41st Annual Scientific Congress of the Royal College of Surgeons of Thailand

Theme: Fundamental Surgery: Time to Reform

16 - 19 July 2016
Ambassador City Jomtien Hotel, Pattaya

PROGRAMME and ABSTRACTS

Content

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Welcome Message

from the President of the Royal College of Surgeons of Thailand

Dear Friends and Colleagues,

On behalf of the Royal College of Surgeons of Thailand, it gives me great pleasure to invite you to participate in the 41st Annual Scientific Congress of the Royal College of Surgeons of Thailand to be held from 16 to 19 July 2016 in Pattaya, Thailand. The theme of the Congress is "Fundamental Surgery: Time to reform".

I am indeed delighted that our distinguished friends and colleagues in the surgical field will be together once again in Thailand to reflect and exchange our views and experiences on the past, present and future. The organising committee has prepared an exciting scientific programme which features useful and thought-provoking symposia, workshops and presentations. An international panel of speakers from around the world will share and present the most recent studies and advances in the various surgical areas. There will be opportunities for hands-on learning and networking as well as exciting social events.

I sincerely hope that you will enjoy the Congress and that your interaction with your colleagues from many different countries will stimulate a creative exchange of ideas and will be personally rewarding. I also hope and trust that you will enjoy your visit to Pattaya with its breathtaking views, delightful food, entertainment and Thai hospitality.

I am looking forward to your participation at the Congress!

General Parinya Thavichaigarn, MD, FRCST, FRCSEd, FRCSI, FACS
President
Royal College of Surgeons of Thailand

Welcome Message

from the Chairman of the Organizing Committee

Dear Friends and Colleagues,

It is our great pleasure to welcome you to the 41st Annual Congress of the Royal College of Surgeons of Thailand (RCST) in Pattaya, Jomtien from 16-19 July 2016.

The theme of this congress is titled **"Fundamental Surgery: Time to Reform"**.

To date, there is the advanced development in surgical treatment among several surgical specialties. With the requirement of using complex instruments and the high expenditure of new technologies, there is a limitation of training materials for surgical trainees. In addition, fundamental surgery, the life saving procedures using simple equipment has not been familiar enough in the current surgical training programs of several medical institutes. The theme of this meeting represents our attempt to make the knowledge of fundamental surgery applicable to the current system of surgical training program in the era of advanced technology.

In this meeting, we strongly intend to provide the extensive communication among surgeons in the Ministry of Public Health, in the university hospitals, and in the educational committee of the Royal College of Surgeons of Thailand in order to make an important collaboration to develop the appropriate training program and to improve the standard surgical service throughout the whole country.

We are pleased to have your suggestions and participations for the most productive activities of this congress. Our communication will be effective through the RCST website "www.rcst.or.th".

We are looking forward to welcoming you to this congress.

Pramook Mutirangura, MD, FRCST, FRCSEd
Chairman of the Organizing Committee
41st Annual Scientific Congress Royal College of Surgeons of Thailand

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41st Annual Scientific Congress of the Royal College of Surgeons of Thailand

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1875
Royal College of Surgeons of Thailand

"Udom Poshakrishana Memorial Lecture"

The Udom Poshakrishna Memorial Lecture was started in 1973 by the Faculty of Medicine Siriraj Hospital when the Faculty initiated an Outstanding Community Doctor Award annually to memorize and praise the contribution of Professor Udom Poshakrishna, then the Dean of the Faculty of Medicine Siriraj Hospital, to the development in surgery and also the improvement of health care and well being of rural people. The award goes to the most devoted doctors that worked in the rural and remote areas with excellent performance. Each year until now, the awardees are invited to present a talk at the memorial lecture.

Since 1991 the Royal College of Surgeons of Thailand has held the Udom Poshakrishna Memorial Lecture at her Annual Scientific Congress to commemorate the great accomplishments in surgery of Professor Udom Poshakrishna and to celebrate the continuation of his goals for development and progress of the Royal College of Surgeons of Thailand.

Prof. Udom Poshakrishna played an active role among 20 pioneer surgeons who established the Royal College of Surgeons of Thailand in 1972 with the objective to improve the country's standard of training in surgery. The Royal College of Surgeons of Thailand was qualified by the Thai Medical Council on 12 November 1973 with Professor Udom Poshakrishna as the first founding President.

Professor Udom Poshakrishna was a charismatic figure and a mentor to many Thai surgeons. He was Head of the Department of Surgery at Siriraj Hospital, Dean of the Faculty of Medicine, Siriraj Hospital, Minister of Public Health and most importantly a role model for most old-day surgeons in Thailand. In addition, he also served the royal family and was the secretary general of the Princess Mother's Medical Volunteer Foundation. Professor Udom Poshakrishna passed away in 1995 at the age of 87.

Today we are greatly honoured that His Excellency the Minister of Public Health, Clinical Professor Emeritus Piyasakol Sakolsatayadorn, will deliver the Udom Poshakrishna Memorial Lecture entitled **"National Health Policy: What surgeons need to know"**.

Citation

"Udom Poshakrishana Memorial Lecture"
Honorary Speaker

His Excellency, the Minister of Public Health, Clinical Professor Emeritus Piyasakol Sakolsatayadorn

His Excellency, the Minister of Public Health, Clinical Professor Emeritus Piyasakol Sakolsatayadorn graduated in medicine from Faculty of Medicine Siriraj Hospital, Mahidol University, Thailand in 1971. He finished his postgraduate surgical training from the same institute and obtained the fellowship of the Royal College of Surgeons of Thailand in 1975. He also succeededthe post-doctoral fellowship in critical care medicine from John Hopkins University, the USA in 1985, and the post-doctoral fellowship
in injury epidemiology from Centers for Disease Control and Prevention, Atlanta, Georgia, the USA in 1988.

After his successful work as a consultant trauma surgeon in Department of Surgery, Faculty of Medicine Siriraj Hospital for 15 years, he has also been achieving the professional career in administration by being appointed in the important academic positions such as Secretary of Mahidol University Council during 1991-1995, Vice President for Administration of Mahidol University during 1991-1995, Dean of Faculty of Medicine Siriraj Hospital during 2000-2007, and President of Mahidol University during 2007-2011. In addition, he was also invited to be the chairman and the president of the significant foundations of the universities and the powerful organizations of public health in Thailand.

With his outstanding professional accomplishment, he has received the Honorary Doctorate in Medicine from Mahidol University in 2015. In the same year, he has been nominated as the Minister of Public Heath by His Majesty King Bhumibol Adulyadej. Among the challenging tasks in the Ministry of Public Health, he has to create the effective strategies and the practical policies to solve the current problems of health care system in Thailand. In this congress, it is the great opportunity

for the Fellows of the Royal College of Surgeons of Thailand to attend the memorial lecture for Professor Udom Poshakrishna entitled **"National Health Policy: What surgeons need to know"** from the honorary speaker who has the magnificent experience in both academic profession and public health administration. On behalf of the organizing committee, we are honored to welcome His Excellency, the Minister of Public Health, Clinical Professor Emeritus Piyasakol Sakolsatayadorn in the 41st Annual Scientific Congress of the Royal College of Surgeons of Thailand during July17-19, 2016.

Professor Pramook Mutirangura, MD, FRCST, FRCS (Edinburgh)
Chairman of the Organizing Committee

Citation

Professor Yik-Hong Ho

Professor Yik-Hong Ho was born and raised in Malaysia, but he completed his medical degree overseas. He received his Bachelor of Medicine and Bachelor of Surgery with honors from the University of Queensland in 1980. Following that he completed his internship at Princess Alexandra Hospital, Brisbane, Australia. In 1983, he moved to Queen Mary Hospital in Hong Kong for his 6-year General Surgery Residency Training. He subsequently moved to Singapore to fulfill his dream and completed his Colorectal Surgery Training from Singapore General Hospital, Singapore, in 1993. He began his first phase of the academic career as a young consultant in the department of colorectal surgery and as an Instructor of Surgery in the Department of Surgery, National University of Singapore. With his outstanding academic interests and contributions, he was quickly promoted and became the Director of Pelvic Floor Laboratory, Singapore General Hospital in 1997. Alongside with his busy clinical appointments, he also spared his time to continue his own study. He received the Doctorate Degree in Medicine from the University of Queensland in 2001.

In 2002, he moved to James Cook University, Australia, to become a chairman and professor of the Discipline of Surgery. He was also promoted as a Deputy Dean, School of Medicine, James Cook University during 2006 and 2007. His leadership there was paramount in making James Cook University one of the most outstanding programs in the region.

Professor Ho has received so many honorary awards and has been elected by his peers to so many important posts that time does not permit a full listing of each. He has been elected to the board of directors and as an officer of numerous professional societies such as the International Advisory Committee member of the American Society of Colon and Rectum Surgeons and the International College of Surgeons.

He has recently become the World President of the International College of Surgeons since 2015. This is indeed the most honored and the most respected position for a surgeon to be a leader of all the surgeons in every field around the world.

Professor Ho has published more than 258 peer-reviewed articles and has written, edited, or coedited 27 major books including 2 books by Thai surgeon editors in colorectal surgery field. He also has given 19 colorectal diseases lectures in Thailand.

Over his years at James Cook University, Queensland, Australia, Professor Ho has mentored and trained hundreds of M.D., Ph.D., or M.D.-Ph.D. pre- and postdoctoral students, these including Professor Art Hiranyakas who is sitting in this room. His talents in writing and teaching have reflected his personality as a deep thinker and a wonderful teacher.

Finally, it should be evident from all perspectives - research, education, and organizational contributions, that Professor Ho has been absolutely stellar as a leader in surgery and particularly colorectal surgery. It is most fitting that the 2016 Honorary Fellowship given by the Royal College of Surgeons of Thailand is presented to him.

Paisit Siriwittayakorn, MD

Citation

Professor Frans L. Moll

Professor Frans L. Moll is one of the world famous vascular surgeons. He graduated in medicine from Utrecht University, Netherlands in 1977. He finished his postgraduate surgical training program at St. Antonius Hospital in 1984. After working as a consultant vascular surgeon for 17 years, he was appointed Professor and Head of Vascular Surgery in University Medical Center Utrecht, Netherlands during 2003-2015 and subsequently the Chairman of Department of Surgery in the same institute during 2008-2015. Concerning his academic positions, he was the President of Dutch Society for Vascular Surgery during 1993-1995, the President of the European Society for Vascular Surgery during 2008-2009, the Chairman of Board Directors of the European Journal of Vascular and Endovascular Surgery during 2007-2012. In addition, he was the executive member organizing a number of world famous international vascular congresses such as VEITH Symposium in the USA, Leipzig Interventional Course (LINC) in Germany, and Charing Cross Symposium in the UK. He was also the editorial boards membership of the outstanding professional vascular journals such as Journal of Vascular Surgery, Journal of Cardiovascular Surgery, Annals of Vascular Surgery and Vascular.

With his outstanding experience in modern vascular surgery, he has been taking the advanced technology to improve the standard treatment of vascular disease in Thailand for more than 10 years. His demonstrations and supervisions on the new vascular and endovascular techniques have been enlightening us to understand and being able to expand these procedures through the whole country. Moreover, he has been providing the vascular surgery training for Thai surgeons in Medical Center of Utrecht University. Subsequently, all of his trainees have been making the magnificent progression of vascular service and training program in Thailand. Because of his generous mind and worldwide spirit, he has been respected and admired not only by vascular sur-

geons from Thailand but also by vascular surgeons around the world.

On behalf of the executive committee, we appreciate Professor Frans L. Moll, one of the most outstanding vascular surgeons of the world to be our Honorary Fellow of the Royal College of Surgeons of Thailand. We do hope that there will be a stronger relationship and more cooperative activities among the surgeons of Netherlands and Thailand in the near future.

Professor Pramook Mutirangura MD, FRCST, FRCS(Edinburgh)

Citation

Professor Nguyen Van Phan

Professor Nguyen Van Phan completed his Medical Degree from Medical University at Ho Chi Minh City in 1985. Between 1989 and 1992, he was trained as a Fellow in Cardiovascular Surgery at Broussais Hospital in Paris, France under the supervision of world famous Prof. Alain Carpentier. In 1998 he got Master of Science degree in Medicine, following by Doctor of Philosophy (PhD) in Medicine in 2006. Since 1992 he has been appointed as Head of Cardiac Surgery Department, Heart Institute, Ho Chi Minh City.

Throughout his long career as a cardiac surgeon, Prof. Nguyen has spent his time focusing on congenital heart and valvular heart surgery. These are major problems for patients in his country. Most of these operations were done as a charity work in his institute. Prof. Nguyen is interested in charity work especially in children with congenital heart disease. He has been the President of Heart Beat Connection Program since 2012. This is a charity program to help poor Vietnamese cardiac patients to get treatment by cardiac surgery. Apart from congenital heart surgery, Prof. Nguyen is also well known as a remarkable valve repair surgeon especially in rheumatic valve repair. His meticulous technique and skill has made valve repair a reliable and better operation for patients with this disease. His contribution is clearly shown by a large number of publications, lectures and workshops. He also serves numerous academic positions in various societies and organizations. He has been appointed as the Vice-President of Association of Cardiovascular and Thoracic Surgery of Vietnam, Councilor of Asian Society of Cardiovascular and Thoracic Surgery (ASCVTS) and many others. Apart from working in his role as cardiac surgeon, he is also a very good teacher. He has set a training course of valve repair in his hospital in Vietnam, a continuous project that has become a milestone for young surgeons to be well equipped with knowledge, skill and strong attitude for valve repair. Many of Thai surgeons today were his student in this

course.

Based on all of his contributions to The Society of Thoracic Surgeons of Thailand and our Thai surgeon community, it is an unanimous decision of the committee to proudly present the Honorary Fellowship of the Royal College of Surgeons of Thailand this year to Prof. Nguyen Van Phan. Thank you.

Taweesak Chotivatanapong, MD, FRCST

Associate Professor Stanley James Rogers

Associate Professor Stanley J. Rogers is the chief of Minimally Invasive Surgery and director of the Bariatric Surgery Center and Liver Tumor Ablation Program at University of California at San Francisco (UCSF) Medical Center. He is the inaugural recipient of the Ruth M. Dunn Endowed Chair in Minimally Invasive Surgery, an honor bestowed to him by a grateful patient. His expertise is in minimally invasive or laparoscopic procedure, in particular within the fields of bariatric surgery, laparoscopic treatment of liver tumors and radiofrequency thermal ablation, and foregut surgery to treat conditions including benign and malignant disorders of the esophagus, stomach, bile ducts and gallbladder. Other areas of expertise include hernia surgery as well as surgical endoscopy.

Associate Professor Rogers treats patients at UCSF Medical Center at Parnassus and the UCSF Helen Diller Family Comprehensive Cancer Center at Mount Zion as well as San Francisco General Hospital where he is co-director of Video-endoscopic Surgery, and a staff and trauma surgeon. He is certified by the American Board of Surgery and a member of several professional organizations including the American College of Surgeons, American Institute of Ultrasound in Medicine, Society of American Gastrointestinal Endoscopic Surgeons, American Society for Metabolic and Bariatric Surgery, and American Gastroenterological Association. He is an associate professor of surgery at UCSF, conducts research and supervises residents and fellows. Associate Professor Rogers is named one of çAmerican's Top Doctorsé in his specialty by the U.S. News & World report, a distinction reserved for the top one percent of physicians in the nation.

