

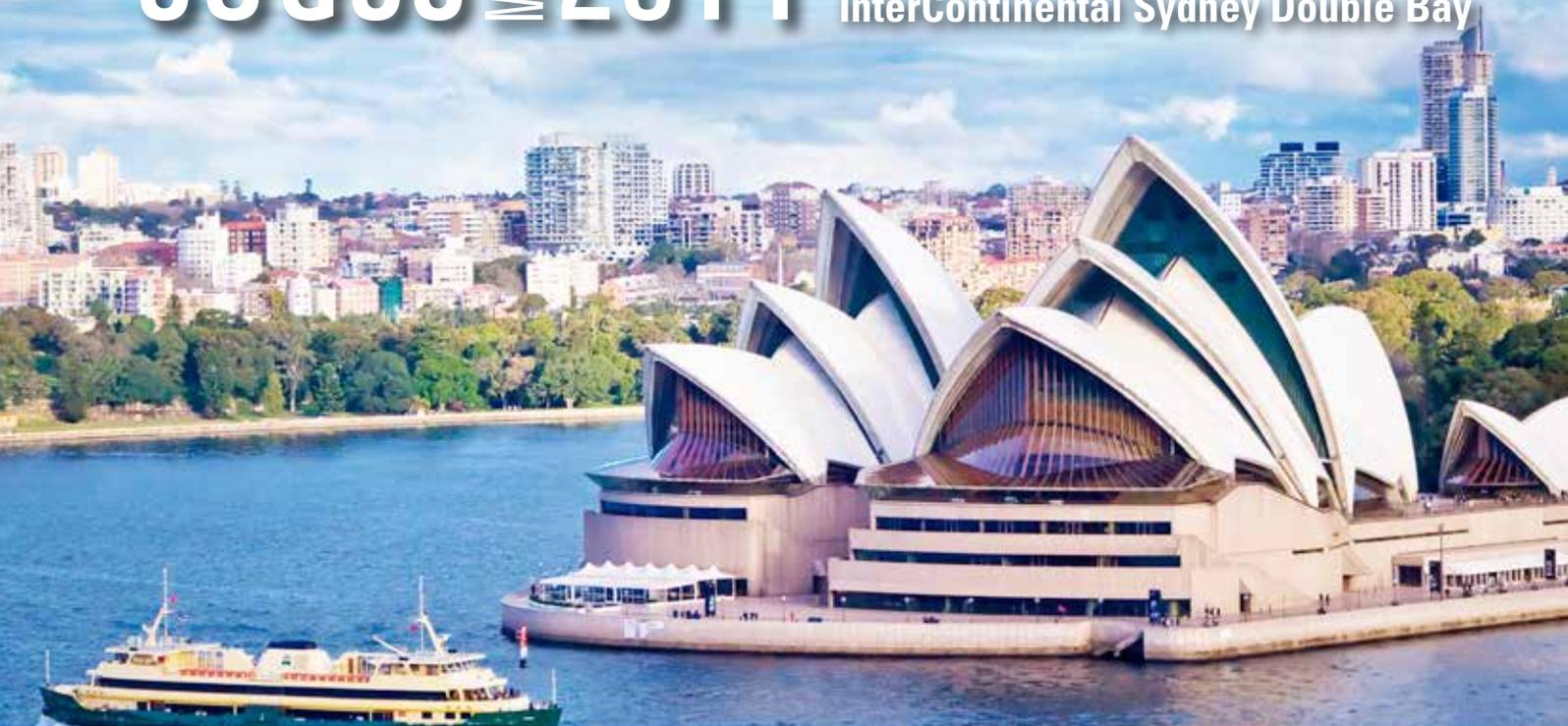
“State of the Art”

