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Indiana University (IU) was established in Bloomington, Indiana, in 1824. In 1829, John Stough Bobbs, the originator of cholecystotomy to remove stones, joined with Dr. William Fletcher and together they opened the Indiana Medical College in Indianapolis, Indiana. This small medical school along with other proprietary medical schools in Indiana eventually joined Indiana University School of Medicine, which had opened in 1903. Indiana University School of Medicine is the only medical school in Indiana and is the largest medical school in the country. Medical Students are educated at one of nine regional 4-year campuses—Bloomington, Evansville, Fort Wayne, Indianapolis, Muncie, Northwest—Gary, South Bend, Terre Haute, West Lafayette and each is affiliated locally with an undergraduate school. For example, the regional medical campuses in Bloomington, South Bend, and West Lafayette are affiliated with Indiana University, Notre Dame University, and Purdue University, respectively. The main academic health center is located in Indianapolis, the state capitol, with the main teaching hospitals on or near the campus of Indiana University-Purdue University Indianapolis (IUPUI). All of the graduate schools of Indiana University in addition to the School of Medicine are located on the same campus, as well.

Indiana University Health is one of the largest healthcare systems in the United States and includes 16 hospitals; a number of other healthcare facilities; Indiana University Health Physicians (IUHP), a >1500 member physicians’ group; and the School of Medicine. IH Health has a >60% market share of all healthcare in Indiana and is widely-respected for its patient-friendly facilities, broad clinical expertise, its commitment to the training of fellows, residents, and students, and its advanced research programs.

The first Chair of the Department of Surgery was John H. Oliver, MD, who served from 1908-1912. Over the next 105 years, there have only been 6 Chairs of the Department of Surgery—Willis D. Gatch, MD (1912-1947), Harris B. Shumacker, Jr, MD (1948-1968), John E. Jesseph, MD (1971-1982), Jay L. Grosfeld, MD (1985-2003), Keith D. Lillemoe, MD (2003-2011), and Gary L. Dunnington, MD (2012- ). There are currently >140 full-time faculty and >100 surgical residents in the Department of Surgery, and they care for surgical patients at 8 hospitals in Indianapolis—IUH University Hospital, IUH Methodist Hospital, Riley Childrens Hospital, IUH North Hospital, IUH West Hospital, IUH Saxony Hospital, Eskenazi Health Hospital (Marion County public hospital, formerly Wishard Hospital), and the Roudebush Veterans Administration.
Hospital, along with Simon Cancer Center based at IUH University Hospital. There are six Divisions in the Department of Surgery, including Cardiothoracic Surgery, General Surgery, Pediatric Surgery, Plastic Surgery, Transplantation Surgery, and Vascular Surgery. Cardiothoracic Surgery is performed at both Methodist (adult) and Riley Childrens Hospital (pediatric) and includes an advanced thoracic aorta surgery program. General Surgery has >55 full-time faculty and includes Acute Care Surgery, Breast, Colorectal, Endocrine, Hepatopancreatobiliary (HPB), and Minimally Invasive/Bariatric Sections. As IU has 2 ACS-certified Level I adult Trauma Centers in Indianapolis (Methodist and Eskenazi), the only two in the entire state, there are 18 double-Boarded faculty surgeons in this Section. The volume of trauma admissions for these 2 adult centers is 5000, and, coupled with the 1145 trauma patients admitted to Riley Childrens Hospital each year, there are over 6100 trauma admissions to the three IU trauma centers each year. In addition, Methodist admits another 1575 Emergency General Surgery patients per year. The HPB Section has one of the busiest programs for pancreatic cancer in the nation and performs >350 pancreatectomies per year. Pediatric Surgery is performed at Riley Childrens Hospital and includes a full range of congenital cardiac procedures, a Level I Pediatric Trauma Center, and a comprehensive oncology program. Plastic Surgery includes a full range of reconstructive and cosmetic surgery, Adult (Fairbanks Burn Center at Eskenazi Hospital) and Pediatric (Riley Hospital Burn Unit) Burn Centers, and a very active research program. Transplantation Surgery is the 4th busiest Division in the United States and offers the complete range of transplants including heart, lung, heart-lung, kidney, pancreas, liver, small bowel and multivisceral. Vascular Surgery offers the full range of endovascular procedures and has special expertise in endostent-grafts for the entire aorta.

Approximately 1/3-1/2 of the surgical residents in each class spend time in a formal research program, and all of these obtain a graduate degree. There is an active research program in surgical education led by the Chair of the Department, Gary L. Dunnington, MD, and a graduate degree is available here, as well. Post-residency fellowships include Acute Care Surgery, Burn, Cardiothoracic, Hepatopancreatobiliary, Minimally Invasive/Bariatric, Pediatric Surgery, Plastic Surgery, Surgical Critical Care, Transplantation, and Vascular and Endovascular Surgery.

In addition to its unique focus on the education of residents and medical
students, the Department of Surgery has a graduated education program in leadership for faculty and has developed CORES—the Center for Outcomes Research in Surgery which includes senior faculty and Ph. D. support for planning of projects and statistical analysis, data collectors, data analysts, and the opportunity for faculty to collaborate with researchers at the internationally recognized Regenstrief Institute affiliated with the School of Medicine. Regenstrief has particular expertise in informatics and healthcare research.

The Department of Surgery at Indiana University School of Medicine is responsible for an almost uncountable number of “firsts” in the state. First clinical description of Overwhelming Postsplenectomy Sepsis, first cardiac and vascular surgery in the state, first adult and pediatric transplant centers in the state, first adult and pediatric trauma centers in the state, first adult and pediatric burn centers in the state, etc. The Department offers exceptional clinical experience and expertise for patients in the Midwest, superior surgical training in general surgery, its subspecialties, and related disciplines in surgery, a rapidly expanding laboratory and clinical research program, and a commitment to educating future leaders in American surgery.
SAVE THE DATE

2018 Annual Meeting
February 10 – 13, 2018
Tampa Marriott Waterside Hotel & Marina
Tampa, Florida

2019 Annual Meeting
February 23 – 26, 2019
The Westin Charlotte
Charlotte, North Carolina
Dear Members and Guests,

Welcome to the 85th Meeting of the Southeastern Surgical Congress. Since the first “Business Meeting” in Augusta, Georgia, in May, 1930, the SESC has met annually except for the years of World War II (1942-3, 1943-44, 1944-45). As the largest regional surgical society in the United States, our annual meeting is unique in its strong focus on broad-based General Surgery and subspecialties for both academic and community surgeons. The SESC continues to be the most welcoming of all surgical groups to Fellows, Residents, and Medical Students for opportunities to present and for professional development.

As in previous years, you will enjoy the numerous educational activities organized by the CME Committee under the leadership this year of Dr. Manny Zervos. From podium papers, to poster presentations, to panels on complex patients, to special luncheon sessions, to Resident Jeopardy, the SESC program has it all this year!

Enjoy your time in Nashville at our 85th Meeting. Thank you for supporting the activities of the SESC.

David V. Feliciano, MD
President, Southeastern Surgical Congress
2016-2017
## 2016-2017 EXECUTIVE COUNCIL

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<tr>
<td>Kevin E. Behrns</td>
<td>1st Vice President</td>
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<tr>
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<td>Communications Chair /</td>
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<td>Benjamin D. Li</td>
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<td>John H. Stewart, IV</td>
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<td>J. David Richardson</td>
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## CME COMMITTEE

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<td>Marjorie Malia</td>
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<td>Jill Willhite</td>
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<tr>
<td>Tracy Brown</td>
<td>Membership, Publications &amp; Events</td>
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<tr>
<td>Laura Fitzgerald</td>
<td>Manager, Finance</td>
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<tr>
<td>Corinne Hornsey</td>
<td>Manager, Meetings &amp; Events</td>
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<tr>
<td>Heather Roderick</td>
<td>Manager, Exhibits &amp; Sponsorship</td>
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<tr>
<td>Mary Kawulok</td>
<td>Coordinator, Registration &amp; Membership Dues</td>
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<tr>
<td>Beth Chernik</td>
<td>Manager, CME &amp; Communications</td>
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<tr>
<td>Nora Barrett</td>
<td>Onsite Registration</td>
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The mission of the Southeastern Surgical Congress (SESC) is to serve as the premier regional surgical organization for general surgeons and sub-specialists. The SESC is dedicated to the presentation, evaluation, and dissemination of current knowledge and research in all phases of general surgery through an annual meeting and “The American Surgeon” journal. Fellowship and collegiality for all members, professional development for young surgeons, and presentation opportunities for trainees are core principles of the SESC.
### PAST PRESIDENTS AND MEETING LOCATIONS

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<td>2014-15</td>
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<td>Frederick L. Greene</td>
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<td>2011-12</td>
<td>Grace S. Rozycki</td>
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<td>2010-11</td>
<td>Anthony A. Meyer</td>
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<td>Kelly M. McMasters</td>
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<td>2008-09</td>
<td>Kirby I. Bland</td>
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<td>1939-1940</td>
<td>R.L. Sanders</td>
<td>Birmingham</td>
<td>11</td>
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<tr>
<td>1938-1939</td>
<td>T.C. Davidson</td>
<td>Atlanta</td>
<td>10</td>
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<tr>
<td>1937-1938</td>
<td>Fred N. Rankin</td>
<td>Louisville</td>
<td>9</td>
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<tr>
<td>1936-1937</td>
<td>C. Jeff Miller (died in office)</td>
<td>Charlotte</td>
<td>8</td>
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<tr>
<td></td>
<td>John Darrington</td>
<td></td>
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<tr>
<td>1935-1936</td>
<td>William D. Haggard</td>
<td>New Orleans</td>
<td>7</td>
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<tr>
<td>1934-1935</td>
<td>Gerry R. Holden</td>
<td>Jacksonville</td>
<td>6</td>
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<tr>
<td>1933-1934</td>
<td>Frank K. Boland, Jr.</td>
<td>Nashville</td>
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<tr>
<td>1932-1933</td>
<td>Willis C. Campbell</td>
<td>Atlanta</td>
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<tr>
<td>1931-1932</td>
<td>Charles W. Roberts</td>
<td>Birmingham</td>
<td>3</td>
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<tr>
<td>1930-1931</td>
<td>Edgar G. Ballenger</td>
<td>Atlanta (Biltmore Hotel)</td>
<td>2</td>
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<tr>
<td>May 15, 1930</td>
<td>First Business Meeting</td>
<td>Augusta</td>
<td>1</td>
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</tbody>
</table>
## Distinguished Service Award Recipients

<table>
<thead>
<tr>
<th>Year</th>
<th>Name</th>
<th>City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>1967</td>
<td>Alton Oschner</td>
<td>New Orleans, LA</td>
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<tr>
<td>1968</td>
<td>Harvey Stone</td>
<td>Baltimore</td>
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<tr>
<td>1969</td>
<td>Howard R. Mahorner</td>
<td>New Orleans, LA</td>
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<tr>
<td>1971</td>
<td>Murray M. Copeland</td>
<td>Houston, TX</td>
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<tr>
<td>1973</td>
<td>Curtis P. Artz</td>
<td>Jackson, MS</td>
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<tr>
<td>1974</td>
<td>George H. Yeager</td>
<td>Baltimore, MD</td>
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<tr>
<td>1975</td>
<td>J.D. Martin, Jr.</td>
<td>Atlanta, GA</td>
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<tr>
<td>1976</td>
<td>Harwell Wilson</td>
<td>Memphis, TN</td>
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<tr>
<td>1978</td>
<td>J. Duffy Hancock</td>
<td>Louisville, KY</td>
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<tr>
<td>1980</td>
<td>William S. McCune</td>
<td>Petoskey, MI</td>
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<tr>
<td>1982</td>
<td>A. Hamblin Letton</td>
<td>Atlanta, GA</td>
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<tr>
<td>1990</td>
<td>Arlie R. Mansberger, Jr.</td>
<td>Augusta, GA</td>
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<tr>
<td>1992</td>
<td>Richard J. Field, Jr.</td>
<td>Centreville, MS</td>
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<tr>
<td>1998</td>
<td>William E. Matory</td>
<td>Washington, DC</td>
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<tr>
<td>2000</td>
<td>R. Benton Adkins</td>
<td>Nashville, TN</td>
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<tr>
<td>2002</td>
<td>Talmadge A. “Joe” Bowden, Jr.</td>
<td>Augusta, GA</td>
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<tr>
<td>2004</td>
<td>Jannette L. Crosby</td>
<td>Atlanta, GA</td>
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<tr>
<td>2007</td>
<td>John E. Skandalakis</td>
<td>Atlanta, GA</td>
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<tr>
<td>2010</td>
<td>Hiram C. Polk</td>
<td>Louisville, KY</td>
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<tr>
<td>2011</td>
<td>R. Phillip Burns</td>
<td>Chattanooga, TN</td>
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<tr>
<td>2012</td>
<td>Henry L. Laws, II</td>
<td>Clanton, AL</td>
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<tr>
<td>2013</td>
<td>J. Patrick O’Leary</td>
<td>Miami, FL</td>
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<tr>
<td>2014</td>
<td>John B. Hanks</td>
<td>Charlottesville, VA</td>
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<tr>
<td>2015</td>
<td>J. David Richardson</td>
<td>Louisville, KY</td>
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</tbody>
</table>
EDUCATIONAL OBJECTIVES

Surgeons must have access to educational activities developed around professional practice gaps. For the Southeastern Surgical Congress, the educational needs center on knowledge, competence and performance, which tie secondarily to patient outcomes. Therefore, we provide evidence-based, up-to-date information around a broad array of surgical topics so our meeting attendees can gain education where information and skills need modification to keep current. The Annual Scientific Meeting provides the latest information by having expert lectures and panels arranged around recognized gaps in patient care or professional development. In addition, scientific presentations and posters are chosen and prioritized by a blinded, peer-review process that ensures high quality, cutting-edge content. The Scientific Meeting encompasses about 60 topics in general surgery that will be delivered through podium/video presentations and our Resident Forum. In addition, over 300 posters have been accepted and will be presented and critiqued at the meeting.

At the end of this activity, participants will be able to:

- Demonstrate increased knowledge and skills, and an intention to change practice in a broad range of general surgery topics
- Show enhanced understanding of controversial surgical techniques
- Gain knowledge and competence related to a variety of surgical topics through exposure to numerous surgical research papers on clinical topics in surgery
- Identify gaps in personal practice and take advantage of opportunities to correct these gaps

CME CERTIFICATES AND EVALUATION FORMS

Evaluation completion, CME and Self Assessment credit will be completed online. You will receive emailed instructions on how to claim CME online immediately following the conference.

DISCLOSURE INFORMATION

In compliance with the 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. A complete disclosure list is posted at the registration desk.
CONTINUING MEDICAL EDUCATION
CREDIT INFORMATION

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

AMA PRA Category 1 Credits™
Annual Meeting
The American College of Surgeons designates this live activity for a maximum of 29.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Of the AMA PRA Category 1 Credits™ listed above, a maximum of 17.5 credits meet the requirements for Self-Assessment.

AMA PRA Category 1 Credits™
PG Course: Hot Topics and Advances in Cancer Care
The American College of Surgeons designates this live activity for a maximum of 4.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Of the AMA PRA Category 1 Credits™ listed above, a maximum of 4.0 credits meet the requirements for Self-Assessment.
GENERAL INFORMATION

HOTEL INFORMATION
Renaissance Nashville Hotel
611 Commerce Street Nashville, TN 37203
t: 615-255-8400

REGISTRATION HOURS
The registration desk is located in the Ballroom Foyer.
Saturday, February 25th 8:00am – 6:00pm
Sunday February 26th 6:15am – 5:00pm
Monday, February 27th 6:15am – 6:30pm
Tuesday, February 28th 6:15am – 12:30pm

EXHIBIT HALL HOURS
The exhibit hall is located in the West/Center Ballroom.
Saturday, February 25th 10:00am – 5:30pm
Sunday February 26th 6:15am – 6:30pm
Monday, February 27th 6:15am – 5:00pm

WEATHER/ATTIRE INFORMATION
Typical highs are in the mid-50s and typical lows in the mid-30s.
The dress code for all sessions and events is business attire.

AUDIO/VISUAL
You are welcome to load your slides at the Audio/Visual table
in the back of the room at any time during the meeting.

Like us on Facebook
/southeasternsurgicalcongress

Follow us on Twitter
@SESC_AmSurg
#SESC17
SCHEDULE
AT A GLANCE
SCHEDULE AT A GLANCE

FRIDAY, FEBRUARY 24, 2017
7:00pm – 9:00pm  SESC Executive Committee  Meeting Rooms 211/212

SATURDAY, FEBRUARY 25, 2017
8:00am – 6:00pm  Registration Open  Ballroom Foyer
9:00am – 12:00pm  Resident Forum  Belmont Room
10:20am – 10:35am  Morning Break and Exhibit Viewing  West/Center Ballroom
11:30am – 12:00pm  SESC Membership Committee Meeting  Jazz
11:30am – 12:30pm  SESC Finance Committee Meeting  Rhythm and Blues
12:00pm – 1:00pm  Resident Forum Luncheon  Music City Ballroom
12:30pm – 1:30pm  Surgical Practice Committee Meeting  Jazz
12:30pm – 1:30pm  SESC Communications Committee Meeting  Rhythm and Blues
1:00pm – 5:30pm  SESC Postgraduate Course: “Hot Topics and Advances in Cancer Care”  East Ballroom
1:30pm – 2:30pm  Fellow, Resident & Medical Student Committee Meeting  Jazz
1:30pm – 2:30pm  Rural Surgery Committee Meeting  Rhythm and Blues
2:30pm – 3:30pm  CME Committee Meeting  Ryman
2:30pm – 3:30pm  Women in Surgery Committee Meeting  Jazz
2:30pm – 3:30pm  Young Surgeons Committee Meeting  Rhythm and Blues
3:25pm – 3:40pm  Afternoon Break and Exhibit Viewing  West/Center Ballroom
3:30pm – 4:30pm  Pediatric Surgeons Committee Meeting  Jazz
3:30pm – 5:00pm  SESC Executive Council Meeting  Rhythm and Blues
5:30pm – 7:00pm  Welcome Reception, Exhibit and ePoster Viewing  West/Center Ballroom
SUNDAY, FEBRUARY 26, 2017

6:15am – 5:00pm  Registration Open  Ballroom Foyer
6:15am – 6:30pm  Exhibit & ePoster Viewing  West/Center Ballroom
6:15am – 8:00am  Continental Breakfast  West/Center Ballroom
6:15am – 7:50am  Grand Rounds of ePosters  West/Center Ballroom
8:00am – 8:30am  Welcome Announcements  East Ballroom
8:30am – 9:10am  A. Hamblin Letton Lecture:
     “Gallbladder Neoplasia and Issues Alike”  East Ballroom
9:10am – 11:50am  Scientific Session I  East Ballroom
10:05am – 10:25am  Morning Break, Exhibit & ePoster Viewing
                    West/Center Ballroom
11:50am – 12:45pm  SESC Presidential Address:
                    “Abdominal Trauma Revisited”  East Ballroom
12:45pm – 2:15pm  Surgical Practice Luncheon  Belmont Room
                    (Pre-registration required)
12:45pm – 2:15pm  Fellow, Resident & Medical Student Luncheon
                    Music City Ballroom  (Pre-registration required)
2:15pm – 3:45pm  American College of Surgeons Session  East Ballroom
3:45pm – 4:00pm  Afternoon Break, Exhibit and ePoster Viewing
                    West/Center Ballroom
4:00pm – 4:45pm  SESC Historical Lecture  East Ballroom
4:45pm – 6:15pm  SESC Resident Jeopardy  East Ballroom
6:15pm – 7:15pm  Young Surgeons Committee Reception  Belmont Room
MONDAY, FEBRUARY 27, 2017

6:15am – 6:30pm  Registration Open  Ballroom Foyer
6:15am – 5:00pm  Exhibit & ePoster Viewing  West/Center Ballroom
6:15am – 8:00am  Continental Breakfast  West/Center Ballroom
6:20am – 7:50am  Grand Rounds of ePosters  West/Center Ballroom
8:00am – 8:50am  Panel Session: Challenging Cases  East Ballroom
8:50am – 11:30am  Scientific Session II  East Ballroom
9:30am – 10:10am  Roger T. Sherman Lecture  East Ballroom
10:10am – 10:30am  Morning Break, Exhibit and ePoster Viewing  West/Center Ballroom
11:30am – 12:10pm  Henry L. Laws, II, Lecture  East Ballroom
12:10pm – 2:00pm  Business Meeting & Luncheon  Music City Ballroom  (SESC Members Only)
2:00pm – 3:40pm  Scientific Session III  East Ballroom
3:40pm – 4:10pm  Debate: Employed vs. Traditional Model  East Ballroom
4:10pm  Presentation of Gold Medal Award and Apple Watch Raffle  East Ballroom
4:15pm – 4:30pm  Afternoon Break, Exhibit and ePoster Viewing  West/Center Ballroom
4:30pm – 5:30pm  Parallel Scientific Session IV: Quick Shots  East Ballroom
4:30pm – 5:20pm  Parallel Scientific Session V: Quick Shots  Belmont Room
5:30pm – 7:10pm  Video Interactive Session  East Ballroom
7:15pm – 9:00pm  President’s Reception  Music City Ballroom  (By invitation only)
TUESDAY, FEBRUARY 28, 2017

6:15am – 12:30pm  Registration Open Ballroom Foyer

6:15am – 7:00am  Continental Breakfast East Ballroom Foyer

7:00am – 8:45am  Parallel Scientific Session VI East Ballroom

8:45am – 9:00am  Morning Break Ballroom Foyer

7:00am – 8:45am  Parallel Scientific Session VII Belmont Room

8:45am – 9:00am  Morning Break Ballroom Foyer

9:00am – 10:00am  Panel Session: Catastrophic Cases I Have Known East Ballroom

10:00am – 12:00pm  Scientific Session VIII East Ballroom

12:00pm – 12:10pm  Closing Announcements & Meeting Adjournment East Ballroom
FEATURED LECTURES
PRESIDENTIAL ADDRESS

Abdominal Trauma Revisited

Sunday, February 26, 2017
11:50am - 12:45pm
East Ballroom

David V. Feliciano, MD was born in New York City and received both undergraduate and medical degrees (AOA) at Georgetown University in Washington, DC. He completed training in general surgery at the Mayo Clinic, in trauma surgery at Wayne State University/Detroit Receiving Hospital, and in vascular surgery at Baylor College of Medicine and was a Lieutenant in the U.S. Navy Medical Corps assigned to the Seabees. His clinical, academic, and administrative activities primarily occurred at Ben Taub General Hospital/ Baylor College of Medicine in Houston, TX (1978-1989) and at Grady Memorial Hospital/Emory University School of Medicine in Atlanta, GA (1991-2011). He was the longest serving Surgeon-in-Chief in Grady’s history and, with Past President Grace S. Rozycki, MD, MBA (2011-2012) and the Grady faculty, trained 30 Fellows in Trauma and/or Surgical Critical Care up to 2011.

From 2013-2016, Dr. Feliciano served as Chief, Division of General Surgery, Department of Surgery, Indiana University School of Medicine, and as Chief of Surgery, Indiana University Hospital, in Indianapolis, Indiana. During his tenure as Division Chief and working with the Chair of Surgery, Gary L. Dunnington, MD, 18 specialty trained General Surgeons were recruited. He is currently Battersby Professor of Surgery, Director of General Surgery at IUH Methodist Hospital, and Chief Emeritus, Division of General Surgery, at Indiana University. In addition, he is a Clinical Professor of Surgery at Mercer University School of Medicine, Macon, GA and Adjunct Professor of Surgery, Uniformed Services University of the Health Sciences, Bethesda, MD.
Dr. Feliciano is Board-certified in Surgery and has an academic practice in reoperative abdominal surgery after trauma or surgical emergencies, endocrine surgery, and broad-based general surgery. He has been recognized as one of “America’s Top Doctors” since 2004 and was one of the “Top Doctors in Surgery” in Indianapolis Monthly Magazine in 2015 and 2016. In addition, he has received 38 teaching awards (Dean 1; Alumni Assn. 1; Department of Surgery 1; Surgery Chief Residents 12; Medical Students 23) from three medical schools and one community residency program in his career. In 2016, he received the first “Teaching Legends Award” from the Department of Surgery at Indiana University School of Medicine.

Active in surgical societies, Dr. Feliciano has been President of the following: Priestley Society (Mayo surgeons), 1991-1992; Southwestern Surgical Congress, 1991-1992; Western Trauma Association, 1992-1993; Panamerican Trauma Society, 1999-2000; Atlanta Surgical Association, 2004-2005: American Association for the Surgery of Trauma, 2006-2007; Georgia Surgical Society, 2009-2010; Southeastern Surgical Congress, 2016-2017. In addition, he was a Director of The American Board of Surgery from 2001-2007, Chair of the Advisory Council for General Surgery, American College of Surgeons, 2007-2011, and has presented 55 named lectureships around the world including the Scudder Oration at the ACS Clinical Congress in 2010. In 2016, he was one of four physicians worldwide to receive a Distinguished Alumni Award from the Mayo Clinic.

A. Hamblin Letton Lecture

This lecture is named for Dr. A. Hamblin Letton to recognize his contributions to the Congress and the field of surgery. His special surgical interest was oncology and, more specifically, breast cancer, which led to the creation of the Breast Center at Georgia Baptist Medical Center, now Atlanta Medical Center. His interest extended to the national forum by service on the Advisory Committee on Cancer Control for the National Cancer Institute and as President of the National American Cancer Society. Dr. Letton’s service to the Congress began as a young surgeon, and he succeeded Dr. B. T. Beasley, the original Secretary of the Congress, in 1960. He retired as the Secretary-Director of the Congress in 1986. Dr. Letton passed away on January 13, 2010, at the age of 93.

Gallbladder Neoplasia and Issues Alike
Sunday, February 26, 2017
8:30am - 9:10am
East Ballroom

Presenter:
Juan M. Sarmiento, MD
Emory University School of Medicine
Atlanta, GA

Dr. Sarmiento’s innovative treatments include a minimally-invasive approach to liver surgery (the only one in the state and one of very few in the country) and laparoscopic surgery of the pancreas. With Dr. Edward Lin, Dr. Sarmiento developed unique techniques for laparoscopic-assisted formal liver resections, such as the performance of laparoscopic hepatectomy through incisions that are much smaller than those of a standard open procedure. Originally from Colombia, Dr. Sarmiento came to the U.S. in 1995 for further surgical training at the Mayo Clinic, Rochester. He then joined the faculty once his training was completed.
ROGER T. SHERMAN LECTURE

This lecture is named for Dr. Roger T. Sherman to honor his contributions to the Congress, the field of surgery and trauma. Dr. Sherman became a member of the Congress while still a resident and presented one of the first Gold Medal Forum papers. He was President of the Congress in 1984-1985, and was named Secretary-Director in 1986. He served in that capacity until 1993. Dr. Sherman was Whitaker Professor of Surgery at Piedmont Hospital and Emory University School of Medicine when he retired in October 1997. Dr. Sherman passed away on April 9, 2006, at the age of 82.

Scoop and Run: It’s Not the Time that Matters
Monday, February 27, 2017
9:30am - 10:10am
East Ballroom

Presenter:
Amy J. Goldberg, MD
Temple University Health System

Dr. Amy J. Goldberg is a graduate of the University of Pennsylvania where she majored in Psychology. She received her medical degree at Mt. Sinai School of Medicine in New York City. She completed her Residency in General Surgery at Temple University Hospital and her Fellowship in Traumatology and Critical Care at the University of Maryland, Shock Trauma Center.

Dr. Goldberg returned to Temple in 1993 to join the surgical faculty. She served with much success as the Chief of the Division of Trauma and Surgical Critical Care for over a decade as well as Program Director of the General Surgery Residency Program. Today, Dr. Goldberg serves as Professor and Chair of the Department of Surgery at the Lewis Katz School of Medicine at Temple University, Surgeon-in-Chief of Temple University Health System, and Medical Director of Perioperative Services at Temple University Hospital.

Dr. Goldberg has dedicated her life’s work to patient care and surgical education at Temple. She is well recognized as a superb educator, winning numerous teaching awards including the Lindback Award, multiple Golden Apple Awards, the Emory Burnett Award for Teaching Excellence, and the Russell Moses Award for Excellence in Clinical Training. Her prolific
contributions to academic medicine have earned numerous accolades throughout her prestigious career, most recently being honored with the Philadelphia Business Journal Humanitarian of the Year Award, the KYW News Radio Woman’s Achievement Award, the Philadelphia Business Journal Woman of Distinction Award, and the College of Physicians of Philadelphia Exemplar of Humanism Award.

Dr. Goldberg has excelled as a gifted clinician and researcher. She is well published and celebrated for her contributions to the prevention and intervention of violence and the treatment of penetrating trauma. Her impassioned commitment to violence prevention and improved outcomes for victims of trauma has been felt at the local and national level. Under Dr. Goldberg’s ardent leadership, The Cradle 2 Grave and Turning Point programs have received national praise for their impact on the lives of youth and patients in North Philadelphia. She has been steadfast in her commitment at the grass roots, local, State and national levels...a mission which has driven efforts toward enhanced awareness of inner city needs and safer, healthier communities.
HENRY L. LAWS, II LECTURE

This lecture is named after Henry L. Laws, II to honor his contributions to the Congress and the field of surgery. Dr. Laws joined the Congress in 1967 and served as President in 1997-1998. He received the Distinguished Service Award in 2012. During his surgical career, Dr. Laws was in private practice, served on the faculty of University of Alabama-Birmingham, was Director of Surgical Residency at Carraway Methodist Medical Center and was a surgeon at the Norwood Clinic. Dr. Laws had a passion for not only clinical care but also for medical education. Dr. Laws passed away on February 25, 2014, at the age of 81.

Measuring Performance in Surgical Training
Monday, February 27, 2017
11:30am - 12:10pm
East Ballroom

Presenter:
Gary L. Dunnington, MD
Indiana University School of Medicine
Indianapolis, IN

Gary Dunnington, MD is the Jay L. Grosfeld Professor and Chair of Surgery at Indiana University School of Medicine. He received his M.D. degree from Indiana University and completed his surgical training at the University of Arizona. Dr. Dunnington came to IU after 15 years at the University of Southern Illinois, where he served since 2000 as the Professor and Chair of Surgery. Prior to SIU, he was Associate Professor of Surgery and Senior Associate Dean for Academic Affairs for the USC School of Medicine. Dr. Dunnington’s area of clinical practice is surgical oncology with a focus in breast and endocrine disease. He has developed two multidisciplinary breast centers, first at the USC Norris Cancer Center and at SIU and served as Medical Director of both centers. He has served as principal or co-Investigator on research projects totaling greater than 5.6 million dollars and has more than 125 peer-review publications. He has received a total of 19 institutional teaching awards, having been named Outstanding Faculty Teacher of the Year nine times at four institutions, including the 2010 Outstanding Teacher of the Year award for the SIU School of Medicine and the 2011 Outstanding Teacher of the Year award at the university level. Also, in 2010, he received
the AOA Robert Glazer Distinguished Teacher award from the AAMC. He is a past president of the Association for Surgical Education and received the 1999 Distinguished Educator award from this organization. He is one of the five founding faculty of the ACS Surgeons as Educators course and served as a faculty member for 15 years. He has been a visiting professor of education to departments of surgery in nearly one-half of the medical schools in the United States.
SESC HISTORICAL LECTURE

The Myths and Histories of Our Surgical Heroes: Who Actually Did the first Whipple?

Sunday, February 26, 2017
4:00pm - 4:45pm
East Ballroom

Presenter:
David Adams, M.D.
Medical University of South Carolina
Charleston, SC

David B. Adams is Professor of Surgery at the Medical University of South Carolina (MUSC). He was born in 1950 in Annapolis, Maryland at the U.S. Naval Academy. As a member of a Navy family, he was raised in Newport, Rhode Island, Arlington, Virginia, and Paris, France. He is a 1969 Cum Laude graduate of the Hotchkiss School in Lakeville, Connecticut and was named a Morehead Scholar at the University of North Carolina in 1969. He graduated Phi Beta Kappa from Chapel Hill in 1973 with a B.A. in Comparative Literature. He obtained his medical degree at the Medical College of Virginia in 1977. After completing his internship and residency in surgery in 1982 at the U.S. Naval Hospital, Portsmouth, Virginia, he was named Chief of Surgery at the U.S. Naval Hospital, Guantanamo Bay, Cuba. In 1983 he returned to the continental United States to the U.S. Naval Hospital, Charleston, South Carolina, where he was named Chief of Surgery prior to joining the faculty in the department of MUSC in 1986. He has served as Medical Director, One West Trauma Center, Program Director of the General Surgery Residency training program, Chief of the Division of Gastrointestinal & Laparoscopic Surgery, Interim Chair of the Department of Surgery and Co-Director of the Digestive Disease Center. He has been the Course Director of the Medical University Department of Surgery Annual Postgraduate Course in Surgery for the past two decades.

Dr. Adams’ research interests are focused on gastrointestinal and laparoscopic surgery. He has special interests in the surgical management of chronic pancreatitis. He has published over 100 works and presented over 100 talks related to his clinical interests. His teaching and clinical interests have been recognized with several awards including the Best Clinical Instructor...
in General Surgery, U.S. Naval Hospital Charleston, MUSC Faculty member Alpha Omega Alpha, MUSC Faculty Excellence Award, the Paul H. O’Brien Resident Teaching Award, The Leonard Tow Humanism in Medicine Award, and the MUSC Health Sciences Foundation Outstanding Clinician Award. He has been awarded the U.S. Navy Letter of Commendation from the U.S. Naval Hospital Guantanamo Bay and Charleston, South Carolina.

He is a member of many surgical organizations including American College of Surgeons, The American Society for Gastrointestinal Endoscopy, The Society of American Gastrointestinal & Endoscopic Surgeons, the Southeastern Surgical Congress, the Pancreas Club, the Society for Surgery of the Alimentary Tract, the International Society for Digestive Surgery, the Surgical Biology Club III, the Societe Internationale de Chirurgie, the Southern Surgical Association, the American Hepato-Pancreato-Biliary Association, the International Association of Pancreatology, the Halsted Society, and the American Surgical Association.