Associate Professor Rogers serves as the His Majesty King Bhumibol Adulyadej, Rama IX Distinguished Professor of Global Surgery. He has been contributing to the educational and health care system of Thailand particularly in the field of Minimally Invasive Surgery for many years. He annually visits

several medical schools in Thailand such as Siriraj, Ramathibodi and Chulalongkorn Hospital to deliver valuable lectures and to guide young surgeons in operations and also participates in surgical workshops. Further, he is the first person to initiate the Thai-UCSF Clinical Fellowship in Minimally Invasive Surgery which gives Thai surgeons an opportunity to be trained in this field at one of top five medical centers in the U.S.A. under his supervision. His significant contribution is truly beneficial towards the betterment of our country's future educational and health care system.

Vitoon Chinswangwatanakul, MD, FRCST

Dr. Ketwut Athiwess
Trat Hospital

The Royal College of Surgeons of Thailand is proud to honor Dr. Ketwut Athiwess, a senior surgeon at Trat Hospital, situated near the Cambodian border, as an Outstanding Surgeon in 2016.

Dr. Ketwut Athiwess graduated with Doctor of Medicine from Chiangmai University and obtained Diploma of Thai Board of Surgery in 1994 from Prapokklao Hospital in Chantaburi Province.

All through his surgical career, he has proven to his colleagues and all medical establishments in Health Region 6 and also across the nearby Koh Kong Island in Cambodia that he is a leader in providing Emergency Medical Service including an effective referral system in cooperation with both government and private health organizations.

He received many awards and recognitions for providing Mobile Medical Unit to relieve emergency situations and also providing training for emergency personnel, both Thais and Cambodians.

He is very energetic and highly responsible for the improvement of both medical and surgical services at Trat Hospital which is located in remote area and has limited resources in manpower and budgets.

Dr. Ketwut Athiwess is currently the Deputy Director of Trat Hospital. Despite of all his success, he still continues to devote his life to the care of his patients. He has been widely recognized by his peers and patients in Trat for his ability, hard work, determination and dedication.

Dr. Narong Khuntikeo
Khon Kaen University

Associate Professor Narong Khuntikeo obtained his medical degree and completed his surgical training from the Faculty of Medicine, Khon Kaen University in the Northeast of Thailand. After being appointed as a teaching staff in the Department of Surgery, he had further training in Hepato-Pancreatic Biliary Surgery and Liver Transplantation at the Princess Alexandra Hospital, Brisbane, Queensland, Australia in 1994. He became board certified in Surgical Oncology in 2007.

Associate Professor Narong Khuntikeo has been a devoted teacher, a surgeon and a well-recognised researcher in cholangiocarcinoma associated liver flukes. His 70 scientific papers on molecular biology, carcinogenesis, immune mechanisms, different modality of treatments and epidemiology are published in international journals. He is guided by his passion to solve this ongoing health problems, endemic area of cholangiocarcinoma, where 6 millions of people are at risk and over 14,000 new cases are expected each year.

In 2013, he was appointed as a Director of Cholangiocarcinoma Screening and Care Program (CASCAP) with support from Khon Kaen University, the National Research Council of Thailand, the Crown Property Bureau Foundation and CP ALL Public Company Limited. The programme was launched for primary prevention, screening, early detection by ultrasonography and appropriate imaging, then surgical intervention for high risk people in endemic area. This year the Ministry of Public Health declared this project as the top priority in health improvement policy.

The Royal College of Surgeons of Thailand recognised Associate Professor Narong Khuntikeo and his team from Khon Kaen University for his determination, knowledge, administration skill in collaboration with all stakeholders to put CASCAP project into action with Data Management and Statistical Analysis Center to evaluate outcome of the project.

We are proud to present Associate Professor Narong Khuntikeo as an Outstanding Surgeon in 2016.

Dr. Prakob Luechakiatisak
Suratthani Hospital

Dr. Prakob Luechakiatisak is highly regarded by his colleagues, patients and community as a very dedicated surgeon whose contributions to improving quality and a variety of surgical services at Suratthani Hospital in the Southern region of Thailand, Health Service Area 11, over the past 25 years are tremendous.

He is a mentor and a role model for medical students, surgical trainees and medical personnel because he possesses all domains of being a noble surgeon. Under his leadership, with up-to-date knowledge, skills and new technology, he implemented excellent surgical care. His well- recognized accomplishments include a scientific paper titled **"Comparison of hand-sew and stapled anastomosis after esophagogastrectomy"**, establishment of Open Heart and Surgical Intensive Care Unit, Cancer Care Center of the health area, provision of holistic care including chemotherapy unit. He also set up **"Renal Transplantation Program"** at Suratthani Hospital, the only one center in the South with high standard of care and acceptable outcome. His latest achievement is organizing a Surgical Training Program at Suratthani Hospital to accommodate the shortage of surgeon in the area.

Dr. Prakob Luechakiatisak always arrived at the ward early, about one hour before official hours almost every day, to conduct the rounds. He is humble, highly dedicated, thoughtful and sacrifices himself for the excellent quality surgical care all through his career.

List of Speakers 2016

No.	Name	C	Specialty
1	Allen BUENAFE	PH	Hernia Surgery
2	Tze Tec CHONG	SG	Vascular Surgery
3	Michael COTTON	CH	Essential Surgery
4	Macky FAYLONA	PH	Hernia Surgery
5	Stanley Duke HERRELL	USA	Urology
6	Yik-Hong HO	AU	Colorectal Surgery
7	Tyler G. HUGHES	USA	Rural Surgery
8	Tom JAKSIC	USA	Pediatric Surgery
9	Jan F. KUKLETA	CH	General Surgery (Hernia)
10	Takaori KYOICHI	JP	General Surgery (Lap Panc)
11	Davide LOMANTO	SG	Hernia Surgery
12	Frans L. MOLL	NL	Vascular Surgery
13	Stan J. MONSTREY	BEL	Plastic Surgery
14	Raghu RAM	IN	Breast Surgery
15	Jaideepraj RAO	IN	Hernia Surgery
16	Anil SHARMAR	IN	Hernia Surgery
17	Martin R. WEISER	USA	Colorectal Surgery
18	Joseph WOO	USA	CVT
19	George YANG	HK	Hernia Surgery
20	Anusak YIENGPRUKSAWAN	USA	General Surgery (MIS)
21	Stanley James ROGERS	USA	Hon. General Surgery (MIS)
22	Prof. NGUYEN Van Phan	VN	Hon. Fellow (CVT)

Invited Guest Speaker 2016

Michael Henry Cotton,
MA (Oxon), MBBS (London),
FRCS (England), FACS, FCS
(ECSA), FMH

BA Hons (Oxon) : Natural Science (Chemistry) 1974; MA (Oxon) 1979; MBBS (London) 1979

FRCS (England) 1983; FACS 1999; Foundation Fellow, (COSECSA) 2002; FMH (Switzerland) 2008

Member, International Society of Surgeons, 1991-present; Research Affiliate, Office of International Surgery, University of Toronto, Canada 2003; Representative for Southern Africa, Global Academy of Surgery, Cairo, Egypt, 2003.

1989	Appointed Consultant Surgeon in Govt Practice, Bulawayo, Zimbabwe at United Bulawayo & Mpilo Central Hospitals.
1989	Set up Flying Surgeon Service to 10 District & Mission Hospitals in Matabeleland, supported by Mission Aviation Fellowship, (active till 2005)
1992-2007	Chairman Surgical Audit United Bulawayo Hospitals responsible for surgical performance & analysis.
1995	Drew up plans for new A & E Dept, Mater Dei (charity) Hospital, Bulawayo (in view of deteriorating services offered in Govt Hospitals)
1997	Published Language guide: Essential phrases for Health Workers (in Shona & isiNdebele)
1999	Elected Fellow American College of Surgeons
2000-2005	Organized Regular Donations of Surgical Equipment to Govt & Mission Hospitals in Matabeleland (worth > £ 500000)

1989-2007	Performed over 7500 major operations in Africa and over 2000 endoscopic procedures
1989-2007	Published over 70 papers including chapters in text book of Tropical Surgery
1989-2007	Mentored over 100 trainee junior surgeons, over 10 from UK
2000-2007	Director, Accident & Emergency Department, Mater Dei Hospital, Bulawayo
Nov 2002	Elected Inaugural Foundation Fellow College of Surgeons of East, Central & Southern Africa (COSECSA)
2003	Introduced Primary Trauma Care to Zimbabwe, running courses in Bulawayo and Binga
2003-7	Examinations Co-ordinator, Membership Diploma, COSECSA (Nairobi, Dar-es-Salaam, Harare, Blantyre, Maputo)
2003-7	Head of Department of Surgery, Mater Dei Hospital, Bulawayo
2004	Co-ordinator, Surgical Skills Courses, Bulawayo
2004-6	Examiner, University of Zimbabwe Medical School, Harare
Apr 2006	Elected Inaugural Professor of Clinical Practice, National University of Science & Technology (new) Medical School, Bulawayo, Curriculum Coordinator & Surgical strategy Planner.
2006-2007	Surgical Outreach in Zomba, Malawi & Ifakara, Tanzania.
2006-	Currently Chief Editor for new Edition of Primary Surgery (vols 1 & 2)
2007	Visiting Consultant Surgeon, University Clinic, Mannheim, Germany
2008	Elected Médecin Associé Emergency Services (Surgery), University Hospital of Vaud, Lausanne, Switzerland.
2011	Founder member & chairman, International Collaboration for Essential Surgery, London, UK
2014	Chief Editor, Tropical Doctor.
2015	Visiting Volunteer Surgeon, Mandritsara, Madagascar.

LANGUAGES SPOKEN: English, French, German, Schwyzerdytsch, isiNdebele

Invited Guest Speaker 2016

S. Duke Herrell, M.D.

Present Positions:	Associate Professor of Urologic Surgery Associate Professor of Biomedical Engineering Vanderbilt University School of Medicine Nashville, TN
Director:	Minimally-Invasive Urologic Surgery / Robotics Program Vanderbilt University School of Medicine
Fellowship Director:	MIS / Robotics / Endourology / Laparoscopy 2-year Post-graduate Clinical/Research Fellowship Recognized by the Endourological Society, Inc.
Medical Director:	Medical Center East Operating Rooms Vanderbilt University Medical Center
Appointed Member:	AUA Practice Guidelines Committee (PGC) AUA Practice Guidelines Oversight Committee Vanderbilt University Medical Center Medical Board
Education:	Undergraduate Education Bachelor of Arts (Summa cum laude) Chemistry, 1986 Medical Education University of Virginia School of Medicine MD, 1990 Urologic Surgery, University of Virginia 1990-1996 Fellowship MIS / Endourology Loyola University 1996-1997

Professional Experience

1997-2000	Assistant Professor of Urology - Medical University of South Carolina, Charleston, SC
2000-2001	Assistant Professor of Urology - University of Kansas Medical Center, Kansas City, KS
2001-2005	Assistant Professor of Urologic Surgery - Vanderbilt Univ. School of Medicine, Nashville, TN
2005- present	Associate Professor of Urologic Surgery - Vanderbilt Univ. School of Medicine, Nashville, TN
2001- present	Endourology/Laparoscopy Fellowship Director, Vanderbilt School of Medicine, Nashville, TN
2010-present	Associate Professor of Biomedical Engineering, Vanderbilt University, Nashville, TN

Select Publications (Peer-Reviewed):

Herrell SD, Smith JA Jr. Robotic-assisted laparoscopic prostatectomy: what is the learning curve? Urology 2005 Nov; 66(5 Suppl):105-7.

Maynes LJ, Levin BM, Webster TM, Baldwin D, Herrell SD. Measuring the true success of laparoscopic pyeloplasty. J Endourol. 2008 June; 22(6):1193-8.

Herrell SD, Kwartowitz DM, Milhoua PM, Galloway RL. Toward image-guided robotic surgery: system validation. J Urol. 2009 Feb; 181(2): 783-9 discussion 789-90. Epub 2008 Dec 16.

Altamar HO, Herrell SD. The current status of robot-assisted laparoscopic prostatectomy. Curr Opin Urol. 2010 Jan;20(1):56-9.

Viprakasit DP, Altamar HO, Miller NL, Herrell SD. Selective renal parenchymal clamping in robotic partial nephrectomy: Initial experience. Urology. 2010 Sep; 76(3):750-3. Epub 2010 Jun 8.

Investigator/Grants (Ongoing):

Principal Investigator - Tracking Renal Tumors After Cryoablation Evaluation (TRACE, Galil Medical)

Co Investigator R21 NIH Webster (PI) Reaching Inaccessible Anatomy via Steerable Needles

Co Investigator R44 NIH Galloway (PI) System for Image-Guided, Minimally-Invasive Kidney Surgery

Invited Guest Speaker 2016

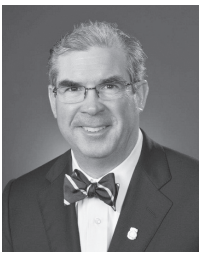
Professor Yik-Hong Ho,
MBBSHons, MD(Qld), FRCSEd, FRCS(Glasg), FRACS, FAMS, FICS

Professor Ho holds the Foundation Chair and is Head of the Discipline of Surgery at the James Cook University. He is currently the World President of the International College of Surgeons. He is also the Chairman of Editorial Board of Techniques in Coloproctology and Associate Editor of International Surgery. He had previously been Chairman of the Academic Board and also Deputy Dean of the College of Medicine, James Cook University. Prior to that, he had been the Senior Consultant and Deputy Head of the Department of Colorectal Surgery at the Singapore General Hospital, and Visiting Staff Senior Consultant Surgeon at the National Cancer Center, Singapore.

He holds a higher Doctor of Medicine (from the University of Queensland, where it is considered a more advanced degree than a PhD). Professor Ho is also an International Fellow of the American College of Colon & Rectal Surgeons, as well as a fellow of several Surgical Colleges and Member of the Colorectal Surgical Society of Australia & New Zealand.He is also an Honorary Member of SociedadParaguaya de CirugiaEndoscopoica. He has recenty been awarded the Honarary Fellowship of the Royal College of Surgeons of Thailand. His practice and research interests have been in Colorectal Surgery. He is particularly known for his publications on haemorrhoids and rectal reservoir function after rectal cancer surgery. To date, he has 281 publications in books, book chapters and peer reviewed international journals.

Since taking up the Chair of Surgery at James Cook University in 2002, Professor Ho has supervised several postgraduate research completions for MD higher doctorate, PhD, DPH and MMed. He has also been a doctorate degree examiner for the University of Hongkong, University of Queensland and University of Melbourne. He was conferred the Honarary Professorship from the Ricardo Palma University, Lima in 2016.His hobbies include photography, cooking, reading (war strategy history) and Tai-Chi.