SUGSS
Sydney Upper GI
Surgical Society


INTERCONTINENTAL
SYDNEY DOUBLE BAY

SUGSS MEETING 2014

Saturday 6 December, 2014
InterContinental Sydney Double Bay



FINAL PROGRAM

& ABSTRACTS

INTERNATIONAL FACULTY

Simon Dexter, UK

AUSTRALIAN FACULTY

Michael Bourke, Sydney

David Gotley, Brisbane

Koroush Haghighi, Sydney

Glyn Jamieson, Adelaide

Ian Martin, Brisbane

Neil Merret, Sydney

David Morris, Sydney

Nick O'Rourke, Brisbane

Charbel Sandroussi, Sydney

Michael Talbot, Sydney

John Yiannikas, Sydney

CONVENORS

David Martin

Michael Talbot



VIDEOS AND CUTTING EDGE TECHNIQUES

- Radical Laparoscopic Resection for Upper GI Cancer
- Evolved Techniques and Status of Laparoscopic Incisional Hernia Repair
- Surgery for Peritoneal Disease in Stomach Cancer
- Cold Isolation for Advanced Liver Resection
- Endoscopic Resection for Upper GI Cancer
- Laparoscopic Anastomotic Techniques for the Oesophagus
- Robotic & 3D Bariatric Surgery
- Vascular Resection in Pancreatic Cancer
- Hiatus Hernia and the Heart - an important indication for surgery
- Consensus Statement on Laparoscopic Liver Resection
- Preventing Recurrence in Hiatus Hernia Repair



PRESIDENT'S WELCOME



Dear Colleagues,

It is with great pleasure that we invite you to the Annual Sydney Upper GI Surgical Society (SUGSS) meeting. This year we are in beautiful Double Bay on the

banks of the Sydney Harbour in pleasant early summer Sydney weather. Set in a boutique harbour bayside suburb we are a stone's throw from both the CBD and stunning beaches and coves.

SUGSS is the first active Upper GI group in Australia and this year, driven by the strength of our NSW Upper GI colleagues, has pulled back on its political hat to rally together to represent the interests of these surgeons, their patients and regions.

This has demonstrated not only the common interests of our group but the benefit of being an organised, co-operative and functional team when required. To this end we invite you to participate in this opportunity for fostering relationships, expanding our horizons and socialising with colleagues, their families and our trainees.

We have put together what we hope you will find is a great one day program, packed full of interesting speakers with challenging and novel topics and enough time to catch up with colleagues from near and far. Conveniently placed on a Saturday with dinner to follow, the line up of speakers from both international and interstate regions, and from within and outside our specialties makes for an invigorating program that we hope will hold very strong interest for both the dedicated subspecialist but also the part timer who is interested in developing skills, technology and changing indications.

For Fellows and registrars it will be a great opportunity, not only to keep abreast of cutting edge changes in surgery, but also to meet current and potential mentors and be stimulated to consider future fellowship and career opportunities.

To make it even more exciting, not only are we holding the conference in the iconic refurbished and recently re-opened Double Bay Hotel, made infamous by Michael Hutchence of INXS fame, but you can continue the rock star feel afterwards at our conference dinner, watching the late summer evening drift on over the harbour at the award winning Catalina Restaurant sitting out above the water in neighbouring Rose Bay. We also have a special prominent National guest speaker for the dinner who will no doubt pique your interest and may provide you with some interesting insight and inspiration.

WELCOME and enjoy!

David Martin

SUGSS

Sydney Upper GI Surgical Society

SUGSS (Sydney Upper Gastro-Intestinal Surgical Society) is the representative body for NSW Upper GI surgeons.

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 co-operative 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).

SUGSS recently represented this group of surgeons with the NSW government during the rationalisation of cancer services.

The board members of **SUGSS** are; David Martin - Chair (Royal Prince Alfred Hospital/Concord Repatriation Hospital), Michael Talbot - Treasurer (St George Hospital), Steve Liebman (Royal North Shore Hospital) and Henry Pleass (Westmead Hospital). The Committee of Management includes Charbel Sandroussi (Royal Prince Alfred Hospital), Koroush Haghighi (St Vincent's and Prince of Wales Hospitals), Nick Williams (Wagga Wagga Base Hospital) and Peter Cosman (Liverpool Hospital).

It is the only local association for Upper GI surgeons in NSW and preceded by the ANZHBPA and ANZGOSA Associations. SUGSS hosts an Annual Meeting in Sydney which is very successful and well attended.

INVITED SPEAKERS



Dr Simon Dexter

Consultant Upper GI Surgeon, Leeds Teaching Hospitals Trust, UK

Dr Simon Dexter has been a consultant upper GI surgeon at the Leeds Teaching Hospitals Trust, UK since 2000.

Dr Dexter has been involved in laparoscopic surgery since its inception in the UK in 1990 and was the UK's first laparoscopic surgery research fellow. His advanced surgical training took him through Leeds General Infirmary, the Chinese University of Hong Kong, Tufts Medical Centre, Boston, USA, and the National Cancer Centre Hospital, Tokyo.

Dr Dexter specialises in oesophago-gastric and bariatric surgery. He is currently Secretary of the Association of Laparoscopic Surgeons of GB and Ireland, and served until recently on the executive council of the British Obesity and Metabolic Surgery Society and the council of the Association of Upper GI Surgeons of GB and Ireland.