He has served as President of the Waring Library Society, President of the South Carolina Surgical Society, President of the South Carolina Chapter of the American College of Surgeons, Southeastern Surgical Congress Vice-President and President-elect, Governor of the American College of Surgeons, Second Vice-President of the Southern Surgical Association, and Secretary-Treasurer, Vice-President and President of the Halsted Society.
RESIDENT FORUM

Saturday, February 25, 2017
9:00am - 12:00pm
The Resident Forum is a highlight of the SESC Program as it helps shape young investigators critical thinking and scientific contributions. The purpose of the Forum is to provide an opportunity for residents to present and discuss their research with others in an atmosphere that encourages academic exchange in a low-pressure setting.

Moderators:
Edward C. Cornwell, III, MD, Howard University College of Medicine
L.D. Britt, MD, MPH, Eastern Virginia Medical School

9:05am - 9:20am
R1. BLOOD TRANSFUSION AND SURVIVAL FOR RESECTED ADRENOCORTICAL CARCINOMA: AN ANALYSIS FROM THE US ADRENOCORTICAL CARCINOMA STUDY GROUP
Caroline Poorman BS
Emory University

9:20am - 9:35am
R2. AN EVALUATION OF PARASTOMAL HERNIA REPAIR USING THE AMERICAS HERNIA SOCIETY QUALITY COLLABORATIVE (AHSQC)
Sarah Fox MD
New Hanover Regional Medical Center

9:35am - 9:50am
R3. HOSPITAL BASED STUDY OF COMPLIANCE WITH NCCN GUIDELINES AND PREDICTIVE FACTORS OF SENTINEL LYMPH NODE BIOPSY IN THE SETTING OF THIN MELANOMA USING THE NATIONAL CANCER DATABASE
Sarah Bashaw MD
Geisinger Medical Center

9:50am - 10:05am
R4. REGIONAL VARIATION IN THE UTILIZATION OF LAPAROSCOPIC RESECTION FOR DIVERTICULITIS: GEORGIA, THE SOUTHEAST, AND THE UNITED STATES
Asif Talukder MD
Augusta University
RESIDENT FORUM CONTINUED

10:05am - 10:20am
**R5. DISPARITIES IN RURAL BREAST CANCER CARE: FACTORS AFFECTING CHOICE OF BREAST RECONSTRUCTION IN A RURAL TERTIARY CARE HOSPITAL**
Tyler Holliday BS
West Virginia University School of Medicine

10:35am - 10:50am
**R6. IMPACT OF INSURANCE STATUS ON BREAST CANCER DISPARITIES**
Celia Quang MD
University of South Alabama Medical Center

10:50am - 11:05am
**R7. IMPACT OF DISTANCE TRAVELLED ON LENGTH OF STAY AND READMISSIONS FOLLOWING PANCREATICODUODENECTOMY**
R. Lane Guyton Jr. MD
East Carolina University

11:05am - 11:20am
**R8. EVALUATING SURGERY TRAINEE TECHNICAL SKILLS: INTESTINAL ANASTOMOSIS IN A PORCINE MODEL**
Brent Soder MD
University of Tennessee College of Medicine Chattanooga

11:20am - 11:35am
**R9. DISPARITIES IN THE CARE OF DIFFERENTIATED THYROID CANCER IN THE UNITED STATES: EXPLORING THE NATIONAL CANCER DATABASE**
Kathryn Jaap MD
Geisinger Medical Center

11:35am - 11:50am
**R10. INPATIENT PERIPHERALLY INSERTED CENTRAL VENOUS CATHETER COMPLICATIONS: SHOULD PICC LINES BE PLACED IN THE ICU SETTING?**
Michael Martyak MD
Eastern Virginia Medical School
RESIDENT FORUM LUNCHEON

Saturday, February 25, 2017  
12:00pm - 1:00pm

“Professional Development: Preparing Surgeons of the Future”
LD Britt, MD, MPH  
Chair, Department of Surgery, Eastern Virginia Medical School

“Disparities Research Influence on Public Policy”
Edward E. Cornwell, III, MD  
Chair, Department of Surgery, Howard University College of Medicine

The luncheon wraps up the scientific papers and provides a unique learning and networking opportunity. There is no additional fee to attend this event, and all interested registrants are welcome to attend.
POSTGRADUATE COURSE:
“HOT TOPICS AND ADVANCES
IN CANCER CARE”

Saturday, February 25, 2017
1:00pm – 5:30pm
Moderator: Michael O. Meyers, MD
University of North Carolina at Chapel Hill

1:00pm  Introduction
Michael O. Meyers, MD
University of North Carolina at Chapel Hill

1:10pm - 1:35pm  How Close is too Close? Margin Assessment
in DCIS and Invasive Breast Cancer
Kandace McGuire, MD
University of North Carolina at Chapel Hill

1:35pm – 2:00pm  Treating the Clinically Node-Negative
Axilla in Breast Cancer
Ingrid Meszoely, MD
Vanderbilt University

2:00pm – 2:15pm  Panel Discussion and Case Examples

2:15pm – 2:45pm  Molecular Diagnostics and Other Advances
in Melanoma
Charles Scoggins, MD, MBA
University of Louisville

2:45pm – 3:15pm  Changes in the Management of Thyroid Neoplasms
and the Role of Gene Expression Testing
Carmen Solorzano, MD
Vanderbilt University

3:15pm – 3:25pm  Panel Discussion and Case Examples
POSTGRADUATE COURSE: “HOT TOPICS AND ADVANCES IN CANCER CARE” CONTINUED

3:25pm – 3:40pm  Break

3:40pm – 4:10pm  Management of Uncommon Gastric Neoplasms
Shishir K. Maithel, MD
Emory University School of Medicine

4:10pm – 4:20pm  Discussion

4:20pm – 5:00pm  Minimally Invasive Surgery for Colorectal Cancer: Good, Bad or Indifferent? (Pro/Con)
Pro:  Alan Herline, MD
     Augusta University Medical Center
Con:  David Shibata, MD
     University of Tennessee Health Sciences Center

5:00pm – 5:15pm  Discussion

5:15pm  Closing comments
AMERICAN COLLEGE OF SURGEONS
SESSION

Sunday, February 26, 2017
2:15pm - 4:45pm
Moderator: David Hoyt, MD
American College of Surgeons

Hear the latest update from the American College of Surgeons, along with updates on surgical training opportunities.

Topics:

- **MACRA Update**
  Patrick Bailey, MD
  Maricopa Medical Center

- **ACS Role in Resident Education**
  J. David Richardson, MD
  University of Louisville

- **What is the Surgeon Registry and What are the Benefits of Participating?**
  Tyler Hughes, MD
  Kansas University School of Medicine

- **SESC Historical Lecture: The Myths and Histories of Our Surgical Heroes: Who actually did the first Whipple?**
  David B. Adams, MD
  Medical University of South Carolina
SOCIAL EVENTS

WELCOME RECEPTION
Saturday, February 25, 2017
5:30pm - 7:00pm

All registrants and guests are welcome to attend to catch up with old friends and make new ones. This is a great way to kick off your 2017 Annual Meeting!

YOUNG SURGEONS COMMITTEE RECEPTION
Sunday, February 26, 2017
6:15pm - 7:15pm

Calling all young surgeons...don't miss this unique Young Surgeons Committee networking reception.

ePOSTERS

ePosters provide an opportunity for poster authors to make an oral presentation to the Grand Rounds Professors and their peers, which enhance the poster exhibits.

Sunday, February 26, 2017
6:20am - 7:50am

Monday, February 27, 2017
6:20am - 7:50am
RESIDENT MEETING HIGHLIGHTS

Resident Forum
Saturday, February 25, 2017
9:00am - 12:00pm

Resident Forum Luncheon
Saturday, February 25, 2017
12:00pm - 1:00pm
Cost: No additional cost, RSVP required

Surgical Practice Luncheon
Sunday, February 26, 2017
12:45pm - 2:15pm
Cost: $50/person

Fellow, Resident & Medical Student Luncheon
Sunday, February 26, 2017
12:45pm - 2:15pm
Cost: $50/person

Resident Jeopardy - a SESC favorite!
Sunday, February 26, 2017
4:45pm - 6:15pm
Cost: No additional cost, RSVP required

Young Surgeons Committee Reception
Sunday, February 26, 2017
6:15pm - 7:15pm
Cost: No additional cost, RSVP required
LOCAL ATTRACTIONS & TOURS
LOCAL ATTRACTIONS

The Renaissance Nashville is located in the heart of downtown Nashville. It is within walking distance to Music City Center and attractions like Bridgestone Arena, Nissan Stadium (formerly LP Field), B.B. King’s Blues Club, Country Music Hall of Fame, Ryman Auditorium and the Historic Second Avenue District.

Country Music Hall of Fame and Museum
The world’s largest popular music museum offers ever-changing exhibits featuring the legends of country music past and today’s hottest stars. http://countrymusichalloffame.org/

Ryman Auditorium
The Ryman Auditorium, also called the “Mother Church of Country Music,” has had artists as diverse as Jon Bon Jovi and Patsy Cline perform on its legendary stage since 1892. You can take a backstage tour and record your own song in the Ryman recording studio. The stars of the Grand Ole Opry perform every Tuesday, Friday and Saturday night (at the Ryman Auditorium November-January; at the Grand Ole Opry House February-October) with guest appearances by the biggest names in music. With 90 years under its belt, it’s the world’s longest-running radio broadcast and shows no signs of slowing down. http://ryman.com/

Nashville Centennial Park
A short drive away from the Renaissance Nashville Hotel is Nashville’s Centennial Park. Here you’ll find the world’s only full-scale reproduction of the ancient Parthenon in Athens, Greece. The Parthenon houses an art gallery and museum as well as Alan LeQuire’s Athena Parthenos. Standing at almost 42 feet in height, Athena is the tallest indoor sculpture in the Western world. Just a mile from The Parthenon is the LeQuire Gallery, where you can visit Alan in his studio and witness one of the nation’s premier sculptors. Centennial Park hours: Dawn to 11:00pm Daily https://www.nashville.gov/Parks-and-Recreation/Parks/Centennial-Park.aspx
LOCAL ATTRACTIONS CONTINUED

NASHVILLE AREA
For additional information on what is happening in Music City during the SESC meeting please visit the Nashville Music City http://www.visitmusiccity.com/ Visitors.

AREA TOUR SERVICES
Discover Nashville Bus Tours
Gray Line
http://www.grayline.com/things-to-do/united-states/nashville/
Phone: 800-251-1864

General Jackson Dinner Cruise & Show in Nashville
Located on Cumberland River
Alcatraz Media Inc.
http://www.nashvillesightseeing.com/?event=offer.detail&offerId=3875
Phone: 888-881-3279

Segway Tour
Downtown Nashville
Segway of Tennessee
www.segwayofnashville.com
Phone: 615-244-0555
SCHEDULE
FRIDAY, FEBRUARY 24, 2017

7:00pm - 9:00pm  SESC Executive Committee Meeting
Rooms 211/212

SATURDAY, FEBRUARY 25, 2017

8:00am - 6:00pm  Registration Open
Ballroom Foyer

9:00am - 12:00pm  Resident Forum
Belmont Room

Moderator:
Edward C. Cornwell, III, MD, Howard University
College of Medicine
L.D. Britt, MD, MPH, Eastern Virginia Medical School

9:05am - 9:20am  R1. BLOOD TRANSFUSION AND SURVIVAL FOR
RESECTED ADRENOCORTICAL CARCINOMA: AN
ANALYSIS FROM THE US ADRENOCORTICAL
CARCINOMA STUDY GROUP
Caroline Poorman, BS
Emory University
Invited Discussant: William Mendez, MD

9:20am - 9:35am  R2. AN EVALUATION OF PARASTOMAL HERNIA
REPAIR USING THE AMERICAS HERNIA SOCIETY
QUALITY COLLABORATIVE (AHSQC)
Sarah Fox, MD
New Hanover Regional Medical Center
Invited Discussant: Benjamin Poulose, MD, MPH

9:35am - 9:50am  R3. HOSPITAL BASED STUDY OF COMPLIANCE WITH
NCCN GUIDELINES AND PREDICTIVE FACTORS OF
SENTINEL LYMPH NODE BIOPSY IN THE SETTING OF
THIN MELANOMA USING THE NATIONAL CANCER
DATABASE
Sarah Bashaw, MD
Geisinger Medical Center
Invited Discussant: John Stewart, MD, MBA
9:50am - 10:05am  R4. REGIONAL VARIATION IN THE UTILIZATION OF LAPAROSCOPIC RESECTION FOR DIVERTICULITIS: GEORGIA, THE SOUTHEAST, AND THE UNITED STATES
Asif Talukder, MD
Augusta University
Invited Discussant: Virginia Shaffer, MD

10:05am - 10:20am  R5. DISPARITIES IN RURAL BREAST CANCER CARE: FACTORS AFFECTING CHOICE OF BREAST RECONSTRUCTION IN A RURAL TERTIARY CARE HOSPITAL
Tyler Holliday, BS
WVU School of Medicine
Invited Discussant: Kandace McGuire, MD

10:20am - 10:35am  Morning Break and Exhibit Viewing
West/Center Ballroom

10:35am - 10:50am  R6. IMPACT OF INSURANCE STATUS ON BREAST CANCER DISPARITIES
Celia Quang, MD
University of South Alabama
Invited Discussant: Anees B. Chagpar, MD, MSc, MA, MPH, MBA

10:50am - 11:05am  R7. IMPACT OF DISTANCE TRAVELLED ON LENGTH OF STAY AND READMISSIONS FOLLOWING PANCREATICODUODENECTOMY
R. Lane Guyton Jr., MD
East Carolina University
Invited Discussant: Sharona Ross, MD

11:05am - 11:20am  R8. EVALUATING SURGERY TRAINEE TECHNICAL SKILLS: INTESTINAL ANASTOMOSIS IN A PORCINE MODEL
Brent Soder, MD
University of Tennessee College of Medicine Chattanooga
Invited Discussant: Pamela Rowland, PhD
11:20am - 11:35am  R9. DISPARITIES IN THE CARE OF DIFFERENTIATED THYROID CANCER IN THE UNITED STATES: EXPLORING THE NATIONAL CANCER DATABASE
Kathryn Jaap, MD
Geisinger Medical Center
Invited Discussant: William Cheadle, MD

11:35am - 11:50am  R10. INPATIENT PERIPHERALLY INSERTED CENTRAL VENOUS CATHETER COMPLICATIONS: SHOULD PICC LINES BE PLACED IN THE ICU SETTING?
Michael Martyak, MD
Eastern Virginia Medical School
Invited Discussant: Nathaniel McQuay Jr., MD

11:30am - 12:30pm  SESC Membership Committee Meeting
Jazz

11:30am - 12:30pm  SESC Finance Committee Meeting
Rhythm and Blues

12:00pm - 1:00pm  Resident Forum Luncheon
Music City Ballroom
Moderator:
Wendy Ricketts Greene, MD
Emory University
“Professional Development: Preparing Surgeons of the Future”
LD Britt, MD, MPH
Eastern Virginia Medical School

“Disparities Research Influence on Public Policy”
Edward E. Cornwell, III, MD
Howard University Hospital

12:30pm - 1:30pm  SESC Communications Committee Meeting
Jazz
12:30pm - 1:30pm  Surgical Practice Committee Meeting
Rhythm and Blues

1:00pm - 5:30pm  SESC Postgraduate Course
“Hot Topics and Advances in Cancer Care”
Belmont Room

Moderator:
Michael O. Meyers, MD
University of North Carolina at Chapel Hill
Pre-registration required

1:00pm  Introduction
Michael O. Meyers, MD
University of North Carolina at Chapel Hill

1:10pm - 1:35pm  How Close is too Close? Margin Assessment in
DCIS and Invasive Breast Cancer
Kandace McGuire, MD
University of North Carolina at Chapel Hill

1:35pm – 2:00pm  Treating the Clinically Node-Negative Axilla in
Breast Cancer
Ingrid Meszoely, MD
Vanderbilt University

2:00pm – 2:15pm  Panel Discussion and Case Examples

2:15pm – 2:45pm  Molecular Diagnostics and Other Advances in Melanoma
Charles Scoggins, MD, MBA
University of Louisville

2:45pm – 3:15pm  Changes in the Management of Thyroid Neoplasms
and the Role of Gene Expression Testing
Carmen Solorzano, MD
Vanderbilt University

3:15pm – 3:25pm  Discussion
3:25pm - 3:40pm  Afternoon Break and Exhibit Viewing  
West/Center Ballroom

3:40pm - 4:10pm  Management of Uncommon Gastric Neoplasms  
Shishir K. Maithel, MD  
Emory University School of Medicine

4:10pm - 4:20pm  Discussion

4:20pm - 5:00pm  Minimally Invasive Surgery for Colorectal Cancer: 
Good, Bad or Indifferent? (Pro/Con)  
Pro: Alan Herline, MD  
Augusta University Medical Center  
Con: David Shibata, MD  
University of Tennessee Health Sciences Center

5:00pm - 5:15pm  Discussion

5:15pm  Closing Comments

1:30pm - 2:30pm  Fellow, Resident & Medical Student Committee Meeting  
Jazz

1:30pm - 2:30pm  Rural Surgery Committee Meeting  
Rhythm and Blues

2:30pm - 3:30pm  CME Committee Meeting  
Ryman

2:30pm - 3:30pm  Women in Surgery Committee Meeting  
Jazz

2:30pm - 3:30pm  Young Surgeons Committee Meeting  
Rhythm and Blues

3:30pm - 4:30pm  Pediatric Surgeons Committee Meeting  
Jazz
3:30pm - 5:00pm  SESC Executive Council Meeting  
Rhythm and Blues

5:30pm - 7:00pm  Welcome Reception, Exhibit and ePoster Viewing  
West/Center Ballroom
SUNDAY, FEBRUARY 26, 2017

6:15am - 5:00pm  Registration Open
                 Ballroom Foyer

6:15am - 6:30pm  Exhibit & ePoster Viewing
                 West/Center Ballroom

6:15am - 8:00am  Continental Breakfast
                 West/Center Ballroom

6:15am - 7:50am  Grand Rounds of ePosters
                 West/Center Ballroom

   ePoster Station #: 1 | Trauma
Moderators:
  Steven Holsten, MD
  Oliver Gunter, MD
  Bradley Dennis, MD
  Joseph Ibrahim, MD

   ePoster Station #: 2 | Trauma II
Moderators:
  Colville Ferdinand, MD
  John Green, MD
  Ashley Britton Christmas, MD
  Errington Thompson, MD

   ePoster Station #: 3 | Trauma III
Moderators:
  Michael Thomason, MD
  Jay Collins, MD
  Alan B. Marr, MD
  Caleb Mentzner, MD

   ePoster Station #: 4 | General Surgery
Moderators:
  Brian Daley, MD
  Jahnvi Srinivasan, MD
  Reid B. Adams, MD
  Alan Herline, MD
ePoster Station #: 5 | General Surgery II
Moderators:
Amy Hildreth, MD
A. Jackson Slappy, MD
Paul Rider, MD
Phillips Smith, MD

ePoster Station #: 6 | Pediatrics
Moderators:
John Draus, MD
Shawn Safford, MD
Don K. Nakayama, MD
Robert Vanderwalle, MD

ePoster Station #: 7 | Cancer
Moderators:
Benjamin Li, MD
James McLoughlin, MD
Shishir Maithel, MD
John Stewart, MD

ePoster Station #: 8 | Endocrine/Cancer
Moderators:
Joe Sharma, MD
Dane Smith, MD
Michael Holzman, MD
William Cheadle, MD

ePoster Station #: 9 | Breast/Cancer
Moderators:
Cletus Arciero, MD
Anees B. Chagpar, MD, MSc, MPH, MA, MBA
Marissa Howard-McNatt, MD
Kandace McGuire, MD

ePoster Station #: 10 | Critical Care/Thoracic/Vascular
Moderators:
Francis Podbielski, MD
Pascal Udekwu, MD
Gus Slotman, MD
8:00am - 8:30am  Welcome Announcements  
East Ballroom

8:30am - 9:10am  A. Hamblin Letton Lecture: “Gallbladder Neoplasia and Issues Alike”  
East Ballroom

**Presenter:** Juan M. Sarmiento, MD  
Emory University School of Medicine  
Atlanta, GA

9:10am - 11:50am  Scientific Session I  
East Ballroom

**Moderators:**  
David V. Feliciano, MD  
Indiana University School of Medicine  
Clay Cothren Burlew, MD  
Denver Health Medical Center/University of Colorado

9:10am - 9:30am  1. INCIDENTAL VS. NON-INCIDENTAL GALLBLADDER CANCER: PATHOLOGIC AND PROGNOSTIC IMPLICATIONS OF DELAYED DIAGNOSIS, A 10-INSTITUTION STUDY FROM THE U.S. EXTRAHEPATIC BILIARY MALIGNANCY CONSORTIUM  
Cecilia Ethun, MD  
Emory University  
Invited Discussant: Reid B. Adams, MD

9:30am - 9:50am  2. OPTIMAL MODIFIED FRAILTY INDEX CUT-OFF IN OLDER GASTROINTESTINAL CANCER PATIENTS TREATED WITH SURGERY  
Molly Garland, MD  
Wake Forest Baptist Health  
Invited Discussant: J. Patrick O’Leary, MD
9:50am - 10:05am  3. SAFETY OF OUTPATIENT THYROIDECTOMY
Jonathan Black, MD
University of North Carolina
Invited Discussant: Denise Carneiro-Pla, MD

10:05am - 10:25am  Morning Break, Exhibit & ePoster Viewing
West/Center Ballroom

10:30am - 10:50am  4. FACTORS AFFECTING CHOICE OF TREATMENT FOR EARLY STAGE BREAST CANCER IN WEST VIRGINIA: A 10 YEAR EXPERIENCE FROM A RURAL TERTIARY CARE CENTER
Patrick Suggs, BA
West Virginia University School of Medicine, Charleston
Invited Discussant: Laura E. Witherspoon, MD

10:50am - 11:10am  5. WHAT CAN YOU DO NEXT WEEK TO IMPROVE CARE FOR YOUR HERNIA PATIENTS? REAL-WORLD RESULTS FROM THE AMERICAS HERNIA SOCIETY QUALITY COLLABORATIVE
Benjamin Poulose, MD, MPH
Vanderbilt University Medical Center
Invited Discussant: Carl Boyd, MD

11:10am - 11:30am  6. RISK FACTORS AND CLINICAL SIGNIFICANCE OF POSTOPERATIVE RENAL REPLACEMENT THERAPY FOLLOWING ENDOVASCULAR OR OPEN ABDOMINAL AORTIC ANEURYSM REPAIR
Aitua Salami, MD, MPH
Albert Einstein Healthcare Network
Invited Discussant: Khanjan Nagarsheth, MD, MBA, RPVI

11:30am - 11:50am  7. IDENTIFYING FUTILE INTER-FACILITY SURGICAL TRANSFERS
Kristy Kummerow Broman, MD, MPH
Vanderbilt University Medical Center
Invited Discussant: Anthony A. Meyer, MD
11:50am - 12:45pm

**SESC Presidential Address:**
“Abdominal Trauma Revisited”
East Ballroom

**Introduction:**
David B. Adams, MD
Medical University of South Carolina
Charleston, SC

**Presenter:**
David V. Feliciano, MD
Indiana University School of Medicine
Indianapolis, IN

12:45pm - 2:15pm

**Surgical Practice Luncheon**
Belmont Room
*Pre-registration required*

**Moderators:**
Jose J. Diaz, MD
University of Maryland Medical Center

Virginia Shaffer, MD
Emory University

**Frailty in the Emergency General Surgery Patient**
Jose J. Diaz, MD
University of Maryland Medical Center

**Surgeon Burnout**
Spence Taylor, MD
University of South Carolina School of Medicine,
Greenville
12:45pm - 2:15pm

**Fellow, Resident & Medical Student Luncheon**
Musical City Ballroom
*Pre-registration required*

**Moderator:**
Benjamin Li, MD
Case Western Reserve University

**How to Optimize Work Life Balance**
Sunil Geevarghese, MD
Vanderbilt University

**Financial Planning: Loan Repayment, Insurance, Retirement Accounts, 529s for your Children**
Bradley Thomas, MD
Carolinas HealthCare System

**Billing and Documentation**
Gopal Kowdley, MD
St. Agnes Healthcare

**Seeking/Providing Mentorship**
Charles Paget, MD
Virginia Tech Carilion School of Medicine

**Lifelong Learning - Developing the Necessary Life Skills/ Habits to Stay Current**
Philip Ramsay, MD
WellStar Atlanta Medical Center

2:15pm - 3:45pm

**American College of Surgeons Session**
East Ballroom

**Moderator:**
David B. Hoyt, MD
American College of Surgeons
2:15pm  Introduction  
David B. Hoyt, MD  
American College of Surgeons  

MACRA Update  
Patrick Bailey, MD  
American College of Surgeons  
Maricopa Medical Center  

ACS Role in Resident Education  
J. David Richardson, MD  
University of Louisville  

What is the Surgeons Registry and What are the Benefits of Participating?  
Tyler Hughes, MD  
McPherson Medical & Surgical Associates  
Kansas University School of Medicine  

3:45pm - 4:00pm  Afternoon Break, Exhibit and ePoster Viewing  
West/Center Ballroom  

4:00pm - 4:45pm  SESC Historical Lecture: The Myths and Histories of Our Surgical Heroes: Who actually did the first Whipple?  
East Ballroom  

Presenter:  
David B. Adams, MD  
Medical University of South Carolina  
Charleston, SC  

4:45pm - 6:15pm  SESC Resident Jeopardy  
East Ballroom  

6:15pm - 7:15pm  Young Surgeons Committee Reception  
Belmont Room
MONDAY, FEBRUARY 27, 2017

6:15am - 6:30pm  Registration Open
                 Ballroom Foyer

6:15am - 5:00pm  Exhibit & ePoster Viewing
                 West/Center Ballroom

6:15am - 8:00am  Continental Breakfast
                 West/Center Ballroom

6:20am - 7:50am  Grand Rounds of ePosters
                 West/Center Ballroom

  ePoster Station #: 1 | Vascular
  Moderators:
  Kanjan Nagarsheth, MD
  Zachary Williams, MD
  Joshua Arnold, MD
  Eugene Langan, MD

  ePoster Station #: 2 | Trauma IV
  Moderators:
  Laura Johnson, MD
  Peter Lopez, MD
  Reagan Bollig, MD
  Glen Franklin, MD

  ePoster Station #: 3 | Trauma V
  Moderators:
  Adrian Ong, MD
  Wendy Ricketts Greene, MD
  Indermeet Bhullar, MD

  ePoster Station #: 4 | GI/General Surgery
  Moderators:
  Jay Collins, MD
  Peter Hallowell, MD
  William Hope, MD
  Matthew Mancini, MD
ePoster Station #: 5 | HPB/GI
Moderators:
Clancy Clark, MD
Iswanto Sucandy, MD
John Stauffer, MD

ePoster Station #: 6 | Colorectal
Moderators:
Guy Orangio, MD
Virginia Shaffer, MD
Dan Stanley, MD
Scott Goldstein, MD

ePoster Station #: 7 | Quality Improvement/Education
Moderators:
Pamela Rowland, MD
Dane Smith, MD
Heath Giles, MD
Shields Frey, MD

ePoster Station #: 8 | Other
Moderators:
George Fuhrman, MD
Thomas Bradley, MD
William Mendez, MD
Bryant Wilson, MD

ePoster Station #: 9 | Hernia/General Surgery
Moderators:
Carl Boyd, MD
Benjamin Poulouise, MD
Jeremy Warren, MD
Stephen McNatt, MD

ePoster Station #: 10 | Critical Care/Trauma
Moderators:
Phillip Ramsay, MD
Nathanial McQuay, MD
8:00am – 8:50am  Panel Session: Challenging Cases  
East Ballroom  

Moderator:  
David V. Feliciano, MD  
Indiana University Medical Center  

Panelists:  
Kenneth W. Sharp, MD  
Vanderbilt University  

Sharona Ross, MD  
Florida Hospital, Tampa  

D. Scott Lind, MD  
University of Florida, Jacksonville  

J. David Richardson, MD  
University of Louisville  

8:50am – 11:30am  Scientific Session II  
East Ballroom  

Moderators:  
Kevin E. Behrns, MD  
St. Louis University  

Don Nakayama, MD  
Sacred Heart Medical Group  

8:50am - 9:10am  8. OUTCOMES FOLLOWING NON-CARDIAC SURGERY IN PATIENTS WITH VENTRICULAR ASSIST DEVICES: A SINGLE-CENTER EXPERIENCE  
Shawna Kettyle, MD  
MedStar Washington Hospital Center  
Invited Discussant: Brian Daley, MD
9.10am - 9.30am  9. EFFECT OF IMPLEMENTATION OF STRAIGHT CATHETER PROTOCOL ON RATE OF URINARY TRACT INFECTIONS IN TRAUMA POPULATION
Katherine Kelley, MD
Eastern Virginia Medical School
Invited Discussant: Oliver L. Gunter, MD

9:30am - 10:10am  Roger T. Sherman Lecture: “Scoop and Run: It's Not the Time that Matters”
East Ballroom

Presenter:
Amy J. Goldberg, MD
Temple University Health System

10:10am - 10:30am  Morning Break, Exhibit and ePoster Viewing
West/Center Ballroom

10:30am - 10:50am  10. EVALUATION OF CARDIOPULMONARY COMPLICATION RATES FOLLOWING PORT INSERTION: IS A POSTOPERATIVE X-RAY NEEDED?
Justin Vaughan, MD
Navicent Health/Mercer SOM
Invited Discussant: James Martin McLoughlin, MD

10:50am - 11:10am  11. AN INNOVATIVE WAY TO SEPARATE GASTROINTESTINAL AND ABDOMINAL WALL RECONSTRUCTION AFTER COMPLEX ABDOMINAL TRAUMA
David Livingston, MD
New Jersey Medical School - Rutgers University
Invited Discussant: Dimitrios Stefanidis, MD, PhD

11:10am - 11:30am  12. PREDICTING POSTOPERATIVE COMPLICATIONS FOR ACUTE CARE SURGERY PATIENTS USING THE AMERICAN COLLEGE OF SURGEONS SURGICAL RISK CALCULATOR
Jessica Burgess, MD
Eastern Virginia Medical School
Invited Discussant: Michael R. Bard, MD
11:30am - 12:10pm  Henry L. Laws, II, Lecture: “Measuring Performance in Surgical Training”
East Ballroom

**Presenter:** Gary L. Dunnington, MD
Indiana University School of Medicine
Indianapolis, IN

12:10pm - 2:00pm  Business Meeting & Luncheon
Music City Ballroom
SESC Members Only

2:00pm – 3:40pm  Scientific Session III
East Ballroom

**Moderators:**
David B. Adams, MD
Medical University of South Carolina

2:00pm - 2:20pm  **13. PREOPERATIVE HYPOALBUMINEMIA IS A PREDICTOR OF SHORT AND LONG-TERM MORTALITY FOLLOWING MAJOR VASCULAR SURGERY**
Aitua Salami, MD, MPH
Albert Einstein Healthcare Network
Invited Discussant: TBD

2:20pm - 2:40pm  **14. IMPACT OF COMPONENT SEPARATION ON QUALITY OF LIFE OUTCOMES FOLLOWING VENTRAL HERNIA REPAIR**
Stephanie Sims, MD
Carolinas Medical Center
Invited Discussant: William W. Hope, MD

2:40pm - 3:00pm  **15. AGE AND ACHALASIA: HOW DOES AGE AFFECT PATIENT PRESENTATION, HOSPITAL COURSE, AND SURGICAL OUTCOMES?**
Alexander S. Rosemurgy, MD
Florida Hospital, Tampa
Invited Discussant: Kevin E. Behrns, MD
3:00pm - 3:20pm  V1. ROBOTIC TRANSHIATAL ESOPHAGECTOMY
Sharona Ross, MD
Florida Hospital, Tampa
Invited Discussant: William David Bolton, MD

3:20pm - 3:40pm  V2. LAPAROSCOPIC OBTURATOR HERNIA REPAIR
Joseph Tingen, MD
Greenville Memorial Hospital
Invited Discussant: Rana Pullatt, MD

3:40pm – 4:10pm  Debate: Employed vs. Traditional Model
East Ballroom

Moderator: Emmanuel Zervos, MD
Eastern Carolina University

Employed Speaker: Timothy Patselas, MD
Onslow Surgical Clinic

Traditional Speaker: Ellis Tinsley, MD
Wilmington Surgical Associates

4:10pm  Presentation of Gold Medal Award and iWatch Raffle
East Ballroom

4:15pm - 4:30pm  Afternoon Break, Exhibit and ePoster Viewing
West/Center Ballroom

4:30pm - 5:30pm  Parallel Scientific Session IV: Quick Shots
East Ballroom

Moderators: Rebecca C. Britt, MD
Eastern Virginia Medical School Norfolk

Brian W. Dach, DO
Greenville Health System
4:30pm - 4:37pm  QS1. REINFORCEMENT OF THE STAPLE LINE DURING GASTRIC SLEEVE: A COMPARISON OF BUTTRESSING OR OVERSEWING, VS NO REINFORCEMENT - A SINGLE INSTITUTION STUDY
Jean Guerrier, MD
University of Virginia
Invited Discussant: Stephen S. McNatt, MD

4:37pm - 4:44pm  QS2. MINIMALLY-INVASIVE INCISION AND DRAINAGE TECHNIQUE IN THE TREATMENT OF SIMPLE PERIANAL ABScesses IN ADULTS IS EFFECTIVE COMPARED TO TRADITIONAL DRAINAGE
Hai Salfity, MD
Indiana University School of Medicine
Invited Discussant: Mark Manwaring, MD

