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SOCIAL EVENTS

Sunday, December 1

1 - 5 p.m.  Men’s Handicap Golf Tournament
            *Old Course*
            Dr. George A. Parker

            Women’s Handicap Golf Tournament
            *Old Course*
            Mrs. Jean Tepas

2 - 4 p.m.  Men and Women’s Skeet Shooting
            *Gun Club*
            Dr. & Mrs. David J. Cole

            Men’s Tennis Tournament
            *Tennis Courts*
            Dr. Walter Lawrence

            Women’s Tennis Tournament
            *Tennis Courts*
            Mrs. Denise Fabian

Monday, December 2

10 a.m. -  Spouses’ Coffee/Tea
12:30 p.m.  Crystal Room

            History Tour
            *Main Lobby*

2 – 4 p.m.  Bridge
            *Tower Suite*

            Segway Tour Trail Ride
            *Allegheny*
Monday, December 2 (continued)
2 – 4 p.m. Group Horseback Trail Rides with Guide
   Front porch of the lobby
   Mrs. Candy Hubbard

5:30 – Welcome Reception for New Members
7 p.m. Grand Ballroom West

Tuesday, December 3
10 - 1130 a.m. Book Club
   Crystal Room
   Mrs. Kim Eberlein, Mrs. Carolynne Flint, Mrs. Jean Tepas

History Tour
   Main Lobby

2 - 4 p.m. Bridge
   Tower Suite

Gourmet Safari
   The Wine Room
   Homestead Executive Chef Mark Gallaudet

6:30 - Presidential Reception
7:30 p.m. Foyer of the Grand Ballroom

7:30 p.m. Association Dinner and Banquet
Grand Ballroom

Wednesday, December 4
Noon President’s Buffet Luncheon
   Crystal Room
   All members and guests are invited.
SCIENTIFIC PROGRAM

Monday, December 2
8:30 a.m.  Morning Session
           Business Meeting
           1.  President
           2.  Secretary
           3.  Chairman, Committee
                on Arrangements
           Presidential Address
           Presentation of Papers 1 – 5

2:00 p.m.  Afternoon Session
           Presentation of Papers 6 – 13

Tuesday, December 3
8:30 a.m.  Morning Session
           Presentation of Papers 14 – 21

2:00 p.m.  Afternoon Session
           Presentation of Papers 22 – 29

Wednesday, December 4
8:30 a.m.  Morning Session
           Presentation of Papers 30 – 36

11:30 a.m. Business Meeting
           1.  President
           2.  Audit Committee
           3.  Shipley Award for 2012

Noon  Meeting Adjournment
Five different methods have been proposed to classify the micrometastatic tumor burden in sentinel lymph nodes (SLN) for melanoma. The purpose of this study was to determine the classification scheme that best predicts non-sentinel node (NSN) metastasis, disease-free survival (DFS), and overall survival (OS).

Methods: A single reviewer re-analyzed tumor-positive SLN from a multicenter, prospective clinical trial of patients with melanoma ≥1.0 mm Breslow thickness who underwent SLN biopsy. The following micrometastatic disease burden measurements were recorded: Starz classification, Dewar criteria (microanatomic location), maximum diameter of the largest focus of metastasis, maximum tumor area, and sum of all diameters. Univariate and multivariate models, as well as Kaplan-Meier (KM) analysis, were used to evaluate each classification system.

Results: We reviewed 204 tumor-positive SLNs from 157 patients. On both univariate and multivariate analyses, all criteria except Starz classification were statistically significant risk factors for NSN metastasis. Using a cut-off of ≥1.0 mm for the maximum diameter classification, the positive and negative predictive values for NSN metastasis were 35.2% and 82.7%, respectively (p=0.023). On multivariate analysis, including Breslow thickness, ulceration, age, gender, and NSN status, maximum diameter (using a cut-off of 3 mm) was the only classification system that was an independent risk factor predicting DFS (p=0.0181) and OS (p<0.0001).
KM analysis, DFS (Figure) and OS (not shown) were significantly different among groups using maximum diameter cut-offs of 1 and 3 mm.

Conclusions: This is the first study to evaluate all proposed classification schemes for SLN micrometastatic tumor burden in melanoma. Maximum tumor diameter outperformed other measurements of nodal micrometastatic tumor burden, including microanatomic tumor location (Dewar criteria), Starz classification, maximum tumor area, and sum of all diameters for prediction of DFS and OS. Maximum tumor diameter is a simple method of assessing micrometastatic tumor burden that should be reported routinely.

Figure: Disease-free survival in patients according to SLN maximum tumor diameter.

The Hiram C. Polk Jr, MD Department of Surgery, Division of Surgical Oncology, University of Louisville, Louisville, KY
2. Long Term Outcomes of Total Pancreatectomy and Intra-Portal-Islet Auto-Transplantation (TP-IAT) for Hereditary/Genetic Pancreatitis

Srinath Chinnakotla*  
David M. Radosevich*  
Melena Bellin*  
Ty Dunn*  
Gregory Beilman*  
Martin Freeman*  
Sarah Jane Schwarzenberg*  
Barbara Bland*  
Selwyn Vickers  
David Sutherland  
Timothy L. Pruett

**Background:** Chronic pancreatitis is a debilitating disease resulting from many etiologies. The subset with genetic defects (HGP) not only has chronic pain, but also an increased risk for pancreatic cancer. TP-IAT outcomes were analyzed for the HGP patients.

**Methods:** Review of a prospectively maintained database of 484 TP-IAT from 1977-2012 at a single-center. Islet cell function was classified as Insulin-independent, partial-islet-cell-function (C-peptide-positive), and Insulin-dependent (C-peptide-negative). Quality of Life (QoL) was measured using the SF-36 in a subset (after 2007)

**Results:** All 68 patients with HGP (PRSS1=39, SPINK1=8, CFTR=15, Familial =6) were narcotic-dependent and failed endoscopic-management or direct-pancreatic-surgery. Post TP-IAT, 98% of the patients were pancreatitis pain-free with sustained-pain-relief; over 65% had partial or full islet function at 3 years (Table 1).—Compared to non-hereditary etiologies, HGP were younger, female, had pancreatitis of longer duration, had a higher-pancreas-fibrosis-score, and trended toward lower Islet yield (Table 1). Using multivariate-logistic-regression, younger-recipients with less fibrotic pancreata were statistically more likely to achieve insulin-independence (p value < 0.001). There was a significant improvement in QoL from baseline, by SF-36, in physical-and mental-component QoL scores (p <0.001). None of the patients in the entire cohort developed pancreatic-cancer in 2,936 person-years of follow-up.

**Conclusions:** TP-IAT provides long-term pain-relief (98%) and preservation of beta-cell-function. Patients with chronic-painful-pancreatitis due to HGP with a high-life-time risk of pancreatic cancer should be considered earlier for TP-IAT before pancreatic inflammation results in higher degree of pancreatic fibrosis and islet cell function loss.

*By Invitation*
## Table 1:

<table>
<thead>
<tr>
<th></th>
<th>Hereditary/Genetic N=68</th>
<th>Non Hereditary n=416</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)*</td>
<td>20.5 ± 1.3</td>
<td>37.4 ± 0.6</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Yrs with Pancreatitis*</td>
<td>8.8 ± 0.9</td>
<td>6.7 ± 0.3</td>
<td>0.017</td>
</tr>
<tr>
<td>Yrs of Narcotic use</td>
<td>2.2 ± 0.4</td>
<td>3.3 ± 0.3</td>
<td>0.027</td>
</tr>
<tr>
<td>Total Islet Equivalents per Kg Body weight *</td>
<td>3567 ± 352</td>
<td>3818 ± 130</td>
<td>0.472</td>
</tr>
<tr>
<td>Pancreas Fibrosis (0 to 10)*</td>
<td>7.1 ± 0.3</td>
<td>4.8 ± 0.1</td>
<td>&lt;0.001</td>
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**Outcomes:**

**Kaplan-Meier Patient survival**

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<tr>
<th></th>
<th>Hereditary/Genetic N=68</th>
<th>Non Hereditary n=416</th>
<th>P Value</th>
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<tbody>
<tr>
<td>1 Year</td>
<td>100%</td>
<td>97%</td>
<td>0.062 / 0.064†</td>
</tr>
<tr>
<td>10 year</td>
<td>97%</td>
<td>83%</td>
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**Pancreatitis Pain**

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<thead>
<tr>
<th></th>
<th>Hereditary/Genetic N=68</th>
<th>Non Hereditary n=416</th>
<th>P Value</th>
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</thead>
<tbody>
<tr>
<td>Pre TP-IAT</td>
<td>100%</td>
<td>100%</td>
<td>0.204</td>
</tr>
<tr>
<td>6 months</td>
<td>4%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>1 year</td>
<td>2%</td>
<td>2%</td>
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**Ever Insulin independent**

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<thead>
<tr>
<th></th>
<th>Hereditary/Genetic N=68</th>
<th>Non Hereditary n=416</th>
<th>P Value</th>
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<tbody>
<tr>
<td></td>
<td>19 (27.9%)</td>
<td>125 (30%)</td>
<td>0.725</td>
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</table>

**Islet cell function %**

(Insulin independent/ partial function/insulin dependent)

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<tr>
<th></th>
<th>Hereditary/Genetic N=68</th>
<th>Non Hereditary n=416</th>
<th>P Value</th>
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</thead>
<tbody>
<tr>
<td>3-months</td>
<td>12.3/77.2/10.5</td>
<td>19.7/60.3/20</td>
<td></td>
</tr>
<tr>
<td>1-year</td>
<td>27.7/51.1/21.3</td>
<td>27.2/47.5/24.8</td>
<td></td>
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<tr>
<td>3-year</td>
<td>37.5/28.1/34.4</td>
<td>31.7/35.4/32.8</td>
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**Prevalence of Narcotic use %**

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<th></th>
<th>Hereditary/Genetic N=68</th>
<th>Non Hereditary n=416</th>
<th>P Value</th>
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<tbody>
<tr>
<td>3-months</td>
<td>48.5 ± 4.6</td>
<td>32 ± 1.8</td>
<td></td>
</tr>
<tr>
<td>1-year</td>
<td>20.0 ± 5.0</td>
<td>23.1 ± 1.9</td>
<td></td>
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<tr>
<td>3 year</td>
<td>2.3 ± 6.2</td>
<td>10.1 ± 2.2</td>
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*Values are mean ± SEM
†Log-Rank/Wilcoxon

*By Invitation
3. Can Laparoscopic Cholecystectomy Be Performed with a Positive Margin at Medicaid Reimbursement Rates?

Richard Frazee*  
Victoria Elliott*  
Wilma Larsen*  
Seth Lerner*  
Keith Minnis*  
Court Huber*  
James Nolan*  
Harry Papaconstantinou*  
W. Roy Smythe

The Affordable Care Act provides health care coverage to an increasing segment of the population at Medicaid reimbursement rates. Health care systems currently offset lower Medicaid reimbursement through higher payers. The ability to “cost shift” will be diminished as the Medicaid population increases.

