

Final Program

2016 Annual Scientific Meeting and Postgraduate Course

Southeastern Surgical Congress

February 20 – 23, 2016

Hyatt Regency Atlanta

Atlanta, Georgia



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. Please see the insert to this program for the complete disclosure list.



ACKNOWLEDGEMENT OF FINANCIAL SUPPORT

**The Southeastern Surgical Congress wishes to recognize
and thank the following companies for their ongoing support
through educational grants**

American College of Surgeons

Ethicon, Inc.



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SAVE THESE DATES

**2017 Annual Scientific Meeting
Renaissance Hotel
Nashville, TN
February 25 – 28, 2017
Abstract Deadline July 7, 2016**



Quick Reference Guide for 2016 Annual Meeting

Saturday, February 20

- 8:00 AM – 6:00 PM Registration Opens—Centennial Ballroom Foyer
9:00 AM – 12:00 PM Residents' Forum—Hanover C
12:00 PM – 1:00 PM Resident's Luncheon—Hanover A
1:00 PM – 5:30 PM Postgraduate Course—Hanover F/G
5:30 PM – 6:30 PM Resident Jeopardy—Hanover F/G
6:00 PM – 7:30 PM Welcome Reception—Regency Ballroom

Sunday, February 21

- 6:15 AM – 5:00 PM Registration Opens—Centennial Ballroom Foyer
6:30 – 7:50 AM Grand Rounds of Posters—Regency Ballroom
8:00 – 12:20 PM Morning Scientific Session—Centennial Ballroom
12:20 – 2:00 PM Round Table Luncheons
Fellow, Resident, and Medical Student Committee—
Hanover F/G
Surgical Practice Committee—Hanover C/D
2:00 – 5:50 PM Afternoon Scientific Sessions—Centennial Ballroom
5:30–6:30 PM Quick Shots—Centennial Ballroom
6:00 – 7:30 PM Young Surgeons Committee Reception—Hanover C

Monday, February 22

- 6:00 AM Registration Opens—Centennial Ballroom Foyer
6:30 – 7:50 AM Grand Rounds of Posters—Regency Ballroom
8:00 AM – 12:00 PM Morning Scientific Session—Centennial Ballroom
12:20 – 2:00 PM Business Meeting and Luncheon of the Fellows—
Hanover C/D
2:00 – 5:20 PM Parallel Session I—Centennial Ballroom
2:00 – 5:20 PM Parallel Session II—Hanover C–E
5:30 – 6:30 PM Video Interactive Session—Hanover C–E

Tuesday, February 23

- 6:15 AM Registration Opens—Centennial Ballroom Foyer
- 7:00 – 9:00 AM Parallel Session III—Centennial Ballroom
- 7:00 – 9:00 AM Parallel Session IV—Regency VI
- 9:10 AM – 12:10 PM Morning Scientific Session—Centennial Ballroom

PROGRAM FEATURES

Podium Presentations

Presentations will be made from the podium, Sunday through Tuesday, including talks from invited guest speakers, videos of surgical procedures, prize-winning Gold Medal Forum papers, and clinical papers selected from over 300 abstracts received for consideration.



Gold Medal Papers

These winning papers, selected from a large number of entries, by the Gold Medal Forum Committee, are identified in the program by the seal of the Congress. The Gold Medal Award is a prestigious recognition of excellent research by young surgeons and medical students. The presenters will also receive cash awards on Monday during the afternoon break.

Saturday Residents' Forum—Please make note of time change

On Saturday, February 20, 9:00 AM–11:50 AM, a number of residents will present surgical research papers. 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. Assigned discussants will also be residents. The Forum will be moderated by Dr. Michael O. Meyers, Dr. J. Patrick O'Leary, and Dr. Joseph B. Cofer. Residents are encouraged to attend and participate in the discussion of papers from the floor, and senior surgeons are invited to assist with discussion. Even though there is no charge, you must register for the Residents' Forum on the registration form.

Resident's Luncheon

Dr. Michael O. Meyers from the Continuing Medical Education Committee along with Dr. J. Patrick O'Leary, Past President of the Congress, and Dr. Joseph B. Cofer, will speak on the Future of General Surgery Training along with how professional organizations such as the Southeastern Surgical Congress can assist them in their professional lives. A ticket is required for this lunch. Be sure to purchase your ticket on the registration form.

Saturday Postgraduate Course “Advances in Hernia Repair”

Saturday, February 20, 2016
1:00 PM–5:00 PM

The course will inform participants of all recent advances in hernia repair and address existing controversies. Nationally recognized faculty will present on the indications of which surgical approach to use in complex ventral hernia repairs, the types and advantages/ disadvantages of different component separation techniques during abdominal wall reconstruction, the importance of abdominal wall closure technique and the use of biologic versus synthetic mesh, the benefits and potential concerns of using mesh in hiatal hernias, the potential

advantages of using the robot for ventral hernia repair, and the incorporation of enhanced recovery evidence-based paradigms after hernia surgery.

Grand Rounds of Posters

These rounds provide an opportunity for poster authors to make an oral presentation to the Grand Rounds Professors and their peers, which enhance the poster exhibits. Scheduled Sunday and Monday, 6:30–7:50 AM. Stroll with the rounding teams while you eat breakfast.

Sunday Round Table Luncheons

Lunch 1—Fellow, Resident, and Medical Student Committee

“Transition and Simulation of the Certifying Examination (Mock Oral)”

Purchase tickets at the registration desk

Lunch 2—Surgical Practice Committee

“ERAS in General Surgery” and “ICD 10 adoption: Like it or Not”

Purchase tickets at the registration desk



AMERICAN COLLEGE OF SURGEONS

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American College of Surgeons Session

The ACS is once again coming to you, the General Surgeon, on Sunday, February 24, from 2:00–5:00 PM. Be sure to attend to

join in the discussion on issues relevant to the general surgeon, and an open question and answer session.

Monday Business Meeting, Election of Officers and Luncheon

This is a time for the Fellows of the Congress to hear reports from their representatives to the Advisory Council, the American Board of Surgery, and the Board of Governors of the American College of Surgeons. It is a time to provide input for these representatives and to conduct the annual business of the Congress. No charge is made to members for lunch, but tickets must be requested at the registration desk. Surgeons, who are not members, and guests of members, may purchase tickets.

Video Interaction Session

On Monday afternoon there will be videos that were not presented during the Program with the authors available for discussion. Refreshments will be served; just wear your badge to attend.

INFORMATION

REGISTRATION

Registration Area is located in the Centennial Ballroom foyer. All surgeons, guests, spouses, and others attending the Postgraduate Courses, Scientific Meeting, and Residents' Forum are requested to come to the Registration Desk. Badges are required for surgeons, guests, and exhibitors to enter the meeting, exhibit areas, and all events. Tickets for the luncheons, if still available, may be purchased at the Registration Desk.

Hours are:

Saturday, February 20, 2016
8:00 AM–6:00 PM

Sunday, February 21, 2016
6:15 AM–5:00 PM

Monday, February 22, 2016
6:15 AM–5:00 PM

Tuesday, February 23, 2016
6:15 AM–9:00 AM

PROGRAM OBJECTIVES

This activity is designed for surgeons, residents, medical students, nurses, and those who work in the surgical community. Upon completion of the annual meeting, attendees will have experienced (1) prominent surgical authorities as invited speakers; (2) presentations with assigned discussants selected from a large number of abstracts; (3) current surgical research projects selected by competition; (4) surgical operative procedures by noted surgeons on video; (5) informal discussion groups at luncheon meetings; (6) specialty panels providing opportunities for active participation by the surgeons attending; (7) and a Poster Session covering a wide variety of general surgical topics, including discussion by a team of rounding professors. As such, attendees will have seen and discussed new and emerging technologies and science, based on accepted recommendations or sound new research, to make surgery safer and more effective for patient care. The Southeastern Surgical Congress monitors impact on practice change by systematic assessment of meeting/course evaluation

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™

The American College of Surgeons designates this live activity for a maximum of 26.75* *AMA PRA Category 1 Credits™*. **Physicians should claim only the credit commensurate with the extent of their participation in the activity.**

*23.25 credits for the Annual Meeting; 3.5 Credits for the PG Course

Of the *AMA PRA Category 1 Credits™* listed above, a maximum of 18.25*credits meet the requirements for Self-Assessment.

*14.75 Self-Assessment Credits for the Annual Meeting; 3.5 Self-Assessment Credits for the PG Course



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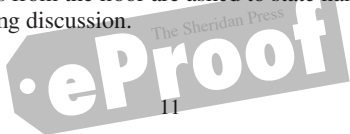
Accredited with Commendation by the
Accreditation Council for Continuing Medical Education

THE AMERICAN SURGEON

The Southeastern Surgical Congress is the owner and publisher of the journal, *THE AMERICAN SURGEON*, which is the official journal of the Congress. Papers presented during the meeting will, at the discretion of the Editor, be published in *THE AMERICAN SURGEON*.

SPEAKERS AND DISCUSSANTS

Speakers and Discussants, please sit near the front of the room to avoid delays in the program. Invited Discussants will open the discussion, and the author/co-author will be invited to close the discussion. For the benefit of your fellow registrants, discussants from the floor are asked to state name and home city clearly before beginning discussion.



AUDIOVISUAL MATERIALS

Speakers should give a CD/DVD to the projectionist by 6:30 AM for the morning session, 10:00 AM for the afternoon session. All materials should be carefully marked with the speaker's name, time of talk, and paper number. Any PowerPoint presentations with imbedded video must be given to the AV technician per the following guidelines:

- If presentation is in the morning—give to AV tech the afternoon before.
- If presentation is in the afternoon—give to AV tech in the morning.
- Please bring a separate file of the video only in addition to the
- PowerPoint file.

SPECIAL ACTIVITIES

Resident Surgical Jeopardy

Saturday, February 20, 5:30–6:30 PM

What is... the best session of the program? Residents from Surgical Programs in the Southeast will compete on surgical knowledge in the style of this favorite game show. Come watch to enjoy the competition and to test your own knowledge of surgical trivia.

Welcome Reception

Saturday, February 20, 6:00–7:30 PM—Exhibit Hall

Meet your colleagues for a reception to kick off the meeting. All registrants and guests are invited to this very special social occasion to re-connect with friends, network with acquaintances, talk to exhibitors, and make new friends to enjoy during the meeting. No fees—just fun. Wear your badge to attend!

Young Surgeons Reception

Sunday, February 20, 6:00–7:30 PM

Please join the Young Surgeons Committee for a networking reception.

Continental Breakfasts

6:15–8:00 AM—Exhibit Hall

Each day you can enjoy a continental breakfast as you visit the exhibits or take a stroll with the Professors to discuss the posters on Sunday and Monday. Spouses are welcome; everyone must wear a badge.

A. HAMBLIN LETTON LECTURE



“Contemporary Management of Borderline and Locally Advanced Pancreatic Adenocarcinoma”

Rebecca M. Minter, M.D.

Alvin Baldwin Jr Distinguished
Professor of Surgery
Vice Chair, Clinical Operations and
Finance
Chief, Section of
Hepatopancreatobiliary Surgery
Division of Surgical Oncology
University of Texas Southwestern
Medical Center *Dallas, TX*

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 the Chair of the Whitaker Professor of Surgery at Piedmont Hospital when he retired in October, 1997. Dr. Sherman passed away on April 9, 2006, at the age of 82.

ROGER SHERMAN LECTURE



“In Pursuit of the Holy Grail- Developing a Trauma System and Improving the Quality of Care”

Loring W. Rue, III, M.D.

Professor of Surgery

John H. Blue Chair in General
Surgery

Vice Chairman for Clinical Affairs

Director, Center for Injury Sciences at
University of Alabama - Birmingham

Chief Medical Officer, University
of Alabama - Birmingham Health
System University of Alabama–
Birmingham *Birmingham, AL*

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.

HENRY L. LAWS, II LECTURE



“Resident Jeopardy”

R. James Valentine, M.D.

Professor of Surgery

Department of Surgery

Vanderbilt University Medical Center

Nashville, TN

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.



David J. Cole, MD **President**

David J. Cole, MD, FACS, completes his term as President of the Southeastern Surgical Congress at the close of this year's annual business meeting. During his term in office he has worked to successfully implement the bylaws changes approved with the Congress in 2015 which required the restructuring of its organization into a committee-based rather than regionally based enterprise. Additionally, he has worked closely with new Secretary-Treasurer to assure a smooth transition

from the leadership of Kenneth Sharp to Tim Farrell and assure the fiscal fidelity of the organization moving forward. He has held key leadership positions in the SESC including serving as the State Counselor from South Carolina, First Vice President, and serving on the SESC Executive Committee as Councilor at Large.

Dr. Cole came to the Medical University of South Carolina in 1994 as an Assistant Professor in the Department of Surgery, Division of General Surgery. He quickly rose through the ranks and was promoted to Professor in 2002. At the same time, Dr. Cole assumed the positions of Vice Chairman for the Department of Surgery and Chief of the Division of General Surgery, which then included Surgical Oncology, Gastro-Intestinal and Laparoscopic Surgery; and Trauma, Vascular, and Acute Care Surgery. In 2003 Dr. Cole was named the A. McKoy Rose, Jr., MD Endowed Chair in Surgical Oncology and selected as Chairman for the Department of Surgery in September of 2007. From 2011-2013 Dr. Cole served as Secretary for MUSC Physicians (known at the time as University Medical Associates) and was elected President of MUSC Physicians in 2013. He held these roles until becoming the seventh President of MUSC on July 1, 2014.

Dr. Cole is Board Certified through the American Board of Surgery with primary clinical fields of interest in breast cancer and gastro-intestinal malignancies. For the past eight years, US News and World Report has recognized Dr. Cole as one of the top surgeons in the nation.

In addition to his clinical expertise, Dr. Cole brings a strong research background with more than 17 years of continuous funding by the National Institutes of Health (NIH). He recently stepped down after seven years as the Medical Director for the Center for Cellular Therapy in order to concentrate on

the needs surrounding his newest role. His research at the Center focused on novel cancer vaccine development and molecular diagnostics. As a thought-leader and innovator, Dr. Cole served as principal investigator for numerous clinical trials through the years and has secured multiple patents. He served on numerous National Cancer Institute (NCI) review panels and study sections, and authored more than 115 peer-reviewed publications and chapters.

A New Mexico native, Dr. Cole received his Bachelor of Science degree in Biology from New Mexico State University in Las Cruces where he graduated with highest honors and was a Rhodes Scholarship finalist. He received his medical degree from Cornell University Medical College in New York and was elected to Alpha Omega Alpha Honor Medical Society. He interned and completed his residency at Emory University Affiliated Hospitals in Atlanta and his fellowship in Surgical Oncology at the NIH/NCI Surgery Branch in Bethesda.

Dr. Cole and his wife, Kathy, live in Mt. Pleasant, SC and have recently become “empty nesters” with their youngest son, Bryan, beginning his college career at the University of South Carolina this past August. Andy, their middle child and oldest son, is currently completing his senior year at Clemson University. The Cole’s oldest child and only daughter, Paige, graduated from Clemson and is a high school English teacher in Greenville.

THE SOUTHEASTERN SURGICAL CONGRESS

OFFICERS

President.....	David J. Cole, MD
Immediate Past President.....	Don K. Nakayama, MD
President-Elect.....	David V. Feliciano, MD
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Second Vice President.....	Dennis W. Ashley, MD
Executive Director.....	Timothy M. Farrell, MD

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and
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Communication Committee.....	John H. Stewart, IV, MD
Fellow, Resident, and Medical Student.....	Brian J. Daley, MD
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Rural Surgeons.....	Richard J. Field, III, MD
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Surgical Practice Committee.....	Ronald H. Clements, MD
Women in Surgery.....	Laura E. Witherspoon, MD
Young Surgeons.....	Rebecca C. Britt, MD

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Richard J. Field, III, MD, *Centreville, MS*

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CONTINUING MEDICAL EDUCATION

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Michael O. Myers, MD
Wendy R. Greene, MD
Seaborn Anderson Roddenbery, MD
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Dennis W. Ashley, MD, Second Vice President
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GOLD MEDAL FORUM COMMITTEE

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Amy R. Quillo, MD
William S. Richardson, MD
Jyotimay “Joe” Sharma, MD

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Chair Alan B. Marr, MD
Chair John H. Stewart, IV, MD
Glen Franklin, MD
Errington Thompson, MD
Gregory Waters, MD

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Co-Chairman	Brian J. Daley, MD
	Reid B. Adams, MD
	Glen A. Franklin, MD
	Benjamin W. Dart, MD
	Therese M. Duane, MD
	Benjamin D. Li, MD
	Jyotirmay “Joe” Sharma, MD
	Christopher M. Bell, MD
	Sunil K. Geevarghese, MD
	Charles J. Paget, MD
	Philip Ramsey, MD
	William S. Richards, MD

Rural Surgeons Committee

Chairman	Richard J. Field, III, MD
	Andrew Calcutt, MD
	Ray E. Stahl, MD
	Mary A. Aaland, MD
	Eugene Shively, MD
	Bryan Richmond, MD

Surgical Practice Committee

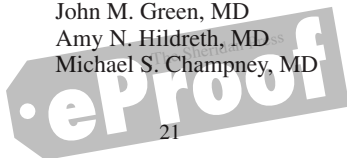
Chairman	Bryan K. Richmond, MD
	Richard J. Field, III, MD
	Laura E. Witherspoon, MD
	Eugene M. Langan, III, MD
	C. Daniel Smith, MD
	Andrew F. Calcutt, MD

Women In Surgery Committee

Chairman	Laura E. Witherspoon, MD
	Jennifer Rosen, MD
	Deborah Martin, MD
	Sharona Ross, MD
	Terri Martin, MD
	Heather Nolan, MD
	Marissa Howard-McNatt, MD

Young Surgeons Committee

Chairman	Rebecca C. Britt, MD
	John M. Green, MD
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	Michael S. Champney, MD





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| * Joseph S. Stewart, MD | * William H. Moretz, MD |
| * Harry Lee Claud, MD | * Isidore Cohn, Jr., MD |

* *Deceased*



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The Southeastern Surgical Congress**

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| C. Melvin Bernhard, MD | John B. Hanks, MD |
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| Timothy C. Pennell, MD | Alexander S. Rosemurgy, MD |
| William H. Edwards, Sr., MD | Frederick L. Greene, MD |
| * Richard J. Field, Jr., MD | Don K. Nakayama, MD |

* *Deceased*

Recipients of Distinguished Service Award

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

Mission Statement

The Southeastern Surgical Congress

Cumming, Georgia

The Southeastern Surgical Congress was founded to provide opportunities for surgeons and surgeons in training to come together for educational, scientific, and social purposes to promote and advance the study and practice of surgery.

The Congress proposes to carry out this mission by holding an annual scientific meeting that consists of one or more postgraduate courses covering new techniques and technology for specific surgical topics plus a three-day plenary session that includes (1) prominent surgical authorities as invited speakers; (2) presentations with assigned discussants selected from a large number of abstracts; (3) current surgical research projects selected by competition; (4) surgical operative procedures by noted surgeons on video; (5) informal discussion groups at luncheon meetings; (6) specialty panels providing opportunities for active participation by the surgeons attending; (7) and a Poster Session covering a wide variety of general surgical topics, including discussion by a team of rounding professors.

At the annual meeting, all papers and videos shall have assigned discussants to insure that the topics are thoroughly covered and discrepancies in research are noted. Time will be allocated for discussion from the floor to increase audience participation.

Papers presented at the meeting will be submitted for peer review and then published, along with manuscripts independently submitted, in *THE AMERICAN SURGEON*, a journal owned and published by the Southeastern Surgical Congress.

The Congress is committed to assisting surgeons keep abreast of new and emerging technologies, based on accepted recommendations or sound new research, to make surgery safer and more effective for patient care. The Southeastern Surgical Congress monitors impact on practice change by systematic assessment of meeting/course evaluations.

Adopted August 16, 2008

Saturday, February 20, 2016
RESIDENTS' FORUM

Purpose: 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: **Michael O. Meyers, MD**, University of North Carolina, *Chapel Hill, NC*
J. Patrick O'Leary, MD, Florida International University College of Medicine, *Miami, FL*
Joseph B. Cofer, MD, Erlanger Medical Center, *Chattanooga, TN*

- 9:00 **Welcome**
- 9:05 **RF1 Quantification of the Effect of Diabetes Mellitus on Ventral Hernia Repair: Results from Two National Registries**
CR Huntington MD; JE Gamble; TC Cox MD; LJ Blair MD; T Prasad MA; AE Lincourt PhD MBA; VA Augenstein MD; BT Heniford MD, Carolinas Medical Center, *Charlotte, NC*
- 9:20 **RF2 The Pathologic Finding of Combined Lobular Carcinoma in Situ and Invasive Lobular Cancer May Indicate More Than Just a High Risk Marker Role of Lobular Carcinoma In Situ**
CJ Jean-Louis DO; JH Masdon MS; OE Battles MD; PS Dale MD, Navicent Health Medical Center/Mercer University School of Medicine, *Macon, GA*
- 9:35 **RF3 Alternatives to Indwelling Urinary Catheters Cause Unintended Complications**
J Nguyen; R Eddy; KM Love MD, VT Carilion School of Medicine, *Roanoke, VA*

- 9:50 **RF4 Analysis of All-Terrain Vehicle Trauma Data: Implications for Increased Regulation and Injury Prevention**
CV Ho MD; JR Dunne MD; WR Stroud;
AH Fonseca MD; FE Davis MD; WJ Bromberg MD,
Memorial University Medical Center, *Savannah, GA*
- 10:05 **RF5 Use of A Novel Accounting and Grouping Method for Major Trunk Injury - Analysis of Data from a Statewide Trauma Financial Survey**
K Joubert MD; C Mabry MD; K Kalkwarf MD;
R Betzold MD; H Spencer MS; K Spinks MD;
A Porter MPH; S Karim PhD; R Robertson MD;
M Sutherland MD; RT Maxson MD, University of
Arkansas for Medical Sciences, *Little Rock, AR*
- 10:20 **Break**
- 10:35 **RF6 Esophagectomy: Comparison of Short-Term Outcomes Between Single Versus Two-Team Approach**
N Iqbal MBBS; J Dove BA; M Hunsinger BSHS;
AT Petrick MD; ME Friscia MD; MA Facktor MD;
TK Arora MD; JA Blansfield MD; MM Shabahang MD,
Geisinger Medical Center, *Danville, PA*
- 10:50 **RF7 Outcomes of the Open Abdomen in Damage Control Surgery**
T Galbreath DO; T Teetor MD; T Bell MS; R Grim MA,
V Ahuja MD, WellSpan Health York Hospital, *York, PA*
- 11:05 **RF8 Unnecessary Transfers for Acute Surgical Care: Who and Why?**
K Kummerow Broman MD; BK Poulouse MD;
SE Phillips MSPH; JM Ehrenfeld MD; KW Sharp MD;
RA Pierce MD; MD Holzman MD, Vanderbilt University
Medical Center, *Nashville, TN*

11:20 **RF9 Cytoreduction with Hyperthermic Intraperitoneal
Chemotherapy: An Appraisal of Outcomes and
Cost at a Newly Established Peritoneal Malignancy
Program**

**NM Hinkle MD; J McDonald MD; JP Sharpe MD;
PV Dickson MD; JL Deneve DO; G Munene MD,**
University of Tennessee Health Science Center,
Memphis, TN

11:35 **RF10 Patients with More Severe Infection Do Not Require
Longer Antimicrobial Therapy for Complicated
Intra-Abdominal Infection**

**R Rattan MD; CJ Allen MD; RG Sawyer MD;
N Namias MD,** University of Miami Miller School of
Medicine, *Miami, FL* and University of Virginia Health
System, *Charlottesville, VA*

11:50 **Evaluate the Course and Adjourn**

2016 Postgraduate Course
Advances in Hernia Repair

Saturday, February 20, 2016

1:00 PM – 5:00 PM

Coordinator—Dimitrios Stefanidis, MD, PhD, Carolinas Healthcare System,
Charlotte, NC

Course Description: The course will inform participants of all recent advances in hernia repair and address existing controversies. Nationally recognized faculty will present on the indications of which surgical approach to use in complex ventral hernia repairs, the types and advantages/ disadvantages of different component separation techniques during abdominal wall reconstruction, the importance of abdominal wall closure technique and the use of biologic versus synthetic mesh, the benefits and potential concerns of using mesh in hiatal hernias, the potential advantages of using the robot for ventral hernia repair, and the incorporation of enhanced recovery evidence-based paradigms after hernia surgery.

Course Objectives: At the end of this course, participants will be able to:

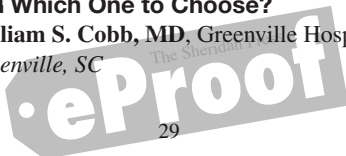
- Define the indications for laparoscopic versus open ventral hernia repair
- Describe the different types of component separation techniques and outline which approach to use for a variety of different clinical scenarios
- Choose the appropriate approach after failed component separation
- Recognize the potential benefits of robotic surgery for complex abdominal wall reconstruction
- Integrate evidence-based approaches for the postoperative care of abdominal wall reconstruction patients to improve their outcomes
- Justify the use of mesh for abdominal wall reconstruction and identify the appropriate mesh for different case scenarios
- Evaluate the benefits/risks of using mesh in the hiatus

1:00 #1 **Who Gets What? Laparoscopic vs Open Ventral Hernia Repair**

William W. Hope, MD, SEAHEC/New Hanover Medical Center, *Wilmington, NC*

1:20 #2 **TAR, Stoppa, Ramirez... What Do All These Mean and Which One to Choose?**

William S. Cobb, MD, Greenville Hospital System, *Greenville, SC*



- 1:40 #3 **Is There a Role for the Robot in Abdominal Wall Reconstruction?**
Alfredo Carbonell, DO, University Medical Group, Greenville, SC
- 2:00 #4 **The Hernia Has Recurred After Component Separation, Now What?**
Bruce J. Ramshaw, MD, Advanced Hernia Solutions at Transformative Care Institute, Daytona Beach, FL
- 2:20 #5 **Panel Discussion—Hope/Cobb/Ramshaw**
- 2:50 **Break**
- 3:10 #6 **Do Mesh Placement and Midline Closure Techniques Matter?**
Benjamin K. Poulouse, MD, Vanderbilt University Medical Center, Nashville, TN
- 3:30 #7 **Biologic or Synthetic Mesh? What Mesh Should I Use and When?**
Brent D. Matthews, MD, Carolinas Healthcare, Charlotte, NC
- 3:50 #8 **Hiatal/Paraesophageal Hernias: To Mesh or Not?**
William O. Richards, MD, University of South Alabama, Mobile, AL
- 4:10 #9 **Laparoscopic versus Open Inguinal Hernia Repair: Who, Why, and How?**
Hartwig Bunzendahl, MD, University of North Carolina, Chapel Hill, NC
- 4:40 #10 **Panel Discussion—Matthews/Richards/Bunzendahl**
- 5:00 **Evaluate & Adjourn**

Sunday, February 21, 2016

Morning Session

Moderator: David J. Cole, MD, President

6:30 **Registration Opens/Grand Rounds of Posters**

8:00 **Opening Session**

8:30 #1 **Letton Lecture Contemporary Management of
Borderline and Locally Advanced Pancreatic
Adenocarcinoma**

SACredit

Rebecca M. Minter, MD, University of Texas Southwestern
Medical Center, Dallas, TX

9:10 #2 **Is there an Optimal Surgical Approach to
Neuroendocrine Tumors of the Ampulla? A Single
Institution Experience Over 15 Years**

SACredit



GG Baptiste BA; LM Postlewait MD; CG Ethun MD;
N Le BS; MC Russell MD; DA Kooby MD;
CA Staley MD; SK Maithel MD; K Cardona MD,
Winship Cancer Institute, Emory University, Atlanta, GA

9:30 #3 **Surgical Resection is Indicated for Low-Grade
Pancreatic Neuroendocrine Tumors (PNET) >2 cm
in Size but not for Smaller Neoplasms**

SACredit

C Mosquera MD; HS Vora MPH; NA Vohra MD;
EE Zervos MD; TL Fitzgerald MD, East Carolina
University, Greenville, NC

9:50 #4 **Evolution of Laparoscopic Surgery for Colorectal
Cancer: The Impact of the COST Trial: A Look into
the SEER Database**

SACredit

M Julien MD; K Halm MD; P Meade MD;
R Khoo MD; J Wild MD; M Shabahang MD;
J Blansfield MD, Geisinger Medical Center, Danville, PA

10:10 **Break**

- 10:30 #5 **Right versus Left-Sided Colectomies:
A Comparison of Outcomes**
SA Groene MD; CV Chandrasekera; T Prasad MA;
AE Lincourt PhD MBA; BT Heniford MD;
VA Augenstein MD, Carolinas Medical Center, *Charlotte, NC*
- 10:50 #6 **The Goalposts Have Moved: Can Surgery Residents
Meet Updated Quality Benchmarks for Adenoma
Detection Rate in Colonoscopy?**
JB Ortolani MD; DR Tershak MD; JJ Ferrara MD;
CJ Paget MD, Virginia Tech-Carilion School of Medicine,
Carilion Clinic, *Roanoke, VA*
- 11:10 #7 **A Cost-Benefit Analysis of Reducing Surgical Site
Infections**
CB Rodriguez, BS; M Weche, BS; K Luberic, MS;
J Whitaker, RN; SB Ross, MD; W Clark, MD;
AS Rosemurgy, MD, Florida Hospital Tampa, *Tampa, FL*
- 11:30 #8 **A Single Surgeon's Experience with Enhanced
Recovery after Surgery (ERAS): An Army of One**
C Mosquera MD; NJ Koutlas BS; TL Fitzgerald MD,
East Carolina University, *Greenville, NC*
- 11:50 #9 **Presidential Address Crossroads ...**
David J. Cole, MD, Medical University of South Carolina,
Charleston, SC



12:30 PM

**Round Table Luncheons
Fellow, Resident, and Medical Student Committee
Making Effective Transition to Fellowship and
Preparing for the ABS Certifying Examination**

