne, Bardiya Zangbar, Narong Kulvatunyou , Terence O'Keeffe, Andrew Tang , Gary Vercruysse, Mindy J. Fain, Randall S. Friese, and Peter Rhee.

**Background:** Frailty Index (FI) has been shown to predict outcomes in geriatric patients. Aim: Validate the modified 15 variable Trauma Specific Frailty Index (TSFI) to predict discharge disposition in geriatric trauma patients.

Design: 1 year prospective analysis of geriatric (≥65y.o.) trauma patients.

Setting: Level 1 trauma center

**Patients and Methods:** Patients discharge disposition was dichotomized into unfavorable outcome defined as discharged to skilled nursing facility or death, or favorable outcome defined discharge to home or rehabilitation center. Patients were evaluated utilizing a 50 variable FI for predicting unfavorable outcome. A 15 variable TSFI (Figure 1) was developed based on the factors most significant for unfavorable outcome. Multivariate logistic regression was performed to identify factors that predict unfavorable outcome.

**Results:** We enrolled 250 patients: 100 for model development and 150 patients for validation. Mean age 77.3 $\pm$ 8 years, median Injury Severity Score (ISS) 12 [8-18], median Glasgow Coma Scale (GCS) 14 [13-15], and mean FI 0.3  $\pm$  0.15. 30% (n=45) patients had unfavorable outcome. After adjusting for age, gender, Injury severity score, Head abbreviated injury scale, and vital on admission, frailty Index (OR: 1.8, 95% CI: 1.2-2.4) was the only significant predictor for unfavorable outcome. Age (OR: 1.3, 95% CI: 0.5-2.2) was not predictive of unfavorable outcome.

Figure 1 : Modified 15 Frailty Index							
Hypertension	Help toileting						
High Cholesterol	Feeling less useful						
History of Cancer	Feel everything an effort						
Dementia	Self-rating of health						
Help for grooming	Feeling lonely						
Help for managing money	Sex ual Activity						
Help climbing stairs	Albumin Level						
Help doing household work							

**Conclusion:** The 15 variable Trauma Specific Frailty Index is an independent predictor of unfavorable discharge disposition in geriatric trauma patients. TSFI is an effective tool that can aid clinicians in planning discharge disposition of geriatric trauma patients. NOTES

### ABSTRACTS CONTINUED

FIRST SCIENTIFIC SESSION Sunday, November 3, 2013 | 7:30am to 12:00 Noon

CHANGING SURGICAL TRENDS IN YOUNG PATIENTS WITH EARLY STAGE BREAST CANCER, 2003-2010: A REPORT FROM THE NATIONAL CANCER DATA BASE Catherine Pesce, Tomasz Czechura, David J. Winchester, David P. Winchester, and Katharine Yao

**Background:** Young patients with breast cancer represent a unique cohort of patients that often have different treatment plans than older patients. Previous studies have shown an increase in bilateral mastectomy, and age has been consistently associated with this trend. **Hypothesis:** We hypothesized that the rate of bilateral mastectomy was significantly higher and lumpectomy significantly lower in young patients compared to older patients and that this trend persists when adjusting for patient, tumor, and facility factors.

Design: Retrospective review of an observational dataset

**Setting:** National Cancer Data Base, a convenience sample of oncology patients collected from Commission on Cancer accredited cancer centers across the United States.

**Patients and Methods:** We analyzed 307,900 patients with AJCC Stage 0-II breast tumors who underwent lumpectomy, unilateral mastectomy, or bilateral mastectomy between January 2003 and December 2010. Neoadjuvant cases and patients diagnosed through an excisional biopsy were excluded.

**Results**: 12.7% of patients were less than 45 years old. Over the entire cohort, lumpectomy rates dropped from 67.7% in 2003 to 65.7% in 2010, unilateral mastectomy went from 28.5% to 24.6%, and bilateral mastectomy from 3.8% to 9.7%. Age was the most significant factor related to an increase in bilateral mastectomy. Amongst patients <50 years old, rates of lumpectomy dropped from 63.5% to 53.6% compared to women >50 years old where lumpectomy rates remained stable at approximately 69%. Amongst women <50 years old, rates of bilateral mastectomy increased from 6.7% to 19.8% compared to women >50 years old with rates of 2.6% to 6.7%. Women less than 45 years old had bilateral mastectomy rates of 8.0% in 2003 increasing to 24.9% in 2010 (Figure 1). Amongst women <45 years old, lumpectomy rates significantly dropped, unilateral mastectomy rates slightly decreased, and bilateral mastectomy rates significantly increased across all tumor stages, size, grade, histology, patient race and facility type. Thirteen percent of women with stage 0, 21.9% of stage I, and 29% of stage II patients underwent bilateral mastectomy in 2010. Multivariate logistic regression showed that women <45 years old compared to

## ABSTRACTS CONTINUED

women >45 years who underwent bilateral mastectomy were more likely to be non-white, have tumors that were ER negative, tumors >2cm, high grade, ductal, and to be treated at an academic center.



Figure 1. Surgical procedure performed from 2003-2010 for AJCC Stage 0-II breast cancer patients <45 years old

**Conclusion:** The rate of bilateral mastectomy continues to increase with a quarter of younger women undergoing bilateral mastectomy. This trend persists across all tumor stages and characteristics, patient race, and facility type.

NOTES

### ABSTRACTS CONTINUED

#### FIRST SCIENTIFIC SESSION Sunday, November 3, 2013 | 7:30am to 12:00 Noon

TEP INGUINAL HERNIA REPAIR: ARE PATIENT OUTCOMES BASED ON ANNUAL SURGEON VOLUME? Yazan N. AlJamal, Benjamin Zendejas, Shahzad M. Ali, Stephanie F. Heller, Michael L. Kendrick, David R. Farley

**Background:** Data for endoscopic totally extra peritoneal inguinal hernia repair (TEP-IHR) suggest that 250 operations are needed to gain mastery, but the annual volume required to maintain high-quality outcomes is unknown.

**Hypothesis:** Greater staff annual volume of TEP-IHR is associated with improved outcomes and may be a better indicator than total volume.

**Design:** An IRB-approved, retrospective review (1995-2011) of every patient undergoing a TEP-IHR at our institution.

Setting: Academic tertiary referral center.

**Patients and Methods:** A total of 1601 patients underwent 2410 TEP-IHR. Analysis focused on the annual volume of 21 surgical staff and their specific patient outcomes broken up into three groups: Group 1 performed >30 repairs per year, Group 2 had 15-30 repairs and Group 3 had <15 repairs.

**Results**: Mean patient age was 55 years (range 16-87), 96% were male, and mean BMI was 26.8 (SD 3.6).

#### Outcomes varied by annual operative volume:

		Group 1		Group 2		Group 3		
		(N=1104 patients/		(N=266 patients/		(N=231 patients/		P value
		1683 repairs)		394 repairs)		333 repairs)		1 -value
OR Time	Unilateral	N=525	78 min	N=138	74 min	N=129	86 min	< 0.01
	Bilateral	N=579	88 min	N=128	82 min	N=102	110 min	< 0.01
Majority of assistants		Interns	50%	PGY4- 5	60%	PGY5	50%	< 0.01
Intra-op Complications		N=10	1%	N=9	3%	N=15	7%	< 0.01
Peritoneotomy		N=29	3%	N=39	15%	N=22	10%	< 0.01
Post-op Complications		N=147	13%	N=71	27%	N=83	36%	< 0.01
Overnight Stay		N=186	17%	N=60	23%	N=67	29%	< 0.01
Recurrence		N=13	1%	N=11	4%	N=8	4%	< 0.01
Median Follow-up in months		80 (0-212)		36 (0-106)		25 (0-140)		<0.01
Median operative times decreased over time in all three groups (p<0.05), but no improvement in intra- and post-operative complications, nor recurrence rates were seen in groups 2 and 3.

**Conclusion:** Patient outcomes were better under the care of more experienced surgeons; annual operative volumes of >30 cases/year maintain high-quality outcomes for TEP-IHR. Surgeons who do not meet these targets should seek and be receptive of mentoring from high-volume surgeons in an effort to "cheat the learning curve". Based on this data we have initiated a TEP-IHR mentoring program at our institution.

FIRST SCIENTIFIC SESSION Sunday, November 3, 2013 | 7:30am to 12:00 Noon

WORKPLACE SATISFACTION AND RETENTION OF SURGICAL SPECIALISTS IN ACADEMIC MEDICINE IN THE UNITED STATES: ANALYSIS OF CRITICAL FACTORS Philip Wai, David M. Radosevich, Valerie Dandar, Linda Brubaker, Ann Steinecke, Paul Kuo

**Background:** Competition amongst academic medical centers for clinical excellence with operational efficiency and financial solvency requires institutions to retain their most productive and skillful surgical specialists. Perceptions of the workplace, overall satisfaction, and intent to leave are relationships that have not been previously examined among U.S. surgeons in academic medicine.

**Hypothesis:** We hypothesized that critical factors related to workplace satisfaction and intention to leave could be identified as important for enhancing institutional retention of academic surgeons.

**Design:** The 2011-2012 AAMC Faculty Forward Engagement Survey evaluated demographic variables, physician workplace satisfaction, and overall engagement among faculty subgroups, including comparison of surgical and non-surgical clinicians. Multiple regression analysis ( $\beta$ = standard regression coefficient) was performed to identify critical factors most closely related to surgeon satisfaction and intent to leave their institutions.

**Results:** 1356/1949 (70%) surgeons from 13 medical schools responded across different faculty subgroups, and comparison was made with 1105 non-surgical clinicians. Multiple regression indicated that strongest predictors of surgeons' overall satisfaction with their department included department governance ( $\beta$ = .36; p<0.001), collegiality and collaboration ( $\beta$ = .23; p<0.001), and relationship with supervisor ( $\beta$ = .17; p<0.001). While compensation and benefits was important ( $\beta$ = .0.08; p<0.001), it did not rank as the most important factor. Promotion equality (odds ratio = .62; p<.05), collegiality and collaboration (odds ratio = .51; p<.05), and perception of individual job factors (odds ratio = .52; p<.05) were most closely related to intent to leave the medical school within 1-2 years.

**Conclusion:** This analysis represents the largest survey focusing on workplace factors affecting surgical faculty satisfaction and intent to leave. Institutional understanding of and improvement in specific work environment factors may enhance recruitment and retention of academic surgeons

#### FIRST SCIENTIFIC SESSION Sunday, November 3, 2013 | 7:30am to 12:00 Noon

#### DIAGNOSTIC VALUE OF EPIGENETIC CHROMATIN CONFORMATION CHANGES IDENTIFIED IN PERIPHERAL BLOOD TO DIFFERENTIATE EARLY STAGE MELANOMA FROM HEALTHY VOLUNTEERS AND OTHER CUTANEOUS MALIGNANCIES

James W Jakub\*, Travis Grotz, Antoni Ribas, Phillip Jordan, Ewan Hunter, Mark Pittelkow, Roger S. Lo, Bartosz Chmielowski, Elizabeth Seja, Aroul Ramadass, Alexandre Akoulitchev , Svetomir Markovic

**Background:** Clinical exam and patient self-reporting are inadequate to reliably diagnose early stage melanoma. A simple screening test to allow for early detection would be ideal.

**Hypothesis:** Epigenetic analysis of blood samples could discriminate patients with melanoma from patients with other cutaneous lesions and healthy volunteers.

Design: Prospective pilot study

Setting: Two tertiary academic centers

**Patients and Methods:** Whole blood was obtained from 59 patients with melanoma, 20 patients with nonmelanoma cutaneous malignancy and 20 healthy volunteers. Utilizing PCR analysis 15 chromatin conformation biomarkers from 5 gene loci were analyzed from each of these samples after 3C modification using the EpiSwitch assay.

**Results:** Stratification of patients with melanoma from healthy controls was correct 85% (51/60) of the time, resulting in a sensitivity of 85% a specificity of 75% a positive predictive value (PPV) of 77% and a negative predictive value (NPV) of 83%. Stratification of patients with melanoma from nonmelanoma cutaneous malignancy was correct 88% (53/60) of the time, resulting in a sensitivity of 88% a specificity of 82% a PPV of 83% and a NPV of 88%. The non-invasive test was more accurate in early stage melanoma (1/10 stage I and 1/16 stage II patients were misclassified) and became less accurate with more advanced stage (3/15 and 4/19 stage III and IV patients were misclassified, respectively). **Conclusion:** We report the results of a blood test analyzing epigenetic changes via

chromosome conformational changes identified in peripheral blood. Using a non-invasive blood test, we were able to differentiate melanoma samples from healthy, benign, or nonmelanoma skin cancers with a high degree of accuracy. The markers were most reliable in early stage disease. This simple blood test has the potential to serve as an accurate diagnostic tool in early stage melanoma. The decreased sensitivity in more advanced stages is likely due to increased genomic instability and polyclonality.

### FIRST SCIENTIFIC SESSION

Sunday, November 3, 2013 | 7:30am to 12:00 Noon

### A PROSPECTIVE THREE YEAR STUDY OF REPEAT HEAD COMPUTED TOMOGRAPHY IN TRAUMATIC BRAIN INJURY

Bellal Joseph, Ammar Hashmi, Viraj Pandit, Narong Kulvatunyou, Hassan Aziz, Terence O'Keeffe, Andrew Tang, Julie Wynne, Gary Vercruysse, Lynn Gries, Randall S. Friese and Peter Rhee

**Background:** Standardization of a routine repeat head computed tomography (CT) in patients with traumatic intracranial hemorrhage is still variable.

**Hypothesis:** Repeat head computed tomography (RHCT) does not lead to neurosurgical intervention in examinable patients without neurologic deterioration.

**Design:** 3-year prospective analysis of all patients with intracranial hemorrhage on initial head CT and a follow-up RHCT

Setting: Level 1 trauma center

**Patients and Methods:** Results of initial and RHCT and indications for RHCT (routine vs. neurologic deterioration) were recorded. Neurosurgical intervention was defined by craniotomy/craniectomy. Neurologic deterioration was defined as altered mental status, focal neurological deficits and/or pupillary changes. Multivariate logistic regression was utilized to assess the relationship between radiographic worsening, neurologic exam, and the need for neurosurgical intervention.

**Results:** 1129 patients underwent a total of 1702 repeat CT scans. Routine RHCT was performed in 1099 patients. The worsening rate was 19.7% (216/1099) with subsequent neurosurgical intervention in 4 patients. No patient with a normal neurological exam needed neurosurgical intervention based on RHCT. 30 patients had a RHCT secondary to neurologic deterioration of which 53% (16/30) had worsening on RHCT and 75% (12/16) required neurosurgical intervention. There was an association between deterioration in neurologic exam and subsequent neurosurgical intervention (odds ratio: 3.98; 95% CI: 1.7–9.1). The positive predictive value (PPV) of a deteriorating neurologic exam in predicting the need for neurosurgical intervention was 75% compared to 0.3% in patients with radiographic worsening in the absence of neurologic deterioration.

**Conclusion:** RHCT in the absence of neurologic decline in an examinable patient is not warranted. RHCT does not substitute neurologic examination in determining the need for neurosurgical intervention in traumatic brain injury patients.

#### FIRST SCIENTIFIC SESSION Sunday, November 3, 2013 | 7:30am to 12:00 Noon

CONCOMITANT CHOLECYSTECTOMY SHOULD BE ROUTINELY PERFORMED WITH LAPAROSCOPIC ROUX-EN-Y GASTRIC BYPASS Anna Weiss, Tazo Inui, Alisa Coker, Ralitza Parina, Garth Jacobsen, Mark Talamini, Santiago Horgan, Bryan Sandler

**Background:** Low rates of gallbladder disease following RYGB and high complication rates of concomitant cholecystectomy have been published, but these population-based studies have lacked long-term data.

**Hypothesis:** We hypothesized that performing concomitant cholecystectomy would have better outcomes than RYGB followed by cholecystectomy.

Design: Retrospective database review.

**Setting:** The California Office of Statewide Health Planning and Development longitudinal database was queried for patients who underwent RYGB between 1995-2009.

**Patients and Methods:** There were 134,584 total patients. 21,0222 of those underwent concomitant cholecystectomy. Additionally patients who underwent cholecystectomy after RYGB were compared to all cholecystectomies in the same time period. Primary outcome was survival; secondary long-term outcomes included cholangitis, common duct stones, dumping syndrome, metabolic derangements, ventral hernia, any hernia, marginal ulcers, and reoperation. Cox proportional hazard analysis was performed to determine adjusted survival and outcomes. Total charges over time were calculated for RYGB with or without cholecystectomy.

**Results:** As rates of laparoscopy increased to over 90%, concomitant cholecystectomy rates decreased to less than 10%. Concomitant cholecystectomy reduced long term complications and improved survival as compared to RYGB alone (HR .75 [.68-.82] and .47 [.45-.5] respectively). The cost of concomitant cholecystectomy is higher (78425.10[75634.72-81215.47]) than RYGB without (70190.34[69353.00-71027.68]). At 10 years 21.8% of patients have gall bladder complications. The rates of conversion, post-operative complication, and death are higher in patients undergoing cholecystectomy if they had previous RYGB (OR 1.58[1.4-1.78], 1.57[1.36-1.6], HR 1.32[1.17-1.5]).

**Conclusion:** While slightly more expensive to perform, concomitant cholecystectomy is protective for RYGB patients. Given high rates of gallbladder disease and increased risk when cholecystectomy is performed following RYGB, cholecystectomy should be considered at the time of RYGB.

#### FIRST SCIENTIFIC SESSION Sunday, November 3, 2013 | 7:30am to 12:00 Noon

ADRENALECTOMY OUTCOMES ARE SUPERIOR WITH THE PARTICIPATION OF FELLOWS Carolyn D. Seib, David Yu Greenblatt, Michael J. Campbell, Wen T. Shen, Jessica E. Gosnell, Orlo H. Clark, Quan-Yang Duh

**Background:** Adrenalectomy is a complex procedure that is performed in a variety of settings, with and without the assistance of residents and fellows. Patients often ask, "who will be performing my operation?" and seek reassurance that involvement of trainees will not adversely affect the quality of care. The purpose of this study was to determine the association between trainee participation and adrenalectomy perioperative outcomes.

**Hypothesis:** Medical centers that have residency and fellowship training programs do not have inferior patient outcomes after adrenalectomy.

Design: Retrospective cohort study.

Setting: Over 300 community and academic hospitals nationwide.

**Patients and Methods:** Patients who underwent adrenalectomy from 2005-2011 were selected from the database of the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP). Trainee participation was determined and classified as none, resident, or fellow, based on the post-graduate year of the assisting surgeon; patients with missing data were excluded (n = 439 of 4133). Associations between trainee participation and perioperative outcomes were determined via univariate and multivariate analyses.