Dr Dexter's clinical interests are functional oesophago-gastric disease, upper GI cancer and bariatric surgery. Away from surgery he is usually busy with his family including 4 daughters, and an increasing number of music and real ale festivals.



Professor Glyn Jameison

Discipline of Surgery, University of Adelaide, South Australia

Professor Jamieson graduated from the University of Adelaide Medical School and obtained his Australasian Fellowship in the College of Surgeons in 1971. He then undertook further surgical training in the United Kingdom and the United States of America before returning to Adelaide as Senior Lecturer in the Department of Surgery in 1975. He was appointed to the Dorothy Mortlock Chair in Surgery at the University of Adelaide in 1982, a position he held until 2012.

His clinical and research interests are concentrated in the area of upper gastrointestinal surgery, with specific interests in upper gastrointestinal motility and surgery of the oesophagus.

His other interests include music, wine and old English glass (collects the glass to drink the wine while listening to the music). He has a small farm, on which he developed a vineyard, and he has a degree in winemaking.



Announcement of \$ 5,000 SUGSS Covidien Travelling Fellowship



A sincere thank you to Covidien, who has been a long term partner and major sponsor of SUGSS, for providing this Travelling Fellowship for this year's Meeting. Two papers were chosen and these will be presented during the "Covidien Prize 2014 Presentation Talk" in the late afternoon session.

ELIGIBILITY

Open to consultants within their first 2 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.

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.

PREVIOUS TRAVELLING FELLOWSHIP RECIPIENT

This year we are very pleased to have a previous SUGSS Covidien Travelling Sponsorship winner, Sebastian Kwon, to talk about his extensive experience with several of the busiest international Upper GI units in South East Asia and the UK and their contrasting approaches to Upper GI cancer.

GUEST SPEAKERS



Prof Michael Bourke

*Director of Gastrointestinal Endoscopy,
Westmead Hospital, Sydney*

Michael is Professor of Medicine, University of Sydney and Director of Gastrointestinal Endoscopy at Westmead Hospital. He is Co-editor of the journal *Endoscopy* and convenor of the Sydney International Endoscopy Symposium (SIES). He and his team have an international reputation for pioneering endoscopic therapy techniques and research to influence clinical practice, particularly in the field of colonoscopy, polypectomy, advanced endoscopic tissue resection ERCP and Barretts neoplasia.

Prof David Gotley

*Head of the Department of Surgery,
University of Queensland, Brisbane*

David Gotley graduated in Medicine from the University of Sydney in 1978 and trained in Surgery at St Vincent's Hospital, Sydney. He obtained his Doctorate from the University of Bristol, England, in Studies on the Genesis of Reflux Oesophagitis. He joined Mark Smithers at the Princess Alexandra Hospital, Brisbane in 1990 and together formed the Upper Gastrointestinal and Soft Tissue Unit, later joined by Ian Martin, Andrew Barbour and Iain Thompson.

Research interests have included the molecular mechanisms of tumour spread, clinical aspects of oesophago-gastric cancer, and laparoscopic techniques in upper gastrointestinal surgery. He has been Professor of Surgery at the University of Queensland since 1998.

Dr Eric Hazebroek

*Department of Surgery, St. Antonius Hospital,
Nieuwegein/Utrecht, the Netherlands*

E.J. (Eric) is a consultant surgeon at St. Antonius Hospital, Nieuwegein/Utrecht, the Netherlands. His main clinical interests are laparoscopic upper GI surgery, oesophago-gastric cancer, and revisional procedures for reflux disease, hiatal hernia and bariatric surgery. He has published widely in journals and textbooks on laparoscopic surgery, anti-reflux surgery and surgery for hiatal hernia repair.

He is currently board member of the Dutch Society of GI Surgery, board member of the Dutch Upper GI Working Group and member of the Committee on Accreditation of Surgical Education of the Dutch Society of Surgery.

He is a lead investigator for two current Dutch RCTs looking at fundoplication and hiatal closure techniques respectively.

Eric is married and father of three sons. In his spare time he likes to play the guitar, does open water swimming and also enjoys tennis and cycling.

Dr Ian Martin

*Hepatobiliary and Upper Gastro-Intestinal
Surgeon, at The Wesley and Princess
Alexandra Hospitals, Brisbane.*

Dr Ian Martin is a hepato/pancreaticobiliary and upper GI Specialist Surgeon working at The Wesley and Princess Alexandra Hospitals in Brisbane and is published widely in his areas of interest.

