



SURGEONS and the UPPER GI TRACT

Friday 9 – Saturday 10
September 2016

InterContinental Hotel
Double Bay, Sydney



Topics include:

- benign and malignant gastroesophageal disorders
- new advances in equipment and techniques
- bariatric surgery
- operative video session
- hiatus hernia

FINAL PROGRAM & ABSTRACTS



ANZGOSA International Speaker

Professor Han-Kwang Yang
Seoul National University Hospital, Seoul

SUGSS International Speaker

Professor Guy-Bernard Cadiere
Saint Pierre University Hospital, Brussels

Joint ANZGOSA / SUGSS International Speaker

Professor Juergen Weitz
University of Dresden, Germany



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Further, Together

\$5000 scholarship prize
for best free paper by
a junior consultant,
trainee, resident
or student.

AUSTRALIAN / NEW ZEALAND FACULTY

- | | |
|------------------------|------------------------|
| Ahmad Aly (VIC) | Steve Leibman (NSW) |
| Roy Brancatisano (NSW) | Andrew MacCormick (NZ) |
| Wendy Brown (VIC) | Neil Merrett (NSW) |
| Paul Burton (VIC) | Les Nathanson (QLD) |
| Gary Crosthwaite (VIC) | Garett Smith (NSW) |
| Krishna Epari (WA) | Mark Smithers (QLD) |
| Greg Falk (NSW) | Craig Taylor (NSW) |
| David Gotley (QLD) | Sarah Thompson (SA) |
| Jeffrey Hamdorf (WA) | Nick Williams (NSW) |
| Michael Hill (VIC) | David Watson (SA) |
| George Hopkins (QLD) | Peter Wu (NSW) |

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INVITED SPEAKERS

- Michael Bourke (NSW)
- David Currow (NSW)
- Chris Naoum (NSW)
- Christoph Reissfelder (GERMANY)
- Payal Saxena (NSW)
- Patrick Walsh (QLD)

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WELCOME



Mr Ross Roberts
President ANZGOSA

Dr David Martin
Chair SUGSS



On behalf of ANZGOSA and SUGSS, we would like to welcome you to our second combined meeting following the success of our previous combined meeting in 2012. This year we are at the outstanding boutique and famous Intercontinental hotel in charming Double Bay in Sydney. On the harbour, a stones throw from the CBD, home to the last two popular annual SUGSS meetings and with a list of celebrity patrons including the likes of George Bush Snr, Madonna, John Travolta and David Gotley, it is a venue that is hard to match. Throw in a cutting edge program with 3 eminent international visitors, national experts and several out of speciality trail blazers, a hands-on 1 day work shop, plus a Marquee conference dinner at the foot of the Opera House under the Sydney Harbour Bridge, this is a meeting that will be more than worth your while.

Headlined by International Gastric cancer and laparoscopic cancer expert, Professor Han-Kwang Yang, Chief of Surgery Seoul National University, and technically gifted Upper GI experts in Minimally Invasive Upper GI pioneer Professor Guy-Bernard Cadere, Chief of Surgery, St Pierre Hospital, Brussels and emerging Robotic and Advanced Upper GI resection expert Professor Juergen Weitz, Chief of Surgery University of Dresden, and including endoscopic envelope pusher Prof Michael Bourke (Westmead) and an expert ANZ faculty, the main 2 day scientific program will cover a range of topics including outcomes and techniques of established and cutting edge open, minimally invasive, and endoscopic Upper GI operations for cancer, benign disease and obesity. This will include video and live operating sessions as well discussion of broader issues including the current rationalisation of Upper GI Cancer Surgery and issues of Specialist representation in a rapidly changing medical landscape. For younger fellows, students and registrars this will be a great opportunity to rub shoulders with world experts, senior colleagues and have a chance at earning \$5000 as part of our Medtronic SUGSS Scholarship prize for best free paper presentation. This year the main Scientific meeting will also be preceded by a single day lab based workshop convened by Michael Talbot focusing on complex Upper GI and bariatric surgery, as well as endoscopic procedures, and which will provide a unique hands-on opportunity to learn from the experts in those fields. So please come along, bring your family, and enjoy what will be a rewarding, invigorating and enjoyable event with great colleagues in beautiful surrounds.

ABOUT ANZGOSA / SUGSS

Australian and New Zealand Gastric and Oesophageal Surgery Association (ANZGOSA)

The Australian and New Zealand Gastric and Oesophageal Surgery Association (ANZGOSA) was formed in 2006, to provide a vehicle for improving the surgical management of diseases of the stomach, oesophagus and upper gastrointestinal tract.

The goals of the ANZGOSA are to:

- further develop and promote the specialty practice of upper gastrointestinal surgery within Australia and New Zealand
- organise appropriate educational activities
- promote multidisciplinary engagement
- organise fellowships and other post-FRACS fellowship training opportunities for surgeons seeking additional training in upper gastrointestinal surgery
- promote, and potentially coordinate, research (particularly clinical)
- interact with government and other professional organisations
- construct and publish clinical guidelines

Sydney Upper Gastro-Intestinal Surgical Society (SUGSS)

SUGSS (Sydney Upper Gastro-Intestinal Surgical Society) is the representative body for NSW Upper GI surgeons. SUGSS recently represented this group of surgeons with the NSW government during the rationalisation of cancer services.

The SUGSS' charter is to foster education and research for surgery of the Upper Gastrointestinal tract, encompassing the oesophagus, stomach, liver, biliary tract, and pancreas, as well as other areas such as endoscopy and hernia surgery with particular reference to the development of cooperative multi-centre studies and cross campus collegiality. When called upon, it is also the collective voice of representation for these surgeons. SUGSS also has fostered close working relationships with the Upper Gastrointestinal Surgery contingent of the RACS (Royal Australian College of Surgeons), as well as with the ANZ Gastro-Oesophageal and Hepatobiliary Pancreatic Surgical Associations (ANZGOSA / ANZHBPA) and Obesity Surgical Society of Australia and New Zealand (OSSANZ).

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MEDTRONIC SUGSS \$5000 SCHOLARSHIP PRIZE

A sincere thank you to Medtronic, who has been a long term partner and principal sponsor of SUGSS, for providing this Travelling Fellowship for this year's Meeting. Four papers were chosen and these will be presented during the "Medtronic Prize 2016 Presentation Talks" at the end of each session.

ELIGIBILITY

Open to consultants within their first 4 years of practice - fellows, registrars, and residents who are planning a career in Upper GI surgery, this scholarship is planned to facilitate travel to expedite the learning of new techniques and processes to which you would not normally be exposed.

PROCESS

Candidates were required to send an original abstract for a 5 minute presentation at the ANZGOSA / SUGSS meeting and an accompanying covering letter outlining as to how they would like to use the \$5,000 travelling fellowship.

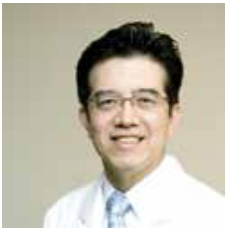
ADJUDICATION

Nominees were judged by a panel based on the quality of the planned presented paper and their plans for use of the travelling scholarship. Previous recipients have used their prize to support a visit of several renowned international units, often with concomitant international conference attendance.

ENTITLEMENTS

The prize winner will also be invited back to a future SUGSS conference to talk on their experiences and an associated Upper GI topic.

