58th Annual Meeting

July 26–29, 2015

Grand Geneva Hotel
Lake Geneva, Wisconsin

MIDWEST SURGICAL ASSOCIATION
58th ANNUAL MEETING

Grand Geneva Hotel
Lake Geneva, Wisconsin
July 26–29, 2015

Table of Contents

Officers, Councilors, & Past Presidents

OFFICERS

James Tyburski, MD	President	2014–2015
Conor Delaney, MD, PhD	President - Elect	2014–2015
William C. Cirocco, MD	Treasurer	2013–2016
Margo C. Shoup, MD	Secretary	2012–2015
Nicholas J. Zyromski, MD	Recorder	2014–2017
Steven De Jong, MD	Representative, ACS	2009–2015
Christopher R. McHenry, MD	ACS Advisory Council for Surgery	2013–2016

COUNCILORS

Akpofure Peter Ekeh, MD	Dayton, OH	2012–2015
Herb Chen, MD	Madison, WI	2012–2015
Mary-Margaret Brandt, MD	Ann Arbor, MI	2012–2015
Samir K. Gupta, MD	Peoria, IL	2013–2016
Elango Edhayan, MD	Detroit, MI	2013–2016
Robert P. Sticca, MD	Grand Forks, ND	2013–2016
Richard Stoltenberg, MD	Racine, WI	2014–2017
Peter Hallowell, MD	Charlottesville, VA	2014–2017
David Linz, MD	Canton, OH	2014–2017

PAST PRESIDENTS

Raymond P. Onders, MD, FACS	Cleveland, OH	2014
Stephen F. Sener, MD	Pasadena, CA	2013
Richard Berg, MD	Grosse Pointe Farms, MI	2012

Committees

LOCAL ARRANGEMENTS COMMITTEE

Constantine Godellas, MD	Maywood, IL	2015
William Cirocco, MD	Columbus, OH	2016

AUDIT COMMITTEE

Roxie M. Albrecht, MD	Oklahoma City, OK	2014–2015
Stephen F. Sener, MD	Pasadena, CA	2014–2015

PROGRAM COMMITTEE

Jeffrey S. Bender, MD	Chair	2011–2016
Margo C. Shoup, MD	Ex Officio	2012–2015
James G. Tyburski, MD	Ex Officio	2014–2015
Nicholas J. Zyromski, MD	Ex Officio	2014–2017
Ashwani Rajput, MD	Advisor	2013–2015
Scott M. Wilhelm, MD		2012–2017
Theodor Asgeirsson, MD		2013–2018
Jonathan M. Saxe, MD		2014–2019

MEMBERSHIP COMMITTEE

Jeffrey M. Hardacre, MD	Chair	2012–2015
Margo C. Shoup, MD	Ex Officio	2012–2015
James G. Tyburski, MD	Ex Officio	2014–2015
Constantine V. Godellas, MD		2012–2015
Mary C. McCarthy, MD		2013–2016
Arthur M. Carlin, MD		2013–2016
Keith W. Millikan, MD		2013–2016
Brian Shapiro, MD		2014–2017

Committees continued

EDITORIAL COMMITTEE

Nicholas J. Zyromski, MD	Chair	2014–2017
Christopher P. Brandt, MD		2011–2015
Samir K. Gupta, MD		2012–2016
Michael F. McGee, MD		2013–2017
Roderich E. Schwarz, MD, PhD		2013–2017

NOMINATING COMMITTEE

Raymond P. Onders, MD	Chair	2015–2019
Stephen F. Sener, MD		2014–2018
Richard A. Berg, MD		2013–2017
Roxie M. Albrecht, MD		2012–2016
Donn M. Schroder, MD		2011–2015

Meeting Information

OBJECTIVES

Upon completion of this activity, participants should be able to:

1. Discuss information presented on the research activities of the association's members and make clinical decisions based on current evidence within their practices.

2. Apply information gained through broad view, collaborative research into future basic and clinical research activities which may in turn benefit the next cycle of members.

3. Utilize research results to initiate optimization of the educational experience to maximally benefit resident training within the framework of work hour restrictions.

The purpose of this conference is to provide a vehicle for the distribution of peer-reviewed basic and clinical science research and to provide an opportunity for dialogue concerning topics of interest to the members of the Midwest Surgical Association. The target audience is surgeons.

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.

Meeting Information continued

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 Midwest Surgical Association. 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 10.50 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Of the *AMA PRA Category 1 Credits™* listed above, a maximum of 8.75 credits meet the requirements for Self-Assessment.

American College of Surgeons
Inspiring Quality:
Highest Standards, Better Outcomes
100+years

AMERICAN COLLEGE OF SURGEONS
DIVISION OF EDUCATION
Accredited with Commendation by the Accreditation Council for Continuing Medical Education

Future Meetings

August 7–10, 2016
Grand Hotel
Mackinac Island, Michigan

Past Presidents of the MSA

Raymond P. Onders, MD	Mackinac Island, MI	2014
Stephen F. Sener, MD	Acme, MI	2013
Richard A. Berg, MD	Mackinac Island, MI	2012
Roxie M. Albrecht, MD	Galena, IL	2011
Donn M. Schroder, MD	Mackinac Island, MI	2010
Jerry M. Hardacre, II, MD	Lake Geneva, WI	2009
James R. DeBord, MD	Mackinac Island, MI	2008
Anthony Senagore, MD	Farmington, PA	2007
Christopher McHenry, MD	Mackinac Island, MI	2006
Steven A. De Jong, MD	Niagara-on-the-Lake, Ontario, Canada	2005
Donald W. Moorman, MD	Mackinac Island, MI	2004
John P. Hoffman, MD	Galena, IL	2003
Larry R. Lloyd, MD	Mackinac Island, MI	2002
Donald J. Scholten, MD	Lake Geneva, WI	2001
Thomas A. Stellato, MD	Mackinac Island, MI	2000
Norman C. Estes, MD	Galena, IL	1999
Darrell A. Campbell, Jr., MD	Mackinac Island, MI	1998
Richard A. Prinz, MD	Sawmill Creek, OH	1997
Thomas A. Broadie, MD	Mackinac Island, MI	1996
Jason H. Bodzin, MD	Grand Traverse, MI	1995
Willard S. Stawski, MD	Mackinac Island, MI	1994
Gerard V. Aranha, MD	Lincolnshire, IL	1993
William C. Boyd, MD	Mackinac Island, MI	1992
Douglas B. Dorner, MD	Grand Traverse, MI	1991
John L. Glover, MD	Mackinac Island, MI	1990
Jack Pickleman, MD	Kohler, WI	1989
Samuel D. Porter, MD	Mackinac Island, MI	1988
William H. Baker, MD	Lake Geneva, WI	1987
Scott W. Woods, MD	Mackinac Island, MI	1986
Angelos A. Kambouris, MD	Lake Geneva, WI	1985
Richard E. Dean, MD	Mackinac Island, MI	1984
Anna M. Ledgerwood, MD	Sawmill Creek, OH	1983
Robert T. Soper, MD	Mackinac Island, MI	1982
G. Howard Glassford, MD	Lake Geneva, WI	1981
Clark Herrington, MD	Mackinac Island, MI	1980

Past Presidents of the MSA continued

Kenneth J. Printen, MD	Lincolnshire, IL	1979
Robert D. Allaben, MD	Mackinac Island, MI	1978
Richard S. Webb, MD	Itasca, IL	1977
Charles E. Lucas, MD	Mackinac Island, MI	1976
Frank A. Folk, MD	Itasca, IL	1975
Robert F. Wilson, MD	Mackinac Island, MI	1974
William H. Marshall, MD	Oakbrook, IL	1973
Ernest M. Berkas, MD	Mackinac Island, MI	1972
Wendell J. Schmidtke, MD	Valparaiso, IN	1971
Robert J. Freeark, MD	Kalamazoo, MI	1970
Robert A. De Bord, MD	Peoria, IL	1969
Vernon L. Guynn, MD	Lake Geneva, WI	1968
Jack C. Cooley, MD	Champaign-Urbana, IL	1967
Robert P. Hohf, MD	St. Charles, IL	1966
Douglas R. Morton, MD	St. Charles, IL	1965
William H. Harridge, MD	St. Charles, IL	1964
John B. Moore, III, MD	Champaign-Urbana, IL	1963
Peter V. Moulder, MD	Genoa City, WI	1962
Thomas W. Samuels, Jr., MD	Chicago, IL	1961
James Cross, MD	Rockton, IL	1960
Loring S. Helfrich, MD	Rockton, IL	1959
Loring S. Helfrich, MD	Rockton, IL	1958

Mission Statement

The Midwest Surgical Association is a surgical organization made up of surgeons who have established reputations as practitioners, authors, teachers, and/or original investigators. The objective of this society is to exemplify and promote the highest standards of surgical practice, especially among young surgeons in the Midwest. The annual meeting is held in late July/early August each year in different locations throughout the Midwest and consists of a stimulating scientific program of the highest quality and a social program planned with children and families in mind.

THE MIDWEST SURGICAL ASSOCIATION
14005 Nicklaus Drive
Overland Park, KS 66223

Telephone: 913-402-7102
Fax: 913-273-1140
Email: events@lp-etc.com
Web: www.midwestsurg.org

New Members 2014

Congratulations and welcome to the following New Members elected at the 2014 Annual Meeting:

Richard Berri, MD	Grosse Pointe, MI
Janak Parikh, MD	Pasadena, CA

Midwest Surgical Association Foundation

The Midwest Surgical Association is happy to announce the establishment of the Midwest Surgical Association Foundation. Foundation funding will be used solely for research awards, programming, special lectureship honorariums, and other appropriate scientific, research, or educational purposes.

The Midwest Surgical Association Foundation is a non-profit organization that is committed to exemplify, support, and promote the highest standards of surgical practice, especially among young surgeons of the Midwest. The Foundation has been organized to pursue exclusively charitable, educational, scientific, benevolent, and eleemosynary purposes including the promotion of surgical education and research that qualifies it as an exempt organization under Section 501©(3) of the Internal Revenue Code of 1986 and exempt from taxation under Section 501(a).

The Foundation may engage directly in charitable, educational, scientific, benevolent, or eleemosynary activities, including activities to promote surgical education and research. With increased support, these key arenas will strengthen the Association.

Not everyone has the time to participate in all Midwest Surgical Association activities and conferences, but by donating to the Foundation you are able to help support current activities, conferences, research, and lectureships as well as future projects.

The Foundation is now able to accept donations from members or nonmembers. If you would like to support the Association through its Foundation, both current and deferred gifts may be made. These donations are tax deductible and should be made out directly to:

Midwest Surgical Association Foundation
14005 Nicklaus Drive
Overland Park, KS 66223

Telephone: 913-402-7102 Fax: 913-273-1140
Email: events@lp-etc.com Web: www.midwestsurg.org

Federal Tax I.D. Number: 20-8529483

You may also make donations on our web site using your Visa, MasterCard, Discover, or American Express credit card: **www.midwestsurg.org**, under MSA Foundation and select Make a Donation.

If you have any questions, please contact MSA Headquarters at **913-402-7102**.

Schedule of Events

SUNDAY, JULY 26, 2015

12Noon – 6:00pm	**MSA Registration Open**, Maple Lawn Foyer
2:00pm – 4:00pm	**MSA Executive Council Meeting**, Fontana Bay Boardroom
5:30pm – 6:00pm	**New Member Reception**, Evergreen Ballroom
6:00pm – 7:00pm	**Welcome Reception**, Evergreen Ballroom
9:00pm – 11:30pm	**Spectacular Problems in Surgery**, Maple Lawn Ballroom

MONDAY, JULY 27, 2015

7:00am – 12Noon	**MSA Registration Open**, Maple Lawn Foyer
8:00am – 12Noon	**Exhibit Displays Open**, Linwood Ballroom
8:00am – 8:20am	**Featured Posters**, Linwood Ballroom
8:20am – 8:30am	**Welcome & Introductions**, Maple Lawn Ballroom
8:30am – 8:30am	**Scientific Session I**, Maple Lawn Ballroom
9:30am – 10:00am	**Scott Woods Memorial Lecture**, Maple Lawn Ballroom
10:00am – 10:15am	**Morning Break/Exhibits & Poster Viewing**, Linwood Ballroom
10:15am – 12:15pm	**Scientific Session II: Surgeon in Training Paper Competition**, Maple Lawn Ballroom
12:15pm – 1:00pm	**William H. Harridge Memorial Lecture**, Maple Lawn Ballroom
6:00pm – 7:00pm	**Cocktail Reception**, Evergreen Foyer
7:00pm – 10:30pm	**Annual Banquet & Dinner Dance**, Evergreen Ballroom

TUESDAY, JULY 28, 2015

7:00am – 12Noon	**MSA Registration Open**, Maple Lawn Foyer
8:00am – 12Noon	**Exhibit Displays Open**, Linwood Ballroom
8:05am – 8:15am	**Welcome & Introductions**, Maple Lawn Ballroom
8:15am – 10:15am	**Scientific Session III**, Maple Lawn Ballroom
10:15am – 10:30am	**Morning Break and Poster Viewing**, Linwood Ballroom
10:30am – 12:15pm	**Scientific Session IV**, Maple Lawn Ballroom
12:15pm – 12:45pm	**Presidential Address: James G. Tyburski, MD**, Maple Lawn Ballroom
12:45pm – 1:30pm	**MSA Annual Business Meeting**, Maple Lawn Ballroom
7:00pm – 9:30pm	**Dinner and Bonfire** – Chalet Lawn

WEDNESDAY, JULY 29, 2015

Guest Departures

Family Program

SUNDAY, JULY 26, 2015

12Noon – 6:00pm	**MSA Registration Open**, Maple Lawn Foyer
5:30pm – 6:00pm	**New Member Reception**, Evergreen Ballroom
6:00pm – 7:00pm	**Welcome Reception**, Evergreen Ballroom
8:00pm – 10:00pm	**Kids Movie Night**, Salon C

MONDAY, JULY 27, 2015

7:00am – 8:00am	**Annual 5K Fun Run**, Meet at Spa
7:00am – 9:00am	**Physician & Spouse Breakfast**, Linwood Ballroom
7:00am – 12:00pm	**MSA Registration Open**, Maple Lawn Foyer
9:30am – 12:30pm	**Spouse Program: Historical Boat Tour along Lake Geneva** Trolley transportation to boat dock, meet in Hotel lobby
1:30pm	**Golf Outing**, Highland Course – Meet at Pro Shop
6:00pm – 7:00pm	**Cocktail Reception**, Evergreen Foyer
7:00pm – 11:30pm	**Annual Banquet and Dinner Dance**, Evergreen Ballroom

TUESDAY, JULY 28, 2015

7:00am – 12:00pm	**MSA Registration Open**, Maple Lawn Foyer
7:00am – 9:00am	**Physician & Spouse Breakfast**, Linwood Ballroom
10:00am – 11:00am	**Spouse Program: Tasty Pastry**, Galewood C
7:00pm – 9:30pm	**Dinner and Bonfire**, Chalet Lawn

WEDNESDAY, JULY 29, 2015

Guest Departures

Note: Children are welcome at all social events.

Note: See MSA Registration Desk for additional details on recreational activities

SCIENTIFIC PROGRAM

Scientific Program

SUNDAY, JULY 26, 2015

12Noon – 6:00pm
MSA Registration Open

2:00pm – 4:00pm
MSA Executive Council Meeting

5:30pm – 6:00pm
New Member Reception

6:00pm – 7:00pm
Welcome Reception

9:00pm – 11:00pm

Spectacular Problems in Surgery

Moderators: James G. Tyburski, MD; Conor P. Delaney, MD, PhD

9:00pm – 9:15pm
SP #1. OVERWHELMING POST-SPLENECTOMY INFECTION LEADING TO DISSEMINATED STREPTOCOCCAL SEPSIS
Yon JR, Messer TA, Poulakidas S, Gupta SK, Bokhari F
Cook County Trauma & Burn Unit

9:15pm – 9:30pm
SP #2. AN UNUSUAL CASE OF POSTOPERATIVE RESPIRATORY DISTRESS
Wright GP, Zadvinskis I
Grand Rapids Medical Educational Partners/Michigan State University

9:30pm – 9:45pm
SP #3. THIS DIAGNOSIS IS NOTHING TO SNEEZE AT!
Pandian T, Farley DR
Mayo Clinic - Rochester

9:45pm – 10:00pm

SP #4. PARASTOMAL HERNIA SECONDARY TO ASCITES DUE TO CONGESTIVE HEART FAILURE

Aaland MO
University of North Dakota

10:00pm – 10:15pm

SP #5. INGUINAL HERNIATION OF THE TRANSPLANTED URETER RESULTING IN HYDROURETERONEPHROSIS

Butt FK, Van Dorp DR, Hawasli A, Schervish E, Granger DK
St. John Hospital and Medical Center

10:15pm – 10:30pm

SP #6. DELAYED EXTRAVASCULAR STRUT MIGRATION OF A GREENFIELD FILTER IN A YOUNG MALE

Kreimier EL, Aziz A, Kaoutzanis C, Cox CE, DeBenedet AT, Anderson HL III
St. Joseph Mercy Hospital - Ann Arbor

10:30pm – 10:45pm

SP #7. UNUSUAL CASE OF MASSIVE MEGACOLON IN A YOUNG FEMALE

Schneider A, Ekeh AP
Wright State University

10:45pm – 11:00pm

SP #8. ANNULAR PANCREAS: A CONGENITAL ANOMALY FOR THE ADULT SURGEON

Visioni, A, Hardacre, J
University Hospitals Case Medical Center

MONDAY, JULY 27, 2015

7:00am – 8:00am
Annual 5K Fun Run

7:00am – 1:00pm
MSA Registration Open

8:00am – 1:00pm
Exhibit & ePoster Displays Open

8:00m – 8:20am
ePoster Viewing

8:20am – 8:30am
Welcome & Introductions

8:30am – 9:15am

Scientific Session I

Moderator: Jeffrey Bender, MD

8:30am – 8:45am

1. USING NEXT-GENERATION SEQUENCING TO DETERMINE POTENTIAL MOLECULARLY-GUIDED THERAPY OPTIONS FOR PATIENTS WITH RESECTABLE PANCREATIC ADENOCARCINOMA