Transition to Fellowship

Setting Goals

New fellowships start date of August 1 -

What it means for the resident

What it means for the program

Change in Qualifying Exam date

Mock Orals

Session 1 with critique

Session 2 with critique

Questions from audience

**Survey for Fellows, Residents, and Medical
Students**

Surgical Practice Committee

ERAS in General Surgery

Allen Herline, MD

ICD 10 Adoption: Like it or Not

R. Lawrence Reed, II, MD

Sunday, February 21, 2016

Afternoon Session

American College of Surgeons Session

Moderator: David J. Cole, MD

- 2:00 #10 **Payment Reform/PQRS**
Patrick V. Bailey, MD, FACS
- 2:30 #11 **Welcome to the Future: How will we measure performance?**
Frank G. Opelka, MD, FACS
- 3:00 #12 **The Second Century**
J. David Richardson, MD, FACS
- 3:30 **Break**
- 3:45 #13 **Burnout/Life Balance Talk and Panel**
Kevin E. Behrns, MD, FACS
- 4 :30 #14 **Surgical History Group**
Lamar S. McGinnis, Jr., MD, FACS
- 5:00 **Adjourn**

Sunday, February 21, 2016

Quick Shots

Moderator: Katherine Morgan, MD


- 5:30 QS1 **Outcomes after Salvage Total Pancreatectomy for Refractory Chronic Pancreatitis**
SACredit **WP Lancaster MD; SM Owczarski PA-C; DB Adams MD; KA Morgan MD, Medical University of South Carolina, Charleston, SC**
- 5:36 QS2 **A Descriptive Analysis of VTE in Georgia TQIP Centers Using Retrospective TQIP Data**
SACredit **DW Ashley MD; CH Ferdinand MD; R Medeiros DNP; BL Adam PhD; R Lassiter MD; E NeSmith PhD; TJ Johns MSN; E Atkins BSN; C Dente MD, Mercer University School of Medicine, Macon, GA, Georgia Regents University, Augusta, GA, Medical Center Navicent Health, Macon, GA, Grady Memorial Hospital, Atlanta, GA**
- 5:42 QS3 **Outcomes of Endoscopic for Traumatic Biliary and Pancreatic Fistulae**
SACredit **JS Richey MD; B Manning MD; WB Jones MD, University of South Carolina School of Medicine, Greenville, SC**
- 5:48 QS4 **Surgical Management of Spontaneous Pneumothorax: A Systematic Review and Meta-Analysis**
SACredit **CL Sudduth BS; JK Shinnick BA; Z Geng MPH; CE McCracken PhD; MS Clifton MD; MV Raval MD, Emory University School of Medicine, Atlanta, GA**
- 5:54 QS5 **Analysis of Profit and Loss by Injury Severity Over 20 Years at a University Level I Trauma Center**
SACredit **JS Young MD and SD Young, University of Virginia, Charlottesville, VA**

- 6:00 QS6 **Ethanol Lock Prolongs Survival and Increases Salvage of Tunneled Central Venous Catheters in Pediatric Patients on Home Total Parenteral Nutrition**
SACredit MM Jordan MD; A Spence PharmD; CJ Streck MD; KH Chessman PharmD; RA Cina MD, Medical University of South Carolina, *Charleston, SC*
- 6:06 QS7 **Ten-Year Evaluation of Colorectal Cancer in Young Adults**
SACredit DE Disbrow MD; D Osborn BS; AL Hale BA; JA Ewing MS; CL McFadden MD, Greenville Health System, *Greenville, SC*
- 6:12 QS8 **A Standardized, Inter-Department, Simulation-Based Central Line Insertion Course Closes an Educational Gap and Improves Intern Comfort with the Procedure**
SACredit J Grudziak MD; B Herndon MD; RD Dancel MD; H Arora MBBS; CJ Tiganelli MD; MR Phillips MD; JR Crowner; NA True; AC Kiser; HP Goodell BS; N Murty BS; RF Ashton MD; MO Meyers MD; SP Montgomery MD, University of North Carolina, *Chapel Hill, NC*
- 6:18 QS9 **Return to the System within 30 Days of Discharge Following Pediatric Appendectomy**
SACredit HL Short MD; KF Heiss MD; S Sarda BS; JJ Chern MD PhD; MV Raval MD MS, Emory University School of Medicine, *Atlanta, GA*
- 6:24 QS10 **Higher Versus Lower FFP-to-PRBC Ratio in Massive Transfusion: A Meta-Analysis of Patient Outcomes**
SACredit RM. Mubang MD; NB Barry MD; DE Evans MD; RS Sharpe MD; PT Thomas DO; JC Cipolla MD; BH Hoey MD; SS Stawicki MD, St Luke's University Health Network, *Bethlehem, PA* and The Ohio State University, *Columbus, OH*
- 6:30 **Evaluate and Adjourn**

Monday, February 22, 2016

Morning Session

Moderator: Michael Meyers, MD


- 6:30 **Registration Opens/Grand Rounds of Posters**
- 8:00 #16 **Panel: Stump the Experts**
Moderator: David V. Feliciano, MD
Panelists: Kenneth W. Sharp, MD
Alexander S. Rosemurgy, MD
J. David Richardson, MD
- 8:50 #17 **Diabetic Foot Ulcers: The Importance of Patient Comorbidity Recognition and Total Contact Casting in Successful Wound Care**
SACredit

M Jagadish; MM McNally MD; S Teffeteller RN; RE Heidel PhD; JD Arnold MD; OH Grandas MD; SL Stevens MD; MB Freeman; MH Goldman MD, University of Tennessee Medical School, Knoxville, TN
- 9:10 #18 **Patients at Increased Risk of Infection Do Not Require Longer Antimicrobial Therapy for Complicated Intra-Abdominal Infection**
SACredit
R Rattan MD; CJ Allen MD; RG Sawyer MD; N Namias MD, University of Miami Miller School of Medicine, Miami, FL and University of Virginia Health System, Charlottesville, VA
- 9:30 #19 **Sherman Lecture**
SACredit
In Pursuit of the Holy Grail- Developing a Trauma System and Improving the Quality of Care
Loring W Rue III, MD, University of Alabama, Birmingham, AL
- 10:10 **Break**

- 10:30 #20 **Pancreatic Leak Predicts Readmission following
Pancreaticoduodenectomy**
SACredit **C Mosquera MD, TL Fitzgerald MD, HS Vora MPH,
NJ Koutlas BS, EE Zervos MD**, East Carolina University,
Greenville, NC
- 10:50 #21 **Impact of Beta-Blockers on Non-Head Injured
Trauma Patients**
SACredit **LE Hendrick MD; TJ Schroepfel MD; JP Sharpe MD;
LJ Magnotti MD; JA Weinberg MD; MA Croce MD;
TC Fabian MD**, University of Tennessee Health Science
Center, *Memphis, TN*
- 
- 11:10 #22 **Neuropsychological Changes in Primary
Hyperparathyroidism after Parathyroidectomy**
SACredit **JY Liu MD; CJ Weber MD; J Sharma MD**, Emory
University School of Medicine, *Atlanta, GA*
- 11:30 #23 **Laws Lecture
Resident Jeopardy**
SACredit **R. James Valentine MD**, Vanderbilt University Medical
Center, *Nashville, TN*
- 12:10 **Business Lunch/Installation of Officers**

Monday, February 22, 2016

Afternoon Session

Moderator—David V. Feliciano, MD

- 2:00 PM #24 **Development of Electronic Medical Record Based Rounds Report Results in Improved Efficiency, More Time for Direct Patient Care and Education, and Less Resident Duty Hour Violations**
SACredit

PB Ham III MD; T Anderton MD; R Gallaher MD; M Hyrman; E Simmerman DO; A Ramanathan MBA; D Fallaw MD; S Holsten MD; CG Howell, MD, Medical College of Georgia, Georgia Regents University, *Augusta, GA*
- 2:20 #25 **Patterns of Recurrence and Mechanisms of Failure after Ventral Hernia Repair with Mesh**
SACredit
S McGrath MD; JA Ewing MS; AM Carbonell MD; WS Cobb IV MD; J Warren MD, Greenville Health System, *Greenville, SC*
- 2:40 #26 **Impact of Bariatric Surgery on Hiatal Hernia Repair Outcomes**
SACredit
VM Sutherland; T Kuwada MD; K Gersin MD; D Stefanidis MD, Carolinas Healthcare System, *Charlotte, NC*
- 3:00 #27 **Video—Laparoscopic Revision of Fundoplication and Hiatal Hernia Repair with Explant of Biologic Synthetic Mesh Causing Hiatal Stenosis**
SACredit
MA Antiporda MD and SP Bowers MD, Mayo Clinic Florida, *Jacksonville, FL*
- 3:20 #28 **Video—Laparoscopic Repair of a Symptomatic Type 4 Paraesophageal Hernia with a Collis Gastroplasty**
SACredit
MM Shah MD; S Gill MD; B Martin MD; JL Stetler MD; A Patel MD; E Lin MD; SS Davis MD, Emory University, *Atlanta, GA*

- 3:40 #29 **Pro/Con Debate**
What is the Best Management of Hinchey III
Diverticulitis
Alan J. Herline, MD vs Robert A. Maxwell, MD
- 4:10 **Break—Presentation of Gold Medal Awards**

Monday, February 22, 2016

Parallel Session I

Moderator: Dimitrios Stefanidis, MD

- 4:30 #30 **The Impact of Chemotherapy on the Complications Associated with Mastectomy and Immediate Autologous Tissue Reconstruction**
SACredit **S Tanaka MD; G Hayek MD; P Jayapratap; Yerramsetti S; H St Hillaire MD; A Sadeghi MD; R Corsetti MD; G Fuhrman MD, Ochsner Medical Institutions, *New Orleans, LA***
- 4:45 #31 **Factors Associated with Positive (+) Margin Status after Breast Conserving Surgery (BCS) in Women with Breast Cancer: An Analysis of the National Cancer Database (NCDB)**
SACredit **JM Hanna; DR Lannin, MD; BK Killelea MD, AB Chagpar, Yale School of Medicine, *New Haven, CT***
- 5:00 #32 **Comparing Radioiodine Seed Localized Excision and Wire Localized Excision of Non-Palpable Breast Lesions: A Single Center Experience**
SACredit **E Dentcheva MD; EC Alberto BS; KZ Allison MD; JP Wilson MD; RA Hoefer DO, Eastern Virginia Medical School, *Norfolk, VA***
- 5:15 #33 **Calculation of the Malignancy Rate, Number Needed to Treat, and Positive Predictive Value for Screening Breast MRI**
SACredit **JS Kennedy MD and P Robbins BS, DeKalb Medical, *Decatur, GA***
- 5:30 **Evaluate and Adjourn**

Monday, February 22, 2016

Parallel Session II

Moderator: Emmanuel Zervos, MD

- 4:30 #34 **Timing of Post-Thyroidectomy Radioactive Iodine Ablation Does Not Affect Overall Survival in Low and Intermediate-Risk Papillary Thyroid Carcinoma**
SACredit
P. Suman MD; S. Rajjoub MD; TA Moo-Young MD; DJ Winchester MD; RA Prinz MD, NorthShore University HealthSystem, Evanston, IL
- 4:45 #35 **The Sonographic Subcentimeter Malignant Thyroid Nodule: What Does It Stand For?**
SACredit
A Pascual MD; E Morfa BS; E Santiago MS; W Mendez MD, University of Puerto Rico School of Medicine, San Juan, PR
- 5:00 #36 **Sonographic Appearance is Useful in Predicting the Extent of Initial Operative Therapy for Thyroid Nodules Classified as “Suspicious for Malignancy” (SFM)**
SACredit
K Statler MD; R Judhan MBBS; S Thompson PhD; B Richmond MD, West Virginia University, Charleston, WV
- 5:15 #37 **Population-Based Study of Factors Influencing Completion Lymph Node Dissection Compliance in Melanoma and its Relationship to Overall Survival Using the National Cancer Database**
SACredit
S Samreen MD; A Allard-Picou MD; M Fluck BS; J Dove BA; M Hunsinger RN BSHS; J Wild MD; M Shabahang MD PhD; J Blansfield MD, Geisinger Medical Center, Danville, PA
- 5:30 **Evaluate and Adjourn**

Monday, February 22, 2016

Interactive Video Session

Moderator: Emmanuel Zervos, MD

- 5:30 VS1 **Laser-Assisted Endovascular Retrieval of an Embedded Vena Cava Filter**
SACredit PF Fischer MD; BW Thomas MD; MJ Avery BS; ML Lessne MD; AB Christmas MD; RF Sing MD, Carolinas Healthcare System, *Charlotte, NC*
- 5:45 VS2 **Robotic Reversal of Roux-En-Y Gastric Bypass due to Recurrent Gastrojejunal Anastomotic Occlusion**
SACredit G McRary, BA and D Stefanidis MD, Carolinas Medical Center, *Charlotte, NC*
- 6:00 VS3 **Laparoscopic Caudate Lobectomy for Colorectal Liver Metastasis**
SACredit BM Martin MD; MM Shah MD; JL Stetler MD; A Patel MD; SS Davis Jr MD; JF Sweeney MD; JM Sarmiento; MD; E Lin DO, Emory University School of Medicine, *Atlanta, GA*
- 6:15 VS4 **Combined Robotic/Laparoscopic Total Gastrectomy with Distal Pancreatectomy and Splenectomy**
SACredit SB Ross MD; TA Bowman BS; P Sukharamwala MD; AS Rosemurgy MD, Florida Hospital Tampa, *Tampa, FL*
- 6:30 VS5 **Rare Extralobar Pulmonary Sequestration Resected Using Robotic- Assisted Thoracoscopic Surgery**
SACredit RJ Sanders MD; S Ben-Or MD; JE Stephenson MD; WD Bolton MD, Greenville Health System, *Greenville, SC*
- 7:00 **Adjourn**

Tuesday, February 23, 2016

Parallel Session III

Moderator: Wendy Greene, MD

- 6:15 AM **Registration Opens**
- 7:00 #38 **Better to be Fat than Thin: Analysis of Mortality in Traumatically Injured Patients Based on BMI and Mechanism Reveals Highest Mortality among the Underweight not the Obese**
SACredit **K Treto MD; C Short MD; T Safcsak; I Bhullar MD,**
Orlando Health, Orlando, FL
- 7:15 #39 **ARDS Incidence, But Not Mortality, Has Decreased Nationwide - A National Trauma Data Bank Study**
SACredit **M Fahr MD; G Jones PhD; D Tatum PhD,** Our Lady of the Lake Regional Medical Center, *Baton Rouge, LA*
- 7:30 #40 **Failure of Chlorhexidine to Prevent Postoperative Pneumonia: Regression Modeling with NSQIP Data**
SACredit **J Bansal ; B Woodall; J Jones; S Fogel,** Virginia Tech Carilion School of Medicine, *Roanoke, VA*
- 7:45 #41 **Arterial Injuries Associated with Blunt Fractures in the Lower Extremity**
SACredit **JJ Coleman MD; S Tavoosi MS; BL Zarzaur MD; BL Brewer MD; GS Rozycki MD; DV Feliciano MD,** Indiana University School of Medicine, *Indianapolis, IN*
- 8:00 #42 **Simple Prediction of Massive Transfusion Need in Geriatric Trauma Patients**
SACredit **SC Fligor BS; KM Love MD; BR Collier DO; ME Hamill MD; EH Bradburn DO,** Virginia Tech Carilion School of Medicine, *Roanoke, VA*
- 8:15 #43 **What's In The Box? The Effectiveness of a Low Volume Massive Transfusion Protocol**
SACredit **ME Barnett BS; MM Ott MD; KA Baysinger MD; KM McBride MD; EK Shaw PhD; JR Dunne MD,** Memorial University Medical Center, *Savannah, GA*

8:30 #44 **Effect of Omission of Daily Chest Radiographs on
Mechanically Ventilated Trauma Patients**
SACredit
SL Carroll MD; RL Griffin PhD; DA Reiff MD;
FN Tessler MD; BB Taylor MD; LW Rue MD, University
of Alabama, *Birmingham, AL*

8:50 **Break**

Tuesday, February 23, 2016

Parallel Session IV

Moderator: Dennis Ashley, MD

- 7:00 #45 **Development and Validation of a Risk Calculator for Renal Complications after Colorectal Surgery using the National Surgical Quality Improvement Program Participant Use Files (NSQIP-PUF)**
SACredit
S Fang MBBS MPH; SD Perez MSPH;
JK Srinivasan MD; PS Sullivan MD; JR Galloway MD;
CA Staley MD; E Lin MD; J Sharma MD;
JF Sweeney MD; VO Shaffer MD, Emory University
School of Medicine, *Atlanta, GA*
- 7:15 #46 **Changing Epidemiology of Diverticulitis in the United States**
SACredit
T Galbreath DO; B Palachick MD; R Grim MA;
T Bell MS; J Martin PhD; V Ahuja MD, WellSpan York
Hospital, *York, PA*
- 7:30 #47 **Can Drains Be Safely Eliminated in Abdominal Wall Reconstruction?**
SACredit
J Dean MD, B Forman, M Fabian MD, K Moore PhD,
B Ramshaw MD, Advanced Hernia Solutions, *Daytona
Beach, FL*
- 7:45 #48 **A Large Single-Center Experience of Lateral Abdominal Wall Hernia Repairs**
SACredit
JA Warren MD; PP Patel DO; R Mansour MD;
AM Carbonell DO, WS Cobb IV, MD, Greenville Health
System, *Greenville, SC*
- 8:00 #49 **For Love, Not Money: The Negative Financial Implications of Surgical Fellowships**
SACredit
PM Inclan BS, AS Hyde PhD, M Hulme PhD,
JE Carter MD, Wake Forest University, *Winston Salem, NC*

- 8:15 #50 **Surgical Mortality Review Reduces Preventable Deaths and Patient Safety Indicators (PSIs)**
SACredit **L Heidelberg, B Singletary, D Reiff, A deRussy, R Heslin, A Mims, J Morgan, WA Smedley, L Rue, M Heslin,**
The University of Alabama at Birmingham, *Birmingham, AL*
- 8:30 #51 **Cadaver-Based Simulation Increases Resident Confidence and May Augment Operative Autonomy**
SACredit **SC Kim MD; JG Fisher MD; KA Delman MD; JM Hinman MPH; JK Srinivasan MD,** Emory University
School of Medicine, *Atlanta, GA*
- 8:50 **Break**

Tuesday, February 23, 2016

Scientific Sessions

Moderator: Alan Marr, MD

- 9:00 #52 **Panel—How Do I Do It: Tips from SESC Experts**
Steven P. Bowers, MD—Lapasroscopic Paresophageal Repair
Steven Hughes, MD—Laparoscopic Distal Pancreatectomy
Sharona B. Ross, MD—SILS Cholecystectomy
Rana Pullatt, MD—Management of Bariatric Surgery Complications
- 10:00 #53 **Video—Robotic Esophageal Diverticulectomy, Heller Myotomy, Toupet Fundoplication, and Hiatal Hernia Repair**
SACredit
JL Stetler MD; S Gill MD; SS Davis MD; E Lin DO;
JF Sweeney MD; A Patel MD, Emory University School of Medicine, *Atlanta, GA*
- 10:15 #54 **Video—Laparoscopic Common Bile Duct Exploration for Primary Choledocholithiasis**
SACredit
RC Kirks MD; RZ Swan MD; D Vrochides MD PhD;
JB Martinie MD; DA Iannitti MD, Carolinas Medical Center, *Charlotte, NC*
- 10:30 #55 **Excessive Postoperative Fluid Administration in infants with Gastroschisis**
SACredit
PC Bonasso MD; GR Hobbs PhD; RA Vaughan MD;
NA Shorter MD; DK.Nakayama MD, West Virginia University School of Medicine, *Morgantown, WV*

- 10:45 #56 **Preoperative Bowel Preparation Prior to Elective Bowel Resection or Ostomy Closure in the Pediatric Patient Population Has No Impact on Outcomes: A Prospective Randomized Study.**
SACredit
M Shah MD; CT Ellis MD; MR Phillips MD;
A Marzinsky BSN, RN, OCN; PA Lange MD;
W Adamson MD; T Weiner MD; K Erickson MD;
SE McLean MD, University of North Carolina,
Chapel Hill, NC
- 11:00 #57 **Video—Robotic-Assisted Laparoscopic Inguinal Hernia Repair With Mesh**
SACredit
GA Darwazeh MD and G Kowdly MD, Saint Agnes
Hospital, *Baltimore, MD*
- 11:15 #58 **Identifying Effectors of Outcomes in Patients with Large Umbilical Hernias**
SACredit
SA Groene MD; Tanushree Prasad MA; DW Heniford;
AE Lincourt PhD MBA; BT Heniford MD;
VA Augenstein MD, Carolinas Medical Center,
Charlotte, NC
- 11:30 #59 **Gluteal Fascial Advancement for Pilonidal Cyst Disease: A 10-year Review**
SACredit
BC Powell MD; CB Webb MD; JA Ewing MS;
DE Smith MD, Greenville Health System, *Greenville, SC*
- 11:30 #60 **Chest Wall Stabilization Leads to Shortened Chest Tube Stay Time in Rib Fracture Patients after Traumatic Chest Wall Injury**
SACredit
MT Fitzgerald MD; H Abukhdeir; MPH;
DW Ashley MD; DB Christie III MD, Mercer University,
Macon, GA
- 12:00 **Evaluate and Adjourn**

SCIENTIFIC ABSTRACTS

#2 Gold Medal—Is there an Optimal Surgical Approach to Neuroendocrine Tumors of the Ampulla? A Single Institution Experience Over 15 Years

GG Baptiste BA; LM Postlewait MD; CG Ethun MD; N Le BS; MC Russell MD; DA Kooby MD; CA Staley MD; SK Maithel MD; K Cardona MD, Winship Cancer Institute, Emory University, Atlanta, GA

Background: Neuroendocrine tumors (NETs) of the ampulla of Vater are rare neoplasms accounting for a small fraction of gastroenteropancreatic NETs. The optimal surgical approach remains controversial. A series of patients with ampullary NETs is presented in an attempt to define the optimal surgical approach.

Methods: Patients who underwent resection of ampullary NETs from 2000-2014 at an academic institution were analyzed.

Results: Twelve patients were identified. The mean age was 58yrs and 67% were men. All were well-differentiated, non-functional NETs. The mean tumor size was 1.7cm and the majority (59%) had an advanced TNM stage. Recurrence occurred in 1pt (8%) and death in 2pts (17%). Eight (67%) patients underwent pancreaticoduodenectomy (PD) and four (33%) underwent transduodenal ampullectomy (TA). When comparing PD pts to TA pts, PD pts were younger (57 vs 62yrs). Although the mean tumor size was similar (1.7 vs 1.8cm), the majority (75 vs 25%) of PD pts had more aggressive tumors, characterized by: advance T stage in 25 vs 0%, lymph node positivity in 75 vs 0%, and LVI/PNI in 60 vs 50%. Complete resection (R0) was achieved in all PD pts vs 66% in TA pts. There was no difference in major complication rate (50 vs 50%). One (25%) pt recurred in the TA group but overall survival was similar (median not reached for either group). **Conclusions:** Ampullary tumors can be aggressive tumors characterized by high regional lymph node involvement. A transduodenal approach to tumors < 2cm may provide an inadequate oncological resection and thus has the potential to understage ampullary NETs. In the era of increasing therapeutic options for gastroenteropancreatic NETs, accurate staging is crucial and appropriate oncologic resection via PD for ampullary NETs should be considered.

#3 Surgical Resection is Indicated for Low-Grade Pancreatic Neuroendocrine Tumors (PNET) >2 cm in Size but not for Smaller Neoplasms

**C Mosquera MD; HS Vora MPH; NA Vohra MD;
EE Zervos MD; TL Fitzgerald MD, East Carolina University,
Greenville, NC**

The role of surgical resection for low-grade PNET is unclear and some suggest that observation of selected subsets may be appropriate. In order to better define the role of surgical resection, data from a large registry was reviewed. Methods: Patients diagnosed with PNET from 1988-2012 were identified in the SEER registry. Patients were excluded if neoplasms were high-grade or if size or lymph node status was unknown. Results: A total of 561 patients met inclusion criteria. A majority were male (50.4%), white (82.9%), and node-negative (69.9%). On univariate analysis, tumor size (< 2 cm 8.3%, 2-4 cm 38.5%, and > 4 cm 40.3%; $p < 0.0001$) and surgery (30.9% vs. 25.3%; $p = 0.0014$) were associated with risk of lymph node metastases (LNM) whereas age ($p = 0.8360$), gender ($p = 0.4903$), and race ($p = 0.4235$) were not. Log-rank test was utilized to define the survival benefits. Five-year disease-free survival was associated with size (< 2 cm 89.4%, 2-4 cm 80.0%, and > 4 cm 74.5%; $p = 0.0089$), LNM (72.4% vs 82.9%; $p = 0.0025$), and surgery (84.3% vs.47.5%; $p < 0.0001$), however not with gender nor race. In a Cox regression model, LNM ($p = 0.0025$) and surgery ($p < 0.0001$) remained significant. Surgery was associated with an improved disease-free survival for tumors > 2 cm (2-4 cm, 84.4% vs 26.0% at 5-years; $p = 0.0003$, and > 4 cm 80.5% vs 49.5% at 5-years; $p < 0.0001$) but not for those < 2 cm ($p = 0.4525$). Conclusions: In this series of low grade PNET, patients with tumors > 2 cm in size have an increased risk of LNM and improved survival with resection. Although sample size is limited, these data suggest for neoplasms < 2 cm in size there is a low risk of LNM and no clear benefit from resection.

#4 Evolution of Laparoscopic Surgery for Colorectal Cancer: The Impact of the COST Trial, A Look Into the SEER database

M Julien MD; K Halm MD; P Meade MD; R Khoo MD;
J Wild MD; M Shabahang MD; J Blansfield MD, Geisinger
Medical Center, *Danville, PA*

Background: In March 2004, the Clinical Outcomes of Surgical Therapy Group (COST) released results of a multi-institutional randomized controlled trial that showed equivalence to open procedures in regards to oncologic outcomes in colorectal cancer (CRC) patients. The aim of this study is to analyze utilization of laparoscopic colectomy for CRC before and after the COST Trial, explore trends in indications, and to track surgical outcomes.

Methods: This retrospective study utilized the Surveillance, Epidemiology, and End Results Program (SEER) and Medicare databases to trend laparoscopic resections for CRC from 2000 to 2009. SEER database was used to look at patient demographics, stage of the tumor, location of the tumor, and surgical outcomes. Logistic regression was used for categorical data, linear regression for continuous data and Cox regression for time to event data. Multivariate logistic regression was then used to test the trend in laparoscopic procedures while adjusting for patient characteristics.

Results: Between 2000 and 2009, 150,056 patients underwent colorectal resection for CRC. In 2000, 1% of colorectal resections were performed laparoscopically and increased to 4% in 2004. There was a dramatic increase in laparoscopic colectomy after the COST Trial and by 2009, 30.1% of colectomies were performed laparoscopically. During this time period the rate of laparoscopic colectomy increased for all tumor locations but right colectomy had the most significant rise from 3% (2004) to 39% (2009). Rectal cancer resection rates had more modest growth (2% in 2004 to 13% in 2009). The rate of laparoscopic colectomy increased for all tumor stages. Early staged tumors (T1) had the highest jump from 4.5% (2004) to 43% (2009) with later staged tumors (T4) having a less significant increase (1.5% in 2004 to 17% in 2009). The number of colectomies performed laparoscopically increased for all hospitals despite the hospital's location but rose more significantly in metropolitan hospitals (3% of resections laparoscopically in 2004 which increased to 32% in 2009). Urban and rural hospitals had a more modest growth in laparoscopic resections with 1% of colorectal surgeries performed laparoscopically in 2004 which increased to 23% and 28% respectively by 2009. The surgical outcomes improved during the study period. Lymph node yield was lowest in 2000 with an average of 8 nodes and highest in 2009 with 16 nodes resected ($p < 0.0001$). Length of stay and 30-day mortality both significantly decreased during the time period (p value = 0.0051, 0.0397, respectively). Finally, readmission rates did not change from 2000 to 2009.

Conclusions: The COST Trial had a significant impact on the number of laparoscopic colorectal resections performed for CRC patients. Although laparoscopic colorectal resections have been widely accepted for all types of CRCs, they are less likely to be performed for more complex procedures and higher stage tumors. As the rate of laparoscopic colectomy increased, the surgical outcomes mirrored in improvement.

#5 Right versus Left-Sided Colectomies:

A Comparison of Outcomes

SA Groene MD; CV Chandrasekera; T Prasad MA;
AE Lincourt PhD MBA; BT Heniford MD; VA Augenstein
MD, Carolinas Medical Center, *Charlotte, NC*

Introduction: A belief among surgeons is that a right hemicolectomy carries less risk than a left or sigmoid colectomy. Our aim was to compare outcomes between right colectomy (RC) and left/sigmoid colectomy (LSC).

Methods: Review of the Carolina Medical Center (CMC) NSQIP data from 2013 to February 2015 was performed. Procedures were categorized as RC vs. LSC based upon CPT codes for both open and laparoscopic colectomies. Demographics, minor and major complications were evaluated using standard statistical methods. **Results:** There were 375 patients in the sample; 164 RC and 211 LSC. Mean age was 63.9 ± 14.2 vs 59.4 ± 13.0 ($p < 0.001$) and BMI was 28.2 ± 8.1 vs 29.0 ± 6.8 ($p = 0.06$) for RC vs LSC, respectively. Patients undergoing RC were more co-morbid: 64.6% with an ASA class of 3-4 vs 51.7% of those undergoing LSC ($p = 0.02$). RC had significantly higher rates of minor complications, including post-op UTIs (7.3% vs 2.8%; $p = 0.04$) and post-op transfusions ($p = 0.01$). Average length of stay was longer for RC ($10.1 \pm 8.6d$ vs $8.3 \pm 7.0d$; $p < 0.01$). After controlling for ASA class and surgical technique (lap vs open), multivariate analysis indicated that RC still required significantly more post-op transfusions than LSC with OR 1.97 (95% CI 1.06, 3.66). There were no differences between the groups in major complications including superficial or deep SSI, anastomotic leak, stroke, MI, AKI, pneumonia or 30 day mortality.

Conclusion: RC patients tended to be sicker and had higher medical complications post-op with initial evaluation of the data. However, when controlling for ASA and techniques, there were no differences in rates of infections or complications following LSC compared to RC other than transfusion. The belief LSC has a higher rate of complications is not supported.