4:44pm - 4:51pm  QS3. OPEN RETROMUSCULAR REPAIR OF PARASTOMAL HERNIAS
Lucas Beffa, MD
Greenville Health System
Invited Discussant: John Daniel Stanley, MD

4:51pm - 4:58pm  QS4. PERCUTANEOUS TRACHEOSTOMY UNDER BRONCHOSCOPIC VISUALIZATION DOES NOT AFFECT SHORT-TERM OR LONG-TERM COMPLICATIONS
Thomas Easterday, MD
Atlanta Medical Center
Invited Discussant: David Ciraulo, DO

4:58pm - 5:05pm  QS5. BICYCLE HELMETS SAVE MORE THAN HEADS: EXPERIENCE FROM A PEDIATRIC LEVEL I TRAUMA HOSPITAL
Patrick Michael, BS
University of Kentucky
Invited Discussant: Shannon Longshore, MD
5:05pm - 5:12pm  QS6. LONG-TERM NUTRIENT DEFICIENCY AFTER ROUX-EN-Y GASTRIC BYPASS: WHO’S RESPONSIBLE?
Matthew Mullen, MD
University of Virginia
Invited Discussant: TBD

5:12pm - 5:19pm  QS7. VIRTUAL REALITY SIMULATION (VRS): BRINGING RESUSCITATIVE ENDOVASCULAR BALLOON OCCLUSION OF THE AORTA (REBOA) CLOSER TO THE POINT OF INJURY
Jason Pasley, DO
University of Maryland
Invited Discussant: Dennis Ashley, MD

5:19pm - 5:26pm  QS8. A DECADE OF SINGLE INCISION LAPAROSCOPY IN PEDIATRIC SURGERY TRAINING
Ilan Maizlin, MD
Children’s of Alabama
Invited Discussant: Don K. Nakayama, MD

4:30pm – 5:20pm  Parallel Scientific Session V: Quick Shots
Belmont Room

Moderators:
Bryan K. Richmond, MD
West Virginia University, Charleston

John R. Porterfield, Jr., MD
University of Alabama at Birmingham

4:30pm - 4:37pm  QS9. LAPAROSCOPIC DISTAL PANCREATECTOMY: AN 8 YEAR EXPERIENCE WITH THE CLOCKWISE TECHNIQUE
John Stauffer, MD
Mayo Clinic
Invited Discussant: Alexander S. Rosemurgy, MD
4:37pm - 4:44pm
QS10. VARIABILITY IN PERIOPERATIVE FASTING PRACTICES NEGATIVELY IMPACTS NUTRITIONAL SUPPORT OF CRITICALLY ILL INTUBATED PATIENTS
Molly Douglas, MD
Maine Medical Center
Invited Discussant: TBD

4:44pm - 4:51pm
QS11. INVESTIGATING THE POST-OPERATIVE CONVERSATION: HOW TO IMPROVE COMMUNICATION TO THE FAMILY WHILE ADDRESSING BARRIERS TO THE SURGEON?
Brandon Singletary, MPH
University of Alabama at Birmingham
Invited Discussant: Frederick L. Greene, MD

4:51pm - 4:58pm
QS12. OPERATIVE OUTCOMES AFTER OPEN ABDOMINAL WALL RECONSTRUCTION WITH RETROMUSCULAR MESH FIXATION USING FIBRIN GLUE VERSUS TRANSFASCIAL SUTURES
Adam Weltz, MD
Anne Arundel Medical Center
Invited Discussant: Brent Matthews, MD

4:58pm - 5:05pm
QS13. THE IMPACT OF HEMODYNAMIC TRANSESOPHAGEAL ECHOCARDIOGRAPHY ON THE USE OF CONTINUOUS RENAL REPLACEMENT THERAPY IN TRAUMA
Madison Griffin, MD
Mercer University SOM/Navicent Health
Invited Discussant: Jay Collins, MD
5:12pm - 5:19pm  
**QS15. CLASSIC SYMPTOMS OF HYPERPARATHYROIDISM ARE ASSOCIATED WITH INCREASED MORTALITY EVEN AFTER PARATHYROIDECTOMY**  
Snehal Patel, MD  
Emory University  
Invited Discussant: TBD

5:19pm - 5:26pm  
**QS16. SURGICAL OUTCOMES OF ROBOT-ASSISTED THYROIDECTOMY FOR THYROID CANCER; A 108 CASES ANALYSIS**  
Daniah Bu Ali, MD  
Tulane University  
Invited Discussant: David V. Feliciano, MD

5:30pm - 7:10pm  
**Video Interactive Session**  
East Ballroom  
**Moderator:**  
Dimitrios Stefanidis, MD  
Indiana University School of Medicine

5:30pm - 5:40pm  
**V3. ROBOTIC RELEASE OF MEDIAN ARCUATE LIGAMENT SYNDROME**  
Sharona Ross, MD  
Florida Hospital, Tampa

5:40pm - 5:50pm  
**V4. LAPAROSCOPIC REDUCTION OF FORAMEN OF WINSLOW HERNIA**  
Robert Lyons, MD  
Eastern Virginia Medical School

5:50pm - 6:00pm  
**V5. VIDEO - LAPAROSCOPIC REPAIR OF A TRAUMATIC BLADDER RUPTURE**  
Bradley Thomas, MD  
Carolinas Medical Center
6:00pm - 6:10pm  
**V6. ROBOTIC HELLER MYOTOMY**  
Scott Richardson, BS  
University of North Carolina, Charlotte

6:10pm - 6:20pm  
**V7. ROBOTIC ASSISTED POSTERIOR ANTRAL GIST RESECTION**  
James W. Rawles, III, MD  
New Hanover Regional Medical Center

6:20pm - 6:30pm  
**V8. LAPAROSCOPIC EXTRACTION OF INTRALUMINAL MAGNETS IN A PEDIATRIC PATIENT**  
Todd Bierman, MD  
University of South Alabama Medical Center

6:30pm - 6:40pm  
**V9. TECHNIQUES OF VIDEOSCOPIC INGUINAL LYMPHADENECTOMY FOR METASTATIC MELANOMA**  
Rami Michael, MD  
Greenville Health System

6:40pm - 6:50pm  
**V10. LAPARO-ENDOSCOPIC SINGLE SITE (LESS) REDUCTION OF A GIANT HIATAL HERNIA WITH TOUPET FUNDOPLICATION**  
Sharona Ross, MD  
Florida Hospital, Tampa

6:50pm - 7:00pm  
**V11. LAPAROSCOPIC MANAGEMENT OF GALLSTONE ILEUS**  
Yana Mikhaylov Schrank, MD  
Medical University of South Carolina

7:00pm - 7:10pm  
**V12. LAPAROSCOPIC, TRANS-GASTRIC ENDOSCOPIC REMOVAL OF A GASTROINTESTINAL Stromal Tumor (GIST)**  
Aaron Lee Wiegmann, BS, MD  
Rush University Medical Center
President’s Reception
Music City Ballroom
By invitation only
Registration Open
Ballroom Foyer

Continental Breakfast
East Ballroom Foyer

Parallel Scientific Session VI
East Ballroom

Moderators:
David J. Cole, MD
Medical University of South Carolina

Bryant W. Wilson, MD
Piedmont Surgical Associates, Atlanta

16. CAN TUMOR BIOLOGY PREDICT OCCULT MULTIFOCAL DISEASE IN BREAST CANCER PATIENTS?
Anees B. Chagpar, MD, MSc, MPH, MA, MBA
Yale University
Invited Discussant: David J. Cole, MD

17. MAMMOGRAPHIC SCREENING AT AGE 40 OR 45? WHAT DIFFERENCE DOES IT MAKE? THE POTENTIAL IMPACT OF AMERICAN CANCER SOCIETY MAMMOGRAPHY SCREENING GUIDELINES
Crystal Fancher, MD
Mercer University School of Medicine
Invited Discussant: Marissa M. Howard-McNatt, MD

18. THE CLINICAL UTILITY AND COST OF POSTOPERATIVE MAMMOGRAPHY COMPLETED WITHIN ONE YEAR OF BREAST CONSERVING THERAPY: IS IT WORTH IT?
Ahkeel Allen, MD
Mercer University School of Medicine
Invited Discussant: Kandace Peterson McGuire, MD
7:45am - 8:00am  
**19. THE SESTAMIBI PARADOX: IMPROVING INTRAOPERATIVE LOCALIZATION OF PARATHYROID ADENOMAS**  
Jessica Buicko, MD  
University of Miami  
Invited Discussant: TBD

8:00am - 8:15am  
**20. AN ANALYSIS OF FACTORS THAT PREDICT HOSPITAL READMISSION AFTER SURGERY FOR PERFORATED APPENDICITIS**  
Jeffanne Millien, MD  
Ochsner Medical Institutions  
Invited Discussant: Bryan K. Richmond, MD

8:15am - 8:30am  
**21. DIFFERENCES IN THE MANAGEMENT OF PERFORATED APPENDICITIS IN CHILDREN BY RACE AND INSURANCE STATUS**  
Randi Lassiter, MD  
Augusta University  
Invited Discussant: Wendy Ricketts Greene, MD

8:30am - 8:45am  
**22. SOCIOECONOMIC FACTORS ASSOCIATED WITH READMISSION AFTER DECEASED DONOR KIDNEY TRANSPLANT**  
Richard Whitlock  
University of Mississippi School of Medicine  
Invited Discussant: Prabhakar K. Baliga, MD

8:45am - 9:00am  
**Morning Break**  
Ballroom Foyer

7:00am - 8:45am  
**Parallel Scientific Session VII**  
Belmont Room  

**Moderators:**  
Richard D. Field, III, MD  
The Field Clinic  
Rick Greene, MD  
Levine Cancer Institute
23. UPPER EXTREMITY PREOPERATIVE PULSE PRESSURE PREDICTS AMPUTATION-FREE SURVIVAL AFTER LOWER EXTREMITY BYPASS
Eric Wise, MD
University of Maryland
Invited Discussant: TBD

24. IN THE ERA OF 64-SLICE CT SCANNERS, DO BLUNT TRAUMA PATIENTS WITH CT MARKERS SIGNIFICANT FOR BLUNT BOWEL OR MESENTERIC INJURY REQUIRE EXPLORATORY LAPAROTOMY?
Katelyn Young, BS
Geisinger Medical Center
Invited Discussant: TBD

25. PHYSIOLOGIC FEATURES OF BRAIN DEATH
Eno-Obong Essien, BA
University of Maryland School of Medicine
Invited Discussant: Indermeet Bhullar, MD

26. FAVORABLE OUTCOMES IN BLUNT CHEST INJURY WITH NON-INVASIVE BI-LEVEL POSITIVE AIRWAY PRESSURE VENTILATION (BIPAP)
Pascal Udekwu, MBBS MBA/MHA
WakeMed Health & Hospitals
Invited Discussant: Glen Franklin, MD

27. PREDICTORS OF SURVIVAL AFTER DECOMPRESSIVE CRANIECTOMY
Abid Khan, MD
Loyola University Medical Center
Invited Discussant: Laura S. Johnson, MD

28. CHEST TUBE REMOVAL IN SIMPLE PNEUMOTHORAX: DOES WATER-SEAL DURATION MATTER?
Lindsay Bridges, MD
East Carolina University
Invited Discussant: TBD
8:30am - 8:45am  29. MEDICATION VARIANCES IN INJURED PATIENTS
Scott Dolejs, MD
Indiana University School of Medicine
Invited Discussant: John M. Green, MD

8:45am - 9:00am  Morning Break
Ballroom Foyer

9:00am - 10:00am  Panel Session: Catastrophic Cases I Have Known
East Ballroom

Moderator:
Kevin Behrns, MD
St. Louis University

Panelists:
Alex S. Rosemurgy, MD
Florida Hospital, Tampa

Brent Matthews, MD
Carolinias HealthCare System

Laura Witherspoon, MD
University Surgical Associates

Bryan Richmond, MD
West Virginia University, Charleston

10:00am - 12:00pm  Scientific Session VIII
East Ballroom

Moderators:
Emmanuel E. Zervos, MD
Eastern Carolina University

Alexander S. Rosemurgy, MD
Florida Hospital, Tampa
30. PREDICTORS OF UTILIZATION AND QUALITY ASSESSMENT IN ROBOTIC RECTAL CANCER RESECTION: A REVIEW OF THE NATIONAL CANCER DATABASE
Christie Buonpane, MD
Geisinger Medical Center
Invited Discussant: Bryant Wilson, MD

31. FACTORS ASSOCIATED WITH GRADE FOR GASTROENTEROPANCREATIC NEUROENDOCRINE TUMOR (GEP-NET): LOCATION, LOCATION, LOCATION
Catalina Mosquera, MD
East Carolina University
Invited Discussant: John A. Stauffer, MD

32. ESOPHAGEAL PERFORATION: A COMMON CLINICAL PROBLEM WITH MANY DIFFERENT MANAGEMENT OPTIONS
Lloyd Felmly, MD
Medical University of South Carolina
Invited Discussant: Alan B. Marr, MD

33. PNEUMATOSIS INTESTINALIS IN PATIENTS RECEIVING TUBE FEEDS
Alex Cavalea, MD
University of Tennessee Medical Center
Invited Discussant: Bryan C. Morse, MD

34. PRESENTING STAGE IN COLON CANCER IS ASSOCIATED WITH INSURANCE STATUS
James Lawrence, MD
Mercer University School of Medicine
Invited Discussant: TBD
11:15am - 11:30am
35. OUTCOMES AFTER MASTECTOMY AND LUMPECTOMY IN OCTOGENARIANS WITH EARLY STAGE BREAST CANCER
Amelia Merrill, MD
Wake Forest School of Medicine
Invited Discussant: Anees B. Chagpar, MD, MSc, MA, MPH, MBA

11:30am - 11:45am
36. TUMOR MITOTIC RATE AND ASSOCIATION WITH RECURRENCE IN SENTINEL LYMPH NODE NEGATIVE STAGE II MELANOMA
Shachar Laks, MD
University of North Carolina
Invited Discussant: Timothy L. Fitzgerald, MD

11:45am - 12:00pm
37. COMPARISON OF THERAPEUTIC BENEFIT OF BUPIVACAINE HCL TRANSVERSUS ABDOMINIS PLANE BLOCKS AS PART OF AN ENHANCED RECOVERY PATHWAY VS. TRADITIONAL ORAL AND INTRAVENOUS PAIN CONTROL AFTER ELECTIVE MINIMALLY INVASIVE COLORECTAL SURGERY
Elizabeth Lax, MD
Providence Hospital
Invited Discussant: J. Daniel Stanley, MD

12:00pm - 12:10pm
Closing Announcements & Meeting Adjournment
East Ballroom
ABSTRACTS
Scientific Session I

1. INCIDENTAL VS. NON-INCIDENTAL GALLBLADDER CANCER: PATHOLOGIC AND PROGNOSTIC IMPLICATIONS OF DELAYED DIAGNOSIS, A 10-INSTITUTION STUDY FROM THE U.S. EXTRAHEPATIC BILIARY MALIGNANCY CONSORTIUM

Cecilia Ethun, MD
Emory University

Background: Most gallbladder cancers (GBC) are discovered incidentally at the time of cholecystectomy. The influence of timing of diagnosis on disease stage, treatment, and prognosis is not known.

Methods: All patients with GBC who underwent resection at 10 institutions from 2000-2015 were included. Patients diagnosed incidentally (IGBC) and non-incidentally (non-IGBC) were compared. Primary outcome was overall survival (OS).

Results: Of 445 pts with GBC, 266 (60%) were IGBC and 179 (40%) were non-IGBC. Compared to IGBC, non-IGBC patients were more likely to have R2 resections (43vs19%; p<0.001), advanced T-stage (T3/T4: 70vs40%; p<0.001), high grade tumors (50vs31%; p<0.001), lymphovascular invasion (LVI: 64vs45%; p=0.01), and positive lymph nodes (LN: 60vs43%; p=0.009). Receipt of adjuvant chemotherapy was similar between groups (49vs49%). Non-IGBC was associated with worse median OS compared to IGBC (17vs32mos, p<0.001; Fig 1A), which persisted among Stage III patients (12vs29mos; p<0.001; Fig 1B), but not Stages I, II or IV. Despite Stage III patients in both groups having similar adverse pathologic factors (grade, LVI, margin, LN), adjuvant chemotherapy was associated with improved OS only in Stage III IGBC, but not in non-IGBC (Fig 1C).

Conclusion: Compared to incidental discovery, non-incidental gallbladder cancer is associated with reduced overall survival, which is most evident in Stage III disease. Despite being well-matched for other adverse pathologic factors, adjuvant chemotherapy was associated with improved survival only in Stage III patients with incidentally discovered cancer. This underscores the importance of timing of diagnosis in gallbladder cancer and suggests that these two groups may represent a distinct biology of disease, and the same treatment paradigm may not be appropriate.
Scientific Session I

2. OPTIMAL MODIFIED FRAILTY INDEX CUT-OFF IN OLDER GASTROINTESTINAL CANCER PATIENTS TREATED WITH SURGERY

Molly Garland, MD
Wake Forest Baptist Health

Background: Gastrointestinal (GI) cancers are a disease of older adults who can present with poor performance status, sarcopenia and malnutrition. The newly characterized modified frailty index (mFI) is a robust predictor of postoperative outcomes for surgical patients. The current study investigates the optimal cut-off for mFI in older GI cancer patients undergoing surgery.

Methods: All patients over 60 years old who underwent surgery for a GI cancer (esophagus, stomach, colon, rectum, pancreas, liver, and bile duct) were identified in the 2005-2012 NSQIP PUF. Patients undergoing emergency procedures, ASA 5, or diagnosed with preoperative sepsis were excluded. Logistic regression modeling and 10-fold cross validation were used to identify an optimal mFI cut-off.

Results: 41,455 patients (mean age 72, 47% female) met the eligibility criteria with the majority diagnosed with colorectal cancer (68%, n=28,708). 19.0% developed a major complication and 2.8% died within 30 days of surgery. Random sampling by cancer site was performed to create a 90% training and 10% test sample datasets. Using an iterative process of 10-fold cross validation, logistical regression models evaluated the association between mFI and endpoints of 30-day mortality and major complication at various cut-offs. Optimal cut-offs for 30-day mortality and major complication were mFI >= 0.1 and >= 0.2, respectively. After adjusting for age, sex, ASA, albumin >= 3g/dl, and BMI >= 30 kg/m2, mFI >= 0.1 was associated with increased mortality (OR 1.49, 1.30-1.71 95% CI, p < 0.001) and mFI >= 0.2 was associated with increased morbidity (OR 1.52, 1.39-1.65 95% CI, p < 0.001).

Conclusion: For older GI cancer patients, even a very low mFI was a predictor of poor postoperative outcomes with an optimal cut-off of two or more mFI characteristics (mFI > 0.18).
Scientific Session I

3. SAFETY OF OUTPATIENT THYROIDECTOMY
Jonathan Black, MD
University of North Carolina

Background: Historically, total thyroidectomy was an inpatient procedure with patients staying up to three days post-operatively to monitor for complications, including hypocalcemia and compressive hematoma. In recent years, total thyroidectomy has transitioned to a 23-hour stay (23HS). National databases such as NSQIP consider <=23 hour stay as outpatient surgery making same day discharge (SDD) challenging to study. We investigated the outcomes of patients undergoing total thyroidectomy with SDD, 23HS and stays that cross 2 midnights (C2M).

Methods: Retrospective review was performed of 414 total thyroidectomies at UNC Hospitals between 2005-2013 after receiving IRB approval. Length of stay data was available on 328 patients. Emergency Department (ED) visits and readmissions within 30 days of surgery were captured but were considered the same for this analysis. The groups were compared based on age, sex, race, and calcium supplementation post-op. IBM SPSS was used to perform Chi-square and t-test analyses as appropriate.

Results: Patients were stratified into SDD (n=80), 23HS (n=216), C2M (n=32). Out of 328 total thyroidectomies performed, 21 patients (6.4%) returned to the hospital. 65.9% (216/328) of patients had a 23h stay, 24.4% (80/328) had a SDD, and 9.8% (32/328) had a C2M. Patients discharged same day were more likely to be white (29.1% vs. 19.0%, p=0.03) and male (31.0% vs. 23.0%) although gender was not statistically significant. The average age was similar between groups (47.3 yrs). 5.0% (4/80) of SDD were readmitted, compared to 6.9% (15/216) of 23HS and 6.3% (2/32) of C2M. There was no difference in readmission rates based on length of stay (p=0.556), age, sex, race or calcium supplementation.

Conclusion: We found no differences in readmission rates for patients undergoing total thyroidectomies for SDD, 23HS C2M. Although the decision of whether to discharge a patient on the day of surgery is surgeon specific, our data suggests that surgeons currently performing outpatient total thyroidectomies with SDD are successfully selecting patients who are safe to be discharged home on the day of surgery. Further studies are needed to determine which specific patient factors are associated with the best SDD candidates.
Scientific Session I

4. FACTORS AFFECTING CHOICE OF TREATMENT FOR EARLY STAGE BREAST CANCER IN WEST VIRGINIA: A 10 YEAR EXPERIENCE FROM A RURAL TERTIARY CARE CENTER.

Patrick Suggs, BA
West Virginia University School of Medicine

Background: Recent literature has shown increasing use of mastectomy (M) and contralateral prophylactic mastectomy (CPM), and a decline in breast conserving surgery (BCS) in women with early stage disease. We analyzed the factors associated with selection of M versus BCS, and use of CPM in WV.

Methods: We conducted a 10-year review of women treated with early stage, unilateral breast cancer. Patient data was obtained via our institutional cancer registry. Variables were compared between patients choosing BCS vs. M. In women who chose M, predictors for CPM were also examined. Variables with P < 0.05 on univariate analysis were entered into a multivariate logistic regression model to define independent predictors of treatment choice.

Results: 1264 were included: 841 BCS/423 M. The M rate increased from 18.0% in 2006 to 40.2% in 2013. On multivariate analysis, insurance status (P < 0.001), comorbidities (P = 0.001), surgeon graduation prior to 1988 (P = 0.010), tumor grade (P = 0.024), tumor size (P < 0.001), and clinically positive nodes (P = 0.003) were associated with likelihood of receiving M. Of those receiving M, 106 (25.1%) elected CPM. Rates of CPM increased from 8.0% in 2006 to 45.0% in 2013. On multivariate analysis, only younger age at diagnosis (P < 0.001) and use of MRI preop (P = 0.012) predicted use of CPM versus M alone.

Conclusion: Rates of M and CPM in early stage breast cancer have increased in WV. Comorbidities, insurance status, surgeon graduation date, and tumor/nodal status affect women’s decision to undergo M versus BCS, while patient age and use of preop MRI affect whether CPM is chosen. Awareness of these factors will aid in counseling women with early stage breast cancer and allow clinicians to address potential biases that may affect treatment choices.
Scientific Session I

5. WHAT CAN YOU DO NEXT WEEK TO IMPROVE CARE FOR YOUR HERNIA PATIENTS? REAL-WORLD RESULTS FROM THE AMERICAS HERNIA SOCIETY QUALITY COLLABORATIVE

Benjamin Poulose, MD, MPH
Vanderbilt University Medical Center

Background: Despite being such a common problem, the management of ventral hernia varies widely in practice with less than ideal outcomes. Although an increasing amount of information is being gathered to help guide the management of ventral hernia patients, few actionable items have been identified to improve outcomes. The Americas Hernia Society Quality Collaborative (AHSQC) strives to identify changes in practice to improve care based on real-world information. We evaluated five areas for potential improvement to help reduce short term wound events, readmission/observation visits, and length of stay.

Methods: Prospectively collected, multi-institutional information from over 3,000 patients between 2013-2015 was retrospectively analyzed. Risk adjustment techniques including matching, multivariate regression, and propensity score analyses were used to evaluate the short term (30 day) impact of bowel preparation, drain use, prehospital chlorhexidine use, robotic surgery, and implementation of a readmission reduction questionnaire.

Results: Avoidance of bowel prep and avoidance of prehospital chlorhexidine use resulted in reduced wound events. In retromuscular repairs, the use of drains reduced wound events while robotic surgery resulted in decreased length of stay. Implementation of a readmission reduction questionnaire did reduce short term readmissions.

Conclusion: Real-world actionable items to improve the care of ventral hernia patients have been identified in the AHSQC. These interventions can be adopted to decrease adverse outcomes. Continuous evaluation of these changes should be initiated within the context of a specialty based quality improvement initiative to help improve care.
Scientific Session I

6. RISK FACTORS AND CLINICAL SIGNIFICANCE OF POSTOPERATIVE RENAL REPLACEMENT THERAPY FOLLOWING ENDOVASCULAR OR OPEN ABDOMINAL AORTIC ANEURYSM REPAIR

Aitua Salami, MD, MPH
Albert Einstein Healthcare Network

**Background:** (1) To determine if modality of elective AAA repair has an effect on risk of renal replacement therapy (RRT) (2) To assess the impact of RRT on length of hospital stay and mortality.

**Methods:** Retrospective observational study using data from the Veterans Affairs Surgical Quality Improvement Program database. All elective procedures for non-ruptured AAAs at participating VA hospitals between 2004 and 2013 were included. Exclusionary criteria included: age < 40 years at the index operation, history of dialysis or acute renal failure 2 weeks prior to surgery, preoperative length of stay >30 days, and intraoperative RBC transfusion >=15 units. Modality of repair, endovascular (EVAR) or open aneurysm repair (OAR), was the exposure of interest. The primary outcome was RRT, defined as worsening renal dysfunction requiring hemodialysis, ultrafiltration, or peritoneal dialysis within 30 days postoperatively, in a patient who did not require dialysis preoperatively. Propensity score-weighted Cox proportional hazards models were used to evaluate associations.

**Results:** A total of 11,180 patients were included, of which 8,027 (71.8%) underwent EVAR. RRT occurred in 135 patients with an incidence rate of 1.2% [0.6% of EVAR and 2.8% of OAR; P<.001]. OAR was associated with an increased risk of RRT on univariate analysis [HR: 4.7, (95% CI: 3.28-6.63), P<.001]. This association persisted following multivariable adjustment [HR: 2.7, (95% CI, 1.29-5.50), P <.001]. On univariate analysis, RRT was strongly associated with mortality [HR: 26.2, (95% CI, 18.35-37.40), P<.001], an association that remained after multivariable adjustment [HR: 3.85, (95% CI, 1.78-8.31), P<0.001](Figure 1). Patients that required RRT were independently at risk of prolonged hospitalization [Median days: 7, P=.002].

**Conclusion:** Compared to EVAR, OAR is associated with a higher risk of early RRT following AAA repair. Patients needing RRT are at increased risk for prolonged hospitalization and early postoperative mortality independent of other postoperative complications.
Scientific Session I
7. IDENTIFYING FUTILE INTER-FACILITY SURGICAL TRANSFERS
Kristy Kummerow Broman, MD, MPH
Vanderbilt University Medical Center

Background: Surgeons perceive that some surgical transfers are futile, but the incidence and risk factors of futile transfer are not quantified. Identifying futile inter-facility transfers could save cost and undue burdens to patients and families. We sought to describe the incidence and factors associated with futile transfers.

Methods: We conducted a retrospective cohort study from 2009-2013 including patients transferred to a tertiary referral center for general or vascular surgical care. Futile transfers were defined as resulting in death or hospice discharge within 72 hours of transfer without operative, endoscopic, or radiologic intervention.

Results: One percent of patient transfers were futile (27/1696). Characteristics of futile transfers included older age, higher comorbidity burden and illness severity, vascular surgery admission, Medicare insurance, and surgeon documentation of end-stage disease as a factor in initial decision-making. Among futile transfers, 82% were designated as do not resuscitate (versus 9% of non-futile, p<0.01) and 59% received a palliative care consult (versus 7%, p<0.01).

Conclusion: A small but salient proportion of transferred patients undergo deliberate care de-escalation and early death or hospice discharge without intervention. Efforts to identify such patients prior to transfer through improved communication between referring and accepting surgeons may mitigate burdens of transfer and facilitate more comfortable deaths in patients’ local communities.
SCIENTIFIC SESSION II ABSTRACTS

Scientific Session II
8. OUTCOMES FOLLOWING NON-CARDIAC SURGERY IN PATIENTS WITH VENTRICULAR ASSIST DEVICES: A SINGLE-CENTER EXPERIENCE
Shawna Kettyle, MD
MedStar Washington Hospital Center

Background: The number of patients with ventricular assist devices (VADs) is increasing as cardiac therapies progress. These patients commonly require non-cardiac surgical (NCS) procedures, though data is scant regarding the safety and timing of operations that may be performed. This study aims to describe our experience with VAD patients undergoing NCS.

Methods: The Advanced Heart Failure VAD database was used to retrospectively review patients who had NCS procedures after VAD implantation between 2013 and 2015 at a single Joint Commission-accredited VAD institution. Data collection included demographics, ischemic cardiomyopathy (ICM) or non-ischemic cardiomyopathy (NICM), operative details, peri-operative anticoagulation management and outcomes.

Results: 72 NCS procedures were performed on 42 patients (27% of all VAD implants) during the study period. 7 procedures in 5 patients were due to cardiac intervention or had incomplete data, so were excluded. 21 (32%) cases were performed by general surgery, 13 (20%) by thoracic, 12 (18%) by plastics and the remaining by urology (5), vascular (4), ENT (4) or other services. Procedures included 13 video-assisted thoracoscopic (VATS) with decortications or lung biopsy (20%), 10 tracheostomies (15%), 4 percutaneous endoscopic gastrostomies (PEG) (6%), 9 exploratory laparotomies (14%) and 8 wound debridements and/or closures (12%). The 10 deaths in the study group were judged not to be directly related to NCS. 11 cases were complicated by post-operative bleeding, and 2 cases had post-operative thrombosis, one which was pump thrombosis. Outcomes are listed in Table 1.

Conclusion: VAD is not a contraindication to NCS, and a variety of NCS procedures can safely be performed. Further study should focus on quantifying and mitigating the risk that VADs bring to NCS procedures.
Scientific Session II
9. EFFECT OF IMPLEMENTATION OF STRAIGHT CATHETER PROTOCOL ON RATE OF URINARY TRACT INFECTIONS IN TRAUMA POPULATION
Katherine Kelley, MD
Eastern Virginia Medical School

Background: Catheter associated urinary tract infections are a significant negative outcome. There are previous studies showing advantages in removing foleys early but no study of the effect of using straight as opposed to foley catheterization in a trauma population. This study evaluates the effectiveness of a straight catheter protocol implemented on the trauma service in February of 2015.

Methods: A retrospective chart review was performed on all patients admitted to the trauma service at a single institution who had a UTI one year before and one year after protocol implementation on 2/18/2015. The protocol involved removing foley catheters early and utilizing straight catheterization. Patients were excluded if they had a burn, injury to the urinary system, were paraplegic, or had a UTI or chronic foley present on admission. Rates were compared with Fisher’s exact test and continuous data were compared using student’s t test.

Results: There were 1477 patients admitted to the trauma service in the control year and 1707 in the study year. The control year had a total of 43 patients found to have a UTI, 28 of these met inclusion criteria. The intervention year had a total of 35 patients with a UTI and 17 met inclusion criteria. The rate of patients having a UTI and meeting inclusion criteria went from 0.019 to 0.010 (p=0.035). In females this rate went from 0.033 to 0.009 (p=0.007) while in males it only went from 0.012 to 0.010 (p=0.837).

Conclusion: This study shows a statistically significant improvement in the rate of UTIs after implementing an intermittent catheterization protocol suggesting that this protocol could improve the rate of UTIs in other trauma centers. This practice is now part of the care for all trauma patients and is being looked at for use hospital wide.
Scientific Session II
10. EVALUATION OF CARDIOPULMONARY COMPLICATION RATES FOLLOWING PORT INSERTION: IS A POSTOPERATIVE X-RAY NEEDED?
Justin Vaughan, MD
Mercer University School of Medicine

Background: Port insertion provides long-term central venous access for delivery of recurring medications. A postoperative chest film is routinely obtained after fluoroscopic guided port insertion to exclude acute cardiopulmonary complications. Recently, the utility of this chest film has come into question. The objective of this study is to provide a cost-benefit analysis through examination of acute complications detected on postoperative port insertion chest films.

Methods: A retrospective chart review of port insertions was conducted over a five-year time period. The route of placement, termination site of catheter, and acute complications detected on the radiograph report were evaluated. Ultrasound assisted internal jugular venous or landmark guided subclavian ports placed with the assistance of fluoroscopy were included.

Results: There were 519 port insertions performed by six different surgeons. 335 were routed via subclavian vein and 183 via internal jugular vein. The distal portion of all catheters terminated within the cavoatrial region. There were three significant complications: two pneumothoraces and one hemothorax, which resulted in a complication rate of 0.58%. The cost for the post-op chest film was $345. The total price of post-op port chest radiographs was $179,400.

Conclusion: Performing chest films on asymptomatic patients following port insertions proved to be of no medical advantage to 516 out of 519 patients. The operative note for each acute complication contained documentation of a procedural abnormality that suggested a chest film would be of medical benefit. Given the extremely low complication rate and financial burden placed on the patient population, discontinuing the routine use of post-op port chest radiographs may be a plausible way to alleviate unwarranted medical cost.
Background: A subset of injured patients surviving damage control laparotomy require a split-thickness skin graft (STSG) to cover the open abdomen. Controversy exists as to whether later reconstruction of the gastrointestinal tract (GI) (i.e., takedown stoma, etc.) should be performed at the same time as abdominal wall reconstruction (AWR) or staged. This series reviews the outcomes of the first reoperation for GI reconstruction or other intra-abdominal procedure performed by elevation of the healed STSG.

Methods: Concurrent data collection on patients undergoing GI reconstruction or other abdominal operation by elevating 180 degrees (or less) of the circumference of the STSG, lysing adhesions only as needed, avoiding detaching underlying omentum or viscera from the underside of the STSG to avoid devascularization, and then reattaching the elevated STSG to the abdominal wall after completion of the abdominal operation.