Wright GP, Chelsa DW, Chung MH
Grand Rapids Medical Education Partners/Michigan State University

8:45am – 9:00am

2. INTRADUCTAL PAPILLARY MUCINOUS NEOPLASM OF THE PANCREAS, ONE MANIFESTATION OF A MORE SYSTEMIC DISEASE?

Roch AM, Rosati CM, Cioffi J, Ceppa EP, Al-Haddad MA, DeWitt JM, House MG, Zyromski NJ, Nakeeb A, Schmidt CM
Indiana University School of Medicine

9:00am – 9:15am

3. IN THE MEGA-OBESE, WEIGHT LOSS AND RESOLUTION OF OBESITY CO-MORBIDITIES AFTER BILIO-PANCREATIC BYPASS/ DUODENAL SWITCH (DS) VARY ACCORDING TO HEALTH INSURANCE CARRIER: MEDICAID VS MEDICARE VS PRIVATE INSURANCE VS SELF-PAY IN 1673 BOLD DATABASE PATIENTS

Gomez, JP, Slotman GJ
Inspira Health Network

9:15am – 9:45am

Scott Woods Memorial Lecture:
Pelvic Fractures: What are the Orthopods Doing?
Rahul Vaidya, MD
Detroit Receiving Hospital, Detroit, MI

9:45am – 10:00am

Morning Break/Ehibits & ePoster Viewing

10:00am – 12:15pm

Scientific Session II: Surgeon in Training Papers

Moderator: James G. Tyburski, MD

10:00am – 10:15am

4. CURRENT ORGAN ALLOCATION DISADVANTAGES KIDNEY ALONE RECIPIENTS OVER COMBINED ORGAN RECIPIENTS

Martin M, Hagan M, Granger, D
St. John Hospital & Medical Center

10:15am – 10:30am

5. REPEAL OF THE MICHIGAN HELMET LAW: THE EVOLVING CLINICAL IMPACT

Striker RH, Chapman AJ, Titus RA, Davis AT, Rodriguez CH
Spectrum Health

MONDAY, JULY 27, 2015 *continued*

10:30am – 10:45am

6. LAPAROSCOPIC TRANSGASTRIC ESOPHAGEAL MUCOSAL RESECTION

Frantzides CT, Daly SC, Frantzides AT, Manelis T, Marcinkevicius A, Luu MB
Chicago Institute of Minimally Invasive Surgery

10:45am – 11:00am

7. CASE COHORT STUDY OF POTENTIAL RISK FACTORS FOR POST-THYROIDECTOMY HEMORRHAGE

Samona S,Hagglund K, Edhayan E
St. John Hospital & Medical Center

11:00am – 11:15am

8. SURGERY AND HORMONE THERAPY TRENDS IN ELDERLY WOMEN OVER 80 WITH INVASIVE BREAST CANCER

Kantor O, Pesce C, Leiderbach E, Wang CH, Winchester DJ, Yao K
University of Chicago

11:15am – 11:30am

9. LIFE AFTER HIPEC; MEASURING QUALITY OF LIFE AND FUNCTIONAL STATUS AFTER CYTOREDUCTIVE SURGERY (CRS) WITH HYPERTHERMIC INTRAPERITEONEAL CHEMOTHERAPY (HIPEC)

Ford JM, Berri R
St. John Hospital & Medical Center

11:30am – 11:45am

10. PATENCY OF THE VIABAHN STENT GRAFT FOR THE TREATMENT OF OUTFLOW STENOSIS IN HEMODIALYSIS GRAFTS

Carmona J, Yevgeniy R, Brandt J, Dowers L, Bednarski D, Rubin J
DMC Cardiovascular Institute

11:45am – 12Noon

11. THE IMPACT OF TREE STAND FALLS ON A LEVEL 1 TRAUMA CENTER IN WEST MICHIGAN

Carroll J, Chapman A, Davis A, Rodriguez C
Grand Rapids Medical Education Partners

12Noon – 12:15pm

12. TRANSIENT POSTOPERATIVE ATRIAL FIBRILLATION PREDICTS LONG-TERM CARDIOVASCULAR MORBIDITY FOLLOWING GASTRECTOMY

V. Chang, Nassoiy SP, Blackwell RH, Kothari A, Zapf M, Kliethermes S, Gupta GN, Abood GJ, Kuo PC
Loyola University Medical Center

9:30am – 12:30pm

Spouse Program: Historical Boat Tour along Lake Geneva
(included in spouse registration fee)

Enjoy a trolley ride from Grand Geneva Resort to Lake Geneva. This 2.5 hour historical tour of the Lake aboard the Polaris Yacht highlights many of the elegant, historical estates as you travel around the lake.

12:15pm – 1:00pm

William H. Harridge Memorial Lecture:
How Did We Go From Operating on All Injured Kidneys to Operating on None of Them? *The 16 Year Saga of Expectant Management of (Even) Severe Renal Trauma*
Richard A. Santucci, MD
The Detroit Medical Center, Detroit, MI

1:30pm

MSA Golf Tournament

6:00pm – 7:00pm

Cocktail Reception

7:00pm – 10:30pm

Annual Banquet and Dinner Dance

TUESDAY, JULY 28, 2015

7:00am – 1:30pm
MSA Registration Open

8:00am – 1:30pm
Exhibitor & ePoster Displays

8:05am – 8:15am
Welcome & Introductions

8:15am – 10:15am

Scientific Session III

Moderator: Theodor Asgeirsson, MD

8:15am – 8:30am

13. HYDROMORPHONE VERSUS FENTANYL FOR EPIDURAL ANALGESIA AND ANESTHESIA

Nguyen MN, Hall Zimmerman LG,Meloche K, Dolman HS, Baylor AE, Fuleihan S, Wilson RF, Tyburski JG
Wayne State University / Detroit Receiving Hospital

8:30am – 8:45am

14. CAN MORBIDLY OBESE PATIENTS WITH REFLUX BE OFFERED LAPAROSCOPIC SLEEVE GASTRECTOMY?

Hawasli A, Reyes M, Meguid A, Harriott A, Almahmeed T, Szpunar S
St. John Hospital & Medical Center

8:45am – 9:00am

15. THE APPROPRIATE MEASUREMENT OF POST-DISCHARGE READMISSIONS IN MEDICARE COLON SURGERY

Fry DE, Pine M, Nedza SM, Pine G
MPA Healthcare Solutions

9:00am – 9:15am

16. CATCH ME IF YOU CAN… EARLY SIMULATION EFFORTS AFFECT FUNDAMENTAL SURGICAL SKILL ASSESSMENT SCORES.

Buckarma E, Gas B, Abdelsattar J, El Khatib M, Pandian T, Finnesgard E, Farley DR
Mayo Clinic - Rochester

9:15am – 9:30am

17. OPEN RETROFASCIAL INCISIONAL HERNIA REPAIR IS A SAFE AND EFFECTIVE OPERATION

Bender JS
University of Oklahoma

9:30am – 9:45am

18. IMPACT OF INAPPROPRIATE INITIAL ANTIBIOTICS IN CRITICALLY ILL SURGICAL PATIENTS WITH BACTEREMIA

Abraham K, Dolman HS, Hall Zimmerman LG, Faris PJ, Edelman DA, Wilson RF, Tyburski JG
Wayne State University / Detroit Receiving Hospital

9:45am – 10:00am

19. WHEN PATIENTS CALL THEIR SURGEON'S OFFICE: AN OPPORTUNITY TO IMPROVE THE QUALITY OF SURGICAL CARE AND PREVENT READMISSIONS

Brekke AV, Elfenbein DM, Madkhali T, Schaefer SC, Shumway C, Chen H, Schneider DF, Sippel RS, Balentine C
University of Wisconsin-Madison

10:00am – 10:15am

20. NEGATIVE PRESSURE WOUND THERAPY FOR TREATMENT OF GIANT OMPHALOCELE

Aldridge BA, Papandria DP, Ladd AP, Finnell SM, Kokoska ER
Indiana University School of Medicine

TUESDAY, JULY 28, 2015 *continued*

10:00am – 11:00am
Spouse Program: Tasty Pastry
(included in spouse registration fee)

Let your creative spirit soar as you learn the culinary secrets to creating three fabulous desserts.

10:15am – 10:30am
Morning Break/Exhibit & ePoster Viewing

10:30am – 12:15pm

Scientific Session IV

Moderator: Jonathan M. Saxe, MD

10:30am – 10:45am
21. THE IMPACT OF ROBOTIC CHOLECYSTECTOMY ON PRIVATE PRACTICE IN A COMMUNITY TEACHING HOSPITAL
Hawasli A, Sahly M, Meguid A, Edhayan E, Guio C, Szpunar S
St. John Hospital & Medical Center

10:45am – 11:00am
22. MODIFIED RETRORECTUS VENTRAL HERNIA REPAIR
Madura JA, Pearson DG
Mayo Clinic - Phoenix

11:00am – 11:15am
23. TRAUMATIC VASCULAR INJURIES: WHO ARE REPAIRING THEM AND WHAT ARE THE OUTCOMES?
He JC, Clancy K, Schechtman DW, Conrad-Schnetz KJ, Claridge JA
MetroHealth Medical Center, Case Western University School of Medicine

11:15am – 11:30am

24. 30-DAY READMISSIONS AFTER INPATIENT LAPAROSCOPIC CHOLECYSTECTOMY: FACTORS AND OUTCOMES

Rana G, Bhullar JS, Subhas G, Kolachalam RB, Mittal VK
Providence Hospital & Medical Centers

11:30am – 11:45am

25. READABILITY OF DISCHARGE SUMMARIES: WHAT LEVEL OF INFORMATION ARE WE DISMISSING OUR PATIENTS WITH?

Zielinski MD, Choudhry AJ, Baghdadi YM, Heller SF, Jenkins DH
Mayo Clinic - Rochester

11:45am – 12Noon

26. COMMON SIDE CLOSURE TYPE, BUT NOT STAPLER BRAND OR OVERSEWING, INFLUENCES SIDE-TO-SIDE ANASTOMOTIC LEAK RATES

Fleetwood VA, Gross KN, Alex GC, Cortina CS, Smolevitz JB, Sarvepalli S, Bakhsh SR, Poirier J, Myers JA, Singer MA, Orkin BA
Rush University Medical Center

12Noon – 12:15pm

27. REOPERATION FOR GROIN PAIN AFTER INGUINAL HERNIORRHAPHY: DOES IT REALLY WORK?

Sun PY, Pandian TK, Abdelsattar JM, Farley DR
Mayo Clinic – Rochester

12:15pm – 12:45pm

Presidential Address: "The Good Old Days..."
James G. Tyburski, MD
Detroit Medical Center/Wayne State University

12:45pm – 1:30pm

MSA Annual Business Meeting

7:00pm – 9:30pm

Tuesday Dinner & Bonfire

4. VALIDATION OF THE AMERICAN COLLEGE OF SURGEONS (ACS) NATIONAL SURGICAL QUALITY IMPROVEMENT PROGRAM (NSQIP) RISK CALCULATOR TO ESTIMATE SERIOUS COMPLICATIONS IN PATIENTS UNDERGOING MAJOR GASTROINTESTINAL ONCOLOGIC RESECTION

Ford JM, Coughlin K, Van Dorp D, Berri R
St. John Hospital & Medical Center

5. PATIENTS' RECOLLECTION OF COLONOSCOPY RESULTS: ARE THEY RELIABLE?

Tarakji M, Al-Raishouni M, Alame a, Berri R
St. John Hospital & Medical Center

6. RECENT EXPERIENCE OF ENDOVASCULAR RELINING FOR PERSISTENT ENDOTENSION-INDUCED EXPANSION OF ABDOMINAL AORTIC ANEURYSM (AAA) SAC FOLLOWING ANEURYSM EXCLUSION USING THE ORIGINAL PERMEABILITY PTFE GRAFT

Yoon WJ, Haouilou JC, Rama K, Berg RA
St. John Hospital & Medical Center

8. DIAPHRAGMATIC REINFORCEMENT DURING HIATAL HERNIA REPAIR WITH A NOVEL BIOLOGICAL URINARY BLADDER EXTRACELLULAR MATRIX

Johnston G, Dan A, Pozsgay M, Bohon A, Hydu R, Zografakis J
Summa Akron City Hospital

9. INVESTIGATION OF THE PATHOLOGIC FEATURES OF DIFFERENTIATED THYROID CANCER (DTC) IDENTIFIED FROM THYROID NODULES WITH FOCAL UPTAKE ON POSITRON EMISSION TOMOGRAPHY (PET)

Jin J, Khoncarly S, Zhang N, Ma B, McHenry C, Siperstein A
MetroHealth Medical Center

10. THE IMMEDIATE LOW PROFILE BUTTON GASTROSTOMY: PATIENTS PREFER IT AND WE SHOULD PROVIDE IT

Onders R, Elmo MJ, Kaplan C, Katirji B, Schilz R
University Hospitals Case Medical Center

11. ETIOLOGY MATTERS: CIRRHOTICS HAVE SIGNIFICANTLY HIGHER MORTALITY AFTER LIVER TRANSPLANTATION

Fleetwood VA, Ramirez C, Poirier J, Hertl M, Chan EY
Rush University Medical Center

13. EXPERIENCE WITH A SIMPLIFIED FEEDING JEJUNOSTOMY TECHNIQUE FOR ENTERAL NUTRITION FOLLOWING MAJOR VISCERAL PROCEDURES

Schwarz RE
Indiana University Health Goshen

14. TOTAL THYROIDECTOMY IN THE MANAGEMENT OF NON-TOXIC GOITER IN AUSTERE CONDITIONS. IS THIS THE PROCEDURE O CHOICE?

Roose, B, Kelly, S, Saxe, J
Wayne State University

15. THE PHYSIOLOGIC RESPONSE TO HIPEC: SIFTING THROUGH PERTURBATION TO IDENTIFY MARKERS OF COMPLICATIONS

Placket TP, Ton-That HH, Mosier MJ, Abood GJ, Kuo PC, Pappas SG
Loyola University Medical Center

16. PRIMING MODALITY AFFECTS KNOWLEDGE RETENTION IN SURGICAL TRAINEES: A RANDOMIZED PILOT STUDY

T.K. Pandian MD MPH, Johnathon M. Aho MD,
Michael L. Kendrick MD, David R. Farley MD
Mayo Clinic - Rochester

17. EVALUATION OF BARRETT'S DISEASE POST GASTRIC BYPASS

Gentile N, Brown C, Linn J, Yen E, Lapin B, Goldstein J, Denham EW, Ujiki M
NorthShore University HealthSystem

18. THE NATURAL HISTORY OF PATIENTS WITH HYPERKINETIC GALLBLADDERS

Afaneh A, Zhubi Y, Kalabat J, Hawasli A
St. John Hospital & Medical Center

19. ROBOT-ASSISTED MEDIAN ARCUATE LIGAMENT RELEASE: A CASE SERIES

Kern BK, Wright GP, Wolf AM
Grand Rapids Medical Education Partners/Michigan State University

20. DO GALLSTONES FOUND BEFORE SLEEVE GASTRECTOMY BEHAVE THE SAME AS THOSE FORMED AFTER WEIGHT LOSS SURGERY?

Conley A, Tarboush M,Manatsathit W, Meguid A, Szpunar S, Hawasli A
St. John Hospital & Medical Center

21. SCRUB NURSE EXPERIENCE REDUCES TOTAL OPERATING ROOM TIME FOR PARATHYROIDECTOMY

Balentine C, Sanghvi M, Patel R, Madkhali T, Chen H, Sippel RS, Schneider DF
University of Wisconsin – Madison

22. ANXIOUS ABOUT SURGICAL RESIDENCY PERFORMANCE? ARE YOU AND YOUR HANDS READY?

EeeLN H Buckarma MD, Becca Gas MS, Denny Yu PhD, Amro Abdelrahman MBBS, Bethany Lowndes MS, Jad M. Abdelsattar MBBS, Susan Hallbeck PhD, David Farley M.D.
Mayo Clinic - Rochester

23. METACHRONOUS TWO STAGE ESOPHAGECTOMY IN THE ERA OF MINIMALLY INVASIVE SURGERY

Demos DS, Hawasli A, Camero L
St. John Hospital & Medical Center

24. LEVAMISOLE INDUCED NECROSIS SYNDROME: PRESENTATION AND MANAGEMENT

Alex GC, Yon JR, Messer TA, Poulakidas S, Luu M, Bokhari F
Cook County Trauma & Burn Unit

26. DEVELOPING AN IORT PROGRAM FOR BREAST CANCER IN A UNIVERSITY SETTING

Kopkash KA, Rao RD, Griem KL, Madrigrano A
Rush University Medical Center

28. DO IT YOURSELF! PERFORM TEP INGUINAL HERNIA REPAIR AT HOME

El Khatib MM, Buckarma EH, Farley DR
Mayo Clinic - Rochester

29. RUPTURED ADRENAL ANGIOMYELOLIPOMA: PRESENTATION, TREATMENT, AND LITERATURE REVIEW

Nally MC, Suman P, Abadin S
Rush University Medical Center

30. FIELD AMPUTATION OF LEFT UPPER EXTREMITY USED IN COMPLEX EXTRICATION

Antpack EA, Schiller HJ, Zietlow SP, Jenkins D
Mayo Clinic - Rochester

31. SMALL BOWEL ADENOCARCINOMA AND A HISTORY OF CONGENITAL MALROTATION: A CASE REPORT

Wood, Kyle MD, Natwick, Raylene, MD, Holman, Kerianne, MD
Spectrum Health Medical Group

32. CHOLECYSTOCHOLEDOCHAL FISTULA: CASE REPORT AND REVIEW OF THE LITERATURE ON MANAGEMENT OF TYPE III MIRIZZI SYNDROME

Chadwick CL, Ongstad TL
Spectrum Health Medical Group

33. WHY ER ADMISSION CHARGES SHOULD INCLUDE CHARGES FOR LIPOSITY AND STEROIDS

Thomae K
Thomae Surgical

ABSTRACTS

Scientific Paper Abstracts

1. USING NEXT-GENERATION SEQUENCING TO DETERMINE POTENTIAL MOLECULARLY-GUIDED THERAPY OPTIONS FOR PATIENTS WITH RESECTABLE PANCREATIC ADENOCARCINOMA

Wright GP, Chelsa DW, Chung MH
Grand Rapids Medical Education Partners / Michigan State University

Objective: Genomic sequencing technology may identify personalized treatments options for patients with resected pancreatic adenocarcinoma.