#6 Gold Medal—The Goalposts Have Moved: Can Surgery Residents Meet Updated Quality Benchmarks for Adenoma Detection Rate in Colonoscopy?

JB Ortolani MD; DR Tershak MD; JJ Ferrara MD; CJ Paget MD, Virginia Tech-Carilion School of Medicine, Carilion Clinic, *Roanoke, VA*

Background: The American Society for Gastrointestinal Endoscopy (ASGE)/ American College of Gastroenterology (ACG) Task Force on Quality in Endoscopy recently released updated quality benchmarks for colonoscopy. Our initial study concluded that surgery residents could perform safe and competent screening colonoscopy within a structured endoscopy curriculum. In this follow up prospective study, we sought to determine whether surgery residents could achieve the increased adenoma detection rate (ADR) benchmarks endorsed by the ASGE/ACG Task Force.

Study Design: An IRB-approved prospective analysis of colonoscopies performed by five PGY-2/PGY-3 surgery residents from 2013-2015 was completed. All colonoscopies were performed under the direct supervision of surgical endoscopists after each resident passed a structured endoscopy simulation curriculum. The following ASGE/ACG quality metrics were recorded: bowel prep quality; cecal intubation rate; polyp and adenoma detection rates; and, complications. Power analysis determined that 108 procedures were required for an 80% probability of data analysis accuracy.

Results: (updated ASGE/ACG benchmark values): 135 screening and diagnostic colonoscopies were performed. Bowel prep was considered “adequate” in 90% of cases. The cecum was reached independently in 95% of cases. Polyp(s) were visualized and removed in 39% of patients. The overall ADR was 31.8% (> 25%). Male ADR was 38.7% (> 30%). Female ADR was 26% (> 20%). Average polyp size was 8.7 mm (range: 1-22 mm). One patient was readmitted for post-polypectomy syndrome, and successfully managed non-operatively.

Conclusions: Using our structured endoscopy curriculum, surgery residents achieved ADRs fully consistent with the updated benchmark values endorsed by the ASGE/ACG Task Force.

#7 A Cost-Benefit Analysis of Reducing Surgical Site Infections

CB Rodriguez, BS; M Weche, BS; K Luberic, MS;

J Whitaker, RN; SB Ross, MD; W Clark, MD;

AS Rosemurgy, MD, Florida Hospital Tampa, *Tampa, FL*

Introduction: Surgical site infections (SSI) represent an onerous burden on our healthcare system. With zero-tolerance for SSI, we initiated a protocol to eliminate SSI with major abdominal surgery. This study was undertaken to determine the impact of the protocol on the frequency and cost of SSI after major abdominal surgery.

Methods: Patients undergoing complex gastrointestinal operations were prospectively followed with IRB approval. In 2013 we closely monitored SSI (organ space, deep, and superficial). In 2014 we initiated a protocol to re-standardize preparation prior to surgery and to use silver dressings. Differences in SSI frequency and SSI cost before vs. after protocol implementation were evaluated.

Results: Prior to protocol initiation, standardized preoperative preparation (MRSA testing, mupirocin intranasal ointment, and chlorhexidine baths) cost \$127 per patient. Protocol implementation (chlorhexidine washcloths and oral rinses, povidone-iodine nasal swabs, Bair Hugger™ gowns, and silver dressings) reduced the cost to \$26 per patient, saving \$101 per patient. With the protocol in place, the SSI rate was reduced from 3.73% (21 of 563) in 2013 to 2.39% (14 of 586) in 2014. Prior to the protocol, the total cost of treatment for SSI was \$498,501 while after the protocol implementation, total cost was \$290,990, a reduction of \$207,511. In all, including savings in operative preparation, the protocol reduced costs by \$266,697.

Conclusions: With preparation and diligence, SSI rate can be reduced and significant cost savings achieved. A protocol to reduce the frequency and cost of SSI is a “win-win” for all stakeholders and should be encouraged with thoughtful and active participation from all disciplines.

#8 Gold Medal—A Single Surgeon’s Experience with Enhanced Recovery after Surgery (ERAS): An Army of One

C Mosquera MD; NJ Koutlas BS; TL Fitzgerald MD,
East Carolina University, *Greenville, NC*

The benefits of ERAS have been demonstrated for multiple surgical procedures in high-volume programs. However, resources required for implementation may be daunting to individual surgeons.

Methods: Patients undergoing elective abdominal procedures from June 2013-April 2015 by a surgical oncologist one year before and after implementing an ERAS protocol were reviewed.

Results: A total of 179 patients were included. Mean age was 63 years, a majority were females (53.6%), white (61.5%), had a Charlson score of 0-2 (45.8%), and a Clavien complication grade of 0-I (60.1%). On univariate analysis, ERAS protocol was associated with shorter length of stay (LOS) (6.2 vs. 9.6 days; $p = 0.024$), lower cost (\$21,674 vs. \$30,380; $p = 0.029$), and lower mortality (0% vs. 3.3%; $p = 0.044$). Differences in Clavien grade (0-I 67.8% vs. 54.4%; II-V 32.2% vs. 42.6%; $p = 0.064$) and readmission (11.5% vs. 21.4%; $p = 0.076$) did not reach statistical significance. Gender, age, race, diagnosis, and types of surgery performed were similar for both groups. Differences were noted in LOS and cost for all procedures but was greatest for hepatic resection (3.8 vs. 8.4 days; $p = 0.025$ and \$16,770 vs. \$28,589; $p = 0.017$), intestinal resection/stoma closure (4.8 vs. 7.6 days; $p = 0.021$ and \$18,391 vs. \$22,239; $p = 0.16$), and other abdominal procedures (5.0 vs. 10.8; $p = 0.013$ and \$17,713 vs. \$30,900; $p = 0.023$). The differences were less for patients undergoing procedures for which postoperative pathways were already in place such as pancreatic (9 vs. 10.8 days, $p = 0.20$; and \$30,524 vs. \$34,291; $p = 0.24$) and colorectal (5.3 vs. 6.5 days; $p = 0.17$ and \$20,733 vs. \$25,150; $p = 0.18$) surgery.

Discussion: An ERAS program can be instituted by an individual surgeon with the benefits of decreased in LOS, cost, and mortality.

QS1 Outcomes after Salvage Total Pancreatectomy for Refractory Chronic Pancreatitis

WP Lancaster MD; SM Owczarski PA-C; DB Adams MD;
KA Morgan MD, Medical University of South Carolina,
Charleston, SC

Introduction: Total pancreatectomy with islet cell auto-transplantation (TPIAT) is a treatment for refractory chronic pancreatitis. Many patients undergoing TPIAT have had previous pancreatic surgery. We sought to determine the long term outcomes of TPIAT as a salvage procedure.

Methods: Retrospective review of a prospectively maintained database identifying patients with previous pancreatic surgery who underwent TPIAT. Preoperative physical and psychological quality of life scores as well as daily insulin requirement were measured and compared with postoperative data. Chi-square and Fisher's exact test were used where appropriate.

Results: A total of 109 patients with previous pancreatic surgery and at least one year of follow-up were identified. Mean age was 41 years and the majority of patients were female (79%). The most common etiology of pancreatitis was sphincter of Oddi dysfunction (43%) followed by pancreas divisum (28%). The most common prior operation was Whipple (17%). Compared with preoperative assessment, physical quality of life improved at 1 year postoperative (28.4 vs. 35.3, $p = 0.001$) and this effect persisted until 3 years postoperative (28.4 vs. 33.5, $p = 0.002$). Psychological quality of life improved at 1 year postoperative (39.4 vs. 43.2, $p = 0.01$) and this change was still seen at 5 years postoperative (39.4 vs. 44.8, $p = 0.05$). The average daily insulin requirement at 1 year postoperative was 24.8 units/day and this was unchanged at 5 years postoperative (28.6 units/day, $p = 0.5$).

Conclusions: TPIAT is an effective salvage operation for refractory chronic pancreatitis. It is safe and offers improved quality of life in patients with previous pancreatic surgery. This effect is durable and can persist for at least five years. Patients can expect to require insulin after salvage total pancreatectomy with islet cell autotransplantation.

QS2 A Descriptive Analysis of VTE in Georgia TQIP Centers Using Retrospective TQIP Data

DW Ashley MD; CH Ferdinand MD; R Medeiros DNP; BL Adam PhD; R Lassiter MD; E NeSmith PhD; TJ Johns MSN; E Atkins BSN; C Dente MD, Mercer University School of Medicine, Macon, GA, Georgia Regents University, Augusta, GA, Medical Center Navicent Health, Macon, GA, Grady Memorial Hospital, Atlanta, GA

Background: The purpose of this review was to determine the incidence of venous thromboembolism (VTE) among Trauma Quality Improvement Program (TQIP) Trauma Centers (TC) in GA, describe the characteristics of VTE & use of chemoprophylaxis for GA TQIP TCs vs national TQIP database.

Methods: Review of the ACS TQIP database 2012- 2014. Total of 325,703 pts from 245 TCs (14 GA TC [N = 14,508 pts] and 231 non-GA TCs [N = 311,195 pts]). VTE definitions from National Trauma Data Standard. Statistical analyses via SPSS software & SigmaPlot comparing GA TQIP to the non-GA TQIP dataset.

Results: Of the 325,703 total pts 6,571 (2.02%) developed VTE. 274 pts (0.08%) were from GA TCs and 6,297 (1.93%) were from non-GA TCs. Overall, the pts who developed VTE tended to be older (53.9 yrs vs. 52 yrs, $p < .00001$) & more likely male (73% vs. 62.7%, $p < 0.0001$). Of pts admitted to GA TCs (mean age 49.4, 65% male), only 50% received documented chemoprophylaxis. VTE rates in the population receiving prophylaxis were 3.2% both in GA and Non-GA TCs. Of the 50% who did not receive chemoprophylaxis, only 0.7% developed VTE in Georgia & 0.6% in Non-GA TCs. Chemoprophylactic regimens remained varied amongst TCs in GA & included unfractionated/ low molecular weight heparins, warfarin, direct thrombin inhibitors & anti-platelet agents. VTE rates were highest in pts receiving unfractionated heparin (5.1% GA, 4.3% Non-GA) but no method of chemoprophylaxis had different efficacy in GA TCs vs. Non-GA TCs.

Conclusion: GA's collaborative successfully utilized the ACS TQIP dataset to identify & compare their rate of VTE & use of chemoprophylaxis to the TQIP dataset. Future research needs to compare these rates across cohorts & carefully analyze pt cohorts to identify risk factors & best practices.

QS3 Outcomes of Endoscopic for Traumatic Biliary and Pancreatic Fistulae

JS Richey MD; B Manning MD; WB Jones MD, University of South Carolina School of Medicine, *Greenville, SC*

The role of Endoscopic Retrograde Cholangiopancreatography (ERCP) in the trauma patient is limited. Therefore, reporting of outcomes is sparse in the literature. In those that have sustained traumatic disruption of the biliary and/or pancreatic ducts at our institution we prefer to endoscopically manage these patients. The purpose of our study was to review outcomes of our patients who underwent ERCP for traumatic biliopancreatic injury. We performed a retrospective review of a prospectively collected database of 1550 ERCP's performed by a single surgical endoscopist who was consulted by the trauma surgical service for the management of traumatic fistulae. Referral was made for those patients with high output (greater than 200ml/day) and/or persistent (failure to resolve within 30 days) fistulae as well as traumatic biliary stricture. Data reviewed included demographics, procedural techniques, stents placed, interval from laparotomy to ERCP, duration of stenting, and post-procedural complications-defined as perforation, hemorrhage, and post-ERCP pancreatitis. Seventeen patients underwent a total of 31 ERCP's for biliary and/or pancreatic injury resulting from abdominal trauma (8-penetrating, 9 blunt) between August 2011 and August 2015. Thirteen patients had ERCP after laparotomy with a mean interval to ERCP of 74 days (Range 4-316). In four patients ERCP was the only intervention required. Fourteen biliary stents were placed, 7 of which were metallic. Ten pancreatic stents were placed, one of which proximally migrated and was successfully retrieved. Four patients had both ducts simultaneously stented. The mean duration of stenting was 158 days (range 65-338). All fistulae resolved after stenting. There were no serious complications.

QS4 Surgical Management of Spontaneous Pneumothorax: A Systematic Review and Meta-Analysis

CL Sudduth BS; JK Shinnick BA; Z Geng MPH;

CE McCracken PhD; MS Clifton MD; MV Raval MD, Emory University School of Medicine, *Atlanta, GA*

Numerous thoracoscopic techniques have been used in the management of primary spontaneous pneumothorax (PSP), including wedge resection, pleurectomy, pleural abrasion, chemical pleurodesis, and staple-line covering. These techniques can be performed independently or in combination. The purpose of this study was to compare outcomes for the most commonly reported techniques. The primary outcome was recurrence rate, and secondary outcomes were chest tube duration and length of stay. A systematic literature search was conducted in accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines using the PubMed database. Fifty-three unique studies comprised of 6711 patients published between January 1988 and June 2015 were identified. Heterogeneity among effect sizes was significant for all outcomes. The lowest recurrence rates were observed in the wedge resection chemical pleurodesis (2%; 95% Confidence Interval (CI), 1 to 3) and the wedge resection pleural abrasion chemical pleurodesis (3%; 95% CI, 2 to 5) groups. The shortest chest tube duration and length of stay was observed in the wedge resection staple-line covering \pm other group (2.1 days; 95% CI, 1.42 to 2.86 and 3.3 days; 95% CI, 2.60 to 4.05, respectively). In conclusion, this systematic review favors wedge resection chemical pleurodesis and wedge resection pleural abrasion chemical pleurodesis in terms of recurrence rate after surgery for PSP. The variability in reported outcomes and the lack of published multicenter randomized controlled trials highlights a need for more robust investigations into the optimal surgical technique in the management of PSP.

QS5 Analysis of Profit and Loss by Injury Severity Over 20 Years at a University Level I Trauma Center

JS Young MD and SD Young, University of Virginia,
Charlottesville, VA

Introduction: We examined profit and loss by injury severity grouping using trauma registry and financial data from a Level I Trauma Center from 1994-2014. We investigated the hypothesis that lower injury severity correlates with increased profitability.

Methods: We used the trauma registry from our Level I Trauma Center from July, 1994 to December, 2014. Financial data included charges, Medicare cost data, final reimbursement, and payor source. We examined the following injury severity score (ISS) groupings: 0-9, 10-14, 15-24, > 24, and > 14.

Results: We had complete data on 27,582 patients. Overall profit/case when subtracting costs from reimbursements was \$1,932/case over the 20 year period (total profit in unadjusted dollars = \$53,475,828 or \$2,673,791/year). Profitability was significantly different between almost all ISS groups and especially 0-14 and 15-24, and >24. The total margin in unadjusted dollars for the ISS 0-14 group was \$26,473,889 and the margin for the ISS 14 group was \$26,942,860. Of the 202 patients with a loss of > \$50,000, the mean ISS was 25 and 77% had an ISS > 14. When charge data was examined the average loss per case was -\$31,313 for the 27,582 patient.

Conclusions: When using cost, and not charge data, overall trauma care brought in more reimbursement than the cost of caring for these patients over this 20 year period. Severely injured patients (ISS > 14) were the most profitable, with a significantly higher profit per case than all other groupings. Our data indicates that a loss of low ISS patients does not preclude profitability. Examination of cost data is critical, and if only charge data had been examined, the overall loss from the 20 year period would have been \$863,675,166 and not a margin of \$53,475,828.

QS6 Ethanol Lock Prolongs Survival and Increases Salvage of Tunneled Central Venous Catheters in Pediatric Patients on Home Total Parenteral Nutrition

MM Jordan MD; A Spence PharmD; CJ Streck MD; KH Chessman PharmD; RA Cina MD, Medical University of South Carolina, Charleston, SC

Background and Aims: Central line-associated bloodstream infections (CLABSIs) are common in children dependent on long-term total parenteral nutrition (TPN). Prior analysis of a small cohort to evaluate the safety of off-label use of ethanol lock to prevent CLABSIs suggested a trend toward increased catheter survival. In this study, we sought to determine whether ethanol lock increased catheter survival and promoted salvage.

Methods: Children receiving home-based TPN via tunneled central venous catheter from January 1, 2003, to January 20, 2011, were included in a retrospective cohort study.

Results: Thirty-three children were identified for inclusion. The non-ethanol lock (EtOH⁻) group included 11 catheters with 959 catheter days (CD), while 58 catheters with 17,008 CD were treated with ethanol lock (EtOH⁺). The EtOH⁺ catheters had an average lifespan of 293 ± 38.2 days compared with 87.2 ± 30.5 days for EtOH⁻ catheters ($p < 0.01$). The frequency of CLABSI was lower in the EtOH⁺ group (2.23 vs. 6.25 per 1,000 CD, $p < 0.01$) as was the rate of catheter removal for infection (15.5% vs. 27.3%, $p = 0.35$). Additionally, EtOH⁻ catheters were prone to earlier infection (31d vs. 159d, $p = 0.012$). In the EtOH⁺ group, 24.1% of catheters required repair (vs. 9.1%), however, the repair rate (1.23 vs. 2.08/1,000 CD, $p < 0.01$) was lower in this group suggesting that ethanol therapy did not lead to breakdown of the catheter material.

Conclusions: Ethanol lock therapy results in longer catheter survival and increased catheter salvage rates in pediatric patients receiving long-term, home-based TPN.

QS7 Ten-Year Evaluation of Colorectal Cancer in Young Adults

DE Disbrow MD; D Osborn BS; AL Hale BA; JA Ewing MS; CL McFadden MD, Greenville Health System, *Greenville, SC*

Colorectal cancer (CRC) in younger patients (< 50 years) is reportedly on the rise. This study presents a 10-year evaluation of “younger” CRC patients, including incidence, symptoms, staging, and survival. CRC patients diagnosed between January 2005 and April 2015 (n = 767) were divided into two groups based on age. Group 1 consisted of patients < 50 years (n = 113) and Group 2 of patients ≥ 50 (n = 654). Demographics, tumor staging, and survival were compared between groups. Additional data was collected on Group 1, including comorbidities, presenting symptom(s), and family history. Group 1 comprised 14.7% (113/767) of all CRC patients. The majority of patients in both groups were Caucasian (Group 1, 77.9% vs. Group 2, 82.6%); gender was also comparable (53.0% vs. 48.2%, male). Mean age was 42.5 ± 6.7 years versus 70.0 ± 10.7 years. Advanced tumor staging (3 or 4) was not significant between groups, but the younger patients did have an increased survival rate (76.1% vs. 62.1%; p = 0.006). Comorbidities in Group 1 included smoking (14.9% current and 75.4% former), hypertension (23.7%), diabetes (9.6%), and inflammatory bowel disease (1.8%). Younger patients were symptomatic at diagnosis (89.5%), with 54.4% having multiple symptoms. These included blood in stool (72.8%), cramping/abdominal pain (51.8%), diarrhea and/or constipation (31.6%), rectal bleeding (26.3%), and unintended weight loss (12.3%). 11.5% of younger patients had primary and 14.9% had secondary family CRC history. These data show no significant increase in the incidence of CRC in younger patients. The majority of patients did present with symptoms; however, family history was not a prognostic factor. Lastly, younger CRC patients were not associated with an increased rate of advanced staging or mortality.

QS8 A Standardized, Inter-Department, Simulation-Based Central Line Insertion Course Closes an Educational Gap and Improves Intern Comfort with the Procedure

**J Grudziak MD; B Herndon MD; RD Dancel MD;
H Arora MBBS; CJ Tignanelli MD; MR Phillips MD;
JR Crowner; NA True; AC Kiser; HP Goodell BS;
N Murty BS; RF Ashton MD; MO Meyers MD;
SP Montgomery MD, University of North Carolina,
Chapel Hill, NC**

Introduction: Central line placement is a common procedure, routinely performed by junior residents in medical and surgical departments. Prior to this project, no standardized instructional course on the insertion of central lines existed at our institution, and few interns had received formal ultrasound training.

Methods: Interns from five departments participated in a simulation-based central line insertion course. Intern familiarity with the procedure and with ultrasound, as well as their prior experience with line placement and their level of comfort, was assessed using a pre- and post-course questionnaire.

Results: 45% of the 100 interns in participating departments have been trained as of October 2015. The majority (63%) had no prior formal ultrasound training. 47% had placed 1-2 lines as primary operator; 37% placed none, and 16% placed 3-5 lines. Intern comfort with ultrasound-guided central line placement increased after the course (pre score 2.39, post score 3.6), as did their comfort with ultrasound basics (2.84 versus 4.1) and interpretation of ultrasound findings (2.58 versus 4.3). 100% of all interns reported the course was “very much” helpful, and 100% reported they felt “somewhat” or “much” more comfortable with the procedure after attendance.

Discussion: To our knowledge, this is the first hospital-wide, standardized simulation based central line insertion course in the United States. Preliminary results indicate overwhelming satisfaction with the course, better ultrasound preparedness, and improved comfort with central line insertion.

QS9 Return to the System within 30 Days of Discharge Following Pediatric Appendectomy

HL Short MD; KF Heiss MD; S Sarda BS;

JJ Chern MD PhD; MV Raval MD MS, Emory University School of Medicine, Atlanta, GA

Post-procedural revisits, readmissions, and reoperations are commonly tracked quality metrics. With reimbursement and hospital-level comparison implications, characterizing these events is key to successful quality improvement efforts. Our purpose was to document revisit, readmission, and reoperation rates after pediatric appendectomy and to identify patient factors related to these metrics. This study included 3756 appendectomies performed at a single institution between 2009 and 2013. Demographic, socioeconomic, and clinical characteristics were prospectively collected in the administrative, business, and operating room databases. Clinical events within 30 days(d) of discharge were reviewed and analyzed. Regression models identified factors associated with each metric. Within 30d of discharge, there were 328 returns to the Emergency Department (ED) (8.7%), 128 readmissions (3.4%), and 41 reoperations (1.0%). The main source of readmission was the ED (n = 118, 92%). Nearly two thirds of readmissions were nonoperative (n = 87, 68%) and 12.5% were readmitted for issues not related to the index appendectomy. Factors associated with readmission include index procedure length > 70 minutes (OR 1.89, p = 0.043) and failed non-operative management of ruptured appendicitis (OR 2.97, p = 0.041). The most common indication for reoperation was intra-abdominal abscess (n = 20, 49%), and over half of these cases (n = 11, 55%) were managed with image-guided drainage by interventional radiology. In conclusion, while 30d revisit, readmission, and reoperation rates after appendectomy are low, there are opportunities for improvement. Furthermore, many 30d readmissions are not related to the index procedure and must be clearly identified to avoid inaccuracies with reimbursement and quality rankings.

QS10 Higher Versus Lower FFP-to-PRBC Ratio in Massive Transfusion: A Meta-Analysis of Patient Outcomes

RM. Mubang MD; NB Barry MD; DE Evans MD; RS Sharpe MD; PT Thomas DO; JC Cipolla MD; BH Hoey MD; SS Stawicki MD, St Luke's University Health Network, *Bethlehem, PA* and The Ohio State University, *Columbus, OH*

Introduction: Controversy continues regarding blood component therapy during massive transfusion events (MTEs) in trauma. Although studies show mortality benefit of high FFP-to-PRBC (F/P) ratios (i.e., > 0.5:1-1:1) during MTEs, generalizability of findings is limited due to narrowly defined institutional characteristics. The aim of this meta-analysis is to validate whether higher F/P ratios are associated with improved mortality following trauma MTEs.

Literature Search: Detailed literature search (> 1,700 references on MTEs, F/P ratios, clinical outcomes) identified 85 preliminary sources. After eliminating studies of non-trauma patients, experimental/non-human studies, those that lacked F/P ratio data, and cases/reviews, 16 acceptable manuscripts were included in the meta-analysis. We used the OpenMetaAnalyst Software using random effects model, with mortality as primary endpoint.

Results: Higher F/P ratios were associated with lower mortality (O.R. 0.554; 95% CI 0.446-0.690, I² = 95%) in a combined cohort of 9,930 patients. When models of F/P ratio versus mortality are superimposed on F/P ratio versus multi-organ failure (MOF), an inverse symmetry emerges. At F/P ratios ≤ 0.25, mortality (> 50%) exceeded the incidence of MOF (30%). The trendlines cross at F/P ratio of approximately the 0.25 (approx. 38% mortality/MOF incidence), and continue towards end-points of minimal mortality (< 25%) and maximum MOF (> 55%) at the F/P ratio of ≥ 1.26.

Conclusions: This study provides strong evidence in support of a quantifiable survival benefit with high (i.e., > 1:1) F/P ratios. As F/P ratio increases, greater incidence MOF appears to be the primary “trade-off” for decreasing mortality. Multi-center, prospective studies are required to validate observations from the current meta-analysis.

**#17 Gold Medal—Diabetic Foot Ulcers:
The Importance of Patient Comorbidity Recognition
and Total Contact Casting in Successful Wound Care**
M Jagadish, MM McNally MD, S Teffeteller RN,
RE Heidel PhD, JD Arnold MD, OH Grandas MD,
SL Stevens MD, MB Freeman, MH Goldman MD, University
of Tennessee Medical School, *Knoxville, TN*

Introduction: Diabetic foot ulcers (DFU) are a major burden the healthcare system and account for approximately \$1.5 billion dollars annually. The purpose of this study is to investigate factors affecting the healing rate of DFU in a university wound care center.

Methods: All records of DFU patients treated in a university wound care center between July 2013 and February 2015 were reviewed. Patient demographics, comorbidities and wound characteristics were analyzed. Treatment modalities including offloading, hyperbaric oxygen treatment, total contact casting (TCC) and bioengineered skin were investigated for correlation to wound healing. All patients underwent weekly debridement regardless of treatment modality. Patients were excluded from the study if they were undergoing treatment or deceased before DFU healing in the study period. Statistical significance was $p < 0.05$.

Results: A total of 114 patients ages 18 to 98 comprised the study population. Total contact casting was the only treatment associated with increased healing ($p = 0.02$). Smoking (OR = 0.19, 95% CI 0.06-0.61) and DVT history (OR = 0.13, 95% CI 0.04-0.42) significantly decreased the likelihood of wound healing. Patients with a past vascular event trended toward longer healing times (106 vs 77 months, $p = 0.07$). Duration of diabetes, neuropathy and renal failure did not affect wound healing rates. Wound characteristics and all treatments other than TCC did not significantly affect wound healing rate.

Conclusion: Total contact casting in combination with weekly wound debridement for diabetic foot ulcer shows benefit in DFU wound healing. Patients with a history of DVT were 87% less likely to heal. Current smokers with DFU were 83% less likely to heal emphasizing smoking cessation inclusion in DFU treatment.

#18 Patients at Increased Risk of Infection Do Not Require Longer Antimicrobial Therapy for Complicated Intra-Abdominal Infection

R Rattan MD; CJ Allen MD; RG Sawyer MD; N Namias MD, University of Miami Miller School of Medicine, *Miami, FL* and University of Virginia Health System, *Charlottesville, VA*

Background: A prospective, multicenter, randomized controlled trial found that 4 days of antibiotics for source-controlled complicated intra-abdominal infection (CIAI) resulted in similar outcomes compared to longer duration. We hypothesized patients with obesity or diabetes had similar outcomes.

Methods: Short-course obese or diabetic patients from the STOP-IT trial were compared to longer duration patients and to short-course patients with a normal BMI or without diabetes. Outcomes included incidence of surgical site (SSI), recurrent intra-abdominal (RIAI), and *Clostridium difficile* (CDI) infections and mortality. Significance was set to $p \leq 0.05$.

Results: P-values were non-significant except where noted. Of 152 obese patients, short-course ($n = 87$) and long-course ($n = 65$) patients had similar incidences of SSI (5.7 v 12.3%), RIAI (16.1 v 7.7%), CDI (1.1 v 3.1%) and mortality (2.3 v 0%). Of 162 short-course patients obese ($n = 87$) and normal BMI ($n = 75$) patients had similar incidences of SSI (5.7 v 10.7%), RIAI (16.1 v 8.0%), CDI (1.1 v 1.3%), and mortality (2.3 v 0%). Of 64 diabetic patients, short course patients ($n = 31$) were older (64 ± 11 v 56 ± 15 yrs, $p = 0.016$) and sicker (APACHE II 12.5 ± 5.2 v 9.7 ± 5.0 , $p = 0.032$). Incidences of SSI (6.5 v 12.1%), RIAI (9.7 v 6.1%), and CDI (3.2 v 3.0%) were similar. There was no mortality. Of 210 short-course patients, diabetics ($n = 31$) were older (64 ± 11 v 51 ± 16 yrs, $p < 0.001$) and sicker (APACHE II 12.5 ± 5.2 v 9.7 ± 5.9 , $p = 0.016$). Incidences of SSI (6.5 v 6.7%), RIAI (9.7 v 11.7%), CDI (3.2 v 1.7%), and mortality (1.1 v 0%) were similar.

Conclusion: Despite patients with obesity or diabetes having an increased risk of infection, a short course of antibiotics for CIAI with source control has similar outcomes to a longer course.

#20 Pancreatic Leak Predicts Readmission following Pancreaticoduodenectomy

C Mosquera MD, TL Fitzgerald MD, HS Vora MPH,
NJ Koutlas BS, EE Zervos MD, East Carolina University,
Greenville, NC

Readmission rates following pancreaticoduodenectomy (PD) are among the highest of any surgical procedure. The purpose of this study was to identify factors present at discharge that predict readmission following PD. **Methods:** All patients undergoing PD between 2010 and 2015 at a very-high volume center were entered into a prospective database. Causes of readmission were categorized as: infectious, failure to thrive, nausea & vomiting or other. Twenty factors present at discharge from index admission were subjected to multivariate analysis to identify those predictive of 30-day hospital readmission.

Results: 226 patients underwent PD during the study period, 88% of whom had cancer. Median age was 64.5 /-11.8 yrs with a slight male preponderance (55%) and significant African American representation (33%). Surgical complications occurred in 45% of patients the most common of which included: pancreatic fistula (7%), delayed gastric emptying (8%), infection(12%), bile leak (3%) cardiac(7%)and respiratory (6.5%). Thirty day readmission rate was 35% due to: infection (39%), failure to thrive (30%), nausea/vomiting (15%) or other (16%). Presence of pancreatic leak at discharge was the only significant predictor of readmission, representing 82% of all readmitted patients ($p = 0.001$). Co-morbidities, length of stay, insurance status, obesity, smoking and discharge facility (vs. home) did not predict readmission.