**Results:** From a total of 3694 adrenalectomies, 732 (19.8%) were performed by an attending surgeon with no assistance from a trainee, 2315 (62.7%) involved a resident, and 647 (17.5%) a fellow. The mean procedure length was shorter for attending surgeons operating alone. Trainee participation did not influence the frequencies of intraoperative blood transfusions or reoperation. There was also no significant association between trainee operative participation and 30-day mortality. Interestingly, the participations (2.8% with fellows vs. 6.0% with residents and 7.9% with no trainees, p<0.001). The mean length of hospital stay was also lower with fellow involvement. In a multivariable model, the odds of 30-day morbidity were similar when attendings operated alone or with residents.

However, the participation of fellows was associated with significantly lower odds of morbidity (adjusted odds ratio 0.53, 95% confidence interval 0.34-0.83).

**Conclusion:** In this analysis of contemporary multi-institutional data, there was no evidence to suggest that trainee participation during adrenalectomy adversely affects the quality or safety of surgical care. In fact, participation of fellows was associated with fewer complications and shorter length of stay. High-volume endocrine surgery programs train future endocrine surgeons and appear to deliver superior patient care.

Outcome	No Trainee (n = 732)	Resident (n = 2315)	Fellow (n = 647)	Р
Mean length of procedure, minutes	141	158	154	<0.001
Intra-operative blood transfusion	3.8%	4.4%	3.3%	0.42
Reoperation	2.6%	2.2%	1.7%	0.53
30d mortality	0.96%	0.73%	0.31%	0.34
Any post-op complication	9.3%	8.1%	5.0%	0.007
Any serious post-op complication*	7.9%	6.0%	2.8%	<0.001
Mean length of stay, days	4.1	4.2	3.2	0.044

**Table.** Perioperative outcomes in 3694 patients who underwent adrenalectomy, stratified by trainee operative participation.

\* Excludes superficial SSI and UTI.

SECOND SCIENTIFIC SESSION Monday, November 4, 2013 | 7:30am to 12:00 Noon

#### **Quick Shots**

#### VOCAL (VOICE OUTCOMES APPRAISAL, LONGITUDINAL) TRIAL: A PROSPECTIVE LONGITUDINAL MULTIMODAL EVALUATION COMPARING VOICE OUTCOMES IN PATIENTS UNDERGOING TOTAL THYROIDECTOMY, PARTIAL THYROID ECTOMY, AND NON-NECK SURGERY

Diego A. Vicente, Nancy P. Solomon, Itzhak Avital, Leonard R. Henry, Robin S. Howard, George L. Coppit, Craig D. Shriver, Chester C. Buckenmaier, Steven K. Libutti, Ashok R. Shaha, Alexander Stojadinovic

#### IMPACT OF MAXIMUM CYTOREDUCTION PLUS REGIONAL CHEMOTHERAPY ON OUTCOME OF GASTRIC CANCER PATIENTS WITH PERITONEAL CARCINOMATOSIS

Udo Rudloff, Russell C. Langan, John E. Mullinax, Seth M. Steinberg, Tatiana Beresnev, Carole C. Webb, Melissa Walker, Mary Ann Toomey, David Schrump, Prakash Pandalai, Alexander Stojadinovic, Itzhak Avital



#### SECOND SCIENTIFIC SESSION Monday, November 4, 2013 | 7:30am to 12:00 Noon

#### PRCT COMPARING STANDARD ORAL ANALGESIA WITH MULTI-MODAL TARGETED OPERATIVE AND PORT-SITE LOCAL ANESTHESIA FOR POST-OPERATIVE PAIN MANAGEMENT IN ELECTIVE LAPAROSCOPIC CHOLECYSTECTOMY (LAPCHOLE)

Mladjan Protic, Radovan Veljkovic, Anton J. Bilchik, Ana Popovic, Aviram Nissan, Bjoern Bruecher, Martin Daumer, Itzhak Avital, Alexander Stojadinovic, M

**Background**: Peri-portal nerve stimulation has recently been suggested as a mechanism for pain after laparoscopic cholecystectomy (LapChole). We therefore conducted a PRCT to evaluate whether somatovisceral pain blockade reduces pain after LapChole.

**Hypothesis**: Analgesic efficacy of multi-modal analgesia is superior to standard analgesia for patients undergoing elective LapChole for symptomatic cholelithiasis. Specifically, topical cystic plate and port-site infiltration with 0.25% bupivacaine significantly reduces pain after LapChole.

Design: Single-blinded PRCT

Setting: Academic medical center

**Patients and Methods**: Between February and May 2010 we randomly assigned 63 patients with symptomatic cholelithiasis in a 1:1 ratio to institutional standard non-opioid/ opioid analgesic combinations (n=32), and institutional standard analgesia plus topical 0.25% bupivacaine spray onto the cystic plate and local 0.25% bupivacaine port-site injection, post-LapChole (n=31). Primary endpoint was patient-reported pain 1, 4, 6, 12, and 24 hours, and 1 week post-LapChole using the Visual Analog Scale (VAS, 0-10). Results: Study groups were comparable clinicopathologically. There were no study-procedure-associated adverse events. A statistically significant reduction in mean pain score was apparent in patients receiving multi-modal analgesia at all early (1-6 hours) post-operative time points and at one week following LapChole(p<0.05).

**Conclusion**: This PRCT shows significantly improved pain reduction with somatovisceral pain blockade than institutional standard analgesic combinations following LapChole for symptomatic cholelithiasis. For centers not utilizing adjunctive local anesthetic for LapChole, this multi-modal analgesic approach may improve patient comfort during recovery. This approach serves as the basis for a planned 4-arm PRCT designed to provide further insights into the role of local anesthetics in multi-modal operative site analgesia.

TABLE 1	Leperoscopic cholecystectomy for symptomatic cholelithiesis Standard analgesis combined with topical and port-site anesthesis anesthesis Total patients						
	No Yes						
Characteristic	Number	Percent Median	Number	Percent Median	P	Number Mean ±	Percent Median
	Wean ± SD	(range)	Mean ± SD	(range)		SD	(range)
SD: median (range)					p=0.361		
				55 (25-	-		53 (21-
Gender, male	49 E 15	51 (21-74)	52 £ 15	(9)		50 £ 15	(6)
concert, mare	N = 6	18.8%	N = 10	32.3%	p=0.257	N = 16	25.4%
Weight, kg, mean ±					- 0 311		
op; median (range)		72 (48-	81.0 ±	76 (55-	p=0.211	78.6 ±	75 (48-
	76.3 ± 18.3	125)	17.7	136)		18.0	136)
Height, cm, mean ±					0-0.069		
		165 (145-	170.5 ±	171 (150-		168.4 ±	168 (145-
Bhill he /mt maan d	166.4 ± 7.7	180)	9.6	188)		8.9	188)
SD: median (range)					p=0.720		
		25.5		26.1			26.0
	27.8 + 5.5	43.3	27.9 + 5.4	(20.2 -		27.6 ±	48.3)
Smoking, yes, active							
Education bighest	N = 5	15.6%	N = 10	32.3%	p=0.148	N = 15	23.8%
level					p=0.23		
Elementary school	N = 2	6.3%	N - 6	19.4%		N = 8	12.7%
High school	N=17	53.1%	N-12	38.7%		N=29	46.0%
Higher education	N=13	40.6%	N-13	41.9%		N=26	41.3%
Occupational physical							
labor intensity					p=0.115		
Light	N - 9	28.1%	N - 4	12.9%		N=13	20.6%
Moderate	N=19	59.4%	N=26	83.9%		N=45	71.4%
Heavy Employed, yes	N - 4	12.5%	N = 1	3.2%		N = 5	7.9%
	N - 16	51.6%	N - 16	50%	p=0.55	N = 32	50.8%
ASA classification					p=1.00		
1	N - 9	28.1%	N - 8	25.8%		N = 17	27.0%
	N = 12	37.5%	N = 13	41.9%		N = 25	39.7%
	N - 11	34.4%	N = 10	32.3%		N = 21	33.3%
RBC, n x 10 <sup>*</sup> /L, mean					n=0 112		
z so, modian (rango)		4.6 (3.9 -		4.8 (4.2 -	p=0.112		4.7 (3.9 -
	4.6 ± 0.5	5.5)	4.7± 0.4	5.6)		4.7 ± 0.4	5.6)
± SD; median (range)					p=0.611		
		6.3 (4.0 -		6.6 (3.9 -	• • •		6.5 (3.9 -
Blood sugar mmol/l	7.3 ± 3.4	22.8)	7.Z ± Z.Z	14.2)		7.2 ± 2.8	ZZ.8)
mean ± SD;							
median(range)		56(41.		55/38.	p=0.808		55/98-
	5.6 ± 0.8	7.0)	$5.5 \pm 1.5$	8.7)		$5.5 \pm 1.1$	8.7)
BUN mmol/L, mean ±							
su; median (range)		5.2 (2.6 -		5.7 (3.2 -	p=0.284		5.7 (2.6 -
	5.5 ± 1.8	9.5)	6.5 ± 4.3	28.3)		6.0 ± 3.3	28.3)
Total bilirubine, mmol/L: mean + SD:							
median(range)					p=0.756		
	98+94	9.1 (5.0 -	105+43	9.0 (6.0 -		10.1 ±	9.0 (5.0 -
Size of largest	0.0 1 0.4						
galistones					p=0.148		
Small (< 0.5 cm)	N = 5	15.6%	N = 10	32.3%		N = 15	23.8%
cm)	N - 9	28.1%	N - 9	29.0%		N = 18	28.6%
(	N - 10		N - 19	-		N - 90	47.6%
Duration of	n = 18	30.57	R = 12	30./7		m = 30	
operation,min, mean ±	1						
SU; measun(range)		40 (15 -	50.1 ±	45 (15 -	p=0.156	46.5 ±	40 (15 -
1	$43.1 \pm 19.1$	90)	28.0	120)		21.8	1201

TABLE 2							
Hospital stay, days,							
meen ± SD: median							
(range)					p=0.066		
1	2.3 ± 0.6	2 (2 - 4)	2.1 ± 0.2	2 (2 - 3)		$2.2 \pm 0.5$	2 (2 - 4)
impairment of							
mobility score day 1							
(VAS: 0 worst; 10							
optimal); mean ± SD;							
meanin (range)					p=0.728		
	5.6 ± 2.6	6 (2 - 10)	5.7 ± 2.7	6 (1 - 10)		5.7 ± 2.6	6 (1 - 10)
impairment of							
MODILITY SCORE day /							
ontimeD: mean + SD:							
median (range)					p=0.104		
				10 (6 -			
	8.4 ± 2.4	9 (1 - 10)	9.3 ± 1.0	10)		8.9 ± 1.9	9 (1 - 10)
Severity of post-							
operative neuses at 1							
10 covere): mean é							
SD: median (range)					D=0.136		
		e (n e)		1 (0 10)			3 (0 10)
Severity of poet-	3.2 I 2.0	3 (0 - 8)	L.L I 3.L	1 (0 - 10)		2.7 2 3.0	2 (0 - 10)
operative neuses at 6							
hours; (VAS: 0 none,							
10 severe); mean ±							
SD; median (range)					p=0.037		
	1.9± 2.4	1 (0 - 8)	1.1 ± 2.3	0 (0 - 10)		1.5 ± 2.4	0 (0 - 10)
Pain score, VAS, at 1							
nour, mean ± SD;					a +0 001		
median (range)					p.0.001		
	8.3 ± 1.7	9 (3 - 10)	6.2 ± 2.5	6 (Z - 10)		7.2 ± 2.4	8 (2 - 10)
Pain score, VAS, at 4							
median (range)					p<0.001		
		7 (2 10)		4/1 100			
Bala score VAS at 6	0.7 ± 2.0	7 (4 - 10)	7.7 2 2.3	+ (1 - 10)		3.0 £ Z.4	a (i - 10)
hours, mean ± SD:							
median (range)					p=0.001		
	54+19	6 (1 - 8)	39+22	3 (1 - 9)		47+21	4 (1 - 9)
Pain acore, VAS, at		· · · · · · · · · · · · · · · · · · ·					
12 hours, mean ± SD;							
median (range)					p=0.343		
	3.7 ± 2.2	4 (1 - 8)	3.2 ± 2.2	2 (1 - 9)		3.5 ± 2.2	3 (1 - 9)
Pain score, VAS, at							
24 hours, mean ± SD;							
median (range)					p=0.146		
1	2.9 ± 1.9	3 (1 - 8)	2.4 ± 2.2	2 (0 - 8)		2.6 ± 2.0	2 (0 - 8)
Pain score, VAS, at 7							
days, mean ± SD;							
median (range)					p=0.000		
1	1.0 ± 0.9	1 (0 - 4)	$0.4 \pm 0.6$	0 (0 - 2)		$0.7 \pm 0.8$	1 (0 - 4)

#### SECOND SCIENTIFIC SESSION Monday, November 4, 2013 | 7:30am to 12:00 Noon

A TWENTY YEAR EXPERIENCE OF HEPATIC RESECTION FOR MELANOMA: IS THERE AN EXPANDING ROLE? Mark Faries, Anna Leung, Donald Morton, Danielle M. Hari, M., Ji H. Lee and Anton Bilchik

**Background:** Melanoma liver metastasis is most often fatal with only a 4-6 month median overall survival (OS). Over the past 20 years surgical techniques have evolved in parallel with more effective systemic therapies. This study reports the largest experience of melanoma metastatic to the liver in the USA.

Hypothesis: We hypothesized a benefit to surgery for metastatic melanoma.

**Design, Setting, Patients and Methods:** Since 1991, 1,074 patients with melanoma metastatic to the liver have been treated at our institution. Only 58 (5.4%) were considered candidates for surgical therapy (resection+/-ablation). OS and disease specific survival (DSS) were calculated from diagnosis of hepatic metastases. Potential prognostic factors including primary tumor type, depth, medical treatment response, location and surgical approach were evaluated.

**Results:** Median OS and 5-year rate of OS were 8 months and 6.6 %, respectively, for the 1,016 nonsurgical patients versus 24.8 months and 30%, respectively, for the 58 surgical patients (p<0.001) (Survival Curve). There was no difference in OS based on type of surgical therapy: median OS was 26.1 months for the 40 patients undergoing resection alone and 18.8 months for 18 patients undergoing either ablation or a combination of ablation and resection. Corresponding rates of 5-year OS were 28.6% and 33.3%, respectively (p=0.726). In the surgical group, the only predictor of longer OS and DSS was stabilization of melanoma on therapy prior to surgery OS: (HR: 0.089 (0.029-0.276), p=0.011)) and DSS: (HR: 0.084 (0.024-0.288), p=0.0008)).

**Conclusion:** In this largest single-institution experience, patients selected for surgical therapy experienced markedly improved survival relative to those who underwent only medical therapy. This represented only 5.8% of the overall population with liver metastases in an era of relatively ineffective medical therapy. Those patients experiencing stabilization of disease on medical therapy enjoyed particularly favorable results, regardless of the number or size of their metastases. The advent of more effective systemic therapy in melanoma may substantially increase the fraction of patients who are eligible for such interventions, and this combination of treatment modalities should be considered whenever it is feasible in the context of a multidisciplinary team.



#### Disease Specific Surgery: Metastatic Melanoma to the Liver – Surgery v. Medical Therapy

#### SECOND SCIENTIFIC SESSION Monday, November 4, 2013 | 7:30am to 12:00 Noon

DO TRAUMA STOMAS EVER GET REVERSED? Laura Godat, Leslie Kobayashi, David Chang, Raul Coimbra

**Background**: There is a paucity of information regarding the frequency and timing of reversal following traumatic stoma creation. In addition, the barriers to reversal faced by these patients are largely unknown. Long term follow-up in trauma patients has historically been lacking contributing the gap in knowledge.

**Hypothesis:** We hypothesize that the rate of stoma creation and reversal are low among trauma patients. Additionally, we sought to identify patient related barriers to stoma reversal.

**Design**: Longitudinal analysis of the California Office of Statewide Health Planning and Development patient database.

Setting: All non-federal hospitals in California from 1995 to 2010.

**Patients and Methods:** Inclusion criteria were all trauma patients with hollow viscus injury requiring stoma creation. Exclusion criteria were presence of a stoma at the time of injury or death within 48hours of admission. Patient characteristics studied included; age, gender, admission year, race, Survival Risk Ratio (a surrogate for ISS), Charlson comorbidity index, insurance status, teaching and trauma center status. Kaplan Meir, logistic regression, and Cox proportional hazard analysis were performed to identify predictors of immediate and eventual reversal.

**Results**: A total of 58,564 patients had hollow viscus injuries, 4,032 resulted in stoma creation; 257 (6.4%) were reversed during their index hospitalization. Following discharge 41% of patients were reversed at 6 months, 61% at 1 year, and 72% at 5 years. Median follow up was 6.5 years. 54% of stoma reversals occurred at a different hospital from the index admission.

During index admission, Black race and being at a teaching hospital had a significantly increased chance of stoma reversal. After initial admission having insurance significantly increased the likelihood of reversal; however, those of Black and Hispanic race had a significantly decreased rate.

**Conclusion**: The true stoma reversal rate appears to be higher than we hypothesized; this is most likely due to the high rate of migration between hospitals. Black and Hispanic races, as well as lack of insurance appear to be significant barriers to reversal following discharge.

#### SECOND SCIENTIFIC SESSION Monday, November 4, 2013 | 7:30am to 12:00 Noon

DIRECT PERITONEAL RESUSCITATION IMPROVES MORTALITY, LIVER BLOOD FLOW, AND FLUID BALANCE IN A RAT MODEL OF ACUTE BRAIN DEATH Jason W. Smith, Paul J. Matheson, Cameron A. Ghazi, Brandon C. Cain, Cynthia D. Downard, R. Neal Garrison, J. David Richardson

**Background:** Brain death in organ donors alters central hemodynamic performance, impairs hormone physiology, exaggerates the systemic inflammatory response, causes endorgan microcirculatory dysfunction, and leads to tissue hypoxia. A new treatment (Direct Peritoneal Resuscitation, DPR) that stabilizes vital organ blood flow in resuscitated (RES) hemorrhagic shock might improve these derangements.

**Hypothesis:** The addition of DPR to the RES of rats undergoing acute brain death (ABD) might improve the associated liver hypoperfusion.

Design: Basic science study with matched controls (Groups 1-3)

**Methods:** Anesthetized male Sprague-Dawley rats were randomized: 1) ABD (supradural balloon inflation) with minimal i.v. RES (2 mL/hr, n=12); 2) ABD + adequate i.v. RES (goal: survival, n=12); 3) ABD with aggressive i.v. RES (goal: MAP>80, n=15); or 4) ABD + i.v. RES + DPR (goal: MAP>80, n=12). Ventilation support, i.v. fluid RES, and DPR were started at loss of reflexes, and MAP, HR, and liver blood flow (LBF) were recorded.