Results: From 1995-July, 2016, 23 patients underwent 26 abdominal reoperations (88.5% GI) through the elevated STSG approach at three Level I trauma centers at a mean interval of 11 months from application of the STSG. One STSG was lost (patient closed with skin flaps), one patient had 30% loss of the STSG (regrafted), and one patient had 10% loss of the STSG (allowed to granulate). There were no GI complications, intra-abdominal infections, or deaths, and all patients were deemed fit to undergo AWR after 3 months.

Conclusion: Major intra-abdominal reoperations can be readily and safely accomplished through the elevated STSG approach in former “damage control” patients with a <4% need for regrafting. This staged approach significantly simplifies and increases the safety of a second stage AWR.
Scientific Session II
12. PREDICTING POSTOPERATIVE COMPLICATIONS FOR ACUTE CARE SURGERY PATIENTS USING THE AMERICAN COLLEGE OF SURGEONS SURGICAL RISK CALCULATOR
Jessica Burgess, MD
Eastern Virginia Medical School

Background: The American College of Surgeons - National Surgical Quality Improvement Program (ACS-NSQIP) surgical risk calculator has been widely used to assist surgeons in predicting the risk of postoperative complications. This study aims to determine if the risk calculator accurately predicts complications in acute care surgical patients undergoing laparotomy.

Methods: A retrospective review was performed on all patients on the acute care surgery service at a tertiary hospital who underwent laparotomy between 2011 and 2012. The preoperative risk factors were used to calculate the estimated risks of postoperative complications in both the original ACS NSQIP calculator and the updated calculator (June 2016). The predicted risk of complications was then compared to the actual rate of complications.

Results: 95 patients were included in the study. Both the original and updated risk calculators accurately predicted the risk of pneumonia, cardiac complications, urinary tract infections, venous thromboembolism, renal failure, unplanned returns to the OR, discharge to skilled nursing facility and mortality. Both calculators underestimated the rate of serious complications (26% vs 39%), overall complications (32.4% vs 45.3%), surgical site infections (9.3% vs 20%) and length of stay (9.7d vs 13.1d). When patients with prolonged hospitalization >30 days were excluded, the updated calculator accurately predicted length of stay.

Conclusion: The ACS NSQIP surgical risk calculator underestimates the overall risk of complications, surgical site infections and length of stay. The updated calculator accurately predicts length of stay for patients not requiring a prolonged hospitalization. The acute care surgical population represents a high risk population with an overall increased rate of complications when compared to the general population. This should be taken into account when using the risk calculator to predict postoperative risk in this patient population.
Scientific Session III
13. PREOPERATIVE HYPOALBUMINEMIA IS A PREDICTOR OF SHORT AND LONG-TERM MORTALITY FOLLOWING MAJOR VASCULAR SURGERY
Aitua Salami, MD, MPH
Albert Einstein Healthcare Network

**Background:** We sought to: (1) determine the prevalence of preoperative hypoalbuminemia among patients undergoing major vascular surgical procedures (2) assess the impact of hypoalbuminemia on perioperative and long-term mortality outcomes following these procedures.

**Methods:** A retrospective cohort study was conducted among patients who underwent surgery for occlusive and aneurysmal vascular diseases (aortic aneurysm repair, major lower extremity amputation, reconstruction for aortoiliac or lower extremity occlusive diseases and carotid endarterectomy) at a tertiary VA Medical Center between 2006 and 2013. Exposure of interest was hypoalbuminemia, defined by a serum albumin concentration < 3.5g/dl in the immediate preoperative period. Endpoints of interest were perioperative and long-term mortality. Propensity score analysis was used to determine the association between hypoalbuminemia and mortality. An adjusted Kaplan-Meier survival plot was used to describe the impact of hypoalbuminemia on long-term mortality. A p<0.05 was deemed statistically significant.

**Results:** A total of 2,154 patients were included, of which 902 (42%) had hypoalbuminemia. Hypoalbuminemia was associated with an increased risk of perioperative mortality [OR: 5.0 (CI: 1.98-12.31) p<0.001]. After propensity score adjustment this association remained significant [OR: 3.3 (CI: 1.25-8.89) p=0.016]. Furthermore, hypoalbuminemia was a significant predictor of long-term mortality [HR: 2.6 (CI: 2.10-3.12) p<0.001], an association that also persisted after propensity score adjustment [HR: 1.95 (1.46-2.60) p<0.001] (Figure 1). The above associations remained statistically significant after accounting for events that were thought to be associated with perioperative and long-term mortality.

**Conclusion:** Hypoalbuminemia is independently associated with an increased risk of perioperative and long-term mortality following major vascular surgery. Patients undergoing these procedures should be risk stratified, and interventions to improve nutritional status should be implemented prior to surgery.
Scientific Session III
14. IMPACT OF COMPONENT SEPARATION ON QUALITY OF LIFE OUTCOMES FOLLOWING VENTRAL HERNIA REPAIR
Stephanie Sims, MD
Carolinas Medical Center

Background: Component separation (CS) is often required to perform closure of the abdominal wall during open ventral hernia repair (OVHR). As quality of life (QOL) has become an increasing focus of hernia repair outcomes, this study aims to determine whether CS at the time of repair of large ventral hernias affects QOL.

Methods: Review of multicenter, prospectively collected data from the International Hernia Mesh Registry was completed. Patients with recorded defect sizes of at least 75cm2 who underwent OVHR with and without component separation were evaluated. QOL was measured at 1, 6, 12, and 24 months post-operatively using the Carolinas Comfort Scale (CCS); a CCS score >= 2 (mild but bothersome) was considered symptomatic. Standard statistical methods were used.

Results: A total of 166 patients were analyzed, with 95 undergoing OVHR with mesh and 71 patients undergoing CS with mesh. Age (56.4 ± 12.1 vs 57.6 ± 12.4), BMI (33.7 ± 8.7 vs 32.6 ± 7.3), and defect size (190.7 ± 190 vs 182.9 ± 156) were similar between the CS and OVHR groups (all p>0.05). CS had significantly higher number of current or previous smokers (71% vs 53%, p=0.02). Post-operative symptomatic CCS scores of pain (70.2% vs 44.4%), mesh sensation (29.8% vs 11.3%) and movement restrictions (73.7% vs 48.6%) in the early post-op period (1 month) were significantly higher in patients with CS compared with OVHR (all p<0.013). No statistically significant differences in QOL measurements were appreciated in the later follow up periods.

Conclusion: When necessary, component separation can be performed at the time of OVHR without concern for negative impact on long-term quality of life. However, patients should be counseled that they may have increased discomfort in the early post-operative period if CS is necessary.
Scientific Session III
15. AGE AND ACHALASIA: HOW DOES AGE AFFECT PATIENT PRESENTATION, HOSPITAL COURSE, AND SURGICAL OUTCOMES?
Alexander Rosemurgy, MD
Florida Hospital Tampa

**Background:** Heller myotomy is the gold standard therapy for achalasia, alleviating symptoms by de-functionalizing the lower esophageal sphincter mechanism. Observation has suggested many differences between young and old patients with achalasia, raising the question: is achalasia in younger patients a different disorder than it is in older patients? This study was undertaken to answer this question.

**Methods:** With IRB approval, 648 patients undergoing laparoscopic Heller myotomy from 1992-2016 were prospectively followed. Patients self-assessed symptom frequency/severity preoperatively and postoperatively using a Likert scale: 0 (never/not bothersome) to 10 (always/very bothersome).

**Results:** Prior to myotomy, frequency and severity of many symptoms (including “dysphagia,” “chest pain,” and “regurgitation”) inversely correlated with age (p<0.01 each). Symptom duration and number of previous abdominal operations positively correlated with age, as did intraoperative complications (e.g., gastrotomy), postoperative complications (e.g., atrial fibrillation) and length of stay (p<0.01 for each). Patients experienced amelioration of all symptoms queried, regardless of age (p<0.01 each). Age did not affect improvement of symptoms (e.g., dysphagia) (i.e., differences between preoperative and postoperative scores) (p=0.88). Age did not influence patient satisfaction.

**Conclusion:** The presentation with achalasia, hospital course, and salutary outcome after myotomy are significantly impacted by age, while patient improvement after myotomy is constant regardless of age. Younger and older patients have different presentations, experiences, and outcomes; these patients seem to have ‘different disorders’, but Heller myotomy provides similar significant amelioration of symptoms.
Scientific Session III
V1. ROBOTIC TRANSHIATAL ESOPHAGECTOMY
Sharona Ross, MD
Florida Hospital Tampa

Background: This video documents a robotic transhiatal esophagectomy for a very large gastrointestinal stromal tumor in the distal esophagus.

Methods: A 12mm port was placed at the umbilicus and two 8mm ports were placed to the right and left of the umbilicus at the mid-clavicular line. Two 5mm ports were placed cephalad to the umbilicus on the right and left auxiliary lines, respectively. Finally, a Gelport® was placed in the right lower quadrant.

Results: The gastrohepatic omentum was opened and then the stomach and duodenum were mobilized. A wide Kocher maneuver was undertaken, and great care was taken to preserve the right gastroepiploic and right gastric arteries. Dissection was carried up into the mediastinum. A pyloromyotomy was undertaken. Vascular and purple-load Endo-GIA staplers were used to divide the left gastric artery at its origin and the proximal stomach. An incision was made on the border of the sternocleidomastoid muscle and dissection began with careful attention to adjacent nerves and vessels. The esophagus was mobilized in the neck and divided. The specimen was removed after being brought into the peritoneal cavity. The stomach was brought up into the neck and stapled esophagastrectomy was constructed.

Conclusion: Interrupted silk sutures were used to close the anastomosis. The stomach was sewn into the crura to avoid any torsion that would threaten the anastomosis. The trocar sites were closed absorbable sutures. A Jackson-Pratt drain was placed in the neck incision, which was closed with interrupted Vicryl sutures.
Scientific Session III
V2. LAPAROSCOPIC OBTURATOR HERNIA REPAIR
Joseph Tingen, MD
Greenville Memorial Hospital

**Background:** Incarcerated obturator hernias are an uncommon diagnosis associated with high morbidity and mortality. These classically present with bowel obstruction in elderly women, often in the absence of prior abdominal surgery. This video presents successful laparoscopic preperitoneal mesh repair of a strangulated obturator hernia requiring small bowel resection.

**Methods:** Video presentation of laparoscopic preperitoneal mesh repair of an obturator after reduction and resection of strangulated small bowel.

**Results:** 83 year-old female presented with clinical and radiologic small bowel obstruction due to an incarcerated obturator hernia. At the time of laparoscopy, the hernia was found to be strangulated. Small bowel resection with intracorporeal anastomosis was performed. This was followed with transabdominal preperitoneal repair of the hernia defect using a large-pore midweight polypropylene mesh secured to Cooper’s ligament, and closure of the peritoneal flap over the mesh. Patient had prompt return of bowel function and was discharged home. No complications have occurred at six-month follow-up.

**Conclusion:** Laparoscopy is an ideal approach for repair of obturator hernias. In the event of strangulation, reduction and resection laparoscopically is feasible. Large-pore midweight polypropylene mesh can be used to safely repair the hernia defect even in the setting of enteric contamination.
Parallel Scientific Session IV - Quick Shots

QS1. REINFORCEMENT OF THE STAPLE LINE DURING GASTRIC SLEEVE: A COMPARISON OF BUTTRESSING OR OVERSEWING, VS NO REINFORCEMENT - A SINGLE INSTITUTION STUDY

Jean Guerrier, MD
University of Virginia

Background: Laparoscopic sleeve gastrectomy (LSG) is a well-established treatment for morbid obesity. Staple line leak (SLL) remains one of the most serious and life-threatening complications following LSG, however, no consensus exists for prevention. The purpose of this study is to review and compare the different methods of staple line management used at our institution.

Methods: Retrospective review of preoperative, intraoperative, and postoperative factors was performed for all patients undergoing LSG at a single institution between September 2010 and August 2015. Primary outcome measure was SLL by reinforcement method (none/Seamguard/Oversewing). Secondary outcomes measures were postoperative bleeding, reoperation, and readmission.

Results: A total of 256 patients undergoing LSG were included, 197 (76.95%) were women and 233 (87.11%) were Caucasian. The patients had a mean age of 44.64 years and a body mass index (BMI) of 49.24 kg/m². Among those patients, 145 (56.64%) had staple line reinforced with suture (28, 10.94%) or Gore Seamguard (115, 44.92%), and 111 (43.36%) had no reinforcement, with no difference in baseline factors between the groups (all p>0.05). Intraoperative staple line bleeding was significantly reduced in the reinforcement group (22.3 vs 37.8%, p = 0.003). Gastric leaks were identified in 9 patients (3.52%) with no difference between reinforcement (2.7 vs 2.1%, p = 0.54) or leak test method (air vs methylene blue). However, oversewing the staple line was associated with higher incidence of stenosis (p <0.01).

Conclusion: SLL after LSG is a serious complication with significant morbidity and mortality. This study demonstrated staple line reinforcement does not provide significant leak reduction but does reduce intraoperative staple line bleeding.
Parallel Scientific Session IV - Quick Shots

QS2. MINIMALLY-INVASIVE INCISION AND DRAINAGE TECHNIQUE IN THE TREATMENT OF SIMPLE PERIANAL ABSCESSES IN ADULTS IS EFFECTIVE COMPARED TO TRADITIONAL DRAINAGE

Hai Salfity, MD
Indiana University School of Medicine

Background: A minimally-invasive (MI) approach using small counter-incisions and vessel loops for drainage of simple perianal abscesses has been described in the pediatric population with decreased post-operative pain and comparable results to the traditional incision and drainage (I&D). The hypothesis was MI I&D will yield similar outcomes in the adult population.

Methods: Patients who underwent I&D of perianal abscesses at an urban tertiary care hospital from January 2008 to December 2015 were identified by CPT code. Patient less than 18 years old, with inflammatory bowel diseases, or fistulae-in-ano were excluded. Recurrences, readmissions, operative time, length-of-stay, complications, and costs were compared.

Results: There were 47 traditional I&D and 96 MI I&D with no significant differences in demographics, average body mass index (30 versus 30.4), tobacco use (67.6% versus 63.9%), diabetes mellitus (37.3% versus 21.8%), and abscess size (10 versus 14 cm). Compared to the traditional approach, there were no significant differences in abscess recurrences (29.4% versus 15.6%), readmissions (21.2% versus 14.3%), length-of-stay (2.6 versus 2.9 days), operative time (20.3 versus 19.8 minutes), or costs (p>0.05). There was, however, a higher incidence of post-operative complications in the traditional group (14% versus 3%, p<0.01) and a significantly lower rate of follow-up (40.9% versus 72.7%, p < 0.05).

Conclusion: The MI I&D for simple perianal abscesses in adults is associated with better compliance and fewer complications than the traditional approach. While further prospective randomized studies are needed to determine if the MI technique confers superiority, this approach should be considered as first line treatment for uncomplicated subcutaneous abscesses in adults.
Parallel Scientific Session IV - Quick Shots

QS3. OPEN RETROMUSCULAR REPAIR OF PARASTOMAL HERNIAS
Lucas Beffa, MD
University of South Carolina School of Medicine, Greenville

Background: Parastomal hernias are a significant cause of morbidity in patients with permanent ostomies. A variety of open and laparoscopic techniques have been described for repair, with or without repositioning of the ostomy. We report our experience with open retromuscular repair of parastomal hernias.

Methods: A prospectively maintained hernia database was reviewed to identify patients undergoing parastomal hernia repair with or without concomitant midline incisional hernia repair. Primary outcomes are surgical site occurrence (SSO), surgical site infection (SSI), and hernia recurrence. Discrete variables were analyzed using Pearson’s chi-square test or Fisher’s exact test. Values of p < 0.05 were considered significant. All analyses were completed using R statistical software, version 3.2.3.

Results: A total of 54 patients underwent retromuscular parastomal hernia repair with mesh. Colostomy was involved in 30 patients, and ileostomy in 24. All patients were repaired using a retromuscular technique by creating a keyhole or slit in the mesh with direct passage of the ostomy through the mesh. Transversus abdominis release (TAR) was performed in 62.9% of cases. Large-pore midweight polypropylene mesh was used in the majority of cases (88.9%), and biologic or bioabsorbable in the remainder. Overall, SSI occurred in 16.7% of patients, SSO in 51.8% and recurrence in 18.5%. No difference was seen in SSO, SSI or recurrence between mesh types, or between colostomy and ileostomy. Resiting of the stoma to a new location resulted in the highest rate of SSI (36.8%) compared to leaving the stoma in situ (10.5%) or rematuring the stoma at the same site (0%; p<0.001. Recurrence and SSO were also greater when resiting the ostomy, but were not statistically significant. The addition of a TAR did not impact SSO, SSI or hernia recurrence.

Conclusion: Open retromuscular repair of parastomal hernias is a viable option with an acceptable recurrence rate and wound complications commensurate with the level of contamination of the surgery. Resiting the stoma to a new location results in the highest rates of SSO, SSI and hernia recurrence.
Parallel Scientific Session IV - Quick Shots

QS4. PERCUTANEOUS TRACHEOSTOMY UNDER BRONCHOSCOPIC VISUALIZATION DOES NOT AFFECT SHORT-TERM OR LONG-TERM COMPLICATIONS

Thomas Easterday, MD
Atlanta Medical Center

**Background:** Percutaneous tracheostomy is a safe and effective bedside procedure. Some advocate use of bronchoscopy during the procedure to reduce the rate of complications. We evaluated our complication rate in trauma patients undergoing percutaneous tracheostomy with and without bronchoscopic guidance to ascertain if there was a difference in the rate of complications.

**Methods:** A retrospective review of all tracheostomies performed in critically ill trauma patients was performed utilizing the trauma database from an urban, Level 1 Trauma Center. Bronchoscopy assistance was utilized based upon surgeon preference. Standard statistical methodology was used to determine if there was a difference in complication rates for procedures performed with and without the bronchoscope.

**Results:** From January 2007 to April 2016, 774 trauma patients (568 male/206 female; Mean age 47.3; Age range 13-98) underwent tracheostomy. The tracheostomy was performed percutaneously in 649 patients; 289 with the aid of a bronchoscope and 360 without. The complications and p values appear in the table below.

<table>
<thead>
<tr>
<th>Complications</th>
<th>With Bronchoscope</th>
<th>Without Bronchoscope</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venous Bleeding</td>
<td>3 (1.0%)</td>
<td>0 (0.0%)</td>
<td>0.20599</td>
</tr>
<tr>
<td>17 (5.8%)</td>
<td>0.876121</td>
<td>0.52669</td>
<td></td>
</tr>
<tr>
<td>24 (6.6%)</td>
<td>Malpositioned</td>
<td>1 (0.3%)</td>
<td></td>
</tr>
<tr>
<td>0.68313</td>
<td>0.876121</td>
<td>0.52669</td>
<td></td>
</tr>
<tr>
<td>Venous Bleeding</td>
<td>3 (0.8%)</td>
<td>0 (0.0%)</td>
<td>0.695714</td>
</tr>
<tr>
<td>6 (2.0%)</td>
<td>0.430491</td>
<td>0 (0.0%)</td>
<td></td>
</tr>
<tr>
<td>10 (2.7%)</td>
<td>Mucus Plug</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>0.566709</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>n/a</td>
</tr>
<tr>
<td>Conversion to Open</td>
<td>2 (0.5%)</td>
<td>0 (0.0%)</td>
<td></td>
</tr>
</tbody>
</table>

There were no statistically significant differences in any type of complication regardless of utilization of a bronchoscope.

**Conclusion:** The addition of bronchoscopy provides several theoretical benefits when performing percutaneous tracheostomy. Our findings, however, demonstrate that there does not appear to be a statistically significant difference in complications between procedures performed with and without a bronchoscope. Use of the bronchoscope should, therefore, be left to the discretion of the performing physician.
Parallel Scientific Session IV - Quick Shots
QS5. BICYCLE HELMETS SAVE MORE THAN HEADS: EXPERIENCE FROM A PEDIATRIC LEVEL I TRAUMA HOSPITAL
Patrick Michael, BS
University of Kentucky

Background: Bicycle accidents are common in the pediatric population. We sought to better understand the injury patterns and outcomes of bicyclists who were treated at our Pediatric Level I Trauma Center. Our hypothesis was that helmeted children had better outcomes.

Methods: Trauma registry data and hospital E-codes were used to identify pediatric bicycle accident victims (age <= 15) between January 2006 and December 2015. Demographic data, injury severity, hospital course, and outcomes were evaluated. Financial data were collected. We compared children who were known to be helmeted to those who were known to be unhelmeted. Patients were excluded if their helmet use was unknown.

Results: Our study cohort consisted of 516 patients. Patients were mostly male (70.2%) and Caucasian (84.7%). The median age was 9 years (range 1 - 15). There were 101 children in the helmeted group and 415 children in the unhelmeted group. Helmeted children were more likely to have private insurance (68.3% vs. 35.9%, p<.001). Unhelmeted children were more likely to be African American (12% vs. 4%, p=0.17), sustain multiple injuries (40% vs. 25.7%, p=.008), and meet our trauma activation criteria (45.5% vs. 16.8%, <.001). Helmeted children were less likely to sustain brain injuries (15.8% vs. 25.8%, p=.037), skull fractures (1% vs 10.8%, p=.001), and facial fractures (1% vs. 6%, p=.040). Median costs by service area are summarized in the table. Overall, outcomes were excellent. The vast majority were discharged home. One unhelmeted child died.

Conclusion: Helmet usage was suboptimal. Although the majority of children sustained relatively minor injuries, unhelmeted children had more injuries and higher costs than those who used helmets. Helmets are effective at preventing bicycle injuries. Injury prevention programs are warranted.
Parallel Scientific Session IV - Quick Shots

QS6. LONG-TERM NUTRIENT DEFICIENCY AFTER ROUX-EN-Y GASTRIC BYPASS: WHO’S RESPONSIBLE?
James Mehaffey, MD
University of Virginia

Background: Monitoring and prevention of long-term nutrient deficiency after Laparoscopic Roux-en-Y Gastric Bypass (LRYGB) remains ill defined due to limited surgical follow-up after bariatric surgery. This study compared nutrient supplementation as well as surgeon and primary care physician (PCP) follow-up between patients with short-term versus long-term follow-up.

Methods: All patients undergoing LRYGB at a single institution in 2004 (long-term group, n=281) and 2012-2013 (short-term group, n=149) were evaluated. Prospectively collected database, Electronic Medical Record (EMR) review and telephone survey were used to obtained follow-up for both cohorts. Multivariate logistic regression was used to assess factors independently predicting multivitamin use.

Results: Complete follow-up was achieved in 172 (61%) long-term and 107 (72%) short-term patients. We demonstrate a significant difference (p < 0.0001) in time since last surgeon follow-up (13.347.8 vs 86.9439.9 months) for the long-term group with no difference in PCP follow-up, (3.144.3 vs 3.743.4). Nutrient supplementation was higher in the short-term group, including multivitamin (70.3% vs 58.9%, p<0.05), iron (84.2% vs 67.1%, p=0.02) and calcium (49.5% vs 32.9%, p=0.01). After adjusting for interval since surgery, %EBMI, and current comorbidities logistic regression (c=0.797) demonstrated shorter time since last surgeon visit was independently predictive of multivitamin use (p=0.001).

Conclusion: While it appears patients prefer to follow-up with their PCP this study reveals a large disparity in malnutrition screening and nutrient supplementation following LRYGB. Therefore, implementation of multidisciplinary, best-practice guidelines to recognize and prevent malnutrition is paramount in the management of this growing population of high-risk patients.
Parallel Scientific Session IV - Quick Shots
QS7. VIRTUAL REALITY SIMULATION (VRS): BRINGING RESUSCITATIVE ENDOVASCULAR BALLOON OCCLUSION OF THE AORTA (REBOA) CLOSER TO THE POINT OF INJURY

Jason Pasley, DO
University of Maryland

Background: Resuscitative endovascular balloon occlusion of the aorta (REBOA) can temporize non-compressible torso and junctional hemorrhage in select patients. Smaller delivery systems and wire free devices may be more easily utilized at the point of injury by non-physician providers. We hypothesized that independent duty military medical technicians (IDMT), are able to learn and perform REBOA correctly and rapidly as assessed by VRS.

Methods: US Air Force IDMTs without prior endovascular experience were included. All subjects received didactic instruction and individual evaluation of technical skills by a trauma surgeon with formal training and clinical experience in REBOA. Procedural time was defined as the time between introducer sheath placement and balloon inflation. A pretest was administered prior to the didactic sessions, and posttest was administered after completion of all trials in order to detect improvements in knowledge. Time to complete trials was compared using paired t-tests. Likert scale was used to subjectively assess confidence before and after instruction.

Results: Seven IDMTs were enrolled. A significant decrease in procedural times was seen from Trial 1 to 6. Overall procedural time decreased from 159±18.9 seconds to 68±47.4 seconds (p<0.0001) resulting in a mean improvement of 90.3±420.5 seconds from the first to sixth trial. Mean difference in procedural time between trials was most marked after the second and third trials with a 33±26.1 and 31.3±37.3 second reduction in time between the trials (p=0.021 and 0.089, respectively). Time between Trial 5 and 6 fell significantly from 73.6±48.9 to 68.7±47.4 seconds (p=0.022). All participants demonstrated correct placement of the sheath, measurement and placement of the catheter, and inflation of the balloon throughout all 6 trials (100%). There was significant improvement in comprehension and knowledge between the pretest and posttest; average performance improved significantly from 33.7±649.3% to 67.8±44.5% (p=0.001). There was also subjective improvement in confidence from 0.71 to 4.0 out of 5 (p=0.0001).

Conclusion: Technology for aortic occlusion has advanced to provide smaller, wire free devices making field deployment more feasible. IDMTs can learn the steps required for REBOA and perform the procedure accurately and rapidly as assessed by VRS, but currently lack the skill set to perform percutaneous common femoral artery cannulation. As clinical data demonstrates, arterial access is a significant challenge in the ability to perform REBOA safely and rapidly, and should be a focus of further training in order to promote this procedure closer to the point of injury.
Parallel Scientific Session IV - Quick Shots

QS8. A DECADE OF SINGLE INCISION LAPAROSCOPY IN PEDIATRIC SURGERY TRAINING
Ilan Maizlin, MD
Children’s of Alabama

Background: Since its introduction in 2006, Single Incision Laparoscopic Surgery (SILS) has gained popularity as a potential alternative to conventional pediatric laparoscopic techniques. Our study aimed to assess the extent of SILS utilization among surgeons who undergo training in it during their pediatric surgery fellowships.

Methods: A survey was designed to query utilization of SILS in pediatric surgery cases as well as perceptions of the technique’s utility and applicability. It was sent to all pediatric surgeons that underwent clinical fellowship training in our facility over the last decade. All questions were composed of multiple-choice or 5-point Likert scales, analyzed by Friedman test.

Results: Seventy-five percent of fellows (N=22) responded to the survey, representing practices in 4 different countries. 73% of respondents indicated use of SILS in their practice and 60% reported frequent utilization (>10 procedures per month). An additional 7% intend to introduce the surgical system in the near future. The most common SILS surgeries were appendectomies (100%), cholecystectomies (91%), diagnostic laparoscopies (82%) and gynecological procedure (73%). Among surgeons not utilizing the SILS technique, most common reasons provided were lack of clear supportive evidence and increased intraoperative time as compared to traditional laparoscopic techniques. While only 31% of respondents believe SILS will replace conventional laparoscopy, 85% believe that it plays an important part in pediatric surgery education and all respondents (100%) consider there to be a future role for SILS in children. Moreover, 77% of respondents believe that SILS procedures result in improved cosmetic outcomes compared to traditional laparoscopy. Table 1 provides further perceptions on pediatric utilization of SILS.

Conclusion: A vast majority of practicing surgeons who received SILS training during their fellowship continue to utilize the technique. Most feel that it was an important part of their training and believe that it has a significant role in the future. As such, SILS should be an integral part of pediatric surgery fellowship curriculum.
Parallel Scientific Session V - Quick Shots

QS9. LAPAROSCOPIC DISTAL PANCREATECTOMY: AN 8 YEAR EXPERIENCE WITH THE CLOCKWISE TECHNIQUE
John Stauffer, MD
Mayo Clinic

Background: Laparoscopic distal pancreatectomy (LDP) has been shown to be feasible, safe, and in our prior studies, associated with some advantages over open distal pancreatectomy (ODP). This study reports the outcomes of LDP using a standardized approach over an 8 year time period.

Methods: From August 2008 to May 2016, 217 LPDs were performed by two surgeons using the same selection criteria, operative technique, and recovery protocols at a single institution. Demographics, operative data, and 90-day outcomes were extracted. The operative technique includes a 4-trocar approach with a clockwise exposure of the distal pancreas. Pancreatic transection was performed with a powered linear stapler with staple line reinforcement applied in a stepwise compression technique.

Results: Details are found in Table 1. Mean age and BMI were 63 and 28 respectively. A hand assist method and conversion to open was required in 12 (5.5%) and 11 (5.1%) respectively. Mean operative time and estimated blood loss was 188 minutes and 168 mL respectively. Splenectomy was utilized in 193 (88.9%) patients. Intraoperative drainage was used for 66 (30.4%) patients and decreased over the study time. Clinically relevant pancreatic fistula was noted in 11 (5.1%) patients and improved over the study time period. Reoperation and readmission rates were 1.4% and 9.2% respectively. 90-day major morbidity occurred in 22 (10.1%) including 1 (0.5%) mortality. Indications for LDP are given.

Conclusion: The clockwise technique for LDP is a standardized operation that results in low operative time and blood loss. Emphasis on a stepwise slow compression using a powered linear stapler with staple line reinforcement results in a very low pancreatic fistula rate that translates into low complication rates and a short hospital stay. Other studies are needed to validate if this technique can be applied by other surgeons and may result in improved outcomes for patients with pathology of the distal pancreas.
Background: Modern pre-anesthetic fasting is done with the intention of decreasing the risk of emesis and to prevent aspiration pneumonitis/pneumonia upon induction of general anesthesia. There is no consensus in the literature on the appropriate “nothing by mouth” interval in the already-intubated surgical population. This study was undertaken as a quality improvement initiative to quantify current institutional practice with regard to pre-operative fast durations and the caloric sequelae in intubated patients.

Methods: This IRB approved retrospective study, analyzed the caloric impact of variability in pre-anesthesia fasting upon adult patients receiving mechanical ventilation in the ICU. Utilizing the electronic medical record, the study population was comprised of mechanically ventilated surgical patients who underwent operation >24 hours from admission at a Level I Trauma Center, over a 15-month period from 2013 to 2015, yielding 132 procedures and 81 patients for analysis.

Results: 82 of the gastric-tube-fed patients undergoing non-emergent operations were fasted for longer than the American Society of Anesthesiologists guideline of six hours, with a concentration of patients fasted for 9-13 hours, and the longest preoperative fast lasting 22 hours. Among emergent cases, all but two (8.7%) were fasted for six hours or less. The median nutritional loss attributable to surgery was 35% of daily needs. No anesthesia complications were observed in any patient. Forty-three percent of cases failed to meet resumption of tube feeds with in 90 minute post op goal. The median time to resumption of feeds was 3.4 hours.

Conclusion: The vast majority of patients were affected by non-medical barriers to the delivery of optimal perioperative nutrition. These results suggest that shorter preoperative fasts may be safe and appropriate in the intubated population.
Parallel Scientific Session V - Quick Shots

QS11. INVESTIGATING THE POST-OPERATIVE CONVERSATION: HOW TO IMPROVE COMMUNICATION TO THE FAMILY WHILE ADDRESSING BARRIERS TO THE SURGEON?
Brandon Singletary, MPH
University of Alabama at Birmingham

**Background:** Perioperative communication between surgeons and family members is an important aspect of patient care, with the post-operative conversation (POC) being the best chance to transfer critical information and instruction. Literature and patient advocacy complaint data suggest that current POC practices may be suboptimal. Identifying barriers and opportunities for improvement could improve patient and family satisfaction and increase surgeon efficiency.

**Methods:** This mixed methods study included a prospective study of all patients undergoing a surgical procedure at an academic medical center between September 2014 and March 2016, and nominal groups of 13 surgeons, 35 families and 9 hospital waiting room personnel (WRP). Nominal group results were collated and ranked by sums of the average rating for each standards of care theme. Bivariate analyses measured differences in communication practice related to the POC.

**Results:** Data on 15,820 surgeon conducted POCs were analyzed across 19 surgical divisions in a predominantly White population (70.2%) with a mean age of 53 (SD 16.9) among elective (78.4%), inpatient (70.3%) procedures. The majority of POCs occurred via phone call (66.2%) to the lobby or consult room versus in-person, with spouses or immediate family members being the primary caregiver contacted (80.1%). The most important opportunities for improvement during nominal groups were regular updates according to caregivers, finding the family post-op according to surgeons and clear physician communication according to WRP.

**Conclusion:** To our knowledge, this is the most comprehensive study of the POC. Nominal groups identified effective communication as the top issue requiring intervention, with current communication practices exhibiting differences across a representative population. Results provide specific factors to consider for developing interventions aimed at improving the POC, with an emphasis on clear information provided to patient families and efficiency for the surgeon.
Parallel Scientific Session V - Quick Shots

QS12. OPERATIVE OUTCOMES AFTER OPEN ABDOMINAL WALL RECONSTRUCTION WITH RETROMUSCULAR MESH FIXATION USING FIBRIN GLUE VERSUS TRANSFASCIAL SUTURES

Adam Weltz, MD
Anne Arundel Medical Center

**Background:** The advantages of mesh to decrease recurrence rate after open abdominal wall reconstruction (AWR) have been documented. However, ideal fixation techniques have not been fully elucidated in literature. We examine operative outcomes after AWR with retromuscular mesh fixation using either fibrin glue (FG) or transfascial sutures (TS).

**Methods:** A retrospective review identified complex hernia patients that underwent open AWR with mesh between November 2012 and April 2016. Multivariate analysis adjusted for potentially confounding variables and examined postoperative complications between the two groups (FG vs. TS).