He also has a special interest in hernia repair, particularly laparoscopic, and has been performing instructional workshops on hernia repairs for the past 15 years. Ian has also published randomised trials and basic research on the subject.

Outside of work, and rather than sleeping, he enjoys elite adventure racing, triathlon and kayaking between countries.

Prof David Morris

*Head of Department (UNSW Department of
Surgery, St George Clinical School, St George
Hospital, Sydney)*

Prof Morris is a world expert and pioneer of peritonectomy surgery in Australia. He has performed over 800 peritonectomies, has over 600 peer reviewed publications, and a cancer lab that is developing 4 cancer medications. His dedication to this difficult work has seen him and this area of medicine prominently placed in the public domain, enticing emotive headlines and political and ministerial responses.

Dr Nicholas O'Rourke

*Laparoscopic and Hepatobiliary Surgeon,
Wesley Hospital, Brisbane*

Dr Nicholas O'Rourke has been consulting in general, laparoscopic and hepatobiliary surgery at the Wesley since 1994. Dr O'Rourke has a special interest in general laparoscopic surgery, including laparoscopic hernia and cholecystectomy. He is renowned nationally and internationally as an expert in laparoscopic liver and pancreatic surgery, and frequently lectures on these topics. Dr O'Rourke also performs other laparoscopic surgery, including laparoscopic banding, thoracoscopic sympathectomy, and has an interest in laparoscopic surgery for the acute abdomen.

Dr O'Rourke has a Bachelor of Medicine and Bachelor of Surgery from the University of Queensland. He is a Fellow of the Royal Australian College of Surgeons and is currently the immediate past President of the Australia and New Zealand Hepato Pancreatic Biliary Association.

Dr John Yiannikas

*Clinical Associate Professor of Cardiology,
University of Sydney*

John Yiannikas is a clinical cardiologist previously on the staff of the Cleveland Clinic and currently is a senior consultant cardiologist at Concord Hospital Sydney. He has published more than 100 peer reviewed papers, abstracts, books and chapters.

He is currently doing ground breaking work on the cardiac effects of hiatus hernia using CT, MRI, and Echo Doppler. His reported work in this field was also published and highlighted with an editorial in the prestigious *Journal of the American College of Cardiology*, and nominated as a highlight of research for that year.

PROGRAM

SATURDAY 6 DECEMBER 2014

Time	Program
0800	Registration Opens
0900 – 1030	MORNING SESSION: Cutting Edge Minimally Invasive Techniques – Chairs David Martin and Garett Smith
0910 – 0920	President's Welcome – David Martin
0920 – 0930	Surgical Technique. <i>Robotic vs 3D for Primary and Revision Roux En-Y Gastric Bypass</i> – Michael Talbot
	 
0930 – 0935	Q & A
0935 – 0950	<i>Through the Scope - Endoscopic Options for Upper GI Malignancy</i> – Michael Bourke (Keynote Speaker)
0950 – 0955	Q & A
0955 – 1010	Video Techniques. <i>The Current Status of Laparoscopic Ventral and Incisional Hernia Repair</i> – Ian Martin (Keynote Speaker)
1010 – 1015	Q & A
1015 – 1025	<i>Laparoscopic Oesophago-jejunostomy - Perfecting the Technique</i> – Simon Dexter (Keynote Speaker, UK)
1025 – 1030	Q & A
1030 – 1100	Morning Tea
1100 – 1240	PRE-LUNCH SESSION: Oesophageal Surgery – Wisdom and New Frontiers – Chairs Steve Leibman and Reg Lord
1100 – 1115	<i>Pearls for Oesophageal Surgeons</i> – Glyn Jamieson (Keynote Speaker)
1115 – 1120	Q & A
1120 – 1130	Video. <i>Laparoscopic Preparation of the Gastric Conduit in Oesophagectomy</i> – Simon Dexter (Keynote Speaker, UK)
1130 – 1135	Q & A
1135 – 1145	Video. <i>Thoracoscopic Lymphadenectomy in Oesophagectomy</i> – David Gotley (Keynote Speaker)
1145 – 1150	Q & A
1150 – 1200	Video. <i>Thoracoscopic Oesophageal Anastomosis – Setting it Up and Getting it Right</i> – Simon Dexter (Keynote Speaker, UK)
1200 – 1205	Q & A
1205 – 1215	<i>Colonic Reconstruction - How I Do It</i> – David Gotley (Keynote Speaker)
1215 – 1220	Q & A
1220 – 1240	PANEL DISCUSSION
1240 – 1340	Lunch