Invited Guest Speaker 2016



Dr. Tyler G. Hughes

Dr. Hughes obtained his medical degree from the University of Texas Southwestern Medical Center at Dallas. Prior to his time in Kansas, Dr. Hughes served as assistant program director and teaching attending at St. Paul Medical Center in Dallas, where he previously completed his general surgery residency. Since moving to McPherson, Dr. Hughes has served as a clinical faculty member at the Kansas University School of Medicine, working primarily with medical students. In 2009 Dr. Hughes was nominated for the school's highest faculty award, and in 2010 received the school's first Outstanding Preceptor Award. Dr. Hughes has been active in the American College of Surgeons (ACS) since he entered practice, serving as Kansas chapter president in 2007. He has also served as an ACS governor-at-large, assisted with the development of the ACS case log system, and is co-editor of the rural surgeons community section of the ACS member portal. In addition, Dr. Hughes serves on the editorial boards of Surgery News, Selected Readings in General Surgery and Evidence Based Reviews in Surgery. He has authored numerous articles for the ACS Bulletin, and served on other ACS committees at the national level. He has also independently developed a rural surgeons network, and sponsors an annual dinner for rural surgeons at the ACS Clinical Congress. In 2011 Dr. Hughes was a co-director of the rural surgical skills course held at Northwestern University as part of the ACS Rural Surgery Symposium. He was choosen as Outstanding Rural Physician of the Year by the National Rural Healthcare Association in 2012. That same year he was selected as Chair of the ACS Advisory Council on Rural Surgery which is charged with recruiting, supporting and assisting in

the training of rural surgeons. In June 2012 he was selected as an at large Director of the American Board of Surgery. As of March of 2014 Dr. Hughes became Editor in Chief of the ACS Web Portal.

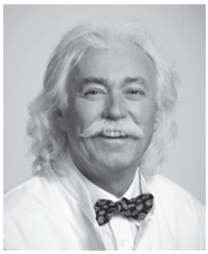
Dr. Hughes has been married for 35 years to Mary Hughes, an actress involved in theater in central Kansas. They have two grown children, Dorothy and Tyler Jr. They live McPherson, KS; a town of 13,000 north of Wichita, KS.

Invited Guest Speaker 2016

Tom Jaksic, MD, PhD

Tom Jaksic, MD, PhD is the W. Hardy Hendren Professor of Surgery at Harvard Medical School and the Vice-Chairman of Pediatric General Surgery at Boston Children's Hospital. Dr. Jaksic graduated from Queens University School of Medicine (Canada) in 1981. In 1986 he obtained a Ph.D. in Nutritional Biochemistry and Metabolism at the Massachusetts Institute of Technology (M.I.T.). Dr. Jaksic completed all of his surgical training at the University of Toronto and was Chief Resident in Pediatric Surgery at the Toronto Hospital for Sick Children. He is a full time clinical pediatric surgeon with a special interest in the treatment of intestinal failure. For the last 17 years he has been the Surgical Director of the Center for Advanced Intestinal Rehabilitation (CAIR) at Boston Children's Hospital. Dr. Jaksic's research focuses on the nutrition and metabolism of the pediatric surgical patient. His work encompasses basic science as well as translational and clinical studies. His clinical investigationsinclude prospective cohort studies as well as the use of stable isotopes to quantify surgically pertinent metabolic pathways. The latter have determined hepatic function in children with intestinal failure-associated liver disease, and optimized protein balance in neonates on extracorporeal membrane oxygenation (ECMO). Dr. Jaksic helped develop the STEP (serial transverse enteroplasty) bowel lengthening procedure in children with short bowel syndrome. Dr. Jaksic has been a principalor co-investigator on multiple National Institute of Health (NIH) grants, one of which currently supports the Harvard Nutrition and Obesity Research Center, for which he is the Director of the Mass Spectrometry and Metabolomics Core. His laboratory has trained 25 post-doctoral surgical research fellows, many of whom have gone on to

successful academic careers. His resident trainees have been recipients of grants and awards for the presentation of outstanding papers at major meetings. He has authored nearly 200 basic science and translational publications and has been an invited speaker at numerous national and international venues. Dr. Jaksic has served on the Committee on Nutrition, American Academy of Pediatrics, and he has authored important policy papers establishing guidelines related to parenteral and enteral nutrition in neonates, older children and adults. He is a past President of the American Society of Parenteral and Enteral Nutrition (A.S.P.E.N.).



Prof. Jan F. Kukleta

Jan F. KUKLETA, MD, FMCH is a visceral surgeon in private practice in Zurich, Switzerland.

Study of medicine 1967 - 1974 and State examination 1974 at University of Zurich, Switzerland.

Doctoral thesis 1972-74 "Sutureless intramyocardial pacemaker-electrode implantation", doctor diploma of University of Zurich 1975. Experimental surgery at Dept. of Surgery of University of Zurich 1972 - 1974.
Since 1984 in private practice of visceral surgery in Zurich.

During 40 years of the never-ceasing surgical training and personal development he concentrated his practical and academic activities on laparoscopic surgery, early adoption of new technologies, herniology and teaching. As a member of international faculty of the European Surgical Institute in Hamburg and Covidien European Training Center in Paris/Elancourt he regularly lectured the parietal repair issues.

Being one of the pioneers of endoscopic tension-free repair he had the chance to accumulate substantial practical and theoretical knowledge in the two last decades. He is member of several national and international surgical societies (SGC, SGVC, ALTC, EAES, EHS-Grepa, AHS, SLS, APHS, SAHC, IEHS and AMEHS), member of International advisory board of "Hernia (The world journal of hernia and abdominal wall surgery)", "European Journal of Coeliosurgery" and "Chirurgische Allgemeine"; founding member and current president of the Swiss Association for Hernia Surgery SAHC; founder and medical director of Laparoscopic Training Center in Zurich to develop

and perfect skills of young surgeons in simulator use. He is a member of the working groups that elaborated European Hernia Society Guidelines in 2008 for treatment of groin hernias with an Update 2013, the Guidelines for endoscopic hernia treatment of the International Endoscopic Hernia Society in 2010 with an Update 2014, Guidelines for laparoscopic treatment of ventral and incisional abdominal wall hernias 2011 and EAES Consensus development conference on endoscopic repair of groin hernias (2013), as well as a frequent contributor to various congresses in all five continents. Operated in 29 countries and lectured in 43 countries in order to share the experience to improve the patient's outcomes.

Currently the head of NetworkHernia - Zurich Hernia Center at Hirslanden Hospital Group.

Kyoichi Takaori, M.D., Ph.D., F.A.C.S.

Director, Pancreas Cancer Unit
Kyoto University Hospital
Secretary General, IASGO

Prof. Kyoichi Takaori is a pancreatic surgeon who has extensive experiences of open, laparoscopic, and robotic surgery. His academic career includes Professor of Surgery at Asahi University, Associate Professor of Leaders of Integrated Medical Science at Kyoto University, and Assistant Professor of Physiology and Biophysics at University of Arkansas for Medical Sciences. Thorough his career as a surgeon, he has struggled to improve the prognosis of pancreatic cancer, which is known as the worst malignancy. First, he has focused on early detection of pancreatic cancer so that surgeons can offer truly curative operations to the patients. In 2003, with Dr. Ralph Hruban, Dr. Takaori organized International Expert Meeting on Precursor Lesions of Pancreatic Cancer and created international consensus on the classification of pancreatic intraepithelial neoplasia (PanIN) and intraductal papillary mucinous neoplasm (IPMN). World Health Organization has adopted this classification system, which helps researchers and physicians better understand the precursor lesions. Furthermore, in pursuit of early diagnosis and treatment of pancreatic cancer in high-risk individuals, he has founded a Japanese Familial Pancreatic Cancer Registry in 2013 and is promoting collateral studies as the chairman of the registry committee of Japan Pancreas Society. Second, he has endeavored to improve the surgical techniques for pancreatic malignancies. In order to improve local control and to perform more oncologic resections, he has re-

fined artery-first pancreatoduodenectomy and developed new techniques of artery-first distal pancreatectomy, and artery-first DP-CAR by utilizing the çTora-no-Anaé approach. He is practicing the artery-first approach in all open, laparoscopic and robotic surgery. Third, he is a great believer of multi-disciplinary approach and presently directing the multi-disciplinary team of Pancreatic Cancer Unit at Kyoto University. Recently, he has conducted international collaborative study on the clinical managements of pancreatic cancer as the leader of International Association of Pancreatology and European Pancreatic Club study group. Last but not least, Dr. Takaori serves patient's advocacy and related activities on the Medical Advisory Board for PanCAN Japan and the Scientific Advisory Board for Pancreatic Cancer UK. He is contributing to scientific journals as the Vice Editor-in-Chief of Pancreatology and Consultant Editor of Digestive Surgery, the official journal of the International Association of Surgeons, Gastroenterologists and Oncologists (IASGO). Professor Takaori has been serving as the Secretary General of IASGO since 2015.

Davide LOMANTO,
MD, PhD, FAMS (Surg), FJSES (hon), FPCS (hon), FPALES (hon); FIAGES (hon), FPBEI (hon), FPERHERI (hon)

INSTITUTE

Department of Surgery
Yong Loo Lin School of Medicine, National University of Singapore.

Current Academic Position

Professor of Surgery,
Senior Consultant Surgeon
Director Minimally Invasive Surgical Centre
Director KTP Advanced Surgical Training Centre
Core Faculty Residency Programme in General Surgery (ACGME)
Department of Surgery
Visiting Senior Consultant Surgeon at NUHS Department of Paediatric Surgery
YLL School of Medicine, National University of Singapore.

PAST EDUCATION

MD (University of Rome "La Sapienza), 1983.
Ph.D. (University of Rome "La Sapienza), 1990.
Specialist in General Surgery (University of Rome "La Sapienza), 1992.
Fellowship in MIS at National University of Singapore, 1999-2000
Fellow Academy of Medicine of Singapore (FAMS Surgery), 2006.

CURRENT POSITION IN PROFESSIONAL SOCIETY

- ELSA (Endoscopic and Laparascopic Surgeons of Asia): President 2011-2013;
- ELSA (Endoscopic and Laparascopic Surgeons of Asia): Secretary General 2013-2015 and 2015-2017
- APHS (Asia-Pacific Hernia Society) Founding Member and Advi-

sory President

- APMBSS (Asia Pacific Bariatric Surgery Society) Founding Member and President (2013-2016)
- AETF (Asia Endoscopic Task Force) Founding Member and Vice-President since 2012
- IFSES (International Federation Surgical Endoscopic Society): Secretary General/Treasurer 2013-2017

Honorary Member

Japanese Society for Endoscopic Surgery (JSES)

Philippines College of Surgeons (PCS)

PBEI Indonesian Society of Endolaparoscopic Surgeon (ISES)

ASEAN Paediatric Endosurgical Group (SEAPEG)

Philippines Association of Laparoscopic and Endoscopic Surgeons (PALES)

Indonesian Hernia Society HIS - PERHERI)

Indian Association of Gastrointestinal Endoscopic Surgeons (IAGES)

Scientific tutor

42 full time international clinical and research fellows

1 Master of Surgery, External reviewer (Chinese Univ Hong Kong)

Editors/Reviewer

Managing Editor - Asia Journal Endoscopic Surgery (ASES)

International Editorial Board Member: Surgical Endoscopy

International Editor of Hernia and Abdominal Wall Surgery

International Editor of Chinese Journal of Hernia and Abdominal Wall Surgery

International Board Member Journal Minimal Access Surgery

Editorial Board Member Annals of Surgical Innovation and Research

International Board of Abdominal Wall Repair Journal

Overseas Guest Advisor: Indian Journal of Surgery

International Member of the Italian National Agency for the Evaluation of Universities and Research Institutes (ANVUR)

Knighthood by the President of the Italian Republic with “Ordine della Stella della Solidarieta’ Italiana” since September 2009

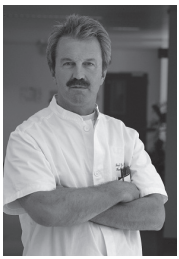
Professor Frans L. Moll

Professor Frans L. Moll is one of the world famous vascular surgeons. He graduated in medicine from Utrecht University, Netherlands in 1977. He finished his postgraduate surgical training program at St. Antonius Hospital in 1984. After working as a consultant vascular surgeon for 17 years, he was appointed Professor and Head of Vascular Surgery in University Medical Center Utrecht, Netherlands during 2003-2015 and subsequently the Chairman of Department of Surgery in the same institute during 2008-2015. Concerning his academic positions, he was the President of Dutch Society for Vascular Surgery during 1993-1995, the President of the European Society for Vascular Surgery during 2008-2009, the Chairman of Board Directors of the European Journal of Vascular and Endovascular Surgery during 2007-2012. In addition, he was the executive member organizing a number of world famous international vascular congresses such as VEITH Symposium in the USA, Leipzig Interventional Course (LINC) in Germany, and Charing Cross Symposium in the UK. He was also the editorial boards membership of the outstanding professional vascular journals such as Journal of Vascular Surgery, Journal of Cardiovascular Surgery, Annals of Vascular Surgery and Vascular.

With his outstanding experience in modern vascular surgery, he has been taking the advanced technology to improve the standard treatment of vascular disease in Thailand for more than 10 years. His demonstrations and supervisions on the new vascular and endovascular techniques have been enlightening us to understand and being able to expand these procedures through the whole country. Moreover, he has been providing the vascular surgery training

for Thai surgeons in Medical Center of Utrecht University. Subsequently, all of his trainees have been making the magnificent progression of vascular service and training program in Thailand. Because of his generous mind and worldwide spirit, he has been respected and admired not only by vascular surgeons from Thailand but also by vascular surgeons around the world.

On behalf of the executive committee, we appreciate Professor Frans L. Moll, one of the most outstanding vascular surgeons of the world to be our Honorary Fellow of the Royal College of Surgeons of Thailand. We do hope that there will be a stronger relationship and more cooperative activities among the surgeons of Netherlands and Thailand in the near future.



Stan J. MONSTREY

- Gent, Belgium (March 5, 1955)

Preplastic Surgery Training:

- Medical Studies in Gent. Graduated in 1980 (Magna cum Laude).
- Residency in General Surgery (1981-1984) at the University Hospital in Nijmegen, The Netherlands.

Plastic Surgery Training:

- Residency in Plastic Surgery (1984-1988) at the University Hospital in Gent (Prof. Dr. G. Matton).
- Doctor's Degree (Ph.D.), University of Nijmegen, 1988.
- Qualified in Plastic Surgery 1988.
- Research Fellowship (1989-1990) at the University of Pittsburgh, U.S.A.
- Clinical Fellowship (1990-1991) in Micro and Hand Surgery at the University of Pittsburgh, U.S.A.

Hospital and Academic Positions:

- Consulting Plastic Surgeon (1988-1989) at the Academic Hospital of the Free University in Brussels.
- Attending Plastic Surgeon (1988-1989), Assistant Professor (1991-1993) and Associate Professor (1993) at the University Hospital in Gent.
- Professor and Chairman (1995) of the Department of Plastic and Reconstructive Surgery at the University Hospital in Gent.
- Appointed as Full Professor at the University of Gent, Faculty of

Medecine, October 1, 2002.

Thesis for a Doctor's Degree (equivalent of Ph.D.) at the Faculty of Medicine of the University of Nijmegen, The Netherlands

Title: "TRAUMA TO THE URINARY SYSTEM"

The Doctor's Degree was obtained on March 1, 1988 after a public presentation in the Aula of the Catholic University in Nijmegen.