**Results:** Seventy-five patients (18 FG vs. 57 TS) with mean age (54.3 vs. 53.9 years, p=0.914), BMI (35.8 vs. 34.7 kg/m2, p=0.623) and ASA (2.6 vs. 2.5, p=0.617) were included. The majority of patients (77.8% F vs. 71.9% S) had a modified Ventral Hernia Working Group grade 2 or 3. Majority had prior ventral hernia repair (66.7 vs. 62.2%, p=0.787). Groups had comparable defect size (374.7 vs. 386.9 cm2, p=0.855), FG had larger mesh (1070 vs. 786.2 cm2, p=0.008). Operative time (262.1 vs. 237.2 mins, p=0.232) was equivalent. Overall wound related complications were significantly lower in the FG group (5.6% vs 33.3%, p=0.030), with lower rates of SSI (0% vs 5.2%), Seroma (0% vs 14.0%) and Wound Dehiscence (0% vs 14.0%). No hernia recurrences were noted in either group at an average of 180 +/- 126 days follow-up.

**Conclusion:** The use of fibrin glue fixation of mesh in the retromuscular location during complex open abdominal wall reconstruction appears to be associated with decrease in wound related complications as compared to transfascial fixation. Our results suggest that early hernia recurrence rates with wide retromuscular mesh overlap are unaffected by mesh fixation technique.
Parallel Scientific Session V - Quick Shots

QS13. THE IMPACT OF HEMODYNAMIC TRANSESOPHAGEAL ECHOCARDIOGRAPHY ON THE USE OF CONTINUOUS RENAL REPLACEMENT THERAPY IN TRAUMA
Madison Griffin, MD
Mercer University School of Medicine

Background: Post-traumatic fluid management is a widely debated topic lacking a best-practice consensus. Adverse outcomes such as AKI or volume overload (v.o.) are common and increase morbidity and mortality rates. CRRT is an adjunct therapy for ARF with electrolyte or acid-base imbalances and v.o. While effective, it is costly and not without risk. hTEE is widely accepted as a reliable, efficient way to monitor volume status and fluid responsiveness of ICU pts. While data exists evaluating hTEE and CRRT independently, there is a lack of research mutually inclusive of the two in the setting of trauma. We hypothesize that the use of hTEE in trauma reduces the need for CRRT by avoiding ARF and v.o. and is therefore more cost effective.

Methods: Retrospective review of a level I Trauma Center from 2009-2015 identified all pts requiring CRRT. In 2013, a protocol was started utilizing hTEE in trauma pts with certain resuscitation needs. We compared CRRT use in trauma pts before and after implementation (pre-and post-hTEE). We analyzed ISS and level of AKI per AKIN classification. Multivariate analysis was performed using two sample t-test and chi-squared test of the odds ratio (O.R.).

Results: 5037 trauma pts in the pre-hTEE group and 6699 in the post-hTEE group were evaluated. Mean ISS was 22 for both (p-value 0.19). Mean AKIN was 2.7 for both (p-value 0.99). 24 pts required CRRT pre-hTEE. 15 required CRRT post-hTEE (p-value 0.02, O.R. 2.1). The odds of CRRT pre-hTEE was 2x more likely.

Conclusion: We conclude that the use of hTEE is associated with a reduction of CRRT in our trauma patients. hTEE costs ~$33/day. CRRT costs ~$3000/day. Given the odds of CRRT without having used hTEE are twice that of CRRT when hTEE is used, hTEE is highly cost effective for assessment of volume status in our acutely ill trauma patients.
Parallel Scientific Session V - Quick Shots

QS15. CLASSIC SYMPTOMS OF HYPERPARATHYROIDISM ARE ASSOCIATED WITH INCREASED MORTALITY EVEN AFTER PARATHYROIDECTOMY

Snehal Patel, MD
Emory University

Background: Presentation of primary hyperparathyroidism (PHPT) has shifted from a classically symptomatic disease (renal stones, bone disease, pancreatitis, fractures, and psychiatric disease) to one of a milder clinical form (fatigue, GERD, headache, constipation, pruritus, and abdominal pain). Untreated PHPT correlates with increased mortality; however, there is a paucity of data on mortality outcomes after parathyroidectomy (PTx). In this study, we compared outcomes in mild and classic disease after PTx.

Methods: We identified 724 consecutive patients who underwent parathyroidectomy (1995-2005) for sporadic PHPT. 120 patients were excluded for missing data. Outcomes, demographics, and symptoms were maintained in an IRB approved prospective database. Kaplan Meier analysis was performed comparing survival in patients with and without classic symptoms of PHPT. Outcomes were estimated using multivariable Cox proportional hazard models to adjust for demographics, biochemical values, symptoms, and comorbidities.

Results: 604 patients were included in this analysis (318 with classic symptoms and 286 mild/asymptomatic). Overall cure rate was 98.9% with mean follow up of 8.7 ±3.6 years. Patients with classic symptoms at presentation had an increased risk of death compared to those with mild symptoms (age-adjusted HR [95%CI], 2.14[1.46-3.14]). Patients with two classic symptoms had a poorer outcome compared to patients with one or zero classic symptoms (15 year survival rates: 41%, 62% or 92%, respectively, p=0.002). In this study, the following were associated with poorer outcome: psychiatric disease, age, male sex, congestive heart failure and peripheral vascular disease (adjusted HR, 2.29 [1.43-3.66], 1.08 [1.06-1.10], 1.55 [1.02-2.35], 2.25 [1.27-3.97] and 2.64 [1.10-6.36], respectively).

Conclusion: Despite curative PTx, classically symptomatic patients have a two-fold increased risk of death compared to mild disease. With each increasing number of classic symptoms, survival is significantly decreased. Therefore, PTx is recommended prior to the onset of classic symptoms.
Parallel Scientific Session V - Quick Shots

QS16. SURGICAL OUTCOMES OF ROBOT-ASSISTED THYROIDECTOMY FOR THYROID CANCER; A 108 CASES ANALYSIS

Daniah Bu Ali, MD
Tulane University School of Medicine

**Background:** Recently, many studies reported the safety and feasibility of robot-assisted thyroidectomy, but most of these studies were performed in South Korea. Although there were several small series and case reports from the United States, most of these cases were for benign disease. The aim of our study is to report the safety and feasibility of robot assisted thyroidectomy for thyroid cancer in the western population.

**Methods:** Retrospective review of all patients who underwent robot-assisted thyroid surgery for thyroid cancer over the last 5 years, in two centers, one in France and one in USA. Those were compared to a control group who underwent conventional cervical approach at the same period. We analyzed demographic data, operative outcome and early oncologic outcome measures including; pathological margins and biochemical (TG level) or radiological evidence for recurrence.

**Results:** Total of 108 robotic cases and 233 conventional cervical operations were included. 28.70% of patients underwent central lymph node dissection and 9.26% had lateral neck dissection. The transaxillary approach was performed in 93.5% and the remaining underwent retroauricular approach. In the robotic cases, the mean age was 45.58±410.58 years and BMI was 26.09±446.47. The average nodule size was 2.05±41.5cm. The mean operative time was 161.1±455.99 minutes with 3 patients required conversion to conventional cervical approach. Complications were reported in 8(7.4%) patients including 1 hematoma, 3 seroma and 5 patients developed transient vocal cord paralysis. Two (1.92%) patients had focal positive margins and two (1.85%) developed recurrence 24 and 16 months following initial surgery. In comparison to patients who underwent open approach, the robotic approach had significantly longer operative time ( p<001). On the other hand, there was no significant difference in the overall complication rate ( p=0.15). The mean TG level was 0.16±40.4 in the robotic group compared to 0.6±40.1 in the conventional open group.

**Conclusion:** Robot-assisted thyroid surgery is a safe and feasible approach for managing selected group of patients with differentiated thyroid cancer in the western population, and is associated with good oncologic outcome comparable to the open conventional approach.
Video Interactive Session

V3. ROBOTIC RELEASE OF MEDIAN ARCUATE LIGAMENT SYNDROME
Sharona Ross, MD
Florida Hospital Tampa

**Background:** This video demonstrates a robotic release of median arcuate ligament undertaken in a 34 year old woman.

**Methods:** Patient presented with severe abdominal pain half an hour after ingestion of food weightloss of 20 lbs over the past 6 months. Patient was 97 lbs (BMI 17.92) at the time of her operation. Her workup including endoscopy, Upper GI series, contrast enhanced CT scan and Duplex Ultrasound which demonstrated a prominent stenosis of the celiac trunk with peak systolic velocities of above 350cm/s, highly suggestive of median arcuate ligament syndrome.

**Results:** Three robotic 8 mm trocars were placed, one in the umbilicus and the other two in the mid-clavicular line on either side of the umbilicus. An additional 5mm assistant port was placed in the left lower quadrant. The gastrohepatic ligament was opened in a stellate fashion. After the right crus of the diaphragm was dissected, the aorta was identified. The esophagus was retracted ventrally with the help of a Penrose drain. The dissection on the aorta was continued caudally. The right inferior phrenic artery was divided between clips. Once the median arcuate ligament was completely divided, the dissection was terminated at the origin of the celiac trunk.

**Conclusion:** The diaphragm was irrigated with bupivacaine solution and the trocar sites were closed with absorbable sutures. The patient was started on diet immediately, which she tolerated well.
Video Interactive Session
V4. LAPAROSCOPIC REDUCTION OF FORAMEN OF WINSLOW HERNIA
Robert Lyons, MD
Eastern Virginia Medical School

**Background:** Foramen of Winslow hernias are rare events and represent approximately 8% of internal hernias but only 0.1% of all abdominal hernias. The most common structures to herniate through this foramen are the small bowel, the cecum, ascending colon, transverse colon, and gallbladder. We discuss a patient who presented to the Emergency Department with a one-day history of right upper quadrant abdominal pain. Her laboratory work was significant for a transaminitis with an AST/ALT of 1145 and 986. Her imaging was significant for a Foramen of Winslow hernia.

**Methods:** Laparoscopic reduction of Foramen of Winslow hernia

**Results:** She underwent successful laparoscopic reduction of the hernia. Due to the large amount of cecum and small bowel that had herniated, a colotomy was required to decompress the cecum in order to reduce the contents back into normal anatomical position. Her significant transaminitis was caused by compression of the portal triad by the hernia contents, essentially a Pringle maneuver. The patient recovered without incident postoperatively and was discharged home on post operative day #3 tolerating regular diet and having full bowel function.

**Conclusion:** We present an unusual case of Foramen of Winslow hernia which initially presented as right upper quadrant pain with significant transaminitis. The diagnosis was made by axial imaging and confirmed during laparoscopy. Due to the large amount of hernia contents, a colotomy was required for successful reduction. This represents a novel way of reducing a Foramen of Winslow hernia laparoscopically.
Video Interactive Session

V5. VIDEO - LAPAROSCOPIC REPAIR OF A TRAUMATIC BLADDER RUPTURE
Bradley Thomas, MD
Carolinas Medical Center

Background: Bladder injury in trauma has an incidence of approximately 1.5%. Within this subset of patients, intraperitoneal bladder rupture (IBR) in blunt trauma occurs with relative frequency. The injury typically occurs at the dome of the bladder as it is the most mobile and largest area of the bladder, making it most likely to rupture with a sudden pressure increase. Traditionally, IBR is repaired through a midline laparotomy by trauma surgeons or urologic surgeons and subsequently treated with bladder drainage during the healing process.

Methods: Methods and Results: A 28-year-old female presented to our Level I trauma center after being struck by an automobile. She was hemodynamically stable throughout her primary and secondary trauma surveys. Physical exam elicited tenderness in the lower abdomen without peritoneal signs. FAST exam was indeterminate, and pelvis x-ray demonstrated pubic rami fractures. CT scan with a bladder delay demonstrated intraperitoneal bladder rupture. Laparoscopic abdominal exploration and bladder repair was subsequently performed within several hours following her admission.

Results: See METHODS

Conclusion: Conclusion: Laparoscopic bladder repair is a viable, safe, and less invasive alternative to laparotomy in the stable patient who is found to have IBR. In this case, follow-up outpatient cystogram demonstrated no leak and the Foley catheter was removed. Intracorporeal suturing techniques and the ability to perform a laparoscopic abdominal exploration are required skills.
Video Interactive Session
V6. ROBOTIC HELLER MYOTOMY
Scott Richardson, BS
Indiana University School of Medicine

Background: Robotic-assisted Heller myotomy (RAHM) is a safe alternative to laparoscopic Heller myotomy (LHM) and has been found to decrease the rate of intraoperative esophageal perforation that occurs in 5-10% of LHM. In this video we present a RAHM with Toupet fundoplication and hiatal hernia repair on a 63-year old female with progressive worsening dysphagia to solids and liquids. Her preoperative assessment included a barium swallow that showed a small hiatal hernia and was suggestive of achalasia, an EGD that revealed retained food in her esophagus, and a manometric evaluation that revealed lack of relaxation of her lower esophageal sphincter and aperistalsis of the esophagus.

Methods: For her operation 4 robotic arms and an additional 5 mm laparoscopic port were used. The esophagus was first dissected off the crura using a right to left approach and the small hiatal hernia was exposed. The esophagus was then mobilized inside the mediastinum to obtain adequate intraabdominal length of > 2 cm. The anterior vagus was dissected off the esophagus and preserved throughout the rest of the procedure. A long myotomy was then created approximately 8 cm on the esophagus and 2 cm on the stomach side using the robotic hook and judicious application of energy. The wide patency of the gastroesophageal junction was confirmed endoscopically after the myotomy had been completed. The small hiatal hernia was repaired loosely around the esophagus with one 0 Ethibond suture posteriorly and a Toupet fundoplication was created posteriorly to the esophagus and was attached to the cut ends of the esophageal muscle bilaterally.

Results: The procedure lasted 2 hours and no intraoperative complications were encountered. The patient had a hospital stay of one night and was discharged home the next day after she was able to eat without dysphagia. No post-operative complications or hiatal hernia were seen in the patient one-year post-operation.

Conclusion: RAMH provides a safe alternative to LHM. The enhanced 3D visualization, platform stability, and improved precision make the use of robotic surgery for complex foregut procedures appealing. Our experience with the procedure in 10 patients has been very positive with excellent outcomes so far.
Video Interactive Session

V7. ROBOTIC ASSISTED POSTERIOR ANTRAL GIST RESECTION
James W Rawles III, MD
New Hanover Regional Medical Center

**Background:** A 46 year old AA male was diagnosed with a 4 cm posterior wall antral GIST incidentally found on EGD for a workup of reflux symptoms. He underwent robotic assisted GIST resection via an anterior gastrotomy. Intraop EGD leak test was negative for leak as was fluoro UGI study on POD 1 at which time he was advanced to a liquid diet. He was discharged home on POD 3, tolerating a regular diet. He was feeling well at 2 week follow up, tolerating a regular diet with improvement in his reflux symptoms. Pathology confirmed GIST with low mitotic rate, tumor free margins, closest margin 1mm.
Video Interactive Session
V8. LAPAROSCOPIC EXTRACTION OF INTRALUMINAL MAGNETS IN A PEDIATRIC PATIENT
Todd Bierman, MD
University of South Alabama Medical Center

Background: Pediatric patients commonly ingest foreign bodies. The problem pediatric surgeons often face is when magnets are ingested which can result in enterotomies or fistula.

Methods: We were able to affectively remove magnets that were ingested, in a timely manner, without injury to bowel or need to make an enterotomy. This was accomplished by laparoscopically running the bowel using the metal instruments to advance the magnets to the rectum where they could be manually extracted.

Results: Successful removal of multiple intraluminal magnets without need for enterotomy or damage to the bowel.

Conclusion: We were able to find an affective alternative for the removal of ingested magnets in a pediatric patient.
Background: Regional lymphadenectomy is an attempt at regional control of metastatic melanoma. Traditionally, patients with lower extremity melanoma with +SLN undergo completion inguinal lymphadenectomy via an open, high-morbid groin incision. First described for genitourinary malignancies, videoscopic inguinal lymphadenectomy has shown to be feasible and oncologically comparable, yet with less wound morbidity compared to traditional open technique.2,3 Since, the technique has been adapted and became a minimally invasive alternative to open lymphadenectomy for regional metastatic melanoma to the inguinal nodal basin. This minimally invasive technique has been shown to offer comparable oncologic outcome while minimizing wound complication.4 Melanoma-specific dissection, however, contains subtle and oncologic important differences as compare to genitourinary malignancies. Techniques for melanoma-specific inguinal lymphadenectomy has been described in details by Martin et al.5 What is lacking in the literature is a video demonstration of this novel minimally invasive technique for regional control of inguinal metastatic melanoma.

Methods: Pertinent literature for videoscopic inguinal lymphadenectomy was reviewed and an edited video demonstration of the personal experience of our surgical oncologists’ techniques in performing the melanoma-specific videoscopic inguinal lymphadenectomy.

Results: Preliminary data has shown less wound complication, but with equal oncologic benefit to open surgery. The result of lymphedema is still the same.

Conclusion: Videoscopic inguinal lymphadenectomy offers a novel, safe, and comparable minimally invasive alternative to traditional, yet highly-morbid open inguinal lymphadenectomy in the management of regional metastatic melanoma.
Video Interactive Session

V10. LAPARO-ENDOSCOPIC SINGLE SITE (LESS) REDUCTION OF A GIANT HIATAL HERNIA WITH TOUPET FUNDOPICATION
Sharona Ross, MD
Florida Hospital Tampa

Background: This video demonstrates a Laparo-Endoscopic Single Site (LESSS) repair of a Type 4 Giant Hiatal Hernia with Toupet Fundoplication.

Methods: Local anesthesia was applied at the umbilicus and a 1.2 cm vertical incision was made over an existing anatomical scar. A SILS port was placed, pneumoperitoneum was established, and under videoscopic guidance, the liver was retracted. The hernia was reduced and the content included small bowel, omentum, transverse colon, splenic flexure of the colon, the entire stomach and the pancreas. The gastrohepatic ligament was taken down in a stellate fashion utilizing bipolar energy. 8cm of esophagus was brought to the peritoneal cavity. Posterior cruroplasty was undertaken in a running fashion, followed by an anterior cruroplasty to bring the left and right crura together to reduce potential tension. Utilizing a 50F bougie, we took attention to constructing the toupet fundoplication. 3 interrupted sutures were utilized to bring posterior fundus to the right side of the esophagus and 3 interrupted sutures to bring anterior fundus to the left side of the esophagus.

Results: Intraoperative EGD was undertaken which documented that the fundoplication was appropriately constructed at and above the GE junction. The posterior fundoplication was anchored to the esophagus and right crus and the anterior fundoplication was anchored to the left crus.

Conclusion: The diaphragm was irrigated with dilute bupivacaine solution to minimize postoperative pain. The umbilical defect was closed along anatomic layers and the skin was approximated with interrupted vicryl sutures and sterile dressing.
Video Interactive Session
V11. LAPAROSCOPIC MANAGEMENT OF GALLSTONE ILEUS
Yana Mikhaylov Schrank, MD
Medical University of South Carolina

Background: Although an unusual consequence of a cholelithiasis, gallstone ileus pertains a high chance of morbidity and mortality without a timely stone removal to minimize complications. Open surgery has been the mainstay of treatment, but laparoscopically assisted approach is becoming more common.

Methods: In this study we describe the case of a 64 year old woman who presented with gallstone ileus detail the technique of her surgery in a video-recording with a total laparoscopic enterotomy for stone extraction, transverse closure of the bowel in two layers with intracorporeal suturing, cholecystectomy, and repair of cholecystoenteric fistula along with review of the current literature.

Results: Patient tolerated the procedure without any complications.

Conclusion: As illustrated in this video, one-stage enterolithotomy with a concomitant cholecystectomy and fistula closure may be performed totally laparoscopically in a select patient population.
Parallel Scientific Session VI

16. CAN TUMOR BIOLOGY PREDICT OCCULT MULTIFOCAL DISEASE IN BREAST CANCER PATIENTS?
Anees B. Chagpar, MD, MSc, MPH, MA, MBA
Yale University

**Background:** Roughly 12% of breast cancer patients undergoing partial mastectomy (PM) who have negative (-) margins will be found to have further disease in cavity shave margins (CSM). We sought to determine if primary tumor markers could predict this phenomenon.

**Methods:** The SHAVE trial is a prospective randomized controlled trial in which 235 women with stage 0-3 disease undergoing PM were randomized intraoperatively to either have routine CSM taken at the time of initial surgery (n=119), or not (n=116). 76 patients had - margins prior to randomization to the “shave” group; 9 (11.8%) of these had occult cancers found in the CSM. 7 had sufficient tissue remaining for further analysis. These patients were age and stage matched in a 1:2 ratio to other patients in the trial who had no further disease found in their CSM (n=13; in one case only one control was identified). A tissue microarray (TMA) was created of the primary tumors. Two pathologists (blinded to final outcome of these patients) independently scored intensity and proportion of tumor stained for markers thought to potentially predict occult multifocal disease [E-cadherin (E), MUC-1 (M) and beta-catenin (B)].

**Results:** There were no significant differences between cases and controls in terms of median invasive tumor size (1.4 cm vs. 1.5 cm, p=1.00), DCIS size (1.9 cm vs. 0.65 cm, p=0.08), volume of initial resection (69.6 cm3 vs. 71.2 cm3, p=0.32), and volume of CSM (median 25.6 cm3 vs. 11.6 cm3, p=0.80). Staining intensity (scored as 0, 1+, 2+, 3+) did not vary significantly between cases and controls for E (p=0.26), M (p=0.31), and B (p=0.33); there was good inter-observer correlation for staining intensity for each of these markers (95%, 75% and 90%, for E, M and B, respectively). Similarly, no differences were noted between cases and controls for median [staining intensity x % cells staining] for each marker: E (180 vs. 180, p=0.59), M (160 vs. 140, p=0.82), and B (0 vs. 5, p=0.59).

**Conclusion:** Nearly 12% of breast cancer patients will have occult disease which can be found in CSM. Primary tumor markers could not predict this phenomenon in this study.
Parallel Scientific Session VI
17. MAMMOGRAPHIC SCREENING AT AGE 40 OR 45? WHAT DIFFERENCE DOES IT MAKE? THE POTENTIAL IMPACT OF AMERICAN CANCER SOCIETY MAMMOGRAPHY SCREENING GUIDELINES
Crystal Fancher, MD
Mercer University School of Medicine

**Background:** This is a 10-year retrospective chart review that evaluates the potential impact of the most recent American Cancer Society Mammography Screening Guidelines which no longer recommends annual screening mammography for patients aged 40-44 years. Instead they recommend screening mammography starts at age 45 with the option to begin screening earlier if the patient desires.

**Methods:** The cancer registry was systematically searched to identify all women aged 40-44 years treated for breast cancer over a 10 year period. These women were separated into 2 cohorts- screening mammography detected cancer (SMDC) and non-screening mammography detected cancer (NSMDC). Statistical analysis of the cohorts was performed for lymph node status (SLN), 5-year disease free survival, and 5-year overall survival.

**Results:** A total of 122 women between the ages of 40 and 44 years were treated for breast cancer over the last 10 years. 54 were SMDC and 68 were NSMDC. Women with SMDC had a significantly lower incidence of SLN positive cancer than the NSMDC group, 8 of 54 (14.8%) vs. 30 of 68 (44%; P < 0.001). The 5 year disease free survival for both groups was 83% for SMDC and 82% NSMDC, this was not statistically significant. The overall 5 year survival was statistically significant at 94% for the SMDC group and 78% for the NSMDC group (P < 0.05).

**Conclusion:** This review demonstrates the significance of mammographic screening for early detection and treatment of breast cancer. Mammographic screening in women aged 40-44 detected tumors with less nodal metastasis, resulting in improved survival, which supports annual mammographic screening in this age group.
Parallel Scientific Session VI
18. THE CLINICAL UTILITY AND COST OF POSTOPERATIVE MAMMOGRAPHY COMPLETED WITHIN ONE YEAR OF BREAST CONSERVING THERAPY: IS IT WORTH IT?
Ahkeel Allen, MD
Mercer University School of Medicine

Background: Breast conserving therapy (BCT), i.e. lumpectomy or segmental mastectomy followed by radiotherapy, is an effective treatment for a majority of breast cancers. According to the National Comprehensive Cancer Network, mammographic imaging should be completed at least six months following completion of radiation. This study evaluates the clinical significance and financial cost of postoperative breast imaging within one year of BCT.

Methods: Patients treated with BCT between 2014-2015 at an academic medical center were identified. Patients with invasive and noninvasive pathology who received post-operative mammogram less than one year after surgery were studied. This study evaluated the clinical significance and the cost of postoperative imaging.

Results: There were 128 patients who underwent BCT during this time period. Of these, 75 patients received mammograms 3-12 months following BCT. Six of the 75 postoperative mammograms required additional imaging and/or intervention for a total of 4 additional imaging studies and 4 procedures, all of which revealed benign findings. None of these patients had physical examination findings that were of clinical concern. Total cost of postoperative imaging and procedures performed less than one year following BCT was estimated $27,756-$31,506 at our institution.

Conclusion: Postoperative imaging performed on breast cancer patients less than one year after BCT proved to be of no medical benefit and revealed no additional significant pathology. The mammographic surveillance in this study did not lead to diagnosis of recurrent malignancy or second primary lesions and placed additional financial burden on the patient population. This study demonstrates that breast imaging within one year following BCT had no clinical impact and resulted in increased cost of care.
Parallel Scientific Session VI

19. THE SESTAMIBI PARADOX: IMPROVING INTRAOPERATIVE LOCALIZATION OF PARATHYROID ADENOMAS

Jessica Buicko, MD
University of Miami

**Background:** Accurate localization of parathyroid adenomas allows for minimally invasive parathyroidectomy. This results in a shorter length of stay and increased patient satisfaction. Preoperative sestamibi scans accurately localize parathyroid adenomas in 70-85% of cases. If a patient has a negative scan, one would think that with a preoperative sestamibi injection, the gamma probe may fail to help find an adenoma. We hypothesized that the gamma probe would not be useful intra-operatively on patients with primary hyperparathyroidism and a negative sestamibi scan.

**Methods:** We retrospectively reviewed the cases of parathyroidectomy at our institution from 2010-2016. We selected out patients with primary hyperparathyroidism and negative sestamibi scan. In all cases an attempt was made to find adenomas intraoperatively with the gamma probe. A frozen section was obtained as well as intraoperative parathyroid hormone levels (IOPTH) to confirm removal of hyperfunctioning parathyroid tissue.

**Results:** There were 132 parathyroidectomies of which 22 had primary hyperparathyroidism and a negative sestamibi scan. One case was excluded due to insufficient documentation of the intraoperative use of the gamma probe. In 19 of the 21 patients analyzed, the gamma probe successfully identified the adenoma in the operating room [sensitivity, 90.5%]. In two patients the gamma probe did not aid in localization. There were no false positives. In all cases, the parathyroid resected was confirmed by frozen section. The IOPTH levels dropped >50% in all but three cases, two of which corresponded to those cases where gamma probe did not help.

**Conclusion:** Even in patients with negative sestamibi scans, intraoperative use of the gamma probe after preoperative sestamibi injection is effective in localizing parathyroid adenomas.
Parallel Scientific Session VI

20. AN ANALYSIS OF FACTORS THAT PREDICT HOSPITAL READMISSION AFTER SURGERY FOR PERFORATED APPENDICITIS

Jeffanne Millien, MD
Ochsner Medical Institutions

Background: We performed this study to develop a better understanding of the issues leading to and the management strategies required for patients readmitted after appendectomy for perforated appendicitis.

Methods: We identified all patients undergoing surgery for appendicitis over the most recent five-year period. We excluded all patients with non-perforated appendicitis and all patients under 18 years of age. We defined perforated appendicitis based on the description in the operative dictation and did not rely exclusively on the pathology report. We recorded all demographic data, length of symptoms prior to the original hospital admission as well length of stay, vital signs on admit, laboratory findings, surgical approach, length of surgery, labs prior to discharge, time to readmission if necessary, length of readmission, and intervention required after readmission. We divided the cohort into two groups depending on whether the patient was readmitted. We used chi square analysis and student’s t test as appropriate to determine difference between the two groups.

Results: A total of 460 patients were identified, but once non-perforated cases and patients under 18 were excluded a total of 86 were left for analysis, with 14 (16.3%) requiring readmission. The only factors analyzed that predicted readmission were longer original appendectomy surgery \( (p=0.03) \) and open surgery \( (p=0.04) \). After readmission, only one patient required re-operation and two required percutaneous abscess drainage. The remaining 11 patients were admitted for a median of two days, received intravenous fluids, and required no additional clinically significant management.

Conclusion: Patients requiring open surgery are at an increased risk for hospital readmission after resection of a perforated appendix. If patients at risk for hospital readmission can be identified early, outpatient intravenous hydration may avoid the need for admission.
Parallel Scientific Session VI

21. DIFFERENCES IN THE MANAGEMENT OF PERFORATED APPENDICITIS IN CHILDREN BY RACE AND INSURANCE STATUS

Randi Lassiter, MD
Augusta University

Background: This study was conducted to assess whether race and socioeconomic status influence treatment of perforated appendicitis.

Methods: A retrospective analysis was performed of 136,994 non-elective pediatric admissions with a primary diagnosis of appendicitis using data from the 2001-2010 Nationwide Inpatient Sample (NIS). International Classification of Diseases 9 (ICD-9) codes were used to define perforated appendicitis. Surgery was defined as appendectomy or colorectal resection. Chi square and Student’s t-test were used to determine association between race, insurance status, median household income based on zip code, population size, surgery, percutaneous drainage, length of stay, and total charges.

Results: Overall, 41,718 (30.5%) patients were determined to have perforation and surgery was performed in 90.2% of these cases. Black children were less likely to have surgery (OR = 0.58) and more likely to undergo percutaneous drainage (OR = 1.68). Insurance status and estimated household income did not predict treatment with surgery or percutaneous drainage. Children from smaller counties with less than 50,000 people were more likely to undergo surgery than those from larger metropolitan areas (OR = 1.27). Minority children had longer lengths of stay (6.1 vs 5.2 days, p < 0.0001) and higher hospital charges ($36,249.73 vs $27,386.42, p <0.0001).

Conclusion: The overwhelming majority of patients are treated surgically during non-elective admissions. While previous studies have attributed racial disparities in outcomes for appendicitis to different rates of perforation and access to care, these findings demonstrate significantly dissimilar management strategies for patients with perforated appendicitis and warrant further investigation.
Background: We hypothesize that socioeconomic disparities are associated with increased risk of readmission within 90 days.

Methods: Patients who underwent deceased donor renal transplantation 2012 - 2015 were identified. Socioeconomic factors included median income, primary support person, distance to transplant center, payor status, employment status, disability status, race, education, and demographics. Other factors including KDPI, EPTS, dialysis duration, age, cold ischemic time (CIT), discharge creatinine, delayed graft function (DGF), and length of stay were included. Main outcome variable was readmission within 90 days. Univariable logistic regression was used to identify variables with meaningful association for inclusion in a multivariable model. Data is presented as odds ratio with 95% confidence intervals.

Results: 325 patients were identified. The overall readmission rate at 90 days was 36% (117/325). On univariable analysis, length of stay was significantly associated with readmission (median 5 (4-8) vs 4 (3-6)).77/225 (34%) of African Americans vs 40/100 (40%) Caucasian (+2 other) were readmitted (0.75, 0.46 - 1.23). Age was not significantly associated with readmission. Disabled status was associated with suggestion of higher likelihood of readmission (40.9% vs 29.5%;).KDPI, EPTS, age, payor status, and employment status had suggestions of association on univariable analysis and are included in the multivariable model. On multivariable analysis, there is a suggested association of length of stay (OR 1.06, p=0.065) and disabled status (OR 2.09, p=0.081).

Conclusion: In our study, length of stay and disabled status are suggested to be associated with readmission after transplant. Interestingly, other socioeconomic factors such as race, median income, EPTS and age were not predictive.
Parallel Scientific Session VII
23. UPPER EXTREMITY PREOPERATIVE PULSE PRESSURE PREDICTS AMPUTATION-FREE SURVIVAL AFTER LOWER EXTREMITY BYPASS
Eric Wise, MD
University of Maryland

Background: Increased pulse pressure reflects pathologic arterial stiffening and predicts cardiovascular events and mortality. We thus investigated whether preoperative pulse pressure could predict amputation-free survival (AFS) in patients undergoing lower extremity bypass for atherosclerotic occlusive disease.

Methods: An institutional database identified 240 bypass patients over ten years. Demographics, cardiovascular risk factors and operative factors were noted, and compared between patients with pulse pressures above and below 80 mmHg. Factors were then analyzed in bi- and multi-variable models to assess independent predictors of AFS. Kaplan-Meier analysis was performed to evaluate the temporal effect of pulse pressure >= 80 mmHg on AFS.

Results: Patients with pulse pressure >= 80 mm Hg were older and male. On bivariate analysis, factors associated with decreased AFS at six months included non-white race, infrapopliteal target, tissue loss and pulse pressure >= 80 mm Hg. At one year, non-white race lost its association but diabetes mellitus, chronic kidney disease, myocardial disease and CHF became significantly associated. Patients with pulse pressure < 80 mmHg demonstrated a survival advantage on Kaplan-Meier analysis at six months (log-rank P=.003) and one year (P=.005; Figure 1). In multivariable analysis, independent risk factors for decreased AFS at six months included non-white race, tissue loss, infrapopliteal target and pre-operative pulse pressure >= 80 mmHg (hazard ratio 2.60; P=.02), while only tissue loss and pulse pressure >= 80 mmHg (hazard ratio 2.30; P=.02) remained predictive at one year.

Conclusion: Increased pulse pressure is independently associated with decreased AFS in patients undergoing lower extremity bypass, though further efforts to characterize this relationship are needed.
Parallel Scientific Session VII

24. IN THE ERA OF 64-SLICE CT SCANNERS, DO BLUNT TRAUMA PATIENTS WITH CT MARKERS SIGNIFICANT FOR BLUNT BOWEL OR MESENTERIC INJURY REQUIRE EXPLORATORY LAPAROTOMY?