Methods: A financial cost and revenue analysis of outpatient laparoscopic cholecystectomy at our institution was performed. Cost was defined as actual expense to the health care institution. Fixed and variable costs were identified to calculate a break-even point. Time spent from check-in to dismissal was based upon historic averages. When actual costs could not be pinpointed, estimates from industry experts were utilized. Reimbursement included surgeon and anesthesia professional fees and facility fees.

Results: Five hundred one laparoscopic cholecystectomies were performed at the main operating room facility in 2012. Annual fixed costs were $252,637. Variable costs were $1860/case. Personnel and single use equipment made the largest contribution to variable costs. Reimbursement for professional and facility fees totaled $2444/case. The break-even point occurred at 454 cases. Based upon historical volume, the break-even point for the calendar year would occur on November 27.

Conclusions: Our analysis demonstrates that laparoscopic cholecystectomy can be performed with a positive margin at Medicaid reimbursement rates with sufficient volume. The minimal margin, however, could significantly limit the ability of lower volume hospitals to provide these services and negatively impact access to care in this patient population.

Department of Surgery, Scott & White Healthcare, Temple, TX
4. 100% Departmental Mortality Review Improves Observed to Expected (OE) Mortality Ratios and University Healthcare Consortium (UHC) Rankings

Martin Heslin
Benjamin Taylor*
Mary Hawn
James Davies*
Ryan Heslin*
Andrew Mims*
Jack Morgan*
Luke Rabun*
Andrew Smedley*
Donald Reiff
Gerald McGwin*
Kirby Bland
Loring Rue

Introduction: Public reporting of mortality, patient safety indicators (PSI), and hospital-acquired conditions (HAC) is the latest paradigm of quality measurement. Review of our department’s data identified opportunities for improvement. We began a surgeon-led, 100% review of mortality, PSIs, and HACs to improve patient care and surgeon awareness of these metrics.

Methods: From 12/2012 through 5/2013, 7868 patients were cared for on 12 surgical services. A surgeon from each service led monthly reviews of all mortality, PSIs, or HACs with central reporting of preventability and coding accuracy. We compared the UHC OE mortality ratios (<1 means less people died than expected) and UHC relative rankings (lower number is better) before and after implementation. Statistical significance was p<0.05 by Poisson regression.

Results: Of the 7868 patients in the study period, there were 181 deaths, 173 PSIs, and 22 HACs reviewed. The most common PSIs were postoperative respiratory failure (41), DVT (40), hemorrhage/hematoma (24), and accidental puncture/laceration (21). Prior to 12/2012, the OE ratio was consistently over 1 and significantly fell below 1 throughout the study period (p<0.05). The OE mortality ratio in the 4th quarter of 2012 was 1.18 and fell to 0.90 in the first quarter of 2013(p<0.05). The overall postsurgical UHC rankings increased from 107/112 to 70/111 during this same time period.
Conclusions: Surgeon-led systematic review of mortality, PSIs, and HACs improved our OE ratio and UHC postsurgical relative rankings. Surgeon engagement and ownership is critical for success.

Department of Surgery, The University of Alabama at Birmingham, Birmingham, AL

5. Subscription to the SCORE Web Portal and Examination Performance

Mary E. Klingensmith*  
Andrew T. Jones*  
Thomas W. Biester*

Frank R. Lewis, Jr.  
Mark A. Malangoni

The SCORE (Surgical Council on Resident Education) curriculum was developed to guide surgery residents in acquisition of knowledge and patient care. This curriculum was delivered via the SCORE web portal without charge in 2009-10 and became a subscription-only resource in 2010-11. We hypothesized that residents in programs that subscribed to the SCORE web portal would perform better on the American Board of Surgery (ABS) surgery qualifying exam (QE).

Methods: Scaled scores and percent passing (Pass%) the 2011 ABS surgery QE for individual residents and programs were compared between programs that subscribed to SCORE in 2010-11 and those that did not subscribe. Regression analyses were
performed to control for program QE Pass% from 2004-08 (baseline performance) as well as demographic factors known to affect examination results.

**Results:** There were 200 programs and 893 residents that subscribed to the SCORE web portal and 33 programs with 139 residents that did not subscribe. Regression analysis comparing predicted 2011 average program scores based on 2004-08 results showed that subscribing programs had an unexpected increase in average scaled scores of 1.4 points (adjusted means of 81.5 and 80.1, respectively), controlling for % of IMG residents and program size \((p = 0.048)\). Individual residents from SCORE subscribing programs had a Pass% that was 1.6% higher than non-SCORE residents, and the average Pass% was higher for subscribing programs (86.4% vs. 82.7%), but neither difference was statistically significant. SCORE subscription status did not correlate with program size, % of IMGs, or baseline scale scores.

**Conclusions:** There was a significant improvement in average QE scaled scores for programs that initially subscribed to SCORE. Pass% showed a trend toward improvement for subscribing programs and their residents. This association is promising and deserves further investigation.

*Department of Surgery, Washington University in Saint Louis, Saint Louis, MO, and the American Board of Surgery, Philadelphia, PA*
6. Cytoreductive Surgery and Hyperthermic Intraperitoneal Chemotherapy (HIPEC) for Disseminated Peritoneal Surface Malignancy: Experience with 1,000 Consecutive Patients

Edward A. Levine
Gregory B. Russell*
Perry Shen

John H. Stewart*
Brian W. Loggie*
Konstantinos I. Votanopoulos*

Peritoneal dissemination of abdominal malignancy (carcinomatosis) has a clinical course marked by bowel obstruction and death; it traditionally does not respond well to systemic therapy and has been approached with nihilism. To treat carcinomatosis, we utilize cytoreductive surgery with HIPEC. Herein, we review THE largest reported single center experience (1,000 patients undergoing 1,095 HIPEC procedures) over the past two decades.

**Methods:** A prospective database of patients, uniformly evaluated for and treated with HIPEC, has been maintained since 1992. The experience was divided into quintiles and compared with outcomes.

**Results:** Between 1991-2013, 1,000 patients underwent 1,095 HIPEC procedures. Average age was 52.9 years and 52.8% were female. Primary tumor sites were: appendix 472(47.2%), colorectal 248(24.8%), mesothelioma 72(7.2%), ovary 69(6.9%), gastric 46(4.6%), others 97(9.7%). Thirty-day mortality rate was 3.6% and median hospital stay was 9 days. Median overall survival (OS) was 29.9 months, with a 5-year survival of 32.5%. Factors correlating with improved survival on univariate and multivariate analysis (p≤.0001 for each) were preoperative performance status, primary tumor type, resection status, and experience quintile (p=.04).
Conclusions: This largest reported single center experience with HIPEC demonstrates that prognostic factors include primary site, performance status, completeness of resection, and institutional experience. The data shows that outcomes have improved over time with HIPEC, more complete cytoreduction, fewer serious complications, and stomas. This resulted from better patient selection and operative experience. HIPEC represents a substantial improvement in outcomes compared to historical series and shows that meaningful long-term survival is possible for selected carcinomatosis patients.

Surgical Oncology Service, Wake Forest University, Winston-Salem, NC

7. A Concept of Composite Quality Index in Kidney Transplantation

Prabhakar Baliga  
David Taber*  
Charles Bratton*  

Angello Lin*  
John McGillicuddy*  
Kenneth Chavin

Background: Through public reporting of patient and graft outcomes in a national registry and close CMS oversight, transplantation is considered a highly regulated surgical discipline. However, transplant surgery lacks comprehensive tracking and reporting of peri-operative quality measures. The aim of this study was to determine the association between a kidney transplant centers’ peri-operative quality benchmarking and graft and patient outcomes.

*By Invitation
**Study Design:** This was an analysis of 2011 aggregate data compiled from two national datasets that track outcomes from member hospitals and transplant centers. The transplant centers included in this study were composed of accredited U.S. kidney transplant centers that report data through the national registry and are associate members of the University HealthSystem Consortium (UHC).

**Results:** 16,811 kidney transplants were performed at 236 centers in the U.S. in 2011, of which 10,241 (61%) from 93 centers were included. Of the six peri-operative quality indicators, three benchmarked metrics were significantly associated with a kidney transplant center’s underperformance: mean ICU length of stay (C-statistic 0.731, p=0.002), 30-day readmissions (C-statistic 0.697 p=0.012) and in-hospital complications (C-statistic 0.785, p=0.001). The composite quality index was strongly correlated with inadequate center performance, as determined by citation from SRTR (C-statistic 0.854, p<0.001, \( R^2 = 0.357 \), see Figure 1). The centers in the lowest quartile of the quality index performed 2,400 transplants in 2011, which led to 2,640 more hospital days, 4,560 more ICU days, 120 more post-operative complications and 144 more patients with 30-day readmissions, when compared to centers in the higher three quality quartiles.

**Conclusions:** An objective index of a transplant center’s quality of peri-operative care is significantly associated with patient and graft survival.

*Division of Transplant Surgery, Medical University of South Carolina, Charleston, SC*

*By Invitation*
8. **Macro versus Micro Level Surgical Quality Improvement: A Regional Collaborative Demonstrates the Case for a National NSQIP Initiative**

Andrew J. Kerwin
Michael S. Nussbaum
Joseph J. Tepas III

The Florida Surgical Care Initiative (FSCI) is a quality improvement collaborative of the American College of Surgeons National Surgical Quality Improvement Program (NSQIP) and the Florida Hospital Association. Data from 54 hospitals participating between March 2011 and July 2012 demonstrate a 14.5% reduction in postoperative occurrences, 165 averted complications, $6,666,431 in avoided expenses, and an estimated 89 lives saved. We analyzed our hospital’s semi-annual measures reports to determine whether this dramatic improvement was driven by specific institutions or a global accomplishment affecting the population treated by all participants.

**Methods:** NSQIP reports of de-identified data for all participants, presented as caterpillar plots from best to worst, were analyzed to determine rank change of O/E ratio for each hospital for the four FSCI outcomes (CAUTI, SSI, Colorectal, and surgery in patients >65 yr.). Data from period 2 from Oct 2011, when the program had reached full function, through Apr 2012 were compared to period 3, extending from May 2012 through July 2012. Rate of improvement of expected to observed for each measure was assessed using t-test to compare proportion of hospitals with O/E<1 for each period. Poor performing outlier hospitals were tracked to determine evidence of improvement from period 2 to 3. Individual facility performance was evaluated by determining proportion of hospitals showing improved rank across all measures.

**Results:** Fifty-four hospitals from all sections of the state were evaluated. Period 2 included 28,112 general and vascular surgical cases. Period 3 added 10,784 more cases. The proportion of institutions with O/E<1 for each measure did not change significantly, and only the UTI and Colorectal measures demonstrated increased number of hospitals with O/E<1. Each institution that was a significant negative outlier in period 2 demonstrated improvement in period 3. Three of 54 hospitals demonstrated improvement across all four measures. Of the 15 hospitals that improved across three measures, all included elderly surgery as one of the measures.