Methods: The study was conducted utilizing a biorepository of tissue specimens obtained from 2011-2014. Patients who consented to enrollment in the biorepository with resected pancreatic adenocarcinoma were identified. Slides were generated from paraffin blocks of tumor tissue and a pathologist confirmed at least 60% tumor nuclei per sample. Next-generation sequencing was performed using the Life Technologies Ion AmpliSeq Cancer Hotspot Panel v2. Outcome measures were the rate of targeted therapies available and clinical trial eligibility based on the genetic profile of each tumor.

Results: Twenty-eight patients were identified. Mean age of the cohort was 64.449.8. They were 64% male and 89% white. T stage was T3 in 96%, 71% had nodal metastasis, and the R0 resection rate was 86%. The incidence of mutations was as follows: KRAS = 86%, TP53 = 68%, CDKN2A = 21%, SMAD4 = 21%, EGFR = 7%. Multiple mutations were found in 75%, with the KRAS/TP53 combination seen in 64%. All CDKN2A mutations occurred in male patients (P=0.06) and there was also a trend towards occurrence of this mutation in patients < 60 years of age (P=0.06). FDA-approved targeted therapies were identified for 7/28 patients (25%). Additionally, 18/28 (64%) had mutations for which phase I clinical trials for applicable targeted therapies are currently underway.

Conclusion: Next-generation sequencing of resected pancreatic adenocarcinoma specimens can determine common genetic mutations and identify patients who may be eligible for off-label use of targeted therapies or clinical trial enrollment.

2. INTRADUCTAL PAPILLARY MUCINOUS NEOPLASM OF THE PANCREAS, ONE MANIFESTATION OF A MORE SYSTEMIC DISEASE?

Roch AM, Rosati CM, Cioffi J, Ceppa EP, Al-Haddad MA, DeWitt JM, House MG, Zyromski NJ, Nakeeb A, Schmidt CM
Indiana University School of Medicine

Objective: Several studies have demonstrated a high prevalence of extrapancreatic malignancies in patients with intraductal papillary mucinous neoplasm (IPMN) of the pancreas, and an association with autoimmune pancreatitis. We hypothesized that IPMN were associated with an increase rate of systemic diseases (extrapancreatic malignancies and autoimmune disease).

Methods: From 1996 to 2012, 841 patients with IPMN were seen at a single academic institution. A retrospective analysis of a prospectively collected database was performed and supplemented with electronic medical charts review.

Results: 220 extrapancreatic malignancies were found in 185 patients(22%). The most common malignancies were colorectal adenocarcinoma(3%), lung carcinoma(2%) and renal cell carcinoma (2%). Chi-square test comparing observed/expected frequencies yielded p-value <0.0001 in those 3 cancers. However, the presence of extra pancreatic malignancy did not influence the subtype of IPMN(p=0.79), the rate of malignancy(p=0.81) or the rate of invasive carcinoma(p=0.89). 110 synchronous autoimmune diseases were found in 96 patients (11%). 51% were symptomatic at diagnosis, whereas 49% were discovered incidentally. Systemic lupus erythematosus was found in 0.7%, rheumatoid arthritis in 1.4% and inflammatory bowel disease in 1.8% with p-values from chi-square comparing observed/expected frequencies of <0.0001, 0.014 and <0.0001, respectively. Patients with associated autoimmune disease had a significantly higher rate of BD-IPMN, resulting in lower rates of malignancy/invasive carcinoma. In patients with autoimmune disease there was no impact of immunosuppressive treatment on the subtype distribution, malignancy/invasive carcinoma rates.

Conclusion: IPMN are associated with surprisingly high rates of extra pancreatic malignancies and autoimmune diseases suggesting that IPMN might be one manifestation of a more systemic disease.

3. IN THE MEGA-OBESE, WEIGHT LOSS AND RESOLUTION OF OBESITY CO-MORBIDITIES AFTER BILIO-PANCREATIC BYPASS/DUODENAL SWITCH (DS) VARY ACCORDING TO HEALTH INSURANCE CARRIER: MEDICAID VS MEDICARE VS PRIVATE INSURANCE VS SELF-PAY IN 1673 BOLD DATABASE PATIENTS

Gomez JP, Slotman GJ
Inspira Health Network

Objective: To identify outcomes variations by health insurance status following DS

Methods: Data from 1,673 Surgical Review Corporation BOLD database patients who underwent DS was analyzed retrospectively in four groups: Medicaid (n=138), Medicare (n=313), Private insurance (n=1,171), and Self-Pay (n=59). Statistics: General Linear Models included baseline and post-operative data, modified for binomial distribution of dichotomous variables.

Results: Pre-operative BMI was 56+-10, 54+-12, 51+-9, and 50+-9 for Medicaid, Medicare, Private, and Self-Pay, respectively. At 18 months: Hypertension, sleep apnea, asthma, abdominal hernia, panniculitis, urinary incontinence, and diabetes were lowest ($p<0.05$) in the Private insurance group. With Self-Pay, weight loss, cholelithiasis, GERD, back/musculoskeletal pain, extremity edema were lowest; asthma, panniculitis, stress incontinence, and liver disease, which increased, were highest ($p<0.05$). Medicare had the highest weight loss, abdominal hernia, and musculoskeletal pain; liver disease and asthma were lowest. In Medicaid, hypertension, sleep apnea, cholelithiasis, GERD, diabetes, back pain, extremity edema were highest ($p<0.05$), musculoskeletal pain and urinary incontinence second ($p<0.05$). Through 12 months, Self-Pay had highest polycystic ovarian disease and alcohol use. Medicaid had highest impaired functional status ($p<0.05$).

Conclusion: Outcomes after DS among mega-obese patients vary widely by health insurance status. Private insurance achieved the greatest overall health improvement. Self-Pay benefits were countered by failed resolution of other co-morbidities. In Self-Pay, highest alcohol use plus liver disease invite speculation. Medicare achieved highest weight loss and lowest liver disease and asthma, however fared poorly with musculoskeletal pain and abdominal hernia development. Medicaid resolved co-morbidities the least. These findings may help direct the choice of DS for the mega-obese.

4. CURRENT ORGAN ALLOCATION DISADVANTAGES KIDNEY ALONE RECIPIENTS OVER COMBINED ORGAN RECIPIENTS

Martin M, Hagan M, Granger D
St. John Hospital & Medical Center

Objective: We sought to quantitate the quality of organs offered to kidney-alone vs. recipients of a kidney-extrarenal transplant.

Methods: The United Network for Organ Sharing (UNOS) began including Kidney Donor Profile Indexes (KDPIs) through DonorNet March 26, 2012. We reviewed all kidney donors from our Organ Procurement Organization (OPO) from March 2012 to December 2014. 380 kidneys were discarded, leaving 1021 kidneys for analysis. We compared the KDPIs of the 919 renal only transplants against the 102 renal-extrarenal transplants. We separately analyzed kidneys without mandatory allocation and performed multivariate analysis including in- vs. out-of-OPO recipients, donor BMIs, and DCD vs. brain-dead donors. Higher KDPI signifies worse quality.

Results: The average KDPI for kidney-alone allografts was 47.27 (range 1-100) (SD 25.83) vs. 26.64 for kidney-extrarenal kidneys (range 1-82) (SD 20.16) ($p<0.0005$ t-test). Removing mandatory allocations resulted in a KDPI of 50.43 for kidney alone and 26.32 for kidney-extrarenal kidneys ($p<0.0005$). Multivariate analysis including in- vs. out-of-OPO recipient, donor BMI, and DCD vs. brain-dead donor continued to show a significantly higher KDPI for kidneys received by kidney-alone recipients.

Conclusion: Kidneys transplanted with extrarenal organs have previously been shown to have a decreased graft survival compared with kidneys transplanted alone. Given that in our OPO nearly 10% of lower KDPI kidneys are being preferentially allocated with extrarenal organs, those waiting for a kidney alone are clearly disadvantaged by the current system. Close attention to the outcomes of kidneys transplanted with extrarenal organs is needed, particularly with the impact of MELD on combined kidney-liver transplants.

5. REPEAL OF THE MICHIGAN HELMET LAW: THE EVOLVING CLINICAL IMPACT

Striker RH, Chapman AJ, Titus RA, Davis AT, Rodriguez CH
Spectrum Health

Objective: The State of Michigan repealed a 35-year mandatory helmet law in April of 2012. One year after the change, we reported decreased helmet use, increased crash scene mortalities and higher medical costs. Our study re-examines the clinical impact of this legislation on a level 1 trauma center in West Michigan.

Methods: This is a retrospective cohort study assessing outcomes in motorcycle crash victims. We examined the 7-month period before the helmet law repeal and the 3 motorcycle seasons following the repeal. Chart review was used to determine helmet status, mortality, Injury Severity Scale (ISS), Abbreviated Injury Scale (AIS) head, ICU length of stay (LOS), hospital LOS, mechanical ventilation time, admission GCS, cost of stay and disposition.

Results: 345 patients were included in the study. The incidence of unhelmeted riders rose significantly from 7% to 28% following the repeal. Unhelmeted crash scene fatalities were significantly higher after the repeal (14.3% vs 68.2%).The unhelmeted cohort had significantly higher in-patient mortality (9.8% vs 3.4%), ISS (19 vs 14.5) and AIS head (2.2 vs. 1.3). Unhelmeted riders also had increased alcohol use, ICU LOS and need for mechanical ventilation. The median hospital charge for the unhelmeted cohort was significantly higher ($p < 0.05$).

Conclusion: The impact of the Michigan helmet law repeal continues to evolve. Three years after this legislative change, we are now observing increased ISS, higher in-patient mortality and worse neurologic injury. These findings are alarming and highlight the need to continue to examine the clinical impact of the motorcycle helmet law repeal.

6. LAPAROSCOPIC TRANSGASTRIC ESOPHAGEAL MUCOSAL RESECTION

Frantzides CT, Daly SC, Frantzides AT, Manelis T, Marcinkevicius A, Luu MB
Chicago Institute of Minimally Invasive Surgery

Objective: The management of Barrett's esophagus with high grade dysplasia is controversial. Current modalities include mucosal ablating techniques and esophagectomy. We present long term follow up data on patients with esophageal high grade dysplasia who were treated with laparoscopic transgastric esophageal mucosal resection (LTEMR).

Methods: LTEMR is accomplished through an anterior gastrotomy. The esophageal mucosa is stripped circumferentially from the Z-line to the proximal extent of abnormal epithelium. The gastrotomy is closed and a fundoplication is performed. Patient demographics, operative outcomes and follow up results were tabulated.

Results: LTEMR was performed in 11 patients (9 male, 2 female). The median age was 54 (44-75) years. All patients had high grade dysplasia on pre-operative biopsy. The median length of the Barrett's esophagus was 4.5cm (0.5cm-8cm). On two patients, the proximal extent of normal epithelium could not be reached with the laparoscopic approach. These two patients had a completion endoscopic muscosal resection in the early post-operative period. The 30 day morbidity or mortality was zero. All patients had high grade dysplasia on pathologic examination and two patients had small regions of carcinoma in situ. The median follow up was 5.2 (2-12) years. One patient developed a recurrence of Barrett's epithelium 2 years after resection. No recurrences of high grade dysplasia or carcinoma were observed in any of the patients. Two patients developed an esophageal stricture; both were treated successfully with endoscopic balloon dilation.

Conclusion: LTEMR is safe and effective alternative method to treat patients with Barrett's esophagus with high grade dysplasia.

7. CASE COHORT STUDY OF POTENTIAL RISK FACTORS FOR POST-THYROIDECTOMY HEMORRHAGE

Samona S, Hagglund K, Edhayan E
St. John Hospital and Medical Center

Objective: To determine potential risk factors for post-thyroidectomy hemorrhage.

Methods: Between December 2008-August 2014, 682 patients underwent thyroid surgery at our institution, and 16 developed post-thyroidectomy hemorrhage requiring re-operation (2.3%). A case cohort study of all patients with post-thyroidectomy hemorrhage was performed. Hemorrhage group was compared to a stratified randomized sample of 32 patients that did not develop post-operative hemorrhage. P value <0.05 was considered statistically significant.

Results: Post-operative hypertension (SBP > 150 mmHg) was the most significant risk factor for post-thyroidectomy hemorrhage ($p < 0.0005$). Additional risk factors include longer (mean 152 4 51 min) versus shorter (mean 115 4 48 min) operative times ($p = 0.015$), substernal versus local neck dissection only ($p = 0.044$), and post-operative vomiting/straining ($p = 0.032$). Swelling was found to be the most consistent sign/symptom seen with post-operative hemorrhage, demonstrated by 81% of our patients. Other risk factors not found to be statistically significant were the presence of autoimmune disorder ($p = 0.592$), hemostatic technique ($p = 0.542$), use of drainage device ($p = 1.00$), lymph node dissection ($p = 0.159$), and active anti-platelet therapy ($p = 0.333$).
Stepwise logistic regression showed patients with post-operative hypertension were 20.3 times more likely to develop post-thyroidectomy hemorrhage

Conclusion: Post-thyroidectomy hemorrhage is a potentially lethal complication that may be prevented. By modifying potentially preventable risk-factors, such as post-operative hypertension and vomiting, we can improve patient safety and satisfaction. At our institution, protocols are being developed based upon this data.

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8. SURGERY AND HORMONE THERAPY TRENDS IN ELDERLY WOMEN OVER 80 WITH INVASIVE BREAST CANCER

Kantor O, Pesce C, Leiderbach E, Wang CH, Winchester DJ, Yao K
University of Chicago

Objective: To determine treatment trends for women ≥80 years old with estrogen receptor (ER) positive invasive breast cancer.

Methods: Using the National Cancer Data Base, we selected 105, 869 women ≥80 years old with invasive, ER+ breast cancer treated from 2004 to 2014. Trends in surgery and hormone therapy utilization were examined.

Results: From 2004-2012, 9.5% of elderly women with non-metastatic invasive breast cancer did not have upfront surgical treatment, 6.8% of which underwent upfront hormone therapy. Of those who underwent hormone therapy primarily, 4.2% continued on to surgery. 2.5% had no treatment reported. The rate of observation (no surgical management) doubled from 5.1% in 2004 to 10.4% in 2012 ($p<0.001$). 58.7% of these women were treated with hormone therapy. African Americans were twice as likely to undergo observation as Caucasians (14.0% vs 6.8%, respectively; $p<0.001$). There was significant regional variation, with only 4.7% of patients undergoing observation in the Mountain region compared to 9.6% in New England ($p<0.001$).

Multivariate regression identified higher clinical stage (OR 7.33 [6.73-7.99] for stage 3 and OR 2.56 [2.39-2.73] for stage 2), older age (OR 2.71 [2.57-2.85]), African American (OR 1.96 [1.79-2.13]) or Hispanic race (OR 1.64 [1.43-1.89]), treatment at an Academic cancer center (OR 1.55 [1.43-1.69]), and higher comorbidity index (OR 1.51 [1.36-1.66]) as the strongest independent predictors of observation.

Conclusion: There has been an increasing trend towards observation of invasive breast cancer in the elderly women over 80, especially in more advanced stages, African American women and at academic centers.

9. LIFE AFTER HIPEC; MEASURING QUALITY OF LIFE AND FUNCTIONAL STATUS AFTER CYTOREDUCTIVE SURGERY (CRS) WITH HYPERTHERMIC INTRAPERITEONEAL CHEMOTHERAPY (HIPEC)

Ford JM, Berri R
St John Hospital and Medical Center

Objective: Patients who receive maximal cytoreductive surgery (CRS) with Hyperthermic Intraperitoneal Chemotherapy (HIPEC) can return to an acceptable performance status (PS) with a normal quality of life 3 months post-operative.

Methods: A HIPEC specific questionnaire was developed based on the validated Functional Assessment of Cancer Therapy Questionnaire. Each patient who received maximal CRS with HIPEC was contacted by phone and questionnaire completed. An averaged score was calculated for each section and stratified to an Eastern Cooperative Oncology Group (ECOG) PS. A retrospective chart review was employed to gather patient characteristics. One-way ANOVA analysis was used to determine if these characteristics correlated to the patient's 3 months post-operative PS.

Results: Sixty three patients were evaluated for maximal CRS with HIPEC between Oct 2011-July 2014; 43 patients received maximal CRS with HIPEC. Thirty- six met inclusion criteria and 33 patients consented; average age was 54.9 years, 35% colorectal and 47% appendiceal malignacy. Average scores were: physical well-being 15.4/20, social well being 17.5/20, recovery 15/20, mental well being 13.4/20 and functional well being 18.1/24. These correlated to an ECOG PS of 1, 0, 1, 1 and 1. Patient's age ($p = 0.235$), operative length ($p = 0.181$), hospital duration ($p = 0.43$), complications or PCI ($p = 0.815$) demonstrated no significance relative to postoperative PS.

Conclusion: Patients can recovery well from CRS and HIPEC. It is possible to return to an acceptable functional status within 3 months postoperative. Age, operative time, length of hospital stay or PCI have no significant effects on long term recovery.

10. PATENCY OF THE VIABAHN STENT GRAFT FOR THE TREATMENT OF OUTFLOW STENOSIS IN HEMODIALYSIS GRAFTS

Carmona J, Yevgeniy R, Brandt J, Dowers L, Bednarski D, Rubin J
DMC Cardiovascular Institute

Objective: To evaluate AV Graft patency when failing grafts are treated with ViabahnR covered stents versus PTA alone.

Methods: A retrospective review of all patients that underwent endovascular interventions for failing grafts at a single institution between January 2010 and July 2013 was performed. Forty four patients were identified who were treated with PTA alone (11) and with ViabahnR stent grafts (33) for stenoses in the venous to graft anastomoses. Patient demographics, procedural success, and intra-operative complications were recorded as well as graft patency at 3, 6, and 12 months. Graft patency was reviewed and compared to PTA alone.