Katelyn Young, BS
Geisinger Medical Center

Background: Past studies have suggested that all blunt trauma patients with computed tomography (CT) evidence of abdominal free fluid without solid organ injury (SOI) should undergo emergent surgical exploration. However, in today’s era of thinly sliced CT, this adage may no longer be appropriate. This large, retrospective study aims to delineate the safety of observation in the absence of the clinical signs and symptoms of bowel injury.

Methods: This was a retrospective review of adult blunt trauma patients with trauma CT scans upon admission to a Level I trauma center between 2012 and 2014. Patients with CT evidence of acute blunt bowel or mesenteric injury without SOI were included.

Results: Two thousand blunt trauma cases were reviewed, and 102 patients (5.1%) met inclusion criteria. The average Injury Severity Score was 14.3 ± 10.3 and the median hospital stay was 4 days. The most common CT finding was free fluid (77 patients, 75.5%). The majority of patients (100, 98.0%) were managed without abdominal surgery during the index admission. One patient (0.98%) was readmitted after 32 days for abdominal pain and underwent exploratory laparotomy, which revealed a walled-off colonic perforation. The remaining 2 patients (1.96%) underwent exploratory laparotomy during their index admission with an average time of 36.2 hours from admission to exploration. The overt surgical indicators were compartment syndrome and worsening abdominal pain.

Conclusion: The majority of patients were effectively managed non-operatively. Those few patients in need of surgical intervention, however, were identified by serial abdominal exams demonstrating clinical decline. Thus, when CT reveals indicators for bowel or mesenteric injury without SOI, blunt trauma patients can be safely managed non-operatively with close observation.
Parallel Scientific Session VII
25. PHYSIOLOGIC FEATURES OF BRAIN DEATH
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University of Maryland School of Medicine

**Background:** Brain death is known to be associated with physiologic derangements but the incidence of these pathologies is poorly described. Precise knowledge of the physiologic disturbances that occur at the time of brain death is important for effective management of the potential organ donor thus we sought to characterize the pathophysiologic disturbances that occur at the time of brain death in patients with traumatic injuries.

**Methods:** All brain dead patients over a 10 year period were identified from the trauma registry at a level 1 urban trauma center. Patient demographics, injury characteristics, and clinical data for defining organ dysfunction were reviewed for the 24 hours surrounding brain death declaration.

**Results:** 273 patients were identified. Mean age was 38 years (41.7.4). 73% were male. Major mechanism of injury was motor vehicle collision in 33%, penetrating injury in 23% and falls in 21% of the patients. Median injury severity score was 33 (IQR 25-43) with a median head abbreviated injury scale score of 5. Patients were pronounced at a median of 24 hours (IQR 15.7-51.7) following admission. The most common physiological disturbance noted was hypotension with 93% of subjects requiring vasopressors. Thrombocytopenia and acidosis both had an incidence of 77% in the subjects. The next most common disturbances were hypothermia (<36°C) in 63% of the patients and moderate to severe respiratory dysfunction (PaO2/FiO2 <201) in 63% of subjects. Myocardial injury (serum troponin >0.02) was seen in 56% but only 5.7% of patients manifested severe cardiac dysfunction with an ejection fraction of <35% on echocardiography. Diabetes insipidus was diagnosed in 45% of patients. Interestingly, coagulopathy (INR >1.4) was noted in only 56% and hyperglycemia (glucose >200mg/dl) was seen in 31% despite widespread belief that these occur nearly universally in the setting of brain death.

**Conclusion:** This is the first and largest study to characterize the incidence of pathophysiologic disturbances following brain death in humans. Appropriate and anticipatory management of these dysfunctions are especially important for adequate support of potential brain dead organ donors.
Parallel Scientific Session VII
26. FAVORABLE OUTCOMES IN BLUNT CHEST INJURY WITH NON-INVASIVE BI-LEVEL POSITIVE AIRWAY PRESSURE VENTILATION (BIPAP)
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WakeMed Health & Hospitals

Background: Good clinical outcomes have been reported for severe blunt chest injury treated with surgical stabilization of rib fractures (SSRF). Non-operative care varies in these studies and is not standardized in practice. This study examines outcomes of blunt chest injury (BCI) patients treated with early bi-level positive airway pressure (BiPAP).

Methods: A retrospective study of adult BCI patients from a Level 1 Trauma Center from 2014-2015 was performed. Inclusion criteria were >= 3 rib fx and/or flail chest and BiPAP utilized as first line treatment for respiratory support. Outcomes included intensive care unit (ICU) length of stay (LOS), hospital (H) LOS, mortality, respiratory failure (need for intubation), pneumonia, and tracheostomy. Data were compared to published outcomes. Logistic and linear regressions were used to identify factors linked to poor outcomes.

Results: Relative to published results with SSRF, the BiPAP sample had shorter HLOS, as well as lower rates of pneumonia, tracheostomy, and respiratory failure. This pattern remained consistent in a more severe subgroup of BiPAP-treated patients (ISS >= 15). In our sample, longer ICU LOS was predicted by bilateral rib fx (? = 5.4, p=.001) and older age (?=.12, p=.017), while HLOS was predicted only by bilateral injury (? = 6.4, p=.002). Respiratory failure was associated with presence of pneumothorax (? = 1.79, p=.023).

Conclusion: Comparable outcomes to SSRF may be obtained when BCI is treated with early initiation of BiPAP. Further research is needed to determine the role of SSRF and the use of BiPAP in patients admitted with mechanical ventilation. Pneumothorax, bilateral rib fx, and older age predict poor outcomes in BiPAP patients. The study is limited by its retrospective nature, and the lack of pulmonary function measures.
Parallel Scientific Session VII

27. PREDICTORS OF SURVIVAL AFTER DECOMPRESSIVE CRANIECTOMY
Abid Khan, MD
Loyola University Medical Center

Background: The benefit of decompressive craniectomy (DC) for severe traumatic brain injury (STBI) remains controversial. DC reduces intracranial pressure and many patients can achieve good long term functional recovery. The purpose of this study was to identify factors that predict survival and improved functional outcome in patients who undergo DC for STBI.

Methods: A retrospective review of STBI patients who underwent DC was performed at two Level 1 Trauma Centers during the 36-month period from 1/2010-12/2013. Head injuries were managed per Brain Trauma Foundation guidelines. Data collected included patient demographics, mortality, Injury Severity Score (ISS), Glasgow Coma Scores (GCS), post-DC intracranial pressure (ICP), time from admission to DC, and Extended Glasgow Outcome Score (eGOS).

Results: Forty-eight STBI patients were treated with DC during the study period. Thirty (63%) patients survived and 18 (37%) expired. The average initial ISS for survivors was 26.1 versus 34.8 for mortalities (p= 0.027). The average admission GCS of survivors was 7.1 and 4.0 for mortalities (p=0.01). The overall average time to DC was 49.4 hours for survivors and 13.0 hours for mortalities (p=0.02). The average post-decompressive craniectomy ICP for survivors was 12.8 mm Hg versus 36.5 mm Hg for mortalities (p=0.001). 15 (50%) survivors had eGOS of 5-8 at discharge signifying moderate to good neurologic outcome.

Conclusion: Factors associated with improved survival in patients with STBI who require DC include a lower admission ISS, higher admission GCS and lower post-decompressive craniectomy ICP. Additionally, improved survival is associated with longer time from admission to DC and longer duration of non-operative management prior to DC. Many STBI patients who survive DC have good overall functional outcome at discharge.
Parallel Scientific Session VII

28. CHEST TUBE REMOVAL IN SIMPLE PNEUMOTHORAX: DOES WATER-SEAL DURATION MATTER?
Lindsay Bridges, MD
East Carolina University

Background: Timing of chest tube removal after transition from suction to water-seal (WS) varies when treating traumatic simple pneumothoraces (PTXs). Longer periods of WS may identify slow occurring PTXs reducing chest tube replacement, while shorter periods may expedite patient disposition and have associated cost savings. Prior studies support the need for an interval of WS. Our aim was to compare durations of WS, looking at rates of recurrent PTX and chest tube reinsertion.

Methods: A 10-year retrospective review was performed. Trauma patients with a simple PTX requiring a chest tube were selected. WS duration of 1-8 hours (short group- SG) vs 18-36 hours (long group -LG) were compared. Durations outside of these common practice patterns were excluded. Univariate analysis and multivariate logistic regression were utilized.

Results: Of 2000 patient charts reviewed, 209 met criteria with 43 in the SG and 166 in the LG. Patient demographics and MOI were similar. Univariate analysis revealed total decreased chest tube time in the SG (47.145.8 hrs vs 69.642.9 hrs, p .0008) and a trend towards less hospital days within the SG (5.6 days vs. 8.4 days, p .06). There was no difference in chest tube replacement (6.9% (SG) vs. 4.8% (LG), p .59). Logistic regression revealed an increase in chest tube replacement if the patient ever had positive pressure ventilation (PPV) (OR 4.1, CI 1.1-17, p .04) and if the patient returned to suction from water-seal (OR 6.3, CI 1.2- 28, p .03).

Conclusion: Short intervals of WS do not lead to increased recurrent PTX or chest tube reinsertion. PPV and return to suction from WS increase the risk for chest tube reinsertion. Providers may adopt a short interval of WS to decrease total chest tube time, the morbidity and distress associated with the chest tube and length of stay/cost.
Parallel Scientific Session VII
29. MEDICATION VARIANCES IN INJURED PATIENTS
Scott Dolejs, MD
Indiana University School of Medicine

Background: Trauma patients are particularly vulnerable to medication error given multiple patient handoffs throughout various hospital units. The purpose of this study was to assess trends in medication errors in trauma patients and the role these errors play in patient outcomes.

Methods: Injured adults admitted from January, 2009 to September, 2015 to a level I trauma center were included. Medication variances were determined based on a nurse driven, validated and widely utilized self-reporting system that is graded from A (low level) to F (high level). Errors of grade C or higher were included. Multivariable logistic regression modeling was used to control for differences between groups.

Results: Among 15,635 injured adults admitted during the study period, 132 patients experienced 243 variances. Variances occurred most regularly in the intensive care unit (ICU) (50.2%) and floor (42.8%) and rarely in the emergency department (6.2%) or operating room (0.8%). Patients who experienced errors had significantly worse injury severity, lower Glasgow Coma Scale scores, higher rates of hypotension, and longer length of stay and ICU days. Prior to adjustment, mortality was similar between groups but morbidity was higher in the medication error group. After risk adjustment, the medication error group had a trend towards decreased mortality with no difference in morbidity.

Conclusion: Medication errors are rare. They tend to occur in significantly injured patients with long hospital stays. After risk adjustment, the lack of morbidity and mortality differences is surprising given the prevalence of literature regarding an association of increased mortality and medication errors. Appropriate adjustment for case mix and for length of stay are important for appropriate reporting of medication errors in trauma patients.
Background: Robotic surgery (RS) is a novel treatment for rectal cancer resection (RCR); however, this technology is not widely accessible. The objective of this study is to evaluate the utilization of RS in RCR compared to open and laparoscopic techniques and to assess the quality of resection.

Methods: RCR from 2010 to 2012 were identified using the National Cancer Database (NCDB) and were placed into categories: open, laparoscopic and robotic.

Results: 23,857 patients who received open, laparoscopic and robotic RCR were included (n = 14,735 (61.8%); 7,185 (30.1%); 1,937 (8.1%) respectively). Over the 3 year period, robotic RCR increased from 5 to 11%; laparoscopic resections increased from 27 to 33% while open resections decreased from 68% to 55% (p < 0.001). Patients over 70 had a lower likelihood of having robotic RCR. Patients with insurance were two times more likely to have robotic RCR compared to the uninsured (OR 2.16; 95% CI: 1.61-2.89). Patients treated at an academic/research program were more likely to undergo RS compared to a community cancer program (OR 3.6; CI: 2.75-4.71). There was no difference in regional nodes examined using robotic (15.4 ± 6.8) compared to laparoscopic technique (15.3 ±10.1) (p = 0.752). Length of stay (LOS) was longer in open (7.9 ± 7.1) versus laparoscopic (6.6 ± 6.3) or robotic (6.8 ± 6.4) RCR (p < 0.0001). While there was an increased likelihood of positive surgical margins with open RCR (OR 1.3; 95% CI 1.059 - 1.61), there was no difference in robotic and laparoscopic techniques.

Conclusion: Younger insured patients at academic/research affiliated hospitals have a higher likelihood of receiving robotic RCR. Compared with open RCR, robotic RCR have a lower likelihood of positive surgical margins and shorter LOS.
Scientific Session VIII
31. FACTORS ASSOCIATED WITH GRADE FOR GASTROENTEROPANCREATIC NEUROENDOCRINE TUMOR (GEP-NET): LOCATION, LOCATION, LOCATION
Catalina Mosquera, MD
East Carolina University

Background: GEP-NETs are rare and abstruse neoplasms with increasing incidence and clinical relevance.

Methods: The NCDB was examined to identify GEP-NET cases from 2004 to 2013.

Results: In total, 39,454 GEP-NET patients were identified. Median age was 61 years. The majority of patients were female (50.13%), white (79.49%), and low-grade (84.39%). On univariate analysis, age, sex, race, primary site, tumor size, regional lymph node (RLN) involvement, and TNM pathologic stage were associated with tumor grade (p<.0001). On multivariate analysis, older age (OR 9.57, 95% CI 8.13-11.34), sex (male, OR 1.29, 95% CI 1.21-1.37), and race (black, OR 0.59, 95% CI 0.53-0.65; other, OR 0.71, 95% CI 0.62-0.82) continued to be associated with high-grade neoplasms (HGN). The primary site also remained a significant predictor of tumor grade. HGNs were less likely to arise in the small intestine (Referent), pancreas (OR 5.34, 95% CI 4.79-5.96), and appendix (OR 5.41, 95% CI 4.56-6.39); but more likely to arise in the esophagus (OR 317.75, 95% CI 219.27-477.51), hepatobiliary (OR 23.15, 95% CI 19.44-27.59), colorectum (OR 14.37, 95% CI 12.98-15.94), ampulla of Vater (OR 11.61, 95% CI 9.03-14.83), and stomach (OR 7.84, 95% CI 6.91-8.89).

Conclusion: The variation of tumor grade for GEP-NETs is highly dependent on the primary site, suggesting these may be biologically distinct diseases. A personalized approach to treatment, tailored to the site of origin, is imperative.
Scientific Session VIII
32. ESOPHAGEAL PERFORATION: A COMMON CLINICAL PROBLEM WITH MANY DIFFERENT MANAGEMENT OPTIONS
Lloyd Felmly, MD
Medical University of South Carolina

Background: Esophageal perforations represent a complex healthcare issue. We report the results of treating 61 consecutive patients who suffered, or were presumed to have suffered, an esophageal perforation.

Methods: With IRB approval, we performed a retrospective review of admissions to the thoracic surgical service over the last six years for patients presumed to have suffered an esophageal perforation.

Results: Between August 2010 and May 2016, 61 patients were treated, or observed, following admission for esophageal perforation at the Medical University of South Carolina (Table 1). Median patient age was 57 but patients treated with observation were much younger. The etiology of the injury was spontaneous (i.e. Boerhaave's) in 56%, iatrogenic in 38%, and malignant in 5%. Perforations occurred along the length of the esophagus but were predominantly distal (49%). Approximate time from injury to admission or treatment was less than 24 hours in 41% of patients, 24-48 hours in 15%, and greater than 48 hours in 25%. The most common methods of intervention consisted of primary repair (38%), esophageal stenting (21%), and drainage (20%). The last approach was commonly utilized for cervical perforations; while T-tube drainage was applied in the chest (n=2). Twelve patients were initially managed non-operatively with only one requiring subsequent surgical intervention. Ten patients required additional operations, two patients who were initially stented required dilation, and overall mortality was 8%.

Conclusion: Esophageal perforations continue to be a common problem faced by thoracic and general surgeons alike. As this abstract demonstrates, the application of different methods of management can produce acceptable clinical outcomes.
Scientific Session VIII
33. PNEUMATOSIS INTESTINALIS IN PATIENTS RECEIVING TUBE FEEDS
Alex Cavalea, MD
University of Tennessee Medical Center

Background: Pneumatosis intestinalis (PI) identified on computed tomography (CT) can suggest concerning underlying pathology. Patients requiring tube feeds can develop PI often requiring consideration for intervention. We sought to identify predictive clinical factors to determine those that are safe to observe versus those that need immediate intervention.

Methods: A retrospective review was performed from 2008 to 2016 with CT findings of PI and an enteric feeding tube. Patients who had not received tube feeds within 1 week of the CT were excluded. We analyzed clinical and CT findings to differentiate a benign outcome from a pathologic clinical course. Statistical analysis was performed to determine significance.

Results: 40 patients who developed PI in the presence of tube feeding were identified. Of these, 24 were categorized as benign and 16 as pathologic. Characteristics demonstrating significance for a pathologic outcome included the presence of free fluid on CT (OR 5.00, 95% CI 1.23 - 20.30, p=0.02), BUN elevation (OR 4.67, 95% CI 1.14 - 19.07, p=0.03), Cr elevation (OR 4.63, 95% CI 1.14 - 18.75, p=0.03), BUN/Cr ratio >30 (OR 8.57, 95% CI 1.79 - 40.98, p=0.006), and the presence of emesis or feeding intolerance (OR 9.38, 95% CI 1.64 - 53.62, p=0.008). A trend towards benign was seen with bowel function within 24 hours of the CT (p=0.13). Exam findings of peritonitis were only seen in pathologic states (p=0.06).

Conclusion: The presence of free fluid on CT, BUN and Cr elevation, BUN/Cr >30, and emesis or feeding intolerance were predictive of a pathologic etiology of PI. Bowel function within 24h of the CT scan suggested a benign etiology, whereas an exam concerning for peritonitis suggested underlying pathology. These clinical factors can assist with determining necessity of operation.
Scientific Session VIII
34. PRESENTING STAGE IN COLON CANCER IS ASSOCIATED WITH INSURANCE STATUS
James Lawrence, MD
Mercer University School of Medicine

Background: Colorectal cancer is the second most common cause of cancer death in the United States and is felt largely to be a preventable disease. Access to healthcare is also a nationwide problem. The purpose of the current study is to compare insurance status with stage of colon cancer at presentation.

Methods: The tumor registry at The Medical Center, Navicent Health was queried for all patient with colon cancer from 2009-2014. Chi-square tests were conducted to determine if differences in stage as well as demographic characteristics differed by insurance status.

Results: There were 434 patients identified that underwent colonic resection during the study period. 224 were female and 210 were male. Of the 434 patients, 388 were insured and 46 were uninsured. When insurance status was compared to tumor grade, there was no difference between the two groups (p=0.77). However, when insurance status was compared with stage at diagnosis there was a statistically significant difference between the two groups. For patients that were uninsured, 13.01% presented with stage I disease, 15.22% with stage II disease, 34.78% with stage III disease, and 36.96 with stage IV disease. For insured patients, 24.03% present with stage I disease, 26.10 with stage II disease, 23.26% with stage III disease, and 29.61% with stage IV disease (p=0.047).

Conclusion: Access to healthcare continues to be a large problem. Patients that are uninsured appear to present with a higher stage of disease compared to patient that are insured, and this may be due to limited access to healthcare and screening colonoscopy.
Scientific Session VIII
35. OUTCOMES AFTER MASTECTOMY AND LUMPECTOMY IN OCTOGENARIANS WITH EARLY STAGE BREAST CANCER
Amelia Merrill, MD
Wake Forest School of Medicine

Background: Prospective studies have shown equal outcomes after mastectomy or breast conservation in patients with invasive breast cancer. We sought to analyze the treatment and survival in octogenarians with breast cancer.

Methods: Patients in their 80s with clinical stage 0-2 breast cancer, undergoing mastectomy or lumpectomy with or without radiation were identified from the prospective SLN database at Wake Forest Baptist Health.

Results: Of 99 patients, twenty-six (26.26%) underwent mastectomy, 24 (24%) underwent lumpectomy with radiation, and 49 (49%) underwent a lumpectomy alone. Significant differences were noted in tumor size, stage (p=0.0044), and positive lymph node (p=0.0195) between the three groups. Only 9% of the patients had chemotherapy, while 51% took tamoxifen or an aromatase inhibitor. Recurrence was noted in 11 patients. On univariate analysis, overall survival did not differ in patients undergoing lumpectomy with radiation, mastectomy, or lumpectomy alone. As patients became older, their risk of death increased (HR=1.187, p=0.0276). Patients who had a positive sentinel lymph node, an axillary dissection, or large tumor size also had an increased risk of death.

Conclusion: Octogenarians with early stage breast cancer undergoing breast-conserving surgery with or without radiation have equivalent survival to patients having a mastectomy. Survival is dependent on tumor factors and lymph node involvement in this age group. Lymph node evaluation is important in treating octogenarian breast cancer patients.
Scientific Session VIII
36. TUMOR MITOTIC RATE AND ASSOCIATION WITH RECURRENCE IN SENTINEL LYMPH NODE NEGATIVE STAGE II MELANOMA
Shachar Laks, MD
University of North Carolina

Background: Tumor mitotic rate (TMR) is a well-accepted prognostic variable in thin melanoma. Its significance in predicting recurrence in Stage II melanoma patients has yet to be clearly demonstrated.

Methods: Retrospective analysis of a prospectively collected IRB-approved single institution database of cutaneous melanoma patients treated from 9/1997-7/2015. All patients with stage II melanoma, documented TMR, and at least 6 months of follow up were included (median follow-up of survivors 4.2 years). Associations of clinical and pathologic variables with Overall Survival (OS) and Recurrence Free Survival (RFS) were evaluated using Cox regression, with hazard ratios and 95% confidence intervals reported.

Results: Two hundred and eighty patients were included. Patient and tumor characteristics are listed in Table 1. 84 (30%) patients developed recurrence during our follow-up period, and 152 (54.3%) patients were alive without evidence of disease at last follow-up. Initial recurrences included 5 local, 41 regional, and 38 distant. Ulceration (HR 1.6 (1.07-2.49)), T stage (HR 1.5 (1.12-2.04)), and Breslow (HR 1.09, 1.02-1.16) were associated with worse OS. Dichotomized TMR (>=1 vs <1, HR 1.36 (0.76-2.44) was not associated with OS, but TMR as a continuous variable was (HR-1.02 (1.003-1.045)). Continuous TMR was also associated with worsening RFS (HR-1.03 (1.008-1.045)). Those with an initial locoregional recurrence were more likely to have a higher median TMR than those with a distant recurrence (4.6 vs. 2.5, p=0.04).

Conclusion: TMR as a continuous variable, along with increasing depth of tumor and ulceration, is associated with increasing risk of recurrence in stage II melanoma. This may be beneficial in selecting surveillance regimens for this disparate patient population.
Scientific Session VIII
37. COMPARISON OF THERAPEUTIC BENEFIT OF BUPIVACAINE HCL TRANSVERSUS ABDOMINIS PLANE BLOCKS AS PART OF AN ENHANCED RECOVERY PATHWAY VS. TRADITIONAL ORAL AND INTRAVENOUS PAIN CONTROL AFTER ELECTIVE MINIMALLY INVASIVE COLORECTAL SURGERY

Elizabeth Lax, MD
Providence Hospital

Background: Enhanced Recovery Pathways (ERPs), when combined with transversus abdominis plane (TAP) blocks, have been proven to reduce length of stay (LOS) and improve quality outcomes. Non-opioid pain management is an essential component of this pathway, leading to a reduction in immobility, post-operative ileus, and an increase in patient satisfaction. TAP block variations have been studied in general surgery and gynecology. This study evaluates the effectiveness of laparoscopic TAP blocks in conjunction with the benefit of an ERP.

Methods: One-hundred and twenty-five consecutive laparoscopic and robotic-assisted colorectal surgery patients received TAP blocks under laparoscopic guidance while under anesthesia; they were blindly randomized to a placebo, bupivacaine TAP block, or bupivacaine TAP block with ERP arm of the trial. Patient demographics, operative techniques and postoperative outcomes were analyzed using statistical analysis software. Our main objective was to determine the short term benefits of the TAP blocks on reducing post-operative pain and total medication consumption. Secondary objectives included effects of TAP blocks on time to ambulation, time to return of bowel function and LOS. In order to isolate the effect of the TAP blocks, no efforts were made to control nursing or patient education.

Results: Of 125 patients, 14 were withdrawn. All cases were elective, with the main diagnosis colon cancer or dysplastic polyps (53%). In each group, the median age 65 and percentage of females (61%) were comparable. Most procedures were segmental colon resections (90%). Thirty-one patients received a placebo, 41 bupivacaine TAP, and 39 bupivacaine TAP plus ERP. In terms of primary endpoints, the bupivacaine plus ERP arm used significantly less IV hydromorphone on postoperative day #1 (p=0.037). All patients ambulated on average within the first 24 hours postoperatively, but the TAP plus ERP group ambulated approximately 0.5 days sooner (p=0.001). The TAP plus ERP group also had a return of bowel function (p=0.001) and LOS (p =0.011) approximately 24 hours earlier. A trend for less narcotic usage was seen in the TAP plus ERP group, but this difference was not statistically significant (Placebo [9.0 mg] vs. TAP [9.0 mg] vs. TAP + ERP [5.1 mg], p=0.081)

Conclusion: This study shows that laparoscopically-placed bupivacaine TAP blocks, when used as part of an ERP, can reduce post-operative narcotic use, time to ambulation, time of bowel function return and LOS. Defined pain regimens with auxiliary staff teaching can add to the improvement in quality outcomes in laparoscopic colorectal surgery, and with the addition of the TAP block, can add to patient satisfaction and lower hospital costs.
ePOSTERS
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SUNDAY, FEBRUARY 26, 2017 — STATION # 1

SUNDAY, FEBRUARY 26, 2017

ePoster Station # 1 | Trauma

3. EARLY ONSET MASSIVE PULMONARY EMBOLISM FOLLOWING PENETRATING TRAUMA IN THE ABSENCE OF DEEP VEIN THROMBOSIS
Christopher Nauser MD
Emory University

4. HELMETS MATTER: KENTUCKY ALL-TERRAIN VEHICLE ACCIDENTS SEEN AT A TENNESSEE TRAUMA CENTER
Daniel Prior DO
East Tennessee State University

5. WHEN YOU HEAR HOOFBEATS, SOMETIMES IT IS A ZEBRA
Jacob Carlson MD
University of Arkansas for Medical Sciences

6. SOFT TISSUE MALIGNANCY DUE TO LONG STANDING FOREIGN BODIES AFTER SHOTGUN BLAST
Emily Pospiech MD
University of Tennessee Medical Center, Knoxville

13. SEATBELT SIGN AS A PREDICTOR OF PLACENTAL ABRUPTION
Brett Tracy MD
Memorial University Medical Center

14. ILIAC ARTERY BULLET EMBOLUS FOLLOWING THORACIC BALLISTIC INJURY
Kevin Treto MD
Orlando Regional Medical Center

15. BULLET EMBOLISM TO THE HEART FOLLOWING ABDOMINAL GUNSHOT WOUND WITH INFERIOR VENA CAVA INJURY
Andrew Loudon MD
Orlando Regional Medical Center
16. MANAGEMENT OF INFERIOR VENA CAVA FILTER MIGRATION TO THE RIGHT VENTRICLE
Indermeet Bhullar MD
Orlando Regional Medical Center

19. RISK FACTORS OF CONTRAST INDUCED NEPHROPATHY IN ELDERLY BLUNT TRAUMA PATIENTS
Mboutidem Etokakpan MD
Geisinger Medical Center

23. FOLLOW UP OF VENOUS BULLET EMBOLIZATION PATIENTS: A CASE SERIES AND REVIEW OF LITERATURE
Brian Sparkman MD, MS
University of Mississippi

25. TRAUMATIC ARTERIOVESICAL FISTULA FROM THE EXTERNAL ILIAC ARTERY FOLLOWING GUNSHOT WOUND TO THE PELVIS: A CASE STUDY
Ashley Williams
Augusta University

29. RELATIVE MORTALITY ANALYSIS OF TRAUMA PATIENTS REQUIRING EMERGENCY SURGERY AT A LEVEL 1 TRAUMA CENTER
Christopher Cramer BS
University of Virginia

31. THE EVOLUTION OF TRAUMA CARE: RELATIVE MORTALITY ANALYSIS AT A LEVEL 1 TRAUMA CENTER OVER TIME
Michael Luu BA
University of Virginia Health System

32. CLINICAL CHARACTERISTICS OF TRAUMA PATIENTS REQUIRING STEROID TREATMENT FOR REFRACTORY HYPOTENSION
Gina Kim BA
University of Virginia Health System
38. CRACKING CHESTS WITHOUT A SCRATCH: A TEN YEAR REVIEW OF EMERGENCY DEPARTMENT THORACOTOMY OUTCOMES AND INJURIES TO PROVIDERS AT A LEVEL II TRAUMA CENTER
Sarah Fox MD
New Hanover Regional Medical Center

39. USE OF QUIKCLOT HEMOSTATIC PADS IN ABDOMINAL TRAUMA: EXPERIENCE AT A LEVEL 1 TRAUMA CENTER
Stephanie Goldberg MD
Virginia Commonwealth University

47. CASE REPORT: LARGE DUODENAL HEMATOMA RESOLVED WITH NON-OPERATIVE MANAGEMENT IN THE SETTING OF BLUNT TRAUMA
Elizabeth Long MD
University of South Alabama

50. DEGLOVING HAND INJURY AND RECONSTRUCTION IN RURAL AFGHANISTAN
Michael Walters MD
Orlando Regional Medical Center
ePoster Station # 2 | Trauma II

53. FOREQUARTER AMPUTATION TO TREAT NECROTIZING FASCIITIS FOLLOWING MINOR MUSCULOSKELETAL TRAUMA
Pallavi Kumbla MD
University of Arkansas for Medical Sciences

56. CHANGING THE LANDSCAPE OF INJURY PREVENTION: GEOSPATIAL ANALYSIS FOR TRAUMA
Christopher McLaughlin BS
Virginia Tech Carilion School of Medicine

64. ACTIVATED PROTHROMBIN COMPLEX VS. FRESH FROZEN PLASMA FOR WARFARIN REVERSAL PRIOR TO OPERATIVE INTERVENTION FOR TRAUMATIC BRAIN INJURY
Indermeet Bhullar MD
Orlando Regional Medical Center

68. A MULTI-SITE INJURY SURVEILLANCE PROJECT IN HAITI: IMPLEMENTATION AND FEASIBILITY OF A PROVIDER-BASED REGISTRY
Martha-Conley Ingram MD, MPH
Emory University

69. DOES GERONTOLOGY IN ELDERLY TRAUMA IMPROVE OUTCOMES?
Christine Ramirez MD
R. Adams Cowley Shock Trauma Center, University of Maryland Medical Center

73. ANALYSIS OF CT SCAN COMPLETION TIMES DURING TRAUMA WORKUP: A REALITY CHECK OR MYTH BUSTERS?
Morgan Lane MD
Grand Strand Medical Center/University of South Carolina

76. PREINJURY ASPIRIN USE AND ELDERLY FALLS: DOES PREDICTABILITY EXIST WITH INTRACRANIAL HEMORRHAGE?
Brant Clatterbuck MD
Grand Strand Medical Center/University of South Carolina
78. A REVIEW OF TEN YEARS OF DOG BITES PRESENTING TO A LEVEL II TRAUMA CENTER
Sarah Fox MD
New Hanover Regional Medical Center

79. MOPED COLLISIONS: LOW SPEED, HIGH IMPACT-A SINGLE CENTER REVIEW
Jennifer Wentzel MD, MS
Grand Strand Medical Center/University of South Carolina

86. TRAUMATIC EPIDURAL HEMATOMA: A RETROPSECTIVE REVIEW OF PATIENT CHARACTERISTICS AND MANAGEMENT
Vatche Melkonian BA
Memorial Regional Hospital

93. NOVEL MANAGEMENT FOR DISTAL RADIUS FRACTURE AFTER TRAUMA
Bryan Brown MD
Orlando Regional Medical Center

100. MANAGEMENT OF HIGH VOLTAGE ELECTRICAL INJURY
Danny Miller MD
Orlando Regional Medical Center

102. MULTIFACETED TREATMENT REQUIRED FOR A BLACK BEAR ATTACK: CASE REPORT
Stephen Spencer MD
Orlando Regional Medical Center

103. DOUBLE TROUBLE: INTRACRANIAL HEMORRHAGE WITH ANTITHROMBOTIC USE AND UNDERLYING THROMBOCYTOPENIA
Matthew Lamb MD
Grand Strand Medical Center/University of South Carolina

109. TRAUMA ASSOCIATED ABDOMINAL COCOON: A CASE REPORT DEMONSTRATING RADIOLOGIC EVOLUTION
Brooke Schermerhorn JMS
Augusta University
116. HEART “TAKES A LICKIN’ AND KEEPS ON TICKIN’”, LEAVE THE BULLET
Lamar Moree MD
Orlando Regional Medical Center
ePoster Station #: 3 | Trauma III

123. TIMING IN LOWER EXTREMITY TRAUMA RECONSTRUCTION: IS A 72 HOUR GOAL NO LONGER NECESSARY?
Eva Dentcheva MD
Eastern Virginia Medical School

124. RETRIEVAL RATES AND PRACTICE PATTERNS OF R-IVC FILTERS IN THE TRAUMA POPULATION AT A COMMUNITY LEVEL II TRAUMA CENTER
James W. Rawles III MD
New Hanover Regional Medical Center

129. OUR FIRST LOOK IN THE MIRROR - BASELINE ASSESSMENT OF TRAUMA RESUSCITATIONS
Thomas Scarritt MD
University of North Carolina

132. A RETROSPECTIVE ANALYSIS OF OUTCOMES OF WEEKEND CHOLECYSTECTOMIES AND APPENDECTOMIES BEFORE AND AFTER ACUTE CARE SURGICAL TEAM IMPLEMENTATION
Leigha High BS
East Tennessee State University