INTERNATIONAL SPEAKERS



Professor Han-Kwang Yang
Chief, Division of GI Surgery

**Department of Surgery &
Cancer Research Institute
Seoul National University
Hospital**

Dr Yang's team performed clinical practice of over 1,000 gastric cancer operations (about 65% by minimal access surgery) and conducted over 30 clinical trials and 20 translational studies in 2014. Dr Yang is involved in several large scale RCT's for gastric cancer treatment. He is Korean PI of REGATTA study (Phase III study for the role of gastrectomy in stage IV gastric cancer with a single incurable factor; a collaboratory study between JCOG and KGCA). He is investigators of CLASSIC trial, KLASS trials as well as the Korean PI of a phase II study for the role of neoadjuvant imatinib treatment in large gastric GIST (a collaborator study between Japan and Korea). He is the founding chairman of KLASS (Korean Laparoscopic Gastrointestinal Surgery Study Group). His translational research interests are Gastric Carcinogenesis, DDS, familial gastric cancer, biomarkers.

Dr Yang is Chairman of Board of directors of Korean Gastric Cancer Association and executive council member of International Gastric Cancer Association. He is editor of "Gastric Cancer" and "Asian Journal of Endoscopic Surgery and editorial board member of several internal journals including Annals of Surgery and JAMA Surgery.



Professor Guy-Bernard Cadiere
Chief of G.I. Surgery

**Saint Pierre University
Hospital,
Brussels**

Dr Yang's team performed clinical practice of over 1,000 gastric cancer operations (about 65% by minimal access surgery) and conducted over 30 clinical trials and 20 translational studies in 2014. Dr Yang is involved in several large scale RCT's for gastric cancer treatment. He is Korean PI of REGATTA study (Phase III study for the role of gastrectomy in stage IV gastric cancer with a single incurable factor; a collaboratory study between JCOG and KGCA). He is investigators of CLASSIC trial, KLASS trials as well as the Korean PI of a phase II study for the role of neoadjuvant imatinib treatment in large gastric GIST (a collaborator study between Japan and Korea). He is the founding chairman of KLASS (Korean Laparoscopic Gastrointestinal Surgery Study Group). His translational research interests are Gastric Carcinogenesis, DDS, familial gastric cancer, biomarkers.



Professor Jürgen Weitz
MD MSc

**University of Dresden,
Germany**

After graduation of Medical School, University of Heidelberg and completion of his theses at the German Cancer Research Center, Jürgen Weitz received his surgical education at the Department of Surgery, University of Heidelberg and at the Memorial Sloan Kettering Cancer Center, New York.

Currently, he is Chairman of the Department of Visceral, Thoracic and Vascular Surgery, University Hospital Carl Gustav Carus, Technical University, Dresden, Germany. The main focus of his clinical work is the surgical management of patient with complex surgical oncological and Hepato-pancreatico-biliary conditions.

He also has a broad background as liver, kidney and pancreas transplant surgeon. Regarding clinical research he has conducted several randomized controlled trials especially in HPB surgery. His translational research interests include detection and characterization of minimal residual disease in malignancies. He has published over 200 peer reviewed papers in the fields of hepato-biliary and pancreatic surgery, transplantation and surgical oncology.



INVITED SPEAKERS

Michael Bourke

Westmead Hospital, Sydney

Professor Michael Bourke is Clinical Professor of Medicine, University of Sydney and Director of Gastrointestinal Endoscopy at Westmead Hospital. He is Co-editor of the journal *Endoscopy*. He is the convenor of the Sydney International Endoscopy Symposium, now in its 7th year with a delegation of more than 600 registrants and Australia's second largest gastroenterology meeting.

His clinical and research interests encompass many different facets of diagnostic and interventional endoscopy. Endoscopic resection for advanced mucosal neoplasia at all sites in the gastrointestinal tract has been a focus. Patients referred to Westmead with early Barrett's neoplasia, duodenal and ampullary lesions, and large sessile polyps or laterally spreading tumours of the colon are invited to participate in prospective studies and randomised trials designed to validate, assess and enhance the safety and efficacy of endoscopic resection for advanced mucosal neoplasia.

Work in the animal laboratory augments the clinical research. He is also active in ERCP research. Original research is published regularly in the leading international journals in Gastroenterology and Endoscopy.

David Currow

David Currow, Cancer Institute, Sydney

Professor David Currow is the Chief Cancer Officer, NSW and Chief Executive Officer, Cancer Institute NSW, the NSW Government's cancer control agency. He was appointed to the position in March 2010. Before that he was the foundation Chief Executive Officer of Cancer Australia, the Commonwealth's cancer control agency.

He leads a team of 200 people whose expertise and remit include prevention (tobacco control, ultraviolet light protection), screening (BreastScreen, Cervical Screening and Bowel Screening), service performance and development (including the population based cancer registry, Australia's only population-based clinical cancer registry), *eviQ* - the world's major evidence-based protocol website in oncology, and *Canrefer*, linking general practitioners and consumers with multidisciplinary teams in two clicks of a button, and strategic research and investment. The role of the Cancer Institute NSW is to decrease the incidence of cancer, increase the survival for people who are diagnosed with cancer and improve the quality of care for people with cancer.

Chris Naom

Monash University, Melbourne

Professor Wendy Brown, MBBS (Hons), PhD, FRACS, FACS, is Chair of the Monash University Department of Surgery at the Alfred Hospital; Director of the Monash University Centre for Obesity Research and Education and Clinical Lead of the National Bariatric Surgery Registry. She works privately at the Avenue and Cabrini hospitals. Her subspecialist interests are oesophago-gastric cancer, gastrooesophageal reflux disease and bariatric surgery.

Christoph Reissfelder

St George Private Hospital, Sydney

Dr Jorgensen specialises in Upper Gastrointestinal Surgery (surgery of the oesophagus, stomach, pancreas; spleen and gallbladder) and Weight Loss Surgery with specific emphasis on laparoscopic (ie keyhole surgery).

Payal Saxena

Royal Prince Alfred Hospital, Sydney

Payal Saxena is a Gastroenterologist and Interventional Endoscopist at Royal Prince Alfred Hospital, Sydney Australia. After completing her training in Gastroenterology in Sydney, she completed a two-year fellowship in Research and Advanced Therapeutic Endoscopy at Johns Hopkins University and Hospital, Baltimore USA.

She performs ERCP, interventional EUS, enteral stenting, double balloon enteroscopy, ESD, POEM and endoscopic suturing. She has over 85 publications in her field and is frequently invited to International meetings as a speaker and to perform live demonstrations. She serves on the editorial review board for *Video GIE*.

She maintains an active role in research and teaching, hosting live endoscopy workshops at RPA each year. Her other interests are novel therapies for dysplastic Barrett's oesophagus, pancreatic cancer screening and serves on the steering committee of the International CAPS consortium.

Patrick Walsh

Circle of Care, Sydney

Dr Roy Brancatisano is a bariatric surgeon who trained in Sydney, where he achieved his surgical qualifications and fellowship of the Royal Australasian College of Surgeons in 1993. He has performed well over 3500 weight loss surgery operations; including laparoscopic gastric banding, gastric sleeve resections and gastric bypass. His expertise includes physician, dietitians, psychologist and physiotherapists.

THE VENUE



InterContinental Sydney Double Bay

33 Cross Street, Double Bay



INTERCONTINENTAL
SYDNEY DOUBLE BAY

Located in the picturesque seaside village of Double Bay, this intimate Sydney hotel offers luxury and privacy at its finest. Only minutes from the CBD of Sydney and 13kms from the airport, guests can enjoy the central location and village atmosphere of Double Bay with boutique shopping, cafes and the beach only a minute's walk from the hotel. At sunset, escape the city for stunning harbour views and a cocktail or two at our rooftop bar

Instantly feel at home in the elegant yet comfortable surrounds of this bayside retreat. Contemporary, stylish abodes all feature lofty windows which open out, allowing natural daylight to pour in, with vistas including the bay, leafy Double Bay village, or the hotel's French provincial courtyard.