Memberships

Belgian Hand Group
Commission on Pressure Sores
European Burn Association (EBA)
International Society of Burn Injuries (ISBI)
European Wound Healing Society
Plastic Surgery Research Council
American Society of Plastic and Reconstructive Surgery
American Society of Reconstructive Microsurgery
Belgian Association for Cancer Research (ABEC/BVSK)
Royal Belgian Surgical Society
Interplast

Active Memberships

Member Medical Council UZGent (01.01.2000-31.12.2006)
Member Royal Belgian Society for Plastic, Reconstructive & Aesthetic Surgery (Treasurer 1997-2007- Vice President 2007-2009 - President 2009-)
Board Member Collegium Chirurgicum Plasticum Belgium (CCP) - Organisator Postgraduate Teaching
President and organisor lok meetings
Member of the Dutch Board of Recognition of Plastic Surgeons in Belgium
VLIR member - Commissie Academisering Geneesheer-Specialisten
Board Memberof the BABI (Belgian Association for Burn Injuries) - President : 1998-2003
Board Member Belgische Brandwondenstichting
Member of the Scientific Committee of the Dutch Burn Association

(1999-2004)

EURAPS (European Association of Plastic Surgery) - Secretary-General (2001-2007)

HBIGDA/WPATH (Harry Benjamin Gender International Gender Dysphoria Association/World Professional) - Board Member 2001-2005 - President 2005-2007

Member of the jury of the European Board of Plastic Surgery (EBOPRAS) : European Postgraduate Teaching in Plastic Surgery

Reviewer scientific journal:

- Burns
- Acta Chirurgica Belgica
- European Journal of Plastic Surgery
- American Journal of Plastic & Reconstructive Surgery
- International Journal of Transgenderism
- Annals of Plastic Surgery

Honory Prizes and Awards:

1973: Honorary Prize of the School: "Primus Perpetuus"
Honorary Prize from the City of Oostende (Mathematics)
Prize "Lauréat Rotary Club 1973" (French language)

1987: Award (50,000$) from the National Fund for Scientific Research in Belgium (together with Dr. Jean Marie Naeyaert from the Department of Dermatology)

Project: The use of cultured keratinocytes in severely burned patients.

1988: Grant from the Foundation Mathilde Horlet-Dapsens for a one year research fellowship in Pittsburgh (20,000$).

1989: Fulbright-Hays Award for Research and Lecturing (6.000$).

1989: NATO Scholarship (6,000$).

1991: Basic Research Grant (5,000$) from the Plastic Surgery Educational Foundation (Sponsor: Neil F. Jones). Project: Transplantation of vascularized knee joints using compound FK506.

1992: Diplomate of the Collegium Chirurgicum Belgicum (C.C.P.), Brussels, June 1992.

1994: European Association of Plastic Surgeons, Geneva, Switserland:

Price for the Best Scientific Presentation (13/05/94).

1994: Joint meeting of the Belgian and the Dutch Societies of Plastic and Reconstructive Surgery, Zwolle, The Netherlands: Price for the Best Scientific Presentation (08/10/94).

1994: Diplomate of the European Boards of Plastic Surgery. Brussels (14-15/11/94)

1995: Member of the Jury of the European Boards of Plastic Surgery. Athens (5-7/11/1995)

1995: Certificate of Accreditated Plastic Surgeon (National Health System)

1995: Grant from the Lyons Club Ghent for the Burn Center of the University Hospital (amount 12.000$).

2007 : Fellow of the Royal College of Surgeons of England
London, January 24, 2007

2016: WPATH Lifetime Achievement Award, Amsterdam, The Netherlands.

Publications & Presentations:

265 peer-reviewed papers, 7 books, 14 book chapters, 422 presentations

Invited Guest Speaker 2016

Dr P. Raghu Ram
MS, FRCS (Edin), FRCS (Eng), FRCS (Glasg), FRCS (Irel), FACS

Padma Shri awarded by Hon'ble President of India (2015)

President, The Association of Breast Surgeons of India

Director & Consultant Breast Surgeon, KIMS-USHALAKSHMI Centre for Breast Diseases and

CEO & Director, Ushalakshmi Breast Cancer Foundation, Hyderabad, India

International Surgical Advisor, The Royal College of Surgeons of Edinburgh

- One of the youngest doctors in the Country to have been conferred the prestigious Padma Shri by Hon'ble President of India in 2015 for his outstanding contribution towards improving breast healthcare, and equally, for his unstinting contribution towards promoting the highest standards of Surgical Education in India through the RCS Ed & RCS England.
- Amongst few in the World to have acquired FRCS from all four Royal Colleges in British Isles (London, Edinburgh, Glasgow, Ireland) & FACS from the American College of Surgeons.
- Conceived, designed & established South Asia's FIRST free standing purpose built comprehensive Breast health Centre @ KIMS Hospitals, Hyderabad, India
- Established Ushalakshmi Breast Cancer Foundation (Hyderabad, India) with a mission to empower women on the importance of early detection of Breast cancer. Many of the innovative initiatives of the Foundation, particularly implementation of South Asia's largest population based Breast Cancer Screening Programme has attracted national & international appreciation.

• Published several articles in peer reviewed Journals and contributed NINE Chapters in THREE Textbooks of Surgery. This includes a Chapter in the widely respected "Recent advances in Surgery" published from London & a Chapter on Breast Surgery in the world renowned & hugely popular ùBailey & Love Companion Guideû.

• In an endeavour to help budding surgeons from India prepare for the prestigious MRCS/FRCS Examinations, successfully conducted TEN Overseas Postgraduate Courses in Hyderabad under the auspices of the Royal College of Surgeons of Edinburgh (RCS Ed) - highest number of Courses ever to be held by the Royal College outside United Kingdom.

• Convenor, Overseas Intercollegiate Final MRCS examination organised by RCS Edinurgh & RCS England in Hyderabad (2008, 2010, 2012, 2015 & 2016). Singularly responsible for making southern Indian States of Telangana & Andhra Pradesh a centre for Intercollegiate MRCS Examination in India, thus helping hundreds of Doctors from this region to accomplish their dream of sitting the prestigious Examination in India without the need to travel all the way to the UK.

• In recognition of his outstanding academic achievements & contribution to the RCS Ed for well over a decade, he was conferred International Gold Medal in 2013 - the highest Award that the Royal College bestows to Surgeons practicing outside of the United Kingdom. He is the youngest ever recipient of this impressive Award in 510 years history of the Royal College.

Invited Guest Speaker 2016

Professor Martin R. Weiser

Martin R. Weiser is the incumbent of the Stuart H.Q. Quan Chair in Colorectal Surgery and an Attending Surgeon on the Colorectal Service at Memorial Sloan Kettering Cancer Center. He is Professor of Surgery at Weill Cornell Medical College. Dr. Weiser received his MD degree from the University Of Chicago Pritzker School Of Medicine and completed residencyat Brigham and Women's Hospital. He has completed fellowships in surgical oncology and colorectal surgery. Dr. Weiser serves as Vice Chair for Education and Faculty Development in the Department of Surgery and has recently served as the Medical Staff President, Memorial Sloan Kettering Cancer Center. Dr. Weiser serves on the editorial board for the Journal of Clinical Oncology, Annals of Surgical Oncology and the International Journal of Surgery. He is the Colorectal Surgery section editor for Up-To-Date and the Annals of Surgical Oncology. Dr. Weiser has been elected to the Southern Surgical Association and the American Surgical Association. He is a fellow of the American College of Surgeons, Society of Surgical Oncology and American Society of Colon and Rectal Surgeons. Dr. Weiser's research interests include modeling outcome and colorectal cancer staging, tumor profiling, mechanisms of tumor resistance to receptor tyrosine kinases, multimodality treatment of colorectal cancer, minimally invasive and robotic surgery. He is the surgical lead on the PROSPECT trial, a cooperative group prospective randomized trial investigating neoadjuvant therapy for rectal cancer. He serves on the ASCRS Fundamentals of Rectal Cancer Surgery Committee, American Joint Committee on Cancer (AJCC) Colorectal Staging Taskforce (7th and 8th editions), and the

AJCC Precision Medicine Committee. He is the past Chair of the Colorectal Task Group for the Society of Surgical Oncology (SSO) and the Colorectal Track Leader for the Education Committee of the American Society of Clinical Oncology (ASCO). Dr. Weiser has mentored over 20 clinical and laboratory research fellows and has published over 170 peer review articles, 60 review articles, book chapters, and editorials.

Professor Joseph Woo

Joseph Woo, M.D. serves as the Norman E. Shumway Professor and Chair of the Department of Cardiothoracic Surgery at the Stanford University School of Medicine. He received his undergraduate degree from the Massachusetts Institute of Technology and his M.D. from the University of Pennsylvania where he also conducted his postgraduate surgical training. At Penn, Dr. Woo also completed a postdoctoral research fellowship in novel molecular strategies for attenuating myocardial ischemic injury for which he won the American Heart Association Vivien Thomas Young Investigator Award. Dr. Woo joined the Penn faculty in 2002 as the Director of the Minimally Invasive Cardiac Surgery Program. He has helped to advance the field of complex valve repair and has developed several innovative new mitral and aortic valve operations. He also led the Mechanical Circulatory Assist and Cardiac Transplant Program and has likewise developed novel LVAD and transplant techniques. Dr. Woo built a robust practice, performing 350-400 pump cases per year and was listed in the Philadelphia Magazine as one of the region's Top Doctor's for several consecutive years. He has been invited to lecture on these topics around the world, and has performed these new operations in several countries. In 2014, Dr. Woo moved to Stanford University to lead the Department of Cardiothoracic Surgery. He continues an active clinical practice and has been recognized in the San Francisco Magazine as one of the region's Top Doctor's since 2014. Overall cardiovascular surgical clinical volume, extramural research funding, and residency education programs in the Department have grown significantly.

Dr. Woo currently runs an NIH R01-funded basic science research lab studying stem cells, angiogenesis, and tissue engineering and has held continuous NIH funding since 2004. He holds an appointment as a Professor by courtesy in the Stanford University Department of Bioengineering. He has also served as PI for several clinical device trials as well as translational scientific clinical trials entailing administration of stem cells during coronary artery bypass grafting and LVAD implantation. He has co-authored 170 peer-reviewed publications. As a teacher and mentor of students, residents, and fellows in the classroom, operating room, and laboratory settings, Dr. Woo has received several awards. Nationally, Dr. Woo has chaired several committees, including the American Heart Association Cardiovascular Surgery and Anesthesia Council. He is an Associate Editor for the Journal of Thoracic and Cardiovascular Surgery and has served as a Guest Editor forCirculation.

Anusak Yiengpruksawan,
MD, FACS, FRCST (hon.)

Anusak Yiengpruksawan, M.D. is a surgical oncologist practicing at the Valley Hospital in Ridgewood, New Jersey, USA. He is also a Director of The Valley Hospital Institute for Minimally Invasive and Robotic Surgery. Dr. Yieng graduated from Tohoku University School of Medicine in Japan and did his fellowships in gastrointestinal cancer surgery at Toranomon Hospital (Tokyo, Japan) and surgical oncology at Memorial Sloan-Kettering Cancer Center. He specializes in treating cancer of the GI system, liver, pancreas and soft tissue sarcomas and is one of few surgeons in the US who performs endoscopic ultrasound and advanced robotic surgical oncology.

Dr. Yieng is one of the pioneers in robotic surgery and has performed more than 1,000 complex robotic procedures at Valley Hospital since 2001. He is one of the founding members of the Clinical Robotic Surgical Association, an international organization devoted to the advancement of clinical robotic surgery based in Chicago. Dr. Yieng is an active member in several surgical societies including American College of Surgeons (ACS), Society of Surgical Oncology (SSO), Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), and American Society of Gastroenterology (ASGE). In 2004, Dr. Yieng established the Valley International Surgical Fellowship to help educate and train young surgeons from Asia on minimally invasive and robotic surgery. He has taught and performed live robotic surgeries in many countries including Thailand, China, Spain, and Brazil. Dr. Yieng was awarded an honorary fellow of the Royal College of Surgeons of Thailand in 2014 for his contribution to Thai surgical community.

Stanley James Rogers, MD

Dr. Stanley J. Rogers is the chief of Minimally Invasive Surgery and director of the Bariatric Surgery Center and Liver Tumor Ablation Program at University of California at San Francisco (UCSF) Medical Center. He is the inaugural recipient of the Ruth M. Dunn Endowed Chair in Minimally Invasive Surgery, an honor bestowed to him by a grateful patient. His expertise is in minimally invasive or laparoscopic procedure, in particular within the fields of bariatric surgery, laparoscopic treatment of liver tumors and radiofrequency thermal ablation, and foregut surgery to treat conditions including benign and malignant disorders of the esophagus, stomach, bile ducts and gallbladder. Other areas of expertise include hernia surgery as well as surgical endoscopy.

Dr. Rogers treats patients at UCSF Medical Center at Parnassus and the UCSF Helen Diller Family Comprehensive Cancer Center at Mount Zion as well as San Francisco General Hospital where he is co-director of Video-endoscopic Surgery, and a staff and trauma surgeon. He is certified by the American Board of Surgery and a member of several professional organizations including the American College of Surgeons, American Institute of Ultrasound in Medicine, Society of American Gastrointestinal Endoscopic Surgeons, American Society for Metabolic and Bariatric Surgery, and American Gastroenterological Association. He is an associate professor of surgery at UCSF, conducts research and supervises residents and fellows. Dr. Rogers is named one of “American’s Top Doctors” in his specialty by the U.S. News & World report, a distinction reserved for the top one percent of physicians in the nation.

Invited Guest Speaker 2016

Dr. Rogers serves as the His Majesty King Bhumibol Adulyadej, Rama IX Distinguished Professor of Global Surgery. He has been contributing to the educational and health care system of Thailand particularly in the field of Minimally Invasive Surgery for many years. He annually visits several medical schools in Thailand such as Siriraj, Ramathibodi and Chulalongkorn hospital to deliver valuable lectures and to guide young surgeons in operations and also participates in surgical workshops. Further, he is the first person to initiate the Thai-UCSF Clinical Fellowship in Minimally Invasive Surgery which gives Thai surgeons an opportunity to be trained in this field at one of top five medical centers in the U.S.A. under his supervision. His significant contribution is truly beneficial towards the betterment of our country's future educational and health care system.