136. FFP TO RBC RATIO IN CORRECTION OF POST-TRAUMATIC COAGULOPATHYRN
Johongir Muradov MD
University of Louisville

142. UNEXPECTED SURVIVORSHIP IN ACUTELY INJURED YOUNG ADULTS: A MORTALITY GAP ANALYSIS OF TRAUMA PATIENTS IN A LEVEL 1 TRAUMA CENTER
Melanie Cabezas BS
University of Virginia Health System
146. A DECADE EVALUATION OF A STATE TRAUMA SYSTEM: HAS ACCESS TO INPATIENT TRAUMA SERVICES AT DESIGNATED TRAUMA CENTERS IMPROVED?
Dennis Ashley MD
Navicent Health

157. MULTI-VEHICLE, MOTORCYCLE ACCIDENTS ARE MORE COMMON DURING DAYLIGHT HOURS: AN 18-MONTH REVIEW OF MOTORCYCLE ACCIDENTS FROM A LEVEL 1 TRAUMA CENTER
William Berglind MD, PhD
Greenville Health System

159. OPERATIVE INTERVENTION FOR BLUNT SPLENIC INJURY OCCURS WITH GREATER FREQUENCY AT LEVEL 2 TRAUMA CENTERS THAN AT EITHER LEVEL 1 OR LEVEL 3 TRAUMA CENTERS
Abid Khan MD
Loyola University Medical Center

160. RETROSTERNAL HEMATOMA CAUSED BY BLUNT TRAUMA LEADING TO EXTRAPERICARDIAL TAMponade: A CASE REPORT
Erika Borgerding MD
Wake Forest School of Medicine

165. SUCCESSFUL INCORPORATION OF PERFORMANCE BASED PAYMENTS FOR TRAUMA CENTER READINESS COSTS INTO A STATEWIDE TRAUMA SYSTEM
Dennis Ashley MD
Navicent Health

174. INCLUSION OF THE ACUTE CARE SURGEON IN THE DIFFICULT AIRWAY PROTOCOL: A 9 YEAR EXPERIENCE
Michael Hurtado MD
Memorial Regional Hospital

175. ALL-TERRAIN VEHICLES ARE ASSOCIATED WITH INCREASED INCIDENCE AND SEVERITY OF TRAUMATIC BRAIN INJURY WHEN COMPARED TO MOTORCYCLE CRASHES
Scott Blair DO
University of South Alabama
180. EMERGENCY DEPARTMENT REPAIR OF BLUNT RIGHT ATRIAL RUPTURE UTILIZING CARDIOPULMONARY BYPASS
Samuel Carmichael MD, MS
University of Kentucky

188. WHAT ARE THE COSTS OF TRAUMA CENTER READINESS? DEFINING AND STANDARDIZING READINESS COSTS OF TRAUMA CARE FOR TRAUMA CENTERS STATEWIDE
Dennis Ashley MD
Navicent Health

189. A RARE CAUSE OF PNEUMOPERICARDIUM IN A PATIENT FOLLOWING A MOTOR VEHICLE COLLISION
Andrew Schneider MD
Greenville Health System

195. TRACHEAL STENOSIS BASED ON SURGICAL TECHNIQUE
John McLain MD
University of Tennessee Medical Center, Knoxville
ePoster Station #: 4 | General Surgery

313. IMPACT OF TIME OF ARRIVAL TO EMERGENCY DEPARTMENT ON PATIENT OUTCOME
Luke Soshnik-Schierling BS
University of Virginia Health System

12. LAPAROSCOPIC SLEEVE GASTRECTOMY IS ASSOCIATED WITH LOWER 30-DAY MORBIDITY VERSUS LAPAROSCOPIC GASTRIC BYPASS: AN ANALYSIS OF THE AMERICAN COLLEGE OF SURGEONS NATIONAL SURGICAL QUALITY IMPROVEMENT PROGRAM
Jean Guerrier MD
University of Virginia Health System

22. SPONTANEOUS INFLAMMATION AND NECROSIS OF THE FALCIFORM AND ROUND LIGAMENTS: CASE REPORT AND REVIEW OF THE WORLD LITERATURE
Asth Bhatt MD
Saint Agnes Hospital

35. INTRAPANCREATIC ENTERIC DUPLICATION CYST MASQUERADING AS GROOVE PANCREATITIS
Remil Simon BS
University of Tennessee College of Medicine at Chattanooga

36. INNOVATIVE SURGICAL TECHNIQUE UTILIZING OMENTUM TO ISOLATE AND CONTROL AN ENTERO-ATMOSPHERIC FISTULA
Andrew Gratzon MD
Orlando Regional Medical Center

45. THE EFFECT OF ENERGY DEVICES ON SURROUNDING TISSUES
John Pendleton MD
Eastern Virginia Medical School

89. MANAGEMENT OF A LARGE UROGENITAL MESENTERIC CYST
Aura Fuentes MD
Orlando Regional Medical Center
90. HEMOSUCCUS PANCREATICUS IN A PATIENT WITH CHRONIC PANCREATITIS WITH A PREVIOUS PUESTOW PROCEDURE
Robert Rampp MD
University of Tennessee College of Medicine at Chattanooga

99. ELEVATED CA19-9 IN COMPLICATED CHOLELITHIASIS: A CASE REPORT
Ayolola Onayemi MD
Grand Strand Medical Center/University of South Carolina

104. INTERNAL ILIAC-ENTERIC FISTULA: A RARE CAUSE OF HEMORRHAGIC SHOCK
Nina Cohen MD
Eastern Virginia Medical School

105. DOES ADMISSION TO MEDICINE VERSUS SURGERY INFLUENCE TIME TO SURGERY/OUTCOMES FOR CHOLECYSTECTOMY?
Michael Eerhart MD
Geisinger Medical Center

107. EOSINOPHILIC CHOLANGITIS: A SMALL CASE SERIES AND REVIEW OF THE LITERATURE
Yamuna Krishna MD
Greenville Health System

108. PRE-PROCEDURAL FASTING: IS IT TIME TO CHANGE PRACTICE?
Justin Vaughan MD
Mercer University/Navicent Health

110. THE EFFECTS ON OUTCOMES OF DISTANCE AND TIME IN TRANSFERS FOR EMERGENCY GENERAL AND VASCULAR SURGERY
Kevin Mensah-Biney BSPH
Virginia Tech Carilion School of Medicine

114. LAPAROSCOPIC APPROACH TO PERFORATED PEPTIC ULCERS TRENDS TOWARDS QUICKER RECOVERY
Salim Hosein MD
Ochsner Clinic Foundation
122. OUTCOMES OF THE MANAGEMENT OF APPENDICITIS WITH THE IMPLEMENTATION OF AN ACUTE CARE SURGERY SERVICE IN A COMMUNITY TEACHING HOSPITAL
Michael Farrell MD, MBS
Christiana Care Health System

137. GASTRIC NECROSIS AFTER EMERGENCY CAESAREAN SECTION FOR ABRUPTIO PLACENTAE
Wei Wei Zhang MD
University of South Florida

138. ACUTE NECROTIZING GASTRITIS
Michael Parmley MD
Charleston Area Medical Center
140. INCIDENTAL FINDING OF HETEROTOPIC PANCREAS AFTER CHOLECYSTECTOMY
Sherard Chiu MD
University of Tennessee Medical Center, Knoxville

141. THE GENERAL SURGEON IN THE MANAGEMENT OF THE PATIENT WITH CYSTIC FIBROSIS AFTER LUNG TRANSPLANT
Ryan Phillips MD
Ochsner Medical Center

147. PERFORATED JEJUNAL DIVERTICULUM: AN EMERGENCY
Daniel Verna MD
Greenville Health System

148. IS ACUTE APPENDICITIS RARE IN SICKLE CELL PATIENTS?
Jin Sol Oh MD
Medical College of Georgia at Augusta University

152. IS IT SAFE FOR SURGERY TO ATTEMPT PEG IN PATIENTS DEEMED UNSAFE BY OTHER SERVICES?
Charles Walker MD
Geisinger Medical Center

155. VAGINAL CUFF DEHISCENCE LEADING TO EVISCERATION
Jonathan Overcash MD
Wellstar Atlanta Medical Center

158. SARCOPENIA PREDICTS POOR OUTCOMES IN URGENT EXPLORATORY LAPAROTOMY
Lisa Francomacaro
Geisinger Medical Center

164. AN INTERDISCIPLINARY PERIOPERATIVE MANAGEMENT PROTOCOL FOR PATIENTS WITH SICKLE CELL ANEMIA - A SINGLE SURGEON EXPERIENCE
Sara Scarlet MD
University of North Carolina
167. CHOLECYSTECTOMY CLIP MIGRATION AND SUBSEQUENT CHOLEDOCHOLITHIASIS
Philip Erwin DO
Greenville Health System

172. INCIDENTAL PELVIC SCHWANNOMA
Ashley Jones DO
Palmetto Health/University of South Carolina School of Medicine

184. PARASTOMAL EVISCERATION: RARE COMPLICATION AFTER TOTAL ABDOMINAL COLECTOMY
Chase Arbra MD
Medical University of South Carolina

201. CHOLECYSTITIS IN SICKLE CELL PATIENTS
Andrew Lawson DO
Augusta University

207. COMPLICATED MAMMOPLASTY AND BREAST SALVAGE WITH APPLICATION OF EXTRACELLULAR DERMAL MATRIX: A CASE REPORT
Amanda Swickard PA-C
Grand Strand Medical Center/University of South Carolina

211. PERIOPERATIVE MORBIDITY AND MID-TERM OUTCOMES OF ROBOTIC ROUX-EN-Y GASTRIC BYPASS
Savannah Bailey
Indiana University

225. PREDICTORS AND RISK FACTORS ASSOCIATED WITH PERFORATED DIVERTICULITIS: AN ANALYSIS OF THE NATIONAL INPATIENT SAMPLE
Ali Al-Ameri MD
Saint Agnes Hospital

226. THE INFLUENCE OF DEPRESSION AND BIPOLAR SYNDROME ON THE CLINICAL OUTCOME OF ACUTE CHOLECYSTITIS
Andrew Harner MD
Medical College of Georgia at Augusta University
314. ASSESSING THE EFFICACY OF THE ALPHA, BETA, GAMMA
TRAUMA ALERT SYSTEM USING THE RELATIVE MORTALITY MATRIX
Luke Soshnik-Schierling BS
University of Virginia Health System

231. A RARE CASE OF INTRAPERITONEAL DEDIFFERENTIATED
LIPOSARCOMA ARISING FROM THE RIGHT COLON
Stacy Ranson MD
Florida State University College of Medicine
ePoster Station #: 6 | Pediatrics

17. LARGE GAP CONGENITAL PYLORIC ATRESIA WITH MECONIUM PERITONITIS: WHEN GASTROJEJUNOSTOMY IS THE BEST OPTION
Rebecca Brown MD
University of North Carolina

18. ABDOMINAL COMPARTMENT SYNDROME AFTER OPEN BIOPSY FOR WILMS’ TUMOR
Don Nakayama MD, MBA
Florida International University

20. USE OF A GASTRODUODENAL TUBE TO PRESERVE THE COMMON WALL DURING EXCISION OF A GASTRIC DUPLICATION
Heather Nolan MD
Mercer University/Navicent Health

57. ANALYSIS OF THE FINANCIAL BENEFIT OF SAME DAY APPENDECTOMY
Colin Muncie MD
University of Mississippi

59. CYSTIC LYMPHANGIOMA OF THE MESENTERIC ROOT IN AN ADOLESCENT, AN OPERATIVE CHALLENGE. CASE REPORT AND LITERATURE REVIEW
Colin Muncie MD
University of Mississippi

94. INJURIES IN CHILDREN DUE TO LARGE ANIMALS-A SINGLE INSTITUTION EXPERIENCE
Robert Vandewalle MD, MBA
Indiana University

118. COMPLICATED COLONIC DUPLICATION IN A NEONATE: AN INTERESTING CASE
Ashlee Justice MD
University of South Carolina/Palmetto Health
126. RENAL COLLECTING SYSTEM-TO-RENAL VEIN FISTULA: SOLVING THE UNIQUE DIAGNOSTIC CHALLENGE UTILIZING FLUOROSCOPY
Aditya Safaya MD
Westchester Medical Center

149. PERSISTENT HEMOLYSIS AFTER LAPAROSCOPIC PARTIAL SPLENECTOMY IN CHILDREN, CASE SERIES AND REVIEW OF THE LITERATURE
Colin Muncie MD
University of Mississippi

163. EXTRACORPOREAL MEMBRANE OXYGENATION FOR HEMORRHAGIC SHOCK AND CARDIOPULMONARY ARREST IN A PEDIATRIC TRAUMA
Katherine Cools MD
University of North Carolina

240. SPONTANEOUS INTESTINAL PERFORATION AFTER INDUCTION CHEMOTHERAPY IN A PEDIATRIC PATIENT: A CASE REPORT
Paul McGaha MD
University of Oklahoma Health Sciences Center

280. SINGLE INCISION LAPAROSCOPIC SURGERY APPROACH IN TREATMENT OF PEDIATRIC MECKEL’S DIVERTICULUM
Ilan Maizlin MD
Children’s Hospital of Alabama

292. UTILIZATION OF MULTIMODALITY SURGICAL APPROACH IN EXTRACTION OF EXTRA-ESOPHAGEAL INGESTED FOREIGN BODY
Ilan Maizlin MD
Children’s Hospital of Alabama

311. PEDIATRIC ALL-TERRAIN VEHICLE TRAUMA: A SINGLE CENTER 10-YEAR EXPERIENCE
Patricia Martinez MD
Medical College of Georgia at Augusta University
317. PATENT OMPHALOMESENTERIC DUCT: A CASE SERIES AND REVIEW OF THE LITERATURE
Michael B. Huck MD
Wake Forest School of Medicine

340. LAPAROSCOPIC VERSUS ROBOTIC ASSISTED PROCEDURES IN THE PEDIATRIC POPULATION: OUR INSTITUTIONAL EXPERIENCE
Maryann Mbaka MD
University of South Carolina/Palmetto Health

345. THE CORRELATION BETWEEN UMBILICAL VEIN CATHETER COMPLICATIONS AND THE DEVELOPMENT OF NECROTIZING ENTEROCOLITIS IN PREMATURE INFANTS
Mansi Shah MD
University of North Carolina

353. CHEST RADIOGRAPH FOLLOWING LINE PLACEMENT IN PEDIATRIC PATIENTS: IS IT ALWAYS NECESSARY?
Jenny Held MD
Naval Medical Center Portsmouth

346. COLOSTOMY AS A BRIDGE TO DEFINITIVE PEDIATRIC SURGICAL CARE: A SUB-SAHARAN AFRICAN EXPERIENCE
Mansi Shah MD
University of North Carolina

355. ML327 INDUCES APOPTOSIS AND SENSITIZES EWING’S SARCOMA CELLS TO TRAIL
Eric Rellinger MD
Vanderbilt University
ePoster Station #: 7 | Cancer

24. CONTINUING ADVANCEMENTS IN MANAGEMENT OF AMPULLARY ADENOMA: A CASE SERIES
Zachary Sanford MD
Marshall University

41. DELAYED PRESENTATION AND TREATMENT OF MELANOMA IN AFRICAN AMERICANS: A CASE SERIES OF AFRICAN AMERICANS WITH PLANTAR ACRAL LENTIGINOUS MELANOMA
L. Ashley Griffin MD
University of Mississippi

46. MYOEPITHELIAL CARCINOMA OF THE THIGH AFTER LIPOMA EXCISION: A CASE REPORT
Jennifer Son MD
Rush University Medical Center

60. SUCCESSFUL LAPAROSCOPIC REMOVAL OF A PERIVASCULAR EPITHELIOID CELL TUMOR (PECOMA)
Rami Michael MD
Greenville Health System

88. INVASIVE PANCREATIC ADENOCARCINOMA ARISING IN INTRADUCTAL PAPILLARY MUCINOUS NEOPLASM OF HETEROTOPIC PANCREATIC ORIGIN LOCATED IN THE STOMACH
Wade Christopher MD
University of Mississippi

101. PREDICTORS OF MORTALITY IN PANCREATIC RESECTION IN THE ELDERLY: A NATIONWIDE ANALYSIS
Ammar Hashmi MD
Geisinger Medical Center

117. RARE CASE PRESENTATION AND MANAGEMENT OF CUTANEOUS MANIFESTATION OF HISTIOCYTIC SARCOMA
Joseph Zakhary MD
University of Alabama at Birmingham
119. COMPARISON OF OUTCOMES BETWEEN OPEN VS. VIDEOSCOPIC SUPERFICIAL INGUINAL LYMPH NODE DISSECTION
Miles Landry MBBS
University of Tennessee Medical Center, Knoxville

168. THE EFFECT OF REGIONAL ANESTHESIA ON ONCOLOGIC OUTCOMES AFTER RESECTION OF COLORECTAL HEPATIC METASTASES
Mary Garland MD
Wake Forest University School of Medicine

179. RENAL CELL CARCINOMA METASTASIS TO THE PANCREAS: A WELL-DOCUMENTED RARE EVENT
Yamuna Krishna MD
Greenville Health System

205. ASSOCIATION OF INCREASING FRAILTY WITH DETRIMENTAL OUTCOMES FOLLOWING PANCREATIC RESECTION
R. Lane Guyton Jr. MD
Brody School of Medicine at East Carolina University

266. THE ENDOVEIN HARVESTER: A NOVEL APPROACH TO MOBILIZATION OF THE ESOPHAGUS DURING ROBOT ASSISTED TRANSHIATAL ESOPHAGECTOMY
Michael Parmley MD
Charleston Area Medical Center

295. ABDOMINAL SPLENOSIS MIMICKING METASTATIC MALIGNANCY IN A PATIENT WITH APPENDICITIS AND REMOTE HISTORY OF TRAUMATIC SPLENIC RUPTURE
Yana Mikhaylov Schrank MD
Medical University of South Carolina

296. LARGE ABDOMINAL MASS: ABNORMAL PRIMARY OVARIAN CANCER 15 YEARS AFTER TOTAL HYSTERECTOMY AND SALPINGO OOPHORECTOMY
Greg Thompson MD
Brookwood Baptist Health
303. NEOADJUVANT TALIMOGENE LAHERPAREPVEC (T-VEC) FOR THE TREATMENT OF METASTATIC MELANOMA
Zachary Stiles DO
University of Tennessee Health Science Center

307. LARGE HEMORRHAGIC METASTATIC MELANOMA TO THE STOMACH: A CASE REPORT
Aaron Bolduc MD
Augusta University

351. ESOPHAGECTOMY WITHOUT INTENSIVE CARE UNIT STAY: RESULTS OF A PILOT TRIAL
Stephen Mahoney MD
University of North Carolina
ePoster Station #: 8 | Endocrine/Cancer

106. PREDICTORS OF CENTRAL NODE DISSECTION FOR DIFFERENTIATED THYROID CANCER: EXPLORING THE NATIONAL CANCER DATABASE
Rebekah Campbell MD
Geisinger Medical Center

130. INTRAOPERATIVE RECURRENT LARYNGEAL NERVE MONITORING FOR THYROIDECTOMY AND PARATHYROIDECTOMY: IS IT LEADING TO FALSE REASSURANCE?
Kristina Blanton BS
Wellstar Atlanta Medical Center

139. ALCOHOL DETOXIFICATION PRIOR TO ADRENALECTOMY FOR PHEOCHROMOCYTOMA: A CASE REPORT
Jenny Held MD
Naval Medical Center Portsmouth

151. HURTHLE CELL TUMOR OF THE THYROID: A CASE SERIES
James Fortson MD, MPH, MBA
Atlanta Cancer Research and Education Foundation

177. THE USE OF MOLECULAR MARKER PANELS FOR TREATMENT OF PAPILLARY THYROID CANCER: KNOWING WHAT WE DO NOT KNOW
James Davis MD
Greenville Health System

193. SURGICAL TREATMENT OF METASTATIC PHEOCHROMOCYTOMA
Tara Hughes MD
University of Mississippi

297. AUTOIMMUNE POLYGLANDULAR SYNDROME TYPE II MASQUERADING AS ACUTE APPENDICITIS
Ilan Maizlin MD
Children’s Hospital of Alabama
301. THE UTILITY OF SESTAMIBI SCANS IN PRIMARY HYPERPARATHYROIDISM: DO SESTAMIBI SCANS CORRELATE WITH NUMBER OF GLANDS INVOLVED?
Jacob Lloyd MD
University of Tennessee College of Medicine at Chattanooga

324. CORRELATION OF CLINICAL AND ULTRASONOGRAPHIC FEATURES TO MALIGNANT DISEASE IN PATIENTS WITH INDETERMINATE THYROID NODULES
Fadi Murad MD
Tulane University

335. DO ANTICOAGULATION MEDICATIONS INCREASE THE RISK OF BLEEDING IN ULTRASOUND GUIDED FINE NEEDLE ASPIRATION OF THYROID LESIONS?
Helmi Khadra MD
Tulane University

337. OUTCOME OF ROBOT-ASSISTED PARATHYROIDECTOMY FOR PRIMARY HYPERPARATHYROIDISM
Daniah Bu Ali MD
Tulane University

347. CAN SUSPICIOUS ULTRASOUND FEATURES PREDICT BRAFV600E STATUS IN PAPILLARY THYROID CANCER?
Helmi Khadra MD
Tulane University

348. THYROID AND PARATHYROID SURGERIES IN OCTOGENARIANS. DOES AGE INFLUENCE OUTCOMES?
Fadi Murad MD
Tulane University

349. SUPERIOR DETECTION OF METASTATIC CYSTIC LYMPHADENOPATHY IN PATIENTS WITH PAPILLARY THYROID CANCER BY UTILIZATION OF THYROGLOBULIN WASHOUT
Helmi Khadra MD
Tulane University
352. LEARNING CURVE OF TRANSCUTANEOUS LARYNGEAL ULTRASOUND AS AN ALTERNATIVE TO FLEXIBLE LARYNGOSCOPY IN VOCAL CORD ASSESSMENT
Daniah Bu Ali MD
Tulane University

360. CAN BRAFV600E STATUS PREDICT EXTRATHYROIDAL EXTENSION IN PAPILLARY THYROID CANCER?
Helmi Khadra MD
Tulane University

362. LATERAL VS. ANTERIOR APPROACH OF TRANSCUTANEOUS LARYNGEAL ULTRASOUND FOR VOCAL CORDS ASSESSMENT
Roostam Kholmatov MD, PhD
Tulane University
ePoster Station #: 9 | Breast/Cancer

30. BREAST CANCER OUTCOMES AFTER MASTECTOMY WITH IMMEDIATE RECONSTRUCTION
Jeremiah Holt BS
University of Tennessee Medical Center, Knoxville

52. IS DEPRESSION ASSOCIATED WITH WORSE OUTCOMES AMONG WOMEN UNDERGOING BREAST RECONSTRUCTION FOLLOWING MASTECTOMY?
James Drinane DO
Medical College of Georgia at Augusta University

84. CASE SERIES OF MALIGNANT PHYLLODES BREAST TUMORS
Shauna Sheppard MD
Rush University Medical Center

111. RETAINED FOREIGN BODY FROM REMOTE PENETRATING TRAUMA PRESENTS AS SUSPICIOUS RADIOGRAPHIC ABNORMALITY ON SCREENING MAMMOGRAM
Andrew Drahos MD
Navicent Health

127. SUICIDE RISK IN MELANOMA: WHAT DO WE KNOW?
Amel Komic MD
Medical College of Georgia at Augusta University

162. MANAGEMENT OF A PATIENT WITH CONCURRENT FUNGATING BREAST MASS AND CHRONIC LYMPHOCYTIC LEUKEMIA
Alex Farnand MD
Presence Saint Joseph Hospital, Chicago

166. PATHOLOGIC COMPLETE RESPONSE (PCR) FOLLOWING A SINGLE CYCLE OF NEOADJUVANT CHEMOTHERAPY FOR HER2+ BREAST CANCER
Isolina Rossi
Rush University Medical Center
178. DO ALL BRCA 1 AND 2 CARRIERS WITH A KNOWN AND UNKNOWN BREAST CANCER CHOOSE BILATERAL MASTECTOMIES?
Michaela Gaffley MD
Wake Forest School of Medicine

181. BREAST CANCER COMPARISONS - NEW HANOVER REGIONAL MEDICAL CENTER VERSUS NATIONAL BENCHMARKS
Sarah Fox MD
New Hanover Regional Medical Center

182. POST-MASTECTOMY RECONSTRUCTION RATES: DOES TUMOR BIOLOGY AND RADIATION THERAPY HAVE A GREATER EFFECT IN YOUNGER WOMEN?
Karishma Reddy MD
University of North Carolina

185. PRIMARY SYNCHRONOUS BILATERAL ANGIOSARCOMA OF THE BREAST
Laurel Mulder MD
Rush University Medical Center

208. METASTASES TO THE BREAST FROM NON-SMALL CELL LUNG CARCINOMA
Celia Quang MD
University of South Alabama

265. EFFECT OF POSITIVE LUMPECTOMY MARGINS ON RECURRENCE RATES
Scott Holt MD
Palmetto Health Richland

302. DUCTAL CARCINOMA IN-SITU IN TURNER SYNDROME PATIENT UNDERGOING HORMONE REPLACEMENT THERAPY
Ilan Maizlin MD
University of Alabama at Birmingham
316. TRIPLE NEGATIVE BREAST CANCER: A SINGLE INSTITUTION REVIEW COMPARING RACE AND SURVIVAL
Scott Holt MD
Palmetto Health Richland

320. AGE DISPARITY EXISTS IN THE USE OF NEOADJUVANT CHEMOTHERAPY FOR BREAST CANCER
Jacquelyn Carr MD
University of North Carolina

330. NATIONAL FORECAST OF RISK AND SURVIVAL IN HEAD AND NECK CUTANEOUS MELANOMA
Fadi Murad MD
Tulane University
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ePoster Station # 10 | Critical Care/Thoracic/Vascular

9. IS TRACHEOSTOMY INSERTION AN INDICATION FOR GASTROSTOMY INSERTION?
Justin Dvorak MD
Loyola University Medical Center

26. MANAGEMENT OF A COMPLEX CASE OF A BRONCHOPLEURAL FISTULA
Nate Walsh MD
Augusta University

37. IS ADDITIONAL INTRA-OPERATIVE HEMODYNAMIC MONITORING HELPFUL?
Brian Wright MS
Mercer University/Navicent Health

49. PERFORMANCE OF RIB PLATE HARDWARE IN AN ELDERLY WOMAN RECEIVING CARDIOPULMONARY RESUSCITATION FOLLOWING SURGICAL RIB FIXATION
Colston Edgerton MD
Medical University of South Carolina
70. STABILIZATION OF GAP AND TIGHT JUNCTIONS IMPROVES TRANSPLANTATION-RELATED ISCHEMIA REPERFUSION INJURY IN A MOUSE MODEL OF LUNG TRANSPLANTATION
Kunal Patel MD
Medical University of South Carolina

112. MORE THAN JUST A SORE THROAT
Jenny Held, MD
Naval Medical Center Portsmouth

150. IMPACT OF SARCOPENIA ON COMPLICATIONS AND SURVIVAL IN PATIENTS UNDERGOING A LOBECTOMY FOR LUNG CANCER
Sean McGrath MD
Greenville Health System

156. ELECTROMAGNETIC NAVIGATIONAL BRONCHOSCOPY IS SAFER THAN CT-GUIDANCE FOR FIDUCIAL MARKER PLACEMENT FOR STEREOTACTIC BODY RADIATION THERAPY IN LUNG CANCER PATIENTS
William Bolton MD
Greenville Health System

161. FECULENT EMPYEMA AFTER PERFORATED APPENDICITIS
Alex Farnand MD
Presence Saint Joseph Hospital, Chicago

173. HEMOCONCENTRATION STRATEGIES IN LIFE-THREATENING ANEMIA IN A JEHOVAH’S WITNESS PATIENT
Katherine Cools MD
University of North Carolina

187. ESOPHAGEAL PERFORATION DUE TO RADIOFREQUENCY ABLATION
Tracy Sambo MD
Presence Saint Joseph Hospital, Chicago
224. CATAMENIAL PNEUMOTHORAX  
Riley Schlub MD  
University of South Carolina

244. A RARE OCCURRENCE OF AN ASBESTOS RELATED HEMORRHAGIC PLEURAL CYST  
J.R. Liggett MD  
Naval Medical Center Portsmouth

282. 40 YEAR OLD FEMALE WITH SUB-STERNAL COLONIC INTERPOSITION VOLVULUS: MINIMALLY INVASIVE TECHNIQUES FAIL, OPEN SURGERY SAVES THE DAY  
Christopher Henry MD  
University of Oklahoma Health Sciences Center

283. CASE REPORT: INCIDENTAL SQUAMOUS CARCINOMA IN-SITU IN A LARGE ZENKER’S DIVERTICULUM  
Sarah Fox MD  
New Hanover Regional Medical Center

284. MANAGEMENT OF PERIPARTUM ANTICOAGULATION DURING EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)  
Emily Newton MD  
University of North Carolina

364. CERVICAL SPINE FRACTURES AND SWALLOWING DYSFUNCTION IN TRAUMA PATIENTS TREATED WITH SEMI-RIGID COLLARS: OUR INSTITUTIONAL EXPERIENCE  
Maryann Mbaka MD  
University of South Carolina/Palmetto Health
MONDAY, FEBRUARY 27, 2017

ePoster Station # 1 | Vascular

81. ENDOVASCULAR TREATMENT OF PERIGRAFT HYGROMA
Constantinos Constantinou MD
Marshall University

135. EMBOLIZATION OF INFERIOR VENA CAVA FILTER STRUT TO THE RIGHT VENTRICLE
Constantinos Constantinou MD
Marshall University

144. A RARE CASE OF TYPE III POPLITEAL ARTERY ENTRAPMENT WITH POST-STENOTIC ANEURYSMAL DEGENERATION
Cesar Molina MD
University of Tennessee, Nashville

145. LONGER PATIENT TRAVEL TIMES ASSOCIATED WITH REDUCED FOLLOW-UP VISIT ADHERENCE AFTER ENDOVASCULAR AORTIC ANEURYSM REPAIR
Andrew Morris MD
Emory University

191. OPERATIVE BYPASS FOR MESENTERIC ISCHEMIA IN A PATIENT WITH ABERRANT HEPATIC ARTERY ANATOMY
Elizabeth Aitcheson MD
John H Stroger, Jr. Hospital of Cook County

198. DIAGNOSIS OF PARTIAL ANOMALOUS PULMONARY VENOUS CONNECTION (PAPVC) BY CENTRAL LINE PLACEMENT
Madison Griffin MD
Mercer University/Navicent Health

203. REVIEW OF SURGICAL IATROGENIC VASCULAR INJURIES AND THEIR MANAGEMENT
Elizabeth Lax, MD
Providence-Providence Park Hospital
215. THREATENED AV ACCESS WITH CENTRAL VENOUS OBSTRUCTION: THORACIC OUTLET DECOMPRESSION VERSUS HERO GRAFT
Stephen Tonks MD
University of Tennessee Medical Center, Knoxville

233. SUCCESSFUL OUTCOMES AFTER RENAL VEIN TRANSPOSITION WITH SAPHENOUS VEIN CUFF FOR THE TREATMENT OF NUTCRACKER SYNDROME IN PATIENTS WITH BASELINE RENAL PATHOLOGY
Mary Arbuthnot DO
Naval Medical Center Portsmouth

235. SURGICAL INTERVENTION IN THE CASE OF AN ABERRANT INTERNAL CAROTID ARTERY BRANCH
Erica Davanian DO
University of Tennessee, Nashville

248. ENDOVASCULAR REPAIR OF INNOMINATE ARTERY ANASTOMOTIC PSEUDOANEURYSM
Martin Zomaya MD
Rutgers University

261. MANAGEMENT OF A PELVIS FULL OF ANEURYSMS
Mary Nally MD
Rush University Medical Center

262. GAS GANGRENE OF FOREARM ARTERIOVENOUS FISTULA
Julia Coughlin MD
Rush University Medical Center

264. CAROTID BODY TUMOR: A RARE PRESENTATION OF 3 SYNCHRONOUS TUMORS AND A NOVEL MANAGEMENT APPROACH
Thuy Pham MD
Medical College of Georgia at Augusta University

273. DISSECTION OF THE INTERNAL CAROTID ARTERY: A CASE REPORT OF AN UNCOMMON POSTOPERATIVE COMPLICATION
Mary Kathryn Huddleston MD
University of Tennessee College of Medicine at Chattanooga
287. VISCERAL ARTERY REVASCULARIZATION AFTER FAILED ENDOVASCULAR THERAPY FOR RECURRENT SYMPTOMATIC CHRONIC MESENTERIC ISCHEMIA
Teena Dhir MD
Albert Einstein Medical Center

319. TERTIARY EXAMINATIONS IN GROUND LEVEL FALLS
Mia Klein MD
University of North Carolina
199. PREVALENCE AND IMPACT OF UNMET SOCIO-LEGAL NEEDS IN TRAUMA PATIENTS
Jennifer Rosen MD
MedStar Washington Hospital Center

200. TRAUMATIC ACUTE EXTERNAL EAR CANAL ATRESIA
Grant Willis MS
University of South Alabama

204. OUTCOMES OF TRAUMA IN PREGNANCY AT LEVEL 1 TRAUMA CENTER: WHEN IS TRAUMA TEAM ACTIVATION JUSTIFIED?
Pascal Udekwu MBBS, MBA, MHA
WakeMed Health & Hospitals

209. FIGHTING STATE HELMET LAW REPEAL DECREASES INJURY RISK AND FINANCIAL BURDEN
A. Britton Christmas MD
The F.H. “Sammy” Ross, Jr. Trauma Center at Carolinas Medical Center