FREE WIFI

The code for internet for our event will be **SUGSS2016**

Just select 'Intercontinental' in the WIFI options. You will then be taken to your browser, then select 'Conference' and enter the code **SUGSS2016**.



FRIDAY 9 SEPTEMBER PROGRAM

0730 Registration opens.

SESSION 1: 0815-1030 Malignant gastroesophageal disorders Chairs: Ross Roberts and David Martin

0815 Welcome and opening meeting (**Ross Roberts and David Martin**)

0830 What is the standard of care (neoadjuvant and surgical) for oesophageal adenocarcinoma in 2016? (**Mark Smithers**)

0845 Current status of minimally invasive oesophagectomy (**Guy-Bernard Cadiere**)

0900 Neoadjuvant and surgical management of large gastric GISTs (**Han-Kwang Yang**)

0915 How we significantly reduced oesophagectomy leaks and the significance of Mean Arterial Pressure (**Christoph Reissfelder**)

0930 Rationalisation of Oesophago-Gastric Cancer in NSW (**David Currow**)

0945 Rationalisation of Upper GI Cancer - A Regional Perspective (**Candice Silverman**)

0955 Rationalisation of Upper GI Cancer - A Metropolitan Perspective (**Neil Merrett**)

1005 Pushing the limits - Major resections in and around the Stomach and Oesophagus (**Juergen Weitz**)

Discussion after each talk

1030 Morning Tea

SESSION 2: 1100-1215 Operating Session - unedited video 3 cases simultaenously Chairs: Guy-Bernard Cadiere, David Martin and Michael Talbot

1100 Unedited Video Segments (20 minutes) - Hiatus Hernia (**Ross Roberts, NZ; Garrett Smith, NSW; Leslie Nathanson, QLD**)

1125 Unedited Video Segments (20 minutes) - Gastric Bypass (**Michael Talbot, NSW; David Martin, NSW; George Hopkins, QLD**)

1150 Unedited Video Segments (20 minutes) - Sleeve Gastrectomy (**Craig Taylor, NSW; Jeffrey Hamdorf, WA; Nick Williams, NSW**)

Discussion throughout each session

1215 ANZGOSA AGM (note starts 15 mins before lunch and overlaps 15 mins into lunch time)

1230 Lunch

SESSION 3: 1330-1515 Free Papers (6 mins + 2 mins Q+A) Chairs: Neil Merrett and Iain Thomson

1330 Introduction and Welcome

1338 Vitamin C deficiency in metropolitan surgical patients (**Kamala Das, Liverpool Hospital, NSW**)

1346 Prospective evaluation of outcome after cardiomyotomy for achalasia using the Chicago Classification (**Peter Hamer, Royal Adelaide Hospital, SA**) **Contender for the SUGSS Medtronic Scholarship Prize Medtronic**

1354 Double-Blind Randomized Clinical Trial of Laparoscopic Toupet versus 180° Anterior Fundoplication for Gastro-oesophageal Reflux Disease (**Eric Hazebroek, St Antonius Hospital, the Netherlands**)

1402 Randomised trial of division vs non-division of short gastric vessels during nissen fundoplication - 20 yr outcomes (**Stephen Kinsey-Trotman, University of Adelaide, SA**)

1410 Venous thromboembolism in patients with esophageal or gastric cancer undergoing neoadjuvant chemotherapy (**Matthew Marshall-Webb, Flinders Medical Centre, SA**)

1418 Discussion

1426 Determining the impact of hiatal repair on oesophago-gastric junction pressure and post-fundoplication dysphagia (**Jennifer Myers, Royal Adelaide Hospital, SA**) **Contender for the SUGSS Medtronic Scholarship Prize Medtronic**

1434 Assessing quality of care in oesophago-gastric cancer surgery in Australia (**Geraldine Ooi, Monash University, VIC**)

1442 Reversing Barrett's Metaplasia in a Novel Organoid Model (**Matthew Read, Peter MacCallum Cancer Centre, VIC**) **Contender for the SUGSS Medtronic Scholarship Prize Medtronic**

1450 Endoscopic Suturing for Gastrojejunal Outlet Dilatation as a Treatment for Weight Regain After Roux-en-Y Gastric Bypass - An Australian Case Series (**Patrick Walsh, Royal Brisbane and Women's Hospital, QLD**)

1458 Long-term efficacy of laparoscopic anti-reflux surgery on regression of Barrett's esophagus using BRAVO® wireless pH monitoring (**Sarah Kathryn Thompson, University of Adelaide, SA**)

1506 Discussion

FRIDAY 9 SEPTEMBER PROGRAM (cont)

1515 Afternoon Tea

SESSION 4: 1545-1730 New Advances - equipment and techniques Chairs: Grant Beban and Robert Finch

1545 The role of the Robot in upper GI malignancy surgery (pros and cons) (Han-Kwang Yang)

1600 Revolutionary New Robotics - what is around the corner (Dhan Thiruchelvam)

1610 Endoscopic Resection of Upper GI dysplasia and early malignancy (Michael Bourke)

1625 Endoscopic therapy to replace surgery in benign and functional conditions (Michael Talbot)

1635 Palliative Biliary Bypass & Other Cool Things You Can do with your Endoscope (Payal Saxena)

1650 The role of gastrectomy in advanced gastric carcinoma (Han-Kwang Yang)

1710 Discussion

1730 Session Closes

1815 Coaches depart from the InterContinental Hotel - Conference Dinner

1900 - Conference Dinner at the Sydney Opera House Marquee

2300 Announcement Best Paper award and Presentation of Certificates of Satisfactory Training

CONFERENCE DINNER

Venue: Sydney Opera House, 'Opera Point Marquee'

Date: Friday 9th September, 7.00pm – 10pm
(Coaches will depart from the InterContinental Hotel at 6:15pm sharp.)

Cost: \$130 per delegate

Includes: 3 course sit-down dinner and drinks

Return coach transfers from the InterContinental Hotel

Located on the picturesque Sydney Harbour foreshore, the Opera Point Marquee offers a magnificent vantage point to enjoy one of the world's most famous views. The venue makes the most of this setting with a private outdoor reception area and clear walls which will ensure you enjoy the vista from every angle.

In May 2012, ARIA Catering became the exclusive resident caterer at Sydney Opera House and is owned and managed by Matt Moran, Australia's well-known celebrity chef, restaurateur and co-owner of a number of successful restaurants including ARIA Sydney and ARIA Brisbane.