Prof. Nguyen Van Phan

Date of birth: May 25th, 1961
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Spoken languages: English, French, Vietnamese

EDUCATION & QUALIFICATION:

- 1985: MD, Medical University - Ho chi Minh city - Viet Nam
- 1985 - 1989: Fellowship on General surgery - Binh Dan hospiotal - VietNam
- 1989 - 1992: Fellowship on Cardio-Vascular surgery at Broussais Hospital - Paris - France

1992: Diploma of Cardio-vascular Surgery - Pierre-Descartes University - Paris VI - Paris - France

- 1998: Master of Science in Medicine
- 2006: Doctor of Philosophy (PhD) in Medicine

TEACHING EXPERIENCE:

- Invited Professor at Medical University - Ho chi Minh city - VietNam
- Invited Professor at Pham ngoc Thach Medical University - Ho chi Minh city - VietNam

MEMBERSHIP OF SOCIETY

- Councilor of Asian Society for Cardio-Vascular and Thoracic Surgery (ASCVTS)
- Member Association of Thoracic and Cardio-vascular Surgeons of Asia (ATCSA)

- Vice President of Association of Cardiovascular and Thoracic Surgery of VietNam
- Councilor of Vietnamese Association of Cardiology
- Reviewer of Asian Cardiovascular & Thoracic Annals

CURRENT POSITION:

- Head of Cardiac Surgery Department - Heart Institute - Ho chi Minh city - Alain Carpentier Foundation
- Head of Cardiac Surgery Department - Trieu An hospital - Ho chi Minh city
- Director of Advanced Mitral Valve Repair Workshop (AMVAR)
- Director of Master the Art of Mitral Valve Repair Workshop (MAMVR)

Faculty Members

International Faculty Members

David Watters	*Australia*	Gabriel L. Martinez	*Philippines*
Yik-Hong Ho	*Australia*	Macky Faylona	*Philippines*
Stan J. Monstrey	*Belgium*	Chong Tze Tec	*Singapore*
Lem Dara	*Cambodia*	Davide Lomanto	*Singapore*
Sok Buntha	*Cambodia*	Kok Sun Ho	*Singapore*
Stephen Wing-Keung Cheng	*Hong Kong*	SRE Sayampanathan	*Singapore*
Anil Sharmar	*India*	Jan F. Kukleta	*Switzerland*
Jaideepraj Rao	*India*	Michael Cotton	*Switzerland*
Raghu Ram	*India*	Richard Montgomery	*UK*
Suresh Vasistha	*India*	Anusak Yiengpruksawan	*USA*
Kiki Lukman	*Indonesia*	Hilary A. Sanfey	*USA*
Takaori Kyoichi	*Japan*	Joseph Woo	*USA*
Vanliem Bouaravong	*Laos*	Martin R. Weiser	*USA*
Dato' P. Kandasami	*Malaysia*	Stanley Duke Herrell	*USA*
Hanafiah Harunarashid	*Malaysia*	Stanley J. Rogers	*USA*
Htun Oo	*Myanmar*	Tom Jaksic	*USA*
Shein Myint	*Myanmar*	Tyler G. Hughes	*USA*
Frans L. Moll	*Netherlands*	Hong Son Trinh	*Vietnam*
Zafar Ullah Chaudhry	*Pakistan*	Nguyen Duc Chinh	*Vietnam*
Allen Buenafe	*Philippines*	Nguyen Van Phan	*Vietnam*
Enrico Ragaza	*Philippines*		

Thai Faculty Members

Akkaraporn Deeprasertvit
Amnat Kitkhuandee
Amonrat Inyeam
Angsu Chartrungsan
Anucha Panoi
Anukoon Krewborisutsakul
Anusak Yiengpruksawan
Apichai Angspatt
Araya Boonyaleepan
Araya Khaimook
Arunothai Siriasawakul
Asada Methasate
Banjerd Praditsuktavorn
Bannakij Lojanapiwat
Boonprasit Kritpracha
Boonsam Roongpuvapaht
Burapat Sangthong
Chadin Tharavej
Chairat Paempikul
Chalit Thongprayoon
Chaloemphon Boonmee
Chanarong Praneechit
Chawalit Wongbuddha
Darin Lohsiriwat
Ekkawit Lamthongin
Gorawee Tepsamrithporn
Jade Suphapol
Jatuporn Sirikun
Jirat Jiratham-opas
Kamtone Chandacham
Kanchana Areerattanavet
Katawaetee Decharun
Kaweesak Chittawatanarat
Khamin Chinsakchai
Khunchai Surasiang
Kidakorn Kiranantawat
Kittichai Luengtaviboon
Kittinut Kijvikai
Komkrit Thanislo
Kongkiat Opaswongkarn
Kriengchai Prasongsukarn
Kris Keorochana
Kritaya Kritayakirana
Mawin Vongsaisuwon
Narain Chotirosniramit
Nat Krairojananan
Nattawut Puangpunngam
Niramol Tantemsapya
Noppadol Trikunakornvong
Nopporn Photirangsiyakorn
Nunthapol Pongrattanaman
NuttawutSermsathanasawadi
Omchai Rattananont
Ongart Somintara
Onuma Chaiwat
Osaree Akaraborworn
Ouchai Kanjanapitak
Paiwit Sripatnapiriyakul
Pakapon Tudsri
Paramin Muangkaew
Parinya Santichartngam
Pasu Promniyom

Pasurachate Samon
Patkawat Ramart
Petch Wacharasint
Phitsanu Mahawong
Piangkhae Parkpibul
Pinij Noorit
Piya Taewprasert
Piyanut Pootracool
Piyasakol Sakolsatayadorn
Ploynapas Limpanudom
Pongpol Sriphan
Pongsasit Singhatas
Pongthep Pisarnturakit
Poonpissamai Suwajo
Pornthep Pungrasmi
Prakasit Chirappapha
Prakob Leuchakiatisak
Pramook Mutirangura
Pramote Porapakkham
Pranom Cometieng
Prasopchai Kongsakphaisal
Prawej Mahawithitwong
Premsant Sangkum
Prinya Sakiyalak
Punnarerk Thongcharoen
Putthiporn Yenbutra
Rangson Chaikitamnuaychok
Rattaplee Pak-Art
Rawisak Chanwat
Rungkit Tanjapatkul
Sa-ard Treepongkaruna
Sahadol Poonyathawon
Saranart Oraphin
Satit Siriboonrid
Seri Singhatanadgige
Sirikarn Limpakan (Yamada)
Siriporn Putharungsri
Siros Jitpraphai
Somkiat Sunpaweravong
Srila Samphao
Suchart Chaiyaroj
Sudarat Chaipiancharoenkit
Suebwong Chuthapisith
Suneerat Kongsayreepong
Supachoke Chitvanich
Supapong Arworn
Supatcha Prasertcharoensuk
Supoj Ratchanon
Suppadech Tunruttanakul
Supparerk Prichayudh
Supreecha Asawakran
Surapong Supaporn
Surasak Sangkhathat
Surawut Charoenkajornchai
Surin Woragidpoonpol
Suriya Chakkaphak
Susan Assanasen
Suthas Horsirimanont
Suwanna Kittinaowarat
Tada Kunavisarut
Tanongsak Hathaivasiwong
Taungprart Srigulawong
Taweechai Wisanuyothin
Taweesak Chotwattanapong
Teerachai Ukritmanoroat
Teerapon Amornvesukit
Teerawoot Jantarawan
Thananchai Bunburaphong

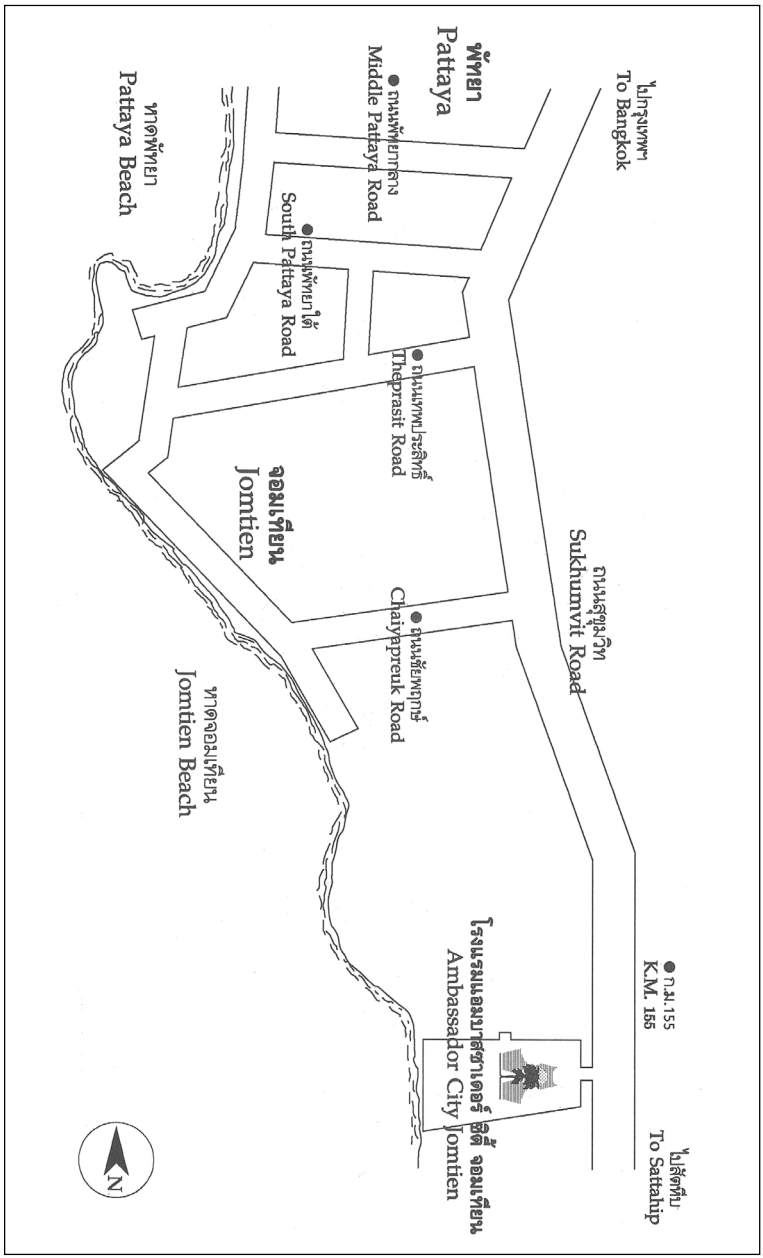
Thanapon Maipang
Thanasak Tongbai
Thanyadej Nimmanwuthipong
Thirapol Boonyaarunnate
Thiravud Kuhaprema
Tri Hanprasertpong
Umaad Aegem
Varut Lohsiriwat
Veera Suwanruangsri
Vibul Trakulhoon
Viratch Tangsujaritvijit
Vor Luvira
Voraboot Taweerutchana
Vorapot Choonhaklai
Vorrapot Vittayakitsirikul
Wanchai Naiyaraksaree
Wanchai Wongkornrat
Wannisa Poocharoen
Wanpredee Tansaynee
Wanwimon Kongsuwan
Watid Karnjanawanichkul
Weerachai Nawarawong
Wichai Vassanasiri
Wichitra Asanprakit
Wilairat Prasert
Wilaiwan Kamkrue
Wimon Sirimaharaj
Wisit Kasetsermwiriya
Wisoot Kongchareonsombat
Wittawat Pibul
Worawit Chittitavorn
Worawong Slisatkorn
Youwanush Kongdan

Date/Time	Function	Venue
Saturday, 16 July 2016		
19.00-22.00 hrs.	**Presidential Dinner** *(by invitation only)*	*Cholburi Room*
Sunday, 17 July 2016		
08.30-11.30 hrs.	**Opening Ceremony with Stage Party** **- Convocation** **- Conferment of Honorary Fellowship** **- Udom Poshakrishna Memorial Lecture**	*Diamond Room*
12.00-13.00 hrs.	**RCST lunch for Honorary Guests** *(by invitation only)*	*Premier Room*
Monday, 18 July 2016		
18.30-22.00 hrs.	**RCST Family Night**	*Diamond Room*

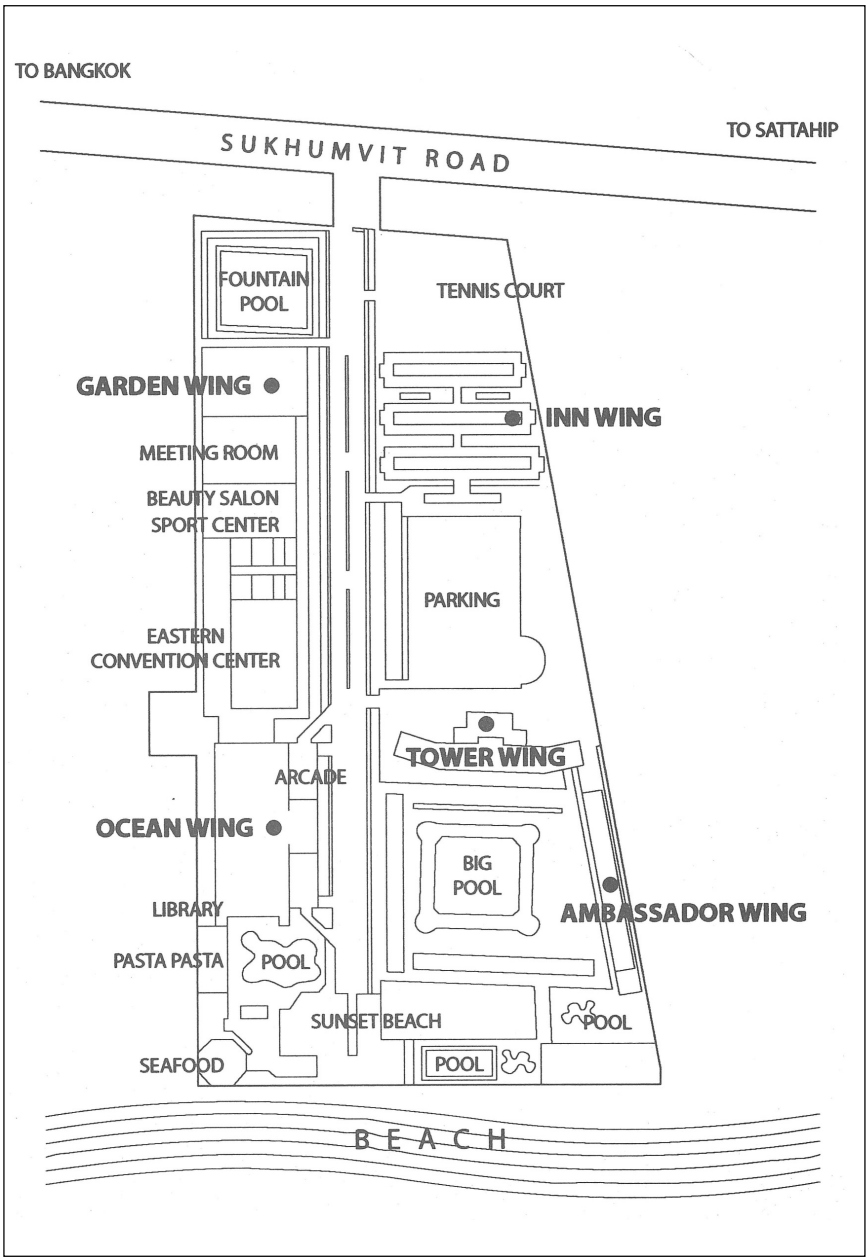
Sport Activities

No.	List of Sports	Time/Venue
Friday, 15 July 2016		
1.	**Golf**	Shot Gun 12.30 hrs. Siam Country Club (Old Course)
Tuesday, 19 July 2016		
2	**Run-Walk Rally**	06.00-07.00 hrs. Ambassador City Jomtien Hotel