**Conclusions:** The dramatic increase in quality achieved across this population of 38,896 surgical patients was the result of a process of quality assessment driven by NSQIP rather than disproportionate improvement of some raising the bar for all. The NSQIP process, applied across a population by committed institutions, produces
dramatic results. Not surprisingly, individual hospital strengths and weaknesses produce varied results across specific measures. As demonstrated by the outliers, this same NSQIP process serves as their pathway to performance improvement.

Department of Surgery, University of Florida College of Medicine-Jacksonville, Jacksonville, FL

9. VEGF-A, A Novel and Highly Accurate Pancreatic Fluid Biomarker for Serous Pancreatic Cysts

C. Max Schmidt *  
Huangbing Wu *  
Ryan P. Dumas *  
Narasimhan Agaram*  
David V. Feliciano  
Michele T. Yip-Schneider*

Mucinous pancreatic cysts (IPMN and MCN) have the potential to progress to invasive pancreatic adenocarcinoma, presenting an opportunity for early detection, prevention, and cure. Serous cystic neoplasms (SCN) have no malignant potential but may mimic mucinous pancreatic cysts on imaging. Therefore, identification of biomarkers that can distinguish between cystic lesions is critically important. We hypothesize that vascular endothelial growth factor (VEGF-A) levels in pancreatic fluid correlate with pathologic diagnosis.

Methods: Pancreatic cyst/duct fluid samples were prospectively collected from patients undergoing pancreatic resection and correlated with surgical pathology. Fluid levels of VEGF-A and VEGF_{165}, the most abundant VEGF-A splice isoform, were detected by enzyme-linked immunosorbent assay. VEGF-A and VEGF receptor 2 expression in pancreatic tissue was localized by immunohistochemistry.

Results: Eligibility criteria for study enrollment was met in 85 patients. Final pathologic diagnoses included pseudocyst (9), SCN (17), MCN (24), IPMN low/moderate grade (16), IPMN high-grade/invasive (10), and pancreatic ductal adenocarcinoma (11). VEGF-A was significantly upregulated in SCN cyst fluid compared to all other diagnoses (81,870+/−20,630pg/ml, P<0.0001). With a threshold level of 8500pg/ml, VEGF-A has 100% sensitivity and 97% specificity (2 false+) as a SCN biomarker. VEGF_{165} is not the predominant splice isoform present in SCN cyst fluid. VEGF-A and VEGF receptor 2 are, correspondingly, overexpressed in SCN cyst tissue. VEGF is not similarly elevated in serum, bile or urine.

*By Invitation
**Conclusions:** This is the first report of a benign SCN biomarker in human pancreatic fluid. The ability to distinguish benign SCN from other premalignant/malignant pancreatic cysts may spare patients from surgical intervention or the cost of lifetime surveillance.

Department of Surgery, Indiana University School of Medicine, Indianapolis, IN

10. **Louis T. Wright, M.D., F.A.C.S.: Academic surgeon, civil rights pioneer**

Don K. Nakayama

Louis T. Wright, M.D., (1881 - 1952) was the most prominent African-American surgeon of his era. Growing up in the Jim Crow South, the grandson of slaves, he had the advantage of the mentorship of his physician stepfather and the support of the educated elite of the Atlanta African-American community. A defining event in his upbringing was the Atlanta Riot of 1906. His stepfather seated the teenager at the front door of the family home and gave him a rifle with instructions to shoot anyone coming through the front gate. Facing racism at medical school at Harvard, his surgical training, and professional career at all levels, he led reforms in desegregating hospitals, training programs for both residents and nurses, and medical schools as national president and later chair of the board of the National Association for the Advancement of Colored People (NAACP). The first African-American director of surgery of Harlem Hospital and the second of his race to be elected a fellow of the American College of Surgeons, he was a prolific clinical researcher with contributions in infectious disease, anti-metabolite chemotherapy, and trauma surgery despite spending his professional life outside of the Caucasian-dominated academy. Through his work to integrate training and education, and setting an example of academic surgical inquiry, Wright also integrated American medical science, his most important legacy.

Department of Surgery, West Virginia University, Morgantown, WV

*By Invitation*
11. Oncologic Outcomes after Videoscopic Inguinal Lymphadenectomy for Stage III Melanoma

Benjamin Martin*  David A. Kooby
Maria Russell*    Viraj Master*
Charles A. Staley  Keith A. Delman
Joanna Etra*

We are the first center to describe videoscopic inguinal lymphadenectomy (VIL) for melanoma. This study reports oncologic outcomes after VIL compared to an open cohort.

**Methods:** Data were prospectively collected on all VILs performed for melanoma from 2008-2012 and compared with a retrospective cohort of open inguinal lymphadenectomies from 2005-2012. Continuous variables were analyzed with Student’s t test, binomial variables with chi-square, and survival curves using log-rank comparison.

**Results:** 40 patients underwent VIL with median follow-up of 16 months. 40 open lymphadenectomy patients had median follow-up of 34 months. There were no statistical differences in demographics (age, gender, BMI, smoking status, Charlson comorbidity index) or clinicopathologic features (primary site, stage, Breslow depth, ulceration). Lymph node yield was similar (VIL: 12.4; Open: 13.7; p=0.246). Overall recurrence rates were similar: 35.0% in the VIL group and 30.8% in the open group (p = 0.689). 6 patients in the VIL group and 3 in the open group had regional recurrences. In each group 1 patient recurred only in the nodal basin. Although median survival was not reached in the VIL group, Kaplan-Meier estimates of disease free survival (p=0.226) and overall survival (p=0.308) were similar. In a comprehensive analysis of wound complications including infection, skin necrosis, and seroma, patients undergoing VIL had markedly less morbidity (VIL: 47.5%; Open: 77.5%; p=0.006).

**Conclusions:** Videoscopic inguinal lymphadenectomy is associated with similar oncologic outcomes compared to open surgery and markedly reduced wound complications. The minimally invasive procedure may be the preferred method for inguinal lymphadenectomy in melanoma.

*Division of Surgical Oncology, Emory University School of Medicine, Atlanta, GA,*
The determination of the primary tumor origin of patients with neuroendocrine tumor liver metastases (NELM) can pose a significant management challenge. A tumor biomarker that could be applied to NELM biopsies and predict the site of origin would help guide the intraoperative localization efforts or the choice of systemic therapy in advanced cases. Recent studies have shown that the alternative lengthening of telomeres (ALT) as a maintenance mechanism is prevalent in some human tumors, including pancreatic neuroendocrine tumors (PanNET), and can be useful in predicting tumor biology. In this study, we aimed to evaluate the utility of ALT as a biomarker in patients with NELM, in particular to predict the site of origin of the neuroendocrine metastases.

**Methods:** Tissue Microarrays (TMAs) were constructed using tumor tissue from NELM patients undergoing liver resection between 1998-2010. These included 43 PanNET and 47 gastrointestinal carcinoid tumors. The TMAs were tested for ALT using telomere-specific fluorescent in-situ hybridization (FISH) and scored by reviewers blinded to the tumor characteristics. The association between ALT positivity and demographic, clinicopathologic data and long-term outcome was investigated.

**Results:** ALT was positive (ALT+) in 26 (29%) of the 90 tumors included in the TMA. PanNET were ALT+ in 56% of cases (24/43), compared to only 4% ALT+ among carcinoid tumors (2/47) (p<0.001). The specificity of ALT for detecting PanNET origin was 96% and the positive predictive value 92%, while the sensitivity was 56% and the negative predictive value 70%. Additionally, ALT was associated with the pattern of metastatic disease: ALT+ NELM were more likely to have oligometastases (≤5 metastases) (p=0.001) and less likely to be bilobar in distribution (p=0.05). Furthermore, ALT+ was associated with improved prognosis in the pNET patient population. With a median follow-up of 49 months, patients with ALT+ tumors
had significantly better median overall survival (OS) of 132 months compared to ALT negative tumors OS of 71 months (HR: 0.33, p=0.043). The only other predictor of outcome was tumor grade (HR: 5.2, p=0.002).

Conclusions: ALT was found to be a useful predictive and prognostic biomarker in patients with NELM. In particular, this marker may be helpful in guiding therapy by identifying the site of origin in patients in whom the primary site is unknown.

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Over the years, few injuries have caused as much debate with respect to management as destructive colon injuries. In fact, the optimal management of these injuries in the setting of an abbreviated laparotomy (AL) remains controversial. For more than a decade, operative decisions (resection plus anastomosis vs diversion) for colon injuries at our institution have followed a defined management algorithm (SSA 2001) based on established risk factors (pre- or intra-operative transfusion requirements of >6 units PRBCs and/or presence of significant co-morbid diseases). Our previous experience has suggested that adherence to this algorithm (ALG) improves outcomes and contributes to a reduction in both colon-related morbidity and mortality (SSA 2011). However, these risk factors were originally identified in, and this management ALG developed for, those patients managed with a single laparotomy. The purpose of this study was to evaluate the applicability of that ALG to destructive colon injuries following AL and to determine whether additional risk factors should be considered.

Methods: Consecutive patients over a 17-year period with colon injuries following AL were identified and stratified by age, injury mechanism, severity of shock, and type of repair. Patients with rectal injuries and early deaths (within 24 hours) were excluded. Patients with non-destructive injuries underwent primary repair (PR) at the initial exploration. Patients with destructive wounds underwent resection at the initial laparotomy with either a staged diversion (SD) or a delayed anastomosis (DA) at the
subsequent exploration. Colon-related morbidity (suture line failure and abscess) and mortality were recorded. Outcomes were then evaluated to determine whether additional risk factors should be considered in the management of destructive colon injuries in the setting of an AL.

**Results:** 149 patients were identified: 33 (22%) patients had non-destructive injuries treated with PR at initial exploration and 116 patients (78%) had destructive injuries and underwent resection at initial exploration. 2 patients with destructive injuries died prior to re-exploration. Overall colon-related mortality was 5%. Of the surviving 114 patients with destructive injuries, 72 (63%) patients underwent SD and 42 (37%) underwent DA at subsequent exploration. Of those undergoing DA, 23 (55%) patients were managed according to the ALG. 7 (17%) patients developed suture-line failure after DA: only one patient managed according to the ALG developed suture line failure. For those patients undergoing DA, adherence to the ALG resulted in a significantly lower incidence of both suture line failure (4% vs 32%, \( p = 0.03 \)) and colon-related morbidity (22% vs 58%, \( p = 0.03 \)) compared to those patients undergoing DA that deviated from the established ALG. No additional specific risk factors for suture line failure following DA were identified.