SATURDAY 10 SEPTEMBER PROGRAM

0730 Registration opens

SESSION 5: 0830-1020 Benign Gastroesophageal Disorders Chairs: Wendy Brown and Paul Burton

0830 The impact of large hiatus hernias on cardiac function - what you, your cardiologist and medical colleagues need to know (**Chris Naoum**)

0845 Reflux and hiatus hernia - What I do (short video) and Why. A European Perspective (**Guy-Bernard Cadiere**)

0900 Reflux and hiatus hernia - What I do (short video) and Why. A South Australian Perspective (**David Watson**)

0915 Reflux and hiatus hernia - What I do (short video) and Why. A NSW Perspective (**Greg Falk**)

0930 Recurrent reflux symptoms after fundoplication - How I Assess (**David Gotley**)

0945 Recurrent reflux symptoms after fundoplication - How I Manage (**Steve Leibman**)

1000 Discussion

1020 Morning Tea

SESSION 6: 1050-1230 Bariatric Surgery Chairs: Steve Liebman and Andrew MacCormick

1050 20 years on - what I think is the perfect bariatric operation in 2016 and where are we going (**Guy-Bernard Cadiere**)

1105 Band, Sleeve, Bypass (RYGB and Mini) and Ringed Bypass - who gets what and why (**Michael Talbot**)

1120 Data from the Australian Bariatric Registry (**Wendy Brown**)

1130 Debate - Why Sleeve is the best revision operation post band! (**Roy Brancatisano**)

1140 Debate - Why the Mini bypass is the best revision operation post band! (**Michael Hii**)

1150 Debate - Why the Roux-En-Y Bypass is the best revision operation after band! (**Ahmad Aly**)

1200 Endoscopic Overstitch for weight regain after bariatric surgery and closing fistulae (**Patrick Walsh**)

1210 Discussion

1230 Lunch

SESSION 7: 1330-1515 Video Session Chairs: Garrett Smith and John Jorgensen

1330 Gastric bypass (**Guy-Bernard Cadiere**)

1345 Minimally invasive gastrectomy (Laparoscopic/Robotic) (**Han-Kwang Yang**)

1400 Laparoscopic & Robotic Oesophagectomy (**Juergen Weitz/Christoph Reissfelder**)

1415 Laparoscopic approach to proximal gastric tumours (**Krishna Epari**)

1430 Thoroscopic Oesophagectomy & Anastomosis (**Guy-Bernard Cadiere**)

1440 Laparoscopic Radical Subtotal & Total Gastrectomy from Laparoscopic Radical Subtotal Gastrectomy (**David Martin**)

1450 Video Vignette 1: Bochdalek Hernia Repair (**Marisol Perez Cerdeira, Tweed Heads Hospital, NSW**)
Contender for the **SUGSS Medtronic Scholarship Prize Medtronic**

1500 Video Vignette 2: Robotic Sleeve Gastrectomy performed in under 60 minutes. The 20th Robotic Sleeve Gastrectomy performed by a consistent surgical team. (**Candice Silverman, John Flynn Private Hospital/ The Tweed Hospital, Gold Coast/NSW**)

Discussion after each talk

1515 Afternoon Tea

SESSION 8: 1545-1730 A perspective on surgery Chairs: Gary Crosthwaite and Krishna Epari

1545 ANZGOSA Audit data on GISTs (**Sarah Thompson**)

1600 Achalasia - the case for Heller's myotomy - a surgical standard (**Michael Talbot**)

1610 Achalasia - the case for pneumatic dilation - the balloon is best (**Peter Wu**)

1620 Achalasia - the case for POEM - the latest & greatest option (**Payal Saxena**)

1630 Discussion

1640 Technical Tips and Tricks for POEM and Heller's myotomy (**Gary Crosthwaite**)

1650 How do you build a great surgical department? (**Juergen Weitz**)

1710 What sacrifices to get to the top? - Can you have it all? Research Surgery Family and Extracurricular? (**Guy-Bernard Cadiere**)

1730 Conference end and closing remarks (**Ross Roberts and Michael Talbot**)

The standard of care of surgery and neoadjuvant therapy for adenocarcinoma

Mark Smithers

Princess Alexandra Hospital, University of Queensland, Brisbane, Australia

The surgical approach to an adenocarcinoma (AC) of the lower oesophagus (Siewert I) or oesophago-gastric junction (Siewert II) should enable complete resection of the primary lesion with a margin of normal oesophagus and stomach along with the draining lymph nodes. For a Siewert I AC, the patient will need either an Ivor Lewis oesophago-gastrectomy of a three field resection (McKweon) with the infra mediastinal and subcarinal lymph nodes. For a Siewert II AC the options are a transhiatal oesophago-gstrectomy, an Ivor Lewis approach or an extended total gastrectomy. The abdominal lymphadenectomy should include station 8a, 11p and 9. The mediastinal dissection should include station 20 and 111 at a minimum. Minimally invasive resection incorporating thoracoscopic and or laparoscopic dissection carries some advantages with respect to patient recovery, particularly relates to less severe respiratory complications. These approaches do not compromise the cancer survival outcomes.

Rationalisation of Upper GI Cancer - A Regional Perspective

Candice Silverman

The Tweed Hospital has been providing a surgical service in Hepato-Pancreatico-Biliary and Oesphago-Gastric surgery since 2001. This presentation describes the evolution of this service and the process and outcomes of complex cancer operations performed in a low volume environment.

Rationalisation of Upper GI Cancer - A Metropolitan Perspective

Neil Merrett

In 2015, SWSLHD (metropolitan) and ISLD (regional) commenced a programme for low volume Upper GI oncology as per the EOI from NSW MOH as a formalised collaborative/mentoring programme.

As well as briefly outlining the history of outcomes with low volume oncology in nsw and queensland, this presentation outlines the progress of the project including current outcomes and discusses the issues which have been identified and potential pitfalls of the project

Unedited Video Segment (20minutes) - Gastric Bypass

Michael Talbot

Unedited Revision Bypass

This video shows the setup and steps involved in a revision Band-to-Bypass procedure following prior elective band removal 3 months previously. Main points covered;

Patient positioning: Supine with footplate allowing the surgery to be performed in steep reverse Trendelenburg position without risk of pressure points.

Camera and port positioning: LUQ camera placement is safe with optical entry, away from midline structures. A camera in this position allows the procedure to be performed in the supracolic compartment with good exposure.

Pouch creation: A narrow, 7-8 cm long lesser curve pouch is created.

Gastro-enterostomy: Handsewn with single-layer 2.0 monofilament. This anastomosis is very safe and reliable with a leak rate and bleed rate of under 0.5%

Entero-enterostomy: Fully stapled, followed by internal hernia defect closure. Standardisation of this anastomosis leads to a short term roux complication rate of almost zero.

FREE PAPERS

Vitamin C deficiency in metropolitan surgical patients

Dr Kamala Das¹, Dr Stephanie Wiltshire¹, Sarah Khan¹, Dr Praveen Ravindran¹, Dr Takako Yabe¹, Professor Robert Wilson^{1,2}

¹Liverpool Hospital, ²Bankstown Hospital

Introduction: To ascertain the frequency of Vitamin C deficiency in surgical patients. To record associated risk factors, symptomatology and patient outcomes.

Methods: A retrospective analysis was performed of prospectively collected data from patients attending a single Upper GI surgeon in Sydney between January 2011 to December 2013. Micronutrient assay, dietary survey and symptoms of Vitamin C deficiency were recorded. Patients were referred to a single experienced phlebotomist for blood samples.

Results: In the patient cohort, 42.9% were found to be Vitamin C Deficient (Vitamin C level below 28umol/l). Of these, 42.6% were symptomatic. Within the deficient group, 37% were severely deficient (Vitamin C <5umol/l) and 55%



of these were symptomatic. Inadequate consumption of citrus fruit (<1 serving a day) occurred in 30% of patients with Vitamin C deficiency and 60% in severely deficient patients. Of the patients who admitted to smoking, 50% had Vitamin C deficiency. Vitamin C deficiency was found in 54.5% patients with active H Pylori infection and 54% of patients who were taking PPIs.

Conclusion: Symptomatic vitamin C deficiency was common in our patient cohort, despite scurvy being often regarded as a third world disease. This has important implications for general surgical, gastrointestinal and bariatric patients. Vitamin C is associated with poor wound healing, impaired white cell function, capillary fragility and increased systemic inflammatory response. Optimization of micronutrient deficiencies is recommended for potential improved surgical outcomes and patient wellbeing.