Conclusions: Patients manifesting pancreatic leak after PD are at high risk for hospital readmission. In order to positively impact readmission rates at our center following PD, enhanced home care resources and very-short interval follow should be considered.

#21 Gold Medal—Impact of Beta-Blockers on Non-Head Injured Trauma Patients

LE Hendrick MD; TJ Schroepfel MD; JP Sharpe MD;
LJ Magnotti MD; JA Weinberg MD; MA Croce MD;
TC Fabian MD, University of Tennessee Health Science Center,
Memphis, TN

Introduction: Catecholamine surge occurring as a result of trauma may lead to dysautonomia with increased morbidity. Small retrospective studies have shown potential benefit of receiving beta-blockers (BB) in trauma patients both with and without traumatic brain injury (TBI) by blocking the resultant surge. The purpose of this study was to evaluate a large multiply injured cohort without TBI that received BB.

Methods: Study patients were identified from the trauma registry from 1/1/2003–12/31/2011. Patients who received > 1 dose of BB were compared to controls. Patients with TBI, LOS < 2 days, and pre-hospital BB were excluded. Outcomes included mortality, ICU LOS, and LOS. Patients were stratified by age, mechanism, gender, transfusions, and injury severity (ISS). Multivariable regression was used to adjust for potential confounders.

Results: 19,148 eligible patients were admitted during the study period. The mean age was 39 years with most being male (74%) with blunt mechanism (75%). 9.7% (1,854) received BB. BB patients were older (51vs38 yrs), more severely injured (ISS 15vs10), and more likely to be in shock on admission (transfusions 5vs1 unit; all $p < 0.001$). BB patients had a longer LOS (16vs6 days), ICU LOS (7vs1 days), and a higher mortality (2.8vs0.5%; all $p < 0.001$). Multivariable regression demonstrated no benefit to BB after adjusting for confounders (OR 0.952; CI 0.620-1.461).

Conclusion: In this largest study to date, patients who received BB were older, more severely injured, and had a higher mortality. Unlike TBI patients, multivariable regression showed no benefit from BB in this population. Further study is warranted to determine if consistent beta-blockade, as opposed to simply receiving BB doses, would be beneficial.

#22 Neuropsychological Changes in Primary Hyperparathyroidism after Parathyroidectomy

JY Liu MD; CJ Weber MD; J Sharma MD, Emory University School of Medicine, Atlanta, GA

Background: Neuropsychiatric symptoms (NPS) of sporadic primary hyperparathyroidism (PHPT) are often subtle and effects of parathyroidectomy (PTX) on these symptoms remains poorly characterized. Our aim was to quantify NPS in patients with PHPT and the effects of PTX on NPS.

Methods: A prospective questionnaire was distributed to all patients undergoing PTX and to a thyroidectomy (TTX) control group. The questionnaire included the validated scales PHQ-9 and GAD-7 to assess for depression and anxiety respectively, as well as questions modified from Pasieka's Parathyroid Assessment of Symptoms (M-PAS). Point values were assigned to questionnaire answers to create a score, with a maximum of 63.

Results: 85 patients were analyzed with 45 undergoing a PTX (52.9%) and 40 a TTX (47.1%). There was a significant difference between PTX and TTX in preoperative total score (PTX 16.24 vs TTX 9.5, $p = 0.03$) and M-PAS means (PTX 4.16 vs TTX 2.03 $p = 0.012$) (Table I). Post-PTX scores were lower than pre-PTX in total score (pre 16.24 vs post 5.62), PHQ-9 (pre 7.07 vs post 2.58), GAD-7 (pre 5.02 vs post 1.67) and M-PAS (pre 4.16 vs post 1.38) (all $p < 0.05$), but was not different pre- and post-TTX. Post-PTX 77.8% and 86.7% of patients showed no symptoms of depression and anxiety respectively, compared to 40.0% and 62.2% pre-PTX. 17.8% and 13.3% of patients had moderately severe to severe depression and anxiety, which fell to 0% post-PTX.

Conclusions: NPS are more common in patients with PHPT when compared to TTX. Patients undergoing PTX have improvements in NPS.

#24 Gold Medal—Development of Electronic Medical Record Based Rounds Report Results in Improved Efficiency, More Time for Direct Patient Care and Education, and Less Resident Duty Hour Violations

PB Ham III MD; T Anderton MD; R Gallaher MD; M Hyrman; E Simmerman DO; A Ramanathan MBA; D Fallaw MD; S Holsten MD; CG Howell, MD, Medical College of Georgia, Georgia Regents University, *Augusta, GA*

Introduction: Surgeons frequently report frustration and loss of efficiency with electronic medical record (EMR) systems. Our hospital hired resident surgeons and a programmer as consultants. Together they created a rounds report (RR) summarizing 24 hours of vitals, intake/output, labs, and other values for each inpatient that were previously transcribed by hand. The objective of this study was to evaluate the RR's on surgical residents.

Methods: Residents were queried to assess the RR's impact after implementation. Outcome measures were: efficiency preparing for rounds, percent of workday in direct patient care, time spent on educational activities, rates of incorrect/incomplete data on rounds, and rate of resident duty hour violations.

Results: Hospital-wide, 17,200 RRs were generated in the one-month study. 23 surgery residents participated. Minutes spent preparing for rounds per floor patient (15.6 ± 3.0 vs 6.0 ± 1.2 , $p < 0.0001$) and per ICU patient decreased (19.9 ± 2.9 vs 7.5 ± 1.2 $p < 0.0001$). The work day percentage spent in direct patient care increased ($45.1 \pm 5.6\%$ vs $54.0 \pm 5.7\%$ $p = 0.0044$). Minutes spent on educational activities increased (35.2 ± 5.4 to 54.7 ± 7.1 per resident per day $p = 0.0004$). There was no significant difference in errors/incomplete data. Reported duty hour violations decreased 58% ($p < 0.0001$). Non-surgery residents' responses were similar. Hospital-wide, resident time savings based on usage was calculated at 1,782 hours per month.

Conclusions: Significant improvements occur when surgeon designed EMR tools are created. Hospitals and EMR companies should consider hiring interested surgeons as consultants and pair them with developers to facilitate EMR enhancements as improvements like RRs can have broad ranging, multidisciplinary impact.

#25 Patterns of Recurrence and Mechanisms of Failure after Ventral Hernia Repair with Mesh **S McGrath MD; JA Ewing MS; AM Carbonell MD; WS Cobb IV MD; J Warren MD, Greenville Health System, Greenville, SC**

Ventral hernia repair (VHR) is a commonly performed procedure in the US. However, recurrence remains a significant complication. Multiple factors, such as obesity, smoking, COPD, and postoperative surgical site infection (SSI) are associated with recurrence. Mesh choice, fixation, sizing, overlap, and fascial closure are important technical factors in recurrence. The purpose of this study is to identify technical aspects of hernia repair that may lead to recurrence. We retrospectively reviewed all patients who underwent open midline VHR between March 2006 and January 2013 (n = 261). Patients with (n = 48) and without (n = 213) recurrence were compared. Primary endpoint was hernia recurrence, and mesh type, position, fixation, and component separation technique (CST) were compared. Secondary outcomes include surgical site occurrence (SSO) and SSI. The majority of recurrences were due to central mesh failure (54.2%), most of which were repaired with light-weight polypropylene (LWPP) mesh (53.8%). Others recurred at the superior (16.7%) or inferior midline (2.1%) or laterally (14.6%). Recurrence was higher if the midline fascia was unable to be closed (p = 0.034). Choice of fixation, CST, nor mesh position was different between groups. Mid-weight polypropylene (MWPP) demonstrated significantly lower recurrence rate than polyester (p = 0.021) or biologic mesh (p = 0.009), and a lower incidence of central mesh failure versus LWPP (p < 0.001). Recurrence due to central mesh failure is significantly higher with the use of LWPP. The use of MWPP is preferred, with lower recurrence rates and no increase in SSO or SSI. We recommend wide coverage of all prior incisions in order to prevent superior, inferior, or lateral recurrences.

#26 Impact of Bariatric Surgery on Hiatal Hernia Repair Outcomes

VM Sutherland; T Kuwada MD; K Gersin MD;

D Stefanidis MD, Carolinas Healthcare System, *Charlotte, NC*

Background: Large hiatal hernias are notorious for their high recurrence rate (up to 50%) after conventional repair. Recurrence rates have been described to be higher in obese patients due to increased intraabdominal pressure (IP). Weight loss is associated with a decrease in IP and may lower recurrences. Our objective was to assess the impact of bariatric surgery on hiatal hernia repair outcomes in obese patients.

Methods: IRB approved review of prospectively collected data in a bariatric center of excellence. The outcomes of patients who underwent hiatal hernia repair (HHR) in conjunction with bariatric surgery between 2006-2014 were reviewed. Patients who had small hiatal hernias (< 2cm) and underwent an anterior repair were excluded. The primary outcome of the study was hernia recurrences; we also recorded weight loss and resolution of reflux and other comorbidities.

Results: Forty-three patients who had bariatric surgery and HHR were identified with a mean follow-up of 19 (2-74) months. Patient mean age was 50 ± 10 years, 89% were women and baseline weight and BMI were 272 ± 39 lbs and 45 ± 5 kg/m², respectively. 70% of patients had gastric bypass and 30% had sleeve gastrectomy. At 2 year follow up weight was 203 ± 40 lbs and BMI 34 ± 6 kg/m². Hernia recurrence rate was 9%; all were small and did not require repair. After surgery comorbidities that improved and/or completely resolved at last follow up included reflux (88%), diabetes (100%), hypertension (87%), and sleep apnea (79%).

Conclusions: Combining hiatal hernia repair with bariatric surgery leads to a low recurrence rate and excellent reflux and other comorbidity resolution during mid term follow up. These results compare very favorably to reported recurrence rates after conventional hernia repair with fundoplication.

#27 Video—Laparoscopic Revision of Fundoplication and Hiatal Hernia Repair with Explant of Biologic Synthetic Mesh Causing Hiatal Stenosis
MA Antiporda MD and SP Bowers MD, Mayo Clinic Florida,
Jacksonville, FL

Implementation of mesh prostheses for crural reinforcement in hiatal hernia repair remains a debated topic. Synthetic meshes are known to be associated with risk of erosion or stenosis resulting in dysphagia. Biologic meshes are hypothesized to diminish these risks due to their absorbability. In this video we show a revisional operation for a patient who had previously undergone fundoplication and hiatal hernia repair with use of biosynthetic mesh for reinforcement of the crura. He developed progressive dysphagia refractory to endoscopic balloon dilatation, and preoperative study showed hiatal stenosis. At the time of surgery, exposure of the hiatus showed that the mesh had undergone minimal resorption and had persisted as an inflammatory foreign body. The patient underwent resection, and re-do fundoplication and hiatal hernia repair without prosthetic reinforcement. Post-operative swallow study showed ready passage of contrast beyond the gastroesophageal junction. In conclusion, biosynthetic meshes may exhibit permanence more akin to synthetic materials, and their use in hiatal hernia repair should be re-considered.

#28 Video—Laparoscopic Repair of a Symptomatic Type 4 Paraesophageal Hernia with a Collis Gastroplasty

MM Shah MD; S Gill MD; B Martin MD; JL Stetler MD; A Patel MD; E Lin MD; SS Davis MD, Emory University, Atlanta, GA

Introduction: Type 4 paraesophageal hernia with organoaxial rotation carries a risk of ischemia. Laparoscopic repair with an esophageal lengthening procedure is safe and feasible.

Procedure: The patient was positioned in a supine fashion. The stomach and colon were reduced into the abdomen. The short gastrics were mobilized. The hernia sac was dissected by identifying the crura on each side. The esophagus was mobilized up to the arch of aorta. A collis gastroplasty was performed due to inadequate intra-abdominal esophageal length with gastroesophageal junction just above the diaphragm. A cruroplasty was performed. A PEG tube was placed. A 19 Fr round Blake drain was placed in the mediastinum.

Results: Upper gastrointestinal X-ray on post-operative day 1 showed no evidence of leak and the gastric folds just above the hiatal closure corroborating the intra-operative findings. The patient recovered well with no reflux and no pain on 2 week outpatient follow-up.

Conclusion: Laparoscopic repair of a type 4 paraesophageal hernia with collis gastroplasty and PEG tube placement has excellent short-term outcomes.

#30 The Impact of Chemotherapy on the Complications Associated with Mastectomy and Immediate Autologous Tissue Reconstruction

S Tanaka MD; G Hayek MD; P Jayapratap; Yerramsetti S; H St Hillaire MD; A Sadeghi MD; R Corsetti MD; G Fuhrman MD, Ochsner Medical Institutions,
New Orleans, LA

We performed this study to evaluate the impact of chemotherapy on the outcomes associated with immediate autologous tissue reconstruction (IATR) in the treatment of breast cancer. All patients that underwent IATR for breast cancer between 2006-2014 were identified from a prospectively maintained database and subjected to a retrospective review. Patients that had IATR followed by chemotherapy were excluded from further consideration. Patients were divided into two groups: Group I received chemotherapy before surgery and group 2 did not receive chemotherapy. Records were reviewed to identify demographics, comorbidities, breast cancer histology, and wound healing complications. Groups were compared using kruskal wallis and fisher's exact tests as appropriate. A total of 201 patients were identified and 73 that received chemotherapy after IATR were excluded leaving 128 patients: 29 received chemotherapy before surgery (Group I) and 99 did not receive chemotherapy (Group II). The demographics were similar between groups. Group I patients were more likely to have type II diabetes 27% vs. 5% ($p = 0.005$) despite both groups having a mean BMI of 30. Group II patients had less advanced stage disease as expected since they did not receive chemotherapy with 37% of patients with Stage 0 breast cancer ($p < 0.001$). The incidence of wound complications that included surgical site infection, delayed healing, ulceration, or necrosis was 17% in Group I and 12 % in Group II which was not statistically significant. Preoperative chemotherapy for breast cancer followed by IATR was associated with more advanced stage disease and type II diabetes; but, no increased risk of healing complications when compared to patients having reconstruction without chemotherapy. IATR can be offered to patients that require preoperative chemotherapy with confidence in that healing will not be impaired as a result of systemic treatment prior to surgery.

#31 Factors Associated with Positive (+) Margin Status after Breast Conserving Surgery (BCS) in Women with Breast Cancer: An Analysis of the National Cancer Database (NCDB)

JM Hanna; DR Lannin, MD; BK Killelea MD, AB Chagpar, Yale School of Medicine, *New Haven, CT*

Introduction: Margin status after definitive BCS is a key predictor of local tumor recurrence. We sought to determine factors associated with margins after BCS in a national dataset.

Methods: The NCDB represents 70% of newly diagnosed cancer cases nationally. Data includes BCS patients diagnosed with Stage 0-3 breast cancer (1998-2010).

Results: Of the 1,170,284 patients in this cohort, 15% had DCIS and 85% had invasive cancer (median tumor size 1.30 cm; median age 61). After definitive surgery, 7.3% of patients had margins. On bivariate analysis, margin status was significantly correlated ($p < 0.001$) with larger tumor size, lymph node positivity (10.5% vs. 5.2%), higher grade (8.0% for high vs. 5.8% for low), and invasive disease (7.5% vs. 6.4% for DCIS). Age, race, ethnicity, treatment facility type and location, Charleson score, receipt of neoadjuvant chemotherapy (NCT), and radiation were also correlated with margin status ($p < 0.001$). On multivariate analysis, clinicopathologic factors remaining significant ($p < 0.001$) included tumor size, lymph node positivity (OR: 1.9), invasive disease (OR: 1.50 vs. DCIS), and high grade (OR: 1.08 vs. low). Patients who were Black, with multiple comorbidities, living in a metro area in a Pacific state, who did not receive radiation nor NCT were more likely to have margins (all $p < 0.05$). While facility type and insurance status remained significant in the model, patient age and ethnicity did not.

Conclusion: While the goal of BCS is the attainment of negative margins, 7.3% of patients have margins after definitive surgery. These patients tend to have more aggressive disease and greater comorbidities, and are less likely to receive radiation therapy.

#32 Comparing Radioiodine Seed Localized Excision and Wire Localized Excision of Non-Palpable Breast Lesions: A Single Center Experience

E Dentcheva MD; EC Alberto BS; KZ Allison MD;
JP Wilson MD; RA Hoefer DO, Eastern Virginia Medical
School, Norfolk, VA

Introduction: Non palpable breast masses account for $> 25\%$ of radiologically suspicious lesions and generally require surgical intervention, with the standard being wire guided localization. A technique using iodine labeled titanium seeds (RSL) to localize lesions has gained popularity in surgical breast oncology. This study evaluates patients undergoing RSL at a regional center and if RSL is a feasible alternative to wire localized excision in non-palpable breast masses.

Methods: Since its introduction at our institution in 2012 the RSL method has been used exclusively to treat breast masses. In this retrospective study we evaluated patients from 2012-2014, diagnosed with a non-palpable breast lesion and compared these to a group of wire guided localization excisions. Our data was reviewed for trends in age, family history of breast cancer, and comorbidities. We also evaluated quality outcomes including margin status, need for further intervention, complications, as well as receptor status, and tumor type.

Results: In all groups examined from 2012-2014, the RSL procedure used at least 1 seed and all seeds were placed at least 1 day prior to the scheduled procedure. Radiation levels at placement were on average < 0.2 mCi, and all seeds were retrieved with no cases of displacement. A negative margin was achieved with an initial procedure in 86% of cases, and sentinel lymph node biopsy was performed successfully in 100% of cases. **Conclusions:** The study groups represented patients with a broad range of demographics as expected. The RSL technique overall had a low rate of positive margin status in comparison to the wire localization technique. Our data supports that the RSL technique is an acceptable alternative to wire guided localization in non-palpable breast lesions.

#33 Calculation of the Malignancy Rate, Number Needed to Treat, and Positive Predictive Value for Screening Breast MRI

JS Kennedy MD and P Robbins BS, DeKalb Medical, Decatur, GA

Objective: Screening breast MRI is being used more frequently for advanced screening for early detection of breast cancer. Patients typically are considered to be at high risk, or are symptomatic, with non-suspicious mammograms. There is little data to guide physicians regarding the likelihood of a recommendation for biopsy, or for detecting a malignancy, in this population. We intended to determine the malignancy rate, the number needed to treat, and the positive predictive value for patients receiving screening MRI at our institution.

Methods: A retrospective review of all breast MRIs from January 2008 through December 2010 was done. Patients with any prior diagnosis of breast cancer, or BRCA+ were excluded.

Results: There were 324 patients. Most common reasons for ordering the breast MRI included: abnormal test result 130 (44%), palpable mass 74 (23%), family history 58 (18%), breast pain 47 (15%), nipple discharge 45 (14%), as well as others. BIRADS classification was 1 or 2 in 36%, 4 or 5 in 18%, 3 in 26%, 0 in 10%, and not given in 9. Biopsy was recommended in 77(24%), with biopsy actually performed in 57(18%). Of the 8 cancers identified, 4(1.2%) were DCIS and 4(1.2%) were invasive cancer, yielding a true positive rate of 2.5%. Number needed to treat was 40.5. Positive predictive value was 14% with a false positive rate of 86%.

Conclusion: In this group of generally higher risk women, typically pre-screened with mammography, 1.2% had an otherwise occult invasive cancer, and another 1.2% had DCIS. Those who undergo biopsy are 6.1 times more likely to have benign pathology. The efficacy of screening breast MRI could be improved through refinements in indication, test interpretation, or alternative screening strategies.

#34 Timing of Post-Thyroidectomy Radioactive Iodine Ablation Does Not Affect Overall Survival in Low and Intermediate-Risk Papillary Thyroid Carcinoma

P Suman MD; S Rajjoub MD; TA Moo-Young MD; DJ Winchester MD; RA Prinz MD, NorthShore University HealthSystem, *Evanston, IL*

Background: Post-thyroidectomy radioiodine (RAI) ablation is controversial for low and intermediate-risk papillary thyroid carcinoma (PTC). Likewise, there is no consensus regarding the timing of RAI ablation in these patients. We analyzed the impact of the timing of administration of initial RAI ablation on overall survival (OS) in low and intermediate-risk PTC.

Methods: The National Cancer Data Base was queried from 2004-2012 for patients with PTC without cervical lymph node (LN) or distant metastases having near/subtotal or total thyroidectomy and adjuvant RAI ablation. Low-risk patients had tumors ≤ 1 cm in size with negative margins. Tumors between 1.1 to 4 cm in size with negative margins or ≤ 1 cm with microscopic margins were classified as intermediate-risk. Early RAI was classified as ≤ 3 months after thyroidectomy whereas delayed was between 3-12 months. Kaplan-Meier (KM) and Cox survival analyses were performed after adjusting for patient and tumor-related variables.

Results: There were 7885 low-risk and 19098 intermediate-risk patients. 18% of low-risk patients received delayed RAI while 14.7% intermediate-risk patients had delayed RAI ablation. KM analysis failed to show a difference in OS for early vs delayed RAI administration in low (10 yr OS 94.6% vs 93.5%, $P .628$), intermediate (10 yr OS 94.8% vs 95.8%, $P .870$) and combined groups (10 yr OS 94.7% vs 95.1%, $P .641$). On adjusted Cox multivariable survival analysis, the timing of RAI ablation failed to affect OS in combined low and intermediate risk patients (HR .92, 95% CI .68-1.24, $P .566$).

Conclusions: The timing of the initial post-thyroidectomy RAI ablation does not affect OS in patients with low or intermediate-risk PTC. This could assist patients and physicians in deciding on timing of RAI.

#35 The Sonographic Subcentimeter Malignant Thyroid Nodule: What Does It Stand For?

A Pascual MD; E Morfa BS; E Santiago MS; W Mendez MD,
University of Puerto Rico School of Medicine, *San Juan, PR*

Background: The current guidelines for management of thyroid cancer are showing a trend toward less extensive surgery in lesions that meet certain favorable criteria. **PURPOSE:** To evaluate if the sonographic size (US size) of a thyroid nodule is a reliable criterion to determine the extent of initial surgery in patients with papillary thyroid cancer. (PTC). **Methods:** Retrospective study using the prospective IRB approved database from 2007 to 2014. The inclusion criteria are patients with a thyroid nodule measuring less than 1 cm in the preop sonogram with a permanent pathology of PTC. Patients with preoperative evidence of multifocal lesions, metastasis were excluded. Patients were then further subdivided into two groups based on US size: A. 1-5mm and B. 6-10 mm. Statistical correlation were made for the presence of the following unfavorable criteria (UC): size > 10mm, multifocality, absence of capsule/capsular invasion, angio/lymphatic invasion, invasion of perithyroidal tissue and presence of metastases. $P < 0.05$.

Results: 1901 thyroidectomies were performed for the study time period. 722 (38%) were done for PTC. 182 (25%) patients met the inclusion criteria. There were 30 patients in Group A (1-5mm) and 152 patients in Group B (6-10 mm). 5 (16.6%) patients in Group A and 53 (35%) patients in Group B presented UC. This was significant.

Conclusions: Malignant thyroid nodules with US size of less than 5 mm can in theory be candidates for partial thyroidectomy, but 17% of them might still need further surgical intervention. Lesions with US size of 6-10 mm still have a moderate to high risk of presenting unfavorable pathological criteria.

#36 Sonographic Appearance is Useful in Predicting the Extent of Initial Operative Therapy for Thyroid Nodules Classified as “Suspicious for Malignancy” (SFM)

**K Statler MD; R Judhan MBBS; S Thompson PhD;
B Richmond MD, West Virginia University, Charleston, WV**

Background: The suspicious for malignancy(SFM) category of the Bethesda System for reporting thyroid cytopathology(BSRTC) predicts an incidence of malignancy from 60-75%.Recommended treatment is either lobectomy or total/near-total thyroidectomy. Identification of predictors of malignancy in this category would be useful in selecting the extent of operative therapy in these patients. Recent literature suggests that suspicious ultrasound(US)findings are useful in predicting malignancy in the benign, atypia/follicular lesion of uncertain significance(AUS/FLUS),and suspicious for follicular neoplasm(SFN) categories. We hypothesize that US would be similarly useful in patients with nodules classified as SFM.

Methods: We performed an analysis of patients with fine needle aspiration biopsies (FNAB) classified as SFM who underwent thyroidectomy from 2007-2012.Data included symptoms, imaging findings, FNAB results, and pathology results- all obtained via chart review. Findings were compared between patients with/without a diagnosis of thyroid cancer. Significance was set at $p < 0.05$.

Results: Of 3839 FNAB, 53 were classified as SFM. Of these, 36 were available for review. Twenty-four (66.7%) carcinomas were identified—19 papillary, 3 follicular variant of papillary, 1 follicular, and one medullary. No symptoms/signs reached significance as a predictor of malignancy. A suspicious ultrasound appearance was significantly associated with an underlying carcinoma ($p = 0.002$).

Conclusions: Patients with a BSRTC report of SFM and suspicious US findings are statistically more likely to harbor an underlying malignancy. This information is useful in selecting which patients are most likely to benefit from total/near-total thyroidectomy as opposed to lobectomy as the initial operative strategy.

#37 Population-Based Study of Factors Influencing Completion Lymph Node Dissection Compliance in Melanoma and its Relationship to Overall Survival Using the National Cancer Database

S Samreen MD; A Allard-Picou MD; M Fluck BS;
J Dove BA; M Hunsinger RN BSHS; J Wild MD;
M Shabahang MD PhD; J Blansfield MD, Geisinger Medical
Center, *Danville, PA*

Introduction: National melanoma guidelines recommend performing completion lymph node dissection (CLND) in patients with a positive sentinel lymph node biopsy (SLNB). Despite this, historical compliance with CLND is approximately 50%. Furthermore, there is no literature that shows a survival benefit when CLND is performed for node positive disease. The primary aim of this study is to evaluate factors that predict compliance to CLND versus SLNB alone. Additionally, we compared overall survival between the groups.

Methods: Using the National Cancer Data Base from 1998-2006, 11,295 lymph node positive melanoma patients were identified. Patients were stratified into SLNB only, and quality CLND groups (ten or more nodes harvested). Univariate analysis, multivariate analysis and propensity matching were performed using the SAS version 9.4.

Results: 2,712 (24%) patients underwent SLNB alone and 7,001 (62%) patients underwent a quality CLND. Age < 70 and male gender were significant predictors of CLND compliance. Academic research programs had the highest compliance (76% of patients underwent CLND). Only 61% of lower extremity lesions underwent CLND versus 75% with other primary sites. CLND increased with increasing T stage (66% utilization in T1 lesions to 73% utilization in T4 lesions). There was no statistical survival difference with SLNB alone compared to a quality CLND ($p = 0.4862$).

Conclusions: Despite national guidelines, only 62% of patients with node positive melanoma underwent a quality CLND. Overall survival is not improved when patients undergo CLND versus SLNB alone in node positive melanoma. Randomized controlled trials such as MSLT-II are needed to provide guidance in the management of patients with node positive melanoma.

VS1 Laser-Assisted Endovascular Retrieval of an Embedded Vena Cava Filter

**PF Fischer MD; BW Thomas MD; MJ Avery BS;
ML Lessne MD; AB Christmas MD; RF Sing MD**, Carolinas
Healthcare System, *Charlotte, NC*

The concept of the retrievable inferior vena cava filter (IVCF) was first introduced in the late 1960s however, it was not until 2004 that devices came to market with FDA approval. In 2010 a FDA communication was issued warning of 921 adverse events due to long term implantation of retrievable IVCFs and recommended considering removal of these filters as soon as protection from pulmonary embolus (PE) is no longer needed. However, retrieval can be complicated by device migration, tilting, embolus, inferior vena cava (IVC) perforation, and filter fracture. The Spectanetics excimer laser has previously been demonstrated to be a viable technology which can be utilized for retrieval of embedded IVCFs. This video contains an approach utilizing a sling technique to capture the embedded tip of a Argon Option filter followed by use of the Excimer laser to dissect the tip and filter from the wall of the IVC. The steps involved for successful explantation are described in detail.

VS2 Robotic Reversal of Roux-En-Y Gastric Bypass due to Recurrent Gastrojejunal Anastomotic Occlusion

G McRary, BA and D Stefanidis MD, Carolinas Medical Center, *Charlotte, NC*

Introduction: Reversal of Roux-en-Y gastric bypass (RYGB) is rarely required; one indication is gastrojejunal anastomotic (GJA) strictures often caused by chronic tobacco abuse. We present a case of a 53-year-old male who underwent RYGB in 2008 for obesity. Patient had great weight loss but developed gastrojejunal ulceration and subsequent stricture due to ongoing smoking. His stricture required GJA revision in 2013; most of his gastric remnant was removed. Patient continued smoking and 2 years later had symptoms of vomiting and 60lb weight loss. Endoscopic evaluation showed complete obstruction of his anastomosis; dilation was not possible. RYGB reversal was indicated, but feasibility was uncertain due to history of gastric remnant removal in his last operation.

Methods: The video describes a robotic reversal of the patient's RYGB. The patient's gastrojejunostomy was easily taken down. The gastric remnant had been removed, but antrum abutted the gastric pouch. An anastomosis of the pouch and antrum was created with robotic sewn two-layered technique without tension. The previous jejunojejunostomy (J-J) anastomosis was taken down and the Roux was reanastomosed to the biliopancreatic limb to reestablish small bowel continuity. A jejunostomy tube was placed in the bowel at the new J-J anastomosis. The robotic approach offered enhanced operative precision when dealing with scarred tissue planes.

Results: The operative time was 6 hours but was completed safely with no apparent complication. Patient was discharged 4 days later and increased his diet and regained some weight. The J-tube was removed at 2 months.

Conclusions: In patients with anastomotic strictures after RYGB related to tobacco abuse, GJA revision is suboptimal treatment if patients continue to smoke and gastric bypass reversal should be considered.

VS3 Laparoscopic Caudate Lobectomy for Colorectal Liver Metastasis

BM Martin MD; MM Shah MD; JL Stetler MD; A Patel MD; SS Davis Jr MD; JF Sweeney MD; JM Sarmiento; MD; E Lin DO, Emory University School of Medicine, Atlanta, GA

Background: The liver is the most common site of colorectal metastases with up to 5% of patients having caudate lobe involvement. Surgical resection offers the greatest likelihood of cure for those with isolated liver metastases. In addition to equivalent oncologic outcomes the laparoscopic approach shortens recovery duration.