Results: There was no statistically significant difference between the two groups regarding gender, frequency of diabetes, HTN, CAD or PAD. Primary technical success defined as residual stenosis ≤ 10% was achieved in 100% of the cases. Follow up was determined by flow velocities during dialysis and ultrasound imaging in the vascular laboratory. At 12 months 87.8% (29/33) grafts with stents were functional vs 36.4% (4/11) of those with PTA alone. Primary patency of the stent group was 61%, 52%, and 42% at 3, 6 and 12 months respectively vs. the PTA group 64%, 45%, and 9%.

Conclusion: Grafts treated with ViabahnR covered stents for outflow stenosis have a superior patency to PTA alone, 12 months after treatment; although, earlier post treatment results are comparable.

11. THE IMPACT OF TREE STAND FALLS ON A LEVEL 1 TRAUMA CENTER IN WEST MICHIGAN

Carroll J, Chapman A, Davis A, Rodriguez C
Grand Rapids Medical Education Partners

Objective: Falls from tree stands are common during the Michigan hunting season. We report the burden of this mechanism of injury on a Level 1 trauma center and rehabilitation facility in West Michigan and explore the impact of BMI.

Methods: This is a retrospective cohort study examining all patients who were admitted to our trauma center secondary to a tree stand fall between 2001 and 2013.

Results: 193 patients were examined. The average BMI was 29.5+5.1. Less than 3% of patients (4/174) were wearing a protective device. Falling from a height greater than 20 feet was associated with a significantly higher ISS ($p = 0.018$) than falling from a height less than 20 feet. Twenty-three patients were classified as normal-weight (NW; BMI < 25), and 104 subjects were overweight (OW). Patients who were OW had a significantly longer LOS ($r=0.18$, $p=0.044$). No significant differences in ISS or GCS were seen between the NW and OW groups. There were 21/23 (91.3%) NW patients who were discharged home, compared to 66/104 (63.5%) OW patients ($p=0.009$). A subgroup analysis of 36 rehab patients revealed median stay was 15 days (3-92) and median cost was $24,048 (2,398-134,752).

Conclusion: Tree stand falls cause significant injury, especially from heights greater than 20 feet. BMI has a major impact on final disposition, with overweight patients more frequently requiring rehabilitation. The infrequent use of safety harnesses is alarming. A program to educate hunters on the importance of tree stand safety devices should be implemented to minimize falls during the Michigan hunting season.

12. TRANSIENT POSTOPERATIVE ATRIAL FIBRILLATION PREDICTS LONG-TERM CARDIOVASCULAR MORBIDITY FOLLOWING GASTRECTOMY

Nassoiy SP, Blackwell RH, Kothari A, Zapf M, Kliethermes S, Gupta GN, Kuo PC, Abood GJ
Loyola University Medical Center

Objective: Postoperative atrial fibrillation following foregut surgery occurs in approximately 9% of cases. Recent evidence suggest that transient postoperative atrial fibrillation leads to future cardiovascular events, even in non-cardiac surgery. The long-term effects of postoperative atrial fibrillation in gastrectomy patients are unknown.

Methods: The Healthcare Cost and Utilization Project State Inpatient Databases for California and Florida were used to identify patients who underwent gastrectomy for malignancy between 2007-2010. Patients with a prior history of atrial fibrillation, coronary artery disease, and/or stroke were excluded. The remaining patients were matched by propensity scores based on age, race, insurance status, and preexisting medical comorbidities. Adjusted Kaplan-Meier time-to-event analysis and Cox proportional hazards models were used to assess the effect of postoperative atrial fibrillation on cardiovascular events (acute myocardial infarction and stroke) over the following postoperative year.

Results: Gastrectomy was performed in 5,065 patients, of whom 408 (8.1%) developed postoperative atrial fibrillation. A significantly higher cumulative incidence of cardiovascular events occurred over the first year in patients who developed postoperative atrial fibrillation (16.7% vs 4.5%, adjusted Logrank p=0.03). Cox proportional hazards regression confirmed an increased risk of cardiovascular events in postoperative atrial fibrillation patients (HR 3.7, p=0.046).

Conclusion: Patients undergoing gastrectomy for malignancy who develop transient postoperative atrial fibrillation are at a significantly increased risk of cardiovascular events within one year postoperatively. Physicians should be vigilant in assessing postoperative atrial fibrillation, even when transient, given the increased risk of cardiovascular morbidity.

13. HYDROMORPHONE VERSUS FENTANYL FOR EPIDURAL ANALGESIA AND ANESTHESIA

Nguyen MN, Hall Zimmerman LG,Meloche K, Dolman HS, Baylor AE, Fuleihan S, Wilson RF, Tyburski JG
Wayne State University/Detroit Receiving Hospital

Objective: Epidural analgesia/anesthesia (EAA) is frequently used in patients undergoing surgery because it dramatically relieves pain and attenuates the stress response. Limited data exists regarding the relative merits of the two most commonly used opioids in epidurals, hydromorphone (HM) and fentanyl (FENT). Hence, we evaluated FENT versus HM to determine safety and effective profiles of these two opioids.

Methods: Prospective case-matched, observational study evaluated consecutive elective surgery patients for seven months; 30 HM and 60 FENT. Hypotension was defined as a decrease in systolic pressure ≥ 20% from baseline. Hemodynamic variables were measured for 24 hours postoperatively. Side effects and hemodynamic variables were measured perioperatively. A p-value < 0.05 was considered significant.

Results: The mean age was 52 yrs; SAPS II was 26 4 10; and ASA score was 2.4 HM vs 2.7 FENT, p=0.03. Patients receiving HM were more apt to be excessively sedated (16% HM vs 1% FENT, p=0.007), and have poor mental unresponsiveness (6% HM vs 0% FENT, p=0.04). HM patients tended to have repeated episodes of hypotension, 50% HM vs 30% FENT, p=0.17) and require vasopressors, (47% HM vs 36% FENT, p=0.22). No difference between groups was seen with hypotension. Intraoperative urine output was different between groups, 1.642.0 FENT vs 0.840.5 HM ml/kg/hr, p=0.05.

Conclusion: In a closely case matched population, fentanyl patients had less excessive sedation and unresponsiveness. Fentanyl patients had better intraoperative urine output and tended to have less repeated episodes of hypotension. Hence, fentanyl appears to be a more suitable epidural analgesic than hydromorphone.

14. CAN MORBIDLY OBESE PATIENTS WITH REFLUX BE OFFERED LAPAROSCOPIC SLEEVE GASTRECTOMY?

Hawasli A, Reyes M, Meguid A, Harriott A, Almahmeed T, Szpunar S
St. John Hospital & Medical Center

Objective: The incidence of reflux in obesity can reach 35%. Most surgeons would recommend Roux-en-y Gastric Bypass (RYGB) to patients with pre-existing reflux. We evaluated the addition of anterior fundoplication (AF) with posterior crura approximation (pCA) to LSG in patients with documented reflux.

Methods: All patients undergoing LSG between February 2011-April 2013 were evaluated with upper endoscopy. Patients with reflux received a pH monitor. Those with confirmed reflux and refusing RYGB were offered LSG with AF/pCA. Post-operatively patients were evaluated by resolution of symptoms and using Quality
of Life (QOL) score.

Results: Forty patients were included; 78% (31) were female. The mean initial weight was 298.0+64.4 lbs. with mean BMI of 49.3+7.8 kg/m2. The DeMeester score was 35.9+26.6 (normal <14.7). Nine (22.5%) patients had esophagitis. Thirty-six (90%) patients had hiatal hernia. There were no intra-operative complications. The mean operative time was 84.1+20.1 min and the mean hospital stay was 1.6+0.9 days. Post-operative complications included one fluid collection (no documented leak) treated conservatively with TPN, one narrowing requiring dilatation, four admissions for nausea and dehydration, one for pancreatitis and one for DVT. Thirty-eight (95%) patients had immediate resolution of reflux, while 2 (5%) patients complained of worsening symptoms. On short term follow-up of 24.4+6.4 months, 56.4% of patients responded to QOL survey with improvement in their median score from 31.0 (IQR 25) pre-operatively to 0.00 (IQR 6.5) post-operatively ($p<0.0001$). Their %Excess BMI loss was 63.2+25.7%.

Conclusion: Morbidly obese patients with documented reflux can still be offered LSG with the addition of AF/pCA.

15. THE APPROPRIATE MEASUREMENT OF POST-DISCHARGE READMISSIONS IN MEDICARE COLON SURGERY

Fry DE, Pine M, Nedza SM, Pine G
MPA Healthcare Solutions

Objective: Shorter lengths of hospitalization have resulted in adverse events of surgical care not being identified until after discharge. The post-discharge period of time that will capture the appropriate adverse outcomes for focused quality improvement is not defined.

Methods: We used Medicare Inpatient data for the years 2010-2012 to identify all elective colon resections that were performed within two days of admission in hospitals with greater than 20 eligible cases for the study period. All readmissions to an acute care hospital were evaluated at 30, 60, and 90 days following discharge. Readmissions due to interval trauma and cancer diagnoses were excluded. The Medicare Severity-Diagnosis Related Group (MS-DRG) for each readmission was evaluated at each interval to ascertain the association with the index colon operation.

Results: There were 110,768 patients evaluated. A total of 12,764 individual patients were readmitted 14,362 times by 30 days, 17,365 were readmitted 21,524 times by 60 days, and 21,407 were readmitted 28,073 times by 90 days. The most common causes of readmission were post-operative infection (n=1,922), intestinal obstruction (n=1,652), major small/large bowel operation (n=1,588), renal failure (n=1,573), and septicemia (n=1,336); respectively, these adverse events occurred 18.2%, 50.8%, 61.7%, 44.6%, and 49.0% between 31-90 days after discharge. Among all readmissions; 51.2% occurred in the first 30 days, 25.5% between days 31-60, and 23.3% between days 61-90.

Conclusion: In elective colon surgery, the traditional 30 days from operation or discharge is inadequate to track relevant readmissions. Instead, a 90-day post-discharge window should be adopted.

16. CATCH ME IF YOU CAN... EARLY SIMULATION EFFORTS AFFECT FUNDAMENTAL SURGICAL SKILL ASSESSMENT SCORES.

Buckarma E, Gas B, Abdelsattar J, El Khatib M, Pandian T, Finnesgard E, Farley DR
Mayo Clinic - Rochester

Objective: Demonstration that early exposure to a surgical simulation curriculum of knowledge and skills would enhance acquired skills for training.

Methods: The "Surgical Olympics" evaluated 29 general surgery interns, which is a series of skills and knowledge testing, such as knot tying and interpreting an ABG. Interns were tested in July and retested in October and January following a general surgery simulation curriculum consisting of 7 sessions. Here, residents were asked to perform abbreviated portions of procedures in a simulated operating room.

Following the July Olympics, the interns were randomly divided into two groups. Group A participated in the 7 week long simulation curriculum once a week for 3 hours while group B attended 7 weeks of lectures on various surgical topics. Residents then participated in the October Olympics. Next, the two groups rotated; group A attended the lectures, while group B underwent the simulation sessions. Lastly, all interns participated in a January Olympics.

Results: Mean total scores were calculated for group A and group B for the July, October and January Olympics. Mean scores (Group A = 182 Group B = 181; p=0.94) were similar in the July Olympics. In October, group A (mean score=233) outperformed group B (mean score=203), (p=0.02). Mean total scores in January (A=290, B= 276; p=0.35) were similar.

Conclusion: Early exposure to a surgical simulation curriculum enhances intern performance in our Surgical Olympics. Later exposure to simulation helps learners close this gap on testing three months later. Simulation may be a superior form of surgical education over staff lectures.

17. OPEN RETROFASCIAL INCISIONAL HERNIA REPAIR IS A SAFE AND EFFECTIVE OPERATION

Bender JS
University of Oklahoma

Objective: Incisional hernias occur in about ten percent of patients following elective abdominal operations. Even though over 100,000 are performed annually in this country, the best method of repair remains controversial. We report the outcomes following a standardized approach by one surgeon

Methods: The operation consisted of placement of polypropylene mesh beneath the fascia with fascial closure. A prospective database was maintained for the time period January, 1995, to December, 2014. All patients were followed for a minimum of six months postoperatively.

Results: There were 538 patients with a mean body mass index of 36.2 kg/m2 and a mean defect size of 134.5 cm2. There were 292 primary hernias with a recurrence rate of 2.7% and 246 recurrent hernias with a recurrence rate of 4.1% (p=0.4). There was one death (0.2%). Forty-three patients (8.0%) developed a wound complication, of which 17 (3.2%) were infections and the rest seromas. Only two required removal of the mesh. There were six patients admitted for postoperative small bowel obstruction, but only one in the immediate postoperative period. There were two enterocutaneous fistulas, both of which resolved nonoperatively. Two patients developed nonfatal pulmonary emboli. Mean length of stay decreased from an average of 4.0 days for the first 100 patients to 2.8 days for the subsequent patients.

Conclusion: :Retrofascial mesh repair for ventral incisional hernias has a both low complication and recurrence rate. It should be considered the gold standard for such repairs.

18. IMPACT OF INAPPROPRIATE INITIAL ANTIBIOTICS IN CRITICALLY ILL SURGICAL PATIENTS WITH BACTEREMIA

Abraham K, Dolman HS, Hall Zimmerman LG, Faris PJ, Edelman DA, Wilson RF, Tyburski JG
Wayne State University/Detroit Receiving Hospital

Objective: Nosocomial blood stream infections in critically ill patients are associated with a mortality as high as 80% and a prolonged hospital stay. We evaluated the impact of inappropriate initial antibiotic therapy in a critically ill surgical patients with bacteremia.

Methods: This retrospective study evaluated consecutive adult critically ill surgical patients with bacteremia. Initial antibiotics were considered appropriate if the pathogen isolated was susceptible based on MIC data and divided into two groups: appropriate (AAT) vs inappropriate (IAAT). Time to AAT was defined as time from initial antibiotics prescribed to administration of appropriate antibiotics.

Results: In the 72 episodes of bacteremia, 57(79%) were AAT and 15(21%) were IAAT, mean age 54417 years and APACHE II of 1748. Time to appropriate antibiotics was longer for IAAT vs AAT, [2.644.7 vs 0.640.8 days, p=0.003]. IAAT was seen primarily with Acinetobacter spp (33% IAAT vs 9% AAT, p=0.01) and Enterococcus faecium (26% IAAT vs 7% AAT, p=0.03). If 2 or more bacteremic episodes occurred, Acinetobacter spp. was more likely, p=0.001. In surviving patients, hospital length of stay (LOS) was longer, [86 IAAT vs 47 AAT days, p=0.03]. In-hospital mortality was more likely if IAAT was prescribed on the evening shift vs day shift, (27% IAAT vs 4% AAT, p=0.02). Variables impacting mortality were lactic acidosis (p<0.001), age >50yrs (p=0.01) and Acinetobacter (p=0.02).

Conclusion: Bacteremias in critically ill surgical patients have significant impact. Use of AAT decreases mortality and LOS. In prolonged stay, Acinetobacter spp. was seen and should be anticipated.

19. WHEN PATIENTS CALL THEIR SURGEON'S OFFICE: AN OPPORTUNITY TO IMPROVE THE QUALITY OF SURGICAL CARE AND PREVENT READMISSIONS

Brekke AV, Elfenbein DM, Madkhali T, Schaefer SC, Shumway C, Chen H, Schneider DF, Sippel RS, Balentine C
University of Wisconsin-Madison

Objective: When patients contact their surgeon's office with questions about surgery or postoperative recovery, calls are often initially handled by the nursing staff. Despite this vital role in coordinating care, little is known about these conversations and how they influence surgical outcomes. This study evaluated conversations between office nurses and surgical patients to identify common issues addressed and their effect on patient care.

Methods: We evaluated medical records using traditional content analysis to identify common themes and questions from pre- and postoperative patient phone calls to their surgeons' offices after thyroidectomy during 2013. We then prospectively observed 50 office calls to determine time spent for each conversation and used qualitative analysis to categorize topics.

Results: The retrospective study identified 183 thyroidectomy patients with 38% contacting our office prior to surgery and 54% within 30 days after surgery. Common reasons for preoperative calls included questions about preoperative evaluation (21%), medications (18%) and insurance/work paperwork (12%). Postoperatively, common topics included medications (23%), laboratory results (23%), and concerns about wounds (12%). Notably, nursing staff prevented unnecessary readmission in 7 patients (4%) while appropriately referring 16 (9%) for early evaluation. During our prospective observation of 50 patient calls, conversations ranged in duration from <1 minute to >14 minutes. During this phase we also confirmed the themes identified from retrospective chart review.

Conclusion: Patients frequently contact their surgeon's office before and after surgery. Our qualitative analysis suggests several potential areas for improving patient education to enhance outcomes. This provides a template for improving care following many general surgery procedures.

20. NEGATIVE PRESSURE WOUND THERAPY FOR TREATMENT OF GIANT OMPHALOCELE

Aldridge BA, Papandria DP, Ladd AP, Finnell SM, Kokoska ER
Indiana University School of Medicine

Objective: Contemporary management of giant omphalocele consists of the application of topical antibacterial to induce sac epithelialization ("paint and wait") or abdominal closure with or without silo or prosthetic mesh. Both methods are associated with high complication rates. We propose negative pressure wound therapy (NPWT) as an alternate method for initial treatment of giant omphalocele.

Methods: We retrospectively examined chart data for patients born with giant omphalocele (fascial defect diameter > 5 cm or circumference > 10 cm) between 2009 and 2014 at our institution. Patients treated with NPWT within the first 5 days of life were included. Outcomes analyzed included mortality, duration of NPWT, time to full enteral feeds, complications associated with NPWT (sac rupture, wound infections, or bowel perforation or fistula), and progress of abdominal wall closure measured by decrease in open wound surface area (OWSA).

Results: Eight patients were reviewed. One neonate died of respiratory complications at day of life 11 and was excluded from further analysis. Among the remaining children, median duration of NPWT was 68 days. Median time to full enteral feeds was 19 days. There were no treatment discontinuations or NPWT-associated complications. The rate of wound contraction markedly slowed at two months or around 7 cm2 OWSA.