Prospective evaluation of outcome after cardiomyotomy for achalasia using the Chicago Classification

Mr Peter Hamer^{1,3}, Professor Richard Holloway^{2,4}, Dr Richard Heddle⁵, A/Prof Peter Devitt^{1,3}, A/Prof George Kiroff^{1,3}, Ms Carly Burgstad⁵, A/Prof Sarah Thompson^{1,3}

¹Discipline of Surgery, Adelaide University, ²Discipline of Medicine, Adelaide University, ³Professorial Unit of Oesophagogastric Surgery, Royal Adelaide Hospital, ⁴Department of Gastroenterology & Hepatology, Royal Adelaide Hospital, ⁵Oesophageal Function Laboratory, Repatriation General Hospital

Introduction: Dividing achalasia into Chicago classification manometric subtypes is now standard clinical practice. Subtypes are hypothesised to predict outcome after treatment. We test this hypothesis using our prospective database of patients who undergo laparoscopic Heller cardiomyotomy with anterior fundoplication.

Methods: Manometry tracings for patients from the prospective Hellers cardiomyotomy database were re-reported according the Chicago classification. Data was collected at the time of surgery and then follow up with questionnaire at 3 months, then annually. Success was defined as a satisfactory modified Eckhardt score with absence of reintervention. Difference in outcome after cardiomyotomy was analysed with a mixed effects logistic regression model.

Results: 195 patients were subtyped, 60 patients type I, 111 type II and 24 type III. Type III achalasia patients were more likely to be older than type I or II patients (mean age 63yo vs. 50 and 49yo for types I and II, p=0.001). 176 patients returned questionnaires postoperatively, a significant difference being observed among subtype groups, with Type III achalasia a predictor of poor outcome (overall outcome III vs. I Odds ratio 0.38, p 0.035; success at 3 year follow up type I 69%; type II 60%; type III 31%).

No difference in outcome was found between type I and II achalasia (II vs. I Odds ratio 0.87, p 0.66).

Conclusion: Type III achalasia is a predictor of poor outcome after cardiomyotomy and alternative procedures may be worth exploring for these patients. No demonstrated difference in outcome was demonstrated between types I and II achalasia.

Double-Blind Randomized Clinical Trial of Laparoscopic Toupet versus 180° Anterior Fundoplication for Gastro-oesophageal Reflux Disease

MD PhD Eric Hazebroek¹

¹St Antonius Hospital, the Netherlands

Background: Meta-analyses have demonstrated that partial funduplications provide similar reflux control with less postfundoplication symptoms compared to Nissen fundoplication for gastro-oesophageal reflux disease (GORD). It remains unclear which partial fundoplication is the surgical therapy of choice. Aim is to compare outcome of 270° posterior laparoscopic Toupet (LTF) with 180° anterior fundoplication (180° LAF).

Methods: A double-blind randomized clinical trial was conducted between 2012 and 2015 in two hospitals specialized in antireflux surgery. Patients were randomized to undergo primary LTF or 180° LAF. Subjective outcome was analyzed at one, three, six, and 12 months following surgery. Objective reflux control was assessed before and three months after surgery.

Results: 94 patients were randomized to LTF (n=47) or 180° LAF (n=47). Subjective outcome at 12 months demonstrated no significant differences in control of reflux or postfundoplication symptoms, except for an increased prevalence of increased flatulence and chest pain after LTF at one and six months respectively (71% vs. 49%, p=0.034; 23% vs. 7%, p=0.039). Furthermore, there were no significant differences in satisfaction and willingness to undergo surgery again. Postoperative endoscopy and 24-hr pH-monitoring demonstrated no significant differences in mean oesophageal acid exposure time or recurrent pathological oesophageal acid exposure.

Conclusions: The results of this trial provide evidence for equal short-term outcomes of LTF and 180° LAF as surgical procedures for GORD, with similar subjective and objective reflux control, postfundoplication symptoms and patient satisfaction. The long-term results of this RCT need to be awaited to evaluate whether differences develop with extension of follow-up.

Randomised trial of division vs non-division of short gastric vessels during nissen fundoplication - 20 yr outcomes

Dr Stephen Kinsey-Trotman¹, Mr Peter Devitt^{2,3}, Mr Tim Bright¹, Dr Sarah Thompson^{2,3}, Mr Philip Game³, Prof David Watson¹

¹Flinders University Department Of Surgery, ²University of Adelaide, ³Royal Adelaide Hospital

Introduction: Nissen fundoplication is an established procedure for gastroesophageal reflux disease. In the 1990's controversy about whether dysphagia side effects could be reduced by division of the short gastric vessels led to the establishment of a randomised trial. Earlier results showed equivalent reflux control and dysphagia, but more bloating after vessel division. This study determined the long term outcomes (11-20 years) from this trial.

Methods: 102 patients underwent laparoscopic Nissen fundoplication for gastroesophageal reflux disease between May 1994 and October 1995, and were randomized to short gastric vessel division (50) vs. non-division (52). Follow-up was obtained yearly to 20 yrs using a standardized questionnaire administered via interview conducted by a blinded investigator.

Results: No significant differences in symptom and satisfaction scores or medication use were found between treatment groups. At 15-20 years follow-up, a significant difference persisted for epigastric bloating: 24% non-division vs 50% in the division group (P = 0.03). Heartburn symptom scores remained low for non-division (mean analogue score 1.5/10 (SD 2.5) and division cohorts (mean analogue score 2.0/10 (SD 2.8). Overall satisfaction following surgery was high in both groups, mean analogue scores - non-division 8/10 (SD = 3.2) vs. division 8.5/10, (SD = 2.6).

Conclusions: Laparoscopic Nissen fundoplication has durable efficacy in reducing heartburn-related symptoms at up to 20 years. Division of short-gastric vessels during Nissen fundoplication does not confer any reduction in side effects, but is associated with persistent epigastric bloat symptoms at late follow-up.

Venous thromboembolism in patients with esophageal or gastric cancer undergoing neoadjuvant chemotherapy

Dr Matthew Marshall-Webb¹, Dr Tim Bright¹, Dr Timothy Price², Associate Professor Sarah Thompson³, Professor David Watson¹

¹Flinders Medical Centre, ²Queen Elizabeth Hospital, ³Royal Adelaide Hospital

Introduction: There is a well-established link between cancer and venous thromboembolism (VTE), and patients receiving chemotherapy for esophageal or gastric cancer appear at high risk of developing VTE. The incidence of VTE in the neoadjuvant setting in these patients is poorly understood, as is the role for thromboprophylaxis during neoadjuvant chemotherapy.

Methods: A PubMed search was conducted using a combination of terms including; esophageal & gastric cancer, deep venous thrombosis (DVT), VTE, neoadjuvant, chemotherapy and chemoradiotherapy. One hundred and fifty four articles were retrieved and a narrative review was conducted.

Results: For patients with esophageal and gastric cancer the incidence of VTE ranged from 4% to 19.4%. Gastric cancer (Odds Ratio (OR) 6.38, (95% CI: 1.96 – 20.80)) and Stage III/IV disease, (OR 5.16 (95% CI: 1.29 – 20.73)) were identified as risk factors for developing VTE. Neoadjuvant chemotherapy was identified as an independent risk factor for developing VTE. Symptomatic and asymptomatic VTE have a similar effect on mortality. Median overall survival for asymptomatic VTE was 13.9 months (95% CI: 5.0 - ∞) versus 12.8 months (95% CI: 4.7 - 30.3) if the VTE was symptomatic.