Methods and Results: A laparoscopic caudate lobectomy was performed under low central venous pressure anesthesia for an isolated colon cancer metastasis. The pars flaccida was opened taking care to preserve a replaced left hepatic artery. The metastatic lesion was localized with the laparoscopic ultrasound probe and the hepatic parenchyma transected along the anteromedial aspect of the inferior vena cava with a combination of clips and the harmonic scalpel. Ultrasound was used to confirm an adequate margin and the specimen removed with an endocatch bag.

Conclusions: Here we demonstrate a successful laparoscopic caudate lobectomy for a solitary colon cancer metastasis utilizing intraoperative ultrasound to localize the lesion.

VS4 Combined Robotic/Laparoscopic Total Gastrectomy with Distal Pancreatectomy and Splenectomy

**SB Ross MD; TA Bowman BS; P Sukharamwala MD;
AS Rosemurgy MD, Florida Hospital Tampa, Tampa, FL**

This video demonstrates a robotic assisted laparoscopic total gastrectomy, distal pancreatectomy, and splenectomy. EGD confirmed the cancer in the proximal stomach. A 12 mm trocar was placed in the umbilicus for the camera. To the left of umbilicus, a 12 mm applied port was placed in the anterior axillary line. Two 8 mm ports were placed at the midclavicular line bilaterally, and a 5 mm subcostal port was placed for liver retraction. The distal esophagus was circumferentially dissected, and the short gastric vessels were divided. The gastrocolic omentum was divided and the splenic flexure of the colon mobilized. Upon mobilizing the stomach, we noted direct extension of the tumor into the anterior surface of the pancreas; the decision was made to distal pancreatectomy and splenectomy. The pancreatic neck was divided a stapler. The very proximal stomach was divided after EGD confirmation of tumor location to ensure an adequate resection margin. The specimen was placed in a laparoscopic extraction bag and removed through the left-sided 12mm port site. After identifying the ligament of Treitz, a 65 cm Roux-en-Y limb was constructed. An EEA stapler was used to construct the esophago-jejunal anastomosis. We oversewed the anastomotic staple lines and the pancreatic stump. A JP drain was laid in the pancreatic bed and brought out through the 5 mm port. The diaphragm was irrigated with bupivacaine solution and the trocar sites were closed with absorbable sutures.

VS5 Rare Extralobar Pulmonary Sequestration Resected Using Robotic- Assisted Thoracoscopic Surgery

RJ Sanders MD; S Ben-Or MD; JE Stephenson MD; WD Bolton MD, Greenville Health System, *Greenville, SC*

Pulmonary sequestration is the abnormal formation of lung tissue that has no connection with the bronchial tree or pulmonary arteries. Two distinct subgroups exist: intralobar sequestration (ILS) accounts for the majority of cases and shares the pleura of the adjacent normal lung tissue; extralobar sequestration (ELS) is less common and is separate from any surrounding lung tissue with its own pluera. ILS typically presents during adolescence and ELS is most common in newborns. In this video, we demonstrate successful robotic resection of a right-sided ELS in a 72-year-old woman. Multiple pulmonary lesions were discovered upon staging CT imaging for previous diagnosis of leomyosarcoma of the left hip. In addition to these pulmonary nodules, a 1.5x2.3cm cystic mass was located at the periphery of the right lower lobe (RLL). The patient was scheduled for robotic-assisted thoracoscopic surgery (RATS) wedge resection for removal of metastatic sarcoma lesions. During the RATS procedure, the previously-mentioned RLL cystic mass was discovered to be an ELS; it was subsequently removed during the same procedure for pathologic confirmation. Patient did well and was discharged on post-operative day 2. This incidental finding of a right-sided ELS in a 72-year-old undergoing RATS for multiple pulmonary nodules provides a unique in vivo perspective of a rare congenital pulmonary malformation.

#38 Better to be Fat than Thin: Analysis of Mortality in Traumatically Injured Patients Based on BMI and Mechanism Reveals Highest Mortality among the Underweight not the Obese

C Short MD; T Safcsak; I Bhullar MD, Orlando Health, Orlando, FL

Objective: To evaluate the effect of BMI on mortality after traumatic injury.

Methods: The records of adult patients from 2012-2015 at a Level I trauma center were retrospectively reviewed. The patients were divided into the following groups based on admission BMI: Under-Weight (UW) (BMI < 19), Ideal-Weight (IW) (BMI 19-24.9), Over-Weight (OW) (BMI 25-29.9), Obese (OB) (BMI 30-39.9) and Morbid Obese (MO) (BMI > 40). The groups were well matched with no significant differences in demographics and ISS. Morality for the IW group was compared to the remaining BMI groups.

Results: A total of 6049 patients were identified. The overall mortality for each BMI group was as follows: UW 8.8% (n = 317), IW 4.1% (n = 2229), OW 3.5% (n = 2052), OB 2.9% (n = 1244), and MO 1.9% (n = 207). In comparison to IW group, the UW mortality was significantly higher (IW vs. UW, 4.1% vs. 8.8%, p = 0.001); however, there was no significant difference with remaining groups. Subgroup analysis was also performed based on mechanism of injury. There was no significant difference in mortality between IW and the remaining BMI groups for patients that went directly to the operating room or for patients that had penetrating trauma (stab wounds and gunshot wounds). However, for blunt trauma, in comparison to the IW group, the UW mortality was significantly higher (IW vs. UW, 4.3% vs. 9.1%, p = 0.001), no different for OW (IW vs. OW, 4.3% vs. 3.7%, p = 0.3) and significantly lower for OB (IW vs. OB, 4.3% vs. 2.8%, p = 0.04) and for MO (IW vs. MO, 4.3% vs. 1.0%, p = 0.03).

Conclusions: After trauma underweight patients (BMI < 19) and not the obese, are at a significantly higher risk for overall mortality; this difference is especially evident after blunt trauma where obesity may actually confer a protective role.

#39 ARDS Incidence, But Not Mortality, Has Decreased Nationwide—A National Trauma Data Bank Study

M Fahr MD; G Jones PhD; D Tatum PhD, Our Lady of the Lake Regional Medical Center, *Baton Rouge, LA*

The incidence of ARDS is reported to have decreased in recent years, likely due to advances in critical care strategies. However, no study to date has examined temporally related changes in post-traumatic ARDS incidence and outcomes on a large scale to determine the effect of these practice changes exclusively in the adult trauma patient population. The NTDB was queried to evaluate ARDS incidence and associated outcomes over a 6 year period (2007-2012). To be included, patients had to be ≥ 18 years old, have at least one ventilator day, and have complications recorded. Trends in ARDS-associated outcomes such as mortality, number of ventilator days, length of stay (LOS), ICU LOS, and complications such as pneumonia, sepsis, and acute kidney injury (AKI) were also analyzed. Post-traumatic ARDS incidence decreased from 21.5% in 2007 to 8.5% in 2012 ($P < 0.001$). LOS, ICU LOS and ventilator days all decreased significantly ($P < 0.0001$) over time, with LOS decreasing by 4 days. Mean age increased ($P < 0.003$), but gender and race did not change. Mortality increased from 21.3% to 24.9% ($P < 0.002$). Both pneumonia and AKI marginally increased (39.5% to 40.9% and 11.4% to 12.3%, respectively). Sepsis trended down from 17.5% in 2007 to 12.0% in 2010, after which the NTDB definition changed and comparable data was not available. National post-traumatic ARDS incidence has decreased significantly in recent years, likely due to improved fluid & transfusion strategies, lung protective ventilation, and infection control protocols. Despite these advancements, post-traumatic ARDS mortality has remained stagnant for the past decade, suggesting it is no longer a viable primary outcome. Future studies should apply a more rigorous definition of ARDS and target a different primary outcome.

#40 Failure of Chlorhexidine to Prevent Postoperative Pneumonia: Regression Modeling with NSQIP Data

J Bansal ; B Woodall; J Jones; S Fogel, Virginia Tech Carilion School of Medicine, Roanoke, VA

Background: Quality improvement initiatives have led to the incorporation of preoperative chlorhexidine (CHX) oral rinses to prevent postoperative pneumonia. However, CHX's use in oral health was previously founded on its anti-plaque efficacy, not on its disinfection capability at the low concentrations being employed. **Methods:** The National Surgical Quality Improvement Program (NSQIP) database was employed to track postoperative pneumonia incidence in a population for 6 months prior to the oral CHX rinse implementation and then for 6 months afterwards. A step-wise regression analysis was used to stratify the populations and assess their risk for postoperative pneumonia based on other factors so that the two groups could be compared.

Results: A higher incidence of pneumonia was present in the CHX group prior to risk stratification. This was not a statistically significant difference once the risk adjustment was employed ($p > 0.7$). The step-wise regression model confirmed the weight of the factors used to risk stratify the control and CHX group. **Discussion:** This was a very well powered study, involving 3,294 patients who met criteria for inclusion within the specified timeframes and had validated data based on its incorporation into the NSQIP database. Chlorhexidine's lack of efficacy in pneumonia prevention can be explained by its low concentration, at which it is a poor, gram-specific disinfectant. **Conclusion:** Chlorhexidine failed to reduce postoperative pneumonia incidence.

#41 Arterial Injuries Associated with Blunt Fractures in the Lower Extremity

JJ Coleman MD; S Tavoosi MS; BL Zarzaur MD;
BL Brewer MD; GS Rozycki MD; DV Feliciano MD,
Indiana University School of Medicine, *Indianapolis, IN*

Objectives: Problems related to the combination of an arterial injury and a blunt fracture in the lower extremity are well-known – delay in diagnosis, loss of soft tissue, and higher amputation rate. The actual incidence of this combination of injuries is unknown, even in the current era of CT–arteriography. The purpose of this study was to determine the current incidence of arterial injuries in patients with blunt fractures in the lower extremities and to assess potential risk factors.

Methods: This was a 7 year (2007-2013) retrospective review of patients ≥ 18 years old with blunt lower extremity fractures treated at a Level I trauma center. Fracture location and incidence of a concomitant arterial injury were determined and patients stratified based on age, gender, and velocity of injury. A low velocity of injury was defined as a fall or assault. A high velocity injury was defined as involving motorized vehicles.

Results: 4413 patients (mean 52.2 years, 54.3% male, mean Injury Severity Score 13.1) met inclusion criteria. 46(1.04%) had arterial injuries (20.4% common femoral artery, 8.2% superficial femoral artery, 44.9% popliteal, 26.5% shank vessels). After stratifying by age and velocity of injury, younger age was associated with a significantly higher rate of vascular injury than older age groups. For high velocity injuries, there was no difference based on age.

Conclusions: The true prevalence of vascular injury after blunt injury lower extremity fractures is 1.04% in our study. There was a significant paradoxical relationship between age and the risk of an associated arterial injury in patients with low velocity injuries. If these data are confirmed in future studies, there should be a low index of suspicion in patients > 55 years after falls.

#42 Simple Prediction of Massive Transfusion Need in Geriatric Trauma Patients

SC Fligor BS; KM Love MD; BR Collier DO;
ME Hamill MD; EH Bradburn DO, Virginia Tech Carilion
School of Medicine, Roanoke, VA

Objectives: Early recognition of massive transfusion (MT) requirement in geriatric trauma patients presents a challenge, as occult hypoperfusion in this population often presents with vital signs outside of traditional thresholds for hypotension and tachycardia. We seek to determine appropriate physiologic criteria to identify geriatric patients at risk of critical bleeding.

Methods: All geriatric trauma patients (age ≥ 65 years) presenting to a Level 1 trauma center with full trauma team activations from January 1, 2010 to December 31, 2013 were extracted from an institutional trauma database. 200 patients with complete data were analyzed. Patients were classified as requiring MT if they received 5 or more units of blood within 24 hours. The area under the receiver operating characteristic curve (AUC) was calculated to assess discrimination of arrival vital signs for MT prediction. Ideal cutoffs with high sensitivity and specificity were identified.

Results: Systolic blood pressure (SBP) has the greatest discrimination for MT with an AUC of 0.887 and is significantly better than diastolic blood pressure (DBP), heart rate, and Glasgow Coma Scale, but not better than the shock index (SI). Using a SBP cutoff of 110mmHg results in a sensitivity of 0.81, a specificity of 0.78, and a positive predictive value of 0.25. Similarly, a DBP less than 60mmHg results in a sensitivity of 0.81, a specificity of 0.84, and a positive predictive value of 0.31. Finally, a SI of 0.8 provides a sensitivity of 0.75, specificity of 0.74, and positive predictive value of 0.20.

Conclusion: MT in geriatric trauma patients can be reliably predicted by arrival vital signs. SBP < 110 , DBP < 60 , and SI > 0.8 should be considered as alternative thresholds to identify critical bleeding in this population.

#43 What's In The Box? The Effectiveness of a Low Volume Massive Transfusion Protocol

ME Barnett BS; MM Ott MD; KA Baysinger MD;
KM McBride MD; EK Shaw PhD; JR Dunne MD,
Memorial University Medical Center, Savannah, GA

Background: Transfusion ratios approaching 1:1:1 of PRBC to FFP to PLT, have been shown to improve outcomes in trauma. There is little data available to describe in what quantity that ratio should be delivered. We hypothesized that lowering the total volume of products delivered in each protocol round would not adversely affect outcomes in the bleeding trauma patient.

Methods: A retrospective review of 9732 trauma patients admitted to a rural Level 1 trauma center over a three year period was performed. Patients who received a massive transfusion (greater than 10 units of blood product transfused in the first 24 hours), between January 2012 and April 2015 were identified as the study cohort. In May of 2014, our institution switched from a massive transfusion protocol (MTP) that included 6 PRBC:6 FFP:1 PLT to a lower volume protocol (LVMTP) that included 4 PRBC:4 FFP:1 PLT. Data collected included patient demographics, vital signs, and outcomes.

Results: 131 patients met study criteria. MTP was activated on 65% of patients (57/88), receiving a massive transfusion during the 28 months prior to implementation of the new protocol. In contrast, LVMTP was activated in 100% of patients (43/43) receiving a massive transfusion in the 12 months following implementation of the new protocol. There was no significant difference in age (36.6 vs. 37.2, $p = 0.87$), ISS (29.8 vs. 32.3, $p = 0.45$), or % penetrating mechanism (43.9% vs. 37.2%, $p = 0.503$) when comparing MTP to LVMTP. There was no significant difference in mortality (47.4% vs. 41.9%, $p = 0.584$), LOS (13.5 vs. 17.1, $p = 0.258$), or vent days (6.4 vs. 8.2, $p = 0.236$) when comparing MTP to LVMTP.

Conclusion: A lower volume massive transfusion protocol is safe and effective for the resuscitation of the trauma patient.

#44 Effect of Omission of Daily Chest Radiographs on Mechanically Ventilated Trauma Patients

SL Carroll MD; RL Griffin PhD; DA Reiff MD;
FN Tessler MD; BB Taylor MD; LW Rue MD, University of
Alabama, *Birmingham, AL*

Introduction: Critically injured trauma patients requiring mechanical ventilation frequently undergo assessment with daily chest radiographs. Evidence suggests that this may be unnecessary, potentially harmful, could lead to excess radiation exposure and increases the cost of care. The purpose of this study is to examine the effect of omitting routine daily chest radiographs on clinical outcomes among critically injured trauma patients.

Methods: Patients admitted to the trauma ICU between 11/29/2013-12/28/2013 (i.e., historical cohort) or 11/29/2014-12/28/2014 (i.e., omission cohort) were included. The two cohorts were compared in regards to ventilator support days, ICU days, hospital length of stay (LOS), mortality, and risk of pneumonia. Also, in a separate secondary analysis, the number of chest radiographs performed (per patient) was compared between the two-week period directly preceding and following the omission of daily chest radiographs.

Results: Compared to the two weeks preceding daily radiograph omission, there was a 30.4% drop in the mean number of chest radiographs per patient (7.1 vs. 4.9, $p = 0.0320$) for the time period following omission of daily radiographs. There was no difference in ICU days, mortality, or risk of pneumonia for the omission cohort vs. historical cohort. Mean ventilator support days was lower for the omission cohort (7.6 vs. 12.1 days, $p = 0.0155$).

Conclusion: Omission of routine daily chest radiographs resulted in no increase in hospital days, ICU days or risk of pneumonia or death. These results suggest that, among critically injured trauma patients, obtaining chest radiographs as needed based on clinical concerns is safe. Future studies should examine the effect of daily radiograph omission in all critically ill patients.

#45 Development and Validation of a Risk Calculator for Renal Complications after Colorectal Surgery using the National Surgical Quality Improvement Program Participant Use Files (NSQIP-PUF)

S Fang MBBS MPH; SD Perez MSPH; JK Srinivasan MD; PS Sullivan MD; JR Galloway MD; CA Staley MD; E Lin MD; J Sharma MD; JF Sweeney MD; VO Shaffer MD,
Emory University School of Medicine, *Atlanta, GA*

Renal failure is a dreaded postoperative complication in colon and rectal surgery. Patients who develop this condition have prolonged hospitalizations, higher morbidity and mortality. Our objective was to identify perioperative factors that predispose patients to postoperative renal failure and subsequently develop a risk calculator. All patients in NSQIP-PUF who underwent colorectal surgery in 2009 were selected (N=21,480). We identified renal complication during 30-day period after surgery. A predictive model, developed in the 2009 dataset using multivariable logistic regression analysis, was validated in dataset of 2010 - 2012. The overall incidence of renal complication among colorectal surgery patients was 1.6%. Significant predictors included male gender (adjusted OR 1.82; 95% CI 1.41-2.35), dependent functional status (OR 1.54; 95% CI 1.36-2.08), presence of dyspnea (OR 1.53; 95% CI 1.15-2.03), hypertension (OR 1.59; 95% CI 1.19-2.13), esophageal varices (OR 6.15; 95% CI 1.65-22.9), preoperative renal failure (OR 2.00; 95% CI 1.21-3.33), American Society of Anesthesiologists class ≥ 3 (OR 2.17; 95% CI 1.49-3.16), preoperative creatinine > 1.2 mg/dl (OR 2.83; 95% CI 2.17-3.69), albumin < 3.5 g/dl (OR 1.77; 95% CI 1.34-2.33), and emergency operation (OR 1.52; 95% CI 1.14-2.02). This final 10-variable model has a c-statistic of 0.795 and it was validated with similar excellent discrimination (c-statistic 0.771). The model was then used to develop a calculator by assigning risk scores to predictors based on ORs. This risk calculator has excellent predictive ability for postoperative renal complication. It can be used to aid clinicians in decision making, patient counseling, and further research on measures to improve patient care using perioperative data.

#46 Changing Epidemiology of Diverticulitis in the United States

T Galbreath DO; B Palachick MD; R Grim MA; T Bell MS; J Martin PhD; V Ahuja MD, WellSpan York Hospital, York, PA

Background: Previously noted is the overall incidence of diverticulitis in the US has increased (Etzioni et al, 2009). This study examines how the incidence of admissions for diverticulitis has changed and whether demographics are related to the frequency of admissions for diverticulitis.

Materials and Methods: 2,191,479 cases from HCUP-NIS discharge data (2002-2011) were collected with primary admission diagnosis of diverticulitis. US census data were used to calculate incidence rates. Exclusion criteria were: < 18 years of age, malignancy, and inflammatory bowel disease. Descriptive, χ^2 , and test of proportion statistics were used to evaluate incidence rates of admission, and demographic changes.

Results: The incidence of hospital admissions for diverticulitis increased from 67.9 to 77.7 per 100,000 ($p < .001$). The incidence remains highest in the 80+ age group, despite a 15% decrease. Patients 18-29 year old experienced the highest increase in incidence of diverticulitis of 57.6%, $p < .001$. By gender, the incidence remains higher in females over the decade by 20% ($p < .001$). Ethnic minorities also had increases: Native Americans (228%), African Americans (81.8%), and Hispanics (66.2%) with Asians experiencing the smallest increase at 10.5% (all $p < 0.001$). Admissions for medical treatment increased by 14.2%, in contrast with those for surgical treatment increasing by 15.6% (all $p < 0.001$).

Conclusions: There is an overall increase in admissions for diverticulitis especially in the young and minorities. The next step is to examine modifiable habits in the youth and minorities so we can implement potential dietary education and change the current trends.

#47 Can Drains Be Safely Eliminated in Abdominal Wall Reconstruction?

J Dean MD, B Forman, M Fabian MD, K Moore PhD,
B Ramshaw MD, Advanced Hernia Solutions,
Daytona Beach, FL

Introduction: The use of closed suction drains in the abdominal wall is a common practice in abdominal wall reconstruction (AWR) operations. Drains can be a conduit for bacteria and can cause pain and discomfort for patients after surgery.

Methods: A single hernia program has implemented the principles of clinical quality improvement (CQI) in an attempt to improve outcomes for patients who undergo an AWR. One attempt at a process improvement was to eliminate the use of drains by adopting techniques such as endoscopic component separation and more recently, a transversus abdominus release (TAR) technique combined with wide resection of skin, scar, soft tissue and umbilicus and layered suture closure to minimize dead space and decrease tension on the closure of the skin and subcutaneous tissue.

Results: A total of 84 patients undergoing AWR were included between 8/11 and 5/15 (45 months). A total of 13 patients had one or more drains placed prior to implementing a process improvement to eliminate the use of drains. A total of 71 patients had AWR without drain placement. In comparing the groups, the patient demographics were similar and mean length of stay was greater in patients who had drains: 11.4 days (range 3-43 days) vs. no drains: 7.0 days (range 0-49 days) and wound complications were higher in the group with drains: 7/13 (54%) vs. 19/71 (27%), including major wound complications being higher in the group with drains: 3/13 (23%) vs. no drains: (1%).

Conclusion: In this group of AWR patients an attempt at process improvement that eliminated the use of drains led to improved outcomes. Drains may be able to be safely eliminated with appropriate technique adaptation for AWR.

#48 A Large Single-Center Experience of Lateral Abdominal Wall Hernia Repairs

**JA Warren MD; PP Patel DO; R Mansour MD;
AM Carbonell DO, WS Cobb IV, MD, Greenville Health
System, Greenville, SC**

Lateral abdominal wall hernias may occur following a variety of procedures, including anterior spine exposure, urologic procedures, ostomy closures, or following trauma. Anatomically, these hernias are challenging and require a complete understanding of abdominal wall, interparietal and retroperitoneal anatomy for successful repair. Mesh placement requires extensive dissection of often unfamiliar planes, and fixation is difficult. We report our experience with open mesh repair of lateral abdominal wall hernias. A retrospective review of a prospectively maintained database was performed to identify patients with a classification of lateral abdominal wall hernia. Review included patients who may have had a midline hernia component as well. A total of 63 patients underwent 66 repairs. Defects were located subcostal (10), flank/iliac (32), and combined flank and midline incisional (23). Mean patient age was 57 years (range 13-78), with a mean BMI of 32 kg/m² (range 19.0-59.1). Mean defect size was 80.4 cm², with a mean greatest single dimension of 9.3cm (range 2-25cm). Retromuscular or interparietal repair was performed in 45.5%, preperitoneal in 33.3%, intraperitoneal in 12.1%, onlay in 6.1%, and primary suture repair in 3%. A component separation was also performed on 28.8% of patients. The rate of surgical site occurrence was 50%, primarily seroma, while the surgical site infection rate was 15.2%. With a mean follow up of 10.7 months, 6 patients (9.1%) have documented recurrence. Synthetic mesh reconstruction of lateral wall hernias is challenging. Our experience demonstrates the safety and success of repair using synthetic mesh primarily in the retromuscular, interparietal, or preperitoneal planes.

#49 For Love, Not Money: The Negative Financial Implications of Surgical Fellowships

PM Inflan BS, AS Hyde PhD, M Hulme PhD, JE Carter MD,
Wake Forest University, *Winston Salem, NC*

Background: In prior research, surgical residents cited an increase in income potential as one motivating factor for pursuing fellowship training (FT). With 70-80% of surgical residents entering FT, this perception deserves closer inspection. Our goal was to quantify the impact of FT on lifetime financial career value (FCV) and offer insight into a possible cause of surgical workforce disequilibrium between generalist and specialist.

Methods: We used net present value calculations – a standard financial technique – to determine FCV for general surgery, orthopedic, and Ob/Gyn practitioners in either private or academic practice. Using MGMA and AAMC data and accounting for a progressive tax structure, educational debt, resident salary, and forgone wages associated with fellowship training, we calculated positive and negative cashflows and discounted these cashflows at a rate of 6% annually.

Results: In general surgery, FT results in a decreased FCV for 71% of private practice careers. By contrast, only 29% of academic practice careers decrease FCV after FT. Trauma and surgical oncology fellowships are notable outliers, decreasing academic FCV by 5.8% and 14.7% respectively. In orthopaedics, FT decreases FCV for 75% of private practice and 50% of academic careers. FT in obstetrics and gynecology results in reduced FCV for 100% of both private practice and academic careers.

Discussion: Contrary to common perception, surgical fellowship training reduces FCV in many private practice and some academic careers. Unless motivated by non-monetary considerations, our study suggests surgical residents would likely benefit from forgoing FT. As a positive side-effect, fewer fellowship trainees would also help mitigate the shortage of unspecialized general surgeons.

#50 Surgical Mortality Review Reduces Preventable Deaths and Patient Safety Indicators (PSIs)

L Heidelberg, B Singletary, D Reiff, A deRussy, R Heslin, A Mims, J Morgan, WA Smedley, L Rue, M Heslin, The University of Alabama at Birmingham, *Birmingham, AL*

Introduction: Financial penalty for unacceptable rates of mortality and PSIs is the reality of external quality management. Review of hospital deaths has been shown to decrease mortality ratios, but there are little data evaluating the long term viability and results of these programs.

Methods: From 1/2013 through 8/2014; 26,699 inpatients were cared for on 12 surgical services. A surgeon from each service led reviews of all mortality and PSIs with central reporting of preventability. We compared the proportion of preventable mortality, PSIs and the UHC Observed to Expected Mortality ratio (OE ratio) (< 1 means less people died than expected) over time. Statistical significance was $p < 0.05$ by Poisson regression.

Results: Of the 26,699 inpatients in the study period, there were 510 deaths (1.9%) and 553 PSIs (2%) reviewed. Of the 510 deaths, 137 were categorized as possibly preventable or preventable. The odds ratio of a preventable mortality was half in the final quarter compared to the first quarter and this reduction was primarily seen in high risk services ($p < 0.05$). The proportion of preventable PSIs fell from 70% to 26% during the same time period ($p < 0.05$). The OE ratio was consistently below 1 and fell throughout the study period ($p < 0.05$).

Conclusions: The improvement in the OE ratio previously seen with hospital mortality review is a sustainable process. With a long term commitment, the additional benefits are a reduction in preventable mortality and PSIs, especially in high risk services. This process is one component that improves outcomes and reduces patient mortality.

#51 Cadaver-Based Simulation Increases Resident Confidence and May Augment Operative Autonomy

SC Kim MD; JG Fisher MD; KA Delman MD;
JM Hinman MPH; JK Srinivasan MD, Emory University
School of Medicine, Atlanta, GA

Background: Surgical simulation has become an increasingly important adjunct in surgical education. The majority of operative procedures can be simplified to core components. This study aimed to describe a cadaver-based simulation curriculum focusing on these fundamentals and quantify its utility in improving anatomic understanding and resident and attending confidence.

Methods: Residents from each post-graduate year were assigned to a group led by a clinical PGY5. The course consisted of a teaching cadaveric dissection, where residents performed skills appropriate for level with PGY5 guidance, and a video-recorded test where they narrated and demonstrated the task independently. Attendings graded each de-identified performance using standardized rubrics. Survey data were collected specifically targeting resident self-assessment of improvement in knowledge and confidence as well as attending confidence in resident ability.

Results: All residents (69) and attendings (14) completed surveys rating non-agreement (1) to complete agreement (5). After the course, residents felt safer in performing procedures in the clinical setting [median (IQR): 4(3-5)] and confidence in completing the assigned skill independently increased from 2(2-3) to 4(3-4), $P < 0.001$. Attendings were more likely to grant more autonomy in the operating room after this exercise [3(3-5)]. All participants wanted to continue the program (100%).

Discussion: A cadaveric skills course for fundamental surgical maneuvers with objective confirmation of successful completion is a viable adjunct to clinical operative learning. This activity improved both resident and attending confidence in trainee operative skill, resulting in increased attending willingness to grant a higher level of autonomy in the operating room.

#53 Video—Robotic Esophageal Diverticulectomy, Heller Myotomy, Toupet Fundoplication, and Hiatal Hernia Repair

**JL Stetler MD; S Gill MD; SS Davis MD; E Lin DO;
JF Sweeney MD; A Patel MD**, Emory University School of Medicine, *Atlanta, GA*

We present a case of a 74 year male with a 5 year history of progressive dysphagia caused by esophageal dysmotility and a large epiphrenic diverticulum. The objective of this video is to demonstrate the surgical technique and treatment of this patient by a robotic assisted esophageal diverticulectomy, heller myotomy, toupet fundoplication, and hiatal hernia repair. Some of the advantages afforded to the surgeon by robotic surgery are demonstrated in this video and include improved visualization and a wide range of instrument articulation that allow for surgical dissection in any angle. Time of operation was 3hr 15min. Blood loss was less than 50 ml. The patient tolerated the procedure well and was able to be discharged on postoperative day two.

#54 Video—Laparoscopic Common Bile Duct Exploration for Primary Choledocholithiasis
RC Kirks MD; RZ Swan MD; D Vrochides MD PhD;
JB Martinie MD; DA Iannitti MD, Carolinas Medical Center,
Charlotte, NC

Choledocholithiasis is found in approximately 10-18% of patients undergoing cholecystectomy for symptomatic cholelithiasis. Over the past 20 years, management of choledocholithiasis has changed dramatically with a commensurate increase in endoscopic therapies. Meta-analytic reviews have demonstrated equivalent rates of mortality, morbidity, and retained stones comparing laparoscopic to endoscopic common duct exploration. However, certain factors exist that decrease the chances of success of endoscopic biliary decompression, such as previous gastric bypass and large stones that cannot be cleared through the Ampulla of Vater. Primary hepatolithiasis and choledocholithiasis are two disease processes endemic to Asian populations and are associated with factors separate from those seen in North American gallstone development; these stones are often multiple, large, and can extend into the intrahepatic biliary tree. Presented in the accompanying video is a technique of common duct exploration via choledochotomy that is uniquely suited to treatment of large common duct stones that are not amenable to endoscopic or transcystic ductal instrumentation. Given the incidence of choledocholithiasis in the population of patients undergoing cholecystectomy each year (approximately 500,000) as well as patients with history of gastroenteric anastomosis, minimally-invasive treatment of choledocholithiasis and treatment of biliary obstruction via multiple approaches is a unique skill of general and specialized hepatobiliary surgeons with advances in surgical technology facilitating change in a classically-described procedure.