**Conclusions:** Adherence to an established ALG, originally defined and validated for destructive colon injuries following single laparotomy, is likewise efficacious for the management of these injuries in the setting of AL. Non-destructive injuries should be primarily repaired. Destructive colon injuries associated with pre- or intra-operative transfusion requirements of > 6 units PRBCs and/or significant co-morbidities are best managed with SD. For those without significant transfusion requirements or co-morbidities, DA may be performed with an acceptably low morbidity and mortality.

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14. A Prospective Trial of Angiography and Embolization of All Grade III-V Blunt Splenic Injuries: Non-Operative Management Success Rate is Significantly Improved

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J. Wayne Meredith

**Introduction:** Non-operative management (NOM) of blunt splenic injury (BSI) is well accepted. Significant failure rates in higher injury grades remain common, with one large report quoting rates of 19.6%, 33.3%, and 75% for grades III, IV, and V. Retrospective data show angiography/embolization (AE) may increase salvage rates in these severe injuries. Thus, we developed a protocol requiring referral of all BSI, grades III-V, without indication for immediate operation for AE. We hypothesized that AE of high grade BSI would reduce NOM failure rate in this population.

**Methods:** This was a prospective study at our Level I trauma center as part of a performance improvement project. Demographics, injury characteristics, and outcomes were compared to historical controls. The protocol required all stable patients with grade III-V splenic injuries to be referred for AE. In historical controls, referral was based on surgeon preference.

**Results:** From 1/1/10-12/31/12, 168 grade III-V spleen injuries were admitted and NOM undertaken in 113(67%). The protocol was followed in 97 with a failure rate of 5%. Failure rate in the 16 protocol deviations was higher at 33% (p=0.02). Historical controls from 1/1/07-12/31/09 were compared to the protocol group. 153 grade III-V injuries were admitted during this period, 80 (52%) underwent NOM. Failure rate was significantly higher than the protocol group (15%, p=0.04).
Conclusions: Use of a protocol requiring AE in all high-grade spleen injuries slated for NOM leads to a significantly decreased failure rate. We recommend AE as an adjunct in NOM of all grade III-V injuries.

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15. The Efficacy of Laparoscopic Pyloroplasty for the Treatment of Gastroparesis

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Ankit D. Patel*  J. Patrick Waring*
Nathaniel W. Lytle*  John F. Sweeney
S. Scott Davis Jr.*  Edward Lin*

Methods: Fifty patients with refractory gastroparesis underwent laparoscopic pyloroplasty between 2006 and 2013 in our institution. Surgical technique was identical in all patients (Hand-sewn, Heinecke-Mikulicz configuration). Pre-operative and post-operative symptom data, gastric emptying scintigraphy (GES), and main outcomes of the procedure were reviewed. Analysis was performed using Excel and SPSS. Results are reported as mean standard deviation or median absolute deviation.

Results: 34/50 (68%) patients had previous foregut procedures and/or cholecystectomy. 32/50 (64%) underwent additional procedures (i.e. Paraesophageal hernia repair, gastrostomy takedown) along with the pyloroplasty. The total OR time including combined procedures, blood loss, and length of stay were 175±56 min, 64±50 ml, 2.5±2.7 days, respectively. There were no conversions to open technique or intraoperative complications. There were no suture line leaks. The readmission rate was 14%, mainly due to PO intolerance and dehydration. One patient had a pulmonary thromboembolism, and 2 patients were found with superior mesenteric artery syndrome from severe weight loss. Mean follow-up was 3 months (1-33). 100% had symptom follow-up and 34/50 (68%) had post-surgery GES. Post-operative symptom improvement was reported by 82% of the patients. Median pre-surgery $T_{1/2}$ was 180±73 min and post-surgery was 60±23 min ($p<0.001$). 5/50 (10%), who had normalized post-surgery $T_{1/2}$ times, required other gastric emptying procedures: Distal gastrectomy (2), duodenojejunostomy (2), and gastric stimulator placement (1).
Conclusions: Laparoscopic pyloroplasty is an effective first line mode of treatment for gastroparesis, with significant improvement in objective gastric emptying times, and low morbidity. The laparoscopic approach does not preclude subsequent surgeries when required.

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Benjamin D. Li

Though nodal metastasis in breast cancer is a harbinger of a worse outcome, even within this subset additional molecular events may contribute to risk for systemic dissemination. Overexpression of eukaryotic translation initiation factor 4E (eIF4E) had been shown to predict a higher risk for recurrence and death in breast cancer patients. In this study, node-positive breast cancer patients were specifically studied to determine if eIF4E elevation increase risk for systemic dissemination, defined as bone, brain, lung, liver, and visceral organs.

Methods: 202 node-positive breast cancer patients were prospectively accrued and treated with standardized treatment and surveillance protocol. eIF4E protein level in cancer specimens was quantified by Western blots as x-fold over benign samples from non-cancer patients. Study primary endpoint was systemic metastasis. Statistical analysis includes Kaplan-Meier survival curve, log-rank test, and Cox proportional hazards model.

Results: Patients were grouped based on previously published tertiles (low <7-fold increase (n=63); intermediate 7- to 14-fold (n=88); high >14-fold increase (n=51)). Systemic recurrence was detected in 22.2% of the low group, 27.3% of intermediate group and 49% of the high group, at a median follow up of 47-month. Kaplan-Meier survival analysis revealed a greater risk for systemic metastasis in the high group compared to low group (Log rank test, p=0.0084). Multivariate analysis using Cox Model demonstrated a 2.3X higher risk for systemic metastasis in the high compared to the low group (HR=2.3, 95% CI 1.1-4.7, p=0.021).

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Conclusions: Overexpression of eIF4E increases risk for systemic metastasis in patients with node-positive breast cancer.

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17. Surgeon-Driven ‘Thyroid Interrogation’ of Patients Presenting With Primary Hyperparathyroidism (pHPT)

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   Daniel Davenport*  Cortney Y. Lee*

Methods: A retrospective review of parathyroidectomy (PTX) patients between January 2008 and October 2012 undergoing both a prospective clinical thyroid evaluation as well as thyroid ultrasound was carried out to determine the impact of a ‘thyroid interrogation’ practice protocol on the surgical treatment of patients with pHPT.

Results: While only 6% of 468 PTX patients were referred to a single surgeon for both parathyroid and thyroid surgical evaluation, 31% of patients had known pre-existing thyroid disease (hypothyroidism most commonly) and 22% of patients had palpable thyroid abnormalities unrecognized in 66% of cases by the referring physician. Of the 468 patients, 3% had a history of childhood radiation exposure, 3% a history of radio-iodine treatment, and 3% a family history of thyroid cancer. Thyroid abnormalities were found on ultrasound in 61% of patients and 26% of patients underwent thyroid biopsies. Parathyroid and thyroid surgery was combined for 18% of patients, indications including obstructive symptoms (3%), hyperthyroidism (1%), intraoperative findings (5%), and concern for malignancy (8%). Malignancy was diagnosed in 23 patients (5%), only 8 of whom had been referred for thyroid evaluation. Histologic types included papillary (19), follicular (1), medullary (1), metastatic breast (1), and direct invasion by parathyroid cancer (1). Of the 19 patients with papillary thyroid cancer (PTC), 12 had either primary tumors greater than 1cm or multifocal PTC.
Conclusions: The majority of patients referred for PTX had evidence of thyroid pathology. For an important minority of these patients, benign and malignant disease was identified that merited surgical treatment at the time of PTX. Surgeons must assume responsibility for complete thyroid evaluation of patients referred for PTX.

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18. Efficacy of Repeat Sentinel Lymph Node Biopsy for Patients Who Develop Recurrent Melanoma

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Background: Even after negative sentinel lymph node biopsy (SLNB) for primary melanoma, patients who develop in-transit melanoma (ITM) or local recurrences (LR) may have subclinical regional lymph node involvement.

Methods: A prospective database identified 33 patients with ITM/LR who underwent Tc-99m sulfur colloid lymphoscintography (LS) alone (n=15) or in conjunction with lymphazurin dye (n=18) administered only if the ITM/LR was concurrently excised.

Results: Seventy nine percent (26/33) of patients undergoing SLNB in this study had prior removal of LNs in the same lymph node basin as the expected drainage of the IT or LR at the time of diagnosis of their primary melanoma. LS at time of presentation with ITM/LR was successful in 94% (31/33) cases, and at least one SLN was found intraoperatively in 97% (30/31) cases. The SLNB was positive in 33% (10/30) of these cases. Completion LN dissection was performed in 90% (9/10) of cases. Nine patients with negative SLNB and ITM underwent regional chemotherapy. Patients in this study with a positive SLN at the time the IT/LR was mapped had a significantly shorter time to the development of distant metastatic disease compared to those with negative SLNs.
Conclusions: This is the first study to demonstrate the technical feasibility and clinical utility of repeat SLNB for recurrent melanoma. Performing SLNB can not only optimize local, regional, and systemic treatment strategies for patients with LR or ITM but also appears to provide important prognostic information.

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19. Perceptions of Graduating General Surgery Chief Residents: Are They Confident in their Training?

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Paul J. Schenarts*  

John D. Mellinger  
Michael L. Cheatham*  
Jon B. Morris*

Debate exists within the surgical education community about: 1) whether five years is sufficient time to train a general surgeon, 2) whether graduating chief residents feel confident in their skills, 3) why residents choose to do fellowships, and 4) the scope of general surgery practice today.

Methods: In May 2013 a 16-question online survey was sent to every general surgery program director in the United States for dissemination to each graduating chief resident (CR).

Results: Of the 297 surveys returned, 76% of CRs trained at university programs, 81% trained at 5-year programs, and 28% were going directly into general surgery practice. The 77% of CRs who had done over 950 cases were significantly more comfortable than those who had done less (P=0.013). Only a few CRs were uncomfortable performing a laparoscopic colectomy (7%) or a colonoscopy (6%), while 80% felt comfortable being on call at a Level I trauma center. Compared with other procedures, CRs were most uncomfortable with: open common bile duct explorations (26%), pancreaticoduodenectomies (38%), hepatic lobectomies (48%), and esophagectomies (60%) (P<0.0001). Of those going into fellowships, 67% said they truly had an interest in that specialty and only 7% said it was because they did not feel confident in their surgical skills.

*By Invitation
Conclusions: Current graduates of general surgery residencies appear to be confident in their skills, including care of the trauma patient. Fellowships are being chosen primarily because of an interest in the subspecialty. General surgery residency no longer provides adequate training in esophageal or hepatopancreaticobiliary surgery.