Conclusions: Neoadjuvant chemotherapy is a significant risk factor for VTE in patients with esophageal and gastric cancer. Intervention to minimize the risk using pharmacological and mechanical thromboprophylaxis should be considered, and this should start in the neoadjuvant period.

Determining the impact of hiatal repair on oesophago-gastric junction pressure and post-fundoplication dysphagia

Dr Jennifer C Myers^{1,2}, Dr Michal M Szczesniak³, Dr Fermin Estremera-Arévalo¹, Prof Glyn Jamieson², Mr Jonathan Shenfine^{1,2}, Prof John Dent⁴

¹Surgery, Royal Adelaide Hospital, ²Surgery, University of Adelaide, ³Gastroenterology, University of NSW, ⁴Gastroenterology and Hepatology, Royal Adelaide Hospital

Introduction: A reduction of circumferential extent of fundoplication has modest impact on minimising post-operative dysphagia risk, indicating that other factors underlie this problem. This study evaluates whether hiatal repair alters crural mechanics and influences post-operative dysphagia, by assessing radial oesophago-gastric junction (OGJ) pressure patterns during normal respiration.

Methods: OGJ pressures were evaluated in 34 patients via station pull-through of a catheter with 8 radial side-holes of 45° separation, before and 6 months after



two types of fundoplication. Inspiratory OGJ pressure change, attributable to diaphragmatic crural contraction, and expiratory OGJ pressure were recorded. A validated questionnaire scored swallowing difficulty for 9 food types (scale 0-45, none to severe).

Results: After 90° fundoplication (N=13), end-expiratory OGJ pressures were highest in the left-anterolateral sectors corresponding to the partial fundoplication, while in other sectors pressures were uniformly elevated above pre-operative baseline. Compared to 90° fundoplication, 360° radial OGJ pressures (N=21) were significantly higher circumferentially ($p=0.004$) and greatest posteriorly. Nine patients with troublesome dysphagia (3x 90°; 6x 360°) compared to those without ($n=25$), had a significantly greater increase in OGJ end-expiratory and peak-inspiratory pressures ($p=0.03$, $p=0.03$) and significantly higher inspiratory pressure at the orientation of maximum asymmetry ($p=0.048$).

Conclusion: Circumferential elevation of end-expiratory OGJ pressure after 90° and 360° fundoplication suggests hiatal repair leads to extrinsic OGJ compression. Localized greater inspiratory OGJ pressure after 90° and 360° fundoplication suggests hiatal repair contributes to a focally more restrictive lumen in troublesome dysphagia. Closer attention to the mechanics of hiatal repair appears warranted.

Assessing quality of care in oesophago-gastric cancer surgery in Australia

Mr Paul Burton^{1,2}, Dr Geraldine Ooi², Mr Andrew Smith¹, Prof Wendy Brown^{1,2}, A/Prof Peter Nottle¹

¹Upper GI Surgery, The Alfred Hospital, ²Monash University

Introduction: Outcomes of oesophago-gastric cancer are poor, and highly variable between centres. It is important that complex multimodal treatments are applied optimally. Detailed analysis across a range of quality domains offers the opportunity to measure performance. However, relatively low numbers performed at Australian centres make analysis of outcomes less reflective of overall quality of care.

Methods: We compared data from the UK National Oesophago-gastric Cancer Audit 2010 to the prospective Alfred Hospital oesophago-gastric cancer database.

Results: There were 314 Alfred and 17,279 UK patients identified. The volume of patients assessed by the Alfred was equal to the second highest quartile UK trust (4-5 new cases per month). Case ascertainment was better, capturing 84% of all oesophago-gastric cancer within the Alfred prospective audit ($p<0.001$). The use of staging CT and PET scan was more common among Alfred patients (99% vs. 89%, $p<0.01$ and 83.8% vs. 17%, $p<0.01$). More

patients embarked on a curative pathway ($p<0.01$), with greater use of neo-adjuvant therapies. Acceptable lymph node yields were less in oesophagectomies (88.2% vs. 96.2%, $p<0.01$), and similar in gastrectomies (77.4% vs. 74.6%, $p<0.61$). Higher overall complications were observed in Alfred patients ($p<0.01$), predominantly due to respiratory complications. Peri-operative mortality after resection, and one-year survival was similar.

Conclusions: Comparing a range of quality domains as a means of identifying differences, deficiencies and achievements, is feasible. This allows for contemporaneous improvements in service quality, and may be more appropriate in the Australian setting than focusing on volume.

Reversing Barrett's Metaplasia in a Novel Organoid Model

Dr Matthew Read¹, Ms Ana Correia², Dr Silvia Calpe², Dr Nicholas Clemons¹, Doctor David Liu¹, Doctor Cuong Duong¹, Professor Wayne Phillips¹, Professor Kausilia Krishnadath²

¹Peter MacCallum Cancer Centre, ²Academic Medical Center

Purpose: Given the poor survival rates for oesophageal adenocarcinoma using current therapies, novel therapeutic targets are keenly sought. One such target involves the Bone Morphogenetic Proteins (BMPs), a family of growth factors that play a critical role in Barrett's carcinogenesis. Using a novel in vivo organoid model of human Barrett's oesophagus, we have started to investigate the potential to reverse the metaplastic process using highly specific Dwarfbodies® (Calpe et al., 2016) designed to inhibit BMP signaling.

Methodology: Biopsies of Barrett's oesophagus were implanted into immunocompromised mice using an intramuscular transplantation technique (Read et al., 2016), in combination with either BMP inhibitor or vehicle treatment. Implants were then cultured for three months in order to form organoid structures. These structures were then assessed both histologically and immunohistochemically using panels of both squamous and intestinal markers.

Results: Barrett's organoids were lined by a functional epithelial layer containing Goblet cells and recapitulated the crypt and villous regions seen within Barrett's glands. Immunohistochemical validation confirmed that the organoids were of human origin and expressed the appropriate markers of intestinal differentiation (CK8, CDX2 and villin). Following treatment with BMP inhibition, organoids demonstrated a tendency to form a multi-layered epithelium that expressed the squamous marker p63.

Conclusion: Preliminary results demonstrate a trend towards the generation of organoids with a squamous-like phenotype following treatment with BMP inhibition using our novel Dwarfbodies. It is hoped that these pre-clinical results may be translated to the clinical setting in order to prevent the development of oesophageal adenocarcinoma.

References: CALPE, S., CORREIA, A. C., SANCHO-SERRA MDEL, C. & KRISHNADATH, K. K. 2016. Comparison of newly developed anti-bone morphogenetic protein 4 llama-derived antibodies with commercially available BMP4 inhibitors. *MAbs*, 8, 678-88.

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Endoscopic Suturing for Gastrojejunal Outlet Dilatation as a Treatment for Weight Regain After Roux-en-Y Gastric Bypass – An Australian Case Series.

Dr Patrick Walsh, Dr Joshua Satchwell, Dr George Hopkins, Dr Payal Saxena

¹Royal Brisbane And Women's Hospital

Introduction: Dilatation of the gastrojejunal anastomosis (GJA) is a significant risk factor for weight regain after Roux-en-Y gastric bypass (RYGB). Endoscopic suturing techniques have been developed to correct this, which may have reduced periprocedural risk compared with revisional bariatric surgery. We describe the first series in Australia of endoscopic suturing using the Overstitch device for this purpose.

Methods: Patients selected for revisional endoscopic suturing had weight regain of at least 10% after RYGB, and endoscopic evidence of GJA stoma dilatation of ≥ 16 mm. All patients had the procedure performed under general anaesthesia and stayed 1 night in hospital. Outcomes measured include complications, BMI and excess weight loss (EWL) achieved. Statistics are reported as a mean \pm standard deviation.