PROGRAM continued

1340 – 1500	POST-LUNCH SESSION: <i>No Surrender - Pushing The Limits To Cure Cancer</i> – Chairs Charlie Mosse and Nick Williams
1340 – 1355	<i>Vasc Techniques in Pancreatic Surgery</i> – Koroush Haghighi
1355 – 1400	Q & A
1400 – 1415	<i>Preservation Techniques for Extending Liver Resection</i> – Charbel Sandroussi
1415 – 1420	Q & A
1420 – 1435	<i>Peritonectomy in the Setting of Upper GI Malignancy</i> – David Morris (Keynote Speaker)
1435 – 1440	Q & A
1440 – 1455	<i>Report from OCT 2014 Japan World Consensus Meeting on Laparoscopic Liver Resection & Video of Current Techniques</i> – Nick O'Rourke (Keynote Speaker)
1455 – 1500	Q & A
1500 – 1520	PANEL DISCUSSION
1520 – 1550	Afternoon Tea
1550 – 1720	AFTERNOON SESSION: <i>The Heart, the Hiatus, the Oesophagus and Prize Winners</i> – Chairs Michael Talbot and Ross Roberts (NZ)
1550 – 1600	<i>What You, Your Cardiologist and Every Doctor Needs to Know About the Effect of the Hiatus Hernia on the Heart</i> – John Yiannikas (Keynote Speaker)
1600 – 1605	Q & A
1605 – 1615	<i>New Frontiers In Oesophageal Diagnostics and Therapeutics</i> – Michael Talbot
1615 – 1617	Q & A
1617 – 1625	<i>Preventing Hiatal Hernia Recurrence in Lap Massive Hiatus Hernia Repair in the Mother Country. The British Perspective</i> – Simon Dexter (Keynote Speaker, UK)
1625 – 1627	Q & A
1627 – 1635	<i>Hiatus Hernia and Fundoplication from the Land of Clogs, Arjen Robben and Randomised Controlled Trials. The Dutch Perspective</i> – Eric Hazebroek
1635 – 1637	Q & A
1637 – 1645	Previous Covidien Scholarship Recipient Talk. <i>Asian vs Western Perspectives on Oesophago-gastric Cancer</i> – Sebastian Kwon
1645 – 1647	Q & A
	Covidien Prize 2014 Presentation Talks
1647 – 1652	Philip Le Page , <i>Surgical and Endoscopic Management of Oesophageal High Grade Dysplasia and Adenocarcinoma</i>
1647 – 1701	1652 – 1654 Q & A
	1654 – 1659 Carlo Pulitano , <i>Replacement of the Inferior Vena Cava with Biological Grafts: the Royal Prince Alfred Experience</i>
	1659 – 1701 Q & A
1701 – 1709	Video Technique. <i>How and Why I do it - Jejunal Pouch for Oesophago-jejunal Anastomosis</i> – Neil Merrett
1709 – 1724	PANEL DISCUSSION
1724 – 1730	Closing Remarks – Michael Talbot
1845	Coach departs the InterContinental Hotel for Catalina Restaurant
1900	Conference Dinner - Catalina Restaurant, Lyne Park, New South Head Rd, Rose Bay



THE VENUE



INTERCONTINENTAL
SYDNEY DOUBLE BAY

InterContinental Sydney Double Bay

33 CROSS STREET, 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.



CONFERENCE DINNER

CATALINA RESTAURANT - Saturday 6 December, 7pm - late

Coach departs the InterContinental at 6:45pm

Lyne Park, New South Head Rd, Rose Bay

Cost: \$ 0 per delegate (included in registration)
\$ 120 per accompanying person (*Unfortunately no children are permitted*)

Includes: Gastronomical menu, accompanied by fine beverages.
Return coach transfers from the InterContinental Hotel.

Catalina is one of Australia's great destination restaurants situated on a landmark Rose Bay site on Sydney Harbour's eastern foreshore. Michael and Judy McMahon opened Catalina in 1994 with a simple goal: to be Sydney's favourite place to eat the best by the water.

Rose Bay was the site of Australia's first international airport. From 1938, flying boats, including the famous Catalinas ruled the skies. In 1957, local identity Jim Bendroit built a restaurant and nightclub called Caprice, jutting out over the water. Caprice captivated Sydney-siders for years and was the hottest spot in town.

After the heyday of the Caprice era and years after the last of the big flying boats had flown out, the McMahons extensively renovated the building with architect Leigh Prentice. The restaurant was designed as a homage to the beauty of Sydney Harbour. Diners have a panoramic view of Sydney Harbour at water-level, punctuated only by the comings and goings of a working harbour, and incoming commuter sea planes based in front of the restaurant.