**Results:** Aggressive i.v. RES or DPR prevented mortality (0%) compared to minimal i.v. RES (81.8%) or mid i.v. RES (16.7%). LBF was decreased in Groups 1 and 2 (2.8 $\pm$ 0.3<sup>\*</sup> and 4.0 $\pm$ 0.5<sup>\*</sup>) vs. baseline, but stable in Group 3 (6.2 $\pm$ 0.5 NS) or improved with DPR in Group 4 (8.6 $\pm$ 0.7<sup>\*</sup>). Groups 1-3 had lung edema (wet-dry weight) and Group 3 had elevated serum Na<sup>\*</sup> (149.8 $\pm$ 1.1), Ca<sup>\*+</sup> (7.6 $\pm$ 0.1) and PO<sub>4</sub><sup>3-</sup> (7.0 $\pm$ 0.2), which was prevented by the addition of DPR in Group 4.

**Conclusion:** DPR improved survival and LBF, required less i.v. RES fluid to stabilize blood pressure, prevented lung edema, and normalized fluid electrolyte balance compared to fluid RES alone groups (1-3). These data suggest a potential role for DPR in organ donors to stabilize cardiovascular function, maintain serum electrolyte balance and normalize compartmental fluid distribution. In organ donors, DPR prior to perioperative RES regimen might improve number of organs suitable for transplantation per donor and post-transplantation organ function.

#### SECOND SCIENTIFIC SESSION Monday, November 4, 2013 | 7:30am to 12:00 Noon

ENDOVASCULAR MANAGEMENT OF POPLITEAL ANEURYSMS Kim Nguyen, M. Ashraf Mansour, Michelle C. Kosovec, Jason D. Slaikeu, Christopher M. Chambers, Robert F. Cuff

**Background:** Popliteal aneurysms (PA) were traditionally repaired by ligation and preferentially vein bypass. Covered stents were introduced 10 years ago and are currently used to repair popliteal aneurysms (PA).

**Hypothesis:** Endovascular repair of PA is equivalent to open repair in short-term and long-term patency, and limb salvage.

Design: Retrospective review of records in a prospective database.

Setting: University affiliated tertiary care hospital.

**Patients and Methods:** In a 10-year period ending in April 2013, we repaired 104 PA in 81 patients (5 women; average age 71), 23 (28%) were bilateral. All patients had preoperative imaging with angiograms or CTA. All patients were followed as outpatients with noninvasive tests. Ambulatory status was recorded.

**Results:** The average PA size was 3.5 cm (range 1.6 – 8.0 cm). Two of the women had atherosclerotic PA and 3 had large pseudoaneurysms after orthopaedic instrumentation. Acutely ischemic limbs were first treated with thrombolysis. Open repair was performed using a vein bypass in 47, PTFE in 11 and Dacron in 9. Viabahn stents were placed percutaneously or via femoral cutdown in 37. Four patients required concomitant fasciotomies and there were 4 acute amputations. Four patients required graft revisions within 30 days. There were no 30-day deaths. In follow-up, the primary assisted patency was 94% at one year for both endovascular and open repair. Since 2009, the majority of PA was repaired using endovascular techniques.

**Conclusion:** The management of PA is changing with the adoption of endovascular techniques as the primary option. This trend is similar to that of aortic aneurysms that are now predominantly repaired with an endovascular graft in the U.S.

#### SECOND SCIENTIFIC SESSION Monday, November 4, 2013 | 7:30am to 12:00 Noon

#### THE VALIDATION OF PREDICTIVE SCORING MODELS IN PRIMARY HYPERPARATHYROIDISM TO DIFFERENTIATE SINGLE-GLAND FROM MULTIGLAND DISEASE

Sapna Nagar, Omran Embia, Edwin L. Kaplan, Peter Angelos, Raymon H. Grogan

**Background:** The majority of people with primary hyperparathyroidism (PHPT) have single-gland disease (SGD). However, it is still difficult to predict those who will have multi-gland disease (MGD). Several scoring models have been created to evaluate this issue.

**Hypothesis:** The primary aim of this study is to determine the utility of two predictive scoring models that have been described in differentiating SGD from MGD in PHPT.

Design: Retrospective Review

Setting: Academic tertiary-care referral center

**Patients and Methods:** We analyzed a database of patients who underwent surgical intervention for PHPT from 2005-2011 at our institution. Demographic, biochemical, preoperative imaging, and pathologic data were collected. The scoring model from UCSF (CaPTHUS) and the Wisconsin Index Nomogram (WIN) scoring model were applied to our cohort of patients.

**Results:** A total of 1071 of our patients were studied; 871 (81.2%) had SGD, and 200 (18.6%) had MGD. In the CaPTHUS scoring model, when a total score of  $\geq$ 3 of the 5 predictors was obtained this correctly identified 70.4% of all patients with SGD with a positive predictive value of 98.7%. For the WIN scoring model, which is based upon correlation between gland weight against calcium, PTH, or WIN we demonstrated only moderate correlation [0.2983, p<0.0001; 0.3970 p<0.0001; 0.4804, p<0.0001, respectively]. Contrary to the original study, as gland weight increased for each WIN category, a lower percentage of patients had MGD. However, in our analysis we found that concordance of sestamibi and ultrasound and elevated WIN were highly predictive of SGD on logistic regression analysis [OR: 6.08, 95%CI: (4.28-8.73); OR: 0.999, 95%CI: (0.998-0.9996), respectively].

**Conclusion:** The CaPTHUS scoring model could not identify 30% of SGD despite its high positive predictive value. The WIN scoring model did not have strong correlations between its predictive parameters in our population. We believe that a better scoring model will encompass elements of each of these scoring models.



#### SECOND SCIENTIFIC SESSION Monday, November 5, 2012 | 7:30am to 12:00 Noon

SINGLE STAGED RESECTION COMBINED WITH MICROWAVE ABLATION FOR BILOBAR COLORECTAL CANCER METASTASES: RESULTS FROM 201 CONSECUTIVE PATIENTS: SUPERIOR TO TWO-STAGE HEPATECTOMY Prejesh Philips, Ryan T Groeschl, Erin M Hanna, Ryan Z Swan, David Sindram, John B Martinie, David A Iannitti, Mark Bloomston, Carl Schmidt, T Clark Gamblin, Robert CG Martin

**Background:** Optimal surgical management of bilobar colorectal liver metastasis has evolved with options including two-stage hepatectomy, combined bilateral segmentectomies, or combination resection and ablation.

**Hypothesis:** Patients undergoing combined liver resection and microwave ablation (MW) for bilobar colorectal metastasis have similar adverse events to MW ablation alone and similar overall survival to patients who undergo two stage hepatectomies.

Design: Prospective evaluation of 201 consecutive patients

Setting: Four large volume academic centers

**Patients and Methods:** Morbidity (90 day) & mortality evaluated in all three groups (MW alone, MW w/ Resection, and two stage hepatectomy).

Characteristics	MW Alone 100 Pts	MW w/ Rx 101 Pts	TwoStage 159 pts	р
Age	65	64	58	0.08
Svnchronous Disease	60%	63%	45%	0.05
Induction Chemo (Y/N)	75% ves	65% ves	95% ves	0.07
CEA	9	122	96	0.04
CRC Risk Score	3	4	4	0.06
Maior Resection	NA	45%	52%	ns
Adverse Events (>2)	0%	12%	35%	0.02
90 mortality	1%	5%	7%	ns
Post Ablation Chemo	44%	56%	52%	ns
Overall Survival	38.3months	37.3months	33.2 mon	ns

#### **Results:**

**Conclusion**: The use of single staged hepatectomy and microwave ablation for contralateral disease is safe and effective in appropriate patients, with similar overall survival to two-staged hepatectomy with less overall morbidity.

#### SECOND SCIENTIFIC SESSION Monday, November 4, 2013 | 7:30am to 12:00 Noon

#### SUCCESS & SUSTAINABILITY: AN ACUTE CARE SURGERY MODEL IN A COMMUNITY HOSPITAL SETTING Michael Shay O'Mara, Lynette A. Scherer, David H. Wisner, Leon J. Owens

**Background:** Implementing an "acute care surgery" (ACS) model, utilizing dedicated acute care surgeons and midlevel's to provide all emergency general surgical care, has been associated with improved outcome measures and efficiency. This model has been most frequently described in academic settings with little being published on the feasibility of this model in a private setting.

**Hypothesis:** We hypothesized that an ACS service could be implemented in a private practice, non-trauma, and community hospital, without altering quality, cost, or outcome of care.

Design: Retrospective review

Setting: Tertiary referral community hospital, without trauma affiliation

**Patients and Methods:** All emergency surgery operations performed during one year prior to and 4 years after implementation of the ACS service were reviewed for demographics, complications, length of stay, type of operation, and hospital costs.

**Results:** 3, 131 operations performed during the 5 year review period (34% appendectomy, 33% cholecystectomy). The overall complication rate was lower after implementation of the ACS service (21% vs 12%, p<0.0001), as was length of stay (6.5 vs 5.7 days, p=.0016) For the most commonly performed operations (appendectomy and cholecystectomy) these gains were clinically meaningful.

	Pre-ACS	Post-ACS	p-value
Appy, complications, %	13	3.7	< 0.0001
Appy, LOS, days	3	2.3	< 0.0001
Appy, Hospital cost, \$	9, 392	5, 872	< 0.0001
Chole, complications, %	21	9	0.012
Chole, LOS, days	5.3	3.8	0.0004
Chole, Hospital cost, \$	12, 526	9, 348	<0.0001

**Conclusion:** An ACS service can be successfully implemented in a community hospital, can be sustainable, and can achieve both excellent acceptance and improved patient outcomes.

#### SECOND SCIENTIFIC SESSION Monday, November 4, 2012 | 7:30am to 12:00 Noon

LAPAROSCOPIC GASTRIC ISCHEMIC PRECONDITIONING IMPROVES FUNCTIONAL OUTCOMES AFTER ESOPHAGECTOMY Sabha Ganai, Mark S. Talamonti, John Howington, Ki-Wan Kim, John Linn, Michael B. Ujiki

**Background:** Esophagectomy is a high-morbidity procedure with a risk of anastomotic leak and stricture potentially influenced by conduit ischemia. Preconditioning of the gastric conduit has been shown experimentally to enhance the gastric microcirculation allowing for reconstruction with an optimally-perfused gastric tube. Despite such theoretical benefits, outcomes after preconditioning remain uncertain in clinical practice.

**Hypothesis:** Ischemic preconditioning may improve gastric conduit functional outcomes after esophagectomy.

Design: Retrospective cohort study.

Setting: University-affiliated tertiary-referral center.

**Patients and Methods:** A retrospective review of 89 consecutive esophagectomies identified 48 patients who underwent laparoscopic gastric ischemic preconditioning followed by staged esophagectomy.

**Results:** Patients were 64±11 years old, 80% male, and had a BMI of 26±5 kg/m<sup>2</sup>. There was a greater proportion of patients with clinical Stage III disease undergoing preconditioning (84% vs. 54%, p<0.001), with more frequent use of EUS (94% vs. 63%, p<0.001), PET imaging (92% vs. 76%, p<0.05), and neoadjuvant therapy (80% vs. 43%, p<0.001) compared to controls (n=41). The median time interval between preconditioning and esophagectomy was 7 days (interquartile range (IQR), 7-8). Median hospital length of stay (LOS) for preconditioning was 2 (IQR 1-3) days with a total LOS of 10 (IQR 9-16) days, which was similar to 11 (IQR 8-19) days in the control group (p=0.88). While there were no significant differences in anastomotic leaks (13% vs. 24%, p=0.16) or dilatations (6% vs. 20%, p=0.10), the preconditioned cohort had significantly lower rates of delayed gastric emptying (DGE, 22% vs. 44%, p=0.04) and strictures (9% vs. 29%, p=0.01). Morbidity and mortality was similar when graded by the Accordian Severity Score (p=0.44).

**Conclusion:** While changes in surgical approach over time may have influenced our results, trends to improvement in rates of anastomotic leaks and dilatations, as well as significant improvements in strictures and DGE were noted after preconditioning. Prospective assessment of functional and quality of life outcomes is necessary to validate these results.

#### SECOND SCIENTIFIC SESSION Monday, November 4, 2013 | 7:30am to 12:00 Noon

IDENTIFICATION OF A HIGH RISK POPULATION OF PATIENTS UNDERGOING ENDARTERECTOMY FOR ASYMPTOMATIC CAROTID STENOSIS Tiffany Y. Wu, Gabriel Akopian, Steven G. Katz

**Background:** Carotid endarterectomy (CEA) is one of the most commonly performed vascular surgical operations. The optimal method of treatment in patients with asymptomatic carotid stenosis has become the subject of debate

**Hypothesis:** A subset of patients at high risk for adverse events following CEA for asymptomatic stenosis can be identified.

Design: NSQIP database analysis

Patients and Methods: The National Surgical Quality Improvement Program (NSQIP) database from 2005-2011 was queried. Patients undergoing CEA for asymptomatic carotid stenosis were identified. Major adverse events (MAE) defined as stroke, death, and myocardial infarction were noted. Pre-operative risk factors and patient demographics were compared. Those factors found to be significant were placed in a step-wise multivariate Cox proportional hazards regression model to determine their individual significance.

**Results:** During a seven-year period 33,225 CEA's performed for asymptomatic carotid stenosis were identified. Patients who possessed any of the following individual risk factors including age greater than 80 years, recent myocardial infarction, angina, chronic lung disease, dyspnea, hypoalbuminemia, co-existing peripheral vascular disease, and an ASA classification greater than or equal to three were significantly more likely to suffer an MAE than those who did not (p<0. 03 for each). In addition, patients who were functionally totally dependent were nine times more likely to suffer an MAE than those who were not (p<0.001).

**Conclusion:** Using the NSQIP database, a high-risk subset of asymptomatic patients undergoing CEA can be identified. By incorporating the risk factors for MAE into the decision making process, it may be possible to better optimize the selection of patients best treated by CEA for asymptomatic carotid stenosis. It would appear that asymptomatic patients who are functionally dependent would be best treated by modalities other than CEA.

#### SECOND SCIENTIFIC SESSION Monday, November 4, 2013 | 7:30am to 12:00 Noon

IS A LOW READMISSION RATE INDICATIVE OF A GOOD HOSPITAL? Ralitza Parina, David Chang, Mark Talamini

**Background:** Hospital readmissions are an increasing focus of healthcare policy. This study explores the correlation between 30-day readmissions and 30-day mortality for surgical procedures.

Hypothesis: Hospital readmission rate is not clearly correlated to mortality

Design: Longitudinal observational analysis

**Setting:** Data from the 1995-2010 California Office of Statewide Health Planning and Development longitudinal patient discharge database

**Patients and Methods:** Seven complex procedures were included: abdominal aortic aneurysm repair, aortic valve replacement, bariatric surgery, coronary artery bypass grafting, esophagectomy, pancreatectomy, and percutaneous coronary intervention. Hospitals were classified into five categories based on their observed-to-expected (O/E) ratios for 30-day mortality and 30-day readmissions. The categories were (1) high readmission, low mortality; (2) high readmission, high mortality; (3) low readmission, low mortality; (4) low readmission, high mortality; (5) normal readmission, high mortality, with "high" and "low" referring to O/E ratios which were significantly different from one, and "normal" no different than one.

**Results:** A total of 1,184,895 patients and 1,029 hospitals were analyzed, with an overall 30-day mortality of 3.58% and 30-day readmission of 12.75%. Of the identified hospitals, 662 had "normal" O/E ratios in both outcomes, 7 had high readmissions but low mortality, 36 had high readmissions and high mortality, 20 had low readmissions and low mortality, 9 had low readmission but high mortality, and 94 had normal readmissions but high mortality.

**Conclusion:** Hospital readmission rate alone is a fallible measure of quality since some hospitals achieve significantly low mortality rates at the expense of 30-day readmissions, while a number of hospitals have normal or better readmissions, but have unacceptably high mortality rates. Hospital readmission rates should be interpreted in conjunction with hospital mortality rates.

### THIRD SCIENTIFIC SESSION

Monday, November 4, 2013, 1:30pm to 4:00pm

### THE ADDITION OF A DEEP INGUINAL DISSECTION DOES NOT IMPROVE NODAL RECURRENCE OR SURVIVAL IN MELANOMA Michael E Egger, Russell E Brown, Brent A Roach, Amy R Quillo, Robert CG Martin II, Charles R Scoggins, Arnold J Stromberg, Kelly M McMasters

**Background**: Controversy exists regarding the value and indications for superficial inguinal dissection (SILND) alone or in combination with iliac and obturator inguinal lymph node dissection (DILND) for melanoma.

**Hypothesis:** The addition of a DILND improves locoregional disease control and survival in melanoma.

Design: Retrospective review

Setting: Multi-center and single-center database.

**Patients and Methods:** 134 patients with median follow-up of 39 months who underwent SILND alone or SILND + DILND for cutaneous melanoma were analyzed. Analyses were stratified and compared by microscopic or macroscopic (palpable or detected by imaging) disease.

**Results:** Indications for inguinal dissection were microscopic disease in 94 (70%) patients and macroscopic nodal disease in 40 (30%) patients. DILND yielded tumor-positive deep nodes in 25% vs. 55% in the microscopic vs. macroscopic groups, respectively (p=0.0973). On multivariate analysis, no independent risk factors for positive deep nodes were identified. Inguinal nodal recurrence rates were essentially the same between SILND and SILND + DILND (19 vs. 18%). For both microscopic and macroscopic disease, the addition of a DILND to a SILND did not significantly reduce the risk of deep nodal recurrence. The 5-year inguinal lymph node recurrence-free survival rate was 77%. Five year overall survival (OS) rates for 4 groups were compared: microscopic disease, SILND alone (72%); microscopic disease, SILND + DILND (68%); macroscopic disease, SILND alone (51%); macroscopic disease, SILND + DILND (44%) (p=0.0163). On KM analysis, the addition of a DILND in either microscopic or macroscopic disease did not affect DFS or lymph node recurrence-free survival. Overall complication rates were equivalent in SILND vs. SILND+DILND (30%).
**Conclusion:** The addition of a DILND to a SILND for both microscopic and macroscopic nodal disease did not significantly affect lymph node recurrence rates, DFS, or OS. These data support a policy of DILND for patients with clinical or radiological evidence of iliac/ obturator nodal disease only with close follow-up for nodal recurrence.