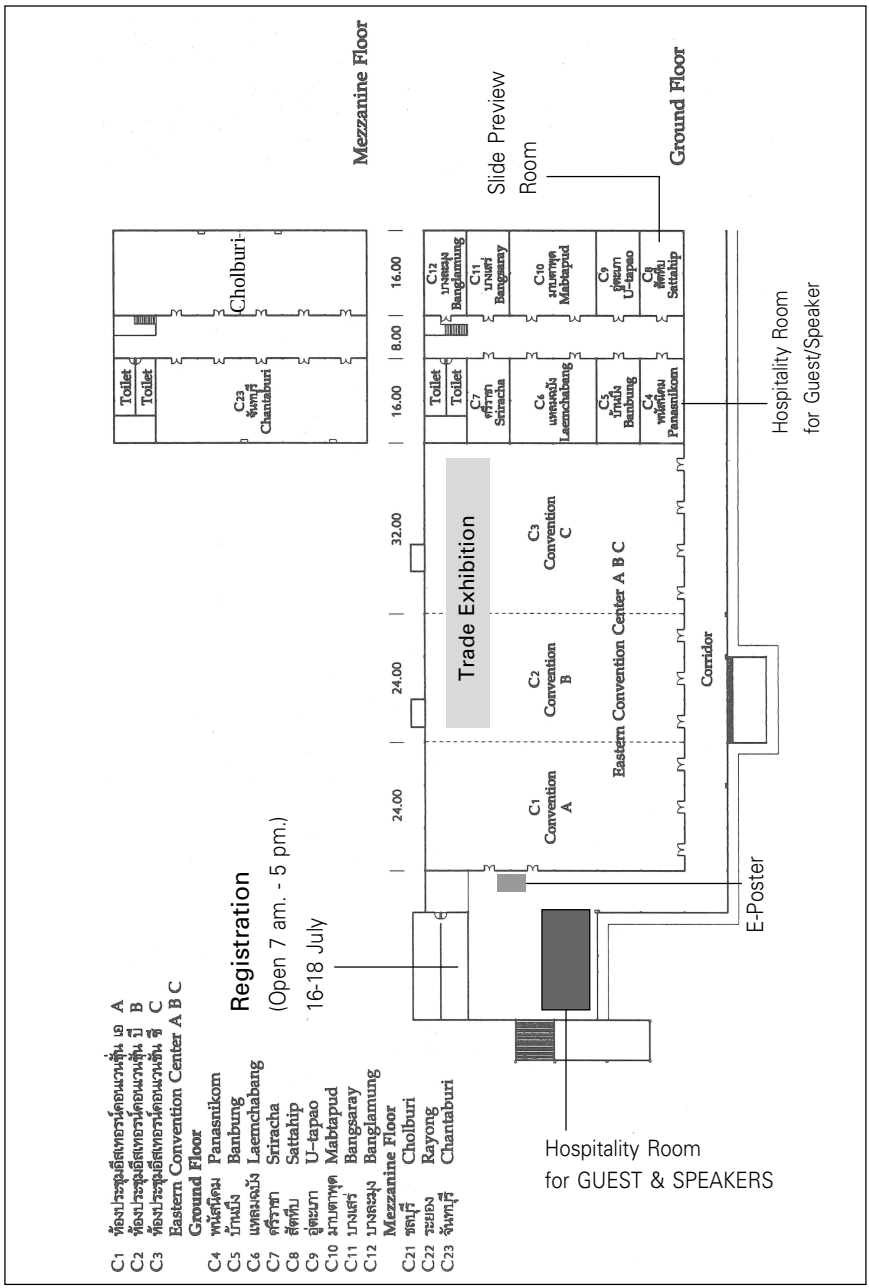
Floor Plan Ambassador City Jomtien Hotel



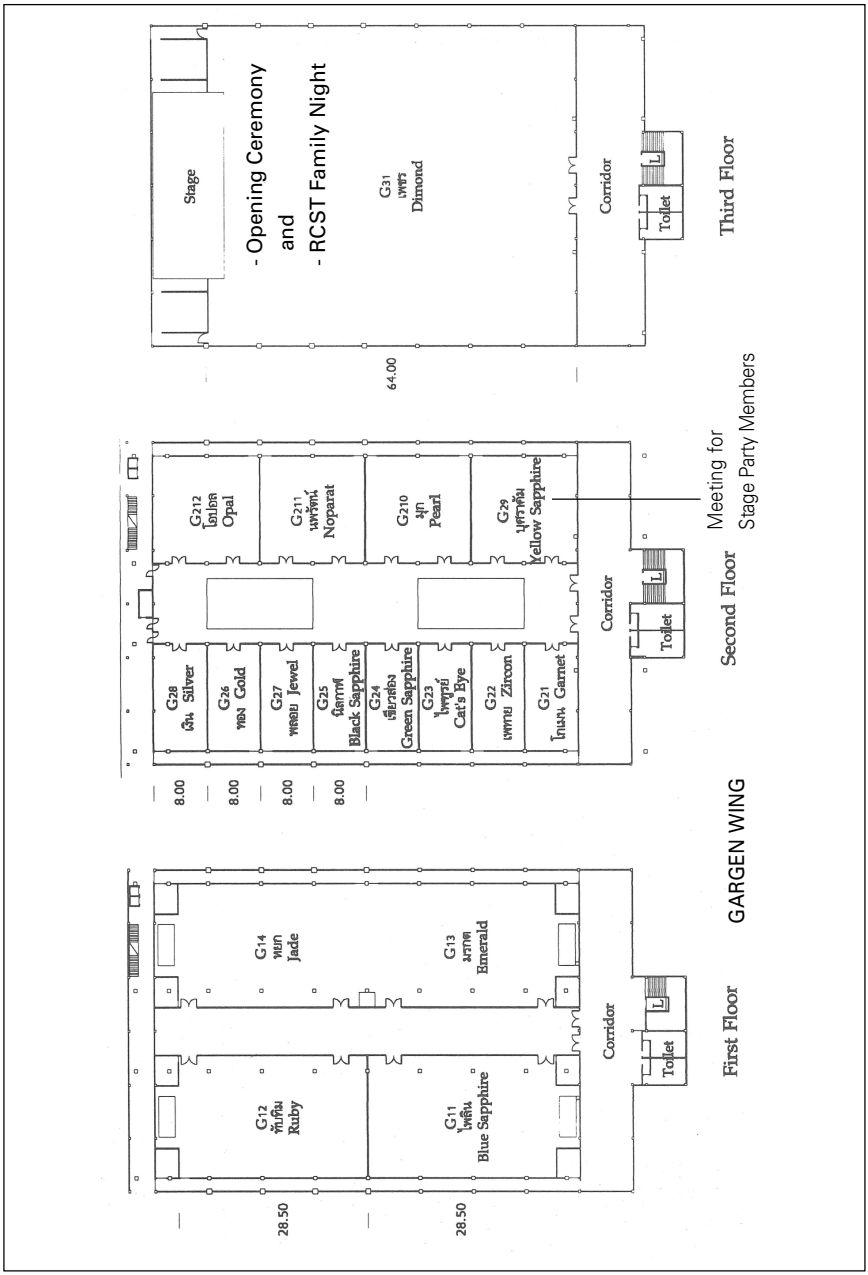
Floor Plan Ambassador City Jomtien Hotel



Floor Plan Ambassador City Jomtien Hotel



Floor Plan Ambassador City Jomtien Hotel



Program at A Glance

Program at A Glance

Tuesday: July 12, 2016 — Precongress Workshop in Bangkok

Open Total Mesorectal Excision: Chulalongkorn Hospital, 4th Fl Padtayapatana Building

Friday: July 15, 2016 — Precongress Workshop in Bangkok

Laparoscopic/Robotic Urological Surgery: Ramathibodi Hospital

Hybrid Hernia 2016: Chulalongkorn Hospital, 4th Fl, Padtayapatana Building

UGIST: Siriraj Hospital, SiTEC, 4th Fl, Srisavarindira Building

Essential Laparoscopic Procedures for Surgeons: Rajvithi Hospital, Surgical Skill Training Center, 2nd Fl, EMS Building, Rajavithi Hospital

Saturday: July 16, 2016 — Pre Congress at Ambassador City Jomtien, Pattaya

Rooms	Times	
Laemchabang	08.30-17.00	Surgical Endoscopy (Postgraduate Course of IAGSO)
Mabtapud	09.30-15.30	Trauma Management Guideline from Evidence Based to Practice
U-tapao	10.00-16.00	Breast Surgery
Banbung	08.45-16.15	Critical Care Strategies to Improve Outcome in Complicated Surgical Patients
Sriracha	13.00-17.00	Vascular Surgery Workshop (Hand on)
Cholburi	08.00-15.00	Vascular Surgery Lecture & Discussion
Blue Sapphire	08.30-16.00	Workshop OR Nurse: Perioperative Management
Emerald	13.00-16.00	Undergraduate Student Activities : Born to be Surgeon

Presidential Dinner (by Invitation) 19.00-22.00 at *Cholburi Room*

Main Congress at Ambassador City Jomtien

Sunday, 17 July 2016

	06.00-07.00	07.00-08.00	08.30-10.00	10.30-12.00	13.30-15.00	15.30-17.00
Diamond			**Opening Ceremony** - Convocation - "Udom Poshakrishna" Memorial Lecture "National Health Policy: What Surgeons Need to Know" *by* **H.E. Clinical Professor Piyasakol Sakolsatayadorn** (The Public Health Minister)		Achieving Quality Surgical Care in Thailand Part 1	Achieving Quality Surgical Care in Thailand Part 2
Banbung					Urologic Surgery 1	Urologic Surgery 2
U-tapao					Hemia Repair Surgery	LEST
Sriracha					Plastic Surgery 1	Plastic Surgery 1
Bangsaray					Colorectal Surgery 1 (in Thai)	Colorectal Surgery 2 (in English)
Banglamung					Pediatric Surgery 1	Plastic Surgery 2
Laemchabung						The Society of Thoracic Surgeons of Thailand
Mabtapud					UGIST 1	UGIST 2

17.00 General Assembly *at* U-tapao Room

Alumni Night

Monday, 18 July 2016

	06.00-07.00	07.00-08.00	08.30-10.00	10.30-12.00	13.30-15.00	15.30-17.00
Premier	Merit Making Ceremony	Undergraduate Activity Evaluation and Award Presentation				
Diamond			Principle of Surgical Practice: Multidisciplinary Session	กระบวนการยุติธรรมและกฎหมายปัจจุบัน ทำลาย หรือ ปกป้อง ศัลยแพทย์ ?	Head, Neck & Breast Surgery	Vascular Surgery 1
Banbung					Urologic Surgery 3	Urologic Surgery 4
U-tapao					Rural Surgery 1	Asean Experiences in Rural Surgery
Sriracha					Plastic Surgery 3: Panel Discussion Difficult Eyelid Surgery	
Bangsaray					UGIST 3	UGIST 4
Laemchabang					Advances in CVT Surgery: Valve Surgery	Advances in CVT Surgery: Aotic Surgery
Mabtapud					Trauma 1 Panel Discussion: Trauma From Scene to ER	Trauma 2 Panel Discussion: Dealing with Bleeding
Banglamung					Pediatric Surgery 3: The Art & Science of Intestinal Failure Managment	Pediatric Surgery 4: Panel Discussion

Monday. 18 July 2016

	06.00-07.00	07.00-08.00	08.30-10.00	10.30-12.00	13.30-15.00	15.30-17.00
Cholburi			Resident Paper Contest 1	Resident Paper Contest 2	TESS Head Neck & Breast Surgery	Breast Surgery
Chantaburi					Vascular Surgery 1	Vascular Surgery 1
Blue sapphire					Young Investigator Award and ACS Award	ICS Inventor Award and PISITH VISETHAKUL Award
Ruby					HPB 1: Liver Resection (VDO)	HPB 2: Pancreatic Resection (VDO)
Emerald					Free Paper Presentation 1	Free Paper Presentation 2
Jade					VDO Contest 1	VDO Contest 2
Yellow Sapphire					Surgical Infection Soceity Thailand Sepsis and Intra-abdominal	Surgical Infection Soceity Thailand Surgical Site Infection
Chantaburi					Vascular Surgery 1	Vascular Surgery 2

RCST Family Night : *Diamond Room* (18.0021.00)

Tuesday, 19 July 2016

	06.00-07.00	07.00-08.00	08.30-10.00	10.30-12.00	13.30-15.00	15.30-17.00
	Walk Ralky					
Laemchabang			*09.00-11.30* **ศัลยแพทย์กับความก้าวหน้าทางวิชาการ** - เกณฑ์การประเมินเพื่อเลื่อนระดับทางวิชาการ - Routine to Research (R2R) - How to do it - How I do it:			
Mabtapud			Advances in CVT Surgery 2016 (3) Coronary Surgery	Advances in CVT Surgery 2016 (4) Thoracic Surgery		
Cholburi			*(09.00-12.00)* **Financial Planning for Surgeons** **การวางแผนการลงทุนสำหรับศัลยแพทย์** **- ภาพรวมตลาดทุน** **- ภาพรวมการลงทุนในไทย** **- Fintech จะสร้างความเปลี่ยนแปลงในโลกการลงทุนอย่างไร** **- Asset Allocation** *ผู้ดำเนินการอภิปราย:* ผศ.นพ.ธัญเดช นิมมานวุฒิพงษ์ *วิทยากร:* ดร.ก้องเกียรติ โอภาสวงการ และคณะ *บรรยายไทย*		

Scientific Programme

Tuesday, 12 July 2016 and Friday, 15 July 2016

41st Annual Scientific Congress of the Royal College of Surgeons of Thailand CONGRESS PROGRAMME

Theme: Fundamental Surgery: Time to Reform

16-19 July 2016

at Ambassador Jomtien Hotel, Pattaya

Precongress Workshops in Bangkok

Tuesday, 12 July 2016	(CME 6 หน่วยกิต)
1. Open Total Mesorectal Excision	*Chulalongkorn Hospital, 4th Fl, Padtayapatana Building*

Friday, 15 July 2016	(CME 6 หน่วยกิต)
1. Laparoscopic/Robotic Urological Surgery	*Ramathibodi Hospital*
2. Hybrid Hernia 2016	*Chulalongkorn Hospital, 4th Fl, Padtayapatana Building*
3. UGIST	*Siriraj Hospital, SiTEC, 4th Fl, Srisavarindira Building*
4. Essential Laparoscopic Procedures for Surgeons	*Rajavithi Hospital, Surgical Skill Training Center, 2nd Fl, EMS Building, Rajavithi Hospital*

Scientific Programme

Saturday, 16 July 2016

Precongress at Ambassador City Jomtien

Saturday, 16 July 2016 (CME 6 หน่วยกิต)

16 July

Time / Room	08.30-10.00	10.00-10.30	10.30-12.00
Laemchabang	**Surgical Endoscopy** **(Postgraduate Course of IASGO)** 08.30-08.45 **Registration** 08.45-09.00 **Opening Speech** *Thawee Ratanachu-Ek* *Thawatchai Akaraviputh* 09.00-09.30 **Laparoscopic CBD Exploration at Sawanpracharak Hospital. How I do it** *Suppadech Tunruttanakul* (S) *Pranot Yimcharoen* (C) 09.30-10.00 **Laparoscopic Whipple's Operation** (Abstr. p. 126) **in Province Hospital:** **How Dream Came True** *Umaad Aegem* (S) *Voraboot Taweerutchana* (C) 10.30-10.45 ***Coffee break*** 10.45-11.15 **Endoscopic Thyroidectomy at Udonthani Hospital New Age of Thyroid Surgery** *Khunchai Surasiang* (S) *Angkoon Anuwong* (C) 11.15-11.45 **KPH GI Bleeding Score: Academic Thinking** (Abstr. p. 127) **in Rural Hospital** *Rangson Chaikitamnuaychok* (S) *Sirikan Limpakan* (Yamada) (C) 11.45-12.15 **Laparoscopic Esophagectomy in Hatyai Hospital: Beyond Imagine** *Araya Khaimook* (S) *Asada Methasate* (C)		