Departments of Surgery: University of Missouri-Kansas City School of Medicine, Kansas City, MO, Guthrie Clinic, Sayre, PA, Ochsner Clinic, New Orleans, LA, University of Nebraska School of Medicine, Omaha, NE, Southern Illinois University, Springfield, IL, University of Pennsylvania, Philadelphia, PA, Orlando Regional Medical Center, Orlando, FL

20. Race Disparities in Peptide Profiles of Wilms Tumor Specimens from North American and Kenyan Patients

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Jaime M. Libes*  Joyce Musimbi*
Erin H. Seeley*  Festus Njuguna*
Jason Axt*  Kirtika Patel*
Janene Pierce*  Gabriel Ellsworth*
Hernan Correa*  Michael Mwachiro*
Mark Newton*  Russell White*
Erik Hansen*  Richard M. Caprioli*
James N’Dungu*  Arlene Naranjo*
Oliver Oruko*  Vicki Huff*

Background: Wilms tumor (WT) is the most common childhood kidney cancer worldwide and arises in children of black African ancestry with greater frequency than other race groups. A biologic basis for this pediatric cancer disparity has not been previously ascribed. We hypothesized that unique molecular compositions underlie the variable incidence and unique disease characteristics of WT observed between race groups.

Methods: To evaluate molecular disparities between WTs of different race groups, the Children’s Oncology Group provided 80 favorable histology specimens divided evenly between black and white patients and matched for disease characteristics. We also obtained WT specimens from 18 Kenyan patients. Tissues were analyzed for peptide profiles using MALDI-TOF imaging mass spectrometry. To control for histologic

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variability within and between specimens, cellular regions were analyzed as triphasic (containing blastema, epithelia, and stroma), blastema-only, and stroma-only. Data were probed using ClinProTools.

**Results:** Among triphasic regions, 560 discriminating peptide peaks were identified (Kruskal-Wallis, p<0.05). An algorithm comprising 19 peaks achieved classification accuracies of 77% for black, 63% for white, and 72% for Kenyan WTs (using 10 iterations of a leave-20%-out cross validation). Classification accuracy improved for blastema- or stroma-only regions. **Blastema** (369 peaks p<0.05): 25 peaks achieved classification accuracies of 83% black, 72% white, and 71% Kenyan. **Stroma** (321 peaks p<0.05): 25 peaks achieved classification accuracies of 86% black, 77% white, and 81% Kenyan.

**Conclusions:** WT specimens arising among different race groups appear to show unique molecular fingerprints that could explain disparate incidences and biological behavior and that could reveal novel therapeutic targets.

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21. **Failure Events in Transition of Care for Surgical Patients**

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Larry C. Martin*
Magdeline Martin*
Marc E. Mitchell

Unexpected clinical deterioration (failure events) in surgical patients on standard nursing units (WARDs) could have a significant impact on eventual survival. We sought to investigate failure events requiring intensive care (SICU) transfer of surgical patients on standard nursing units (WARDs) in an academic hospital setting.

**Methods:** Surgical patients admitted to WARDs over a 12 month period who unexpectedly deteriorated were reviewed. Severity of illness (APACHE II), time to deterioration since WARD arrival, clinical factors, and outcome were identified. A physician review panel determined the preventability of failure events.

**Results:** Ninety-eight patients experienced 111 failure events requiring SICU transfer. Most (57%) were trauma or acute care surgery patients. Of 111 events, 90% had been previously discharged from SICU or Post Anesthesia Care Unit (PACU). The median

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time to failure was 2 days. Patients failing in < 2 days were compared to those failing in > 2 days (Table). Recognition of failure was by nursing (54%) and on routine physician rounds (33%). Rapid response or code was less common (11%). A second physician notification was needed in 29% with delays due to failure to identify severity of illness. Most commonly respiratory events prompted notification (77/111, 63%). The overall mortality was 26/98 (27%).

<table>
<thead>
<tr>
<th></th>
<th>Respiratory</th>
<th>Infection</th>
<th>Cardiovascular</th>
<th>Early SICU or PACU Transfer</th>
<th>Possibly or Preventable</th>
<th>APACHE II</th>
</tr>
</thead>
<tbody>
<tr>
<td>All (n=111)</td>
<td>41 (37%)</td>
<td>31 (28)</td>
<td>25 (23%)</td>
<td>24 (21.6%)</td>
<td>48 (43.2%)</td>
<td>19</td>
</tr>
<tr>
<td>&lt;2 days (n=59)</td>
<td>20 (34%)</td>
<td>17 (29%)</td>
<td>9 (15%)</td>
<td>20 (34%)</td>
<td>33 (56%)</td>
<td>19</td>
</tr>
<tr>
<td>&gt;2 days (n=52)</td>
<td>21 (40%)</td>
<td>14 (27%)</td>
<td>16 (31%)</td>
<td>4 (8%)</td>
<td>15 (29%)</td>
<td>19</td>
</tr>
<tr>
<td>p value</td>
<td>NS</td>
<td>NS</td>
<td>0.08</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>NS</td>
</tr>
</tbody>
</table>

Table: Comparison of early and late failures

**Conclusions:** Respiratory complications were the most common cause of WARD failures. Patients most at risk for WARD failures were those with acute surgical emergencies or recently discharged from SICU/PACU. Early failures may have been due to premature transfer from SICU/PACU, and many may have been preventable. Failure events on WARDS can have lethal consequences.

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22. Influence of In-house Attending Presence on Trauma Outcomes and Hospital Efficiency

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Anthony J. Bottiggi*  
Phillip K. Chang*  
Cynthia L. Talley*  
Brian Tucker*  
Daniel L. Davenport*  
Paul A. Kearney

**Background:** The influence of in-house (IH) attendings on trauma patient survival and efficiency measures such as emergency department length of stay (EDLOS), ICU length of stay (ICULOS), and hospital length of stay (HLOS) has been debated for over 20 years. No study has definitively shown improved outcomes with IH versus home-call (OH) attendings. This study examines trauma outcomes in a single, level I trauma center before and after the institution of IH attending call.

**Methods:** Patient data was collected from the University of Kentucky’s trauma registry. Based on the trauma and injury severity score (TRISS), survival rates were compared between the IH and OH groups. To evaluate efficiency, EDLOS, ICULOS, and HLOS were compared. A separate sub-analysis for the most severely injured patients (trauma alert red, TAR) was also performed.

**Results:** The OH group (n = 4804) was younger (p = 0.018) with a higher injury severity score (p = 0.003) than the IH group (n = 5259), but there was no difference in TRISS (p = 0.205) between groups (Table 1). IH attending presence did not reduce mortality. EDLOS, ICULOS, and HLOS were shorter during the IH period. ED to OR time was not different. There was no change in TAR mortality with an attending present (20.7% vs. 18.2%, p = 0.198).
<table>
<thead>
<tr>
<th>Date Range</th>
<th>OH Attendings, Jul ’09 – Mar ’11 (n = 4804)</th>
<th>IH Attendings, Jul ’11 – Mar ’13 (n = 5259)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRISS, median (iqr)</td>
<td>0.993 (0.972-0.997)</td>
<td>0.993 (0.970-0.997)</td>
<td>0.205</td>
</tr>
<tr>
<td>All trauma deaths in-hospital, %</td>
<td>5.9</td>
<td>5.3</td>
<td>0.177</td>
</tr>
<tr>
<td>EDLOS, h:m (iqr)</td>
<td>7:29 (4:21-12:04)</td>
<td>6:32 (3:52-10:13)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ICULOS, median h (iqr)</td>
<td>89 (40-233)</td>
<td>64 (28-183)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>HLOS, median d (iqr)</td>
<td>3 (1-7)</td>
<td>3 (1-7)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ED to OR time, median h (iqr)</td>
<td>7 (3-12.5)</td>
<td>6 (3-12)</td>
<td>0.080</td>
</tr>
</tbody>
</table>

Table 1. Patient outcomes for all trauma alerts during OH and IH periods.

**Conclusions:** IH attending presence does not improve trauma patient survival. For the most severely injured patients, attendings’ presence does not reduce mortality. IH coverage may improve hospital efficiency by decreasing EDLOS, HLOS, and ICULOS.

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23. **Long-Term Results of Phase II Ablation after Breast Lumpectomy Added To Extend Intraoperative Margins (ABLATE I) Trial**

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Ronda Henry-Tillman*  
Matthew Hardee*  
Laura Adkins*  
Maureen McCarthy*  
Jeannette Lee*  
Sharp Malak*  
Soheila Korourian*

Excision followed by radiofrequency ablation (eRFA) is an intraoperative method that utilizes intracavitary hyperthermia to create an additional tumor-free zone around the lumpectomy cavity in breast cancer patients similar to partial breast irradiation. We hypothesized that eRFA after lumpectomy for invasive breast cancer could reduce the need for re-excision for close margins as well as potentially maintain local control without the need for radiation.

**Methods:** This prospective Phase II institutional review board (IRB)-approved study was conducted from March 2002 to April 2010. A standard lumpectomy was performed, then the RFA probe was deployed 1 cm circumferentially into the walls of...
the lumpectomy cavity and maintained at 100 degrees C for 15 minutes. Validated doppler sonography was used to intraoperatively determine adequacy of ablation.

**Results:** 100 patients were accrued to the trial. **AGE:** 65.02 years ± 10.0 years. The stages were Tis:30, T1imc:1, T1a:9, T1b:27, T1c:22, T2:10 T3:1. Grades were I: 48, II:29, III: 23. 78 subjects had margins >2 mm (negative), 22 patients had margins ≤ 2mm of which 12 were close and 3 focally positive which at our institution would have required re-excision, only one of this group had re-excision. There were 6% post-operative complications. 24 patient received XRT. During the study follow-up period of 65.8 months ± 22.2 months in patients not treated with XRT, there were 3 in sight tumor recurrences. All three were re-resected and two have and one will receive XRT.

**Conclusions:** Long-term follow-up suggests that eRFA may reduce the need for re-excision for close or focally positive margins in breast cancer patients. eRFA may be a valuable tool for treating favorable patients that desire lumpectomy who either cannot or do not want radiation. A multicenter trial has been initiated based on these results.

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24. **Biologic vs. Synthetic Inguinal Hernia Repair: 1-Year Results of a Randomized Double-blinded Trial**

**Methods:** A prospective, randomized, double-blinded, single center trial was conducted by a group of 12 surgeons to evaluate the efficacy of a biologic Inguinal Hernia Matrix (IHM) compared to polypropylene mesh (PP) using Lichtenstein’s inguinal hernia repair in a 3 year outcome study. Patients were evaluated for recurrence and complications by a blinded surgeon at 2 weeks, 3 months, 6 months, and one year post procedure. Patient demographics, including comorbidities and nutrition status, were recorded. Intraoperative information, including hernia type and location, procedure time, level of difficulty, and degree of surgeon frustration were collected. Surgeon information, including years of experience and number of prior hernia repairs, was recorded.
**Results:** 100 male patients [age: mean, 57; range, 24-87; BMI: mean, 24; range, 18-39] provided informed consent and underwent Lichtenstein's hernioplasty (n = 50 each group). There were no significant differences in degree of difficulty and level of attending surgeon frustration between the 2 study groups. At 1 year follow-up, 3 recurrences were diagnosed in the IHM group as compared to none in the PP group (p=0.11). Persistent pain trended higher in the PP group (6% vs. 4%). All 3 recurrences occurred in the direct inguinal hernia group and were performed by attendings in the first year post training (3 different attendings). No recurrences occurred in patients operated on by more senior surgeons.