#### THIRD SCIENTIFIC SESSION Monday, November 4, 2013 | 1:30pm to 4:00pm

#### REINFORCEMENT OF THE INTESTINAL MUCUS LAYER PROTECTS AGAINST CLOSTRIDIUM DIFFICILE INTESTINAL INJURY IN VITRO Lawrence N. Diebel, MD, David M. Liberati, MS

**Background:** *Clostridium difficile* associated disease (CDAD) is increasing in incidence and severity. Attributable factors include virulence factors including *C. diff.* toxins A and B as well as host immunological status. We have previously demonstrated the importance of secretory IgA (SIgA) and the mucus component of the intestinal epithelial barrier in limiting CDAD. The mucus component of the intestinal barrier is impaired by malnutrition, shock insults, and alterations in the gut microbiome. Phosphatidylcholine (PC) is an important component of the mucus barrier; reinforcement of the mucus layer by exogenous PC is of therapeutic benefit in chronic ulcerative colitis. We therefore studied the role of exogenous PC combined with SIgA on intestinal barrier function against CDAD *in vitro*.

**Methods:** HT29 intestinal epithelial cell (IEC) monolayers were established. Both non mucus (control) and mucus producing (HT29-MTX) clones were used. SIgA and exogenous PC were added in subsets. After addition of toxin A; TNF, IL-6, toxin A uptake, IEC monolayer permeability and necrosis were determined.

	TNF	IL-6	Necrosis	toxA (ng/	Perm	
	(pg/ml)	(pg/ml)	(MFI)	ml)	(nmol/cm <sup>2</sup> /hr)	
HT29	39.8±2.5	25.3±1.7	17.9±0.7	98.3±7.9	0.76±0.03	
HT29+IgA	21.5±1.8*	12.1±1.6*	8.5±0.6*	45.6±5.2*	0.66±0.02*	
MTX+IgA	10.7±1.6*	6.7±1.2*	5.9±0.2*	20.9±2.1*	0.36±0.01*	
HT29+PC+IgA	7.0±1.0#	6.1±0.7#	6.8±0.3#	18.5±0.9#	0.23±0.01#	
MTX+ PC+IgA	6.5±1.2#	3.4±1.0#	3.4±0.2#	10.7±0.8#	0.18±0.02#	

	<b>Results:</b>	mean	± S.D.	, N =	4 for	each	group
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\*p<0.001 vs. HT29, #p<0.001vs.same group no PC.

**Conclusion:** Mucus or "exogenous" mucus in the form of PC has a synergistic role with SIgA in barrier defense against *C. diff.* toxin A. Exogenous PC administration may be a therapeutic adjunct in patients with severe or recalcitrant CDAD.

#### THIRD SCIENTIFIC SESSION Monday, November 4, 2013 | 1:30pm to 4:00pm

### INDIVIDUALIZED MULTIMODALITY MANAGEMENT OF ELDERLY PATIENTS WITH PANCREATIC CANCER

Amanda B. Cooper, Holly M. Holmes, Jude KA des Bordes, David Fogelman, Shana Palla, Nathan Parker, Jason B. Fleming, Jeffrey E. Lee, Peter W.T. Pisters, Douglas B. Evans, Christopher Crane, Robert A. Wolff, Gauri Varadhachary, and Matthew H.G. Katz

**Background:** A well-defined treatment strategy for elderly patients with resectable pancreatic cancer has not been established. Multiple reports have found that highly selected older patients with cancer may successfully undergo pancreatectomy. However, multimodality therapy is essential for long-term survival, and elderly patients are at high risk for not receiving postoperative therapy following surgery.

**Hypothesis:** An individualized treatment strategy for elderly pancreatic cancer patients can maximize completion of multimodality therapy.

Design: Retrospective analysis

Setting: Tertiary/quaternary cancer center.

**Patients and Methods:** The treatment plan, short-term outcomes and overall survival of all patients 70+ years old who presented to our institution over a 9-year period and were treated for resectable pancreatic cancer were reviewed.

**Results:** 179 (76%) of 236 patients with resectable pancreatic cancer were treated with curative intent. 153 (85%) of these patients received neoadjuvant therapy prior to intended resection. Of them, 74 (48%) underwent pancreatectomy and 79 did not due to disease progression (n=46), insufficient performance status (n=23), or other reasons (n=10). Among the 26 patients who underwent surgery first, 11 (42%) received postoperative therapy. Univariate predictors of longer survival following pancreatectomy were absence of comorbidity, low CA19-9 level, negative lymph nodes, and receipt of preoperative therapy. Only receipt of preoperative therapy retained significance on multivariate analysis (HR 0.44, CI 0.27-0.73, p=0.03). Resected patients had a 2% in-hospital mortality rate and 91% were discharged home.

**Conclusion:** 36% of all patients 70 years and older with anatomically resectable pancreatic cancer received all components of multimodality therapy and over 90% who underwent pancreatectomy were discharged home. These data demonstrate a role for neoadjuvant therapy in selecting elderly patients for surgery and support further studies to refine individualized treatment protocols for this high-risk group of patients.

#### FOURTH SCIENTIFIC SESSION Tuesday, November 5, 2013 | 8:00am to 11:00am

HORMONE RECEPTOR STATUS DOES NOT AFFECT PROGNOSIS IN METAPLASTIC BREAST CANCER G. Paul Wright, Marianne K. Melnik, Mathew H. Chung

**Background:** Metaplastic breast cancer is a rare histologic variant amongst breast cancers with a presumably poor prognosis.

**Hypothesis:** Hormone receptor positivity does not improve prognosis in patients with metaplastic breast cancer. **Design:** Retrospective review.

Setting: Surveillance Epidemiology and End Results (SEER) database.

**Patients and Methods:** A query was made for patients with metaplastic breast cancer from 2000-2010. A separate query identified all patients with other types of invasive breast cancer. Effect of hormone receptor status was evaluated using a Cox regression analysis including age, race/ethnicity, grade, and stage. Significance was assessed for p<0.05.

**Results:** A total of 2338 patients with metaplastic breast cancer were available for study. Presenting stage was as follows: I=25.6%, II=55.8%, III=12.6% IV=6.0%. Most tumors were hormone receptor negative (83.6%) and  $\geq$  grade 3 (82.9%). For comparison, 430,298 hormone receptor positive and 102,631 hormone receptor negative non-metaplastic breast cancer cases were obtained. Even in patients with early stage disease (T1/2,N0), mastectomy rates were higher for metaplastic cancers (46.0% vs. 36.5%, p<0.001). Overall 5- and 10-year survival for metaplastic breast cancer were 62.2% and 49.4%, respectively, compared to 80.9% and 65.9% for non-metaplastic breast cancers (p<0.001). For metaplastic cases, no difference in 5- or 10-year overall survival was found between hormone positive and hormone negative tumors (65.7%/54.7% vs. 63.5%/51.8%, p=NS). Multivariate analysis demonstrated metaplastic histology as an independent risk factor for cancer-related mortality both amongst hormone positive (HR 3.4, 95% CI 2.7-4.2, p<0.001) and hormone negative (HR 1.4, 95% CI 1.2-1.5, p<0.001) breast cancers.

**Conclusion:** Metaplastic breast cancer is an aggressive histologic variant that portends a poor prognosis compared to other breast cancer subtypes. Contrary to other breast cancers, hormone receptor positivity does not improve prognosis in metaplastic breast cancer.

FOURTH SCIENTIFIC SESSION Tuesday, November 5, 2013 | 8:00am to 11:00am

HIGHER ALCOHOL INTOXICATION IS ASSOCIATED WITH LESS SEVERE INJURIES AFTER BLUNT TRAUMA Douglas Z Liou, Matthew Bloom, Nicolas Melo, Marko Bukur, Daniel R Margulies, Ali Salim, Eric J Ley

**Introduction:** Prior trauma studies suggest positive blood alcohol (ETOH) is associated with lower mortality. We investigated the relationship between increasing ETOH levels and mortality after motor vehicle collisions (MVC) and then explored why this association occurs.

Methods: A retrospective review of the Los Angeles County trauma database from 1/2003-12/2008 was performed. Patients ≥16 years of age with a mechanism of MVC and admission ETOH level were considered. Patients were stratified according to ETOH: ETOH0 (<0.01), ETOH1 (0.01-0.08), ETOH2 (0.09-0.16), ETOH3 (0.17-0.24), ETOH4 (0.25-0.32) and ETOH5 (>0.32). Demographic data was compared among the groups. Logistic regression was used to determine predictors of mortality.

**Results:** A total of 12,540 patients were included with an overall mortality rate of 2.2%. Mortality was lowest in ETOH3 (1.6%) and ETOH4 (1.3%), though the crude difference among all groups was not statistically significant (p=0.07). Although the rate of GCS  $\leq 8$  increased with higher ETOH, head AIS was similar among the groups (p=0.14). Decreased rates of ISS  $\geq 16$  were noted with increasing ETOH, which was largely due to reduced chest and abdomen/pelvis AIS. Adjusted mortality was lower in ETOH3 and ETOH4 (both AOR 0.4, p<0.001).

**Conclusions:** ETOH between 0.17 and 0.32 after MVC predicted lower mortality. Increasing ETOH was associated with lower injury severity, lower chest and abdomen/pelvis AIS, and no change in head AIS. Our findings suggest that a protective effect of ETOH may be related to decreased truncal injury burden rather than protection after head injury.

	ETOH0	ETOH1	ETOH2	ЕТОН3	ETOH4	ETOH5	
	(n=6591)	(n=1036)	(n=1353)	(n=1829)	(n=1207)	(n=524)	p-value
GCS <8	4.7%	6.2%	8.6%	9.5%	8.0%	11.6%	< 0.001
SBP <90 mmHg	1.2%	1.6%	3.0%	2.1%	1.3%	1.9%	< 0.001
ISS <u>≥</u> 16	20.6%	21.5%	24.3%	20.9%	15.7%	9.7%	< 0.001
Head AIS	0.8	0.7	0.7	0.8	0.8	0.6	0.14
Chest AIS	0.5	0.5	0.5	0.4	0.3	0.2	< 0.001
Abd/pel AIS	0.3	0.3	0.3	0.2	0.2	0.1	< 0.001
Mortality	2.3%	2.8%	2.7%	1.6%	1.3%	2.1%	0.07
AOR for mortality	0.7	1.0	0.6	0.4*	0.4*	0.8	≤0.01*

#### FOURTH SCIENTIFIC SESSION Tuesday, November 5, 2013 | 8:00am to 11:00am

#### NON-OPERATIVE MANAGEMENT OF MAIN PANCREATIC DUCT INVOLVED INTRADUCTAL PAPILLARY MUCINOUS NEOPLASM MAY BE INDICATED IN SELECTED PATIENTS

Alexandra M Roch, John M DeWitt, Mohammad A Al-Haddad, Christian M Schmidt II, Eugene P Ceppa, Michael G House, Nicholas J Zyromski, Attila Nakeeb, C Max Schmidt

**Background:** Although the natural history of IPMN remains unclear, large surgical series have reported malignancy in 40-90% of main pancreatic duct (MPD) involved IPMN. Accordingly, the 2012 International Consensus Guidelines (ICG) recommends surgical resection in patients with suspected MPD involvement.

**Hypothesis:** We hypothesized that non-operative management of select patients with suspected MPD involved IPMN may be indicated

**Setting:** From 1992 to 2012, 362 patients underwent surgical resection for pathologically confirmed IPMN at a single academic center.

Design: A retrospective review of prospectively collected data.

**Patients and Methods:** Clinical, radiological and pathological parameters were reviewed. MPD involvement was suspected with a MPD diameter ≥5mm on preoperative cross-sectional imaging. A multivariate analysis was conducted to assess predictors of malignancy.

**Results:** Of 362 patients, 334 had complete data for analysis. Main duct involvement was suspected preoperatively in 171. Final pathology revealed 20% high grade dysplasia and 27% invasive IPMN (47% malignant). Preoperative cytopathology and serum CA19-9 level independently predicted malignancy (p=0.003, p=0.002) and invasiveness (p<0.0001, p=0.001). Patients with both negative preoperative cytopathology and normal serum CA19-9 (i.e., *double negatives*) had a lower rate of malignancy and invasiveness (27% and 9% vs. 58% and 38%, p<0.0001). MPD diameter did not predict malignancy or invasiveness (p=0.36 and p=0.46).

**Conclusion:** Patients with suspected main duct involved IPMN have a highly variable rate of malignancy. Despite recent ICG recommendations, these data suggest MPD diameter is not an optimal gauge of malignant risk. Non-operative management of suspected MPD involved IPMN in select patients, particularly *double negatives*, may be indicated. Depending upon age and co-morbidity, operative risk may outweigh the risk of malignant progression in these

#### FOURTH SCIENTIFIC SESSION Tuesday, November 5, 2013 | 8:00am to 11:00am

FLUORESCENTLY-LABELED CHIMERIC ANTI-CEA ANTIBODIES ENABLE FLUORESCENCE-GUIDED LAPAROSCOPIC SURGERY OF PANCREATIC CANCER Cristina A. Metildi, Sharmeela Kaushal, George A. Luiken, Mark A. Talamini, Robert M. Hoffman, Michael Bouvet

**Background:** The frequency of laparoscopic surgery for pancreatic cancer has increased in recent years.

**Hypothesis:** Fluorophore-conjugated chimeric anti-CEA antibodies can enable fluorescence-guided laparoscopic surgery of primary pancreatic cancer and improve surgical outcomes in orthotopic mouse models.

**Design:** A randomized active-control trial comparing fluorescence-guided laparoscopic surgery (FGLS) to bright-light laparoscopic surgery (BLLS) of pancreatic cancer.

Setting: Laboratory-based translational research.

**Patients and Methods:** Orthotopic models were established with human BxPC-3-RFP pancreatic tumor in 20 nude mice. FGLS of pancreatic tumors was performed in 10 mice using a 3 mm laparoscope with a 495-nm emission filter and a Stryker L9000 LED light source 24 hrs after tail vein injection of anti-CEA-Alexa 488 antibody. BLLS was performed in the remaining 10 mice using a laparoscope with a Stryker X8000 xenon light source. Perioperative images were taken to evaluate tumor size and margins, and mice were followed for recurrence. Intravital and ex vivo images were obtained at termination to evaluate tumor burden.

**Results:** Labeling with anti-CEA-Alexa 488 antibodies improved real-time detection of pancreatic tumor. Background illumination was adequate for surgical navigation permitting improved resection. At termination, the FGLS group compared to the BLLS group had less pancreatic tumor burden (5.75 mm<sup>2</sup> vs 28.43 mm<sup>2</sup>; p=0.012) and smaller tumors (21.1 mg vs 174.4 mg; p=0.033). FGLS compared to BLLS decreased local (47.4% vs 78.9%, p=0.046) and distant recurrence (68.4% vs 94.7%, p=0.045). More mice in the FGLS group compared to BLLS mice were free of tumor at termination (30% vs 8%, p=0.047). Two FGLS mice were tumor free one year postoperatively. BLLS mice had a mean disease-free and overall survival of 8.5 and 25.5 weeks, respectively (p=0.022 and p=0.040).

**Conclusion:** Fluorophore-conjugated antibodies enabled FGLS of primary pancreatic tumor with significantly improved outcomes compared to BLLR. Fluorescence-guided surgery using fluorophore-conjugated antibodies has the potential to improve laparoscopic surgery for cancer.

#### FOURTH SCIENTIFIC SESSION Tuesday, November 5, 2013 | 8:00am to 11:00am

#### REOPERATIVE SURGERY: A CRITICAL RISK FACTOR FOR COMPLICATIONS INADEQUATELY CAPTURED BY OPERATIVE REPORTING AND CODING OF 'LYSIS OF ADHESIONS'

Thomas A. Aloia, Amanda B. Cooper, Weiming Shi, Jean-Nicolas Vauthey, Jeffrey E. Lee

**Background:** Reoperative surgery is suspected, but not proven, to increase postoperative complication rates. In the absence of a specific definition for reoperative surgery, the ACS-NSQIP has proposed using procedural coding for lysis of adhesions (LOA) as a surrogate for reoperative surgery to risk-adjust hospitals.

**Hypothesis:** Real-time coding of reoperative surgery will be associated with worse 30-day outcomes and, for abdominal procedures, will be more accurate than operative dictation and coding of 'lysis of adhesions'.

**Design:** Reoperative surgery was categorized in real-time from 2/2012 to 12/2012 for all NSQIP cases collected at a single institution by independent Surgical Clinical Reviewers. Reoperative surgery classification and coding of LOA were compared to each other and to 30-day outcomes.

Setting: Tertiary cancer center, multispecialty NSQIP model

**Patients and Methods:** During the study period, 2,325 cases were classified as non-reoperative, regionally reoperative (prior surgery in the adjacent area of current operation), or locally reoperative (prior surgery at exact site or organ, i.e., true reoperation).

**Results:** In the multispecialty cohort, the non-risk-adjusted rates of overall 30-day morbidity, serious morbidity, and mortality were 19%, 7%, and 0%. Regionally reoperative surgery was associated with higher overall morbidity (34%) and serious morbidity (11%) rates, while locally reoperative surgery only impacted the overall morbidity (22%) rate. 199 of the 327 GI cases were recorded as reoperative (local or regional), but only of 20 of these were CPT-coded as LOA (sensitivity=10%). Patients coded as LOA had a 30% morbidity rate and a 5% serious morbidity rate.

**Conclusion:** Reoperative surgery is frequent, increases the risk of complications, and can be captured. Operative LOA coding vastly underreports reoperative surgery, and therefore, is not an adequate surrogate for this important risk factor.

#### FOURTH SCIENTIFIC SESSION Tuesday, November 5, 2013 | 8:00am to 11:00am

#### METASTATIC LYMPH NODE RATIO SUCCESSFULLY PREDICTS PROGNOSIS IN WESTERN GASTRIC CANCER PATIENTS Onur Kutlu, Mitch Wachtel, Sharmila Dissanaike

**Background:** Lymph node positivity is a strong prognostic indicator in many cancers including gastric cancer. The extent of surgical resection directly influences the number of lymph nodes available for staging, with the lesser D1 resection that is standard practice in non-Asian countries typically providing fewer nodes for analysis. The widely used AJCC TNM staging system has been criticized for under-staging and stage migration where < 15 nodes are resected, which is often the case. The ratio of positive to total nodes harvested – Lymph Node Ratio (LNR) – has been proposed as an improved and more widely applicable prognostic indicator.

**Hypothesis:** The LNR is a reliable and accurate prognostic indicator of survival in a Western gastric cancer population.

**Patients and Methods:** The Survival Epidemiology and End Results database (SEER) was queried for patients over 17 years at the time of diagnosis with histologically proven gastric adenocarcinoma, with at least one month of follow-up, diagnosed between 1988-2009. Outcome variable was death from any cause; patients with unknown T stage or metastatic disease were excluded. The survival package of R was used to analyze the data. Log normal accelerated failure time regression was used to provide estimates and 95% confidence intervals of survival time ratios. Models were compared with the Bayesian Information Criterion (BIC); the model with the lowest BIC was deemed to have the greatest explanatory power. Null hypotheses were rejected when P < 0.05.