#55 Excessive Postoperative Fluid Administration in infants with Gastroschisis

PC Bonasso MD; GR Hobbs PhD; RA Vaughan MD;
NA Shorter MD; DK.Nakayama MD, West Virginia University
School of Medicine, Morgantown, WV

Background: Careful fluid management is a cornerstone of neonatology because the cardiovascular and respiratory systems in newborn infants are sensitive to overhydration. Fluid management in gastroschisis, complicated by evaporative water loss from exposed viscera and postoperative third-space fluid shifts, has not undergone the same degree of scrutiny.

Methods: Reviewing all infants with gastroschisis over the past five years, we reviewed fluid administration and urine output after primary closure, and after final closure for those undergoing staged repair. Data recorded included presence of intestinal atresia, weight, and duration of tube gastric decompression, parenteral nutrition support, and total hospitalization. Paired t-test gave statistical comparisons with significance at $p < 0.05$. **Results:** There were 24 patients, 17 primary and 7 staged closures. Fluid administration was in excess of 100 mL/kg/d for after primary closure, and significantly higher (> 150) after staged closure. Urinary output was 75-100 mL/kg/d (3.1-4.2 mL/kg/h) for both groups, higher volumes after staged closure. Two patients died of sepsis. All survivors were discharged with intestinal continuity, gaining weight on oral feeding.

Conclusion: Large fluid volumes were given after gastroschisis closure despite urine output in excess of accepted values of 24-40 mL/kg/d (ca. 1.0-1.5 mL/kg/h) and positive daily fluid balances exceeding 100 mL/kg/d. Our data suggest that the amounts of fluid generally administered in gastroschisis following both primary and definitive closure after staged reduction are excessive and potentially hinders recovery.

#56 Preoperative Bowel Preparation Prior to Elective Bowel Resection or Ostomy Closure in the Pediatric Patient Population Has No Impact on Outcomes: A Prospective Randomized Study

M Shah MD; CT Ellis MD; A Marzinsky BSN, RN, OCN;
PA Lange MD; W Adamson MD; T Weiner MD;
K Erickson MD; SE McLean MD, University of North
Carolina, Chapel Hill, NC

Purpose: The role of preoperative bowel preparation in the pediatric surgical population is uncertain and its use based on surgeon-preference. We performed a randomized prospective study to evaluate non-inferiority between the presence or absence of preoperative bowel preparation in elective pediatric bowel surgery on post-operative outcomes.

Methods: At our institution, patients aged 3 mo. to 18 yrs. scheduled to undergo elective bowel surgery were recruited. Patients were randomized to the bowel preparation group (Golytely with clear liquid diet day before surgery) or the no bowel preparation group (clear liquid diet day before surgery). All patients received peri-operative antibiotics. Patients were evaluated in-hospital and at post-operative clinic visits.

Results: 32 patients were recruited. 16 per group. Data analysis was completed using Fisher's exact test. There was no statistical difference ($p > 0.05$) in complications between the groups. Complications were observed in 5 (31%) patients in each group. In the bowel preparation group, 2 (12%) had wound infection (vs. 3, 19%), 0 had an intra-abdominal abscess (vs. 1, 6%), 1 (6%) had sepsis (vs. 1, 6%), 1 (6%) had an anastomotic leak (vs. 0), 3 (19%) had a bowel obstruction (vs. 1, 6%), and 0 had extra-abdominal complications (vs. 0).

Conclusion: There were no statistically significant differences in the number of complications between pediatric patients that received a pre-operative bowel preparation and those who did not. This study did not reach the planned sample size of 100 patients per group, which would have achieved enough power to make conclusions about the significance of the need for bowel preparation. Further research is warranted, but may require a multi-institutional trial to recruit sufficient numbers.

#57 Video—Robotic-Assisted Laparoscopic Inguinal Hernia Repair With Mesh

GA Darwazeh MD and G Kowdley MD, Saint Agnes Hospital,
Baltimore, MD

Laparoscopic inguinal hernia repair has certain advantages over open repair, including less post-operative pain and earlier return to normal activity. Robotic-assisted surgery provides surgeons with improved three-dimensional visualization and enhanced dexterity with articulating instrumentation. The ease of performing intracorporeal suturing to fix the mesh in robotic surgery substitutes the use of the relatively expensive tackers, and substantially reduces the cost of the procedure to the cost of laparoscopic inguinal hernia repair. This video demonstrates performing robotic-assisted laparoscopic inguinal hernia repair with mesh using intracorporeal suturing.

#58 Identifying Effectors of Outcomes in Patients with Large Umbilical Hernias

SA Groene MD; Tanushree Prasad MA; DW Heniford;

AE Lincourt PhD MBA; BT Heniford MD;

VA Augenstein MD, Carolinas Medical Center, *Charlotte, NC*

Introduction: Quality of life (QOL) has become an important focus of hernia repair outcomes. This study aims to identify factors which lead to ideal outcomes (asymptomatic and without recurrence) in large umbilical hernias (defect size $\geq 9\text{cm}^2$).

Methods: Review of the prospective International Hernia Mesh Registry was performed. The Carolinas Comfort Scale (CCS) was used to measure QOL at 1, 6, 12 and 24-month follow-up. Demographics, operative details, complications and QOL data were evaluated using standard statistical methods.

Results: Forty-four large UHR were analyzed.. Demographics included: average age 53.6 ± 12.0 and BMI $34.9 \pm 7.2 \text{ kg/m}^2$. The mean defect size was $21.7 \pm 16.9\text{cm}^2$, and 72.7% were performed laparoscopically. Complications included hematoma (2.3%), seroma (12.6%) and recurrence (9.1%). Follow up and ideal outcomes were: 1 month- 28.2%, 6 months- 42.9%, 1 year- 55.6%, 2 years- 54.6%. All patients who remained symptomatic at 1 and 2 years were significantly symptomatic before surgery. Symptomatic pre-op activity limitation was a significant predictor of non-ideal outcomes at one year ($p = 0.02$). Symptomatic pre-op pain was associated with non-ideal outcomes at one year, though the difference was not statistically significant ($p = 0.06$). Operative technique, mesh choice and fixation technique did not impact recurrence or QOL.

Conclusion: Repair of UH with defects $\geq 9\text{cm}^2$ had a surprising low rate of ideal outcomes (asymptomatic and no recurrence). All patients with non-ideal long-term outcomes had pre-operative pain and activity limitations. These data may suggest that UH be repaired when they are small and asymptomatic.

#59 Gluteal Fascial Advancement for Pilonidal Cyst Disease: A 10-year Review

BC Powell MD; CB Webb MD; JA Ewing MS;

DE Smith MD, Greenville Health System, Greenville, SC

Pilonidal cyst disease is common and can be managed by a variety of surgical treatments. Elective excision of non-infected cysts has historically been plagued by a high rate of complications, such as wound breakdown and recurrence. As a result, debate remains regarding the most effective method of wound closure. We previously reported on a small group of patients ($n = 17$ out of 83 patients) in which a novel technique was used to decrease wound complications and recurrence. The purpose of this paper was to build on that prior study by evaluating the utility of the gluteal fascial advancement method to decrease recurrence and dehiscence over a 10-year period. We retrospectively reviewed all patients who underwent surgery for pilonidal cyst excision between 2008 and 2014; this was then added to the data from 2004 to 2007 ($n = 217$). Patients were divided into two cohorts: those who underwent elective excision with simple primary closure ($n = 163$) and those who underwent bilateral gluteal fascial advancement flaps ($n = 54$). Primary endpoints included recurrence and dehiscence. Overall, demographic characteristics were statistically comparable in both groups. The rate of recurrence was not significantly different between groups. However, wound closure using bilateral gluteal fascial advancement flaps was associated with a significantly lower rate of dehiscence when compared to standard primary closure (13% vs. 44%; $p < 0.001$). This data indicates that the use of bilateral gluteal fascial advancement flaps is a superior method for closing elective pilonidal cyst excisions.

#60 Chest Wall Stabilization Leads to Shortened Chest Tube Stay Time in Rib Fracture Patients after Traumatic Chest Wall Injury

MT Fitzgerald MD; H Abukhdeir; MPH; DW Ashley MD; DB Christie III MD, Mercer University, Macon, GA

Background: Rib fracture fixation has become an appealing strategy for trauma patients with displaced rib fractures and hemo/pneumothoraces (HTX/PTX). Rib plating improves pain control and respiratory mechanics thereby reducing recovery times and associated morbidity and mortality. Traditional treatment of HTX/PTX has been chest tube placement, pain control, and pulmonary toilet. With rib plating and chest wall stabilization, the resolution of HTX/PTX is expected to occur in a more expeditious and durable fashion.

Purpose: The study compares chest tube stay time in patients receiving rib plating to patients managed conservatively. We hypothesize that chest tube stay times are reduced in patients after plating.

Methods: With IRB approval, a retrospective review of our trauma registry, a Level I Trauma Center, was performed. Patients admitted from 2013-15 who received rib plating(n=70) were compared to a randomly selected, non-operative, injury-matched control group(n=60) admitted from 2003-08. Demographic data was obtained. Independent variables analyzed included ISS, ICU days, total length of stay and chest tube stay times.

Results: 60 non operative patients with rib fractures and HTX/PTX had an average ISS of 19, and age of 51 compared to an average ISS of 20 and age of 56. Plated patients had a reduction in chest tube days 6.5 days vs 8.4 days, p-value = 0.02. Plated patients had 14 ICU vs 19 days, p-value = 0.09. T-test were performed to confirm significance.

Conclusion: Reduction in chest tube days improves patient pain, satisfaction and allows for improved ambulation and pulmonary toilet, helping reduce respiratory complications. Our review shows plating may prove beneficial in reducing complications associated with chest tube and rib fractures.

GRAND ROUNDS OF POSTERS

Objectives: To provide discussion and insights from academic and private practice surgeon moderators. The dialogue will cover expanding and enhancing the information covered by the posters. This will be a meaningful experience and an opportunity to exchange ideas and information.

Rounding Schedule: Poster presentations will take place each Sunday and Monday mornings from 6:30–7:50 AM. Meet the Rounding Professors each morning at the first poster for each team.

Sunday		Monday	
A	1-12	A	39-51
B	13-25	B	64-76
C	26-38	C	87-94
D	52-63	D	103-116
E	77-86	E	131-145
F	95-102	F	158-169
G	117-130	G	184-196
H	146-157	H	211-223
I	170-183	I	237-249
J	197-210	J	263-276
K	224-236	K	291-305
L	250-262	L	306-315
M	277-290		

Poster
Number

- P1 Laparoscopic Resection of a Congenital Solitary Hepatic Cyst in an Infant**
Gan MD and JM Draus MD, University of Kentucky Children's Hospital, *Lexington, KY*
- P2 Necrotizing Fasciitis in a Healthy Pediatric Patient Caused by Enterobacter Cloacae and Serratia Marcescens: A Case Report and Discussion of Diagnosis and Management**
KA Tyler MD; A Patterson MD; A Hebra MD, Medical University of South Carolina, *Charleston, SC*
- P3 Successful Closure of Delayed Traumatic Esophagomediastinal Fistula in Pediatric Patient via Endoscopic Fulguration and Fibrin Injection**
II Maizlin MD; JS Chen MD; N Smith MD; DA Rogers MD, Children's Hospital of Alabama, University of Alabama in Birmingham, *Birmingham, AL*
- P4 Extralobar Pulmonary Sequestration with Accompanying Ipsilateral Diaphragmatic Eventration**
ES Godshall MD; AL Navarro MPH; AP Leshner MD, Medical University of South Carolina, *Charleston, SC*
- P5 Ileocolic and Jejunal Intussusceptions Requiring Surgical Intervention in a Pediatric Patient with Post-Transplant Lymphoproliferative Disorder**
II Maizlin MD; DA Klima MD; EA Beierle MD, Children's Hospital of Alabama, University of Alabama in Birmingham, *Birmingham, AL*
- P6 Pediatric Laparoscopic Splenectomy Using Only Ultrasonic Energy Device**
BM Cason MD; I Payne MD, J Glasser MD; WO Richards MD, University of South Alabama College of Medicine, *Mobile, AL*

- P7 Fetus in fetu: A Case Report with a Variant Host Anastomosis**
BP Blackwood MD; MN Tran MD; MD Landin MD;
AN Shah MD, Rush University Medical Center, *Chicago, IL*
- P8 Management of Patients requiring ECMO for Respiratory Failure and Concurrent Gastroschisis**
AM Lalani MS; PB Ham III MD MS; LJ Wise MSN RNC-NIC
C-NPT K; C Walters MD; WL Pipkin MD; B Stansfield MD;
RM Hatley MD; J Bhatia MD, Medical College of Georgia at
Georgia Regents University, *Augusta, AL*
- P9 Preduodenal Portal Vein: A Rare Cause of Bowel Obstruction**
WF Weber MD and JM Draus MD, University of Kentucky
Graduate Medical Education, *Lexington, KY*
- P10 Management of Giant Omphalocele with Delayed Closure Using Musculocutaneous Flaps**
KJ Smith MD; RM Hatley MD; CG Howell MD, Georgia
Regents University, *Augusta, GA*
- P11 Delayed Presentation of Congenital Hernia- Its Embryonic Factors**
S Remersu MD; S Koganti MD; B Gilchrist MD, Bronx Lebanon
Hospital Center, *Bronx, NY*
- P12 Paratubal Cyst Torsion with Compromise of the Fallopian Tube in an Adolescent Girl**
JL Ottino DO and RL Ricca MD, Naval Medical Center
Portsmouth, *Portsmouth, VA*
- P13 Caudal Duplication: Management of a Rare Congenital Condition**
JC Harris MD; B Blackwood MD; S Pillai MD; R Kanard MD,
Rush University Medical Center, and University of Illinois Chicago,
Chicago, IL
- P14 A Rare Diagnosis for Unexplained, Persistent Fevers and Abdominal Pain in the Pediatric Population**
YT Krishna MD; HR Howe III MD; RS Abrams MD; RL Gates
MD, Greenville Health System, *Greenville, SC*

- P15 Venovenous Extracorporeal Membrane Oxygenation (VV-ECMO) in Pediatric Respiratory Failure**
B Hwang MS; PB Ham MD; LJ Wise BSN; KC Walters MD;
WL Pipkin MD; R Hatley MD, Medical College of Georgia,
Augusta, GA
- P16 Analysis of Congenital Hypertrophic Pyloric Stenosis Using the Nationwide Inpatient Sample (NIS) Database: Epidemiology, Socioeconomic Data, and a Comparison of Outcomes with Laparoscopic Versus Open Pyloromyotomy**
PB Ham III MD; MT Simmons MD, Z Klaassen MD, RM Hatley MD; WL Pipkin MD, KC Walters MD, CG Howell MD,
Children's Hospital of Georgia, Medical College of Georgia, and Georgia Regents University, *Augusta, GA*
- P17 Familial Intussusception—Younger Age at Presentation, Male Predisposition, More Difficult to Reduce Radiographically, and More Likely to Recur**
P Erwin DO; PB Ham III MD; CJ Mentzer DO;
RM Hatley MD; WL Pipkin MD; CG Howell MD;
KC Walters MD, Children's Hospital of Georgia, Medical College of Georgia, Georgia Regents University, *Augusta, GA*
- P18 Necrotizing Fasciitis in a Healthy Pediatric Patient Caused by Enterobacter Cloacae and Serratia Marcescens: A Case Report and Discussion of Diagnosis and Management**
KA Tyler MD; A Patterson MD; A Hebra MD, Medical University of South Carolina, *Charleston, SC*
- P19 WITHDRAWN**
- P20 Is the Duration of Right Lower Quadrant Pain Associated with the Presence of Sonographic Secondary Signs in Suspected Pediatric Appendicitis?**
KN Partain; A Patel; C Travers MPH; C McCracken PhD;
J Loewen MD; K Braithwaite MD; KF Heiss MD;
MV Raval MD, Children's Healthcare of Atlanta, *Atlanta, GA*

- P21 The Jacksonville Omphalopagus Conjoined Twins: The Importance of Preoperative Planning and Timing in Achieving Success**
DK Robie MD; N Poulos MD; S Dunn MD, Nemours Children's Specialty Care and Wolfson Children's Hospital, *Jacksonville, FL*
- P22 A Review of Complications Associated with Nuss Bar Fixation following Surgical Repair of Pectus Excavatum**
M Shah MD; R Frye MD; MR Phillips MD;
A Marzinsky BSN RN OSN; W Adamson MD; SE McLean MD, University of North Carolina, *Chapel Hill, NC*
- P23 Pediatric Secondary Overtriage in a Statewide Rural Trauma System: Are These Transfers Necessary?**
A Leung MD; J Con MD; D Long PhD; R Vaughan MD, West Virginia University, *Morgantown, WV*
- P24 Occult Heterotopic Gastric Mucosa as a Lead Point for Ileocolic Intussusception in an Adolescent: a Rare Finding with Inherent Diagnostic Challenges**
HR Nolan MD; JB Glenn MD; AP Bozeman MD, Mercer University School of Medicine/The Medical Center Navicent Health, *Macon, GA*
- P25 Chylous Ascites in a Neonate with Non-Immune Hydrops Fetalis**
JM Held MD; RD Restrepo MD; RL Ricca MD, Naval Medical Center Portsmouth, *Portsmouth, VA*
- P26 A Novel Technique Using Intraoperative Fluoroscopy as a Tool to Achieve Negative Margins after a Wire-guided Partial Mastectomy**
S Beierle MD; E Heidel PhD; J. Lewis MD; E Stewart BS; J Bell MD; K Gray MD; M Lapinska MD; M Mancini MD; HS Nelson MD; J McLoughlin MD, University of Tennessee Graduate School of Medicine, *Knoxville, TN*
- P27 Paget's Disease of the Breast: Institutional Review and Surgical Management**
AW White MD; EA Levine MD; M Howard-McNatt MD, Wake Forest School of Medicine, *Winston-Salem, NC*

- P28 The Impact of Lumpectomy and Mastectomy With or Without Reconstruction on the Time from Breast Cancer Diagnosis to Surgery and Chemotherapy**
GA Hayek MD; D Barak MD; T Lynch BS; RL Corsetti MD; C Babycos MD; H St Hillaire; A Sadeghi MD;
GM Fuhrman, Ochsner Medical Institutions, *New Orleans, LA*
- P29 Neuroendocrine Breast Cancer in a Male Patient: A Rare Entity**
RJ Gore MD; K Kopkash MD; L Rosen MD, Rush University Medical Center, *Chicago, IL*
- P30 Variation in Follow-Up of Asymptomatic Breast Cancer Patients: Can We Choose More Wisely?**
AB Chagpar MD; T Hughes MD; K Hunt MD; J Aguirre MD; G Babiera MD, Yale University School of Medicine,
New Haven, CT
- P31 Breast Reconstruction Cost Analysis in Academic Medical Center**
Z Baghmanli, MD; M Welch, MD; M Nazzal, MD; S Chang, MD, The University of Toledo, *Toledo, OH*
- P32 Optimizing the Use of Local Anesthesia for Ultrasound-Guided Core Breast Biopsy**
JS Kennedy MD, DeKalb Medical, *Decatur, GA*
- P33 Congenital Symmastia: A Reconstruction Technique**
EB Almon MD; CE Fancher MD; PJ Syribeys MD; DB Christie MD, Mercer University School of Medicine / The Medical Center, Navicent Health, *Macon, GA*
- P34 Arthritic Shoulder Effusion Masquerading as an Acute Inflammatory Breast Mass: A Case Report and Literature Review**
E Mejia; D Sirovich; K Braiwithwaite DO; I Mukherjee MD; J D'Anna MD, Staten Island University Hospital, *Staten Island, NY*
- P35 Intracystic Papillary Carcinoma of the Breast: A Case Study and Clinical Update**
TK Kelley MD; JC Chohonis; LR Brounts, Dwight D. Eisenhower Army Medical Center, *Augusta, GA*

- P36 Does Breast Conservation Therapy Produce Equivalent Outcomes to Mastectomy in Patients with Triple Negative Breast Cancer?**
MA Sicard MD; E Breaux BS; BDL Li MD, Louisiana State University Health, *Shreveport, LA*
- P37 Invasive Carcinoma of Breast Arising in a Fibro-Adenoma: Case Report of a Rare Condition**
S Bibi MD; V Gollapoli MD; M John MD; R Gupta MD; AJ Shah MD, Bronx Lebanon Hospital, *Bronx, NY*
- P38 Triple Positive Breast Cancer in a Male with Cardiac Disease**
JW Rosenberg MD; K Friend MD; R Somers MD, Einstein Medical Center, *Philadelphia, PA*
- P39 Reality Check: A Nationwide Assessment of Practice Patterns and Outcomes Associated With the Use of Paravertebral Block in Breast Surgery**
NE Lopez MD; ER Newton MD; K Gallagher DO; KP McGuire MD; P Strauss MSPH, University of North Carolina, *Chapel Hill, NC*
- P40 Basal Cell Carcinoma of the Nipple-Areola Complex: An Unusual Presentation of a Common Tumor**
LM Fluke DO; MK Arbuthnot DO; L Kropcho MD, Naval Medical Center, *Portsmouth, VA*
- P41 Detection of Breast Cancer from Measures of Resting State Dynamics of the Hemoglobin Signal**
AP Asarian MD; NATretyakova MD; LS Dresner MD; HL Graber PhD; RL Barbour PhD, The Brooklyn Hospital Center, *Brooklyn, NY*
- P42 A Large Breast Hamartoma in an 18 Year Old Female: A Case Report**
IK Kabir; KM Kelley MD; RC Britt MD, Eastern Virginia Medical School, *Norfolk, VA*
- P43 Isolated Extranodal Rosai-Dorfman Disease of the Breast in a 71-year-old Female: A Case Report**
HG Cox; KM Kelley MD; RC Britt MD, Eastern Virginia Medical School, *Norfolk, VA*

- P44 A Rare Case of Spindle Cell Sarcoma Presenting as a Recurrent Breast Cyst**
BD Hristov MD; S Biswas MD; H Cadot MD, Brookdale Hospital Medical Center, *Brooklyn, NY*
- P45 Metastatic Breast Cancer to the Gallbladder: An Atypical Presentation of Right Upper Quadrant Abdominal Pain**
PA Kumbala MD; MF Lin-Duffy DO; R Henry-Tillman MD, University of Arkansas for Medical Sciences, Little Rock, AR
- P46 Early Results of Irreversible Electroporation (IRE) for Tissue Ablation in Soft Tissue Tumors**
CJ Mentzer; JK Gable; NJ Walsh; BP Bateson; EJ Kruse, Georgia Regents Medical Center, Medical College of Georgia, *Augusta, GA*
- P47 A Rare Case of Plasmablastic Lymphoma Mimicking Adenocarcinoma of the Sigmoid Colon**
KL Kleppe MD; KD Gray MD; JA Stancher MD; LD Duncan MD; JW Vaughn MD; A Orucevic MD, University of Tennessee Medical Center, *Knoxville, TN*
- P48 PET/CT Changes Management in Selective Stage II Melanoma Patients**
M Landry MBBS; JM Lewis MD; YC Bradley, University of Tennessee Medical Center, *Knoxville, TN*
- P49 Recurrent Cervical Cancer Presenting as Inflammatory Breast Cancer**
V Gonzalez MSc; LF Petersen MD; R Ghai MD, S Dewdney MD; A Madrigano MD, Rush University, *Chicago, IL*
- P50 Single-Site Laparoscopic Splenectomy for Isolated Splenic Metastasis**
JO Green MD; K Somani MD; VG Patel MB BS FRCS FRCS(Ed), Atlanta Medical Center, *Atlanta, GA*
- P51 Feasibility and Safety of Irreversible Electroporation in Locally Advanced Pelvic and Retroperitoneal Tumors**
BP Bateson; NJ Walsh; JK Gable; CJ Mentzer; EJ Kruse, Georgia Regents Medical Center, *Augusta, GA*

- P52 HIV Related Malignancy: The Rise and Fall of Kaposi's Sarcoma with HAART**
PD Lorimer MD; RC Kirks MD; K Walsh MS; S White BS;
MR Forster MD; JC Salo MD; RL White MD; JS Hill MD,
Levine Cancer Institute, Carolinas Medical Center, *Charlotte, NC*
- P53 Adenocarcinoma of the Oropharynx: A Case Report and Review of the Literature**
JK Fortson MD; R Su MD; VJ Patel MD, ENT Associates of
South Atlanta, *Atlanta, GA*
- P54 Mucoepidermoid Carcinoma of the Lingual Tonsil**
JK Fortson MD; R Su MD; VJ Patel MD, ENT Associates of
South Atlanta, *Atlanta, GA*
- P55 Prophylactic Laparoscopic Gastrectomy for CDH1 Mutations**
J Broucek MD; C Fredericks MD; M Luu MD, Rush University
Medical Center, *Chicago, IL*
- P56 Early Results of Irreversible Electroporation (IRE) for Tissue Ablation in Soft Tissue Tumors**
CJ Mentzer; JK Gable; NJ Walsh; BP Bateson; EJ Kruse,
Georgia Regents Medical Center, Medical College of Georgia,
Augusta, GA
- P57 Institutional Risk in Meeting the American College of Surgeons (ACS) Commission on Cancer Benchmarks – Evaluation of Nonmalignant Lesions Leading to Breast Cancer Diagnoses**
YE Warren Jr; CS Cox; FL Greene MD, UNC School of
Medicine, Levine Cancer Institute, *Charlotte, NC*
- P58 Cytoreduction with Hyperthermic Intraperitoneal Chemotherapy: An Appraisal of Outcomes and Cost at a Newly Established Peritoneal Malignancy Program**
NM Hinkle; J McDonald; JP Sharpe; PV Dickson; JL Deneve;
G Munene, University of Tennessee Health Science Center,
Memphis, TN

- P59 Jejunum Intussusception: A Rare Presentation of Carcinoid Tumor**
U Kannan; AA Rahnamai-Azar; AN Patel; V Gaduputi;
AK Shah, Bronx- Lebanon Hospital Center, *Bronx, NY*
- P60 Gargantuan Gastrointestinal Stromal Tumors: Surgical Treatment of Locally Advanced GISTs**
AA Vinyard MD; AC Mallette MD; S Yelverton BS;
TM Earl MD; WS Orr MD, University of Mississippi Medical Center, *Jackson, MS*
- P61 An Unusual Presentation of Diffuse Large B-cell Lymphoma**
LM Fluke DO; D Green MD ; G Robles MD; C Oxner MD,
Naval Medical Center, *Portsmouth, VA*
- P62 Hyperthyroidism and Thyroid Carcinoma**
E Vázquez-Quintana MD and DE Vázquez-Torres, MD,
- P63 Solitary Fibrous Tumor Series: A Radiographic and Histopathologic Perspective**
MA Smith DO; KJ Smith MD; EJ Kruse DO, Georgia Regents University, *Augusta, GA*
- P64 Right Thigh Pseudotumor, a Three Year Sequela of Gallstone Spillage**
JG Vaughan MD and P Dale MD, Mercer University, Navicent Health, *Macon, GA*
- P65 Minimally Invasive Management of Infected Pancreatic Necrosis**
BM Dennis MD; RN Lesperance MD; OL Gunter MD,
Vanderbilt University School of Medicine, *Nashville, TN*
- P66 Improved Post-Operative Survival for Intraductal Growth Subtype of Intrahepatic Cholangiocarcinoma**
LL Dover; P Li, DT Redden; R Jacob; JA White; SH Gray;
DE Eckhoff; DA DuBay, University of Alabama at Birmingham, *Birmingham, AL*

- P67 Laparoscopic vs Open Distal Pancreatectomy: A Comparative Study of Perioperative Outcomes**
OC Kutlu MD; KA Morgan MD; DB Adams MD, Medical University of South Carolina, *Charleston, SC*
- P68 Laparoscopic Resection of Extrahepatic Mucinous Cystadenoma, Choledochoduodenostomy and Cholecystectomy**
Y Cozacov MD; F Safdie; C Simpfendorfer, Cleveland Clinic Florida, *Weston, FL*
- P69 Acute Care Surgery: Redefining Management of the Pancreatic Pseudocyst**
S Sivaraman MD; M Magarakis MD; NM Vranis BA; R Tesoriero MD; B Bruns MD; M Narayan MD; M Lauerman MD; J Diaz MD, University of Maryland School of Medicine, *Baltimore, MD*
- P70 Robotic Hepaticojejunostomy Following Common Bile Duct Injury**
TE Barnes MD; E Baker MD; D Vrochides MD; DA Ianitti MD; R Swan MD; JB Martinie MD, Carolinas Medical Center, *Charlotte, NC*
- P71 Primary Lymph Node Gastrinoma: A Case Report**
BK Sparkman MD and TM Earl MD, University of Mississippi Medical Center, *Jackson, MS*
- P72 Gangrenous Cholecystitis Discovered During Elective, Outpatient Cholecystectomy: A Case Series**
MB Huck MD; KI Habenicht MD; MA Giffen DO; VM Hathuc MD; S McNatt MD; C Westcott MD; CJ Clark MD, Wake Forest Baptist Health, *Winston-Salem, NC*
- P73 Intrapancreatic Accessory Spleen Mimicking a Potential Pancreatic Tumor**
CF Uribe MD; KS Somani MD; PT Ramsay MD, Atlanta Medical Center, *Atlanta, GA*