**Conclusions:** IHM hernioplasty compares favorably to PP mesh in one-year follow-up with similar recurrence rates and complications. Surgeon experience appears to be a major factor affecting a successful outcome.

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25. **Permissive Hypertension During Awake Eversion Carotid Endarterectomy: A Physiological Approach for Cerebral Protection**

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William B. Harris*

Standard surgical practice for cerebral protection during carotid endarterectomy (CEA) often employs general anesthesia and routine shunting to normalize cerebral hemodynamics. Selective shunting can be considered when cerebral hypoperfusion is induced by temporary clamping of the distal internal carotid artery with noted: low cerebral stump pressures, altered cerebral oximetry, and abnormal electroencephalogram changes, as well as in patients with neurologic change occurring while awake/sedated. Permissive hypertension (PH) is the temporary intraoperative process of altering cerebral hemodynamics by standard inotropic medications to recruit the cerebral collateral network reducing the requirement for shunting.

**Methods:** Retrospective review of all CEA procedures from July 2006 to April 2013.

**Results:** During the study time, 239/320 CEA were performed who met the inclusion criteria, additionally, medical/surgical high-risk patients qualifying for carotid artery stenting were excluded. Patient demographics were similar in the study groups, with

*By Invitation*
54% male, average age 68.4 years, and 23% symptomatic at presentation. The procedures were divided into three groups: 80 procedures; Pre-PH phase (Group A), 36 procedures; PH-test phase (Group B), and 123 procedures; routine PH phase (Group C). In Group A, 8 procedures required a shunt, and in 4 procedures experimentally increased blood pressure as a result of neurologic compromise with clamping (index cases). In Group B, 9 procedures required increased blood pressure and 0 shunts were placed. In Group C, 100% procedures employed the technique of “Permissive Hypertension” with 1 procedure requiring a shunt. When combining Groups A and B, 22/116 (19%) required a response to neurologic compromise after clamping the internal carotid artery either with a shunt or altered blood pressure hemodynamics. After employing Permissive Hypertension as a standard intraoperative technique, neurologic compromise requiring a response occurred in 1/123 (.81%) procedures (p= < .001).

**Conclusions:** Intraoperative normalization of cerebral hemodynamics by shunting is required in approximately 1 out of 5 procedures for CEA, and the routine use of PH during clamp time can recruit the cerebral collateral network significantly reducing the need for shunting.

*Department of Surgery, Vascular Section, University of Tennessee, Chattanooga TN*

**26. The President’s Been Shot and They’re Bringing Him to the Emergency Room**

**Ronald C. Jones**

On November 22, 1963, I was having lunch in the Parkland Memorial Hospital cafeteria with Dr. Malcolm Perry and suddenly heard several STAT pages for various department chairmen over the loudspeaker. I went to the telephone in the cafeteria, called the operator, and asked why she was paging so many chairmen STAT. She replied "The president has been shot and they are bringing him to the emergency room and need physicians."

After experiencing a tremendous rush of adrenaline, Dr. Malcolm Perry and I, along with a fourth-year resident, Dr. James "Red" Duke, took the back steps down one flight to the emergency room. Dr. Perry and I went to Trauma Room One and Dr. Duke went to Trauma Room Two. As I entered the room, the president was already on a cart, motionless, his eyes open with a stare. Mrs. Kennedy was standing in the corner near
the doorway. Dr. James Carrico, a second year resident, was attempting to intubate the president, and two junior residents were attempting to start an IV line but were unsuccessful. It was obvious to me that the president was not breathing although Dr. Carrico had earlier seen agonal respirations. I noted a small wound, about 1/4 inch, in the anterior midline of the neck. The president had thick, bushy hair and we noted he had a large wound in the back of his head but this was not immediately examined. The room quickly filled with physicians and personnel. Dr. Perry started a tracheostomy and I cut the coat sleeve and performed a cut down on the cephalic vein in the left arm. Intravenous access was obtained in less than 1 min. As the tracheostomy was being performed a gush of air was noted to come from the neck and the possibility of a pneumothorax or tracheal injury was entertained. Dr. Perry and I agreed that I should insert a left anterior chest tube. Nothing was returned and with the assistance of Dr. Paul Peters, Chairman of Urology, and Dr. Charles Baxter, who was now assisting Dr. Perry with the tracheotomy, I inserted a right chest tube. A portable electrocardiogram was moved into the room and a tracing obtained on the president revealed a straight line. All of this occurred within 10 minutes.

The head wound was extensive and, upon closer evaluation, it became obvious that the President Kennedy could not be resuscitated. Mrs. Kennedy was in the room, and the president was not turned over for examination of his back. We had no information about how, where, or with what type of gun the president had been shot.

Since shots were thought to have come from the Texas School Book Depository all the employees were assembled and Oswald was the lone absentee. A description was soon broadcast, and police began looking for the suspect. Oswald was noted to be walking very fast in the Oak Cliff area of Dallas, and Patrolman J.D. Tippit stopped him and called him to the car. As Mr. Tippit got out of his car Oswald pulled a .38-caliber revolver and shot four times, killing him instantly at 1:16 p.m. The Texas Theater was approximately 8 blocks from where Oswald shot Patrolman Tippit, and he entered the theater without purchasing a ticket. The ticket agent called the police who were already in the area as a result of Tippit having been killed. They entered the theater, turned on
the lights, and identified the suspect. Oswald was arrested and taken to police headquarters at 1:51 p.m., approximately 80 minutes after President Kennedy had been killed.

It was not until the next day, after the president's body had been taken to Bethesda Naval Medical Center and Commander James Humes had performed an autopsy, that we were informed the president had been shot in the back. Commander Humes could not find an exit wound since Dr. Perry's tracheotomy incision was through the ¼ inch midline wound in the anterior neck.

Jack Ruby shot Oswald at 11:21 a.m., on Sunday, November 24, 1963, in the basement of the Dallas Police Station. Since I was on trauma call every other night, I helped treat Oswald as he came to the emergency room, lifeless but with a heartbeat. I performed a cut down on the left cephalic vein and inserted a left anterior chest tube. He was taken to the operating room in less than 10 minutes. Drs. Tom Shires, Jr., Malcolm Perry, Robert McClelland, and I operated on Oswald. He lived approximately 1 ½ hours during surgery but died of massive intra vascular injuries.

Research into the events in Dallas on the day of the shooting, as well as photos and slow motion videography, ballistic testing, re-creation of the event, and lessons learned will be presented.

Department of Surgery, Baylor University Medical Center, Dallas, TX

27. Esophageal Perforation Management Using a Multidisciplinary Minimally Invasive Treatment Algorithm

Kfir Ben-David*  
Kevin Behrns  
Steven N. Hochwald  
Georgios Rossidis*  
Angel Caban*  
Cristina Crippen*  
Thomas Caranasos*  

Steven Hughes*  
Peter Draganov*  
Christopher Forsmark*  
Shailendra Chauhan*  
Mihir Wagh*  
George Sarosi

Introduction: Esophageal perforation (EP) is a dreaded condition with a high morbidity and mortality rate. The diagnosis frequently depends on clinical suspicion and radiographic/endoscopic testing confirming EP. Successful EP management often
depends on time elapsed between perforation and diagnosis, size of rupture, degree of contamination, health of the patient, and has shifted towards less-invasive luminal stenting, and minimally invasive surgical therapies.

**Methods:** An IRB-approved retrospective review of all acute EP between 2007-2013 was performed. Patient demographic, clinical outcome data and hospital charges were collected.

**Results:** We reviewed 76 consecutive patients with acute EP presenting to our tertiary-care-center. Median age was 64 (25-87), with 50 males and 26 females. 90% of EP was of the distal esophagus. 67% was iatrogenic occurring within 4cm of the gastroesophageal junction. All patients were treated within 24 hours of initial
presentation with a removable partially covered esophageal stent. Leak occlusion was confirmed within 48 hours of esophageal stent placement in 68 patients. Median length of ICU and hospital stay was 3 and 10 days, respectively (1-86 days). 33% of the patients were noted to have prolonged intubation (> 7 days), pneumonia and required a tracheostomy. One in-hospital mortality occurred within 30-days. Median total hospital charge for EP is $85,945.

**Conclusions:** Endoscopically placed removable esophageal stents with minimally invasive repair and feeding access is an effective treatment method for patients with EP. This multidisciplinary method enabled us to care for severely ill patients while minimizing the morbidity and mortality and avoiding major open esophageal surgery.

*Division of General Surgery, University of Florida, Gainesville, FL*

28. **Introduction of Mechanical Sphincter Augmentation for GERD into Practice: Early Clinical Outcomes and Keys to Successful Adoption**

C. Daniel Smith
Kenneth R. DeVault*

**Objectives:** A new device to effect mechanical sphincter augmentation (MSA) of the lower esophageal sphincter (LES) was approved by FDA on March 22, 2012. Herein we report the post-market-release early experience with MSA at a single center, specifically addressing postoperative management compared to similar patients undergoing fundoplication.

**Methods:** Between October 1, 2011 and June 1, 2013, 102 patients were evaluated for MSA (a waiting list was generated prior to FDA approval). Of these, 48 patients underwent device implantation, with the first implant on April 10, 2012. All patients had objectively confirmed GERD with pH testing, acceptable esophageal motility, and no evidence of significant hiatal hernia (> 3cm) or advanced GERD. All patients also experienced clinical improvement on antisecretory medication, but incomplete symptom control, medication intolerance, or side effects.
Results: All patients were successfully implanted without intra- or peri-operative complications. Average length of hospital stay was 0.7 days.

<table>
<thead>
<tr>
<th>Demographics MSA</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No. patients</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>M:F</td>
<td>18:29</td>
<td></td>
</tr>
<tr>
<td>Age (yrs)</td>
<td></td>
<td>52.6</td>
</tr>
<tr>
<td>Age &gt;65</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>BMI (wgt/ht²)</td>
<td>25.7 (17.6-34.1)</td>
<td></td>
</tr>
<tr>
<td>BMI&gt;30</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>pH (% time &lt; 4)</td>
<td>9.6 (1-32)</td>
<td></td>
</tr>
<tr>
<td>Follow-up (mon)</td>
<td></td>
<td>6.2</td>
</tr>
<tr>
<td>Follow-up 0-6 months</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Follow-up &gt; 6 months</td>
<td>40%</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes MSA</th>
<th></th>
<th>Dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. patients</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Off PPIs</td>
<td>68%</td>
<td></td>
</tr>
<tr>
<td>0-6 months</td>
<td>61%</td>
<td>0-6 months</td>
</tr>
<tr>
<td>&gt; 6 months</td>
<td>80%</td>
<td>&gt; 6 months</td>
</tr>
<tr>
<td>GERD HRQL</td>
<td>9.9 (0-25)</td>
<td>EGD</td>
</tr>
<tr>
<td>0-6 months</td>
<td>8.4 (3-25)</td>
<td>Barium Swallow</td>
</tr>
<tr>
<td>&gt; 6 months</td>
<td>3.6 (0-18)</td>
<td>pH testing</td>
</tr>
</tbody>
</table>

All patients required distinctly different peri-operative management when compared to patients undergoing fundoplication for GERD. Calls with questions and nursing involvement in first 6 months after MSA were 3X what is typical for fundoplication patients. Dysphagia and regurgitation were the most common concerns. All these symptoms were improving over time.