**Results:** 19.913 subjects were included, with a median 11 (interquartile range 6-18) lymph nodes examined; 7,235 (36.3%) had 15 or more nodes. Compared with patients who have no lymph node metastases, survival times for those with 1-10%, 11-50%, and 51-100% positive lymph nodes decreased by about one-fifth, one half, and three-fourths, respectively. LNR produced reliable, and internally consistent survival curves for this population, suggesting it would be a valuable prognostic indicator.

**Conclusion:** LNR is an effective tool to predict survival in a western gastric cancer patient population, where the majority of the patients have limited lymph node dissection.

#### FOURTH SCIENTIFIC SESSION Tuesday, November 5, 2013 | 8:00am to 11:00am

CONCURRENT BETA-BLOCKERS REDUCE MORTALITY AMONG PATIENTS WITH SEPSIS Irada Ibrahim-zada, Randall S. Friese, John Santoro Jr, Kara Snyder, Peter Rhee

**Background:** Early studies on human sepsis found contradictory effect of beta-blockers (BB) on mortality. Recently, a retrospective Italian study on almost 10,000 patients showed that chronic prescription of BB may confer a survival advantage among patients with severe sepsis in intensive care unit (ICU). There are no prospective studies that tested the utility of concurrent administration of BB in septic patients yet.

**Hypothesis:** Beta-adrenoreceptor antagonists administered in ICU patients with sepsis have potential survival benefits.

Design: Nester case-control study in the prospective cohort



#### Setting: Tertiary referral center

**Patients and Methods:** We identified 304 patients hospitalized in critical care unit with sepsis from 1/1/08 through 3/31/2011. All patients have been identified through prospectively collected database. Propensity matching analysis has been performed to match patients who received BB with controls based on source of infection, severity of disease, laboratory results, ventilator settings, hemodynamic parameters, and supportive measures. Our primary outcomes were in-hospital mortality and patients' disposition.

**Results:** 208 patients (68%) were included in the propensity matched analysis (104 in each group). 33% of patients on BB treatment had died compared to 58% of patients without BB (p<0.001). Median survival in BB group was 45 days vs. 13 days in control group. Kaplan-Meyer survival analysis showed improved in-hospital survival in patients on BB treatment with HR = 0.36 (95%CI 0.23 to 0.55), p<0.0001.

**Conclusion:** Septic patients on beta-blockers showed 3-fold decrease in in-hospital mortality. Concurrent prescription of beta-blockers during stay in ICU is associated with reduced mortality among patients with sepsis.



# 120<sup>th</sup> Transactions

The Annual Meeting of the Western Surgical Association 2012, Volume 120

Edited by Kelly McMasters, M.D. Recorder of the Association

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#### Raymond J. Joehl, M.D. President, 2012

#### PRESIDENTIAL ADDRESS: "A Precious Resource"

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This is the 120<sup>th</sup> Annual Meeting of the Western Surgical Association, one of the oldest surgical societies. This is the 14<sup>th</sup> meeting of "The Western" in Colorado Springs. In 1997, our 12<sup>th</sup> meeting here, Past President Dr Jack Pickleman's address to the Western Surgical, entitled ANOTHER LETTER TO THE PRESIDENT, detailed his concerns about health care to President Clinton (1). Like virtually all of Jack's addresses, it was thoughtful, colorful and entertaining as he detailed proposals for Medicare recipients, medical savings accounts, Surgeon General's role in public health and threats to Graduate Medical Education funding.

I have been privileged to serve as your President this year, an honor that I did not deserve though humbly accepted. In this presidential election year, we have heard too many polarizing political statements about our high though declining national unemployment rate, the housing crisis that is dissipating, and the slow economy. In spite of these economic and political issues, we are again reminded of our sometimes tenuous existence after witnessing yet another natural disaster in Hurricane Sandy on the East coast. Today, my objective is to describe a "precious resource" that most of us have experienced and that continues to be a vital part of our profession and discipline.

The Merriam Webster online dictionary defines "precious" as something of 'great value or high price,' as 'highly esteemed or cherished,' and as 'priceless or valuable'. It defines "resource" as a 'source of supply or support', or as a 'natural feature or phenomenon that enhances the quality of human life.'

While I have no conflicts of interest and have no disclosures to make, I do have a passion for this 'precious resource,' which has been a major part of my professional life since I was a medical student in the early 1970's. Today, I will speak to you and describe the VA.

The VA provides a robust and rich environment for the veteran as a patient, the trainee— whether a medical student or resident—as learner, and the attending surgeon as provider, teacher and as investigator to meet and work in concert to accomplish the mission of the Veterans Health Administration. This health care, educational, and research environment is unique, yet similar to the academic center, and indeed, is a "precious resource" to bring opportunities for patient care, learning, discovery and scholarly achievement, which are of great value, which are priceless and valuable, and are cherished. The VA environment is also, indeed, a significant resource for patients to receive high quality health care, for trainees to have opportunities and primary responsibility not otherwise available in other parts of the private health care sector, and for faculty surgeons to acquire clinical experiences, which enhance their skill set, sharpen expertise and advance their careers.

I had unique learning experiences and opportunities in my junior and senior year medical student rotations at the John Cochran VA in St Louis. I remember my first operation in 1972, an AV fistula for hemo-dialysis. I assisted Dr. Rocco Fiordelisi, a beginning third year surgical resident at St. Louis University; our attending surgeon was Dr. Don Kaminski, a retired member of the Western Surgical. I especially remember this first operation for the scrub nurse's role in Rocco's training. Rocco made several consecutive requests for specific instruments, and repeatedly, after each request, the male scrub nurse (apologies to the scrub nurse for not remembering his name) gave Rocco a different instrument. Finally, after four or five of these instrument passes, Rocco paused, gazed at me, and with genuine appreciation, complimented the scrub nurse, saying, "Thanks for helping me, and for giving me what I need and not what I ask for!" We all laughed, especially Dr. Kaminski, who had just returned from his research fellowship, and was setting up his research lab. I remember this early experience as a student for the teachable moment, the fun we had, and that the teacher was the VA scrub nurse.

The history of care for veterans can be traced to the earliest days of our country (2). In 1636, the Pilgrims of Plymouth Colony passed a law supporting disabled soldiers, which stated, "If any man shall set forth as a soldier and shall return maimed, he shall be maintained competently by the colony during his life". More than a century later, in 1776, the Continental Congress provided pensions for injured soldiers, and, in 1789 after the Revolutionary War, the US Congress passed a law providing pensions to disabled veterans and their dependents. In the early 19<sup>th</sup> century, as our country matured and prospered, Congress expanded support of veterans. In 1811, the first domiciliary and medical facility was mandated. During the Civil War in mid 19<sup>th</sup> century, Union Forces had 359,000 soldiers killed and 280,000 wounded, creating a large number of new disabled veterans. In 1866, after the Civil War ended, Congress established National Homes for Disabled Veterans in Togus Maine, Dayton Ohio, and Milwaukee Wisconsin. Interestingly, no care was authorized for >100,000 wounded Confederate veterans until 1958, just before the last confederate soldier died in 1959 (3). Before his assassination in 1865, President Lincoln

again affirmed our nation's commitment to its disabled soldiers with his famous statement,

"To care for him who shall have borne the battle and for his widow, and his orphan." This statement, engraved on a plaque, greets all who enter VA Central Office at 810 Vermont Avenue NW, Washington, DC.

In the latter 19<sup>th</sup> century after the Civil War, benefits were extended to veterans of other wars including the Indian Wars, Spanish-American War, and the Mexican border disputes. World War I resulted in 116,000 deaths and 204,000 wounded service men. The Bureau of War Risk was created and it authorized care for veterans in Public Health Service Hospitals, which numbered 52 in 1920.

In 1921, President Harding created the Veterans Bureau, which combined the Public Health Service Hospitals with the Bureau of War Risk, while the National Homes and the Bureau of Pensions remained separate. Colonel Charles Forbes was the 1<sup>st</sup> Director of the Veterans Bureau; he had many political difficulties, likely due to delegating too many responsibilities. He resigned in 1923. The 2<sup>nd</sup> Director was General Frank Key Hines, a veteran of Spanish American War and WWI; he was quiet and efficient. He avoided and overcame political crises, though had great difficulty recruiting physicians, who disliked reporting to non-medical supervisors and administrators in Civil Service. A 34-physician council recommended medical school affiliations, hospitals managed by medical professionals, MD pay comparable to private sector, et al. Many physician groups opposed changes, and veterans perceived they would be used as guinea pigs. In the ensuing years from 1924-1930, Congress failed to pass any of the 9 legislative bills proposing changes to the Veterans Bureau.

In 1930, President Hoover merged the Veterans Bureau and Cemeteries with the Bureau of Pensions and the National Home for Disabled Volunteer Soldiers, creating the <u>Veterans Administration</u>, whose mission was to distribute disabled veterans' pensions, maintain domiciles for disabled veterans, and veterans' cemeteries.

In 1943, with WWII ongoing, Dr Paul Magnuson, an orthopedic surgeon and leader at Northwestern's medical school, proposed affiliations of VA hospitals with medical schools to increase physicians in VA service and to train residents.

In 1945, at the end of WWII, 17 million injured or disabled veterans sought health care state-side. The VA had few physicians and nurses, and even fewer hospitals. General Omar Bradley, Administrator of the VA, and General Paul Hawley, Surgeon General of the Army, engaged Dr Magnuson's proposal for medical school affiliation (4).

In 1946, President Harry Truman established the VA Department of Medicine and Surgery to "streamline & modernize the practice of medicine for veterans", signing Public Law 79-293. The VA promptly published <u>VA Policy Memorandum #2</u> on January 3, 1946, which became known as the affiliation "Magna Carta". It was only 5-pages long, and was written concisely to 1) describe the mutual understanding and cooperation between the VA and medical school affiliate, 2) define the memorandum's purpose to "afford the veteran a much higher standard of care", 3) define responsibility as the VA assumed care

of veteran and the medical school educated residents and medical students, and 4) defined the roles of VA administration, medical school leaders, service chiefs, and the full and parttime physicians and consultants.

The next day, January 4, 1946, the first VA affiliation with a medical school quickly occurred, by no coincidence, between the Edward Hines, Jr. VA Hospital and two medical schools in Chicago, Northwestern University and the University of Illinois, as 56 residents began rotations at the Hines VA. To commemorate the 50<sup>th</sup> anniversary of this 1<sup>st</sup> affiliation in 1996, the VA and the AAMC placed a plaque in the corridor between the Ward and Tarry Buildings at Northwestern's Feinberg School of Medicine in downtown Chicago. The plaque is signed by then VA Secretary Jesse Brown, a disabled veteran and Chicago resident, now deceased, and by Dr Jordan Cohen, then AAMC President.

Following this notable event in 1946, more than 100 academic affiliations were established, and 70 new VA hospitals were built in the 1950s. Medical specialties and hospital inpatient care was viewed as the best medical care. The VA hospital system grew along with its government bureaucracy. Nonetheless, VA hospitals were a rich resource for education of medical students and residents.

In the last 40 years, the period of my professional life, the VA Healthcare system has grown. In the 1970s and 1980s, Vietnam veterans seeking care increased, and health care quality and access were often criticized. In 1989, in an effort to improve the VA and its image, President George HW Bush elevated the VA to cabinet status, changing its name from Veterans Administration to the Department of Veterans Affairs. In the 1990s, the VA was the largest US health care provider. There were 172 VA hospitals, 131 skilled nursing facilities, 206 counseling centers and other facilities. The VA had 210,000 employees, and 1.1 million veterans were admitted per year. The VA was sometimes described as indifferent, inefficient and incompetent (5).

In January 1994, President Bill Clinton appointed Dr Kenneth Kizer as VA Undersecretary for Health. Dr Kizer was a registered republican and former Head of the California Department of Public Health, and his vision was based on the Value = Quality / Cost equation. In his words, "In an integrated health-care system, physicians, hospitals and all other components share the risks and the rewards, and support one another. In doing so, they blend their talents and pool their resources; they focus on delivering "best value" care. To be successful, the integrated health-care system requires management of total costs, a focus on populations rather than individuals, and a data-driven, process-focused customer orientation." Primary care and chronic disease management were emphasized while not ignoring acute care; performance of all types was measured, health information was increasingly managed electronically, and funding (reimbursement) for basic and complex care was differentiated.

During Dr Kizer's tenure as Undersecretary, the VA Health system was transformed. From 1995-1999, many VA Health System changes were accomplished: 1. 22 Veterans Integrated Service Networks or VISNs were created.

- 2. 29,000 acute care hospital beds were closed, and bed days of care were reduced 68%
- 3. 350,000 fewer patients were admitted, while >700,000 more pts were treated, a 24%
- 4. VA staff was reduced by 26,000 FT employees, a 12% decrease
- 5. 302 community-based outpatient clinics or CBOCs were established and primary care provided
- 6. 2800 forms were eliminated, and most of the remainder were automated
- 7. 52 medical centers were merged into 25 multi-campus facilities
- 8. Expenditures per patient decreased 25%
- 9. Surgical cases increased 10%, and the proportion of ambulatory surgical cases increased from 35% to 80%

10. Perhaps most importantly, the largest ever electronic medical record deployment and implementation was completed in less than 3yrs. The Veterans Health Information Systems and Technology Architecture, known as VistA, and its graphic user interface, the Computerized Patient Record System, or CPRS, are "open source" eMR programs that have been adopted in many countries including Finland, Germany, Egypt, Nigeria, Mexico, India, Pakistan, Uganda, Jordan, and recently Australia, while only a handful of US hospitals use it.

There have been many notable VA process improvements in Surgery from 1995 – present. Attending surgeon physical presence at the point of care is much more evident. Close proximity of the attending surgeon has improved timeliness of decision making and surgical treatments. Improved supervision and training of surgical residents and students is clearly evident, while maintaining a culture of delegated and progressive trainee responsibility. Better documentation of trainee supervision has occurred. Multidisciplinary patient management, so necessary in managing complex health problems, is now evident.

Preoperative patient review and preparation is reliably accomplished by routine and systematic practices. Operating Room and other efficiency initiatives have been welcomed by all health care providers as we provide high quality care, and more of it, while being good stewards of scarce resources. When complications and adverse events occur, mortality and morbidity conferences are now supplemented by focused review and discussions at many levels to regularly initiate system-wide improvements beyond the scope of the Surgery Service.

As VA has quietly improved its systems of care and its overall quality, a recent

book was published, which was well-received, as one might expect, by VHA leaders. Phillip Longman is senior fellow at the New America Foundation; he has written and authored numerous articles and books on healthcare & public policy. *Fortune* magazine asked him to find the best solutions for the US healthcare crisis. After significant research, and inspired by his wife's 10-month futile struggle with breast cancer, he finished his book now in its 2<sup>nd</sup> edition. Two reviewers had these comments:

– "..Longman describes turnaround of VA, recognized now as leading the nation in quality and costs, and offers insights useful to patients and policy makers."

Dr. Elliott Fisher, Dartmouth

– "Students of quality improvement will find lesson after lesson in this important case study." Dr. Donald Berwick, Harvard, former CMS Administrator.

Longman cites literature showing many specific improvements in VA health care, some of which include: overcoming racial healthcare disparities, better quality measures than Medicare, better management of diabetics in numerous quality measures, greater life expectancy of VA elderly than comparable Medicare beneficiaries, better inpatient satisfaction in veterans than Medicare beneficiaries, and similar 30-day unadjusted postop mortality after common general surgery operations, and VA mortality after CABG less than private sector. In safety, Longman quotes Dr Lucian Leape, who states VA has "quickly emerged as a bright star" largely due to VA's longstanding leadership in Quality Improvement and Information Technology.

Current VA Health Care can be characterized by its robust electronic medical record – CPRS (GUI) and VistA – which supports all healthcare efforts to manage chronic diseases over a long-term for a defined population. VA healthcare emphasizes primary care and preventive medicine, provides acute care and treatment when indicated, minimizes redundant diagnostic testing, all in an environment striving for optimal patient safety. When adverse events occur, they are quickly analyzed for quality improvement purposes and are fully disclosed to patients and families when appropriate. System-wide improvements in quality and safety are evident in all VA facilities.

Education continues as one of VA's four missions after more than 66 years since President Truman established the Department of Medicine and Surgery in VA. The VA's education programs are implemented through affiliations with 1) 107/125 allopathic and 15/25 osteopathic medical schools, 2) 26/56 dental schools, and 3) 1,200 colleges. Each year, more than 100,000 trainees in the health professions receive part or all their education in the VA. This number includes approximately 34,000 medical residents (including those in the surgical specialties), 19,000 medical students, 600 dental residents, and nearly 50,000 trainees in more than 40 associated health education programs. In addition, the VA independently sponsors health training programs in psychology, pharmacy, podiatry, optometry and speech-language pathology. VA is the third largest source of funding for Graduate Medical Education in the United States after Medicare and Medicaid, VA recently increased the number of funded residency positions from 9,000 to

11,000, which constitutes approximately 10% of the US total (6). It is been determined that 59% of all US physicians received at least a part of their education or training in the VA (7). Furthermore, 85% of trainees rate VA training better than or equal to non-VA training, and 90% of trainees would recommend VA training to their peers (8).

VA policy provides medical students and surgical residents a direct role in surgical patient care albeit with close supervision by a faculty surgeon. Like many academic teaching services, VA Surgical Services use a team-approach consisting of a faculty surgeon, chief resident, junior residents, and medical students to provide veterans surgical care. "Mid level" providers, i.e. nurse practitioners and physicians assistants, now are integrated into surgical teams to provide process of care continuity, support 80-hr work rule requirements, perform care coordination and fill gaps in care and treatment when students and residents are not available (9). Medical students and surgical residents have numerous opportunities for longitudinal care involvement during preoperative, operative and postoperative periods, and in outpatient and hospital settings. Students and residents are intimately Involved in their veteran patient's care and often perform preoperative processes to discuss, plan, assess risk, optimize and select patients, provide informed consent, render social and family support, perform procedures and postop care with active supervision, and instruct patients at discharge and in postop follow-up visits. Students and residents alike routinely 1) are identified by the veteran as her/his "doctor" or significant care giver and 2) receive significant expressions of gratitude, and not infrequently receive gifts, from their veteran patients for timely, sometimes continuous, and thoughtful care and treatment. The quality and quantity of these experiences occur much less frequently in private sector teaching settings where insurance reimbursement mandates the faculty surgeon to be very close to the patient, and the trainee all too often is in the background.