210. USE OF LEFT VENTRICULAR ASSIST DEVICE AND INTRA-AORTIC BALLOON PUMP IN BLUNT CARDIAC INJURY
Kyle Kleppe MD
University of Tennessee Medical Center, Knoxville

212. BULLET EMBOLISM
Andrew Van Sickler MD
Palmetto Health/University of South Carolina School of Medicine

216. SURGICAL CONFERENCES ARE ASSOCIATED WITH INCREASED MORTALITY FROM PENETRATING INJURY AT TRAUMA CENTERS WITHOUT AMERICAN COLLEGE OF SURGEONS VERIFICATION
Peter Jenkins MD, MSc
Indiana University, Methodist Hospital
218. DELAYED TRAUMATIC TRICUSPID VALVE INJURY
Brian Bateson DO
Medical College of Georgia at Augusta University

222. THE TREATMENT AND RECONSTRUCTION OF CUTANEOUS MUCORMYCOSIS AFTER PENETRATING TRAUMA
Sean O’Connor MD
Wake Forest School of Medicine

223. FORMALIZING THE TRAUMA BAY: DOES IT HELP?
Christopher Bell MD
University of Tennessee College of Medicine at Chattanooga

234. IS THERE A HIGHER INCIDENCE OF DEEP VENOUS THROMBOSIS ASSOCIATED WITH COOLING CATHETER USE IN SEVERE TRAUMATIC BRAIN INJURY PATIENTS?
Katherine Kelley MD
University of Maryland

236. SCREENING FOR PATIENTS AT RISK FOR POST-TRAUMATIC STRESS DISORDER AND DEPRESSION AT LEVEL ONE TRAUMA CENTER
Brice Hwang BS
Augusta University

243. DURATION OF ANTIBIOTIC PROPHYLAXIS IN PATIENTS WITH GUNSHOT WOUNDS TO THE HEAD
Jonathan Vignali BS
Eastern Virginia Medical School

246. ACUTE BURN INJURY DRAMATICALLY REDUCES PLASMIN ACTIVITY IN PATIENTS
William Oelsner BS
Vanderbilt University

247. HEALTHCARE WORKER ATTITUDES TOWARD ORGAN DONATION AT TWO LEVEL 1 URBAN TRAUMA CENTERS
John Cull MD
Greenville Memorial Hospital
251. TREATMENT OF TRAUMATIC VASCULAR INJURY USING ENDOVASCULAR TECHNIQUES: A PARADIGM SHIFT
Phillip Rideout MD
Navicent Health

255. PNEUMORACCHIS (AIR IN THE SPINAL CANAL): A CONTRAINDICATION OF AIRWAY PRESSURE RELEASE VENTILATION (APRV) IN THE POLYTRAUMA PATIENT
Amy Trammell
Greenville Health System
ePoster Station #: 3 | Trauma V

96. WHO IS JOHN DOE? A CASE-MATCH ANALYSIS
Christopher Janowak MD
Indiana University

257. TRAUMATIC EXTERNAL CAROTID ARTERY AVULSION NOT EVIDENT ON CT ANGIOGRAM: A CASE REPORT
Timothy Hester DO
University of Florida College of Medicine – Jacksonville

263. HEROIN RELATED COMPARTMENT SYNDROME: AN INCREASING PROBLEM FOR ACUTE CARE SURGEONS
Matthew Benns MD
University of Louisville

272. GENERAL SURGERY RESIDENT PLACEMENT OF INTRACRANIAL PRESSURE MONITORS, AN INSTITUTIONAL EXPERIENCE
Daniella Kington MD
Atlanta Medical Center

275. MORTALITY RATE OF TRAUMA PATIENTS REQUIRING MULTIPLE VASOPRESSORS; BETTER THAN EXPECTED?
Matthew Ng MD
Eastern Virginia Medical School

279. REPEATABILITY OF RESUSCITATIVE ENDOVASCULAR BALLOON FOR OCCLUSION OF THE AORTA AS AN UNFORESEEN TOOL
Joseph Ibrahim MD
Orlando Regional Medical Center

299. PROPELLER DAMAGE TO THE PAROTID DUCT
Rohan Kambeyanda MD
Medical University of South Carolina

304. ANGIOEMBOLIZATION OF SHOTGUN PELLETS IN THE SETTING OF VASCULAR AND TRACHEAL INJURY
Justin Hunter MD
University of South Alabama
305. CHEST WALL STABILIZATION WITH RIB PLATING AFTER CARDIOPULMONARY RESUSCITATION
Michael Fitzgerald MD
Navicent Health

306. CHEST WALL STABILIZATION AND RIB PLATING IN 15 YEAR OLD MALE AFTER BLUNT THORACIC TRAUMA
Michael Fitzgerald MD
Navicent Health

308. SAFETY BAR COMPLIANCE ON SKI LIFTS: FACTORS OF AGE AND LIFT BAR TYPE IMPACT RISK TAKING BEHAVIOR
David Ciraulo DO, MPH
Maine Medical Center

309. EFFECTIVE REGIONALIZATION OF CARE FOR TRAUMATIC BRAIN INJURY IN A LARGE RURAL AREA
Audrey Butcher MD
Memorial University Medical Center

315. ADULT SPONDYLOTIC SCIWORA: THE ATYPICAL TRAUMATIC CENTRAL CORD SYNDROME
Georgina Alizo MD
Grand Strand Medical Center/University of South Carolina

318. THE EFFECT OF PREINTUBATION GCS ON PNEUMONIA IN TRAUMA PATIENTS
Melissa Maxey MD
University of South Carolina

321. DEATH AFTER DISCHARGE FROM ISOLATED SUBDURAL HEMATOMA: AGE MATTERS
Sarah Abdulla BA
Virginia Tech Carilion School of Medicine
ePoster Station #: 4 | GI/General Surgery

48. EARLY FOLLOW UP OF THE LINX REFLUX MANAGEMENT SYSTEM FOR GERD PATIENTS
Elizabeth Long MD
University of South Alabama

125. ALTERNATIVE METHOD OF GASTRIC FOREIGN BODY RETRIEVAL
Anthony Scott MD
Navicent Health

171. VARIATION IN CLINICAL CHARACTERISTICS OF WOMEN VERSUS MEN PRE-OPERATIVE FOR LAPAROSCOPIC ROUX-EN-Y GASTRIC BYPASS (LRYGB): ANALYSIS OF 83,059 PATIENTS
Jandie Schwartz DO
Inspira Health Network

238. FIRST 100 PATIENTS UNDERGOING LAPAROSCOPIC HELLER MYOTOMY: DO LONG-TERM OUTCOMES JUSTIFY CONTINUED APPLICATION?
Alexander Rosemurgy MD
Florida Hospital Tampa

239. PRIMARY RETROPERITONEAL FASCIITIS WITH ABSCESS: A CASE REPORT OF A RARE CONDITION
Andrew Jones BS, BA
Augusta University

249. EOSINOPHILIC ENTEROPATHY PRESENTING AS SMALL BOWEL OBSTRUCTION
Katharine Boyd MD
Bronx Lebanon Hospital Center

250. LOCALIZED LYMPHEDEMA OF THE CALF PRESENTING AS A PEDUNCULATED SOFT TISSUE MASS
Luis Serrano MD
East Tennessee State University
254. HIGH MORTALITY IN ELDERLY PATIENTS WITH ACUTE CHOLECYSTITIS AND DO NOT RESUSCITATE STATUS
Lissa Sakata MD
Sinai Hospital

258. MODERN MANAGEMENT OF ESOPHAGEAL DIVERTICULA: LESSONS LEARNED OVER FORTY-FIVE CASES
Michael Antiporda MD
Mayo Clinic Florida

268. ANTICOAGULATION MANAGEMENT FOR NON-CARDIAC SURGERY IN PATIENTS WITH VENTRICULAR ASSIST DEVICES
Shawna Kettyle MD
MedStar Washington Hospital Center

271.SURGICAL SCAR ENDOMETRIOSIS AFTER CESAREAN SECTION: CASE SERIES AND REVIEW OF LITERATURE
Ayesha N. Lovick MD
Wellstar Atlanta Medical Center

274. COMPLICATED ILIOPSOAS COMPARTMENT ABSCESS WITH EXTREMITY EXTENSION
Jaine McKenzie MD
Augusta University

281. ROBOTIC VERSUS LAPAROSCOPIC SPLENECTOMY: FASTER RECOVERY DOES NOT YET JUSTIFY THE HIGHER COSTS
Randi Lassiter MD
Augusta University

289. CANCER OF MECKEL’S DIVERTICULUM REVIEW OF ENGLISH LITERATURE
Mahmod EL-Tayash MD
Saint Agnes Hospital

294. THE UTILITY OF THE ALVARADO SCORING IN DIAGNOSIS OF ACUTE APPENDICITIS IN ELDERLY
Rebecca Brown MD
University of North Carolina
344. A CLINICAL REVIEW OF RESUSCITATIVE ENDOVASCULAR BALLOON OCCLUSION OF THE AORTA FOR NON-TRAUMATIC INTRA-ABDOMINAL HEMORRHAGE
Natasha Hansraj MD
University of Maryland

357. A REVIEW OF LITERATURE TO ASSESS OPTIMAL MANAGEMENT OF LAPAROSCOPIC CHOLECYSTECTOMY IN PATIENTS WITH LEFT VENTRICULAR ASSIST DEVICES
Samuel Schadt
Philadelphia College of Osteopathic Medicine
ePoster Station #: 5 | HPB/GI

28. RETROVERSUS IMPLANTATION OF A SITUS SOLITUS DECEASED DONOR LIVER INTO A SITUS INVERSUS TOTALIS RECIPIENT
Rondi Kauffmann MD, MPH
Vanderbilt University Medical Center

66. PANCREATIC LYMPHANGIOMA: A DIAGNOSTIC AND TREATMENT DILEMMA
Megan Johnson MD
University of Tennessee Medical Center, Knoxville

115. EMPHYSEMATOUS GASTRITIS: A REPORT OF FOUR CASES AND LITERATURE REVIEW
Kaitlyn Rountree DO
Henry Ford Macomb Hospital

154. ATYPICAL MULTI-FOCAL LIVER ABSCESES LEADING TO SEPSIS AFTER GASTRIC BYPASS; A CASE STUDY AND LITERATURE REVIEW
Sherard Chiu MD
University of Tennessee Medical Center, Knoxville

170. MESENCHYMAL STEM CELL COTRANSPLANTATION IN TOTAL PANCREATECTOMY WITH ISLET AUTOTRANSPLANTATION
Taylor Turnbull BS
Medical University of South Carolina

192. SMALL BOWEL OBSTRUCTION FROM 3 CM GALLSTONE IN THE SETTING OF CHILD-PUGH C LIVER CIRRHOSIS: A CASE REPORT AND LITERATURE REVIEW OF GALLSTONE ILEUS
Charles Grigsby MD
Augusta University

213. MANAGEMENT OF INTRA-ABDOMINAL BILOMA IN THE SETTING OF CHRONIC STEROID USE FOR NEPHROTIC SYNDROME: A CASE REPORT
Gifty Abraham MD
University of South Alabama
219. EARLY ONSET PANCREATIC ADENOCARCINOMA: AN ASSESSMENT OF CLINICAL, PATHOLOGIC AND TREATMENT OUTCOMES
Emily Shih BS
Eastern Virginia Medical School

220. PRIMARY HEPATIC SARCOMA PRESENTING WITH RUPTURE: TWO CASES
Kasey Cox MD
University of Mississippi

237. PERFORATION OF THE DUODENUM SECONDARY TO INGESTED TOOTHPICK TREATED WITH PRIMARY REPAIR
Alicia Register MD
Mercer University/Navicent Health

245. EVALUATION OF A TRIAL OF A DESUFFLATION TECHNIQUE TO DECREASE THE RATE OF POST-OPERATIVE PERCUTANEOUS ENDOSCOPIC GASTROSTOMY PNEUMOPERITONEUM
Allison Cauthen MS
Mercer University/Navicent Health

252. THE TREATMENT OF INCIDENTAL GASTROINTESTINAL Stromal TumORS DURING ELECTIVE LAPAROSCOPIC SLEEVE GASTRECTOMY
Nikky Bardia MD
University of South Alabama

276. DIRECT PERITONEAL RESUSCITATION IN THE SETTING OF HEMORRHAGIC PANCREATITIS
Jaine McKenzie MD
Augusta University

277. MIDGUT VOLVULUS IN ADULTS WITH CONGENITAL INTESTINAL MALROTATION
Kayla Smith MD
Medical College of Georgia at Augusta University
285. DIAGNOSIS, MANAGEMENT, AND OUTCOME OF LYMPHOPLASMACYTIC (AUTOIMMUNE) PANCREATITIS
Susan Wcislak MD
University of Tennessee Health Science Center

288. DIAPHRAGMATIC HERNIA AFTER HEPATIC RESECTION: 2 CASE REPORTS
Suzie Lee MD
Vanderbilt University Medical Center

290. HEPATIC CYSTO-ENTERIC FISTULA: A CASE OF HEPATIC CYST COMPLICATION
Aubrey Place BS
Augusta University
ePoster Station #: 6 | Colorectal

1. THE FINANCIAL IMPACT OF AN ENHANCED RECOVERY PROTOCOL IN COLO-RECTAL SURGICAL CARE
Nathan Johnson BS
Virginia Tech Carilion School of Medicine

27. SURGICAL SITE INFECTION RATES IN A DISPROPORTIONATE SHARE HOSPITAL (DSH) QUALITY IMPROVEMENT PROJECT (QIP) FOR COLON AND RECTAL RESECTIONS IN BENIGN AND MALIGNANT DISEASE: ARE THE RISK FACTORS DIFFERENT?
Elyse Bevier-Rawls MD
Louisiana State University

33. ANAL GLAND ADENOCARCINOMA: A SURGICAL DILEMMA
Mary Chavez MD
Morehouse School of Medicine

40. THE USE OF FLUORESCENCE ANGIOGRAPHY FOR CONFIRMATION OF HEMORRHOID DEARTERIALIZATION
Nishant Sharma MD
Morehouse School of Medicine

42. RECURRENT CLOSTRIDIUM DIFFICILE INFECTION AFTER DIVERTING LOOP ILEOSTOMY AND COLONIC LAVAGE: AN UNREPORTED COMPLICATION OF THE NOVEL SURGICAL THERAPY
Anna Fashandi MD
University of Virginia Health System

54. RARELY REPORTED COMPLICATION OF COLONOSCOPY
Darley Solomon MD
Chrissie Tomlinson Memorial Hospital

55. COLON AND RECTAL NEUROENDOCRINE TUMORS: ARE THEY REALLY ONE DISEASE? A SINGLE-INSTITUTION EXPERIENCE OVER 15 YEARS
Justine Broecker MD
Emory University
62. J POUCH PROLAPSE AS A LATE COMPLICATION OF RESTORATIVE PROCTOCOLECTOMY
Keith Hollister MD
University of Tennessee College of Medicine at Chattanooga

71. IMPROVED OUTCOMES IN COLORECTAL SURGERY WITH AN ENHANCED RECOVERY PROTOCOL WITH AN EXPANDED PRE-OPERATIVE COMPONENT
Nathan Johnson BS
Virginia Tech Carilion School of Medicine

82. NARCOTIC DEPENDENT PATIENTS DERIVE EQUAL BENEFIT FROM ENHANCED RECOVERY
Julia Ross BA
Virginia Tech Carilion School of Medicine

120. ‘ENHANCED RECOVERY’ PROTOCOL COMPLIANCE INFLUENCES LENGTH OF STAY: RESOLVING BARRIERS TO IMPLEMENTATION
Evon Zoog MD
University of Tennessee College of Medicine at Chattanooga

197. SOLITARY RECTAL ULCER SYNDROME: AN ATYPICAL PRESENTATION AND REVIEW OF THE LITERATURE
Audrey Spencer MD
Christian Care Health Systems

270. INTERNAL HERNIA BEHIND THE ILEAL POUCH ANASTOMOSIS LEADING TO STRANGULATION; A CASE REPORT
Aaron Bolduc MD
Augusta University

310. RECTUS FLAP RECONSTRUCTION AFTER CHEMORADIATION AND ABDOMINOPERINEAL RESECTION, A CASE SERIES
Michael Williams MD
Morehouse School of Medicine
327. MORBIDITY ASSOCIATED WITH DIVERTING LOOP ILEOSTOMIES: WEIGHING DIVERSION IN RECTOSIGMOID AND HIGH RECTAL RESECTION
Alexander Hawkins MD, MPH
Vanderbilt University Medical Center

363. MASQUERADING AS SIGMOID ADENOCARCINOMA: A UNIQUE CASE OF HIGH GRADE SEROUS CARCINOMA ARISING FROM ENDOMETRIOSIS
Wali Johnson MD
Vanderbilt University Medical Center
ePoster Station # 7 | Quality Improvement/Education

44. PERFORMANCE OF SOUTHEASTERN SURGICAL CONGRESS EXAMINEES ON THE AMERICAN BOARD OF SURGERY EXAMINATIONS: AN EDUCATIONAL OPPORTUNITY FOR REGIONAL COLLABORATION
John Falcone MD, MS
One Health

51. DOES ENHANCED RECOVERY AFTER SURGERY PROTECT AGAINST POST-OPERATIVE PNEUMONIA AND LOWER THE RATE OF RE-INTUBATION?
Jing Chen PhD
Virginia Tech Carilion School of Medicine

75. PREFERENCE CARD CLEANUP: METHODOLOGY AND OUTCOMES
Ethan Talbot MD
Bassett Medical Center

85. PREDICTIVE FACTORS OF TIMELINESS IN THE GENERAL SURGERY CLINICS OF AN ACADEMIC CENTER: A PROSPECTIVE OBSERVATIONAL STUDY
Katelyn Young BS
Geisinger Medical Center

92. THE IMPACT OF MISSED AMBULATION EVENTS AFTER ABDOMINAL SURGERY ON HOSPITAL LENGTH OF STAY
Trent Stethen BS
University of Tennessee Medical Center, Knoxville

98. EVALUATION OF RISK STRATIFICATION IN GENERAL SURGERY
Sandy Fogel MD
Carilion Clinic

113. IMPROVEMENT IN RESIDENT ROBOTIC SURGICAL PERCEPTION WITH A CADAVER TRAINING LAB
David Hall MD
University of Florida
121. EFFICIENCY AND UTILIZATION OF A SURGICAL PROCEDURE PROFICIENCY IDENTIFICATION CARD TO VERIFY RESIDENT COMPETENCY FOR BEDSIDE PROCEDURES
Brice Hwang BS
Augusta University

133. SCREENING COLONOSCOPY PROCESS IMPROVEMENT USING LEAN METHODS
Andrew Jones BS, BA
Augusta University

202. A HISTORY OF THE UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE-CHATTANOOGA GENERAL SURGERY RESIDENCY PROGRAM
Jacob Dowden MD
University of Tennessee College of Medicine at Chattanooga

227. SURGICAL TRAINEES’ CONFIDENCE IN THE OR IMPROVES OVER TIME WITH A CORRESPONDING INCREASE IN RESPONSIBILITY
Juyeon Park BA
Virginia Tech Carilion School of Medicine

232. EMERGENT AND ELECTIVE PATIENTS BENEFIT FROM ENHANCED RECOVERY
Scott Ryan MD
Virginia Tech Carilion School of Medicine

253. PREHABILITATION IMPROVES OUTCOMES IN SURGICAL PATIENTS
Allison Farris MD
Carilion Clinic

259. INTRODUCTION OF VENOUS THROMBOEMBOLIC EVENT PROPHYLAXIS PROTOCOL AT A LEVEL 1 TRAUMA CENTER
Delquis Mendoza MD
Atlanta Medical Center

291. ALCOHOL ABUSE AND HOSPITAL OUTCOMES IN BARIATRIC SURGERY PATIENTS
Aaron Bolduc MD
Augusta University
326. COMPLIANCE AND VARIATIONS IN TEACHING ASSISTANT EXPERIENCE DURING SURGICAL RESIDENCY
Mitesh Patel MD
Providence-Providence Park Hospital

334. MULTI-INSTITUTIONAL TRIAL OF A NOVEL WEB-BASED LAPAROSCOPIC TECHNICAL SKILLS ASSESSMENT AND TESTING INSTRUMENT
Alex Cantafio MD
University of Tennessee Medical Center, Knoxville
ePoster Station #: 8 | Other

8. POST-GRADUATE YEAR DOES INFLUENCE OPERATIVE TIME IN LAPAROSCOPIC CHOLECYSTECTOMY
Vernon Horst MD
Brookwood Baptist Health System

34. ASSESSMENT OF FAT FRACTION ON MRI AS A SENSITIVE AND RELIABLE PREDICTOR OF SARCOPENIA IN LIVER TRANSPLANT RECIPIENTS
Sunil Shenvi MS, MCh
Medical University of South Carolina

43. MODIFICATION OF THE FRICKE FLAP FOR TOTAL LATERAL EYELID AND CANTHUS RECONSTRUCTION
L. Ashley Griffin MD
University of Mississippi

63. ANTIBIOTIC USE IN OPEN ABDOMENS
Amelia Pasley DO
University of Maryland

67. SOLVING THE NORTH DAKOTA RURAL SURGERY SHORTAGE ONE COMMUNITY AT A TIME
Mary Aaland MD
University of North Dakota

80. IMPLEMENTATION AND VALIDATION OF AN OBJECTIVE FORMULA FOR RANKING AND SELECTING GENERAL SURGERY RESIDENCY APPLICANTS
Samantha Lane MHS
Geisinger Medical Center

83. CHARACTERIZATION OF THE RELATIONSHIP BETWEEN EMOTIONAL INTELLIGENCE AND NON-TECHNICAL SKILLS FOR SURGEONS: A PROSPECTIVE OBSERVATIONAL STUDY
Katelyn Young BS
Geisinger Medical Center
87. ANGIONEUROTIC EDEMA PRESENTING AS MASS-LIKE BLUE TONGUE AND LARYNX
Roger Su MD
Atlanta Cancer Research and Education Foundation

134. EXCISION OF A PRESACRAL GANGLIONEUROMA IN A YOUNG MALE: A CASE REPORT
Eileen O’Halloran MD
Loyola University Medical Center

153. NODULAR LYMPHOCYTE PREDOMINANT HODGKIN LYMPHOMA IN A 13 YEAR-OLD GIRL: A CASE REPORT AND ACADEMIC DISCUSSION
James Fortson MD, MPH, MBA
Atlanta Cancer Research and Education Foundation

169. OVER-THE-SCOPE CLIP CLOSURE OF ENTEROCUTANEOUS FISTULA: A NOVEL APPROACH
Kaci Sims MD, MPH
University of South Alabama

217. INTRAOPERATIVE COMMUNICATION AND THE EFFECT OF NAVIGATIONAL GRIDS DURING LAPAROSCOPIC CHOLECYSTECTOMIES
Tyler Goff BA
University of South Carolina

229. THE DELETERIOUS EFFECTS OF A VAGINAL PESSARY IN A PATIENT WITH A HISTORY OF RADIATION THERAPY INVOLVING THE POSTERIOR VAGINAL WALL.
Adrienne Christopher BA
Sidney Kimmel Medical College

269. PREVENTION OF IMPLANTED CENTRAL VENOUS PORT EROSION WITH PROPHYLACTIC MESH TISSUE AUGMENTATION
David Palange DO
Rutgers University
7. LAPAROSCOPIC APPROACH TO MORGAGNI HERNIAS
Kelsey Guerreso BS
Mercer University/Navicent Health

72. USE OF LOCAL ANESTHETIC BLOCKS TO ATTEMPT TO REDUCE POST-OPERATIVE OPIOID REQUIREMENTS AFTER ABDOMINAL WALL RECONSTRUCTION
Michael Lew MD
University of Tennessee Medical Center, Knoxville

95. THE UTERINE FLAP: AN OPTION FOR AUTOGENOUS REPAIR OF PERINEAL HERNIA FOLLOWING ABDOMINOPERINEAL RESECTION
David Hall MD
University of Florida

97. EXPERIENCE OF PATIENTS WITH VENTRAL HERNIAS AND MORBID OBESITY PRESENTING TO A SURGERY CLINIC
Margaret Plymale DNP
University of Kentucky

128. STAGED MANAGEMENT OF GIANT INGUINOSCROTAL HERNIA
Hope Sprunger BS
Greenville Health System

131. NOVEL METHOD FOR REPAIR GIANT ABDOMINAL SOFT TISSUE DEFECT
Trevy Ramos DO
East Tennessee State University

143. PREOPERATIVE DIAGNOSIS OF A RARE VARIATION OF AMYAND’S HERNIA: ACUTE APPENDICITIS & A PERIAPPENDICULAR ABSCESS WITHIN THE SCROTUM OF A RECURRENT INGUINAL HERNIA
Nils-Tomas McBride MD
Easton Hospital
190. VITAMIN C DEFICIENCY IN THE HERNIA POPULATION
Nikky Bardia, MD
University of South Alabama

228. THE USE OF BOTULINUM TOXIN IN COMPLEX ABDOMINAL WALL RECONSTRUCTION (AWR)
Stephanie Sims MD
Carolinas Medical Center

260. CONCURRENT LAPAROSCOPIC HERNIA REPAIR AND CYSTOSCOPIC LASER CYSTOLITHOLAXAPY FOR URINARY BLADDER CALCULUS CONTAINED WITHIN A DIRECT INGUINAL HERNIA
Benjamin Hancock
University of South Carolina

267. TWO CASES OF FORAMEN OF WINSLOW HERNIAS
Robert Lyons MD
Eastern Virginia Medical School

293. STRANGULATED INGUINAL HERNIA WITH EXTENSIVE ISCHEMIC BOWEL AND PORTAL VENOUS GAS
James Rawles MD
New Hanover Regional Medical Center

325. OUTCOMES OF LAPAROSCOPIC SLEEVE GASTRECTOMY (LSG) AFTER ORTHOTOPIC LIVER TRANSPLANTATION (OLT)
Diego Villacreses, MD
Mayo Clinic Florida
61. INTRAVENOUS KETAMINE FOR AGITATION IN CRITICAL CARE
Ashton Lee MD
Orlando Regional Medical Center

65. PROPRANOLOL USE IN SEVERE TRAUMATIC BRAIN INJURY IS ASSOCIATED WITH DECREASED MORTALITY
Christopher Bell MD
University of Tennessee College of Medicine at Chattanooga

322. OUTCOMES AFTER REVERSAL OF COMBAT RELATED OSTOMIES
Luke Johnston MD
Uniformed Services University- Walter Reed National Military Medical Center

323. GERIATRIC TRAUMA VOLUME DETERMINES THE THRESHOLD OF MINIMIZING MORTALITY VARIANCE AMONG TRAUMA CENTERS
Darwin Ang MD, PhD, MPH
Ocala Health

329. RAPID REVERSAL OF COAGULOPATHY IN MULTI-TRAUMA PATIENTS USING FOUR-FACTOR PROTHROMBIN COMPLEX CONCENTRATE, A RETROSPECTIVE COHORT
Majel Purvis MD
University of South Alabama

332. GUIDELINE DRIVEN CARE IMPROVES OUTCOMES IN PATIENTS WITH TRAUMATIC RIB FRACTURES
Thomas Schroeppel MD
Memorial Hospital, University of Colorado Health

333. THE EFFECT OF SMOKER STATUS ON BURN INJURY OUTCOMES IN PATIENTS WITHOUT PREEXISTING RESPIRATORY DISEASE
Laquanda Knowlin MD
University of North Carolina
338. PERSONAL WATERCRAFT INJURY: A SINGLE TRAUMA CENTER 16 YEARS OF EXPERIENCE
Seung Shin MD
University of Miami

339. THE ROLE OF DIVERTING COLOSTOMY IN TRAUMATIC BLUNT OPEN PELVIC FRACTURES
Caitlin Fitzgerald MD
Emory University

341. RESUSCITATIVE ENDOVASCULAR BALLOON OCCLUSION OF THE AORTA (REBOA) IS FEASIBLE IN PATIENTS AT RISK FOR AGE-RELATED VASCULAR DISEASE
W. Bryan Gamble MD
Shock Trauma Center, University of Maryland

342. LIFE OVER LIMB: LOWER EXTREMITY ISCHEMIA IN THE SETTING OF RESUSCITATIVE ENDOVASCULAR BALLOON OCCLUSION OF THE AORTA (REBOA)
Philip Wasicek MD
University of Maryland

343. OUTCOMES OF CARDIOPULMONARY RESUSCITATION IN TRAUMATIC ARREST: AN OPPORTUNITY FOR CHANGE AT A LEVEL ONE TRAUMA CENTER
Katherine McBride MD
Memorial University Medical Center

350. ADMISSION VITAL SIGNS OF THE AGING TRAUMA POPULATION: ARE OLD STEREOTYPES DANGEROUS?
W. T. Hillman Terzian MD
St. Luke’s University Health Network

354. EARLY FEEDING AFTER PENETRATING GASTRIC INJURIES: IS IT SAFE?
Timothy Mansour MD
University of South Alabama
358. ACUTE SUBDURAL HEMATOMA IN TRAUMATIC INJURY AMONG THE ELDERLY: REDUCING READMISSION RATES
Tarik Wasfie MD
Genesys Regional Medical Center

359. TRAUMA INVOLVING COMPLETE RENAL PARENCHYMAL MASS: PRINCIPALS AND GUIDELINES OF MANAGEMENT
Gregory Coffman MD
Atlanta Medical Center

361. TOO MUCH OF A GOOD THING? PROLONGED AORTIC OCCLUSION IS ASSOCIATED WITH DECREASED SURVIVAL
Melanie Hoehn MD
University of Maryland
NEW MEMBERS
NEW MEMBERS

Vriti Advani Winter Haven, FL
Patrick Bosarge Birmingham, AL
Jessica Burgess Norfolk, VA
Ayana Chase Atlanta, GA
Subrato Deb Oklahoma City, OK
Jeremiah Deneve Collierville, TN
Matthew Doepker Columbia, SC
Christopher DuCoin New Orleans, LA
Truman Earl Jackson, MS
Nicole Garcia Greenville, NC
Alexander Hawkins Nashville, TN
Thomas Herron Tampa, FL
Steven Holsten, Jr. Augusta, GA
Michael Honaker Macon, GA
Mary Killackey New Orleans, LA
James Korndorffer New Orleans, LA
Stefan Leichtle Richmond, VA
Joe Liles Mobile, AL
John McGillicuddy Charleston, SC
Gerald McKinney Ridgeland, MS
Caleb Mentzer Miami, FL
Craig Messick Houston, TX
Wayne Orr Ridgeland, MS
Snehal Patel Atlanta, GA
Ankit Patel Atlanta, GA
Jonathan Pollock Atlanta, GA
Tyler Reynolds Decatur, GA
Roy Roberts Knoxville, TN
Shawn Safford Roanoke, VA
Rebecca Schroll New Orleans, LA
David Shibata Memphis, TN
Matthew Spann Nashville, TN
John Sweeney Atlanta, GA
Jared White Birmingham, AL
Danny Yakoub Miami, FL
Kristen Zeller Winston Salem, NC
NEW MEMBERS - RESIDENTS

<table>
<thead>
<tr>
<th>Name</th>
<th>City, State</th>
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<tbody>
<tr>
<td>Anthonia Adewole</td>
<td>Atlanta, GA</td>
</tr>
<tr>
<td>Colleen Alexander</td>
<td>Johnson City, TN</td>
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<tr>
<td>Georgina Alizo Arruebarrena</td>
<td>Myrtle Beach, SC</td>
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<td>Mary Arbuthnot</td>
<td>Portsmouth, VA</td>
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<td>Todd Bierman</td>
<td>Mobile, AL</td>
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<td>Jonathan Boguski</td>
<td>Greenville, SC</td>
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<td>Jessica Buicko</td>
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<td>Artem Dyatlov</td>
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<td>Tanya Egodage</td>
<td>Chicago, IL</td>
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<td>Trine Engebretsen</td>
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<td>Mike Mallah</td>
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<td>Maryann Mbaka</td>
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<td>Amelia Merrill</td>
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<td>Heather Peluso</td>
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<td>Kimberly Ramonell</td>
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<td>Robert Rhyne</td>
<td>Greenville, SC</td>
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<tr>
<td>Adil Shah</td>
<td>Washington D.C.</td>
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</tbody>
</table>
NEW MEMBERS CONTINUED

NEW MEMBERS - RESIDENTS

Erika Simmerman  Augusta, GA
Brian Sparkman  Jackson, MS
Zachary Stiles  Memphis, TN
Ethan Talbot  Cooperstown, NY
WT Hillman Terzian  Bethlehem, PA
Celso Uribe  Atlanta, GA
Daniel Verna  Greenville, SC
Yancey Warren  Charlotte, NC
Sharon Yu  Atlanta, GA
NECROLOGY
NECROLOGY

2013
Eric R. Frykberg, MD—Jacksonville, FL
Charles D. Knight, MD—Shreveport, LA
M. Gage Ochsner, MD—Savannah, GA
Douglas H. Riddell, MD—Nashville, TN

2014
Carl H. Almond, MD—Columbia, SC
Richard J. Field, Jr., MD—Centreville, MS (PAST PRESIDENT, 1993-1994)
Henry L. Laws, MD—Birmingham, AL (PAST PRESIDENT, 1997-1998)
Myron W. Wheat, Jr., MD—Gainesville, FL

2015
Norman E. McSwain, Jr., MD—New Orleans, LA
William W. Pfaff, MD—Gainesville, FL
Judson G. Randolph, MD—Nashville, TN

2016
John C. Baldwin, MD—Lubbock, TX
Isidore Cohn, Jr., MD—New Orleans, LA (PAST PRESIDENT, 1972-1973)
Mark L. Friedell, MD—Kansas City, MO
Theron T. Knight, Jr., MD—Beech Mountain, NC
Hugh B. Lynn, MD—Winchester, VA
Chad A. Rubin, MD—Columbia, SC
John P. Wilson, MD—Palmetto, GA

2017
Ronald H. Clements, MD—Nashville, TN