Conclusions: Single-center early results are promising and parallel those from the multi-center pivotal trial. There is significant interest in MSA from patients and GIs, with many referrals and direct patient appointments specifically for MSA. Outcomes improve over time after implantation. Surgeon learning curve is different than Nissen, both in operative technique and postoperative management. This is a promising new offering for patients with GERD and surgeons will need to learn how to integrate it into their practices.

Departments of Surgery and Medicine, Mayo Clinic in Florida, Jacksonville, FL

*By Invitation
29. Impact of Burn-Induced Diabetes on Patient Outcomes

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Arham Ali*  
Josef Mclean*  
Nicole Benjamin*  
Robert P. Clayton*  
Heriberto Juarez*  
Johnathan Gibson*  
Clark Andersen*  
Walter J. Meyer*  
David N. Herndon

**Background:** Severely burned patients experience hyperglycemia. We compared glucose kinetics and outcomes of children with massive burns requiring no insulin or insulin to maintain blood glucose <180mg/dL.

**Methods:** Patients 0-18 years old with burns covering ≥30% of the total body surface area and randomized to the control group in ongoing randomized trials were enrolled. Patients were stratified into 2 cohorts – those receiving no insulin (NI, n=62) or clinical insulin (CI, n=62) when glucose >180mg/dL. During acute hospitalization and up to a year post-injury, endpoints included glucose levels, resting energy expenditure, body composition, and inflammatory markers. Data were compared to the previously published intensive insulin (II, n=49) and control (IIC, n=137) groups.

**Results:** Maximal glucose levels occurred within 10 days post burn in all cohorts. Glucose was significantly elevated with CI versus NI, p<0.05. Daily average, 6am, and daily maximum glucoses were not different between II and NI; daily minimum glucose levels were significantly different, p<0.05, due to high incidence of hypoglycemia with II. Of the 4 cohorts, maximum daily glucose levels were elevated for prolonged periods in the CI group, p<0.05. Loss of lean body mass, bone mineral content, and bone mineral density were greatest in the NI group, p<0.05. In the NI group, normoglycemia was achieved ~121 days post burn, ~150 days before patients in the remaining cohorts.

**Conclusions:** A subset of severely burned children develops burn-induced hyperglycemia. Despite adequate glucose control in the NI patients, outcomes indicate that intervention is still necessary to reduce the hypermetabolic response.

*Department of Surgery, University of Texas Medical Branch and Shriners Hospital for Children, Galveston, TX*
30. The Impact of Chronic Renal Insufficiency on the Early and Late Clinical Outcomes of Carotid Artery Stenting Utilizing Serum Creatinine versus Glomerular Filtration Rate

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Shadi Abu-Halimah*  
L. Scott Dean*  
Patrick A. Stone*

Background: Only two previous studies have reported on the outcome of carotid artery stenting (CAS) in patients with chronic renal insufficiency (CRI) according to the glomerular filtration rate (GFR) using the Modification of Diet in Renal Disease (MDRD) equation. This study analyzed the impact of CRI on early and late clinical outcomes of CAS utilizing both serum creatinine (Cr.) levels and the GFR (MDRD).

Methods: 313 CAS patients who had Cr. and GFR were analyzed. Patients were classified into: normal (Cr. <1.5 mg/dL or GFR ≥60 ml); moderate CRI (Cr. ≥1.5 - 2.9 or GFR ≥30 - 59), and severe CRI (Cr. ≥3 or GFR <30). Major adverse events ([MAE] combined stroke, death, and MI) were compared for all groups. Univariate and multivariate regression analyses were used to compare clinical outcomes.

Results: Perioperative stroke rates for normal, moderate, and severe CRI were: 5%, 0%, and 25% (p=0.05) and MAE (stroke/death and MI) rates were 5%, 2.1% and 25% using Cr.; in contrast to 4.6%, 3.7%, and 11.1% and a MAE rate of 4.6%, 4.6%, and 11.1% (p=0.666) using GFR. Perioperative MAE rates for symptomatic were 9.3% and 0% (p=0.355) and for asymptomatic 2% and 5.9% (p=0.223) in normal versus moderate/severe CRI using Cr. and 8.1% and 7.8% for symptomatic and 2.5% and 3% (p=1) for asymptomatic using GFR. At a mean follow-up of 21 months (range: 1-78 months), the late MAE rates for symptomatic were 5.7% versus 18.8% (p=0.026) using GFR, but not significant using Cr. Kaplan Meier curves showed no difference in the rates of freedom from MAE at three years for normal and moderate/severe CRI (71% versus 68%); however these rates were significantly lower in symptomatic patients with moderate/severe CRI (46% versus 81%, p=0.0198). Late death rate was 0.55% in normal (GFR ≥60) versus 7.6% (p=0.002) in moderate/severe CRI (GFR <60). A
multivariate Cox regression analysis showed that a GFR of <60 had an odds ratio of 1.6 (p=0.222) of having a MAE after CAS.

**Conclusions:** GFR was more sensitive in detecting late MAE after CAS in these patients. CAS, in moderate CRI patients, can be done with a satisfactory perioperative outcome; however, late death was significant and must be taken into account.

*Department of Surgery, Robert C. Byrd Health Sciences Center/ West Virginia University, Charleston Area Medical Center, Charleston, WV*

31. **ECMO Support of Patients with Congenital Diaphragmatic Hernia: How Long Should We Treat?**

David W. Kays*  
Saleem Islam*  
Shawn D. Larson*  
Joy Perkins*  
James L. Talbert

**Methods:** This is a retrospective review of 19 years of ECMO treatment in a high volume congenital diaphragmatic hernia program.

**Results:** Two hundred sixty-eight consecutive patients with CDH were encountered, and 28 (10%) were excluded from subsequent analysis because of highly severe or lethal associated anomalies, leaving 240. Ninety-six of these were treated with ECMO (40%), of whom 72 (75%) survived to discharge. Eighty were treated with a single run of ECMO and 65 survived (81%), 15 were treated with a second run of ECMO and 7 survived (47%), and 1 was treated with a third run of ECMO and did not survive. Of patients who required more than 2 weeks of ECMO support, 57% survived, at 3 weeks 52% survived, and at 4 weeks, 50% of patients still on ECMO survived to discharge. After 5 weeks of ECMO survival had dropped to 15%, and after 40 total days of ECMO support there were no survivors. Overall 210 of 240 survived to discharge (88%), and all were discharged breathing spontaneously with no ventilatory support other than nasal cannula oxygen if needed.

*By Invitation*
Conclusions: In patients with CDH, improvement in pulmonary function sufficient to wean from ECMO support may take 4 weeks or longer, and 15% may require a second course of support. Pulmonary outcomes in these severe CDH patients can still be excellent, and the assignment of arbitrary ECMO treatment deadlines shorter than this should be re-evaluated.

Division of Pediatric Surgery, University of Florida School of Medicine, Gainesville, FL

32. Conservative Axillary Surgery in Breast Cancer Patients Undergoing Mastectomy: Long Term Results

Michael S. Cowher*       Stephen R. Grobmyer
Colin O’Rourke*          Joanne Lyons*
Joseph P. Crowe*

ACOSOG-Z0011 demonstrated that axillary dissection (ALND) can be avoided in breast cancer (BC) patients with 1-2 positive lymph nodes (N+) treated with lumpectomy, adjuvant medical, and radiotherapy. However, for N+ mastectomy patients, full ALND (~15-16 nodes) remains the standard of care. We hypothesize that omission of full ALND is safe in N+ mastectomy patients. In 2000, conservative axillary regional excision (CARE), consisting of removal of SN and other palpable nodes (without intraoperative frozen section or reoperation for ALND) was initiated in clinically node negative (N-) mastectomy patients.

Methods: We performed a retrospective review of BC patients undergoing mastectomy with CARE between 2000-2010. The multidisciplinary treatment team individualized radiation and chemotherapy treatment decisions. Recurrence free survival (RFS) was estimated using the Kaplan-Meier method and compared using Cox proportional hazards.

Results: 597 patients underwent mastectomy with CARE. A median of 8 nodes was removed (1-27). Median follow-up was 5.25 years. Patient data, treatments, and recurrence by nodal stage are in Table:

*By Invitation
<table>
<thead>
<tr>
<th>N Stage</th>
<th># Pts</th>
<th>% Radiation</th>
<th>% Chemo or Hormone</th>
<th>5-year Recurrence-free Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>N0</td>
<td>384</td>
<td>13%</td>
<td>62.3%</td>
<td>97.5% (95.8% – 99.3%)</td>
</tr>
<tr>
<td>N1</td>
<td>147</td>
<td>37.4%</td>
<td>97.2%</td>
<td>88.1% (82.5% – 94%)</td>
</tr>
<tr>
<td>N2</td>
<td>55</td>
<td>78.2%</td>
<td>96.4%</td>
<td>82.6% (72.9% – 93.7%)</td>
</tr>
<tr>
<td>N3</td>
<td>11</td>
<td>81.8%</td>
<td>100%</td>
<td>58.9% (34.6% – 100%)</td>
</tr>
</tbody>
</table>

There were 7 regional recurrences including 3 axillary recurrences (AR) (0.5%). The 3 AR were in N1 patients (2%) at 1.29 and 2.17 and 2.94 years, all in patients not receiving radiation. Comparing N1 patients who received and did not receive radiation, there was no significant difference in RFS (HR = 2.2; 95% CI 0.9–5.8) or OS (HR = 1.8; 95% CI 0.8–4.4).

**Conclusions:** These data demonstrate that full ALND can be safely avoided in N1 mastectomy patients who receive adjuvant medical therapy. Axillary recurrence rate is low in N1 mastectomy patients having CARE, even in those who did not receive adjuvant radiation.

*Section of Surgical Oncology, Department of Surgery, Cleveland Clinic, Cleveland, OH*

33. **Ventral and Incisional Hernia Repair with Preperitoneal Mesh Placement: An Analysis of Technique with Long-Term Follow-up**

B. Todd Heniford
Kris B. Williams*
Joel F. Bradley*
Blair A. Wormer*
Igor Belyansky*

Amanda L. Walters*
Amy E. Lincourt*
Kristian T. Dacey*
Kent W. Kercher*
Vedra A. Augenstein*

**Background:** Mesh reinforcement in ventral hernia repair has proven to decrease recurrence rates. Herein, we report our experience of large, complex ventral hernia repair utilizing mesh placed in the preperitoneal space (PP-VHR).