In Dr. Bill Cheadle's 2005 Presidential Address to the Association of VA Surgeons, he described the many facets of the VA research program (10). Its portfolio is broad and covers military occupational and environmental exposures, service related limb loss, acute traumatic injury (TBI), aging, mental illness, diabetes, cancer, chronic disease, special populations like blind and spinal cord injury. There have been many highlights in VA research including TB treatment, prosthetics development, blind rehabilitation, implantable pacemakers, concepts leading to CT scanning, the first liver transplant by Dr. Starzl at the Denver VA, nicotine patch, computerized ventilator, the insulin pump, colonoscopy screening, and inguinal hernia repair. Numerous VA Cooperative trials have been highly successful in cardiac surgery (x 8 since 1965), vascular surgery (x 7 since 1977), various miscellaneous surgical trials (x 6 since 1983). There have been three VA investigators who were Nobel Prize winners: in 1977 Andrew Schally at the New Orleans VA for identifying hypothalamic releasing factors and Rosalind Yalow at the Bronx VA for developing radioimmunoassay, and in 1998 Ferid Murad at the Palo Alto VA for his finding of nitric oxide mediation of nitroglycerin-induced vasodilation. The VA's Merit

Review program (that funded my lab for 15 years), Career Development awards and Health Services Research program have supported scores of surgical investigators, some of whom are here today.

Perhaps, the shining star highlighting VA research has been the National Surgical Quality Improvement Program or NSQIP. It is an outcome-based program, which is risk-adjusted and contains validated clinical data of which there are 45 preoperative, 17 intra-operative, 33 outcome variables entered into a database by trained nurse reviewers at each VA hospital. It was spawned by reports of poor surgical results in VA. Congress mandated the VA to compare VA surgical outcomes to the private sector. From 1991-1993, the National VA Surgical Risk Study entered numerous clinical data from 83,958 pts into clinical database, and a risk stratification index was developed. Participants were the 44 VA hospitals performing cardiac surgery. Data were analyzed and hospitals were ranked by observed/expected (O/E) ratio of mortality and morbidity. These results were provided as feedback to participating hospitals, and the hospitals with lowest (best) O/E ratios identified 'best practices' and care processes that were passed on to those with highest O/E ratios, and process improvements were implemented. In 1995, the methodology was rolled out to all VA hospitals. NSQIP identified five significant risk factors predicting postoperative mortality, including serum albumin, age, emergency operation, ASA class, and disseminated cancer. Over the course of the last 20 years from 1991-2011, VA surgical mortality rate has decreased nearly three-fold.

Many credit the VA Transformation for improved postop 30-day mortality and improved surgical outcomes to NSQIP, as demonstrated in this graph of <u>VA 30-day Unadjusted Postop Mortality Rate (%)</u>, for the recent 21-year period, 1991-2011. VA un-adjusted 30-day postop mortality rate for major cases fell progressively from 3.2% in 1991-1993 to 1.2% in 2011.

Ladies and gentlemen as I end this presentation, I thank my mentors, John Waldhausen, who passed away this year, and Dave Nahrwold, for teaching and coaching me. I thank all my colleagues from Northwestern and Loyola, especially Jim Yao, Bob Rege, Rich Gamelli, Gerry Aranha, Geoff Silver and Paul Kuo.

Also, I cannot thank my family enough for all their support and tolerance over many decades. My wife Julia, who is here today, and 6 children, pictured here- Jake, Sam, Hillarie, Sarah, Claudia and Hannah, and my son-in-law, Mark Richards, who with daughter Sarah, have blessed Julia and I with two wonderful grand-children, our grandson, Owen (now 2 and ½ y/o) and newest grand-daughter, Maya Jane (now 6 weeks old). Ladies and gentlemen, I appreciate your attention and hope you enjoy this 120<sup>th</sup> meeting of the Western as much as I have the enjoyed them since my first meeting in 1987. Thank you for this honor and privilege.

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# **Bylaws**

#### **ARTICLE I: Membership**

SECTION 1. The ACTIVE MEMBERSHIP shall be limited to three hundred and fifty (350). The HONORARY MEMBERSHIP shall be limited to fifteen (15).

SECTION 2. ACTIVE MEMBERS. To be eligible for consideration for active membership, an individual shall be a graduate of an accredited medical school, shall have completed formal residency training at least three (3) years prior to nomination, and shall have been established in his/her current practice locale for a minimum of two years. To be considered, the individual must have established an excellent reputation as a surgeon. The individual must be recommended by the Membership Committee of the Association and approved by at least three-fourths of the Executive Committee to be presented to the members of the Association. Nominees to be Active Membership shall be elected to membership by the favorable vote of three-fourths of the members voting by secret ballot at the Executive Session of the Annual Meeting. Membership shall not be denied because of race, creed, color, or sex. Desired qualifications include:

- a. Practice limited to a surgical specialty, to a career in academic surgery, or to a career in administrative surgical fields.
- b. Certification by the American Board of Surgery or by the Board of another surgical specialty, or Fellowship in a recognized College of Surgeons.
- c. Fellowship in the American College of Surgeons
- d. Contributions to scientific literature and/or documented leadership activity in local, state, or regional medical and surgical organizations.
- e. Evidence of a sincere interest in making a professional contribution to the Association.

Under special circumstances, renowned surgeons not meeting the above requirements may be granted membership.

A nomination shall be initiated by a member sponsor who shall be responsible for obtaining the curriculum vitae of the nominee which is to be submitted on a form provided by the Secretary of the Association. The nomination shall be endorsed by two (2) members. The completed nomination form and letters of recommendation from the sponsor and endorsers must be received in the office of the Secretary by May 1 of the year in which the nominee is to be considered.

# BYLAWS CONTINUED

SECTION 3. The Secretary will solicit additional letters of comment on the nominees from members of the Association. Each completed nomination received by the Secretary shall be presented to the Chairman of the Membership Committee. The Membership Committee shall consider all nominations and make recommendations to the Executive Committee. A final list of nominees shall be prepared by the Executive Committee for presentation to the members at the Annual Business Meeting for approval and acceptance.

SECTION 4. Upon notification by the Secretary of election to membership in the Association, the nominee must accept the election within three (3) months by payment of the initiation fee and the annual dues to the Treasurer of the Association. To become an Active member, the nominee shall be expected to attend the first Annual Meeting after election to be introduced to the Association and to receive the certification of membership. Should the nominee fail to attend the first subsequent meeting, the second Annual Meeting must be attended. If the nominee is unable to attend the second meeting, membership will not be conferred subject to action by the Executive Committee. Fees contingent on membership will not be refunded.

SECTION 5. Nominees who have not been recommended for active membership after three (3) consecutive years of consideration by the Membership Committee and the Executive Committee shall be withdrawn from consideration. This action shall not preclude subsequent nominations for membership after an interval of two (2) years.

SECTION 6. A Senior Membership shall be any active member who has reached the age of sixty (60) years, or has retired from the active practice of surgery. He/she may be recommended for Senior Membership for other acceptable reasons if so ordered by the Executive Committee. A Senior Member shall retain all rights and privileges of membership, but he/she shall be relieved of the rules of attendance. He/she shall pay dues and any assessments until the age of sixty-five (65) or upon retirement, whichever shall occur first.

SECTION 7. HONORARY MEMBERS may be selected from individuals of scientific eminence or from among those who have made unusual contributions to surgery. They shall be proposed to the Association by the Executive Committee and elected in the same manner as active members. They shall not be required to pay dues or fees nor shall they be privileged to vote or hold office.

SECTION 8. The resignation of a member in good standing submitted in writing may be accepted by the Executive Committee.

SECTION 9. Any Active Member who fails to attend three consecutive annual scientific meetings shall be notified of his/her absences by the Secretary. Written requests for excused absence will be considered by the Executive Committee. If the truant member fails to attend the next successive Annual Meeting, membership shall be forfeited unless for good and sufficient cause which the Executive Committee shall determine otherwise.

SECTION 10. Any member may be expelled for unprofessional or unethical conduct by unanimous vote of the Executive Committee. This action requires confirmation by the Association at the next Executive Session. Charges shall be preferred in writing and signed by three (3) members before consideration by the Executive Committee. If the vote of the Executive Committee is not unanimous, the charges may be adopted by mutual consent of the members of the Executive Committee, or they may be presented by the Executive Committee to the Association in Executive Session.

A three-fourths vote of the members voting by secret ballot (Article VI, Section 2) at the Executive Session of the Annual Meeting shall be required for expulsion.

SECTION 11. An active member, temporarily residing outside the continental limits of the United States or Canada, may be placed on temporary inactive status if such request is presented in writing and approved by the Executive Committee. Temporary inactive status relieves the member of attendance requirements and dues payment. Such status shall be granted for a period no longer than three (3) years.

#### **ARTICLE II: Duties of Executive Committee and Officers**

SECTION 1. The EXECUTIVE COMMITTEE shall be the executive body of the Association and shall consider all the business and policies pertaining to the affairs of the Association. It shall make nominations for officers and fill vacancies arising among officers. It shall select the sites and dates for Annual Meetings and appoint the Chairman of the Committee on Local Arrangements. It shall recommend the amount of the dues for the consideration of the membership. It shall make recommendations for Active, Senior, Honorary and Temporary Inactive Membership and shall act upon resignations and forfeitures of membership as necessary. It shall consider and act upon charges of unprofessional conduct and charges against members for alleged offenses against the Constitution and Bylaws. It shall also submit, for the vote of the membership in Executive Session, its recommendation concerning expulsion of a member. It shall direct the conservation and investment of funds held by the Association.

A report of the Executive Committee shall be presented to the members during the Executive Session of the Association during each Annual Meeting. No decisions or recommendations of the Executive Committee shall be binding on the Association unless accepted by a three-fourths vote of the members voting in Executive Session at the Annual Meeting.

Meetings of the Executive Committee shall be held at the call of the Chairman of the Executive Committee. Seven members present shall constitute a quorum.

The most immediate Past President of the Association in attendance shall be Chairman of the Executive Committee, and the Secretary of the Association shall be Secretary of the Executive Committee.

SECTION 2. The PRESIDENT shall preside at the meetings of the Association, preserve order, regulate debates, appoint committees not otherwise provided for, announce results of elections, perform all other duties appertaining to his office, ex-officio member of all committees. The President shall hold office for one (1) year. In the absence of the President, the order of succession to the Chair shall be the First Vice President, the Second Vice President and then the Senior Member of the Executive Committee present.

SECTION 3. The SECRETARY shall attend to the correspondence of the Association, shall notify officers and new Members of their election, and shall notify and instruct new members of the Program Committee, the Membership Committee, and of other specially designed committees. The Secretary shall keep minutes of the Executive Committees executive sessions. Such minutes shall be the property of the Association and shall be the Custodian of the Seal of the Association and shall, upon direction by the Executive Committee, affix it to papers and documents. Together with the President, the Secretary shall sign all official papers. The Secretary shall pass upon all bills for expenses to be paid by the Treasurer. The Secretary shall publish a list of all nominees presenting their age, address, surgical board certification status, College of Surgeons fellowship status, and the names of the sponsor and endorsing members. This information on the nominees will be mailed to the members of the Association with a request for comment on individual nominees at an appropriate interval before the meeting of the Membership Committee. The Secretary shall send invitations to guests invited to attend the Annual Meeting at the request of a member. The Secretary shall be custodian of the records of attendance of all meetings of the Association. The Secretary shall make an annual report to the Executive Committee and to the Membership at the Annual Executive Session of the Association. The Secretary shall be an ex-officio member of all committees.

### BYLAWS CONTINUED

SECTION 4. The TREASURER shall be the custodian of all the moneys of the Association and shall be responsible to the Executive Committee. The Treasurer shall keep full and accurate books of account, containing a record of all moneys received and expended, which books shall be the property of the Association and open to the inspection of the authorized officers at all reasonable times. The Treasurer shall collect initiation fees, dues and assessments, and shall report to the Executive Committee the names of those members in arrears. The Treasurer shall present an annual report of account for audit which shall be made a part of the report of the Executive Committee. The Treasurer shall cooperate with the Chairman of the Local Committee on arrangements regarding finance.

SECTION 5. The Association shall have an official journal chosen by vote of the membership. The RECORDER will be the liaison between the Association and the editor of the official journal. The Recorder shall contact the corresponding authors of all scientific papers presented before the Association. Authors shall be instructed to forward manuscripts to the Editor of the official journal prior to presentation at the annual meeting. The Recorder shall be responsible for the Transactions of the Western Surgical Association, published in the Program Book. The Transactions includes a list of past presidents and meeting places; a list of J. Bradley Aust awardees; the previous year's scientific program; the previous year's Presidential Address; and a list of deaths and memorials. The Recorder will send one copy of the Transactions to the National Library of Congress to be kept in perpetuity. The Recorder shall maintain an up-to-date file of the membership.

SECTION 6. The RECORDER shall act as Historian for the organization and maintain and transfer appropriate archival material from the organization to the Library of Medicine.

SECTION 7. DISTRICT REPRESENTATIVES. There shall be four (4) District Representatives, one of whom shall be elected each year for a term of four (4) years. The tenure of office shall be staggered in order to facilitate continuity in committee activities. These representatives shall be elected to represent widely diverse geographical sections of membership. They shall represent the best interests of the entire Association to the membership of their general areas, and in turn shall represent the will and pleasure of the membership of their general geographical areas to the Executive Committee.
# BYLAWS CONTINUED

SECTION 8. The Association is represented on the American Board of Surgery. When requested by the Board, the Executive Committee shall submit the names of three (3) member nominees for each position to the membership for approval of an Annual Meeting. Upon approval the panel of nominees will be forwarded to the American Board of Surgery who will notify the Association of the nominees selected for this office.

SECTION 9. The Association is regularly represented on the Board of Governors of the American College of Surgeons by one (1) member. When required, the Executive Committee shall submit the names of three (3) nominees approved by the membership for this office.

SECTION 10. The Association is regularly represented on the Advisory Council on Surgery of the American College of Surgeons by one member. When requested, the Executive Committee shall submit the names of three (3) nominees approved by the membership of this office.

### **ARTICLE III: Initiation Fee and Annual Dues**

SECTION 1. Every active member on his/her election shall pay an initiation fee, thereby acknowledging and accepting the Constitution and Bylaws. The amount of the fee may be changed at any Annual Meeting on recommendation of the Executive Committee and approved by a majority of the membership of the Association at the Executive Session of the Annual Meeting.

SECTION 2. Annual dues of every active member shall be paid by May 1 of each calendar year. The amount of the dues may be changed at the Executive Session of the Association on recommendation of the Executive Committee and approval by the majority of the members present.

SECTION 3. Any member who fails to pay dues or assessments for one year shall be notified by the Treasurer in writing. If the member fails to pay the required dues within two (2) months thereafter, the membership will be forfeited. The Treasurer shall notify the Executive Committee of this forfeiture. Waiver of membership fees or assessments shall be the prerogative of the Executive Committee.

### **ARTICLE IV: Programs and Publications**

SECTION 1. A balanced program for the Annual Scientific Meeting will be arranged by the Program Committee, a copy of which shall be distributed to the membership. Abstracts submitted for consideration to be included in the program shall represent original material which shall not have been submitted for publication previously.

SECTION 2. All papers read before the Association shall be presented by a member or sponsored guest. The sponsoring member or co-author member shall be responsible for the content and quality of presentation. An excuse not to do this will require permission of the President.

SECTION 3. The time allowed for presentation of papers shall be determined by the Program Committee. The manuscript must be completed for publication in accordance with the guidelines of the official journal of the Association, and must be submitted in a timely fashion in accordance with published guidelines of the Association.

SECTION 4. The Executive Committee shall have full power to omit from the published records any paper, in part or in whole, which may have been read before the Association.

SECTION 5. The Executive Committee shall cooperate with the editorial board of the official journal of the association to obtain prompt publication of the scientific papers.

SECTION 6. The expense of publication of papers and costs in excess of that allowed by the publisher shall be subject to assessment against the author. All papers published in the official journal identified with the Western Surgical Association shall have been read before the Association.

### **ARTICLE V: Meetings**

SECTION 1. The place and time of the Annual Meeting and the Chairman of the Committee on Local Arrangements shall be selected by the Executive Committee.

- a. The date and location of the three (3) succeeding meetings shall be published in the program at the time of the Annual Meeting each year.
- b. After such publication, the selected place of the meeting may be changed only by unanimous vote of the Executive Committee.
- c. Members shall sign the permanent register of the Association as a record of their attendance.
- d. A special register shall be provided for guests.

SECTION 2. A special meeting of the Association may be called at any time by the President, with the concurrence of the Executive Committee, and it shall be his duty to do so upon receipt of a written petition signed by ten (10) percent of the members.

SECTION 3. A member may invite a Doctor of Medicine or other distinguished scientist to participate in the scientific and social functions of the Association. A member inviting a guest to the Annual Scientific Meeting should send the name to the Secretary at least one (1) month before the date of the Annual Meeting. The Secretary shall forward an official invitation to the guest. The invited guests attending the meeting will receive a program of the meeting at the time of their registration. The President may extend to guests the privilege of participating in the discussions. Each guest will be assessed a Registration Fee. A senior medical student or a resident in surgery from an accredited residency program may attend the scientific meetings without charge upon presentation of appropriate identification and certification at the time of registration.

### **ARTICLE VI: Quorum**

SECTION 1. A minimum of twenty-five (25) percent of the membership shall be required at any Executive Session to form a quorum for transaction of the ordinary business of the Association, for elections, for changes in the Constitution and Bylaws, or for ordering assessments.

SECTION 2. A minimum of fifty-one (51) percent of the membership shall be required to form a quorum to consider the expulsion of a member.

### **ARTICLE VII: Committees**

SECTION 1. All standing and ad hoc committees shall act in an advisory capacity to the duly elected Executive Committee of the Association.

SECTION 2. The Membership Committee shall be composed of six (6) members: four (4) presidential appointees, each to serve for a period of four (4) years; the other two (2) members shall be District Representatives assigned by the Executive Committee for the latter two-year (2-year) portion of their term of office. The President, the Secretary, and the Treasurer shall be ex-officio members of the Committee.

- a. The Chairman shall be the senior appointed member of the Committee, i.e. that appointed member who is in his/her fourth year on the Committee.
- b. The deadline for submission of applications to the Secretary of the Association shall be May 1 preceding the Annual Meeting.
- c. The Secretary of the Association shall send all applications and related data to this Committee at an appropriate interval preceding the Annual Meeting.
- d. The Membership Committee shall convene and present annually to the Executive Committee the complete list of candidates and their recommendation on each of them.

SECTION 3. The Program Committee shall consist of six (6) members: four (4) presidential appointees, each to serve for a period of four (4) years; the other two (2) members shall be District Representatives assigned by the Executive Committee for the first two-year (2-year) portion of their term of office. The President, the Secretary, and the Recorder shall be ex-officio members.

- a. The Chairman shall be the senior appointed member, i.e. that appointed member who is in his/her fourth year on the Committee.
- b. The deadline for submission of abstracts to the Secretary of the Association shall be in accordance with published guidelines of the Association.
- c. After individual preliminary evaluation of all abstracts, this Committee shall convene for purposes of final selection of the program for the Annual Meeting.