Awards



**** Tickets are still available, see the registration desk! ****

AFTER DINNER SPEAKER

Dr David Cropley

University of South Australia

Innovation and creativity and healthy lifestyles (for the busy Surgeon)

David Cropley is an academic, author and TV host who specialises in creativity and innovation and has also set 2 world records in endurance indoor rowing. He was featured in the ABC series "Redesign you Brain" with Todd Sampson.



ABSTRACTS

Michael Talbot

Upper Gastrointestinal, Laparoscopic and Endoscopic Surgeon,
St George Hospital, Sydney

Robotic vs 3D for Primary and Revision Roux En-Y Gastric Bypass

Robotic and 3D laparoscopy are adjuvants to the laparoscopic technique which may improve outcomes in complex surgery by improving visualization and depth perception (Robotic and 3D laparoscopy), as well as fatigue reduction, improved surgical access, precision and dexterity (Robotic).

While these modalities offer clear advantages for surgeons in their learning curve, it is likely that surgery which is truly complex enough to burden experienced surgeons is uncommon enough to make proving a clinical benefit rather difficult.

Revision bariatric procedures contain elements which could benefit from learning curve reduction (dissection and suturing) and reduction in physical work (fatigue from prolonged surgery). In this presentation I will go through the aspects of both adjuvant techniques in a relatively common and complex procedure, the revision roux-en-y gastric bypass.

Ian Martin

Consultant Hepatobiliary and Upper Gastro-Intestinal Surgeon
The Wesley and Princess Alexandra Hospitals, Brisbane

The Current Status of Laparoscopic Ventral and Incisional Hernia Repair

An anecdotal approach to laparoscopic incisional hernia repair will be presented including tips and pitfalls. Patient selection, port site positioning, mesh types and fixation techniques will be covered.

David Gotley

Upper Gastrointestinal and Soft Tissue Unit,
Princess Alexandra Hospital, Brisbane

Thoracoscopic Lymphadenectomy in Oesophagectomy

In oesophageal resection for cancer we employ a Two Field "Standard" lymphadenectomy en bloc with a subtotal oesophagectomy. In this operation, overlying pleura, nodal tissue inferior to the azygos arch, right and left bronchial and sub-carinal nodes, and tissue between the oesophagus and aorta to the diaphragm, including thoracic duct as appropriate, are resected.

The approach is via 3 or 4 ports in the right posterior thorax with the patient in the prone position with the head in a Mayfield support. After staple division of the azygos vein, the oesophagus and nodal tissue are dissected and slung at a level below the sub-carinal nodes. The dissection proceeds using the diathermy hook, along the aorta to the diaphragm, then along the posterior border of the lung. Sub-carinal/bronchial nodes are then dissected. Large vessels are secured with clips, and the thoracic duct is ligated and clipped inferiorly in the posterior thorax. The video clip shows some of the key stages of the dissection.

The technique has been designed to mimic what is achieved in open thoracotomy, to be safe in a teaching environment, is relatively inexpensive in terms of resources, and is facile with a mean operating time of 75 minutes. It has been employed to date in 680 of 970 oesophagectomy patients in our Unit.

David Gotley

Upper Gastrointestinal and Soft Tissue Unit,
Princess Alexandra Hospital, Brisbane

Colonic Reconstruction – How I do It

Traditional teaching 30 years ago had trans-thoracic colonic interposition as the ideal reconstruction technique after oesophagectomy. However, in patients with benign oesophageal disease or with long-term survival after oesophagectomy for cancer, the colonic interposition becomes dilated, elongated and tortuous providing side effects of stasis and regurgitation that can be intolerable. From 2003, we dealt with existing troublesome colon interpositions by "sleeve resection coloplasty". We also changed our method of colonic reconstruction to a retro-sternal position, after trialling a variety of reconstruction techniques.

The key features of our current technique include: Use of iso-peristaltic transverse and proximal descending colon, vascular supply based on the ascending branch of the left colic artery, minimal length of colon interposition in the abdomen, and anastomosis distally to a 45cm Roux-en-Y loop of jejunum. This presentation outlines the important points of the technique that ensure a safe and reproducible operation, giving excellent long term functional results and no incidence to date of a need for late reoperation.

Currently, gastric pull-up is the reconstruction of choice after oesophagectomy in our view. The indications for colonic reconstruction are relatively few but include absence of satisfactory stomach, including previous gastric conduit necrosis, or inability to satisfactorily negotiate the intra-thoracic space. During the past 10 years, we have undertaken 23 such substernal colonic reconstruction operations, with no instances of anastomotic leak or colonic conduit necrosis.