Results: 10 patients underwent endoscopic suturing over 5 months (mean age 47 ± 9.1 years, 8 female). Mean BMI at the time of RYGB was 43.1 ± 7.2 kg/m². Post operative nadir BMI was 30.6 ± 6.4 kg/m². Mean BMI at endoscopic intervention was 35.4 ± 5.6 kg/m². Mean interval between RYGB and endoscopic intervention was 42.3 ± 13.3 months. Mean GJA aperture was 18.8 ± 2.3 mm, procedure time was 78 ± 16 minutes, and number of sutures used was 2.5 ± 0.7 . Mean stoma size after suturing was 8 ± 2.1 mm.

No complications were reported. At the last follow-up point at 6 months, mean BMI change and mean EWL change after Overstitch were 3.2 ± 2.14 kg/m² and $19.6 \pm 10.96\%$ respectively.

Conclusions: Endoscopic revision of the GJA appears to be safe and can potentially be done as a day only case. Initial results demonstrate a positive trend in EWL but longer follow up is needed.

Long-term efficacy of laparoscopic anti-reflux surgery on regression of Barrett's esophagus using BRAVO® wireless pH monitoring

Mr Benjamin Knight¹, Associate Professor Peter Devitt¹, Professor David Watson², Ms Lorelle Smith¹, Professor Glyn Jamieson¹, A/Prof Sarah Kathryn Thompson¹

¹University of Adelaide Discipline of Surgery, ²Flinders University Department of Surgery

Objective: To assess the longterm efficacy of anti-reflux surgery on Barrett's esophagus using BRAVO® wireless pH monitoring.

Background: Barrett's Esophagus (BE) is associated with chronic gastro-esophageal reflux and esophageal cancer. To date, studies have failed to demonstrate that preventing gastro-esophageal reflux with anti-reflux surgery halts the progression of BE, often due to difficulties in objectively proving an effective anti-reflux barrier.

Methods: Since 1991, all patients undergoing anti-reflux surgery across 2 hospital sites have been followed in a prospective database. Patients with BE and at least 5 years follow up were identified. All patients completed a clinical outcome questionnaire and underwent endoscopic assessment and pathological evaluation of their Barrett's esophagus. 48 hour pH monitoring was then performed with the wireless BRAVO® system.

Results: 50 patients (40M:10F) were included in the study, with average follow up of 11.9 years. 92% (46/50) reported their outcome of surgery as "excellent" or "good" and 86% (43/50) reported "none" or "mild" symptoms. Histological regression of Barrett's esophagus was seen in 40% (20/50). Percentage time pH<4 was significantly higher in those showing no pathological regression (p=0.008). 64% (32/50) showed endoscopic reduction in the length of Barrett's esophagus. Acid exposure was significantly less in this group (%time pH<4, 0.2 vs. 3.6 p=0.007).

Conclusion: Anti-reflux surgery is safe and effective in patients with Barrett's esophagus. An intact fundoplication, as assessed with BRAVO® wireless pH monitoring, suggests that anti-reflux surgery may halt the progression of Barrett's esophagus, and this might reduce the risk of cancer development.



Revolutionary New Robotics - what is around the corner

Dhan Thiruchelvam

Current robotic Surgery uses cable driven laparoscopic instruments to allow precision surgery and uses multiple ports and "straight stick" instruments with wristed graspers.

We have built and tested prototypes of magnetic actuated surgical instruments to allow either NOTES deployment or a single incision deployment of multiple instruments which operate intra abdominally freely via a magnetic actuated system.

This opens a world of vision and range of movement intrabdominally which is currently limited by port position and instrumentation Current robotic laparoscopic devices are connected to external power units by long rigid mechanical linkages, and so intra-abdominal dexterity of the tools are severely constrained.

This constraint can be removed by replacing the rigid mechanical link with magnetic linkages which couple the intra-abdominally deployed robotic surgical devices to the external power unit across the abdominal wall. This allows the device to be completely unattached to the external unit and to be fully inserted into the abdominal cavity via a single small incision or through the GI tract, providing the device with easy access to the entire abdomen. The device, embedded with small magnets, will be anchored to position on the abdominal wall by magnetic coupling of internal and external magnets. The external power unit can be achieved through another set of external and internal permanent magnets coupling across the abdominal wall, similar to a mechanical gear system, but in a magnetic version, for actuation of the robotic device. The actuation can also be accomplished using electromagnets on the external side which is the prototype we have developed.

Endoscopic Resection of Upper GI dysplasia and early malignancy

Michael Bourke

Early cancer and high grade dysplasia in the upper GI tract are increasingly detected due to the widespread adoption of endoscopy and endoscopic screening programs. In societies that have established endoscopic screening programs for upper GI malignancy, endoscopic treatment is now firmly entrenched as the first line therapy for early cancer due to superior cost, morbidity and mortality profiles with equivalent long term cure rates for early disease. Moreover endoscopic treatment provides definitive T staging as a result of complete excision of

the primary lesion and does not preclude or hamper the potential for subsequent surgery in the case of unexpectedly locally advanced or deeply invasive disease. For early cancer in the oesophagus or stomach, this is now routinely done by endoscopic submucosal dissection. This allows en bloc excision with wide and clear lateral margins and a deep margin to the level of the muscularis propria layer in a procedure that takes 1-2 hours with only a single overnight stay in hospital. The risk of adverse events in an appropriately resourced and experienced tertiary centre is negligible, perforation occurs in 1% but this is easily recognised and managed endoscopically. I will discuss the techniques involved in the endoscopic treatment of early cancer and high grade dysplasia in the UGIT and the international and local results.

Endoscopic therapy to replace surgery in benign and functional conditions

Michael Talbot

The last decade has seen flexible, intraluminal endoscopy encroach on traditional surgical procedures in the same way that laparoscopy encroached on open surgery during the previous decade. ERCP dominates the management of bile duct stones despite the development of laparoscopic techniques, and endoscopic resection/ablation dominates management of pre-and-early stage malignant conditions of the entire foregut despite the parallel introduction of minimally invasive surgical techniques.

Two recent and successful major forays into traditional surgical spheres include endoscopic management of GI perforations and fistulae and development of endoscopy in the submucosal plane for per-oral endoscopic myotomy, pyloromyotomy and submucosal tumour resection. These techniques will be discussed including setup, equipment, and current indications/limitations.

Two major areas of endoscopic endeavour into laparoscopy, reflux and bariatrics, are yet to be successful despite significant industry investment however general surgeons should consider all of these fields as being of increasing importance and consider either learning the techniques or referring patients on in cases where clear benefits are present.

Recurrent reflux symptoms after fundoplication - How I Assess

David Gotley

Modern laparoscopic fundoplication is an effective, safe and long-term management strategy for GORD. Over the long-term between 5 and 10% of patients will re-present with recurrent symptoms. However not all of these patients

will have recurrent reflux, and those that do will not always require a revision operation.

It is crucial therefore to get management decisions right.

Assessment of patients requires a full and careful history and investigations. Did the patient actually have reflux in the first place? Recurrent symptoms are usually the same as the original ones, though less severe. Regurgitation is by far the most reliable symptom, followed by classical heartburn. Far less reliable are laryngo-pulmonary symptoms and chest pain. Primary mouth symptoms are very unreliable. Requisite investigations include careful endoscopy, taking note of any oesophagitis and the state of the LOS. If still unsure, pH monitoring is still the gold standard. A solid phase gastric emptying study should be done if delayed gastric emptying is suspected.