12.00-13.00	13.30-15.00	15.00-15.30	15.30-17.00

Surgical Endoscopy (continued)

(Postgraduate Course of IASGO)

13.15-13.45 **Synchronous LC with ERCP in Combined Cholecysto-docholithiasis: Something Could Happen only in Small Hospital**
Chaloemphon Boonmee (S)
Suppa-ut, Pungpapong (C)

13.45-14.15 **Screening Colonoscopy for Colon and Rectum Cancer in District Hospital: Time to protect our people**
(Abstr. p. 129)
Taungprart Srigulawong (S)
Chainarong Phalanusitthepha (C)
Supakit Khomvilai (C)

14.15-14.45 **Laparoscopic Bariatric Surgery at Hatyai Hospital: End of the Fatty Era**
Jirat Jiratham-opas (S)
Poochong Timratana (C)

14.45-15.15 **How to Kick off Laparoscopic Colectomy in My Hospital**
Paiwit Sripatnapiriyakul (S)
Jirawat Pattana-arun (C)

15.15-15.45 ***Coffee break***

15.45-16.15 **Lap. Inquinal Hernia Repair: From Routine to Research**
Taweechai Wisanuyothin (S)
Supakarn Techapongsatorn (C)

Meet the World Expert in Minimally Invasive Surgery

16.15-16.45 **What's New in Robotic Surgery**
Anusak Yiengpruksawan

16.45-17.00 **Award Presentation & Closing Speech:**
Thawatchai Akaraviputh

18.00 **Faculty Dinner**

16 July

16 July

Time / Room	08.30-10.00	10.00-10.30	10.30-12.00
Mabtapud	***(9.30-10.30)*** **Trauma Management Guideline: From Evidence Based to Practice 1** 1. Subclavian Injury (Guideline for Investigation and Management) *Supatcha Prasertcharoensuk* 2. Blunt Thoracic Aortic Injury *Kritaya Kritayakirana* 3. Portal Triad Injury, Juxtahepatic Venous Injury *Akkaraporn Deeprasertvit* 4. Mesenteric Vascular Injury *Pongpol Sriphan*		***(10.45-12.00)*** **Trauma Management Guideline: From Evidence Based to Practice 2** 1. ED Thoracotomy, Sub-xyphoid Window, Peri-cardiocanthesis *Wanpredee Tansaynee* 2. (Who, Whom, When) Penetrating Neck Injury (Guideline for Approach) *Putthiporn Yenbutra* 3. Cervical Spine Clearance *Amnat Kitkhuandee* 4. Cerebro Vascular Injury (Guideline for Screen and Management) *Anukoon Krewborisutsakul*
U-tapao			***10.00-10.30*** **Thai Breast Disease Society Opening** *Surapong Supaporn* ***10.30-11.00*** **Which Benign Lesions Need to be Removed ?** *Sudarat Chaipiancharoenkit* ***11.00-11.30*** **Nipple Discharge and Duct Excision** *Wichitra Asanprakit* ***11.30-12.00*** **Technique for Ultrasound Guided Wide Local Excision** *Ongart Somintara*

12.00-13.00	13.30-15.00	15.00-15.30	15.30-17.00
	(13.00-14.00) **Trauma Management Guideline: From Evidence Based to Practice 3** 1. Rib Fracture Pulmonary Contusion and Flail Chest *Vorapot Vitayakritsirikul* 2. Penetrating Abdominal Trauma *Pasurachate Samon* 3. Blunt Abdominal Trauma *Kris Keorochana* 4. Pelvic Fracture Hemorrhage *Nat Krairojananan*		***(14.15-15.30)*** **Trauma Management Guideline: From Evidence Based to Practice 4** 1. Difficult Abdominal Closure (Timing, Method) *Narain Chotirosniramit* 2. Venous Thromboembolism Prophylaxis in Trauma *Kamtone Chandacham* 3. Massive Transfusion Protocol (Indication, Ratio) *Banjerd Praditsuktavorn* 4. Pain Control in Trauma *Pongsasit Singhatas*
	13.00-13.30 **Technique for Needle Loca-lized Wide Excision** *Mawin Vongsaisuwon* ***13.30-14.00*** **Management of LABC** *Suebwong Chuthapisith* ***14.00-14.30*** **Sentinel Lymph Node Biopsy in 2016** *Srila Samphao* ***14.30-15.00*** **Oncologic Safety in Breast Surgery** *Prakasit Chirappapha*		***15.30-16.00*** **Management of Phyllodes Tumor** *Pongthep Pisarnturakit* ***16.00-17.00*** **Case Discussion** ***Moderator:*** *Sukchai Satthaporn* **Discussants:** *Surapong Supaporn* *Youwanush Kongdan* *Wichai Vassanasiri* **Presenters:** **Case I:** *Kanchana Areerattanavet* **Case II:** *Noppadol Trikunakornvong* **Case III:** *Piangkhae Parkpibul*

16 July

16 July

Time / Room	08.30-10.00	10.00-10.30	10.30-12.00
Banbung	**Critical Care Strategies to Improve Outcome in Complicated Surgical Patients** ***08.45*** **Opening:** *Vibul Trakulhoon* ***09.00-10.30*** **Critical Care Strategies to Improve Outcome in Surgical Patient** - **Enhanced Recovery After Surgery (ERAS) Protocol and the Critically Ill Surgical Patients** *Pongsasit Singhatas* - **Sepsis: New Definition and Evidence of Care in 2016** *Viratch Tangsujaritvijit* - **Post-operative Delirium & Pain Management: Significant Information** *Onuma Chaiwat* ***10.45-12.15*** **Critical Care Strategies to Improve Outcome in GI Surgery Part I** - **Intra-abdominal Hypertension** *Osaree Akaraborworn* - **Hemodynamic Monitoring: What has been left, what's new** *Petch Wacharasint* - **Ventilation & Perioperative Lung Protection: What's new** *Thananchai Bunburaphong*		
Sriracha			

12.00-13.00	13.30-15.00	15.00-15.30	15.30-17.00
	13.00-14.30 **Critical Care Strategies to Improve Outcome in GI Surgery Part II** - **Fluid Management: Surgical Perspective & Intensivist Perspective** *Sahadol Poonyathawon* - **Perioperative AKI: How important & what to do** *Suneerat Kongsayreepong* - **Nutrition in Complicated Case** *Kaweesak Chittawatanarat* ***14.45-16.15*** **Critical Care Strategies to Improve Outcome in Traumatic Surgery** - **Resuscitation in Severe Traumatic Injury: Should we go for Hypotensive Resuscitation?** *Jatuporn Sirikun* - **Critical Care Approach for Traumatic Brain Injury: What needs to be done** *Ploynapas Limpanudom* - **Practical Key Points of Appropriate Prescription of EEF in Trauma Surgery** *Vibul Trakulhoon* ***16.15*** **Summary and Closing Remarks** *by Vibul Trakulhoon*		
	Hands-on Vascular Workshop 1 **Duplex Ultrasonography in Vascular Surgery Arterial Disease** - **Arterial Anatomy & Physiology** - **Arterial Stenosis** - **Arterial Thrombosis**		**Hands-on Vascular Workshop 2** **Ultrasound-guided Insertion of Central Venous Catheter** - **Duplex Ultrasounds** - **Vascular Models**

16 July

Time / Room	08.30-10.00	10.00-10.30	10.30-12.00
Sriracha			
Chantaburi	**Challenges in Aortic Pathology** ***08.00-08.40*** **Registration** ***08.40-08.45*** **Opening Speech** *Pramook Mutirangura* **Abdominal Aortic Seciton** **Commentator** *Boonprasit Kritpracha* ***08.45-08.57*** **Severe Neck Angulation: How to get the Sucessful Landing Zone** *Boonprasit Kritprach* ***08.57-09.09*** **Aortic Neck Thrombus and Calcification: Tips and Tricks to Avoid Complications during EVAR** *Saranart Oraphin*		**Thoracic Aortic Section** **Commentator** *Kittichai Luengtaviboon* ***10.30-10.42*** **Spinal Cord Protection** *Surin Woragidpoonpol* ***10.42-10.54*** **Arch Hybrid Procedure: Indication and Technique** *Wanchai Wongkornrat* ***10.54-11.06*** **Fenestrated and Branch Endograft** *Worawong Slisakorn* ***11.18-11.30*** **Avoidance of Retrograde Type A Dissection during TEVAR in Type B Aortic Dissection** *Angsu Chartrungsan*

12.00-13.00	13.30-15.00	15.00-15.30	15.30-17.00
	- **Aneurysm** - **Arterio Venous Fistula** **Venous Disease** - **Venous Anatomy & Physiology** - **Deep Vein Thrombosis** - **Varicose Venous** - **Chronic Venous** - **Insufficiency**		
	Case Discussion **Commentator** *Kittichai Luengtaviboon* *Boonprasit Kritpracha* ***13.00-13.15*** **Abdominal Aortic Case** *Nattawut Puangpunngam* ***13.15-13.30*** **Thoracic Aortic Case** *Wittawat Pibul* ***13.30-13.45*** **Abdominal Aortic Case** *Veera Suwanruangsri* ***13.45-14.00*** **Thoracic Aortic Case** *Vorrapot Vittayakitsirikul* ***14.00-14.15*** **Abdominal Aortic Case** *Pinij Noorit*		

Time / Room	08.30-10.00	10.00-10.30	10.30-12.00
Cholburi	***09.09-09.21*** **Narrowing Aortic Bifurcation: How much is the narrowest diameter for biburcated EVAR?** *Khamin Chinsakchai* ***09.21-09.33*** **Severe Tortuous and Calcified Iliac Artery: Does it limit EVAR?** *Piyanut Pootracool* ***09.33-09.45*** **AAA with both CIAAs: What are the strategies for EVAR?** *Ghong Tze Tec* ***09.45-10.00*** **Q & A**		***11.30-11.42*** **Decision Making in Aortic Surgery-Do's and Don'ts** *Kittichai Luengtaviboon* ***11.42-12.00*** **Q & A**

16 July

12.00-13.00	13.30-15.00	15.00-15.30	15.30-17.00
	14.15-14.30 **Thoracic Aortic Case** *Teerawoot Jantarawan* ***14.30-14.45*** **Abdominal Aortic Case** *Supatcha Prasertcharoensook* ***14.45-15.00*** **Thoracic Aortic Case** *Chawalit Wongbuddha*		

16 July

Time / Room	08.30-10.00	10.00-10.30	10.30-12.00
Blue Sapphire CNEU 6 หน่วยกิต	**Workshop for OR Nurse 1** ***08.30-09.00*** *Chair: Manida Vassanasit* *C0-chair: Pornpimol Promkan* **Opening and Overview Perioperative Nursing Management** *นายกสมาคมพยาบาลห้องผ่าตัดแห่งประเทศไทย* *Siriporn Phutharangsii* ***09.00-09.30*** **Perioperative Nursing Management: Laparoscopic Surgery and Autosuture** *Wilaiwan Khamkrue* ***09.30-10.00*** **Perioperative Nursing Management: Skin Preparation** *Wanvimol Kongsuwan* ***10.00-11.00*** แบ่งกลุ่มย่อย ***11.00-12.00*** แลกเปลี่ยนเรียนรู้และสรุป		
Emerald			

Presidential Dinner *(*by *Invitation)* ***19.00-22.00***
Chol-buri Room

12.00-13.00	13.30-15.00	15.00-15.30	15.30-17.00
	Workshop for OR Nurse 1 (continued) ***13.00-13.30*** **Perioperative Management: Prevention of Pressure Sore** *Amornrat Intarayam* ***13.30-14.00*** **Perioperative Management: Stoma Care** *Suwanna Kittinouvarat* ***13.30-14.00*** แบ่งกลุ่มย่อย ***15.00-16.00*** แลกเปลี่ยนเรียนรู้และสรุป		
	Activities for Undergraduate Students: Born to be Surgeon 1 Surgical Quiz, Surgical OSCE, Trauma Scenario		**Activities for Undergraduate Students: Born to be Surgeon 2 Surgical Quiz, Surgical OSCE, Trauma Scenario**

16 July

Scientific Programme

Sunday, 17 July 2016

Main Congress

Sunday, 17 July 2016 (CME 3 หน่วยกิต)

Time / Room	08.30-10.00	10.00-10.30	10.30-12.00
Diamond	**Opening Ceremony** **- Convocation** **- UdomPoshakrishna Memorial Lecture** **"National Health Policy: What Surgeons Need to Know"** *by H.E. Clinical Professor Piyasakol Sakolsatayadorn*		
Banbung			

17 July

12.00-13.00	13.30-15.00	15.00-15.30	15.30-17.00
	Achieving Quality Surgical Care in Thailand: Part 1 *Chairman: Prinya Sakiyalak* *Co-chair: Michael Cotton* **1. Rural Surgery: A Worldwide Issue** *Tyler Hughes* (Abstr. p. 130) **2. How to Achieve Quality Surgical Training in USA** *Martin R. Weiser* **3. How to Maintain Lifelong Surgical Career** *David Watters* **4. How to Organize Surgical Subspecialization in the Next Decade** *Frans L. Moll* **5. Managing Changes, Managing Future: How to Prepare and Shape our Specialty** *Joseph Woo*		**Achieving Quality Surgical Care in Thailand: Part 2** *Chairman: Prinya Sakiyalak* *Co-chair: Thanyadej Nimmanwudipong* **1. Development of Rural Surgery Training Program** *Tyler Hughes* (Abstr. p. 131) **2. Essential Surgery: A Bridge to Rural Surgery** *Michael Cotton* (Abstr. p. 132) **3. Current Status of Surgical Care in Thailand** *Chalit Thongprayoon* **4. MPH Policy to Achieve the Goal** *Pranom Cometieng* **5. Progress with Global Surgery Metrics and National Surgical Planning** *David Watters*
	Urology Surgery 1 *Chairman: Choosak Pripatnanont* *Co-chairman: Supoj Ratchanon* **1. Radical Prostatectomy in Oligometastasis** *Kittinut Kijvikai* **2. New Technology Platforms in the Future of Urology: Robotics and Imaging** *Stanley Duke Herrell* (Abstr. p. 134) **3. Retroperitoneal Robotic Partial Nephrectomy: Approach and Technique** *Stanley Duke Herrell* (Abstr. p. 135)		**Urology Surgery 2** *Chairman: Thanasak Tongbai* *Co-chairman: Vorapot Choonhaklai* **1. Surgical Aspect and Update in KT** *Siros Jitpraphai* **2. Kidney Transplantation in Provincial Hospital: The Way to Success** **- Buddhachinaraj Hospital Experience** *Thanasak Tongbai* (Abstr. p. 136)