David Morris

UNSW Department of Surgery, St George Hospital, Sydney

Peritonectomy/HIPEC for Gastric Cancer

We have done well over 800 peritonectomy/HIPEC procedures but less than a handful for gastric cancer.

Peritonectomy/HIPEC is indicated in gastric cancer with peritoneal disease if the PCI is less than 10 based on a number of cohort studies and one RCT with an expected 5 year survival of 20%.

PCI is easily calculated – 9 quadrants + 4 small bowel; 0-3 each; 0=0, 1=<5mm; 2=5mm-5cm; 3=>5cm.

If you do staging laparoscopy please use midline ports.

In full thickness gastric cancer without peritoneal disease there are 10 x RCT showing significant advantage to IP chemo. Couldn't we see them?

Nicholas O'Rourke

Laparoscopic and Hepatobiliary Surgeon
Wesley Hospital, Brisbane

Report from OCT 2014 Japan World Consensus Meeting on Laparoscopic Liver Resection & Video of Current Techniques

The first consensus meeting on laparoscopic liver surgery was held in Louisville Kentucky in 2008. Joe Buell was the convenor and I was fortunate to be on the organizing committee for this. The subsequent publication in annals of surgery in 2009 has been very influential.

The second consensus meeting was held in early October 2014 in Morioka Japan. This was convened by Go Wakabayashi. This consensus meeting was more formally run along the lines of a Zurich consensus model. Multiple experts delivered presentations on predetermined topics to a panel of independent jury members who then shall formulate a statement based on their assessment of these reports.

The jury members included Steven Strasberg as chief, Russell Strong, Bill Jarnagin, C.M.Lo, and Jeffrey Barkum. Among others. I was fortunate enough to present on pain differences in laparoscopic surgery versus open and also on the role of CO₂ pneumoperitoneum and the Pringle maneuver.

For this presentation I shall summarise the highlights of the meeting and entertain the crowd with lewd photographs.

John Yiannikas

Clinical Associate Professor University of Sydney
Senior Consultant Cardiologist
Concord Repatriation General Hospital, Sydney

Cardiac Effects from Large Hiatus Hernia

Large hiatus hernia is a relatively common condition and of little interest to cardiologists. Dyspnoea and poor effort tolerance is however common in these patients. Dyspnoea is frequently misdiagnosed in this cohort and patients are denied surgery because of perceived increased operative risk from 'unrelated cardio-respiratory problems'. We have documented that respiratory function on average is normal in these patients. The close proximity of the oesophagus to the left atrium, pulmonary veins and coronary sinus suggests that cardiac compression may be important.

We have prospectively studied the pathophysiology and clinical significance of such cardiac compression and find:

1. Significant compression of Left Atrium, Pulmonary Veins and Coronary Sinus is common.
2. Poor exercise capacity is common; dramatically improved post-operatively and predicted by degree of pre operative Left Atrial compression.
3. Hiatus hernia related compression reduces maximal LA filling and active LA emptying and enhances passive LA emptying.
4. Dynamic worsening obstruction documented following meals, exercise and Valsalva.
5. Many unrecognised clinical patterns of presentation observed.
6. Results allow better selection of patients for significant clinical benefit from laparoscopic surgery for patients previously denied this therapy.

Michael Talbot

Upper Gastrointestinal, Laparoscopic and Endoscopic Surgeon,
St George Hospital, Sydney

New Frontiers In Oesophageal Diagnostics and Therapeutics

High Resolution Manometry with or without Impedance or 3D measurements (HRM, HRIM, 3DHRM) has become the gold standard in diagnosing oesophageal motility disorders allowing not only greater ease of testing but also the ability to detect disorders that are unable to be easily characterized with single channel catheters. With newer diagnoses coming on-line we now also have an expanding group of therapies that we have previously been unable to offer.

There have been parallel (although less significant) changes in reflux diagnosis and therapeutics with the ability to more accurately detect proximal and non-acid reflux, and also the development of less invasive surgery to treat reflux.

The aim of this presentation is to cover some of the aspects in these advances that will impact upon surgical practice.

Neil Merrett

Program Director of Surgery SWSLHD, Head: Upper GI Surgery SWSLHD,
Director of Surgery: Campbelltown Hospital, Sydney

Hunt-Lawrence Pouch Reconstruction Following Radical Total Gastrectomy

Radical Total gastrectomy including a D1+/D2 lymphadenectomy is now regarded as standard of care for the treatment of carcinoma of the Gastric body, fundus, Siewert 1 COJ tumours and selected siewert 2 tumours. Methods of reconstruction however have not been standardised.