SECTION 4. The Executive Committee shall act as a Budget Committee with reference to necessary secretarial expenditures for officers and committee members, subject to the approval of the membership.

SECTION 5. ADVISORY NOMINATING COMMITTEE. The Executive Committee shall act as the Nominating Committee at the Annual Meeting. In turn, the Executive Committee shall appoint an Advisory Committee, consisting of the three (3) immediate Past-Presidents and the senior District Representative. The Chairman of this Advisory Committee shall be the immediate Past-President. This Advisory Committee shall discuss suitable nominees to fill the officer and representative vacancies which shall occur at the time of the Annual Meeting, and shall submit its recommendations to the Executive Committee for consideration. The President and Secretary shall serve as ex-officio members.

SECTION 6. The Executive Committee shall appoint the Chairman of the Committee on Local Arrangements at least one (1) year in advance. In coordination with the Secretary and Treasurer he/she shall be responsible for all details pertaining to the Annual Meeting unless otherwise ordered by the Executive Committee.

### ARTICLE VIII: Seal and Certificate of Membership

SECTION 1. The Seal shall be circular in form and bear the name of the Association about the border. In the center shall be portrayed the Western Country, similar to the State Seal of Kansas. The Association was founded in Topeka, Kansas, 1891.

SECTION 2. The Association shall issue a Certificate of Membership signed by the President and Secretary.

SECTION 3. The Certificate of Membership shall be as follows:



### WESTERN SURGICAL ASSOCIATION FOR THE CULTIVATION PROMOTION AND DIFFUSION OF KNOWLEDGE OF THE ART AND SCIENCE OF SURGERY HAS ELECTED

### TO ACTIVE MEMBERSHIP OR HONORARY MEMBERSHIP

President

Secretary

Date

### **ARTICLE IX: Nominations and Elections**

SECTION 1. Nominations for all Officers shall be made at the Executive Session of the Annual Meeting by the Executive Committee of the Association. Additional nominations may be made from the floor.

SECTION 2. The election of Officers shall take place at the Executive Session of the Annual Meeting. An affirmative vote of a majority of the members voting at the Executive Session shall constitute an election.

SECTION 3. Any vacancy occurring during the year among the Officers of the Association shall be filled by the action of the Executive Committee. Any vacancy occurring among Committee Members shall be filled by action of the President.

### **ARTICLE X: Order of Business**

SECTION 1. Order of Business of the Executive Committee

- 1. Reading of minutes of last meeting
- 2. Reports:
  - a. Secretary
  - b.Treasurer
  - c. Recorder
- 3. Reports of Program and Membership Committees
- 4. Reports of Representatives of American Board of Surgery and the Board of Governors and Advisory Council on Surgery of the American College of Surgeons
- 5. Unfinished Business
- 6. New Business
- 7. Nominations:
  - a. Locations of Future Meetings

b. Chairman of Committee on Local Arrangements

- 8. The report of the Advisory Committee on Nominations shall be considered, and a slate of nominations for officers shall be prepared.
- The report of the Executive Committee of the Association shall be discussed in preparation for its presentation by the Secretary to the membership of the Association in Executive Session at the Annual Meeting.

SECTION 2. Executive Session of the Annual Meeting

- 1. Reading of previous year's minutes of the Executive Session of the Annual Meeting
- 2. Report of Executive Committee meetings to the Association by the Secretary
- 3. Report of the Treasurer
- 4. Report of the Recorder
- 5. Report of the Representative Board of Governors, American College of Surgeons
- 6. Report of the Representative American Board of Surgery
- 7. Report of the Representative Advisory Council on Surgery, American College of Surgeons
- 8. Report of Program & Membership Committees
- 9. Unfinished Business
- 10. New Business
- 11. Election of New Members
- 12. Election of New Officers
- 13. Adjournment

### ARTICLE XI: Alterations in the Constitution and Bylaws

No part of the Constitution or Bylaws may be amended, altered or replaced, except at a regular Annual Meeting of the Association in Executive Session. The suggested amendment, alteration or repeal in the Constitution or Bylaws must have been presented in writing at the Executive Session of the previous Annual Meeting, signed by three (3) members. Notice of the proposed amendment, alteration or repeal shall be given in writing with the call to the Annual Meeting. The adoption of the suggested amendment, alteration or repeal shall be by vote of three-fourths of the members voting, a quorum being present at the Executive Session.

### **ARTICLE XII: Parliamentary Authority**

Sturgis' Standard Code of Parliamentary Procedure, the current edition, shall be the parliamentary authority in all matters not specified in the Constitution, Bylaws or standing rules of this organization.



# Past Presidents & Meeting Places

PRESIDENT	PLACE	YEAR
S.S. Todd*	Topeka	1891
Milo B. Ward*	Kansas City	1892
Milo B. Ward*	Des Moines	1893
Lewis Schooler*	Omaha	1894
John E. Summers, Jr.*	Kansas City	1895
Thomas J. Beattie*	Topeka	1896
Joseph Eastman*	Denver	1897
David S. Fairchild*	Omaha	1898
Homer C. Crowell*	Des Moines	1899
O. Beverly Campbell*	Minneapolis	1900
August F. Jonas*	Chicago	1901
James E. Moore*	St. Joseph	1902
Alexander H. Ferguson*	Denver	1903
Charles H. Mayo*	Milwaukee	1904
Harvey D. Niles*	Kansas City	1905
Malcolm L. Harris*	Salt Lake City	1906
Charles W. Oviatt*	St. Louis	1907
William W. Grant*	Minneapolis	1908
Arthur L. Wright*	Omaha	1909
John P. Lord*	Chicago	1910
Amos W. Abbott*	Kansas City	1911
Lewis L. McArthur*	Cincinnati	1912
Jabez N. Jackson*	St. Louis	1913
Bryon B. Davis*	Denver	1914
Joseph R. Eastman*	Des Moines	1915
Lawrence W. Littig*	St. Paul	1916
Leonard Freeman*	Omaha	1917
James F. Percy*	Chicago	1918
Roland Hill*	Kansas City	1919
Arthur T. Mann*	Los Angeles	1920
Charles D. Lockwood*	St. Louis	1921
Miles F. Porter*	Minneapolis	1922
Horace G. Wetherill*	Colorado Springs	1923
Donald Macrae, Jr.*	French Lick Springs	1924
Willard D. Haines*	Wichita	1925
Robert C. Coffey*	Duluth	1926
Lewis H. McKinnie*	Omaha	1927
Kellog Speed*	Chicago	1928
E. Starr Judd*	Del Monte	1929

PRESIDENT	PLACE	YEAR
Carl E. Black*	Kansas City	1930
Clarence G. Toland*	Denver	1931
Harry P. Ritchie*	Madison	1932
Samuel C. Plummer*	Cincinnati	1933
Frank R. Teachenor*	St. Louis	1934
Reginald H. Jackson*	Rochester	1935
Thomas G. Orr*	Kansas City	1936
Fred W. Bailey*	Indianapolis	1937
Casper F. Hegner*	Omaha	1938
Vernon C. David*	Los Angeles	1939
Alfred Brown*	Topeka	1940
Albert H. Montgomery*	St. Paul	1941
Willis C. Gatch*	No General Meeting	1942
Willis D. Gatch*	No General Meeting	1943
Willis D. Gatch*	Chicago	1944
James C. Masson*	Chicago	1945
Arthur R. Metz*	Memphis	1946
William M. Mills*	Colorado Springs	1947
Harry B. Zimmerman*	St. Louis	1948
Robert L. Sanders*	Santa Barbara	1949
Warren H. Cole*	Minneapolis	1950
Erwin R. Schmidt*	Colorado Springs	1951
George B. Packard*	Houston	1952
Lawrence Chaffin*	Chicago	1953
Herbert H. Davis*	Colorado Springs	1954
Michael L. Mason*	Seattle	1955
Charles G. Johnston*	Cincinnati	1956
Everett P. Coleman*	Salt Lake City	1957
James B. Brown*	Rochester	1958
James T. Priestley*	Colorado Springs	1959
Caleb S. Stone, Jr.*	Detroit	1960
John T. Reynolds*	San Francisco	1961
Jacob K. Berman*	St. Louis	1962
Charles W. Mayo*	Galveston	1963
Eugene A. Osius*	Colorado Springs	1964
Arthur J. Hunnicutt*	Omaha	1965
Walter W. Carroll*	Phoenix	1966
O. Theron Claggett*	Los Angeles	1967
Merle M. Musselman*	Chicago	1968

PRESIDENT	PLACE	YEAR
Arthur C. Pattison*	Dallas	1969
Kenneth C. Sawyer*	Colorado Springs	1970
Raleigh R. White*	Portland	1971
Carl P. Schlicke*	Rochester	1972
Tom D. Throckmorton*	Houston	1973
Darrell A. Campbell*	San Francisco	1974
Chester B. McVay*	Colorado Springs	1975
William P. Mikkelsen*	Coronado	1976
Allen M. Boyden*	Las Vegas	1977
D. Emirick Szilagyi*	Scottsdale	1978
Harvey R. Butcher, Jr.*	Colorado Springs	1979
William H. ReMine*	Salt Lake City	1980
Paul E. Hodgson	Albuquerque	1981
James J. Berens*	Kansas City	1982
Robert E. McCurdy*	Monterey	1983
George L. Jordan, Jr.*	Colorado Springs	1984
Martin A. Adson*	Rochester	1985
R. Dale Liechty	Detroit	1986
Alexander J. Walt*	Dallas	1987
Melvin A. Block	Coronado	1988
J. Bradley Aust*	St. Louis	1989
David G. Ashbaugh	Scottsdale	1990
John L. Glover*	Colorado Springs	1991
Arthur J. Donovan	San Antonio	1992
George E. Block*	Seattle	1993
Basil A. Pruitt, Jr.	Palm Desert	1994
Norman W. Thompson	Chicago	1995
Jon A. van Heerden	Portland	1996
Jack R. Pickleman	Colorado Springs	1997
Jay L. Grosfeld	Indianapolis	1998
Thomas V. Berne	Santa Fe	1999
Amilu S. Rothhammer	Dana Point	2000
J. David Richardson	San Antonio	2001
Claude H. Organ*	Vancouver, British Columbia	2002
Richard A. Prinz	Tucson	2003
Fabrizio Michelassi	Las Vegas	2004
Arthur S. McFee	Rancho Mirage	2005
Richard C. Thirlby	Los Cabos, México	2006
Merril T. Dayton	Colorado Springs	2007

PRESIDENT	PLACE	YEAR
Bruce L. Gewertz	Santa Fe	2008
Wayne H. Schwesinger	San Antonio	2009
Michael B. Farnell	Chicago	2010
Gregory J. Jurkovich	Tucson	2011
Raymond J. Joehl	Colorado Springs	2012
Clive S. Grant	Salt Lake City	2013

\*Deceased



A look back at

last year's Scientific Program

### FIRST SCIENTIFIC SESSION

Sunday, November 4, 2012 – 7:30am – 12Noon

Moderator: Dr. Raymond J. Joehl

#### Risk Factors For Prolonged Hospital Stay In Laparoscopic Ventral Hernia Repair

*Juliane Bingene*, Malek S. Hussein, William S. Harmsen, *Michael L. Kendrick* Mayo Clinic Rochester

#### The Urinalysis Rules Out Urinary Tract Infection In The Critically Ill Trauma Patient

Robert T Stovall, Jim Haenal, Timothy C. Jenkins, Fredric Pieracci, Gregory J. Jurkovich, Walter Biffl, Jeff L. Johnson, Carlton Barnett, D. Bensard, Ernest E. Moore, Clay Cothren Burlew Denver Medical Health Center

#### Novel Theranostic Nanoparticle Causes Increased Cytoplasmic Uptake Of Doxorubicin In Mcf-7 Breast Cancer Cell Lines Leading To Increased Apoptosis

Dinesh Vyas, Mohammad Eldakdouki, Marc Basson, L. S. Chaturvedi, Arpita Vyas, P. V. Mohankumar, Xuefei Huang Michigan State University

- Preoperative Axillary Ultrasound In Breast Cancer: Safely Avoid Frozen Section Of Sentinel Lymph Nodes In Breast Conserving Surgery Irada Ibrahim-Zada, Judy C. Boughey, *Clive S. Grant* Mayo Clinic Rochester Invited Discussant: Amy Waer, Tucson, Arizona
- Osteopontin Up-Regulates Critical EMT Transcription Factors To Induce An Aggressive Breast Cancer Phenotype
   N. Li, C. Weber, Z. Mi, T. Lynch, M. Kundu, Paul Kuo Sponsor: Raymond J. Joehl Loyola University
   Invited Discussant: Nora Hansen, Chicago, Illinois

- Late Recurrence In Melanoma Mark B. Faries, Shawn Steen, Xing Ye, Myung Sim, Donald L. Morton Yale University Invited Discussant: James Jakub, Rochester, Minnesota
- Is Sentinel Lymph Node Biopsy Necessary For Desmoplastic Melanoma? Michael E. Egger, Katherine M. Huber, Erik M. Dunki-Jacobs, Amy R. Quillo, *Charles R. Scoggins, Robert C.G. Martin, II*, Arnold J. Stromberg, *Kelly M. McMasters*, Glenda G. Callender University of Louisville Invited Discussant: Ashwani Rajput, Albuquerque, New Mexico

#### INTRODUCTION OF NEW MEMBERS

#### PRESENTATION OF "J. BRADLEY AUST AWARD" FOR BEST PAPER BY A NEW MEMBER

#### RECIPIENT OF "J. BRADLEY AUST AWARD" 2011 M. B. Majella Doyle\*, MD

#### ....INTERMISSION.....

Moderator: Dr. Robert V. Rege

Presidential Address – Dr. Raymond J. Joehl

5. Improving Clinical Productivity In An Academic Surgical Practice Through Transparency

*Charles R. Scoggins*, Robert M. Cannon, Timothy Crockett, Lex Wafford, *Kelly M. McMasters* University of Louisville **Invited Discussant: Merril Dayton, Buffalo, New York** 

6. No Trainee Left Behind: A Preemptive Attack On Behalf Of Duty Hour Regulated Surgery Residents Shahzad M. Ali, Roberto Hernandez-Irizarry, *David R. Farley* Mayo Clinic Rochester Invited Discussant: Tyler Hughes, McPherson, Kansas

7. Negative Appendectomy In The U.S. 1998-2009: A Population-Based Analysis James A. Madura\*, II, David A. Etzioi Indiana University Invited Discussant: David Sheldon, Kalispell, Montana

### SECOND SCIENTIFIC SESSION

Monday, November 5, 2012 – 7:30am – 12noon

Moderator: Dr. Raymond J. Joehl

#### Sarcopenia And Frailty In Elderly Trauma Patients

Berry Fairchild, *Travis Webb*, Susan Tsai, Qun Xiang, *Karen Brasel* Medical College of Wisconsin

Hemoglobin A1c Predicts Post-Operative Morbidity In Elective Colectomy Patients Claire Peeples, Andrew Shaffer, Elizabeth Gates, Carla Ferrise, Thomas Riggs, James Catto, Ananias Diokno

#### Non-Acid Reflux: A Potential Contributor To Reflux-Related Respiratory Symptoms

Candice L. Wilshire, Stefan Niebisch, Nikita Chapurin, Thomas J. Watson, Virginia R. Litle, Christian G. Peyre, Carolyn E. Jones, *Jeffrey H. Peters* 

- Increasing Experience With Total Mesorectal Excision Allows For Selective Use Of Neoadjuvant Therapy In Patients With Rectal Cancer Jean H.Ashburn, *David W. Dietz*, Feza H. Remzi Sponsor: David Dietz Cleveland Clinic Invited Discussant: Herb Phelan, Dallas, Texas
- 9. Current Utilization And Surgical Efficacy Of Laparoscopic Colectomy (Lc) In Colon Cancer (Cc) *Robert P. Sticca*, Steven R. Alberts, Michelle R. Mahoney, Daniel J. Sargent, Lisa Finstuen, Garth Nelson, Timothy Husted, Jan Franko, Charles Goldman, Barbara A. Pockaj University of North Dakota Invited Discussant: John Russell, Albuquerque, New Mexico

- 10. Readmission Following Rectal Resection: Indication, Length And Complexity Of Surgery Are Predictive Factors Matthias Turina, Feza H. Remzi, *David W. Dietz*, Ravi P. Kiran, Dilara Khoshknabi, Jon D. Vogel Cleveland Clinic Invited Discussant: Scott Thomas, Temple, Texas
- Creation Of A Non-Operative, True Orthotopic Gastric Cancer Murine Model Using Electrocoagulation Jasneet Singh Bhullar, Gokulakkrishna Subhas, Tafadzwa Makarawo, Boris Silberberg, Jacqueline Tilak, Melissa Decker, *Vijay K. Mittal* Providence Hospital and Medical Center Invited Discussant: Carlton Barnett, Denver, Colorado
- 12. Chronic Groin Discomfort After Laparoscopic Tep Inguinal Hernia Repair Shahzad M. Ali, Benjamin Zendejas, Roberto Hernandez-Irizarry, Christine Lohse, *David R. Farley* Mayo Clinic Rochester Invited Discussant: Richard Frazee, Temple, Texas

#### ....INTERMISSION.....

Point / Counterpoint: Moderator: Dr. Jerry Jurkovich

#### Surgeon Fatigue - Can We Be Too Tired to Work?

Karen Borman, Abington, Pennsylvania Steven Stain, Albany, New York

#### Public Reporting of Surgical Outcomes: What Should It Look Like, What Will It Look Like?

Robert Cima, Rochester, Minnesota Richard Thirlby, Seattle, Washington

13. The Biopsy-Proven Benign Thyroid Nodule: Is Long-Term Follow-Up Necessary? Sukhyung Lee, Thomas S. Skelton, Katherine A. Schwartz, Nancy D. Perrier, Jeffrey E. Lee, Naifa L. Busaidy, Elizabeth G. Grubbs\* MD Anderson Cancer Center Invited Discussant: Glenn Winslow, Great Falls, Montana 14. The Assignment Of TASC Classification And Runoff Score: Are We Speaking The Same Language? Tiffany Y. Wu, Steven G. Katz University of Southern California Invited Discussant: William Pearce, Chicago, Illinois

### THIRD SCIENTIFIC SESSION

Monday, November 5, 2012 – 1:30pm – 4:00pm

Moderator: Dr. William Dolan

- 15. Aspiration, Localized Pulmonary Inflammation, And Predictors Of Early-Onset Bronchiolitis Obliterans Syndrome After Lung Transplantation *P. Marco Fisichella*\*, Christopher S. Davis, Cynthia Weber, Erin Lowery, Luis Ramirez, Elizabeth J. Kovacs, Richard L. Gamelli Loyola University Medical Center Invited Discussant: Alden Harken, Oakland, California
- 16. Excellent Long-Term Patient And Graft Survival Are Possible With Appropriate Use Of Livers From Deceased Septa- And Octogenarian Donors Marcio F. Chedid, *Charles B. Rosen\**, Scott L. Nyberg, Julie K. Heimbach Mayo Clinic Rochester Invited Discussant: William Chapman, St. Louis, Missouri
- 17. Outcomes With Split Liver Transplantation Are Equivalent To Whole Organ Transplant
  M.B. Majella Doyle\*, Erin Maynard, Ying Lin, Neeta Vachharajani, Surendra Shenoy, Christopher Anderson, Mark Earl, Jeffrey A. Lowell, William C. Chapman
  St. Louis, Missouri
  Invited Discussant: Sue Orloff, Portland, Oregon
- Resection Of The Inferior Vena Cava And Liver For Malignancy Alan W. Hemming\*, Ivan Zendejas, Robin Kim, Alan Reed, Kristin Mekeel University of California San Diego
   Invited Discussant: Thomas Aloia, Houston, Texas

....INTERMISSION.....