**Methods:** A prospectively maintained institutional hernia-specific database was queried (2004-2013) for all PP-VHR. Demographics, operative details, LOS, complications, and recurrence rates were examined using standard statistical analysis.

*By Invitation*
Results: A total of 738 PP-VHR was identified, all using mesh. Average demographics were: age-56.2±12.6 years, BMI-33.4±8.0kg/m\(^2\), 54.4% female, 68.8% with a recurrent hernia. Types of repair included ventral/incisional (97.2%), flank (2.4%), parailiac (0.3%) and lumbar (0.1%). Common co-morbidities were HTN (46.1%), diabetes (19.1%), tobacco use (16.6%), morbid obesity (13.6%), and CAD (6.9%). The average hernia was large (187.4±186.4cm\(^2\)); component separation was performed in 34.2% of cases and panniculectomy in 28.2% of cases. The average mesh size was 778.5±443.8cm\(^2\). EBL was 135.7±132.3cc, and LOS was 6.5±7.3days. The most common immediate post-operative complication included cardiac arrhythmia (8.3%); in-hospital mortality was 0.6%. With a mean follow-up of 13.5 months, the most common complications were: wound cellulitis (21.0%), wound breakdown (16.8%), seroma (15.2%), 30-day readmission (8.6%) and recurrence (5.9%), and mesh infection (3.2%).

Conclusions: This series, the largest reported in the world, demonstrates that the preperitoneal space can be effectively developed in patients with large, complex hernias. The technique allows for substantial mesh overlap, can be combined with components separation, and has acceptable rates of complications with a low recurrence rate.

Division of Gastrointestinal and Minimally Invasive Surgery, Carolinas Medical Center, Charlotte, NC

34. Hepatic Resection for Hepatocellular Carcinoma: Do Contemporary Morbidity and Mortality Rates Demand a Transition to Ablation as First-Line Treatment?


Despite the rising incidence of hepatocellular carcinoma (HCC), controversy persists in optimizing treatment. As recent randomized trials suggest that ablation may have oncologic equivalence compared to resection for early HCC, the relative morbidity of the two approaches becomes the central issue in treatment decisions. Although excellent contemporary perioperative outcomes have been reported by a few HPB units, it is not clear that they can be replicated in broader practice. Our objective was to
inform this treatment dilemma by defining perioperative outcomes in a broader set of patients as represented in NSQIP-participating institutions.

**Methods:** Mortality and morbidity data was extracted from the 2005-10 NSQIP user files based on CPT (hepatectomy and ablation) and ICD-9 (HCC). Perioperative outcomes were reviewed and, with multivariate logistic regression, factors associated with morbidity and mortality identified.

**Results:** 837 (52%) patients underwent minor hepatectomy, 444 (28%) underwent major hepatectomy, and 323 (20%) underwent surgical ablation. Mortality rates were 3.4% for minor hepatectomy, 3.7% for ablation, and 8.3% for major hepatectomy (p < 0.01). Major complication rates were 21.3% for minor hepatectomy, 9.3% for ablation, and 35.1% for major hepatectomy (p < 0.01) (Table). When controlling for confounders, ablation was associated with decreased mortality (AOR 0.20, 95% CI 0.04-0.97, p=0.046) and major complications (AOR 0.34, 95% CI 0.22-0.52, p<0.001).

<table>
<thead>
<tr>
<th>Primary/Secondary Outcome Measure</th>
<th>Minor Hepatectomy (n=837)</th>
<th>Ablation (n=323)</th>
<th>Major Hepatectomy (n=444)</th>
<th>P Value Relative to Major Hepatectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-Day Postoperative Death</td>
<td>28 (3.4)</td>
<td>12 (3.7)</td>
<td>37 (8.3)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Overall Complication Rate</td>
<td>225 (26.9)</td>
<td>37 (11.5)</td>
<td>182 (41.0)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Major Complication Rate</td>
<td>178 (21.3)</td>
<td>30 (9.3)</td>
<td>156 (35.1)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Organ/Space SSI</td>
<td>44 (5.3)</td>
<td>5 (1.6)</td>
<td>37 (8.3)</td>
<td>0.03</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>37 (4.4)</td>
<td>9 (2.8)</td>
<td>31 (7.0)</td>
<td>0.05</td>
</tr>
<tr>
<td>Septic Shock</td>
<td>26 (3.1)</td>
<td>8 (2.5)</td>
<td>29 (6.5)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Prolonged Ventilation</td>
<td>36 (4.3)</td>
<td>8 (2.5)</td>
<td>40 (9.0)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Acute Renal Failure</td>
<td>12 (1.4)</td>
<td>5 (1.6)</td>
<td>21 (4.7)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Bleeding within 72 hours</td>
<td>56 (6.7)</td>
<td>4 (1.2)</td>
<td>55 (12.4)</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

*By Invitation*
Conclusions: Exceedingly high complication rates following major hepatectomy for HCC exist in the broader NSQIP treatment environment. These data strongly support the use of parenchymal-sparing minor resections or ablation over major hepatectomy for early HCC whenever feasible.

Division of Surgical Oncology, Duke University Medical Center, Durham, NC

35. A Single Institution’s Experience with Surgical Cytoreduction of Stage IV, Well-Differentiated, Small Bowel Neuroendocrine Tumors (NETs)

J. Philip Boudreaux
Yi-Zarn Wang*
Anne E. Diebold*
Daniel J. Frey

Lowell Anthony*
Ann Porter Uhlhorn*
Pamela Ryan*
Eugene A. Woltering*

Well-differentiated neuroendocrine tumors (NETs) of the gastrointestinal tract are rare, slow-growing neoplasms. Clinical outcomes in a group of stage IV, well-differentiated NET patients with small bowel primaries undergoing cytoreductive surgery and multidisciplinary management at a single center were evaluated.

Methods: The charts of 189 consecutive patients who underwent surgical cytoreduction for their small bowel NETs were reviewed. Information on the extent of disease, complications, and Kaplan-Meier survival were collected from the patient records.

Results: A total of 189 patients underwent 229 cytoreductive surgeries. Ten percent of cases required an intra-operative blood transfusion and 3% (6/229) had other intra-operative complications. For all 229 surgeries performed, the mean stay (± SD) in the ICU was 4 ± 3 days and the mean stay (± SD) in the hospital was 9 ± 10 days. Prior to discharge, 51% of patients had no post-operative complications and 39% of patients had only minor complications. In a 30-day follow-up period from discharge, 85% of patients had no additional complications and 13% had only minor complications. The 30-day post-operative death rate was 3% (5/189). Mean survival from pathologic diagnosis of a NET was 236 months. The 5-, 10-, and 20-year Kaplan-Meier survival rates from diagnosis were 87%, 77%, and 41% respectively.
Conclusions: Cytoreductive surgery in patients with well-differentiated midgut NETs have low mortality and complication rates and is associated with prolonged survival. We believe that cytoreductive surgery is a key component in the care of NET patients.

Division of Surgical Endocrinology, Louisiana State University Health Sciences Center, New Orleans, LA

36. Long-Term Coagulation Changes after Resection of Thoracoabdominal Malignancies

Robert M. Van Haren*  Danny Sleeman*
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Theoretically, surgical resection should reverse cancer-induced hypercoagulability, but our recent study showed otherwise. The purpose of this study was to follow-up those recent findings and evaluate the long-term coagulation status after malignancy resection.

Methods: A prospective trial with informed consent was conducted in patients undergoing malignancy resection. Blood samples were obtained and the intrinsic (INTEM), extrinsic (EXTEM), and fibrin (FIBTEM) phases of the coagulation cascade were tested with rotational thromboelastometry (ROTEM) pre-operatively and for up to one year post-op.

Results: In 52 patients, age 66±10 yrs and 60% male, cancers primarily involved the pancreas (n=18, 35%), esophagus (n=13, 25%), and liver (n=7, 14%). In general, maximum clot firmness (MCF) in all three pathways increased immediately post-op, but then decreased at long-term sample (9.2±4.1 months). However, this pattern depended on histologic type and cancer location. Adenocarcinomas displayed the biphasic pattern, but no other histologic type had a reversal of hypercoagulability. Esophageal cancers demonstrated biphasic patterns for MCF in all pathways (all p<0.05). For pancreatic cancers, MCF was also increased post-operatively in all pathways (all p<0.05), but there was no long-term reversal. For liver cancers, there were no significant changes. Three patients (6%) developed venous thromboembolism (VTE) and were hypercoagulable pre-op (increased MCF and alpha-angle and decreased clot formation time).

*By Invitation
<table>
<thead>
<tr>
<th></th>
<th>Pre-Op</th>
<th>Post-Op Day 1</th>
<th>Long-Term</th>
<th>p=</th>
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<tbody>
<tr>
<td>Max Clot Firmness (MCF)</td>
<td></td>
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<tr>
<td><strong>Esophagus (n=13)</strong></td>
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<tr>
<td>INTEM</td>
<td>59.5±3.8*</td>
<td>65.2±7.0*</td>
<td>60.7±7.1</td>
<td>0.010</td>
</tr>
<tr>
<td>EXTEM</td>
<td>63.2±4.5*</td>
<td>69.3±4.9*</td>
<td>65.3±6.2</td>
<td>0.003</td>
</tr>
<tr>
<td>FIBTEM</td>
<td>17.9±4.3*</td>
<td>25.8±5.8*†</td>
<td>19.7±5.2†</td>
<td>0.003</td>
</tr>
</tbody>
</table>

| **Pancreas (n=18)**  |            |               |           |        |
| INTEM                | 62.3±5.9*  | 65.4±6.1*     | 65.4±8.0  | 0.145  |
| EXTEM                | 65.0±6.9*  | 68.9±5.4*     | 65.9±11.1 | 0.284  |
| FIBTEM               | 20.4±5.5*  | 26.8±8.2*     | 26.1±14.5 | 0.140  |

| **Liver (n=7)**      |            |               |           |        |
| INTEM                | 60.4±4.3   | 58.7±5.7      | 59.6±13.9 | 0.803  |
| EXTEM                | 63.3±5.0   | 62.9±5.2      | 64.3±10.5 | 0.823  |
| FIBTEM               | 19.0±9.2   | 17.9±7.5      | 22.4±10.0 | 0.375  |

Repeated measures ANOVA. * p<0.05 on post-hoc analysis with Bonferroni correction

**Conclusions:** Cancer patients at risk for VTE can be identified with ROTEM and should be treated with additional anticoagulation. This is the first study to demonstrate that reversal of cancer-induced hypercoagulability varies based on tumor histology and location.

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