Conclusion: Our data suggest that NPWT is a safe and effective alternative for the initial management of giant omphalocele that can permit successful enteral feeding. This therapy appears to provide maximal benefit with respect to wound closure during the first two months of application.

21. THE IMPACT OF ROBOTIC CHOLECYSTECTOMY ON PRIVATE PRACTICE IN A COMMUNITY TEACHING HOSPITAL

Hawasli A, Sahly M, Meguid A, Edhayan E, Guio C, Szpunar S
St. John Hospital & Medical Center

Objective: Through aggressive marketing, Robotic Cholecystectomy (RC) began to gain popularity during the last few years. We wanted to evaluate the impact of this technology on private practice and hospital volume.

Methods: From November 2012 to April 2014, all elective cholecystectomies were evaluated for type of procedure, insurance, payment, and hospital length of stay (LOS). Data was analyzed using the chi-squared test, Student's t-test and the Mann Whitney U test.

Results: There was a statistically significant difference in direct cost in RC vs. LC but not in margin. This was due to more patients in the RC group with better insurance. There was no impact on private practice in number of cases being done robotically, nor there was an increase in hospital volume in the 18 months of this study. This study did not factor in the cost of the robot or the cost of the maintenance contract.

Conclusion: Two hundred forty-six patients were evaluated; 84.1% (207) were female. The average age was 45.4+17.1 years. These were divided into two groups; Group 1: 220(89.4%) patients had Laparoscopic Cholecystectomy (LC) and Group 2: 26(10.6%) patients had RC. The mean direct cost for group 1 vs. group 2 was $1,712.51+379.50 vs. $2,704.08+308.40 p<0.0001, and the median gross margin was $1,726.00 (IQR $1,480) vs. $1,593.00 (IQR $3,936) respectively p=0.85. The insurance distribution for Group 1 vs. Group 2 was BCBS/Commercial (40.0% vs. 61.6%), HMO/PPO (19.1% vs. 19.2%), Medicare (21.4% vs. 3.8%) and Medicaid HMO (19.5% vs. 15.4%) (p=0.009). The mean (LOS) was 1.02+0.15 vs. 1.00+0.00 (p=0.44).

22. MODIFIED RETRORECTUS VENTRAL HERNIA REPAIR

Madura JA, Pearson DG
Mayo Clinic Phoenix

Objective: Review the surgical outcomes and complications of patients undergoing a modified retrorectus ventral hernia repair (RRVHR) for primary and recurrent ventral incisional hernias.

Methods: A retrospective review of all seventy nine patients who underwent retrorectus ventral hernia repair (RRVHR) by a single surgeon between 2009 and 2014. All were treated with primary posterior rectus fascia closure, retrorectus mesh placement, and primary closure of anterior rectus fascia without requirement of lateral component separation. Sublay standard weight polypropylene mesh was used in all cases with polypropylene tacking sutures to the posterior rectus sheath.

Results: A spectrum of hernias were repaired but predominantly midline ventral incisional were treated. Thirty-nine cases (49%) were recurrent hernias. Hernia recurrence after RRVHR was uncommon, occurring in only 2 patients (2.5%) at mean follow-up 2.4 years. There were 4 cases of infection (5.1%) which were superficial, not requiring mesh removal and resolved with oral antibiotics. Seroma occurred in 1 (1.3%) patient who did not require intervention. Two patients (2.5%) had subcutaneous hematomas requiring evacuation. The overall complication rate was 20.2%. Late abdominal pain was documented in 6 (7.6%) patients, two of whom required referral to our pain clinic (2.5%); the others reported only mild discomfort not requiring ongoing medication or treatment. There were no mortalities, bowel obstructions, fistulae or mesh complications.

Conclusion: In our experience a modified RRVHR, avoiding transfascial suture fixation of mesh, resulted in low complication and recurrence rates with minimal abdominal wall pain.

23. TRAUMATIC VASCULAR INJURIES: WHO ARE REPAIRING THEM AND WHAT ARE THE OUTCOMES?

He JC, Clancy K, Schechtman DW, Conrad-Schnetz KJ, Claridge JA
MetroHealth Medical Center, Case Western University School of Medicine

Objective: This study characterizes the incidence of vascular injuries at a level I regional trauma center and determines the need for vascular surgeons in repairing these injuries. Outcomes between patients repaired by vascular versus trauma surgeons are compared.

Methods: Patients with age ≥ 14 who required operations for acute traumatic vascular injuries from 1/1/2008 to 12/31/2013 were analyzed. A p-value of ≤ 0.05 was considered statistically significant.

Results: 385 (1.4%) of 27,224 trauma patients needed operations for acute vascular injuries. Mean age was 34; 84% were male, and median Injury Severity Score (ISS) was 14. Trauma and vascular surgeons repaired 40% and 37% of these patients respectively. The rest were repaired by other subspecialty surgeons. The need for vascular surgeons varied significantly based on body region injured, trauma staff experience, and individual practice (all p-values≤0.01).
Patients repaired by vascular surgeons had similar demographics, but sustained more blunt traumas (p-value=0.026) and were more often transfers from other hospitals (p-value=0.018). On average, they had 42 minutes longer admission to OR time, 72 minutes longer operation time, 3 days longer hospital stays, and required 3 more units of PRBC perioperatively (all p-values≤0.025). 5% more of them needed unplanned procedure postoperatively (p-value=0.04) and 7% more suffered limb loss (p-value=0.05). They had 16% less inpatient mortality (p-value=0.001), but the significance dissipated after excluding deaths within 24 hours from admission.

Conclusion: 1.4% of trauma patients treated required vascular operative intervention. A significant portion was repaired by trauma surgeons alone, achieving similar short-term patient outcomes as those managed by vascular surgeons.

24. 30-DAY READMISSIONS AFTER INPATIENT LAPAROSCOPIC CHOLECYSTECTOMY: FACTORS AND OUTCOMES

Rana G, Bhullar JS, Subhas G, Kolachalam RB, Mittal VK
Providence Hospital and Medical Centers

Objective: 30-day Readmissions are a considerable financial burden on medical institutions due CMS penalties for high readmission rates since 2012. Efforts are ongoing to determine factors that lead to higher readmission rates.

Methods: A retrospective chart review of 30-day readmissions from 747 patients was performed at an urban community hospital from January 2009 to March 2013. The data was subdivided into medical severity-diagnostic related groups (MS-DRG) 417,418 and 419, as categorized by the CMS. Demographic features, perioperative variables, diagnostic workup, operative interventions, and postoperative morbidity and outcomes were analyzed.

Results: 44 (5.9%) readmissions of inpatient laparoscopic cholecystectomy cases were recorded, out of a total of 747 inpatient discharges, within the first 30 days. The readmission data was further divided into DRGs 417, 418, and 419 with readmission rates of 13.6, 3.6 and 5.4% respectively. The highest rate of readmission was within the first 7 days at 50% (n =22). Etiology was divided into surgical (54.5%) and non-surgical (45.4%). Surgical causes included biliary (22.7%) and non-biliary (31.8%). Surgical team was not consulted in 31.8% of the readmissions. Other predictors of readmission were found to be intraoperative drain placement (29.5%) and postoperative pain.

Conclusion: Patients with major comorbidities had a higher rate of readmission ($p<0.05$). In 45.4% of the readmissions, the cause was found to be non-surgical; in such cases, it is difficult to use readmissions as a quality assessment tool. Multiple other variables were explored, however, given the small sample size the data could not reach significant p-values.

25. READABILITY OF DISCHARGE SUMMARIES: WHAT LEVEL OF INFORMATION ARE WE DISMISSING OUR PATIENTS WITH?

Zielinski MD, Choudhry AJ, Baghdadi YM, Heller SF, Jenkins DH
Mayo Clinic - Rochester

Objective: Health literacy is defined as the capacity to obtain, interpret, and understand information needed for health related decisions. Disparity between the literacy of the average US adult and patient health information is increasingly being cited as a barrier to patient involvement in their own care. The National Institute of Health (NIH) and American Medical Association (AMA) advise writing health information at a sixth grade level.

Methods: We reviewed adult trauma patient discharge notes from August to December 2014. The Flesch-Kincaid Grade Level (FKGL) and Flesch Reading Ease Scores (FRES); two universally accepted scales for evaluating the readability of medical information were used. Data was presented as means 4 standard deviation, $p<0.05$ was significant.

Results: A total of 504 patients (63% male) were included with a mean age of 57 4 22 years. Mean Injury Severity Score (ISS) and Glasgow Coma Scale(GCS) score of 1149 points and 1443 points respectively. The mean length of stay was 546 days. Mean FKGL was 10 4 1 and mean FRES was 44 4 7 including 132 summaries(26%) classified as very or fairly difficult. There were no differences in FKGL and FRES based on GCS, ISS, and LOS (all $p>0.5$). Compared to other miscellaneous services, discharge notes of the trauma service were at a lower grade level (9.6 versus 10.7) and higher reading ease score(49 versus 40)(all $p<0.0001$).

Conclusion: Patient discharge instructions are written at too high of an educational level. Further studies are needed to determine if appropriate level discharge notes will improve readmission rates and overall quality.

26. COMMON SIDE CLOSURE TYPE, BUT NOT STAPLER BRAND OR OVERSEWING, INFLUENCES SIDE-TO-SIDE ANASTOMOTIC LEAK RATES

Fleetwood VA, Gross KN, Alex GC, Cortina CS, Smolevitz JB, Sarvepalli S, Bakhsh SR, Poirier J, Myers JA, Singer MA, Orkin BA
Rush University Medical Center

Objective: Anastomotic leak (AL) occurs in 3-19% of patients and may increase costs, length of stay, and cancer recurrence. Although studies show lower AL rates with side-to-side stapled anastomosis (SSA) vs. handsewn, none identify specific technical risk factors for AL within SSA types. We hypothesized that stapler characteristics and closure technique of the SSA common enterotomy affect AL rates.

Methods: Retrospective review of bowel resections with side-to-side anastomoses at a tertiary medical center 2009-2012 was performed. Data included stapler brand and length, staple line oversewing, and common side closure method (handsewn closure, HC; linear stapler [Barcelona technique], BT; transverse stapler, TX). The primary endpoint was AL, radiographic or clinical. Statistical analysis included Fisher's exact test.

Results: 463 patients were identified. Common enterotomy closure was accomplished by BT, 58.5%, HC, 21.2%, and TX, 20.3%. 59.7% were oversewn (62.5% partial, 37.5% complete). Covidien staplers comprised 74.9% (60 or 80 mm), Ethicon 18.1% (45, 60, or 75 mm). The overall AL rate was 5.4%. Oversewing did not reduce leak rate (4.2%, none; 7.1%, partial; 5.0%, complete). There were no differences between stapler brands or lengths (Covidien 5.8%, Ethicon 6.0%). However, AL rates varied by common side closure - BT closure had fewer AL than TX (3.7% vs. 10.6%, p=0.017); while HC AL fell in between (5.1%).

Conclusion: Method of closure of the SSA common side impacts AL rates. Barcelona technique has fewer leaks than transverse stapled closure. Further prospective evaluation is recommended.

27. REOPERATION FOR GROIN PAIN AFTER INGUINAL HERNIORRHAPHY: DOES IT REALLY WORK?

Sun PY, Pandian TK, Abdelsattar JM, Farley DR
Mayo Clinic - Rochester

Objective: Due to conflicting data on the success of reoperation for groin pain following inguinal herniorrhaphy, we aimed to characterize this difficult problem in a large tertiary referral center.

Methods: An IRB-approved retrospective review of adults who presented with groin pain following IH repair (IH-R) from 1995 to 2010 was performed. Patient and operative characteristics were analyzed from our electronic medical record (EMR).

Results: Forty-six patients with previous IH-R (8 laparoscopic, 38 open), underwent reoperation for groin pain (R-GP); 83% were male and median age was 50 years (range 23-82). General anesthesia was administered in most (83%) reoperations. Twenty-five (54%) patients had hernia recurrence at the time of R-GP; of these, 19 (76%) underwent mesh re-repair. Available operative reports suggested 15 (33%) patients had resection of the ilioinguinal, iliohypogastric, and/or genitofemoral nerve. Reported complications included: 1 hematoma, 1 patient with urinary retention, and 2 seromas. Nine patients (20%) underwent >1 R-GP. Median follow-up was 1 year (range 2 months – 12 years). Of 22 patients with clear documentation on follow-up surgical visits, only 5 (23%) were pain-free. Seventeen patients (77% of 22 and 37% of the total cohort) reported at least some persistent pain after initial R-GP. Twenty-four patients had unclear or no follow-up in our EMR.

Conclusion: Outcomes after R-GP following IH-R are disappointing. While 1-in-5 patients may improve with surgical intervention, more than 1-in-3 continue to suffer from symptomatology. Alarmingly, more than half are lost to follow-up or their pain is not documented in ongoing care notes in our EMR.

ePoster List

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St. John Hospital & Medical Center

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Mayo Clinic - Rochester

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Grand Rapids Medical Education Partners/Michigan State University

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St. John Hospital & Medical Center

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University of Wisconsin – Madison

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Mayo Clinic - Rochester

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St. John Hospital & Medical Center

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Cook County Trauma & Burn Unit

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Rush University Medical Center

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Mayo Clinic - Rochester

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Thomae Surgical

Poster #4. **VALIDATION OF THE AMERICAN COLLEGE OF SURGEONS (ACS) NATIONAL SURGICAL QUALITY IMPROVEMENT PROGRAM (NSQIP) RISK CALCULATOR TO ESTIMATE SERIOUS COMPLICATIONS IN PATIENTS UNDERGOING MAJOR GASTROINTESTINAL ONCOLOGIC RESECTION**

Ford JM, Coughlin K, Van Dorp D, Berri R
St John Hospital and Medical Center

Objective: The ACS NSQIP Risk Calculator was developed to estimate the chance of complications or death after surgery. We sought to validate use of the calculator for estimating serious complications in patients undergoing gastrointestinal oncologic resection.

Methods: From August 2012 – November 2014, 255 oncologic resections were performed by a single surgeon (R.B.) in the setting of a multidisciplinary Surgical Oncology Program. A database was maintained that included serious postoperative complications as defined by the ACS. A retrospective chart review was performed; the 21 input variables for the calculator were collected. The calculator was then used to obtain the risk frequencies for each patient prior to resection. Frequency tables for estimated and observed complications were created and compared using paired two tailed t-tests. P value was significant if $p<0.05$.

Results: Of the 255 patients included in this analysis, 72 patients underwent Cytoreductive surgery and Hyperthermic Intraperitoneal Chemotherapy, 60 hepatopancreaticobiliary, 36 colorectal, 38 cytoreduction, 28 gastrectomies, and 21 other resections. The estimated mean frequency of serious complications for the group was 11.93%, while the observed mean frequency was 8.5%. When the estimated risk for serious complications reached 16.04%, observed complications were significantly higher (SD 9.3, $p=0.011$) in that subset of patients.

Conclusion: The ACS NSQIP risk calculator can be used to estimate the likelihood of serious complications for patients undergoing oncologic resection. The utilization of the risk calculator for this group of patients will allow clinicians and patients to make informed decisions in the preoperative period regarding patient and procedure-specific postoperative risks.

Poster #5. **PATIENTS' RECOLLECTION OF COLONOSCOPY RESULTS: ARE THEY RELIABLE?**

Tarakji M, Al-Raishouni M, Alame A, Berri R
St John Hospital and Medical Center

Objective: Colonoscopies are often performed and patients have a variable understanding of the findings and recommendations. The aim of our study was to evaluate our patients' recollection of the results of their colonoscopy findings and follow-up recommendations.

Methods: Patients were randomly selected and surveyed via telephone. Patients were split into 4 groups based on time lapsed from their last colonoscopy: 4 years,2 years,1 year, and less than 2 month. Patients were asked to recall the date of their last colonoscopy and the findings including: polyps and quantity, and recommended follow-up interval. Answers were compared to the electronic health record.

Results: Two hundred patients, fifty patients in each group, were contacted. When recalling the average time since their colonoscopies, only 42%, 30%, and 28% of patients in the 1,2, and 4 year groups could accurately remember to within a 6 month period the date of their scope. Of the 2 month group, 94% accurately remembered the date of their last scope to within 1 month. The number of patients that knew about polyps on their endoscopy is 65.2%,31.6%,35.7%, and 37.5%; the number of patients who accurately recalled the number of polyps on their exam was 39.1%,10.5%,7.1%,6.25% (2 month, 1,2 , 4 year groups).

Conclusion: Patient recollection of having any polyps in their scope is less than 40% when over 1 year lapses from the time of a colonoscopy. Clinically significant information in regards to the number of polyps found is unreliable. Thus, physicians should always obtain the endoscopy report before making clinically significant decisions.

Poster #6. **RECENT EXPERIENCE OF ENDOVASCULAR RELINING FOR PERSISTENT ENDOTENSION-INDUCED EXPANSION OF ABDOMINAL AORTIC ANEURYSM (AAA) SAC FOLLOWING ANEURYSM EXCLUSION USING THE ORIGINAL PERMEABILITY PTFE GRAFT**

Yoon WJ, Haouilou JC, Rama K, Berg RA
St. John Hospital and Medical Center

Objective: Endovascular relining with a less permeable endograft has been reported to be effective in treating continuously enlarging aneurysm sac due to endotension following abdominal aortic aneurysm (AAA) repair. The objective of this study was to review our recent experience with this approach in the treatment of endotension-induced AAA sac expansion.

Methods: A retrospective analysis of patients who developed persistent sac enlargement after AAA repair and thus underwent secondary intervention between 2012 and 2015 was performed. The contrast-enhanced computed tomography images were reviewed for identification of endotention, the absence of endoleak.

Results: We identified six patients, all of whom underwent initial AAA repair procedures using the original more porous polytetrafluoroethylene (PTFE) graft. Four patients had initial open repair, whereas two patients underwent endovascular repair. The existing original grafts were relined endovascularly with low-permeability endoprostheses in five patients. The average time from the original AAA repair to relining was 8.5 years (range, 1-14). Mean diameter of the original aneurysms was 6.05 cm (range, 5.2-7.0), and the mean aneurysm diameter at relining was 10.6 cm (range, 7.08-14.0). Hounsfield units of sac contents averaged 21.35 (range, 18.79-24.75). There was no mortality associated with the relining procedures. At a mean of 10.3-month follow-up after relining, there was no recurrence of sac enlargement.