- P74 Gastrointestinal Stromal Tumor Masquerading as a Solid Pseudopapillary Tumor of the Pancreas; Implications of Tyrosine Kinase Inhibitor Therapy (TKI) in Childbearing Women**
BR Ford MD; CJ Hruska MD; KD Gray MD; YD Young MD,
University of Tennessee Medical Center, *Knoxville, TN*
- P75 Iatrogenic and Traumatic Injury of the Gallbladder: A Two Patient Series**
SA Hart MD and JS Beatty MD, East Tennessee State University,
Quillen College of Medicine, *Johnson City, TN*
- P76 A Case of Pancreatic Intraductal Tubular Carcinoma: A Rare Entity with Improved Prognosis**
SG Bhat MD; JM McLoughlin MD; A Orucevic MD PhD,
University of Tennessee Medical Center, *Knoxville, TN*
- P77 Malignant Large Bowel Obstruction: A Rare Presentation of Metastatic Pancreatic Cancer**
KM Kelley MD and JJ Berger MD, Eastern Virginia Medical School, *Norfolk, VA*
- P78 Pancreas-Associated Enteric Duplication Cyst: A Case Report**
A Landmann MD; JL Calisto MD; FM Balla MD;
JS Bender MD, University of Oklahoma Health Sciences Center,
Oklahoma City, OK
- P79 Duplication of Extrahepatic Bile Duct Found in Laparoscopic Cholecystectomy**
V Gollapalli, MD and BF Gilchrist, Bronx-Lebanon Hospital,
Bronx, NY
- P80 Zollinger Ellison Syndrome In An Adolescent**
M El Zaedi MD; MM John MD; U Kannan MD;
BF Gilchrist MD, Bronx-Lebanon Hospital, *Bronx, NY*
- P81 Subacute Necrotizing Cholecystitis Masquerading as Malignancy—An Unusual Clinical and Radiographic Presentation**
MP Taylor MD; TA Ramos DO; JS Beatty MD, East Tennessee State University, *Johnson City, TN*

- P82 Diagnosis, Treatment, and Management of a 70 Year Old Patient with VIPoma**
AE Guinn BS; TA Ramos DO; JR Lee MD, Philadelphia College of Osteopathic Medicine, Georgia Campus, ETSU College of Medicine, *Johnson City, TN*
- P83 Management of an Unusual Complication Post-Pancreaticoduodenectomy**
NS Patel BS; MM Ramseyer MD; JR Lee MD, Brody School of Medicine at ECU, ETSU Quillen College of Medicine, *Johnson City, TN*
- P84 Giant Cystadenocarcinoma: A Report of a Case and Review of Treatment Recommendations**
C Butler MD; A Landmann MD; R Postier MD, University of Oklahoma Health Sciences Center, *Oklahoma City, OK*
- P85 Impact of Healthcare Worker Attitudes Toward Organ Donation**
JD Cull MD; TL Spivey MD; VA Fleetwood MD; EY Chan MD, Greenville Health System, *Greenville, SC*
- P86 Impact of Ethnicity on Liver Transplant Graft Survival**
Z Baghmanli MD; R Liu PhD; J Mei; D Heidt MD; J Ortiz MD, The University of Toledo, *Toledo, OH*
- P87 Anatomical Study about the Intra Individual Variability of the Superior Laryngeal Nerve: What is the Helpful Surgical Take-Away?**
A Bove MD PhD; A De Carlo MD; A Minni MD; RM Di Renzo MD; G Papa MD; S Rossi MD; G Bongarzone; H.Traxel, G D'annunzio Medical School, *Chieti, Italy*, La Sapienza Medical School, *Rome, Italy*, Wien University Medical School, *Austria*
- P88 Ovarian Thyroid Cancer: A Case Report**
RW Randle MD; RE Rebowe MD; P Persad MD; T Zhao MD; M Kelly MD; C Burns MD; J Cannon MD, Wake Forest School of Medicine, *Winston-Salem, NC*

- P89 Pheochromocytoma Diagnosed after Presentation with Acute Pancreatitis**
TE Sambo MD; A Therasse MD; C Sturgeon MD;
DM Elaraj MD, Presence St. Joseph Hospital, *Chicago IL*,
Porter Health, *Valparaiso, IN*, and Northwestern Memorial Hospital,
Chicago, IL
- P90 Hypoglycemia Following Laparoscopic Adrenalectomy for Pheochromocytoma in an 18 year-old: A Case Study**
JM Hebert MD; JB Wooldridge MD; WS Richardson MD,
Ochsner Clinic Foundation, *New Orleans, LA*
- P91 Accuracy of Sestamibi Scans in Localizing Parathyroid Adenomas in a VA Hospital Population**
AS Snider MD and JR Wells MD, University of South Carolina
School of Medicine, *Columbia, SC*
- P92 Laparoscopic Ultrasonographic Localization and Resection of Pancreatic Head Insulinoma**
AV Patel BS; JK Fortson MD; VG Patel MB BS, Atlanta Medical
Center South Campus, *East Point, GA*
- P93 The Fiscal Impact of Thyroidectomy and Parathyroidectomy on a Trauma Service**
T Capasso MD and A Rosenthal MD, Memorial Regional
Hospital, *Hollywood, FL*
- P94 Thyroidectomy for Compression Symptoms: Are There Predictors for Outcome?**
A Pascual MD; J Matias BS; W Mendez MD, University of
Puerto Rico, *San Juan, PR*
- P95 The Use of Intraoperative Nerve Monitor during Thyroid and Parathyroid Related Surgeries and its Impact on the Rate of Nerve Injuries**
IM Mbaka MD; SJ Craft MS; F Navarro MD, Palmetto Health
Hospital/University of South Carolina *Columbia, SC*
- P96 Gastric Adenocarcinoma Presenting after Revisional Roux-en-y Gastric Bypass**
VA Fleetwood MD; L Petersen MD; KW Millikan MD, Rush
University Medical Center, *Chicago, IL*

- P97 Laparoscopic-Assisted Endoscopic Retrograde Cholangiopancreatography in Patients with Roux-en-y Anatomy: A Single Institution Case Series**
D Yearsley MD; G Wynn MD; I Irgau MD; D Witmer MD; M Peters MD, Christiana Care Health System, *Newark, DE*
- P98 Single Institution Review of Single Port versus Multi-port Sleeve Gastrectomy**
C Clark MD; M Garland MD; E Krebs MD; M Powell MD, Wake Forest University School of Medicine, *Winston-Salem, NC*
- P99 Case Report: Recurrent, Multiple Intussusceptions after Roux-en-Y Gastric Bypass**
JO Green MD PhD and H Urrego MD, Atlanta Medical Center, *Atlanta, GA*
- P100 Lap-Assisted ERCP Following Laparoscopic Roux-en-y Gastric Bypass: A Case Series**
C Connor MD; G Cote MD; TK Byrne MD; R Pullatt MD, Medical University of South Carolina, *Charleston, SC*
- P101 Chronically Incarcerated Internal Hernia After Roux-en-y Gastric Bypass: A Case Study**
SE Baker MD and WS Richardson MD, Ochsner Clinic, *New Orleans, LA*
- P102 Retrograde Intussusception (RI) after Roux-en-Y Gastric Bypass (RYGB)**
AN Mukerji MD; R Gupta MD; V Gollapalli MD; U Kannan; S Koganti; V Parithivel, Bronx Lebanon Hospital Center, *New York, NY*
- P103 Pitfalls in the Management of Small Bowel Obstruction**
LM Cerda MD; JG Mariadason MD; JJ Degliuomini MD; AM Srinivasan MD; MK Wallack MD, Metropolitan Hospital Center, *New York, NY*
- P104 Perioperative Statin Treatment: Can it Decrease Post-Surgical Cardiac Event Risk in Noncardiac Surgery?**
MG Spivey MS; SL Fogel MD; J Atwood, Virginia Tech Carilion School of Medicine, *Roanoke, VA*, and Virginia Tech LISA, *Blacksburg, VA*

- P105 Surgeon-Performed Ultrasound for Detection of Abdominal Wall Adhesions in the Reoperative Abdomen: An Initial Prospective Study**
RB Baucom MD; MD Holzman MD; KW Sharp MD;
BK Poulouse MD, Vanderbilt University Medical Center,
Nashville, TN
- P106 Gender Affects Presentation of Complicated Intra-Abdominal Infection**
R Rattan MD; CJ Allen MD; RG Sawyer MD; N Namias MD,
University of Miami Miller School of Medicine, *Miami, FL*, and
University of Virginia Health System, *Charlottesville, VA*
- P107 Selected Use of Permanent Mesh in Hernia Repairs with Wound Contamination: A Retrospective Review**
MC Tufts MD and SS McNatt MD, Wake Forest Baptist Medical
Center, *Winston Salem, NC*
- P108 Unicentric Castleman's Disease Masquerades as a Carcinoid Tumor in the Small Bowel**
W Akram MD; J Degliuomini; MK Wallack;
S. Huang MS III; E. Okechukwu MS III; E Tam MS III,
New York Medical College, Metropolitan Hospital Center,
New York, NY
- P109 Ultrasound Course at a Surgery Residency Program**
AJ Bhatt; M Hosseini; GC Kowdley, St Agnes Hospital,
Baltimore, MD
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SG Bhat MD; A Orucevic MD PhD; JL Bell MD, University of
Tennessee Medical Center, *Knoxville, TN*
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NA King MD; A Kunac MD; DJ Anjaria MD, New Jersey
Medical School, *Newark, NJ*

- P113** **Diagnosis and Complications of Acute Appendicitis in Diabetics**
WJ Loggins BS; AE Donovan BS; LM Bach BS;
SA Thompson PhD; BK Richmond MD, West Virginia University
School of Medicine, *Charleston, WV*
- P114** **Appendix Neoplasms in a Rural County: A Review of an Unexpected Number of Cases**
KP Wood MD; KJ Hoeffner RN; RJ Johnson MD, Aurora
Medical Center, *Two Rivers, WI*
- P115** **What is the role of the General Surgeon in Treating Metastatic Ovarian Cancer to the Upper Abdomen? A Case Presentation and Literature Review**
TW Wood MD, Northside Hospital, *Atlanta, GA*
- P116** **Laparoscopic Approach to a Rare Disease: Multicystic Peritoneal Mesothelioma**
Y Cozacov MD; M Roy MD; R Shah MD; C Simpfendorfer MD,
Cleveland Clinic Florida, *Weston, FL*
- P117** **Utilization of Radiology Rotations during General Surgery Training: Are they Needed?**
JJ Eid MD; FI Macedo MD; VK Mittal MD, Providence Hospital
and Medical Centers, *Southfield, MI*
- P118** **Preliminary Results of an Ongoing Study of a Consumer-Based Activity Monitor (Fitbit Zip™) in Evaluating Perioperative Activity of Older Adults Undergoing Major Abdominal Surgery**
M Tufts MD; S Lewis RN; N Fino MS; C Clark MD, Wake Forest
Baptist Health, *Winston-Salem, NC*
- P119** **The Utility of Abdominal CT for Pre-operative Planning of Percutaneous Endoscopic Gastrostomy Tube Placement**
M Garland MD; PR Miller MD; AN Hildreth MD; AL Hale;
ML Kaiser MD, University of South Carolina School of Medicine,
Greenville, SC

- P120 The Role of Endoscopy After Upper Gastrointestinal Bleeding in Sub-Saharan Africa: A Prospective Study**
JR Gallaher MD; G Mulima MBBS; JS Qureshi MD;
CG Shores MD; BA Cairns MD; AG Charles MD, University of
North Carolina, *Chapel Hill, NC*
- P121 Polycythemia Vera, An Unusual Suspect in the Case of Spontaneous Splenic Rupture**
DM Hardy MD; ES Simmerman DO; A Lewis MD; B Lane MD,
Georgia Regents University Medical Center, *Augusta, GA*
- P122 Old Man Gallbladder Syndrome: Gangrenous Cholecystitis in the Unsuspected Patient Population**
TD Dhir MD and RS Schiowitz, Albert Einstein Medical Center,
Philadelphia, PA
- P123 Three Cases Of Benign Gastric Pneumatosis**
AE Wall MD; M Linger MD; KW Sharp MD, Vanderbilt
University Medical Center, *Nashville, TN*
- P124 Giant Abdominal Lipoma**
R Michael MD; JS Richey MD; BM Manning MD;
DE Smith MD, Greenville Health System, *Greenville, SC*
- P125 Clip Migration Causing Cholangitis Following Laparoscopic Cholecystectomy**
JL Overcash MD and PT Ramsay MD, Atlanta Medical Center,
Atlanta, GA
- P126 Predictors and Risk Factors Associated with Perforated Appendicitis: An Analysis of The National Inpatient Sample.**
A Al-Ameri MD; T Sabo DO; A Sill; N Goussous;
J Sanchez FACS; G Kowdley MD, Saint Agnes Hospital,
Baltimore, MD
- P127 Mechanical Small Bowel Obstruction Caused By A Retained Free Intraperitoneal Staple Following Laparoscopic Appendectomy**
DH Craig MD; E Lagergren MD; LM Sieren MD, Wake Forest
Baptist Medical Center, *Winston-Salem, NC*

- P128 Robotic versus Laparoscopic Cholecystectomy**
X Yang MD; B Beteck MD; N Karnik BS; S Yang;
G Kowdley MD, St. Agnes Hospital, *Baltimore, MD*
- P129 Robotic Curriculum in a Community Surgical Training Program**
B Beteck MD; X Yang MD; N Karnik BS; S Yang;
G Kowdley MD, St. Agnes Hospital, *Baltimore, MD*
- P130 Just a Little Too Tight: Revision Abdominoplasty and Asymptomatic Internal Hernia Result in Abdominal Compartment Syndrome and Venous Mesenteric Ischemia**
ML Leatherman DO; WH Ward MD; TM Polk MD, Naval Medical Center, *Portsmouth, VA*
- P131 Use of Fluorescent Dye Technology**
L Blackmon; J Motts; DM Countryman, Ralph Johnson VA Medical Center and Medical University of South Carolina, *Charleston, SC*
- P132 A Rare Infectious Cause of Postoperative Anemia**
AB Goetz MD; JH Pang MD; ART Joshi MD, Einstein Healthcare Network, *Philadelphia, PA*
- P133 Missed Extravasation Injury from Peripheral Infusion of Norepinephrine Resulting in Forearm Compartment Syndrome and Amputation**
CM Alexander MD; M Ramseyer MD; JS Beatty MD, East Tennessee State University, *Johnson City, TN*
- P134 First Reported Case of Pericardial NUT Midline Carcinoma**
PMH Tran; LKH Tran; PB Ham III MD; CJ Mentzer DO; A Polimenakos MD; WL Pipkin MD, Georgia Regents University Medical College of Georgia, *Augusta, GA*
- P135 Atypical Cause of Subcutaneous Emphysema**
TJ Painter MD and JA Ibrahim MD, Orlando Health, *Orlando, FL*

- P136 Splenectomy for Primary and Secondary Malignancies: A Case Series**
JC Kubasiak MD; C Fredericks MD; MB Luu MD, Rush University Medical School, *Chicago, IL*
- P137 Selected Complex Appendicitis Managed with a Standard Perioperative Protocol**
AC Gratzon MD; K Safcsak RN; JA Ibrahim MD; AM Bada MD; ML Cheatham MD; CP Smith MD, Orlando Regional Medical Center, *Orlando, FL*
- P138 A Novel Technique for Open Ventral Hernia Repair—The S.U.T.R. First Technique**
C Lewis MD; C Moore MD; V Patel MD; C Clark MD; L Bacon MD; F Jones MD, Morehouse School of Medicine, *Atlanta, GA*
- P139 Predicting Resident Performance—Are Letters of Recommendation Useful?**
A Demeusy MD and G Kowdley MD, Saint Agnes Hospital, *Baltimore, MD*
- P140 Pancreas Transplant Necrosis Causes Hemorrhagic Shock**
JS Beatty MD and TA Ramos DO, East Tennessee State University, *Johnson City, TN*
- P141 Laparoscopic Adrenalectomy versus Robotic Adrenalectomy: A Retrospective Review of Cases at a Single Institution**
TL Floyd MD and F Navarro MD, University of South Carolina, *Columbia, SC*
- P142 Acute Pancreatitis Caused by a Migrated Gastrostomy Tube Resulting in Death**
SJ Hermiz and MA Jones, University of South Carolina/Palmetto Health, *Columbia, SC*
- P143 Bowel Herniation through Drain Sites—A Report of Two Cases**
C Eden MD and M Connolly MD, Presence Saint Joseph Hospital, *Chicago, IL*

- P144 An Interesting Case of Sigmoid Diverticulitis**
N Panko and M Osipova, Presence Saint Joseph Hospital,
Chicago, IL
- P145 A 15-Year Experience with Gastric Carcinoid Tumors:
Does Type Make a Difference?**
LM Postlewait MD; GG Baptiste BA; CG Ethun MD; N Le BS;
K Cardona MD; MC Russell MD; DA Kooby MD;
CA Staley MD; SK Maithel MD, Winship Cancer Institute, Emory
University, *Atlanta, GA*
- P146 Outcomes of Patients with Ventriculoperitoneal Shunts
Undergoing Abdominal Procedures**
D Lapham DO and AW Ong MD, Reading Hospital, *Reading, PA*
- P147 Duodenal Leiomyoma Causing Duodenojejunal
Intussusception**
MG Griffin MD; HR Nolan MD; CA Wengler MD;
M Ayoub MD; D Ashley MD, Mercer University Medical School,
Macon, GA
- P148 ERCP Procedures at Cabell Huntington Hospital and St.
Mary's Medical Center: A Retrospective Analysis**
Z Sanford MS4 and S Lahiry MD, Joan C Edwards School of
Medicine, Marshall University, *Huntington, WV*
- P149 A 15-Year Experience with Gastric Carcinoid Tumors:
Does Type Make a Difference?**
LM Postlewait MD; GG Baptiste BA; CG Ethun MD; N Le BS;
K Cardona MD; MC Russell MD; DA Kooby MD;
CA Staley MD; SK Maithel MD, Winship Cancer Institute,
Emory University, *Atlanta, GA*
- P150 Surgical Management of GI Bleeding in Bloodless
Medicine Patients**
JO Green MD; S Yu MD; P Ramsay MD, Atlanta Medical Center,
Atlanta, GA
- P151 Doxorubicin Induces an Increase in the Permeability of
Intestinal Epithelia In Vitro**
JS Carr MD; YE Huh MS; CM Dekaney PhD; IM Carroll PhD,
University of North Carolina at Chapel Hill, *Chapel Hill, NC*, and
North Carolina State University, *Raleigh, NC*

- P152 Independent Preoperative Predictors of Prolonged Length of Stay after Laparoscopic Appendectomy in Patients Over Thirty Years of Age: Experience From a Single Institution**
ES Wise MD; SM Gadomski MD; AM Ilg BS; C Bermudez BS; EW Chan BS; ML Izmaylov BS; SJ Gridley BA; JV Kaczmarek BS; SNT Melancon BA; SB Ahmad MD; KM Hocking PhD; JJ Diaz MD; SM Kavic MS; University of Maryland, *Baltimore, MD* and Vanderbilt University School of Medicine, *Nashville, TN*
- P153 Robotic Transhiatal Esophagectomy in a Community Hospital: Our Technique and Initial Experience**
VD Horst MD and SC Hewlett MD, Princeton Baptist Medical Center, *Birmingham, AL*
- P154 Robotic Dor Fundoplication in Scleroderma Esophagus with Aperistalsis on Manometry**
A Andrade MD; M Folstein MD; BR Davis MD, Texas Tech University Health Sciences Center, *El Paso, TX*
- P155 Acute Jejunal Intussusception Due To Massive Gastric Heterotopia**
BL Douglas MD; BD Hoagland MD; TA Platz DO; LM Krevetski MD; TM Polk MD, Naval Medical Center, *Portsmouth, VA*
- P156 Small Bowel Intussusception due to Celiac Disease**
SH Greer MD; JD Stanley MD; WH Giles MD, University of Tennessee College of Medicine Chattanooga, *Chattanooga, TN*
- P157 Laparoscopic Duodenojejunostomy for SMA Syndrome: A Case Series**
GC Alex MD; C Fredericks MD; MB Luu MD, Rush University Medical School, *Chicago, IL*
- P158 Rapunzel Syndrome: Diagnostic, Radiologic, and Clinical Features of an Unusual Case of Trichobezoar**
RS Ahuja MD; EK Arleo, MD; F Latif, MD; JB Wani, MS, DNB; CH Kale, MS; J Henderson, MD; ART Joshi, MD, Albert Einstein Medical Center, *Philadelphia, PA*

- P159 Alternate Approach to the Rendezvous Procedure for Obstructive Jaundice**
S Yim, BS and I M Best, MD, Emory University School of Medicine, *Atlanta, GA*
- P160 Benign Pneumatosis Intestinalis: Can We Avoid the Knife? A Case Report and Review of the Literature**
KA Den Beste MD; ES Frey MD; TL Weaver DO, Baptist Health System, *Birmingham, AL*
- P161 Non-Operative Treatment of Emphysematous Gastritis with Portal Venous Gas Caused by H. Pylori**
LA Bradney MD; KJ Kalkwarf MD; RD Betzold MD; AT Mancino MD, University of Arkansas for Medical Sciences, *Little Rock, AR*
- P162 Idiopathic Colo-Colic Intussusception with Synchronous Colon Cancer in an Adult**
SJ Hermiz MD; A Afshari MD; MA Jones MD, University of South Carolina/Palmetto Health, *Columbia, SC*
- P163 Master Maverick: Myriad Manifestations of Meckel's Diverticulum (MDv)**
AN Mukerji MD; R Gupta MD; SB Remersu MD; E Choi BS; V Kella MD, Bronx Lebanon Hospital Center, *New York, NY*
- P164 Mesenteric Variant of a Meckel's Diverticulum Containing a Carcinoid Tumor**
AH Vinyard DO and CW Baker MD, Medical College of Georgia at Augusta University, *Augusta, GA*
- P165 A 51 year old Female with Small Bowel Obstruction 9 Years after Renal Transplant: A Rare Late Presentation of Encapsulating Peritoneal Sclerosis**
BC Harding; KM Kelley MD; TJ Novosel MD, Eastern Virginia Medical School, *Norfolk, VA*
- P166 Cardiac Tamponade from Pneumopericardium due to Gastropericardial Fistula—A Complication of Perforated Gastric Ulcer Within a Hiatal Hernia**
A Dyatlov MD; A Amin MD; R Malekan MD; A Kaul MD, New York Medical College—Westchester Medical Center, *Valhalla, NY*

- P167 Post-Operative Mesenteric Venous Thrombosis- Challenges in Diagnosis and Management**
SB Koganti MD ,MM John MD ,VS Gowda MD, A
N Mukerjee MD, F Daniel MD, BF Gilchrist MD,
Bronx Lebanon Hospital Center, *New York, NY*
- P168 Overwhelming Recurrent C. difficile Infection following Reversal of Diverting Loop Ileostomy for Prior Fulminant C. difficile Colitis**
SR Ellis; PW Smith MD; PT Hallowell MD, University of
Virginia, *Charlottesville, VA*
- P169 Laparoscopic Revision of Transoral Incisionless Fundoplication to Nissen Fundoplication**
A Farukhi MD; BR Davis MD; B Clapp MD, Texas Tech
University Health Sciences Center, *El Paso, TX*
- P170 WITHDRAWN**
- P171 Suture to Wound Length Ratio in Abdominal Wall Closure: How Well Are We Doing?**
ZF Williams; PL Tenzel; WB Hooks; WW Hope, New Hanover
Regional Medical Center, *Wilmington, NC*
- P172 Combined Endoscopic Myofascial Release of External Oblique and Retrorectus Hernia Repair: A Safe Technique for Complex Recurrent Incisional Hernia**
IC Payne DO; JD Simmons MD; WO Richards MD, University
of South Alabama Medical Center, *Mobile, AL*
- P173 To Lap or Not to Lap: Comparing Two Techniques Used in the Repair of Incisional Hernias**
YW Chang MS and SL Fogel MD, Virginia Tech Carilion School
of Medicine, *Roanoke, VA*
- P174 The Use Of Abdominal Wall Tension Measurements In Abdominal Wall Hernia Repair**
ZF Williams; JR Rawles; WB Hooks, WW Hope, New Hanover
Regional Medical Center, *Wilmington, NC*

- P175 Multipoint Suture Fixation Technique for Abdominal Wall Reconstruction with Component Separation and Onlay Biological Mesh Placement**
BD Denney MD; JI de la Torre MD, University of Alabama at Birmingham School of Medicine, *Birmingham, AL*
- P176 Laparoscopic Management of a Foramen of Winslow Hernia**
J Univers MD; J Linton MD; S Tonks MD; M Mancini, University of Tennessee Medical Center, *Knoxville, TN*
- P177 Interparietal Hernia Complicating Retromuscular Ventral Hernia Repair**
JR Davis MD; JE Villarreal MD; WS Cobb MD; AM Carbonell MD; JA Warren MD, Greenville Hospital System-University of South Carolina, *Greenville, SC*
- P178 Incidental Morgagni Hernia after Motor Vehicle Collision**
AE Justice MD; HO Berdel MD; Christopher Watson MD, University of South Carolina, *Columbia, SC*
- P179 A Case Series of Giant Inguinoscrotal Hernias Requiring a Modified LaRoque Approach**
SW Schimpke MD; JA Myers MD; DJ Deziel MD; BR Veenstra MD; MB Luu MD, Rush University Medical Center, *Chicago, IL*
- P180 Iatrogenic Parahiatal Hernia with Gastric Herniation and Necrosis Following Robotic Hiatal Hernia Repair**
WPL Main DO and KM Tymitz MD, Good Samaritan TriHealth Hospital, *Cincinnati, OH*
- P181 Transversus Abdominis Release (TAR) for Ventral Hernia Repair**
RC Kirks MD; RZ Swan MD; D Vrochides MD PhD; JB Martinie MD; DA Iannitti MD, Carolinas Medical Center, *Charlotte, NC*
- P182 Hiatal Hernia Crural Closure Using the V-Loc™ Wound Closure Device**
A Wade; A Dugan; M Plymale; J Hoskins; A Zachem; JS Roth, University of Kentucky, *Lexington, KY*

- P183 The Vicious Cycle of Motorcycle Rally Casualties: A Single Center's Experience**
A Pinnola MD; JD Sciarretta MD; S Gibson; K Muertos MPH;
C Fernandez MD; A Romano MD; J Davis MD;
A Pepe MD, University of South Carolina, *Myrtle Beach, SC*
- P184 A Rare Cause of Bowel Obstruction, An Incarcerated Obturator Hernia**
JF Vance DO and BS Scharfstein, East Tennessee State University,
Johnson City, TN
- P185 Management of Bilateral Spigelian Hernias**
A Afshari MD; L Nguyen MD; SJ Hermiz; PN Chaipis,
University of South Carolina, and Dorn VA Medical Center,
Columbia, SC
- P186 Unusual Lateral Abdominal Wall Hernia after Removal of a Spinal Stimulator**
WW Cross MD, Riverside Tappahannock Hospital,
Tappahannock, VA
- P187 Occult Rectal Prolapse in a Perineal Hernia: Repair by Altmeier**
MN Mustian MD and MS Morris MD, University of Alabama at
Birmingham, *Birmingham, AL*
- P188 Colonic Adenocarcinoma Presenting as Recto-Sigmoid Intussusception; A Case for Intussusception Reduction**
T Tatarian MD; D Arkonac BS; B Phillips MD;
GA Isenberg MD; SD Goldstein MD, Thomas Jefferson University
Hospital, *Philadelphia, PA*
- P189 Perianal Leiomyoma: Diagnostic Pitfalls and Treatment Recommendations**
SM Bedzis MD; WH Ward MD; MR Wilson MD, Naval Medical
Center, *Portsmouth, VA*
- P190 Effect of Exparel® TAP Infiltration on Postoperative Outcomes in Colorectal Surgery**
ER Lagergren MD; C Bourean BS; R Wells MD; D Jaffe MD;
G Russell; GS Waters MD; JL Bohl MD, Wake Forest School of
Medicine, *Winston-Salem, NC*

- P191 The Limitations of Age Related Screening in Colorectal Cancer**
DM Irizarry MD and RJ Nauta MD, Mount Auburn Hospital,
Cambridge, MA
- P192 Transanal Minimally Invasive Surgery (TAMIS) for Local Excision of Rectal Neoplasms**
MP Abraham MD; AJ Russ MD; MA Casillas MD, University of
Tennessee Medical Center, *Knoxville, TN*
- P193 Clostridium difficile Enteritis**
JD Stanley MD; EC Nelson MD; S Lorenzo-Rivero MD;
RA Moore MD; EN McKeown MD, University of Tennessee,
Chattanooga, TN
- P194 Repair of Coloanal Anastomotic Dehiscence and Sinus Formation Using Intraluminal Application of Endo-SPONGE®**
WTH Terzian MD; WT Reilly MD; DJ Bowers MD;
DJ Eyvazzadeh MD, St. Luke's University Health Network,
Bethlehem, PA
- P195 Changing Trends in the Adoption of Laparoscopic Colorectal Surgery: A NIS Study**
MI Mohammed Ilyas MBBS MS MRCS; B Z Sabegh MD;
V N Nfonsam, MD, Kastruba Medical College, *Mangalore, India* and University of Illinois College of Medicine,
Urbana-Champaign, IL
- P196 Case Discussion of Turnbull-Cutait Procedure for Complex Ano-Vaginal Fistula: Revival of the Delayed Colo-Anal Pullthrough Procedure and its Application for the Modern Surgeon**
MN Saidy MD; AD Adewole MD; WL Ambroze MD;
ME Schertzer MD; DN Armstrong MD, Georgia Colon & Rectal
Surgical Clinic, *Atlanta, GA*
- P197 Effectiveness of the Ligation of Intersphincteric Fistula Tract (LIFT) with Biologic Mesh Interposition in the Treatment of Fistula-In-Ano**
MP Abraham MD; A Russ; M Casillas, University of Tennessee
Medical Center, *Knoxville, TN*