The next step is to decide whether the patient should have remedial surgery, and here traditional indications apply-effect on QOL, and complications such as aspiration. Ultimately, many are best treated with medication rather than operation.

Composite fundoplication for reflux disease: technique and rationale (NSW)

Gregory L Falk, Trevor J D'Netto

Aim: video description of a novel technique based upon historical methods of fundoplication designed to reduce the potential for recurrent reflux due to anatomical disruption.

Methods: video demonstration of the current status of the development of the technique with discussion of recurrence type and potential benefits of the technique

Band, Sleeve, Bypass (RYGB and Mini) and Ringed Bypass - who gets what & why

Michael Talbot

While gastric band, sleeve and bypass are well described procedures which can be learned and taught by surgeons, most practitioners tend to strongly favour a preferred operation that will account for >80% of their caseload. In a multi-procedure practice, all procedures are offered but this involves significant complexity for both the surgeon and the patient. For the surgeon the learning curve is a significant barrier as are the widely differing practice requirements and consent processes. For the patients there is a significant learning requirement to understand the differences in the positive and negative physiologies of these operations and the differing requirements for follow-up and psychological and behavioural change.

It has been, and it remains the authors view that all the current procedures have validity and can be offered to patients as part of "standard of care".

Gastric bands have been shown to work well in motivated patients whose weight-loss goals are consistent with what the procedure can offer and in whom the barriers to initial follow-up can be easily managed. Revision bands work well in patients who have had good weightloss with the device but have developed complications that have not adversely affected oesophageal function.

Sleeve gastrectomy allows good weight loss in patients who perceive barriers to some of the compliance that the LAGB requires, or whom functional or medical conditions may not be predictably resolved. While followup is still likely to be important, the majority of patients will not develop dangerous side effects from non-compliance with diet, supplements, and specialist advice. From the surgeon's point of view this creates the illusion that followup may not be required. While the sleeve may provide a degree of medicolegal protection from failure to provide structured followup, the patient may well fail to maintain long term benefits from surgery. The sleeve will function well as a revision procedure in patients with preserved oesophageal (motor and sensory) function.

Gastric bypass surgery requires climbing a significant learning curve and creation of a complex follow-up program with all of its cost and logistical implications. It is not a procedure that perhaps is as broadly applicable to many of that patients we see but the data for a range of conditions such as super-obesity, severe diabetes, reflux and in the revision patients remain compelling.

In this presentation the data and philosophy behind the advice given to patients before surgery will be discussed.

Debate - Why the Mini bypass is the best revision operation post band!

Michael Hii

Adjustable gastric banding is a popular bariatric procedure, however there is a long-term revision rate, which can necessitate conversion to alternate procedures. Single anastomosis gastric bypass is emerging as a standard primary procedure and has been reported as a promising revision option for patients requiring an alternate procedure after gastric banding.



Bochdalek Hernia Repair

Perez Cerdeira M^{1,2}, Bull N^{1,2}, Ghusn M^{1,2}

¹Tweed Hospital, ²John Flynn Hospital

66 year old female presented to Emergency Department with acute epigastric pain, nausea and vomiting. Abdominal CT showed a paraoesophageal hernia. With the suspicion of incarceration patient had a laparoscopy where both hiatal and Bochdalek's hernias were found. Patient had an uneventful recovery.

We presented the surgical steps of the operation, including mesh repair of the Bochdalek's defect.

Robotic Sleeve Gastrectomy performed in under 60 minutes. The 20th Robotic Sleeve Gastrectomy performed by a consistent surgical team.

Silverman C¹, Ghusn M¹

¹John Flynn Private Hospital

This video aims to illustrate technical points in utilising the robot to perform a sleeve gastrectomy. The sleeve gastrectomy is seen as an ideal training operation to perform when introducing the da vinci Robot into a bariatric surgical practice. Theatre Set up, Port positioning, and Surgical technique has evolved over the course of 20 Robotic Sleeve Gastrectomy procedures performed by a consistent surgical team. Each aspect is discussed and illustrated with video.

Sleeve gastrectomy can be performed safely robotically prior to using the robot for more complex bariatric procedures such as gastric bypass where the advantage of the robot may be more evident.

Achalasia - the case for Heller's myotomy - a surgical standard

Michael Talbot

Achalasia has become a disorder of increasing interest. There are improved technologies available to help in the diagnosis and classification of the condition, leading to earlier and perhaps more frequent diagnosis and the arrival of a third method of treatment has disturbed the uneasy rivalry of pneumatic dilation and laparoscopic Heller.

In this presentation I will discuss the current indications and limitations of these procedures from the perspective of a surgeon who freely offers all 3 treatments so is happy to declare a bias based on outcomes experienced with the treatments and how this affects what patients are offered.

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With great enthusiasm we wish to invite you to Sydney in 2016 to discuss some of the more difficult areas of Bariatric Surgery. With an experienced Australasian and New Zealand faculty and invited speakers renowned for their ability to manage complex patients we aim to delve into the issues that concern us most when trying to manage our patients on a day to day basis.

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Michael Talbot, 2016 OSSANZ Conference Convenor



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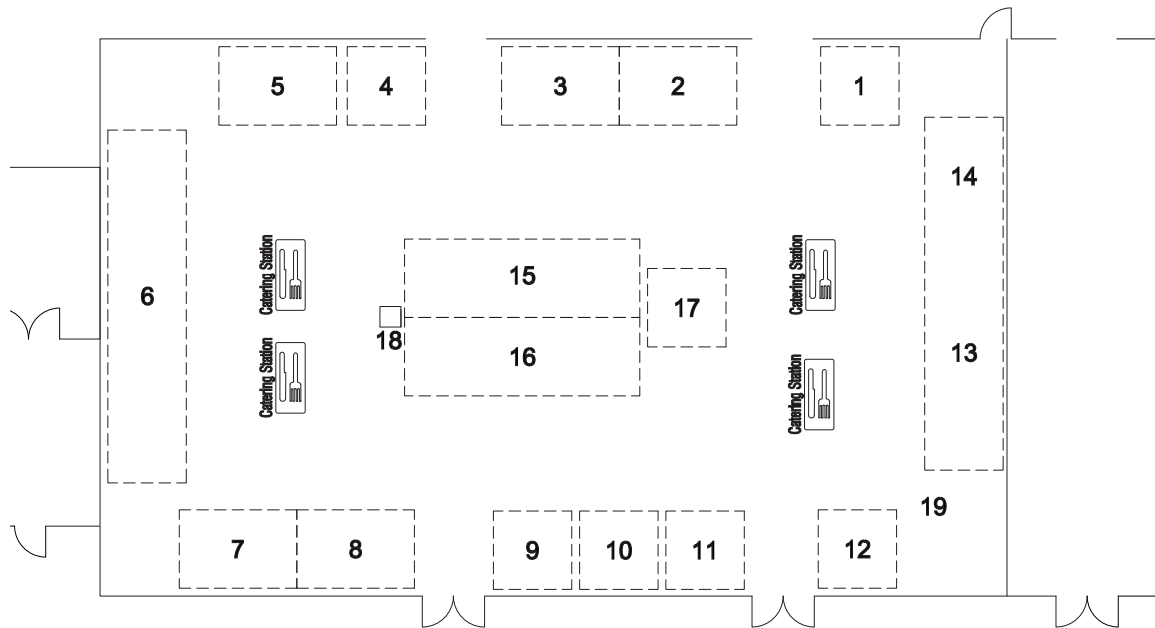


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