Conclusion: Our experience demonstrated that the endovascular relining is an effective and safe option in treating delayed aneurysm sac enlargement after repair with the original permeability PTFE graft, and further adds to the growing body of literature.

Poster #8. **DIAPHRAGMATIC REINFORCEMENT DURING HIATAL HERNIA REPAIR WITH A NOVEL BIOLOGICAL URINARY BLADDER EXTRACELLULAR MATRIX**

Johnston G, Dan A, Pozsgay M, Bohon A, Hydu R, Zografakis J
Summa Akron City Hospital

Objective: Mesh reinforcement during Laparoscopic Hiatal hernia repair (LHHR) has been shown to reduce recurrence rate. Biologically-derived products including porcine and human dermis have been utilized with much success. The Urinary Bladder Matrix (UBM) represents a new generation of extracellular matrix biologically-derived mesh that has anecdotally shown clinical success and may improve site specific tissue remodeling and healing.

Methods: IRB approval was obtained for this retrospective study performed on patients undergoing LHHR from 8/2009- 5/2014. Diaphragmatic reinforcement was performed with porcine UBM mesh to determine the feasibility, safety and efficacy in LHHR. Primary outcome being recurrence: UGI with >2cm defect above the diaphragm at 3 months. Data collected included, intra/postoperative complications, pre/postoperative GERD, dysphagia and proton-pump-inhibitor (PPI) therapy.

Results: 62 patients undergoing LHHR with UBM mesh were studied. Average age was 62 years, female to male ratio of 53:9, and average BMI of 32.7kg/m2. Preoperatively 61/62(98%) patients had GERD, 12/62(19%) dysphagia, and 61/62(98%) were on PPI. UGI was performed on 41/62(66%) at 3 months postoperative. 8/41(19%) had an UGI with recurrence >2cm. 35/62(56%) remained on PPI, and only 10/62(16%)($p<0.001$) remained symptomatic. Dysphagia improved in 8/12(75%)($p=0.05$) patients. Zero intraoperative complications were recorded, with only one mortality from a cardiac event unrelated to LHHR.

Conclusion: UBM mesh is both effective and safe for LHHR. In addition to reducing the rate of recurrence compared to primary repair, the UBM properties including site specific/constructive tissue remodeling may add additional benefits over other biologic products. This study represents the first evaluation of UBM mesh to our knowledge in LHHR.

Poster #9. **INVESTIGATION OF THE PATHOLOGIC FEATURES OF DIFFERENTIATED THYROID CANCER (DTC) IDENTIFIED FROM THYROID NODULES WITH FOCAL UPTAKE ON POSITRON EMISSION TOMOGRAPHY (PET)**

Jin J, Khoncarly S, Zhang N, Ma B, McHenry C, Siperstein A
MetroHealth Medical Center

Objective: Incidental thyroid nodules with focal uptake on PET have increased risk for malignancy, however, it is unclear whether they behave more aggressively. This study aims to evaluate the pathologic features of DTC discovered incidentally on PET.

Methods: Electronic medical record of two tertiary medical centers were queried between 2001-2011 for patients who underwent PET for non-thyroid related causes and were found to have focal thyroid uptake. Patients who underwent fine needle aspiration biopsy (FNAB) and subsequent thyroidectomy were reviewed. A matched comparison group (n=54) was selected from consecutive patients who underwent surgery for DTC but did not have their initial discovery on PET.

Results: 137 (0.8%) patients were found to have focal uptake and underwent FNAB: 24 patients had cancer (15 papillary thyroid cancer (PTC), 7 metastases, 2 lymphoma). Forty patients underwent thyroidectomy: 15 with cancer and the rest for indeterminate FNAB. Twenty-one patients were confirmed pathologically to have cancer (PTC=19, lymphoma=2) that corresponded to the PET uptake. While the PET PTC group showed similarity in multifocality and tall cell variant when compared to the control, more advanced tumor stage (p=0.09) and increased BRAF mutation positivity (p=0.05) were observed.

Conclusion: This study demonstrates that DTC detected on PET is of the papillary type. Despite the small sample size, the results do suggest that they may be more aggressive than PTC detected through other means. A larger, multi-centered study will be necessary to validate our findings and further evaluation of the tumor biology may have potential treatment implication.

Poster #10. **THE IMMEDIATE LOW PROFILE BUTTON GASTROSTOMY: PATIENTS PREFER IT AND WE SHOULD PROVIDE IT**

Onders R, Elmo MJ, Kaplan C, Katirji B, Schilz R
University Hospitals Case Medical Center

Objective: Over 100,000 percutaneous endoscopic gastrostomies (PEG) are placed in the US yearly. Patients with PEGs often report negative body image, social isolation and decrease in quality of life. The low profile gastrostomy (button) has been a therapeutic option for over 30 years and is more accepting than standard PEG but is usually not offered during the primary insertion. The objective of this study is to determine patient preference of feeding tube style and results of immediate placement in patients with neuromuscular disease.

Methods: Subgroup analysis of all ALSMND patients who were being evaluated for diaphragm pacing (DP) and offered a choice between standard PEG or button at a single institution.

Results: During evaluation of 138 ALS patients, 64 had bulbar symptoms with 42 of them presenting without PEG. Seventy-eight out of 81(97%) patients choosing DP with gastrostomies chose the button. Three patients received the standard PEG. Ten patients with a standard PEG had it changed to the button. Two patients had a button replacement in the first week from balloon rupture with no adverse events. After two months, two patients required conversion to standard PEG due to body habitus.

Conclusion: When given a choice, patients selected the immediate button. All patients preferred the aesthetics of it. This study showed that immediate button placement is safe and has a low complication rate. Simultaneous DP and button placement can be performed. Abdominal size is a limiting factor. Offering direct button placement could positively affect patients' acceptance of a feeding tube.

Poster #11. **ETIOLOGY MATTERS: CIRRHOTICS HAVE SIGNIFICANTLY HIGHER MORTALITY AFTER LIVER TRANSPLANTATION**

Fleetwood VA, Ramirez C, Poirier J, Hertl M, Chan EY
Rush University Medical Center

Objective: 93% of liver transplant recipients have cirrhosis; these patients are frequently older and more comorbid than their noncirrhotic counterparts. No studies have addressed the effects of cirrhosis on outcomes. We hypothesized that given advanced age and comorbidities, cirrhotics have worse graft survival and mortality after transplant.

Methods: The Organ Procurement and Transplantation Network registry from 2002 to 2013 was reviewed. Etiology, age, gender, BMI, MELD, and co-morbidities were analyzed. Noncirrhotic etiologies were most metabolic diseases, benign tumors, and biliary atresias. Outcomes were rejection, graft failure, and death. Fulminant liver failure, prior and multi-organ transplantations, and split-liver grafts were excluded. Analysis utilized Fisher's exact test, multivariate analysis, and log rank test.

Results: 48,440 cirrhotics were identified and 3,154 noncirrhotics. Groups differed significantly: cirrhotics were older(53 vs. 24, $p<0.001$), more overweight(28.7 vs. 22.9, $p<0.001$), had higher MELD(20.6 vs. 14.7, $p<0.001$), diabetes rates(23% vs. 8%, $p<0.001$), and hypertension rates(18% vs. 10%, $p<0.001$). Cirrhotics rejected less at 6 (12% vs. 21%, $p<0.001$) and 12 months(14% vs. 25%, $p<0.001$). Graft survival was clinically similar(12% vs. 11%, $p=0.07$) but survival curves differed by log rank test($p=0.01$). Mortality was increased in the cirrhotic group(24% vs. 13%, $p<0.001$) and significant by log rank test($p<0.001$). On multivariate analysis, cirrhosis remained a significant contributor to mortality($p<0.001$).

Conclusion: Cirrhotics are older, more comorbid, and have higher mortality; even when adjusted for age and disease, cirrhosis remains an independent risk factor for mortality. Further study should establish whether earlier transplantation in cirrhotics mitigates differences in mortality.

Poster #13. **EXPERIENCE WITH A SIMPLIFIED FEEDING JEJUNOSTOMY TECHNIQUE FOR ENTERAL NUTRITION FOLLOWING MAJOR VISCERAL PROCEDURES**

Schwarz RE
Indiana University Health Goshen

Objective: Postoperative benefits of feeding tubes must be weighed against the morbidity related to placement and use. A simplified technique of jejunostomy tube placement was evaluated for outcomes.

Methods: A 16 Fr. rubber tube was placed through the left abdominal wall, secured with a 3-0 seromuscular triangular pursestring at the jejunal entry site without Witzel tunnel, followed by a continuous 3-0 PDS placed circumferentially and alternating between jejunal wall and parietal peritoneum. Prospectively collected data were retrospectively reviewed.

Results: The technique was performed in 343 of 803 major hepatopancreatobiliary and upper GI resections (43%). Of these patients (male=53%, median age: 66.8 years, range 24-98), 88% had a cancer diagnosis. The procedures included pancreatectomy (n=190, 55%), gastrectomy (n=109, 32%), esophagectomy (n=19, 6%) and others (n=25, 7%). The operative intent was curative in 78%, palliative in 10%, or combined in 12% of patients. The postoperative morbidity rate was 40%, with 16 lethal events (4.7%), and a median length of stay of 10 days (4-111). Tube feeds were administered in 123 patients (36%), and in 14% continued at time of discharge. Use of the feeding tube was linked to diagnosis (p=0.008), procedure (p=0.01), complications (p=0.04) and gender (p=0.05). Tube-related events in 34 patients (10%) included occlusion (n=14), drainage around the tube (n=13), pain (n=3), and accidental removal (n=4) but no intraabdominal leaks, infections, or obstructions.

Conclusion: The technique described is safe and expedient, and the overall tube-related morbidity is low. This procedure is recommended in cases at risk for major morbidity and nutrition support needs.

Poster #14. **TOTAL THYROIDECTOMY IN THE MANAGEMENT OF NON-TOXIC GOITER IN AUSTERE CONDITIONS. IS THIS THE PROCEDURE O CHOICE?**

Roose B, Kelly S, Saxe J
Wayne State University

Objective: Increasingly American surgeons are lending their expertise in areas of the world, which are chronically underserved. These austere environments do not include the ancillary services most surgeons expect. Due to the lack of immediate pathology and complex laboratory support total thyroidectomy was determined to be the procedure of choice for thyroid surgery at a single mission hospital. The purpose of this study is to review this protocol and determine if this procedure was the best choice under austere conditions.

Methods: An IRB approved retrospective review was performed of all thyroid procedures performed at a single mission hospital over a two year period. Data elements obtained included; Age, Sex, Pre-op exam, Pre-op US, Pre-op Thyroid function studies, FNA results, Pre-op diagnosis, Total Time of Symptoms, Operative findings, Pathology, size of specimen and Follow-up/complications.

Results: Forty-four patient charts were available for review. The average age was 30.7 y/o, with 80% of the patient being female. Only one of the patients had pre-operative respiratory symptoms. The average size of the glands removed was 135 gms.. Thyroid cancer was found is 20% of the specimens.

Conclusion: The high percentage of occult tumor (20%) in this group justifies the protocol. This review would support the contention that total thyroidectomy should be the procedure of choice in hospitals located in austere environments

Poster #15. **THE PHYSIOLOGIC RESPONSE TO HIPEC: SIFTING THROUGH PERTURBATION TO IDENTIFY MARKERS OF COMPLICATIONS**

Placket TP, Ton-That HH, Mosier MJ, Abood GJ, Kuo PC, Pappas SG
Loyola University Medical Center

Objective: To characterize the post-operative physiologic response to hyperthermic intraperitoneal chemotherapy (HIPEC) and its relationship to major complications.

Methods: All patients undergoing HIPEC from 4/2013 through 2/2015 were retrospectively identified (n=29). The medical record was reviewed for patient demographics, cancer characteristics, vital signs, laboratory results, and major complications (leak, dehiscence, or infection).

Results: Temperature rose from 36.6 4 0.3 °C pre-operatively to 37.1 4 0.6 °C on POD 1, and remained elevated through POD5. Heart rate rose from 77.3 4 15.3 bpm pre-operatively to 102.7 4 19.9 bpm on POD1, then slowly decreased. Mean arterial pressure dropped from 93.3 4 11.5 mmHg to 72.9 4 5.9 mmHg on POD1 and returned to baseline by POD 4. Hemoglobin decreased from 12.1 4 1.6 g/dL pre-operatively and to 8.2 4 0.8 g/dL by POD3, where it plateaued. Serum bicarbonate decreased from 26.5 4 2.2 mEq/L to 21.7 4 2.2 mEq/L immediately post-operative, then peaked at 27.1 4 2.5 mEq/L on POD4. Serum creatinine rose from 0.78 4 0.24 mg/dL to 0.89 4 0.29 mg/dL by POD1 and returned to baseline by POD3. The strongest predictor of major complications was the temperature on POD2 (AUC 0.737) with a temperature ≥37.3 °C having a sensitivity of 0.818 and specificity of 0.722. Lesser predictors were a serum creatinine that has not returned to below baseline by POD2 or serum bicarbonate ≤21 mEq/L immediately post-operative.

Conclusion: HIPEC results in a hypermetabolic response that generally returns to baseline around POD3. Elevated temperature on POD2 was the best predictors of major complications.

Poster #16. **16. PRIMING MODALITY AFFECTS KNOWLEDGE RETENTION IN SURGICAL TRAINEES: A RANDOMIZED PILOT STUDY**

T.K. Pandian MD MPH, Johnathon M. Aho MD,
Michael L. Kendrick MD, David R. Farley MD
Mayo Clinic - Rochester

Objective: This pilot study sought to compare the effects of physical (PR) and cognitive rehearsal (CR) on knowledge retention in surgical training.

Methods: Surgical interns (n=10) devoted two days, 1-week apart, to attend a supervised, operative workshop. Prior to each session, trainees were randomized to a CR (n=5) or PR (n=5) activity. The CR group viewed a video walkthrough of a small-bowel resection with a hand-sewn anastomosis (HSSBA). The PR group performed HSSBA on a felt, small-bowel model. The subsequent workshop (using an anesthetized pig) consisted of four open procedures including HSSBA. At 1- and 12- weeks post-workshop, residents took a 31-question assessment of anatomical and technical knowledge based on the procedures performed.

Results: All interns had similar clinical and operative exposure prior to this workshop. At 1-week post-workshop, mean CR test scores were higher than PR (CR= 24.7 4 1.6 vs. PR= 21.8 4 1.7; p=0.02). After 12 weeks, mean test scores were similar for both groups (CR= 23.3 4 2 vs. PR= 21.7 4 1.8; p=0.7). Knowledge decay over the study period was similar between groups (CR= -1.4 4 1.6 vs. PR= -0.1 4 2.4; p=0.4).

Conclusion: Our pilot data involving acquired technical knowledge suggests that while cognitive rehearsal may be of early benefit to surgical learners, neither modality is more advantageous for improving retention. Further study will be needed to build upon these pilot efforts.

Poster #17. **EVALUATION OF BARRETT'S DISEASE POST GASTRIC BYPASS**
Gentile N, Brown C, Linn J, Yen E, Lapin B, Goldstein J, Denham EW, Ujiki M
NorthShore University HealthSystem

Objective: Evaluate if disease regression occurs in patients with known BE (Barrett's esophagus) who undergo gastric bypass and determine if age, gender, body mass index (BMI), smoking and alcohol history are predictors.

Methods: Retrospective review of adult NorthShore University HealthSystem patients with BE from January 2000 to November 2010 queried by a single investigator using ICD 9 code 530.85.

Index esophagogastroduodenoscopy (EGD) with pathological documentation of BE and follow up EGD post gastric bypass was required. Endoscopy reports were reviewed for short segment (<3 cm), long segment (≥3 cm), or disease regression, defined as complete lack of specialized intestinal metaplasia following index EGD. Data were analyzed using SAS version 9.3.

Results: Of the 1831 patients with BE, 10 gastric bypass patients had an index EGD with post-operative EGD and Barrett's biopsies. The median age of BE diagnosis was 49.5 years (range 33-71) with 50% females. Initial BMI was 45.5 4 8.2, at 6 months 34.4 4 5.2, at 1 year 31.8 4 3.8. Long segment disease was found in 20% at time of index EGD. Progression from short segment to long segment BE was found in 10%. Overall 50% had disease regression with mean time from gastric bypass to follow-up endoscopy of 1508 days. No patients progressed to dysplasia at last EGD. Neither smoking nor alcohol were predictors of regression.

Conclusion: Regression was seen in 50 % of patients with pre-existing BE who underwent gastric bypass. Lower BMI both pre and post bariatric surgery were associated with regression of BE.

Poster #18. **THE NATURAL HISTORY OF PATIENTS WITH HYPERKINETIC GALLBLADDERS**

Afaneh A, Zhubi Y, Kalabat J, Hawasli A
St. John Hospital & Medical Center

Objective: The purpose of this study was to investigate the natural history of patients with hyperkinetic gallbladders defined as ejection fractions (EF) > 80% on HIDA scan.

Methods: The charts of 286 patients with biliary pain and a HIDA scan with EF>80% were reviewed over 12.3 years. Patients were interviewed by phone with a scripted survey. Patient characteristics, presenting symptoms, present and past pain levels, and surgery date and satisfaction, if conducted, were recorded.

Results: A total of 67 patients with a mean EF of 88.645 were interviewed. Fifty-eight patients did not have surgery (NOP) and 9 had surgery (OP). In the NOP cohort the past (at presentation) and present (at interview) pain scores were 7.141.9 vs. 4.143.2 ($p<0.0005$). In the OP cohort the past and present pain scores were 7.141.8 vs. 2.042.6 ($p=0.001$). Four operated patients also had gallstones. We were unable to find a significant difference in the drop of pain score between those who had surgery and those who did not ($p=0.067$).