Quality of life following Total Gastrectomy is impaired by effects include early satiety, failure to gain weight, epigastric pain, bile reflux, and early and late dumping. With improvements to long term survival following radical gastrectomy for cancer, these effects can be debilitating for the patient. In an attempt to improve some of these effects, reconstruction with various forms of pouches have been proposed since the early 1980s. Reconstruction with a Hunt-Lawrence pouch is one such method which has been used as the routine method of reconstruction following radical total gastrectomy in Bankstown Hospital since 1995.

This talk comprises a literature review of outcomes as well as local early and oncological outcomes with the technique. The method of construction of a Hunt-Lawrence pouch is illustrated via stills and short video presentation.

Philip Le Page

Upper GI, Laparoscopic, Obesity, General Surgeon
Concord Hospital, Sydney

Surgical and Endoscopic Management of Oesophageal High Grade Dysplasia and Adenocarcinoma

BACKGROUND: The introduction of endoscopic techniques has led to debate about optimal management of early oesophageal adenocarcinoma. The aim was to evaluate patient selection and outcomes for endoscopic or surgical treatment at a tertiary referral centre.

METHODS: A prospectively collected database of consecutive patients staged with high-grade dysplasia (HGD) or T1 oesophageal adenocarcinoma treated with curative intent between 2005 and 2013 was undertaken. All patients were discussed at the multidisciplinary team meeting. Surgical treatment was by thoracoscopic assisted or standard/laparoscopic assisted Ivor Lewis oesophagectomy. Endoscopic treatment was a structured program of endoscopic mucosal resection (EMR) and/or radiofrequency ablation (RFA). Outcomes included treatment variables, recurrence and complications.

RESULTS: 83 patients treated; 50 with endoscopic therapy (EMR only-4, EMR then RFA-22, RFA only-24,) and 38 by surgery (33 straight to surgery and 5 following EMR). Median age (67) and mean follow-up (21 months) were similar. HGD was more common in the endoscopic group (32/50, 64%, vs. 3/33, 9%, $p=0.0001$). Significant complications were more common following surgery (13/38, 34%, vs. 1/50, 2%, $p=0.0001$). There were two in-hospital deaths following oesophagectomy (1 open, 1 thoracoscopic). Endoscopic treatment beyond 12 months for persisting HGD/intramucosal disease was required in 2 patients. Recurrence of HGD/invasive cancer was diagnosed in 2/36 (5.6%, T1a recurrence) of endoscopic and 1/38 (2.6%, T2N0 - subsequent hepatic metastases) surgical patients.

CONCLUSION: A management algorithm including both endoscopic treatment and oesophagectomy provides optimal outcome for these patients. Due to additional morbidity of surgery, endoscopic treatment is appropriate first-line treatment.

Carlo Pulitano

Fellow
Royal Prince Alfred Hospital, Sydney

Replacement of the Inferior Vena Cava with Biological Grafts: the Royal Prince Alfred Experience

BACKGROUND: Resection and reconstruction of the inferior vena cava (IVC) is occasionally required in the surgical treatment of intra-abdominal tumours. IVC reconstruction can be performed with biological or synthetic graft material, with most centres preferring synthetic grafts. Despite the potential advantages of biological grafts in terms of handling characteristics, and safety; very limited data is available about their use in patients requiring IVC resection.

METHODS: Medical records of 38 patients who underwent IVC resection and reconstruction from 1990 and 2013 with autogenous peritoneo-fascial (APF) (N=22) and bovine pericardial (N=16) grafts were reviewed.

RESULTS: A tangential resection with patch repair was performed in 10 patients, while in the remaining 28 it was necessary to resect and replace a segment or all of the retrohepatic IVC. Concomitant liver resection was performed in 18 patients, nephrectomy in 10, and pancreaticoduodenectomy in 2 patients. There were no acute or late complications related to graft thrombosis or infection. Three patients died as a consequence of multiorgan failure. Overall survival at 1 and 5-years was 79% and 50%, respectively.

CONCLUSIONS: The preferential use of synthetic grafts in IVC replacement is not evidence based. Selection of an appropriate prosthetic graft for IVC reconstruction should be based on the safety and its handling features. The use of biological grafts for IVC repair is a valid alternative to current synthetic materials and may in fact be superior in terms of biocompatibility, ease of handling, reduced rate of infection, and improved long-term patency without permanent anticoagulation.

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