- P198 National Results in Laparoscopic Appendectomy: Quantifying the Increased Risk Associated with Perforation**
SW Ross MD; AB Christmas MD; PE Fischer MD;
BW Thomas MD; JM Green MD; BT Heniford MD;
RF Sing DO, Carolinas Medical Center, *Charlotte, NC*
- P199 Long-Term Results with THD Hemorrhoidectomy in Hemorrhoidal Disease**
QH González MD; M De Jesús MD; JA Bahena MD;
MV Hernández MD, Humanitas Medical Group, *Coyoacán, Mexico City, Mexico*
- P200 Colitis Cystica Profunda: A Case Report of Radiographic, Endoscopic and Laparoscopic Findings**
MB Huck MD and JL Bohl MD, Wake Forest Baptist Health, *Winston-Salem, NC*
- P201 Gastrointestinal Stromal Tumor with Metastasis to the Corpus Cavernosum: A Case Report**
JT Carlson MD and JS Mizell MD, University of Arkansas for Medical Sciences, *Little Rock, AR*
- P202 Lung Metastasis Presenting as Rectal Mass**
JA Jarrard MD; JS Cudnik; WM Thompson, Mercer University/ Medical Center Navicent Health, *Macon, GA*
- P203 Two Separate Primary Colorectal Granular Cell Tumors: A Case Report**
DG Giugliano MD and GI Isenberg MD, Thomas Jefferson University Hospitals, *Philadelphia, PA*
- P204 Is It Possible To Predict A Difficult Pelvic Case Preoperatively?**
A Raza MD; A Khan MD; S Tan MD; R Zlotecki MD;
L Chihray MD; A Iqbal MD, University of Florida, *Gainesville, FL*
- P205 Laparoscopic Ileocelectomy and Ladd's Procedure for Crohn's Ileocolitis with Mesenteric Abscess and Congenital Malrotation**
A Raza MD; B Safar MD; A Iqbal MD, University of Florida, *Gainesville, FL*

- P206 Robotic Rectopexy for Rectal Prolapse in Pediatric Patients**
DJ Hiller MD; JL Bohl MD; KA Zeller MD, Wake Forest School of Medicine, *Winston-Salem, NC*
- P207 Ileal Volvulus with Chronic Obstruction**
RM Butler BS; ESL Zoog MD; JD Stanley MD, University of Tennessee College of Medicine, *Chattanooga, TN*
- P208 The Colectomy Improvement Project: Do Evidence-Based Guidelines Improve Institutional Colectomy Outcomes?**
DA Mammo MS; MD Honaker MD, HJ Wasvary MD, William Beaumont Hospital, *Royal Oak, MI*
- P209 Solitary Fibrous Tumor at the Anal Margin**
NK Krementz; JT Terlizzi MD; JC Casey MD; JP Palazzo MD; GI Isenberg MD, Thomas Jefferson University Hospital, *Philadelphia, PA*
- P210 Adult Intussusception Caused by Ileocecal Clostridium Difficile Pseudomembranous Colitis: A Case Report**
ESL Zoog MD; KC Turza MD; GR Major MD; JD Stanley MD, University of Tennessee College of Medicine at Chattanooga, *Chattanooga, TN*
- P211 Liposomal Bupivacaine Intercostal Nerve Blocks in Elderly Trauma Patients with Multiple Rib Fractures**
MT Martyak MD; L Hodge PharmD; JN Collins MD, Eastern Virginia Medical School, *Norfolk, VA*
- P212 Are Massive Transfusion Protocols Being Utilized Efficiently in Damage Control Resuscitation?**
C Lin MD; LJ Weireter MD; TJ Novosel MD; JN Collins MD; LD Britt MD, Eastern Virginia Medical School, *Norfolk, VA*
- P213 Antifibrinolytics in a Rural Trauma State: Assessing the Opportunities**
JM Bardes MD; A Palmer MD; N Cornell MS; A Wilson MD; G Schaefer MD, West Virginia University, *Morgantown, WV*

- P214 Screening Tool for High-Risk Geriatric Patients Predicts Discharge Disposition**
A Register MD; E Sigman MS; DW Ashley MD;
R Ackermann MD; AB Christie MD, Mercer University School of
Medicine, *Macon, GA*
- P215 Limb Salvage Following Below-the-Knee Arterial Injury**
GL Lynch MD and LC Martin MD, University of Mississippi
Medical Center, *Jackson, MS*
- P216 Alcohol, Injuries, and Outcomes Comparing Injured Moped and Motorcycle Drivers**
DC Holst MD; JB Carr MD; AN Miller MD, Wake Forest Baptist
Health, *Winston Salem, NC* and University of Virginia School of
Medicine, *Charlottesville, VA*
- P217 Is Orange the new Kool-Aid Flavor? Time for an Evidence Based Approach of the Resources for Optimal Care of the Injured Patient 2014**
R Robledo DO; D Tatum PhD; M Duke MD; L Nelson DO;
B Vanderlain MD; T Jacome MD; J Duchsene, MD, North Oaks
Healthcare System, Shock Trauma, *Hammond, LA*
- P218 “The Golden Hour”: Its Impact is Still Flying High**
MD Duke MD; WB Vanderlan MD; R Robledo DO;
L Nelson DO; D Tatum PhD; T Jacome MD;
J Duchesne MD, North Oaks Medical Center, *Hammond, LA*
- P219 Non-Operative Management of a Penetrating Injury to the Retrohepatic Inferior Vena Cava**
CM McGreevy MD; A Kunac MD; DJ Anjaria MD, Rutgers-
New Jersey Medical School, *Newark, NJ*
- P220 Dysphagia among Geriatric Trauma Patients: A Population Based Study**
DN Ang MD; J Hagan MD; J Clark MD; J Farrah MD;
A Garcia MD; S Waters SLP; H Liu MS, M Ziglar MSN,
J Hurst MD, Ocala Regional Medical Center, *Ocala, FL*

- P221 The Effect Of Pre-Existing Comorbidities On Burn Injury Mortality**
LT Knowlin MD; LB Stanford BS; AG Charles MD;
BA Cairns MD, University of North Carolina, *Chapel Hill, NC*
- P222 Traumatic Bilateral Anterior Cerebral Artery Entrapment with Subsequent Cerebral Infarction: Case Report and Review of the Literature**
JC Castillo MD; CM DeLa'O MD; CE Goettler MD, Vidant
Medical Center/East Caroline University, *Greenville, NC*
- P223 Comparative Analysis of Disposable Pump and Epidural Catheters for Local Anesthesia in Elderly Trauma Patients with Multiple Rib Fractures**
BS Shapiro MD; T Wasfie MD; M Chadwick DO;
KR Barber PhD; R Yapchai BS, Genesys Regional Medical
Center, *Grand Blanc, MI*
- P224 Primary Fistulotomy and Surgical Drainage Abscess is Associated with Low Fistula Recurrence Rate**
QH González MD; M De Jesús MD; JA Bahena MD;
MV Hernández MD; H Peña MD, Humanitas Medical Group
Coyoacán, Mexico City, MEXICO
- P225 Severe Dysphagia and the Need for Gastrostomy Following Cervical Spine Fracture Fixation**
J Bailey MD; J Adams MD; L DiFazio MD; AS Livingston BA;
DH Livingston MD, Rutgers-New Jersey Medical School and
Morristown Medical Center, *Newark, NJ*
- P226 The Implementation of a Dedicated Geriatric Trauma Service Reduces Hospital Stay in Elderly Patients with Femur Fractures**
B Putty MD; E Price MS; J Sawadogo MSc; R Gandhi MD;
T Duane MD, JPS Hospital, Fort Worth, TX
- P227 Trauma Team Activation for Pediatric Falls—Is It Necessary?**
AW Ong MD; R Trupp BS; S Wilhelm PA-C; P Jones CRNP;
S Layser RN; K Sandel MD; FB Fernandez MD, Reading
Hospital, *Reading, PA*

- P228 Blunt Splenic Trauma in the Setting of Situs Inversus**
PT Davis MD; JM Lopez MD; PR Miller MD, Wake Forest School of Medicine, *Winston Salem, NC*
- P229 ED Thoracotomy is Life-Saving for Blunt Cardiac Rupture**
JP Farrah MD; JD Hagan MD; AJ Garcia MD; JM Clark MD; DN Ang MD, Ocala Health Trauma, *Ocala, FL*
- P230 Utilization of Abdominal Ultrasound as Primary Screening Modality in Children with Blunt Abdominal Trauma**
PU Udekwu MBBS MBA/MHA and Debra Petrarca BA, WakeMed Health & Hospitals, *Raleigh, NC*
- P231 Abdominoperineal Resection as Salvage Treatment for Severe Blunt Anorectal Trauma Resulting from a Mining Accident**
DC Prior DO; AJ Joyner MD; JS Beatty MD, East Tennessee State University, *Johnson City, TN*
- P232 A Retrospective Look at Cervical Collar Immobilization Usage by Emergency Personnel in the Population of Trauma Patients with Cervical Spine Injury**
BJ Daley MD; AJ Lewis MD; DR Jeffcoach MD, University of Tennessee Medical Center, *Knoxville, TN*
- P233 Trauma Survival Margin Analysis: A Dissection of Trauma Center Performance through Initial Lactate**
OM Kassar BA; EA Eklund BS; WF Barnhardt BS; NJ Napoli MS; LE Barnes PhD; JS Young MD, University of Virginia School of Medicine, *Charlottesville, VA*
- P234 Early Airway Management at a Trauma Center with an EM Residency Program: Is There a Need for an Anesthesiologist?**
RJ Simon MD; N Cemalovic MD; ND Caputo MD, Lincoln Medical Center, *Bronx, NY*
- P235 Twenty-Four Hour Requirement of PRBC is the Strongest Independent Predictor of Mortality in Adult Trauma Patients**
RJ Simon MD; L Flax MD; A Arslan MD; AH Raja MD; MP Kanter MD; ND Caputo MD, Lincoln Medical Center, *Bronx, NY*

- P236 Fall From Heights: Does Height Really Matter?**
G Alizo MD; JD Sciarretta MD; S Gibson; K Muertos MPH;
A Alashari MD; A Romano MD; J Davis MD; A Pepe MD,
University of South Carolina, *Myrtle Beach, SC*
- P237 Mopeds Are Just As Dangerous As Motorcycles**
JL Weaver MD and BG Harbrecht MD, University of Louisville
School of Medicine, *Louisville, KY*
- P238 Trauma Mortality Data Sets Narrowed to Eliminate
“Noise” from Data Collection and Definition Variability
Provide Basis for Rational Inter-Institutional Comparison
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P Udekwu MBBS MBA/MHA and S Schiro PhD, WakeMed
Health & Hospitals, *Winston-Salem, NC*, and University of North
Carolina, *Chapel Hill, NC*
- P239 Danger on the Farm: A Comparison of Animal- and Farm-
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JL Weaver MD; CW Kimbrough MD;
K Broughton-Miller APRN; M Frisbie APRN; J Wojcik APRN;
K Penticost APRN; MC Bozeman MD; NA Nash MD;
BG Harbrecht MD, University of Louisville School of Medicine,
Louisville, KY
- P240 WITHDRAWN**
- P241 Acquired Tracheoesophageal Fistula with Spontaneous
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A Landmann MD and AR Ruiz-Elizalde MD, University of
Oklahoma Health Sciences Center, *Oklahoma City, OK*
- P242 Improbable Outcome from an Ipsilateral Triple Vascular
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AJ Garcia MD; S Karruppiah MD; B Thompson PA-C;
JP Farrah MD; J Hagan MD; J Cark MD; D Ang MD,
Ocala Health Trauma and University of South Florida, *Ocala, FL*
- P243 Blunt Abdominal Aortic Injury and Traumatic Abdominal
Wall Hernia Following Motor Vehicle Collision**
R Aparajita MD; KH Nagarsheth MD; D Ranev MD; S Zia MD;
K Singh MD; J Schor MD; J Deitch, Staten Island University
Hospital, *Staten Island, NY*

- P244 Management of the Mangled Extremity from Shotgun Blast Injury: A Case Report and Review of the Literature**
P Martinez MD; C Mentzer DO; C White MD;
Abuzeid MBBS, Georgia Regents University, *Augusta, GA*
- P245 The Novel use of REBOA to Explore a Retroperitoneal Hematoma in a Hemodynamically Unstable Patient**
MD Rosenthal MD; A Raza,MD; CA Croft MD; AM Mohr MD;
RS Smith MD, University of Florida, *Gainesville, FL*
- P246 Hemoglobin as the Sole Transfusion Trigger in Otherwise Stable Trauma Patients**
M Garland MD; P Miller MD; T Wyman; T Anderson,
M Kaiser, MD, Wake Forest University School of Medicine,
Winston-Salem, NC
- P247 Delayed Tension Pneumopericardium after Severe Blunt Chest Trauma: A Case Report Demonstrating a Minimally Invasive Technique**
BD O'Dwyer MD; SK John MD; AW Gamenthaler MD, Halifax
Health, *Daytona Beach, FL*
- P248 A Case of Iliac Crest Avulsion with Bowel Herniation after Blunt Trauma. A Review of Traumatic Hernia Following Iliac Fracture**
T Puzio MD; M Shah MD; J Chen MD; K Caddell MD;
AG Charles MD, University of North Carolina, *Chapel Hill, NC*
- P249 Penetrating Spinal Cord Trauma: A Unique Patient Presentation and Management Strategy**
EB Almon MD; EO Richter MD; DW Ashley MD;
DB Christie MD, Mercer University School of Medicine / The
Medical Center, Navicent Health, *Macon, GA*
- P250 Eliminating Catheter Associated Urinary Tract Infections in the Trauma Intensive Care Unit: Two Balloons are Better Than One**
R Borrego MD; D Hristov MD; T Lama MD; E Misquith MD;
M West MD; A Elhaddad MD; K Lytle RN; J Rogers RN;
L Lottenberg MD, St. Mary's Medical Center,
West Palm Beach, FL

- P251 Managing Inferior Vena Cava Pseudo Aneurysms in Blunt Abdominal Trauma with Successful Non-Operative Management**
E Mejia; D Sirovich; I Mukherjee MD; K Singh MD;
C Fasanya MD, Staten Island University Hospital,
Staten Island, NY
- P252 Recanalized Umbilical Vein as a Source of Hemorrhagic Shock**
JA Ibrahim MD, Orlando Health, *Orlando, FL*
- P253 Modern Management of Medieval Injury: Cardiac Trauma Sustained by Crossbow**
JK Reynolds MD and VA Mejia MD, University of Tennessee,
Chattanooga, TN
- P254 Thoracic Trauma in the Oldest of the Old: An Analysis of the Nationwide Inpatient Sample**
CJ Mentzer; Z Klaassen; NJ Walsh; CH Ferdinand;
KF OMalley, Medical College of Georgia-Georgia Regents
University, *Augusta, GA*
- P255 Novel Treatment of Acute Respiratory Distress Syndrome Following Chlorine Gas Inhalation Injury**
B Warren MD; N Royall MD; H Smith MD; I Bhullar MD,
Orlando Health, *Orlando, FL*
- P256 A Review of Shark Attacks at a Coastal Level II Trauma Center**
ZF Williams; JR Rawles; WW Hope; WB Hooks, New Hanover
Regional Medical Center, *Wilmington, NC*
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- P258 Delayed Splenic Rupture with Normal Initial CT Scan after Blunt Trauma**
JS OH MD; CJ Mentzer DO; CK Grigsby MD; OO Fasusi MD;
SB Holsten MD, Medical College of Georgia, Georgia Regents
University, *Augusta, GA*

- P259 Survival of Left Chest and Mediastinal Impalement with a Fence Post**
AM Loudon MD; HG Smith MD; M Mattes MSIII;
IS Bhullar MD, Orlando Health, *Orlando, FL*
- P260 Comparison of Patient Disposition When Transported to a Trauma Center Based on State Trauma Triage Criteria versus Paramedic Judgment**
TD Husty MD; JB Burns DO; DJ Chesire PhD; DJ Ebler MD,
University of Florida College of Medicine, *Jacksonville, FL*
- P261 Popliteal Vascular Injuries in Pediatric Extremity Trauma: A Cautionary Tale**
R Borrego MD; D Hristov MD; A Elhaddad, MD; T Lama MD;
M West MD; E Misquith MD; L Lottenberg MD, Florida Atlantic
University School of Medicine, *Boca Raton, FL*
- P262 Vaginal Birth after Cesarean: A Case Involving the Trauma Surgery Service**
M Morton BS; C Fredericks MD; JR Yon MD; T Egodage MD;
F Bokhari MD, John H. Stroger Hospital, *Chicago, IL*
- P263 Traumatic Aorto-Right Ventricular Fistula from Stab Wound**
T Egodage MD; C Fredericks MD; JR Yon MD;
M Morton BS; F Bokhari MD, John H. Stroger, Jr. Hospital of
Cook County, *Chicago, IL*
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- P265 Delayed Development of Extrathoracic Lung Herniation Following Blunt Thoracic Trauma**
RF Brown MD and AG Charles MD, University of North
Carolina, *Chapel Hill, NC*
- P266 A Violation of Occam's Razor: Acute Appendicitis Following Motor Vehicle Crash**
SW Ross MD; JD Bouchez MD; PE Fischer MD;
RA Brintzenhoff MD; AB Christmas MD; RF Sing DO;
BW Thomas MD, Carolinas Medical Center, *Charlotte, NC*

- P267 Acute Long Bone Fractures and the Weekend Effect**
B Lamb MD; D Jeffcoach MD; R Childress PT; RE Heidel PhD;
B Daley MD, University of Tennessee Medical Center,
Knoxville, TN
- P268 Management of Multisystem Complications Following Incarcerated Incisional Hernia Repair with Mesh**
NN Branch MD; K Ayre MD; G Washington MD; S Siram MD;
W Greene MD, Howard University Hospital, *Washington, DC*
- P269 Portable Chest Radiographs in Patients with Spinal Cord Injury and Ventilator-Associated Pneumonia, Are They Helpful?**
D Younan; N Terry; T Beasley; S Singh, University of Alabama in Birmingham, *Birmingham, AL*
- P270 Take Out the Foley! Minimizing Indwelling Urethral Catheters after Acute Spinal Cord Injury**
DJ McPhee; ME Lueders MD; S Priovolos MD; S Kigongo MD;
R Simon MD, Lincoln Medical Center, *Bronx, NY*
- P271 Caught in Limbo: The Effect of ICU Boarding Time of Overall Hospital Length of Stay in Trauma Patients**
GM Diaz MD; BR Collier DO; EH Bradburn DO;
KM Love MD; ME Hamill MD, Virginia Tech Carilion School of Medicine, *Roanoke, VA*
- P272 The Achilles Heel of Impedance Cardiography: A Pilot Study**
AA Vakili BS; S Ahmadi BS; JM Van De Water MD;
BE Mount BS; CJ Knott MPH; JA Hudson MD; RL Vogel PhD,
Mercer University School of Medicine, *Macon, GA*, Medical Center
Navicent Health, *Macon, GA*, and Georgia Southern University,
Statesboro, GA
- P273 Tracheocarotid Fistula: A Case Report and Literature Review**
JK Fortson MD; R Su MD; G Marcan; PG Bhat; VJ Patel MD,
ENT Associates of South Atlanta, *Atlanta, GA*

- P274 Should We Skip SCIP-INF-4?**
C Fredericks MD; JR Yon MD; A Plewa PharmD;
DJ Kacey MD; AJ Sauper MD; P Napoles MD, John H. Stroger,
Jr. Hospital of Cook County, *Chicago, IL*
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MR Phillips MD; M Shah MD; SE McLean MD;
AG Charles MD, University of North Carolina School of Medicine,
Chapel Hill, NC
- P277 Contemporary Management of Boerhaave Perforation**
KJ Dickinson MBBS; N Buttar MD; LM Wong Kee Song MD;
CJ Gostout MD; SD Cassivi, MD; MS Allen MD;
FC Nichols III MD; KR Shen MD; DA Wigle MD;
SH Blackmon MD, Mayo Clinic, *Rochester, MN*
- P278 Mycobacterial Sternal Wound Infections: Are They
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Infections?**
MJ Bartz MD; G Bhatia MD; B Davis MD; JA Ewing MD;
S Ben-Or MD; JE Stephenson MD; SH Johnson MD;
WD Bolton MD, Greenville Health System, *Greenville, SC*
- P279 Life Saving Extracorporeal Membrane Oxygenation
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NN Branch MD; K Ayre MD; G Washington MD;
S Siram MD; S Aziz MD; W Greene MD, Howard University
Hospital, *Washington, DC*
- P280 Non-Steroidal Anti-inflammatory Drugs, Not Anti-
Histamines, Predict Postoperative Complications after
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A Doud; A Monafu; M Palilonis; M Ladd; K Zeller; L Neff,
Wake Forest Baptist Health, *Winston-Salem, NC*

- P281 Gastric Emptying after Esophagectomy: A Single Center Study Comparing Pyloric Botox Injection and Pyloric Botox with Dilatation**
CJ Snyder MD; T Fabian MD; A Ata MPH, Albany Medical Center, *Albany, NY*
- P282 Repair of Pectus Excavatum in an Adult- An Example of Disease Progression**
HR Howe III; G Bhatia; CC Wright; BR Davis, RL Gates, Greenville Health System/University of South Carolina, *Greenville, SC*
- P283 Mediastinal Thyroid Mass: A Case Report and Review of Literature**
JK Fortson MD; R Su MD; G Marcan; PG Bhat; VJ Patel MD, Atlanta Cancer Research and Education Foundation, *Atlanta, GA*
- P284 Esophageal Perforation in a Sword Swallower**
E Aitcheson MD; JR Yon MD; AM Popoff MD; W Warren MD; A Basu MD; AJ Sauper MD; DJ Kacey MD; P Napoles MD, John H. Stroger, Jr. Hospital of Cook County, *Chicago, IL*
- P285 Ten-Year Review of Radiation Exposure in Vascular Surgery Training**
SA Tonks MD; J Univers MD; RE Heidel PhD; JD Arnold MD; MB Freeman MD; OH Grandas MD; SL Stevens MD; MH Goldman MD; MM McNally MD, University of Tennessee Medical Center Knoxville, *Knoxville, TN*
- P286 En Bloc Resection of Retroperitoneal Adenopathy with an Associated Aortoiliac Aneurysm Using a Modified “Floppy” Graft**
TJ Irwin BS; AC Ring MD; MG Kaag MD; DC Han MD, Pennsylvania State University College of Medicine, *Hershey, PA*
- P287 Carotid Artery Revascularization Combined with Coronary Artery Bypass Grafting, Then and Now**
T Chadid MD; S Arya MD; Y Duwayri MD; RK Veeraswamy MD; RR Rajani MD; SM Shafii MD; A Salam MD; TF Dodson MD; LP Brewster MD, Emory School of Medicine, *Atlanta, GA*

- P288 Heterotopic Ossification Leading to Vascular Occlusive Disease Requiring Operative Intervention**
MC Nally MD; R Keen MD; J Durham MD; E Farlow MD,
Rush University Medical Center, and Cook County Health and
Hospitals System, *Chicago, IL*
- P289 Independent Predictors of Venous Thromboembolism Following Pancreatic Debridement for Infected, Necrotizing Pancreatitis**
M Zomaya MD; R Duncan MD; KH Nagarsheth MD, Rutgers -
Robert Wood Johnson Medical School, *New Brunswick, NJ*
- P290 Morbid Obesity is an Independent Risk Factor for Wound Complications Following Endovascular Abdominal Aortic Aneurysm Repair (EVAR)**
CW Mangieri MD and DS Kauvar MD, Dwight D. Eisenhower
Army Medical Center, *Ft Gordon, GA*
- P291 Differences between Aortic Endothelial Cell and Microvascular Endothelial Cell Chemotaxis Under Hyperglycemic Conditions**
AD Morris MD; H Li; K Kuo; LP Brewster MD, Emory
University Hospital, *Atlanta, GA*
- P292 Symptomatic Late Saphenous Vein Graft Aneurysm in an Upper Extremity Bypass: An Interesting Case Report**
A Lawson DO; JS Oh MD; N Walsh MD; M Strode MD;
P Burgess MD; M Ramirez MD, Georgia Regents University,
Augusta, GA
- P293 Tumor Embolus after Lung Resection for Cancer**
JM Duke MD; LC Lyons MD; KJ Kalkwarf MD;
RD Betzold MD; MA Steliga MD; AT Ali MD, University of
Arkansas for Medical Sciences, *Little Rock, AR*
- P294 AbsorbaSeal Vascular Closure Device: An Acute and Chronic Animal Study**
LJ Blair MD; B Oommen MD; CR Huntington MD;
TC Cox MD; EH Lipford MD; AE Lincourt PhD;
VA Augenstein MD; BT Heniford MD, Carolinas Medical Center,
Charlotte, NC

- P295 Percutaneous Treatment of Superficial Femoral Artery Stenosis Secondary to Radiation Arteritis**
HD Pham MD; MG Prather MD; DS Rush MD, East Tennessee State University, *Johnson City, TN*
- P296 Iatrogenic Pseudoaneurysm following Femoral Neck Fracture Fixation**
E Mejia; D Sirovich; I Mukherjee MD; K Atanassov MD, Staten Island University Hospital, *Staten Island, NY*
- P297 Axillary Artery Aneurysm Presenting as Acute Limb Ischemia**
MM Ramseyer MD and D Rush MD, East Tennessee State University Quillen College of Medicine, *Johnson City, TN*
- P298 Dual Incision Remote Endarterectomy is a Novel Treatment Option for Long Segment Superficial Femoral-Popliteal Artery Occlusive Disease**
KS Lavingia MD; RE Redlinger MD; FN Parent MD, Eastern Virginia Medical School, *Norfolk, VA*
- P299 Transection of External and Ligation of Internal Carotid Artery from Hemorrhage Control Efforts during Routine Tonsillectomy**
KM Relihan MD; NA Royall MD; IS Bhullar MD, Orlando Health, *Orlando, FL*
- P300 Endovascular Repair of Aortic Perforation due to Inferior Vena Cava Filter**
EN Perez; JM Poindexter; WC Rayford Methodius, Georgia Vascular Specialist and Atlanta Medical Center, *Atlanta, GA*
- P301 Massive Gastrointestinal Hemorrhage Resulting from Arterio-Rectal Fistula via a Left Internal Iliac Artery Aneurysm**
B Richmond MD; M Choueri MD; R Herron III DO, West Virginia University, *Charleston, WV*
- P302 Recent Management of Blunt Traumatic Thoracic Aortic Injuries**
SD Richardson MD; J Stinson MD; M Mitchell MD; MD Martin MSN; LC Martin MD, University of Mississippi Medical Center, *Jackson, MS*

- P303 Traumatic Posterior Tibial Artery Pseudoaneurysm**
C Constantinou MD, Marshall University, *Huntington, WV*
- P304 Systemic Review of Open versus Endovascular Repair of Thoracoabdominal Aneurysms with Regards to Mortality and Neurological Complications**
RD Andres MD and K Huseynova MD, West Virginia University Hospitals, *Morgantown, WV*
- P305 Ruptured Renal Artery Aneurysm Presenting as Acute Abdominal Pain**
SJ Hermiz MD; A Afshari MD; RS Smith MD; W Fry MD ,
University of South Carolina/Palmetto Health, *Columbia, SC*
- P306 A Trauma Patient Advocate Is A Valuable Addition To The Multidisciplinary Trauma Team: A Process Improvement Project**
JL Hartwell MD; K Albanese BS; A Retterer MD;
SA Martin MS; MS O'Mara MD, Grant Medical Center,
Columbus, OH
- P307 The Current State of Ultrasound Training in United States General Surgery Residency Programs**
AH Chau MD and A Mahmoud MD, San Joaquin General Hospital, *French Camp, CA*
- P308 Ejection Fraction and Left Ventricular Diastolic Diameter are Not Predictive in Identifying Patients That Would Benefit from Mechanical Support**
RL Lyons MD, Eastern Virginia Medical School, *Norfolk, VA*
- P309 Three Cases of Retained Wound VAC® Sponge Following Negative Pressure Wound Therapy (NPWT) for Complicated Hernia Repair**
SA Bielby; JK Cone; DL Cull; AL Hale; R Fitzgerald,
University of South Carolina School of Medicine-Greenville and Greenville Health System, *Greenville, SC*
- P310 The Use of Autogenous Split Thickness Skin Grafting in the Management Chronic Mosaic Verrucae Plantaris**
MJ Bartz MD and RH Fitzgerald DPM, Greenville Health System, *Greenville, SC*

- P311 Giant Lipomas in HIV Patient Taking HAART**
R Gupta MD; AN Mukerji MD; E Chau MS; U Kannan;
S Koganti; V Parithivel MD, Bronx Lebanon Hospital Center,
New York, NY
- P312 Effect of Transfusion Setting on Venous**
Thromboembolism Risk in Orthopedic Trauma Patients
KJ McGurk BA; EH Bradburn DO; ME Hamill MD,
Virginia Tech Carilion School of Medicine, *Roanoke, VA*
- P313 Spontaneous Renal Calyceal Rupture: A Rare Cause of an**
Acute Abdomen in Pregnancy
LM Fluke DO; BD Hoagland MD; SM Bedzis MD;
MG Johnston MD, Naval Medical Center, *Portsmouth, VA*
- P314 WITHDRAWN**
- P315 Predictive Factors of Discharge Navigation Lag Time**
C Walker MD; S Bozorghadad; L Scholtis, PA-C;
C Sherman CRNP; J Dove BA; M Hunsinger RN BSHS;
J Blansfield MD; M Shabahang MD, Geisinger Medical Center,
Danville, PA

**New Members
as of**

Regular Fellows

Cletus Arcier, MD, Atlanta, GA

Joshua Arnold, MD, Knoxville, TN

Prabhakar Baliga, MD, Charleston, SC

Jarret Brashear, MD, New Orleans, LA

Erin Felger, MD, Washington, DC

Darren Hunt, MD, Chattanooga, TN

Meghann Kaiser, MD, Greenville, SC

Jerimiah Mason, MD, Hendersonville, NC

Kandace McGuire, MD, Chapel Hill, NC

Kristin Turza, MD, Keswick, VA

Resident Fellows

Elizabeth Aitcheson, MD, Chicago, IL

Joanelle Bailey, MD, Newark, NJ

T. Ellis Barnes, MD, Charlotte, NC

Philip Erwin, MD, Greenville, SC

Charles Fredericks, MD, Chicago, IL

Mike Fruscione, MD, Charlotte, NC

Jenny Held, MD, Portsmouth, VA

Angela Kao, MD, Charlotte, NC

Tyler Koestner, MD, Chattanooga, TN

Marissa Mencio, MD, Chattanooga, TN

Benjamin Motz, MD, Charlotte, NC

William Sherrill, MD, Charlotte, NC

Zachary Williams, MD, Wilmington, NC