Conclusion: Pain symptoms resolved in both groups (NOP vs. OP). The surgical group had a greater decrease in pain scores. The small number of OP patients, subjectivity of pain scores and recall bias limit our study. The presence of stones in the surgical group may also raise the possibility of under diagnosis of hyperkinetic gallbladders. Hyperkinetic gallbladder dysfunction requires further analysis to understand its optimal treatment.

Poster #19. **ROBOT-ASSISTED MEDIAN ARCUATE LIGAMENT RELEASE: A CASE SERIES**

Kern BK, Wright GP, Wolf AM
Grand Rapids Medical Education Partners/Michigan State University

Objective: To examine our initial experience with robot-assisted median arcuate ligament release and to describe our outcomes in one of the larger case series available

Methods: A retrospective review of patients diagnosed with MALS admitted between July 1, 2012 to January 1, 2015 who underwent release of the median arcuate ligament by robot-assisted technique by a single surgeon (AW). Data collection included all aspects of diagnosis, work-up, operative time and technique, hospital course and follow-up. The primary outcome measure was the resolution of abdominal pain. Secondary outcome measures include cessation of narcotics, length of stay, readmission, and associated morbidity.

Results: Of the 8 patients identified (4 males, 4 females), the median age was 52.5 years (range 20-68). Median BMI was 29.6 (range 22.4 – 35). The mean operative time was 100 min (SD 4 35.8), however two patients had concordant hiatal hernia repairs. Mean operative time adjusted for the hiatal hernia repairs was 84 min (SD 4 21.2). 5/8 patients were outpatient procedures. Five patients (62.5%) had pain resolution at follow-up. Morbidities were identified in 2/8 (25%). These included one patient with a superficial venous thrombosis and one with intra-operative bleeding secondary to a splenic capsular tear while repairing a co-existing hiatal hernia.

Conclusion: This is the largest case series of patients with MALS treated by robot-assisted release. This modality provides symptom relief and has a morbidity rate comparative to previous studies with shorter operative duration and hospital stay. Robot-assisted median arcuate ligament release is a viable option for patients suffering from MALS.

Poster #20. **DO GALLSTONES FOUND BEFORE SLEEVE GASTRECTOMY BEHAVE THE SAME AS THOSE FORMED AFTER WEIGHT LOSS SURGERY?**

Conley A, Tarboush M, Manatsathit W, Meguid A, Szpunar S, Hawasli A
St. John Hospital & Medical Center

Objective: Prophylactic cholecystectomy at time of bariatric procedure is not uncommon for patients with asymptomatic cholelithiases. We believe that pre-operative gallstones behave differently than those formed after weight loss after Sleeve Gastrectomy (SG); hence, prophylactic cholecystectomy for asymptomatic cholelithiases may not be warranted.

Methods: Patients undergoing SG from January 2011 - May 2012 were evaluated. We excluded patients with a history of previous cholecystectomy and those without preoperative or post-operative imaging. Institutional review board approval was obtained.
Patients with pre-operative gallstones or those who developed post-operative gallstones were evaluated for development of symptoms.

Results: Thirty-seven patients were evaluated and divided into two groups. Group-1 (n=18) were patients who had asymptomatic pre-op gallstones. Group-2 (n=29) were patients who developed gallstones after weight loss. Both groups' demographics were similar. The percent of females was 72.2% in group-1 and 72.4% in group-2. Symptomatic gallstones occurred in one (5.6%) patient in group-1 and 9 (31.0%) patients in group-2 (p=0.19). Percent weight loss (%WL) was 26.8%+9.2% and 32.6%+6.4% (p= 0.02) in group-1 and group-2 respectively. The mean follow-up period was 8.9+6.2 and 14.7+3.9 months for groups-1 and 2 respectively (p=0.005). Regression analysis of initial weight and length of follow up on weight loss showed no statistical significant difference by group (b=8.7, p=0.273)

Conclusion: Asymptomatic gallstones before SG tended to have a lower risk of becoming symptomatic than those formed after weight loss. There was no statistically significant difference between the two groups due to the small sample. Our data, however, suggests that prophylactic cholecystectomy may need to be re-evaluated.

Poster #21. **SCRUB NURSE EXPERIENCE REDUCES TOTAL OPERATING ROOM TIME FOR PARATHYROIDECTOMY**

Balentine C, Sanghvi M, Patel R, Madkhali T, Chen H, Sippel RS, Schneider DF
University of Wisconsin - Madison

Objective: Working with more experienced scrub nurses can reduce operative time during complex inpatient surgery, but no studies have evaluated whether there is a benefit for outpatient surgery. The goal of this study is to see if scrub nurses experience influences operative time for parathyroidectomy.

Methods: We used a prospective database to analyze patients having unilateral parathyroidectomy from 2010 to 2014. We excluded bilateral explorations, previous neck operation, and concurrent thyroidectomy. Details of the surgery were abstracted from electronic medical records. Scrub nurse experience was analyzed as both a continuous and categorical variable. Multivariable linear regression was used to determine the effect of scrub nurse experience on operative time.

Results: We evaluated operative time (incision to closure) and total operating room time for 484 parathyroidectomies. Unadjusted median operative time for nurses who assisted with ≥20 cases was 47.5 minutes versus 50 minutes for nurses with <20 cases ($p<0.05$). After adjusting for surgeon effects, nurse experience did not significantly reduce operative time. For total operating room time, cases where nurses had assisted with ≥20 cases finished an average of 5 minutes faster than cases with less experienced nurses. After adjusting for surgeon effects and other confounders, this difference remained significant ($p<0.01$).

Conclusion: Although scrub nurse experience did not influence the duration of surgery, total operating room time was reduced when working with more experienced nurses. Future studies should investigate the mechanism behind this observed difference.

Poster #22. **ANXIOUS ABOUT SURGICAL RESIDENCY PERFORMANCE? ARE YOU AND YOUR HANDS READY?**

Buckarma EH , Gas B, Yu D, Abdelrahman A, Lowndes B, Abdelsattar JM, Hallbeck D, Farley D
Mayo Clinic - Rochester

Objective: We sought to demonstrate that a performance anxiety questionnaire could show relationship between anxiety scores and performance on FLS peg transfer between surgical resident trainees. Further studies are needed to see if anxiety scores can predict technical skill performance.

Methods: Seventeen residents were asked to perform the FLS peg transfer. Pegs out of the field of vision are recorded in addition to total time with penalties of 15 seconds for each peg dropped. Residents completed a validated sports anxiety survey that was adapted to surgical tasks. On a 4-point scale (1= not at all, 2= sometimes, 3= often, 4= very often) residents rated the frequency with which they experienced the 15 anxiety related symptoms. These were categorized into 20 point somatic, worry and concentration scores. A univariate general linear model was conducted on SPSS (v22) to investigate the relationship between FLS times and the factors: resident experience, gender, and the 20-point anxiety categories (worry, somatic, and concentration).

Results: Overall anxiety was not associated with performance time. Analysis of the anxiety categories found: positive association between worry scores and longer performance times ($F(1,9)=5.6$, $p<0.05$) and significant associations between concentration scores and faster performance times ($F(1.9)=6.9$, $p<0.05$).

Conclusion: Our preliminary data illustrates higher anxiety measures in worry items correlated with faster performance in the FLS peg transfer while higher concentration anxiety improved performance with surgical interns at our institution.

Poster #23. **METACHRONOUS TWO STAGE ESOPHAGECTOMY IN THE ERA OF MINIMALLY INVASIVE SURGERY**

Demos DS, Hawasli A, Camero L
St John Hospital and Medical Center

Objective: Esophagectomy is a high-risk lengthy operation. The combination of the long operative time and the thoracotomy adds to its pulmonary complication and requirement for post-operative ventilation. We decided to separate the two stages with 2 days interval

Methods: Between September 2010 and January 2014, twelve patients with esophageal cancer underwent laparoscopic mobilization of the stomach with pyloromyotomy and feeding jejunostomy followed by open thoracotomy Esophagectomy within two days.

Results: Eleven males and two females, mean age 61 + 11.21 years were evaluated. The mean operative time for stage one and stage two were 114 + 11.09 and 189 + 39.63 minutes respectively. All patients were extubated post-operatively. An Epidural catheter was placed in 10 of 12 patients. The mean length of stay (LOS) in the Intensive Care Unit was 1.25 + 0.96 days. The mean hospital LOS was 11 + 3.26 days. One patient had leak from pulled feeding jejunostomy and developed peritonitis requiring reoperation 10 days after Esophagectomy. He had sepsis and required transfer to outside facility for ECMO treatment. One patient had prolonged gastroparesis. There were no anastomotic or gastric leaks.

Conclusion: Breaking a lengthy operation into two reasonable ones decreased the risk for prolonged post-operative respiratory complication. The laparoscopic mobilization of the stomach allows the stomach time to redistribute its blood flow hence decreasing possible ischemia and leak with faster use of the gut leading to decrease LOS.The metachronous two-stage Esophagectomy should be considered as a method to decreasing the risk of the traditional synchronous two-stages.

Poster #24. **LEVAMISOLE INDUCED NECROSIS SYNDROME: PRESENTATION AND MANAGEMENT**

Alex GC, Yon JR, Messer TA, Poulakidas S, Luu M, Bokhari F
Cook County Trauma & Burn Unit

Objective: Levamisole is an anti-helminthic drug with immunomodulatory properties. Recent estimates suggest that over 70% of the cocaine in the United States is adulterated with levamisole. Levamisole induced necrosis syndrome (LINES) is characterized by vasculitis, neutropenia, and purpura that progresses to skin necrosis. Diagnosis relies on physical exam findings and history of previous cocaine use. The purpose of this series is to describe the pathophysiology, diagnosis, and management of LINES.

Methods: Medical records for patients with suspected LINES at the Cook County Burn Unit were reviewed. Hospital course, wound management, and outcome were evaluated retrospectively.

Results: Three patients presented to the ED with levamisole induced vasculitis after cocaine ingestion. All three presented with necrotic skin lesions. One patient was managed with supportive care only. The second patient was managed with excision and split thickness skin graft. The third patient was managed with debridement, amputation, and grafting. Two of three had multiple admissions for LINES due to ongoing cocaine abuse.

Conclusion: Approximately 2.1 million people use cocaine monthly in the United States. The rapidly increasing presence of levamisole in the nation's illicit drug supply represents a growing public health problem. LINES is resistant to steroid treatment and is initially managed conservatively. Operative intervention should occur for wound sepsis or full thickness necrosis. Outcomes can be good for LINES patients, but are directly related to the areas involved and degree of necrosis. Diagnosis of LINES requires a high index of suspicion and this syndrome should be discussed with all patients who abuse cocaine.

Poster #26. **DEVELOPING AN IORT PROGRAM FOR BREAST CANCER IN A UNIVERSITY SETTING**

Kopkash KA, Rao RD, Griem KL, Madrigrano A
Rush University Medical Center

Objective: Detail the creation of an Intra-Operative Radiation Therapy (IORT) Program for breast cancer at a tertiary care academic institution

Methods: IRB-approved retrospective chart review

Results: 20 patients were treated with IORT for breast cancer in a 9 month period. These patients fell into two categories; those who were suitable according to the American Society of Radiation Oncology criteria and those who IORT was considered a "salvage therapy" as they had very limited adjuvant treatment options. Patients were either seen in the Comprehensive Breast Clinic by surgical oncology, radiation oncology, and medical oncology prior to treatment or their case was presented at the Multi-Disciplinary Breast Conference for input from all specialties. Mean patient age was 69 years old and mean tumor size was 11 mm. All 20 patients had mammograms prior to treatment, 18 underwent ultrasound, and 11 patients had MRI. All patients received 20 Gray IORT prescribed to the surface of the balloon; mean duration of radiation delivery was 10 minutes. On final pathology, 19 patients had invasive ductal carcinoma while 1 patient had no residual disease and clear margins were obtained in 19 patients. 19 patients were ER+ and HER2- and the sentinel node was negative in 18/18 cases. Post-operatively, 4 patients had a seroma, 4 patients were treated for cellulitis, and the patient with positive margins pursued mastectomy. At 6 month follow-up, there have been no in-breast, regional or distant failures.

Conclusion: Breast Cancer IORT programs are most successful when they focus on careful patient selection and a multi-disciplinary treatment approach.

Poster #28. **DO IT YOURSELF! PERFORM TEP INGUINAL HERNIA REPAIR AT HOME.**

El Khatib MM, Buckarma EH, Farley DR
Mayo Clinic - Rochester

Objective: Despite the popularity that totally extra-peritoneal inguinal hernioplasty (TEP-IH) has gained in the last two decades, teaching and mastering this procedure has always been a challenge. The purpose of this study is to create a low-cost TEP-IH simulator with high functional task alignment to provide a tool for deliberate practice on different steps of the procedure for interested trainees.

Methods: Our 3D TEP-IH simulator was created using layered Saran wrap and packing-tape that was molded around a volunteer's pelvis. Colored felt was used simulate abdominal wall layers. Pieces of yarn and silastic tubing were used as vessels, nerves and the vas deferens. Sponge, foam and a cheap Halloween plastic skeleton were utilized as well. To examine its content validity, a five-point Likert scale questionnaire consisting of 10 questions was created. Two experienced surgeons filled out the questionnaire after examining the simulator.

Results: The simulator took approximately 4 hours to build with materials costing $9.76. Our simulator mean total score on the experienced surgeon questionnaires was 33.5 4 3.5 (Mean 4 SEM) favoring our model (Top score = 40). They strongly agreed upon the value, learning benefit (anatomy and technique), dimension reality and engagement ability of our reusable model.

Conclusion: We report an affordable model for TEP-IH practice that can be easily replicated by trainees. Feedback suggests that providing the necessary repetition to master key technical aspects of the procedure is possible with $9.76 model.

Poster #29. **RUPTURED ADRENAL ANGIOMYELOLIPOMA: PRESENTATION, TREATMENT, AND LITERATURE REVIEW**

Nally MC, Suman P, Abadin S
Rush University Medical Center

Objective: Describe presentation and treatment of rare adrenal angiomyelolipoma and review limited published accounts of previously reported cases.

Methods: Extensive literature review revealed a few hundred cases of reported adrenal angiomyelolipomas. Initially, PubMed search engine was utilized looking for articles containing "angiomyelolipoma." Two articles were discovered describing case reports. Additional articles were located through related citations.

Results: From 1975 to present, 101 articles reported cases of pathology confirmed angiomyelolipoma. Most discussed single cases, although there were case series with up to 7 cases from single institutions. According to the reviewed literature, angiomyelolipomas are rare tumors found in various locations, including the adrenal gland, composed of mature adipocytes and normal hematopoietic tissue. Most are small and asymptomatic, incidentally found during imaging or autopsy. Pathogenesis is unknown, but theories include capillary reticuloendothelial cell metaplasia, bone marrow embolism, etramedullary hematopoiesis, or adenoma degeneration. Most are nonfunctional and they have no proven malignancy potential, although hemorrhage is described. We present a 63yo with acute onset of left flank pain and hypotension. Computerized tomography revealed a large left sided retroperitoneal hematoma and ruptured adrenal mass with calcifications. Once stabilized, the patient underwent open resection for risk of adrenocortical carcinoma. The left adrenal gland was resected in its entirety and the retroperitoneal hematoma was evacuated. Pathology demonstrated angiomyelolipoma arising from the adrenal gland.

Conclusion: This case describes an adrenal tumor that is rarely encountered and seldom documented in the literature. Primary treatment includes adrenalectomy for tumors that are large, have mass effect, or have radiographic characteristics concerning for malignancy.

Poster #30. 30. **FIELD AMPUTATION OF LEFT UPPER EXTREMITY USED IN COMPLEX EXTRICATION**

Antpack EA, Schiller HJ, Zietlow SP, Jenkins D
Mayo Clinic - Rochester

Forty-year-old female had left upper extremity mangled in auger at work. Difficult extrication required a proximal transhumeral amputation after administration of fentanyl and ketamine. Combat tourniquet and combat gauze were applied for hemostasis, and patient was flown to Mayo Clinic in Rochester, MN by helicopter. Three units of plasma and packed red blood cells were given during transport. Additional injuries included left 5-9 rib fractures. After primary and secondary surveys in ED she underwent brachial artery and vein ligation in the OR. After multiple debridements, Plastic Surgery performed a free TRAM flap for coverage of wound.

Poster #31. **SMALL BOWEL ADENOCARCINOMA AND A HISTORY OF CONGENITAL MALROTATION: A CASE REPORT**

Wood K, Natwick R, Holman K
Spectrum Health Medical Group

Patient Description: 62 year old male with a history of congenital malrotation status post repair in infancy. Two months prior to admission following a screening colonoscopy, developed abdominal pain, which progressed. Upon admission: imaging showed narrowing in the proximal small bowel. Labs: INR 3.4, normal CMP/CBC. Albumin 3.1. No history of anticoagulation.

Intervention: Exploratory-laparotomy revealed diffuse carcinomatosis. Pathology: adenocarcinoma. Patient elected hospice.

Discussion: Case demonstrates a delayed diagnosis in a patient with minimal risk factors which combined with history of malrotation and a coagulopathy without etiology, creates a unique clinical case that warrants further investigation.

Poster #32. **CHOLECYSTOCHOLEDOCHAL FISTULA: CASE REPORT AND REVIEW OF THE LITERATURE ON MANAGEMENT OF TYPE III MIRIZZI SYNDROME**

Chadwick CL, Ongstad TL
Spectrum Health Medical Group

This is a case presentation of a patient with Type III Mirizzi syndrome. The patient's hospitalization and outpatient management are reviewed in the electronic medical record and discussed with the attending surgeon. Mirizzi Syndrome (MS) and internal biliary fistulas are researched in PubMed to review management of this rare condition. The patient's fistula was discovered intraoperatively after incision of the gallbladder and removal of the stone revealed a preoperatively placed stent in the common duct. A drain was left in the gallbladder, the stent was left in place, and the patient has had no further recurrence of biliary disease.

Poster #33. **WHY ER ADMISSION CHARGES SHOULD INCLUDE CHARGES FOR LIPOSITY AND STEROIDS**

Thomae K
Thomae Surgical

Objective: Spectacular General Surgery ER Admission with discussion of Two Major Morbidities: Obesity & Steroids

Methods: Case report of a spectacular surgical ER admission, operation, and hospital course which includes the pertinent discussion on co-morbidities surgeons deal with and are usually not reimbursed for: obesity & steroid use

Results: Case report of a successful surgical treatment of a complex, spectacular problem due to liposity and steroids.