*Thomas Aloia\**, Junichi Shindoh, *Eddie Abdalla*, Steven Huang, Michael Wallace, Steven Curley, *Jean-Nicolas Vauthey* MD Anderson Cancer Center **Invited Discussant: Alan Hemming, San Diego, California** 

20. Laparoscopic Ivor Lewis Esophagectomy With Prior Gastric Ischemic Conditioning: A New Standard Of Care For Esophageal Cancer *Swee H Teh\**, David McCaslister Kaiser Permanente Invited Discussant: Charles Scoggins, Louisville, Kentucky

4:00pm – 5:00pm ANNUAL ASSOCIATION BUSINESS MEETING (members only)

# FOURTH SCIENTIFIC SESSION

Tuesday, November 6, 2012 – 8:00am- 11:00am

Moderator: (President Elect)

- 21. Duration Of Chronic Critical Limb Ischemia Predicts Amputation-Free Survival Jayer Chung, David A. Timaran, Chul Ahn, Mitchell Plummer, Carlos H. Timaran, Melissa L. Kirkwood, Mirza S. Baig, *R. James Valentine* UT Southwestern Medical School Invited Discussant: Ashraf Mansour, Grand Rapids, Michigan
- Barriers To Efficient Trauma Care Associated With CT Scanning
   Daniel Shouhed, Renaldo Blocker, Eric Ley, Ken Catchpole, Doug Wiegmann,
   Steven Rudd, Jennifer Blaha, Jean-Phillipe Okhovat, Mark Paulsen, B
   ruce L. Gewertz
   Cedars-Sinai Medical Center

   Invited Discussant: Jason Fleming, Houston, Texas

- 23. Post-Injury Hyperfibrinogenemia Compromises Efficacy Of Heparin-Based Vte Prophylaxis
  Jeffrey N. Harr, *Ernest E. Moore*, Arsen Ghasabyan, Theresa L. Chin,
  Eduardo Gonzalez, Max Wohlauer, Anirban Banerjee, Christopher C. Silliman
  University of Colorado Denver
  Invited Discussant: Leigh Neumayer, Salt Lake City, Utah
  24. Postoperative Plasma Aldosterone Level As An Outcome Predictor After
- Adrenalectomy For Primary Hyperaldosteronism
   Michael Tsinberg, Robin M. Cisco, Chienying Liu, Anouk Scholten,
   Wen T. Shen, Jessica Gosnell, Orlo H. Clark, Quan-Yang Duh
   University of California San Francisco
   Invited Discussant: Melanie Richards, Rochester, Minnesota
- 25. Living Donor Kidney Transplantation Using Laparoscopically Procured Multiple Renal Artery Kidneys And Right Kidneys Marcio F. Chedid, Carl Muthu, Justin M. Burns, Tim G. Lesnick, Walter Kremers, *Mikel Prieto*, Julie K. Heimbach, George Chow, Mark D. Stegall, *Patrick G. Dean\** Mayo Clinic Rochester Invited Discussant: Michael Marvin, Louisville, Kentucky

#### 26. Machine Perfusion: Not Just For Marginal Kidney Donors Robert M Cannon, Guy N Brock, R Neal Garrison, Michael R Marvin\*, Glen A Franklin University of Louisville Invited Discussant: Patrick Dean, Rochester, Minnesota

27. Development And Validation Of A Necrotizing Soft-Tissue Infection Mortality Risk Calculator Using NSQIP Iris Faraklas, Greg Stoddard, *Leigh Neumayer*, Jeffrey Saffle, *Amalia Cochran* The University of Utah Invited Discussant: Karen Brasel, Milwaukee, Wisconsin

Meeting Concludes

Italics indicates a member of the Western Surgical Association \*Indicates a new member I Indicates Aust Award Candidate





# DEATHS & MEMORIALS

### DEATHS REPORTED 2012-2013

Paul Hodgen, MD

Thomas D. Kirksey, MD

Dale Liechty, MD

Leon Morgenstern, MD

Joe Pinkerton, MD

Robert L. Schmitz, MD

Robert T. Soper, MD



## In Memoriam Paul Hodgen, MD

Paul was born on December 14, 1921 in Milwaukee, Wisconsin. He received his bachelor's degree from Beloit College of Beloit, Wisconsin. After completing his medical degree at the University of Michigan in Ann Arbor, Michigan, he continued at that institution as a surgery intern, junior resident, and chief resident. Beginning in 1952, Dr. Hodgson served as a faculty member at the University of Michigan, first as an instructor, then as an assistant professor, and finally as an associate professor. From 1956 to 1960, he was the Chief of the Surgical Service at the VA Hospital in Ann Arbor, Michigan. He was recruited to the University of Nebraska in 1962 as a Professor of Surgery. During his tenure at the University of Nebraska, he served as Assistant Dean for Academic Affairs from 1969 to 1972, and Chairman of the Department of Surgery from 1974 to 1984. Dr. Hodgson retired from the University of Nebraska College of Medicine in 1988 and served as an Emeritus Professor of Surgery up to the time of his death on August 28, 2013.

During his professional career, Paul was extremely active in Surgery, both at the regional and national levels. He served on numerous committees for the American College of Surgeons. He joined the Western Surgical Association in 1963 and served as secretary from 1976 to 1980, and finally as president from 1980 to 1981.

He is remembered as a true gentleman who lived his life to the highest principles, a meticulous surgeon who always put the interest of the patient in the forefront, and an outstanding mentor and role model for the surgical trainee.

He was preceded in death by his beloved wife of sixtyfive years, Barbara "Oz" Hodgson. He is survived by his daughter, Ann Baldwin, and a son, Paul Clinton Hodgson.



# In Memoriam Thomas D. Kirksey, MD

Thomas David Kirksey, M.D., died March 17, 2013. Tom led a devoted life of service to the field of medicine. His accomplishments and contributions were many, including a cardiovascular and thoracic surgical career that spanned 30 years, a life dedicated to servant-centered leadership of organized medicine and a faithful steward to medical education, patient safety and client care. Tom received his medical degree and six-year residency from the University of Texas Medical Branch in Galveston. He served in the US Army from 1966-1968 at the Surgical Research Unit at Brook General Hospital, where he helped design the burn patient evacuation system from Vietnam and the U.S.S. Hope. In 1972, he joined Brackenridge Hospital in Austin, Texas as director of medical education and later served as Medical Director of Seton Healthcare Network. Tom developed a community-based university-affiliated graduate medical program which enabled Brackenridge to continue medical education. An active advocate for indigent care, he helped change the nature of medical services by establishing the Emergency Medical Service (EMS) in the 1970s. He chaired the American College of Surgeons' Credentials Committee throughout much of the 90s. Tom was appointed to the Texas State Board of Medical Examiners by Governor George Bush in 1995 where he served for six years, later he was elected to the Board of Directors and then served as President to the Federation of State Medical Boards of the United States. He adored his wife of 54 years Gene, and their four daughters, five grandchildren, and his great-grand daughter.



### In Memoriam Dale Liechty, MD

Richard Dale Liechty passed away on Thursday, 9/12/2013. Dale was born in Lake Geneva, Wisconsin 10/20/25 and after high school he served in the Navy for two years, prior to entering Yale University where he as a full-back on the football team and graduated with honors.. He returned to the Midwest to Northwestern University Medical School and then did his residency at the University of Michigan. Dale began his surgical career at the University of Iowa where he rose to the rank of Professor with a dedicated interest and practice in endocrine surgery. He was recruited to Denver in 1971 by Tom Starzl and was devoted to teaching and operating at the University of Colorado for the next 24 years. At the University of Colorado he focused on surgery of the thyroid and parathyroid and also started a bariatric surgery program. He co-edited "Synopsis of Surgery" in 1968 which had 5 editions published. He published over 40 manuscripts. Dale proudly served as President of the Western Surgical Association in 1984. His Presidential addresses was titled "Humor and the Surgeon." Despite having polio in his youth he remained active and was an avid tennis player. He enjoyed badgering his opponents in good humor.

Dale is survived by his wife Valerie, two sons Bob and Rich, and 7 grandchildren. Dale was preceded in death by his daughter Ann Liechty-Millikan.



# In Memoriam Leon Morgenstern, MD

Leon Morgenstern, MD, a beloved colleague and the founding director of surgery for Cedars-Sinai Medical Center, died Dec. 23, 2012 at his home in Malibu at age 93. He paused in his reading of a novel, took a nap in his favorite chair and never woke up. A surgeon, scholar, humanist, medical researcher and prolific author, he remained exceptionally active after his retirement and was working in his Cedars-Sinai office as recently as 2 days before his death.

Leon joined Cedars of Lebanon as an attending physician in 1953 and became Director of Surgery in 1960. In 1970, at the creation of Cedars-Sinai, he assumed the leadership of the merged institution. He served in this role until 1988, presiding over a time of sweeping change in his field, in medicine and at the medical center. Indeed, the Department of Surgery had only 2 full-time members when he

started; there are more than 60 faculty in the department now, thanks in no small measure to his tireless work, his professional accomplishments, his generous, principled and compassionate leadership and, above all, his personal touch. He was a warm, brilliant and innovative man who helped to transform the field and his institution.

He was one of seven American Surgical Association fellows at Cedars-Sinai. A member of Alpha Omega Alpha, the national medical honorary society, he had served on the editorial board of *Surgical Innovations* and was a regular reviewer for *Archives of Surgery*. He was a professor emeritus in surgery at UCLA School of Medicine, was an adjunct ethics professor at the University of Judaism, Los Angeles, and was an advisory board member to the Pacific Center for Health Policy and Ethics at USC..

The surgeons he recruited and who counted him as both mentor and dear friend include George Berci, MD, a colleague for more than a half century who has been honored for helping to develop the tools and techniques for minimally invasive surgery, Edward Phillips, MD, a nationally recognized leader in breast cancer care and laparoscopic surgery and Jon Hiatt MD, renown surgical educator and currently vice-dean at UCLA.

One of the most prominent surgeons interested in clinical medical ethics, he established Cedars-Sinai's Center for Healthcare Ethics, which helps patients, caregivers, policy-makers and others in the challenging struggles of how best to care for and treat patients and how to raise professionals' awareness of ethics in their practice. He provided leadership in his writings and his daily conversations across the medical center on difficult topics such as end of life care and helping those in pain and discomfort. By example and in his teaching and writing, Leon insisted that physicians always put patients and their needs first – with gentle and compassionate care. He wrote to criticize doctors who got wrapped up in jargon and acronyms. And he urged even the busiest doctors to spend time, seated at the bedside of those in their care, listening patiently, closely and carefully to every comment and complaint.

He could take a longer view, because among his many other achievements, Morgenstern was an accomplished medical historian, speaking on the Napoleonic legacy to French medicine, publishing about Russian author Anton Chekhov's time in medical school or the role played by the Shah of Iran's spleen in contemporary Middle Eastern affairs. As a writer, he was crisp, learned and enriched his work with personal experience – how it felt to be a patient; what it was like as an emeritus to receive late-night anxious calls from patients inquiring about impending operations; and how he had consulted with colleagues about his own wishes for care at the end of his life.

Simply stated, Dr. Morgenstern was an inspiring and remarkable human being who leaves a legacy of honor and grace. I will always treasure our regular lunches together over the last 7 years. He always marveled at the progress of medicine yet invariably had a highly inspiring or pertinent insight, all of which I still remember with greatest clarity and appreciation. Our condolences go out to his wife, Laurie Mattlin; sons, David Ethan and Seth August; and five grandchildren.

Bruce L. Gewertz, MD Los Angeles, Ca



# In Memoriam Joe Pinkerton, MD

Joe A. Pinkerton Jr., M.D., died March 20, 2011. He was 71. He was born in Franklin, TN. He attended Vanderbilt University and its medical school. After serving as a captain in the U.S. Air Force and completing his surgery residency at Vanderbilt, he entered private practice at Saint Luke's Hospital of Kansas City where he practiced thoracic, vascular, and general surgery for 35 years. He was a diplomat of the American Board of Surgery, with certification in Vascular Surgery, and the American Board of Thoracic Surgery. He was also associated with Children's Mercy Hospital and Truman Medical Center in Kansas City, MO, and was a clinical professor at the University of Missouri-Kansas City School of Medicine. He was involved in surgical education for the entirety of his career. Joe served as chairman of the Department of Surgery, president of the hospital staff, and a member of the boards of Saint. Luke's Hospital and the Saint Luke's Hospital Foundation for Medical Education. His contributions to vascular surgery in the Kansas City community were unparalleled, as was his quiet temperament, steady demeanor, and dedication to his profession. He is survived by his wife of 48 years, Mary Ann; children, Beth, Lisa, and Debbie; and seven grandchildren, whom he cherished and with whom he spent every spare moment.

Submitted by Paul W. Nelson, MD and Thomas S. Helling, MD.



### In Memoriam Robert L. Schmitz, MD

Chicago lost a legacy April 8, 2012 when Dr. Robert Lenzen Schmitz.

Born on Logan Street on March 10, 1914 to prominent OB/GYN Dr. Henry Schmitz and his wife Meta (nee Lenzen), Robert joined brothers Henry L. and Herbert. All three followed in their father's footsteps and became prominent Chicago physicians, educators, and volunteers, forever impacting Chicago and the field of medicine.

A 1931 graduate of Francis F Parker School, Robert attended the University of Chicago where he played basketball and received his BS and MD degrees. His illustrious career as a physician began in 1939 as the International Cancer Research Foundation Fellow,

under the renowned Alexander Brunschwig at the U of Chicago. The following three years he was a Fellow in Surgery at the Mayo Clinic in Rochester, MN and then first assistant to O.T. Clagett, MD at the Mayo Clinic. Unfortunately, in 1939, during Robert's internships, his father died from complications caused by radiation exposure.

When World War II broke out, Robert enlisted in the US Navy and became a Lieutenant aboard the USS Hamilton DMS 18. He spent the next two years in the Pacific sweeping for mines and was ultimately awarded a Unit Citation.

Following his honorable discharge from the Navy in 1946, he began a storied medical career, joining his two older brothers in the Henry Schmitz Medical Group. He spent nearly four decades as a surgeon at Mercy Hospital (1946-84) and as an attending physician at Cook County Hospital (1958-69). He was also named a Professor of Surgery at the Loyola University Stritch School of Medicine from 1952-1972, again following in the esteemed footsteps of his father and brothers. In 1972 he was appointed a Professor of Surgery at the University of Illinois College of Medicine, where he taught until 1984. During this 30-year span he trained many of Chicago's most prominent physicians.

He also volunteered his time serving in leadership positions for the Chicago Medical Society, Chicago Surgical Society (President, 69-70), Illinois Medical Society, Illinois Surgical Society (President, 73-74), American Medical and Surgical Associations, American College of Surgeons (President, Metropolitan Chapter, 1963), and the Western Surgical Association. He worked with the American Cancer Society for 25 years and the US Department of Health, Education and Welfare Cancer Control Program from 1962 -80.

His lifelong mission, as with his father and brothers, was to heal and help wherever possible, regardless of ability to pay. He was determined to make this world a better place and his driving passion was the eradication of cancer. He and his family before him have left a lasting mark on the world of medicine and thousands of grateful Chicagoans.



### In Memoriam Robert T. Soper, M.D.

Dr. Robert T. Soper 87 of Iowa City, died October 3, 2012. Dr. Soper was a prominent pediatric surgeon at the University Of Iowa Carver College Of Medicine for almost four decades and had served as an Emeritus Professor since his retirement in 1995.

Dr. Soper was born at the University of Howa hospital and grew up in Emmetsburg, Iowa. He served in the US Navy in the Pacific theater of World War II and was proud to have been on a destroyer that participated in the Tokyo Bay ceremony ending the war. He graduate Phi Beta Kappa from Cornell College in Mt. Vernon, Iowa where he met his future wife the daughter of a Cornell College Professor of Music. Drawn to a calling in medicine, he attended the University of Iowa College

of Medicine and then trained in Cleveland and Mason City before returning to Iowa for a general surgery residency. He then took his fledgling family to Liverpool England where he performed a one-year fellowship in pediatric surgery a new specialty that was just emerging. Dr. Soper returned to Iowa City to join the faculty at the University of Iowa. He rose through the professional ranks and ultimately served as the interim Chair of the Department of Surgery from 1992 – 1995. Dr. Soper was the first and only surgeon to specialize in pediatric surgery in the state of Iowa for many years, treating thousands of children during his long and productive tenure at the university.

Dr. Soper had a very distinguished academic career. He was the editor of 7 textbooks of surgery and more than 200 scientific articles. He was invited to give lectures throughout the world on various topics in pediatric surgery and demonstrated operations in several foreign countries. He also performed missionary work in the Congo and on a Navajo reservation.

Dr. Soper was a mentor to many medical students and surgical residents. He was instrumental in training hundreds of surgeons who carried his passion for surgery to all corners of the state of Iowa and across the United States. He received the prestigious Ernest Theilen Clinical Teaching and Service Award from the University of Iowa Carver College of Medicine in 1996 and the Distinguished Alumnus Award in 2006. In 1998 the Robert T. and Helene J Soper Chair of Surgery was established, the first endowed chair within the Department of Surgery.

Dr. Soper had a positive influence on many people and was revered by all who came in contact with him as an honest, dedicated, and humble individual. He took care of his patients passionately and treated those around himself with respect and dignity. He also He cared deeply about his family and managed to care out time from his incredibly busy profession to be involve in the lives of those he loved. He and his wife, Helene were married for 61 years and created an atmosphere of love and inclusiveness with a passion for music, the arts and science in their household. Their loving partnership touched many lives beyond their nuclear family.

His legacy will remain vibrant and his spirit lives on in our hearts and minds.

Submitted by Nathan Soper, MD