Conclusion: In a era when general surgery has lost respect, credentials, reimbursement, business viability, and "general" trust, we the general surgeons are STILL the backbone core answer of the spectacular ER surgical patient problems.

Spectacular Problems in Surgery

1. OVERWHELMING POST-SPLENECTOMY INFECTION LEADING TO DISSEMINATED STREPTOCOCCAL SEPSIS

Yon JR, Messer TA, Poulakidas S, Gupta SK, Bokhari F
Cook County Trauma & Burn Unit

A 50 year-old patient presented with high fevers and signs of sepsis. He had a remote history of splenectomy after abdominal gunshot wound 15 years previously. His initial hospital course was one of fulminate sepsis requiring intubation and vasopressor therapy leading to multiple organ system failure. Cultures grew Streptococcus pneumoniae and Klebsiella pneumoniae. On hospital day three, patient had hemorrhagic and non-hemorrhagic bullae form on his extremities, trunk, abdomen, face, and mouth, affecting 40% of his total body surface area. The patient required multiple debridements, skin grafting, and bilateral above knee amputations, but eventually recovered over a prolonged hospital course.

2. AN UNUSUAL CASE OF POSTOPERATIVE RESPIRATORY DISTRESS

Wright GP, Zadvinskis I
Grand Rapids Medical Educational Partners/Michigan State University

A 76 year-old female underwent an elective gynecologic procedure. On the first postoperative night she experienced mental status changes and hypoxemia that did not improve with naloxone. PCO2 was 83. CT angiogram of the chest demonstrated significant interval enlargement of a substernal goiter causing near complete obstruction of the trachea. General and cardiothoracic surgery consultants recommended operative intervention. A collar incision was performed but there was no thyroid tissue in the neck. A median sternotomy was required to perform total thyroidectomy. Pathology noted nodular hyperplasia of a 460 g gland. The patient's PCO2 normalized and she was extubated.

3. THIS DIAGNOSIS IS NOTHING TO SNEEZE AT!

Finnesgard E, Pandian T, Farley DR
Mayo Clinic – Rochester

A 26-year old male with dialysis-dependent renal disease presented with bilateral shoulder masses (size of grapefruits) and a fractured sternum after sneezing. Labs demonstrated an abnormally high PTH of 590pg/mL [normal: 15-65pg/mL], phosphorous of 7.2mg/dL [2.5-4.5mg/dL], and calcium of 11.3mg/dL [8.9-10.1mg/dL]. He underwent cervical exploration for presumed secondary hyperparathyroidism. Three large glands were removed, the PTH and calcium normalized, and the masses decreased in size. The shoulder masses enlarged the following year and multiple orthopedic bony excisions were performed. Pathology revealed tumoral calcinosis; a poorly-understood disorder of inappropriate phosphate metabolism resulting in calcium deposition.

4. PARASTOMAL HERNIA SECONDARY TO ASCITES DUE TO CONGESTIVE HEART FAILURE

Aaland MO
University of North Dakota

84 year old active female with ischemic cardiomyopathy with poorly controlled ascites presented with a parastomal hernia. The hernia was so large, her arms were not long enough to change the ostomy bag.

5. INGUINAL HERNIATION OF THE TRANSPLANTED URETER RESULTING IN HYDROURETERONEPHROSIS

Butt FK, Van Dorp DR, Hawasli A, Schervish E, Granger DK
St. John Hospital and Medical Center

We report the case of a 67-year-old male who presented with right groin pain 12 years after receiving a deceased donor kidney transplant for polycystic kidney disease. Imaging identified enlargement of the right native kidney with significant compression and hydroureteronephrosis of the transplanted kidney, as well as herniation of the transplant ureter through the inguinal canal. The problem was approached in a staged fashion with initial placement of a ureteral stent, followed by native nephrectomy. Later, reduction of the herniated ureter and preperitoneal repair of the right inguinal hernia with mesh resulted in resolution of hydroureteronephrosis and the abdominal pain.

6. DELAYED EXTRAVASCULAR STRUT MIGRATION OF A GREENFIELD FILTER IN A YOUNG MALE

Kreimier EL, Aziz A, Kaoutzanis C, Cox CE, DeBenedet AT, Anderson HL III
St. Joseph Mercy Hospital Ann Arbor

We present a 34-year-old male involved in a motor vehicle collision in 1999, resulting in multiple injuries and subsequent deep vein thrombosis. A Greenfield filter was placed given significant injury and contraindication to anticoagulation. He was recently involved in another motor vehicle collision. Imaging revealed extrusion of the filter struts through the vein wall, with one anterior strut appearing to perforate the duodenum. Push enteroscopy demonstrated no encroachment to the duodenum lumen. Treatment considerations for this asymptomatic patient included laparotomy and filter removal, surgical trimming of the offending struts, or observation. A treatment plan of observation was chosen.

7. UNUSUAL CASE OF MASSIVE MEGACOLON IN A YOUNG FEMALE

Schneider A, Ekeh AP
Wright State University School of Medicine

19-year-old female with history of constipation since birth - occasionally going for weeks without a bowel movement. No prior operations. Presented acutely with abdominal pain and distension. CT imaging demonstrated a markedly enlarged colon -19cm in diameter at the sigmoid colon. She worsened over the next 2 days and thus taken to the OR for exploration. A massive megacolon was encountered involving the entire large intestine – distal colon 30cm in diameter. A subtotal colectomy and ileostomy was performed. Ganglion cells and muscular hypertrophy seen on histopathology, no obstruction seen. She recovered and was discharged uneventfully with ileostomy functioning normally.

8. ANNULAR PANCREAS: A CONGENITAL ANOMALY FOR THE ADULT SURGEON

Visioni A, Hardacre J
University Hospitals Case Medical Center

Annular pancreas is a rare congenital anatomic anomaly in which the pancreas encircles the duodenum and can result in obstruction. It often presents in neonates as feeding intolerance. However, many patients will not experience symptoms until adulthood. Adult surgeons should be familiar with this condition since it can have a more subtle presentation than seen in children. Here we present two patients with annular pancreas. The first is a 51 year-old man and the second is a 35 year-old woman. Both patients had a chief complaint of abdominal pain and weight loss and were treated effectively with a duodenoduodenostomy.

LECTURES

Scott Warner Woods, 1927–2003

When attending a Midwest Surgical Association meeting, it takes little effort to almost believe that the haunting notes of a bagpipe still echo in the air. For many years, that sound accompanied the sight of a kilt-clad Scott Warner Woods as he stood wearing his trademark hand-tied tartan bow tie and played to announce the beginning of another annual meeting.

Scott W. Woods, except for his brief stint in Korea with the U.S. Army at the end of World War II, was a life-long Michiganian. He was born in Detroit and in 1950 he received his undergraduate degree from the University of Michigan. He then attended Wayne State University College of Medicine and graduated in 1954. After an internship at Wayne County General Hospital, he completed a surgical residency at Wayne State University in 1960. That same year, he achieved his second greatest accomplishment when he established his first solo practice in Ypsilanti, MI. By 1964, he managed to attain his life's greatest accomplishment when he married his beloved Bette.

Second only to his family, Scott loved the Midwest Surgical Association best and served it tirelessly. He was Treasurer of the Association for a decade before ascending to its presidency in 1986. He championed the controversial decision to bring the Annual Meeting to Mackinac Island. Widely questioned at the time due to the island's remoteness and perceived inaccessibility, this location has easily become the best attended and most well-loved site for the annual conference. In 1987, after a long and successful surgical career as a private practitioner and as Clinical Associate Professor of Surgery at Wayne State University, Scott retired from active surgical practice in 1987 due to complications from arthritis. Scott and Bette remained together in Ypsilanti for the rest of his life.

Scott viewed retirement as a chance to cut back to only 50 or 60 hours of work each week. He remained an important part of his community in Ypsilanti, where he served on the city council, the board of the Ypsilanti Savings Bank, the Chamber of Commerce (including a term as president), with the Lions Club and as a trustee of Cleary College. He reviewed disability claims for the state and worked for the Michigan Peer Review Organization. Scott received many honors and awards from the numerous professional organizations that were proud to call him a member. These organizations included the American College of Surgeons, the Academy of Surgery of Detroit and the Detroit Surgical Association. He was awarded an honorary doctorate from Cleary College for his years of service. His highest accolade occurred in 1995 when both Scott and Bette were selected to receive the Distinguished Philanthropist Award from the American College of Surgeons.

Surgeon, teacher, community leader, philanthropist, husband, father and friend—Scott's death left an empty place in the hearts of all who knew him. He gave selflessly during life and will continue to give in death. Gone is the man, but not the memory.

2015 Scott Warner Woods Memorial Lecture

Pelvic Fractures: What are the Orthopods Doing?

Monday, July 27, 2015
9:15am – 9:45am
Introduction: James Tyburski, MD

Featuring

Rahul Vaidya, MD
Detroit Receiving Hospital
Detroit, MI

Rahul Vaidya, MD, FRCSc, is a graduate of McGill University Medical School (1991) and Residency (1996). He did fellowships in Orthopaedic Traumatology and Spinal Surgery and joined the Detroit Medical Center in 2006 after working at Henry Ford Hospital , McGill University and the University of British Columbia. He is a Reservist with the Canadian Military and served two tours of duty in Afghanistan during Operation Enduring Freedom.

His career has involved Orthopaedic surgical education, Clinical Outcomes Research, Biomechanical Research ,the development of new surgical procedures, and helping to resurrect the Orthoapedic Department and Residency at the Detroit Medical Center. He has won awards for his research on rHBMP-2 and its complications associated with Spinal Fusion Surgery and the development of the Pelvic InFix device which was contemplated after a tour in Afghanistan with the Canadian Military. This device has helped to reduce surgical infection in patients who were once treated by external pelvic fixation, improves ambulation and comfort especially in Obese patients and for military transport. His research also focuses on surgical education and recently developed the Bonesetter App used for planning Orthopaedic Surgery. Dr. Vaidya is on the Editorial Board of the European Spine Journal, Journal of Orthoapedic Trauma and reviews for many other prominant Orthopaedic Periodicals. He serves on the Amercian Academy of Orthopaedic Surgeons Central Evaluation Committee which organizes the yearly In Training exam for Residents and the Michigan Orthopaedic Society and was invited to be a Orthopaedic Trauma Surgeon for the 2010 Vancouver Winter Olympic Games for the EVAC / Medical Unit at Whistler British Columbia. Current Interests include 1)a Hospital Implant Donation Program in co-operation with the AO Foundation which has already donated over 1000000 dollars in equipment to Hospitals in Haiti and India 2) Developing cheap and effective implants for the use in Disaster Relief , Third World Hospitals and Damage Control Orthopaedic Surgery.

He has Academic Appointments at Wayne State University and Michigan State University where he is currently Professor of Orthopaedic Surgery, and serves as the Specialist in Chief and Chair of the Orthopaedic Residency Program at the Detroit Medical Center as well as several Hospital and System committees.

William Hunter Harridge, 1919–1971

Bill Harridge was a man of uncommon energy, integrity, and honesty. His personal enthusiasm, as well as his organizational abilities, made him an outstanding leader of men and organizations. This was evident early in his life as he served with distinction as a company commander of an Army tank unit. In 1945, he suffered a severe open-chest wound in France causing his discharge from the Army with the rank of major.

In 1963, after much discussion and thought, a decision was made to disband the Midwest Surgical Society. Fortunately for our present Society, Bill was persuaded to assume the Presidency for the coming year. Under his leadership, the Society was resurrected, its geographical base was expanded, and it has flourished ever since.

With the exception of his father, Will Harridge, Sr., who was the President of the American Baseball League, Bill's relationship with Dr. Warren Cole was the most important in his life. Dr. Cole writes: "Bill had good judgment, sincerity, determination, willingness to discipline himself...he had complete honesty and integrity...compassion, a characteristic so necessary if one is to become a fine physician."

Bill graduated from the University of Illinois College of Medicine in 1950 and served his internship and residency under Dr. Cole from 1950 to 1956. While he entered private practice in Evanston, Illinois, he maintained an active clinical affiliation with the University and was promoted to the rank of Clinical Professor. In May of 1970, he received the Distinguished Service Award in recognition of his contribution to the Department of Surgery.

Bill was a strong advocate of doctors determining their own professional organizations. He was a Diplomat of the American Board of Surgery and belonged to the Warren H. Cole Society (President 1968-69), Midwest Surgical Association (President 1964-65), North Suburban Branch of the Chicago Medical Society (President 1969-70), Chicago Surgical Society (Recorder 1967-70), The Western Surgical Association, The Illinois Surgical Society, The Society for Surgery of the Alimentary Tract, North Shore Chapter American Cancer Society (President 1966-68), The Institute of Medicine of Chicago and the American College of Surgeons. His many contributions to the surgical literature were primarily related to peripheral vascular and biliary tract disease.

Beloved by his patients and respected for his abilities by his surgical colleagues, Bill Harridge is most remembered for his rigid adherence to the principle of fairness, honesty, and forthrightness in all situations.

2015 William Hunter Harridge Memorial Lecture

How Did We Go From Operating on All Injured Kidneys to Operating on None of Them? The 16 Year Saga of Expectant Management of (Even) Severe Renal Trauma

Monday, July 27, 2015
12:15pm – 1:00pm
Introduction: James Tyburski, MD

Featuring

Richard A. Santucci, MD, FACS
The Detroit Medical Center
Detroit, MI

Dr. Santucci is the Director of the Center for Urologic Reconstruction™ and Specialist-in-Chief for Urology at the 9-hospital Detroit Medical Center. He runs the Urology residency training program centered at the Michigan State College of Osteopathic Medicine (MSCOM) and is a full clinical professor.

Dr. Santucci's clinical practice focuses on urologic reconstruction and trauma, including urethral stricture disease, ureteral injury, spinal cord injury and urinary fistula. He has a keen interest in surgical education, and has been active in lecturing and demonstrating surgeries at training centers in the United States, Europe, South America and Africa.

As an author of more than 100 scientific articles, Dr. Santucci has served on the editorial boards of twelve journals. He is the co-editor of the texts *Emergencies in Urology*, the *Atlas of Urethroplasty*, and *Penile Reconstructive Surgery*. He is the founding Editor-in-Chief of the online open-access Urology journal "Advances in Urology", and co-creator of the world's first high definition surgical video website, *iclinics.org*.

Dr. Santucci is a graduate of the AUA Leadership Program Class of 2009, was a member of the AUA Urotrauma Guidelines panel, the AUA Urotrauma Legislation Task force, the WHO International Consultation on Urologic Diseases (ICUD-urethra), and is an advisor to the US Marines Dismounted Blast Injuries Task Force. He is currently the co-Chairman of the AUA Urethroplasty Guidelines panel. Dr. Santucci sat on the Board of Chairman of the Societé Internationale D'Urologie (SIU) and the Executive Committee of the Michigan Urologic Association (MUS) and currently serves as its President.

William Hunter Harridge Lecturers

Jeffrey L. Ponsky, MD	2014
Fred A. Weaver, MD, MMM	2013
Daniel B. Michael, MD, PhD	2012
Leigh Neumayer, MD	2011
Kirby I. Bland, MD	2010
Jay L. Grosfeld, MD	2009
Douglas J. Mathisen, MD	2008
Terry Hicks, MD	2007
George I. Irvin, III, MD	2006
J. David Richardson, MD	2005
Josef E. Fischer, MD	2004
Stephen D. Leach, MD	2003
Charles E. Lucas, MD	2002
J. Wayne Meredith, MD	2001
Michael W. L. Gauderer, MD	2000
Glenn D. Steele, Jr., MD, PhD	1999
Layton F. Rikkers, MD	1998
Gregorio A. Sicard, MD	1997
John P. Delaney, MD, PhD	1996
Keith A. Kelly, MD	1995
Robert E. McAfee, MD	1994
Richard L. Simmons, MD	1993
David S. Mulder, MD	1992
Donald D. Trunkey, MD	1991
Lazer Greenfield, MD	1990
Erwin R. Thal, MD	1989
J. Patrick O'Leary, MD	1988
Robert W. Barnes, MD	1987
Jeremiah G. Turcotte, MD	1986
Steven G. Economou, MD	1985
Jerry M. Shuck, MD	1984
Robert E. Hermann, MD	1983
Ward O. Griffen, MD	1982
Robert Condon, MD	1981
Robert J. Freeark, MD	1980
John Glover, MD	1979
Robert Bartlett, MD	1978
J. Wesley Alexander, MD	1977
Raymond Read, MD	1976
*Hushang Javid, MD	1975
Alexander J. Walt, MD	1974
Warren H. Cole, MD	1973
Lester R. Dragstedt, MD	1972
Allan M. Lansing, MD	1971
Lester R. Dragstedt, MD	1962
Warren H. Cole, MD	1960

**First official Harridge Lecturer*

In Remembrance

Ben L. Bachulis
University Park, FL

Jason H. Bodzin
Southfield, MI

Dolores F. Cikrit
Indianapolis, IN

Robert E. Condon
Clyde Hill, WA

Raymond C. Read
Rockville, MD

Thomas R. Russell
Philo, CA

Edwin R. Thal
Dallas, TX

Notice of Change

Please make the following changes to my listing:

NAME

SPOUSE'S NAME

ADDRESS

ADDRESS

ADDRESS

CITY, STATE, ZIP

PHONE

FAX

E-MAIL

SURGICAL SPECIALTY

YEAR OF INDUCTION INTO MSA MEMBERSHIP

Send to: **Midwest Surgical Association**
14005 Nicklaus Drive
Overland Park, KS 66223

Telephone: 913-402-7102
Fax: 913-273-1140
Email: events@lp-etc.com
Web: www.midwestsurg.org

Notice of Death

NAME

DATE

Send to: **Midwest Surgical Association**
14005 Nicklaus Drive
Overland Park, KS 66223

Telephone: 913-402-7102
Fax: 913-273-1140
Email: events@lp-etc.com
Web: www.midwestsurg.org

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