17 July

Time / Room	08.30-10.00	10.00-10.30	10.30-12.00
Banbung			
U-tapao			
Sriracha			

17 July

12.00-13.00	13.30-15.00	15.00-15.30	15.30-17.00
	4. Cost Utility of Robotic Surgery *Supoj Ratchanon* **5. Laser Prostatectomy** *Teerapon Amornvesukit*		- **Sunpasittiprasong Hospital Experience** *Tri Hanprasertpong* - **Suratthani Hospital Experience** *Tanongsak Hathaivasiwong*
	Hernia **Hernia Repair Surgery: Beyond the Fundamental** *Moderator: Suthep Udomsawaengsup* *Co-moderator: Davide Lomanto* **Functional of the Abdominal Wall** *Jan F. Kukleta* (Abstr. p. 137) **Update in Abdominal Wall Closure** *Allen Buenafe* **Hernia: A Metabolic Disease?** *Davide Lomanto* **World of Mesh** *Jan F. Kukleta* (Abstr. p. 138)		**LEST** *Moderator: Thawatchai Akraviputh* *Vitoon Chinswangwatanakul* **Back to the Basic with Robotic Surgery** *Anusak Yiengpruksawan* (Abstr. p. 140) **Artery-first Approach to Distal Pancreatectomy** *Kyoichi Takaori* (Abstr. p. 141) **From Basic to Advanced Laparoscopic Adrenalectomy** *Voraboot Taweerutchana*
	Plastic Surgery 1: Burn Update *Moderator: Chalermpong Chatdokmaiprai* ***13.30-13.50*** **Burn Injuries from the Erawan Shine Bombing** *Apichai Angspatt* ***13.50-14.10*** **New Trends in Burn Management** *Stan J. Monstrey* (Abstr. p. 139) ***14.10-15.00*** **The Development of Thai Skin Bank** *Pornthep Pungrasmi* **Q & A**		**Plastic Surgery 2 Sex Reassignment Surgery and Genital Reconstruction** *Moderator: Apichai Angspatt* ***15.30-15.50*** - **Update Standard of Care in Gender Identity Disorder (GID)** *Stan J. Monstrey* (Abstr. p. 142) ***15.50-16.10*** - **Future Trends in Phalloplasty** *Stan J. Monstrey* (Abstr. p. 143) ***16.10-16.30*** **Paraffinoma of Phallus: The Treatment and Outcome in Thai Male** *Pasu Promniyom*

17 July

	08.30-10.00	10.00-10.30	10.30-12.00	12.00-13.00
Bangsaray				
Banglamung				
Laemchabang				
Mabtapud				

17.00 **RCST General Assembly** at ***U-tapao Room***
***Alumni Night**

12.00-13.00	13.30-15.00	15.00-15.30	15.30-17.00
	Colorectal Surgery 1 **Interhospital Conference** **Colonic Obstruction** *Chairman: Jirawat Pattana-Arun* *Co-chair: Woramin Riansuwan*		**Colorectal Surgery 2** *Chairman: Ton Kongpensuk* *Co-chair: Varut Lohsiriwat* - **What's New in Colorectal Cancer Staging?** *Martin R. Weiser* - **Local Advanced Rectal Cancer: Present and future** *Martin R. Weiser* (Abstr. p. 144) - **Managing Complicated Diverticular Disease: Asian vs Australian Experience** *Yik-Hong Ho*
	Pediatric Surgery 1 *Chairman: Sumate Teeraratkul* *Co-chairman: Niramol Tantemsapya* **The Morbidity, Mortality and Management of Necrotizing Enterocolitis** *Tom Jaksic*		**Pediatric Surgery 2** **Free Paper** *Chairman: Sani Molagool* *Co-chairman: Prapapan Rajatapiti* **Meet the Experts: Difficult case Presentation** *Chairm : Taweesak Chotwatanapong* *Weerachai Nawarawong*
			The Society of Thoracic Surgeons of Thailand
	UGIST I *Chairman: Suriya Chakkaphak* *Co-chairman: Chadin Tharavej* ***13.30-14.15*** **Meet the Experts: Upper GI Surgery in Rural Areas (I)** *Ouchai Kanjanapitak* *Darin Lohsiriwat* *Thanapon Maipang* *Thiravud Kuhaprema*		**UGIST II** *Chairman: Suriya Chakkaphak* *Co-chairman: Chadin Tharavej* ***15.30-16.15*** **Gastric Surgery in Rural Area (I)** *Ekkawit Lamthongin* *Pakapon Tudsri* *Asada Methasate* *Sirikarn Limpakan* *Piya Taeprasert*

17 July

Scientific Programme

Monday, 18 July 2016

Monday, 18 July 2016			(CME 6 หน่วยกิต)
Time / Room	08.30-10.00	10.00-10.30	10.30-12.00
Mabtapud			
Premier	***06.00-07.00*** **Merit Making Ceremony** ***07.00-08.00*** **Undergraduate Activity Evaluation and Award Presentation**		
Diamond	**Multidisciplinary Sessions** *Chairman: Vitoon Chinswangwattanakul* *Co-chairman: Aattaporn Trakarnsanga* **1) The First Hour Resuscitation: Make Patient Alive (Modern Concept for Treatment of Shock)** *Chairat Paempikul* **2) Preoperative VTE Prevention - When and How** *Piyanut Pootracool* **3) How to Control Major Surgical Bleeding** *Komkrit Thanislo* **4) Antibiotics in MDR Era: What Surgeons Should Know** *Visanu Thamlikitkul* **5. Head Injury: Neurosurgeons think, general surgeons do** *Supachoke Chitvanich* (Abstr. p. 145)		**กระบวนการยุติธรรมและกฎหมายปัจจุบัน ทำลาย หรือ ปกป้อง ศัลยแพทย์ ?** *ประธาน:* *สุทธจิต ลีนานนท์* *ประธานร่วม:* *ธัชพงษ์ วิสุทธิสังวร* ***บรรยายโดย*** ***นพพร โพธิรังสิยากร*** *ผู้พิพากษา หัวหน้าคณะในศาลฎีกา* ***ชาญณรงค์ ปราณีจิตต์*** *ผู้พิพากษาหัวหน้าคณะในศาลอุทธรณ์ประจำสำนักประธานศาลฎีกา* ***ธัญเดช นิมมานวุฒิพงษ์*** *ศัลยแพทย์*

12.00-13.00		15.00-15.30	15.30-17.00
	14.15-15.00 **Meet the Experts: Upper GI Surgery in Rural Areas (II)** *Ouchai Kanjanapitak* *Darin Lohsiriwat* *Thanapon Maipang* *Thiravud Kuhaprema*		***16.15-17.00*** **Gastric Surtgery in Rural Area (II)** *Ekkawit Lamthongin* *Pakapon Tudsri* *Asada Methasate* *Sirikarn Limpakan* *Piya Taeprasert*

Time / Room	08.30-10.00	10.00-10.30	10.30-12.00
Banbung			
U-tapao			

18 July

12.00-13.00	13.30-15.00	15.00-15.30	15.30-17.00
	Urology Surgery 3 *Chairman: Bannakij Lojanapiwat* *Co-chairman: Satit Siriboonrid* **1. Intraoperative Urologic Consultation** *Watid Karnjanawanichkul* **2. Perfect PCNL: Do we need all sizes of nephroscope?** *Bannakij Lojanapiwat* **3. Surgical Management of Varicocele** - Microsurgical Varicocelectomy *Wanchai Naiyaraksaree* - Open Varicocelectomy *Vorapot Choonhaklai* - Laparoscopic Varicocelectomy *Satit Siriboonrid*		**Urology Surgery 4** *Chairman: Wanchai Naiyaraksaree* *Co-chairman: Wisoot Kongchareonsombat* **1. The Role of Keyhole Operation in Radical Cystectomy** *Wisoot Kongchareonsombat* **2. Urologic Problems in Anorectal Malformations** *Phitsanu Mahawong* **3. Surgical Management for Stress Urinary Incontinence** *Patkawat Ramart* **4. What's New in Penile Prosthesis Placement Surgery** *Premsant Sangkum*
	Rural Surgery 1 *Moderators: Prinya Sakiyalak, David Watters* **1. Scope and Limitation of Rural Surgery** *Tyler Hughes* (Abstr. p. 146) **2. Rural Surgery in Australia** *David Watters* **3. Retention and Professional Development in Rural Surgery** *Tyler Hughes* (Abstr. p. 147)		**Rural Surgery 2** *Moderators: Tyler Hughes, Thanyadej Nimmanwutipong* **Rural Surgery in ASEAN: Safe Surgery for All** **Thailand: Litigation, Unexpected Obstacle of the Great Plains** *Kiki Lukman* **Philippine: What is to be Expected from a Surgeon in Land of Thousand Islands, Volcanoes and Typhoons** *Kiki Lukman*

18 July

Time / Room	08.30-10.00	10.00-10.30	10.30-12.00
U-tapao			
Laemchabang			
Mabtapud			

18 July

12.00-13.00	13.30-15.00	15.00-15.30	15.30-17.00
			Malaysia: Rural Surgery in Malaysia, Where Everyone is Within Reach in 5 Hours *Hanafiah Harunarashid* **Indonesia: How the Surgeons Serve Hundreds of Islands and Hundreds of Millions Indonesians** *Kiki Lukman* **Myanmar: Surgery in Vast Terrains and Multi Ethnic Groups** *Htun Oo*
	Advances in CVT Surgery 2016 (1) **Valve Surgery** - **MV Repair** - **Minimal Invasive Valve Surgery** *Joseph Woo* - **Surgical Repair of Tricuspid Valve** *Nguyen van Phan* (Abstr. p. 148) - **Transcatheter AV & MV** - **Sutureless AVR**		**Advances in CVT Surgery 2016 (2)** **Aortic Surgery** *Chairman: Vichao Kojaranjit* *Co-chair: Pramote Porapakkham* - **TEVAR** *Pramote Porapakkham* - **Complex Thoracic Aortic Surgery** *Kittichai Luengtaviboon* - **AV Sparing Operation** *Joseph Woo* - **Acute Aortic Dissection** *Surin Woragidpoonpol*
	Trauma 1 **Panel Discussion:** **Trauma From Scene to ER** 1. **PHTLS: Updated** *Nat Krairojananan* 2. **Ultrasound for Trauma: More than FAST or EFAST** *Supparerk Prichayudh* 3. **C spine Clearance in CT Era** *Teerachai Ukritmanoroat*		**Trauma 2** **Panel Discussion:** **Dealing with Bleeding** 1. **All About Hemostatic Tools** *Wisit Kasetsermwiriya* 2. **REBOA: Realities** *Narain Chotirosniramit* 3. **Massive Transfusion Protocol in Pediatric** *Burapat Sangthong* 4. **Interventionist is not Available: What should I do?** *Rattaplee Pak-Art*

Time / Room	08.30-10.00	10.00-10.30	10.30-12.00
Sriracha			
Bangsaray			

18 July

12.00-13.00	13.30-15.00	15.00-15.30	15.30-17.00
	Plastic Surgery 3 **Business Meeting** **The Society of Plastic and Reconstructive Surgeons of Thailand** *Chairman: Sirachai Jindarak* *Co-chairman: Apichai Angspatt* **The Society of Aesthetic Plastic Surgeons of Thailand** *Chairman: Apichai Angspatt* *Co-chairman: Chalermpong Chatdakmaiprai* ***14.10-15.00*** **Modetator:** *Apichai Angspatt* **Panel Discussion: Difficult Eyelid Surgery** *Wimon Sirimaharaj* *Poonpissamai Suwajo* *Rungkit Tanjapatkul* *Adunhai Thammasangsert* *Kidakorn Kiranantawat*		
	UGIST III *Chairman: Darin Lohsiriwat* *Co-chairman: Voraboot Taweerutchana* ***13.30-14.00*** **Laparoscopic Heller Myotomy: How I do it** *Stanley Rogers* ***14.00-14.30*** **Laparoscopic fundoplication: How I do it** *Stanley J. Rogers* ***14.30-15.00*** **Case Discussion** *Voraboot Taweerutchana*		**UGIST IV** *Chairman: Somkiat Sunpaweravong* *Co-chairman: Sirikarn Limpakan* ***15.30-16.15*** **Esophageal Surgery in Rural Area (I)** *Prakob Leuchakiatisak* *Surawut Charoenkajornchai* *Chadin Tharavej* *Somkiat Sunpaweravong* *Suriya Chakkpaphak* ***16.15-17.00*** **Esophageal Surgery in Rural Area (II)** *Prakob Leuchakiatisak* *Surawut Charoenkajornchai* *Chadin Tharavej* *Somkiat Sunpaweravong* *Suriya Chakkpaphak*

Time / Room	08.30-10.00	10.00-10.30	10.30-12.00
Banglamung			
Cholburi	**Resident Paper Contest 1** *Chairman: Apichart Ploysangwal* *Co-chairman: Pornchai O-charoenrat* 8 Papers (Abstr. p. 153-160)		**Resident Paper Contest 2** *Chairman: Apichart Ploysangwal* *Co-chairman: Pornchai O-charoenrat* 7 Papers (Abstr. p. 161-168)

18 July

12.00-13.00	13.30-15.00	15.00-15.30	15.30-17.00
	Pediatric Surgery 3 *Chairman: Surasak Sangkhathat* *Co-chairamn: Wannisa Poocharoen* **The Art and Science of Intestinal Failure Management**		**Pediatric Surgery 4** *Moderator: Surasak Sangkhathat* *Patchaleeporn Tamming* **Panel Discussion** **The Management of Intestinal Failure in Children: Experience from Thai Pediatric Surgery Centers** *Surasak Sangkhathat* *Wannisa Poocharoen* *Nutnicha Susamanapun* *Jiraporn Khorana*
	TESS **Head, Neck & Breast Surgery** *Chairman: Suchart Chantawibul* *Co-chairman: Suebwong Chuthapisith* **"Roadmap to CPG of Solitary Thyroid Nodule and Differentiated Thyroid Cancer in Thailand"** **Discusstants** *Thirapol Boonyaarunnate* *Araya Boonyaleepan* *Boonsam Roongpuvapaht* *Walliya Jongjaroenprasert* *Putthiporn Yenbutra* *Wilairat Prasert* *Faculties from Thai Endocrine Surgeons Society (TESS)*		**Breast Surgery** *Chairman: Wichai Vassanasiri* *Co-chairman: Youwanush Kongdan* **Sentinel Lymph Node Biopsy for Rural Surgeons** *Prakasit Chirappapha* **How to Apply Ultrasound Guided Excision Breast Lesion** *Wichitra Asanprakit* **Management of Locally Advanced Breast Cancer: Indian Experience** *Ragu Ram* (Abstr. p. 149) **Management of Metastatic Breast Cancer for General Surgeron** *Surapong Supaporn*

18 July

Time / Room	08.30-10.00	10.00-10.30	10.30-12.00
Blue Sapphir			
Ruby			
Emerald			
Jade			

18 July

12.00-13.00	13.30-15.00	15.00-15.30	15.30-17.00
	Young Investigator award *Chairman: Songchai Simaroj* *Co-chairman: Pornprom Muangman*		**ICS Inventor Award** *Chairman: Supakorn Rojananin* *Co-chairman: Thavatchai Akaraviputh*
	ACS Award *Moderator: Kitti Kanpirom*		**Pisith Viseshakul Award in Trauma** *Chairman: Taweewong Chulakamontri* *Co-chairman: Teerachai Ukritmanoroat*
	HPB 1 **Liver Resection (VDO Session)** *Chairman: Anon Chotiroseniramit* *Co-chairman: Rawisak Chanwat* **1. Principle to Concern** *Supreecha Asawakran* **2. Open Technique (VDO)** *Sanhawit Junrungsee* **3. Laparoscopic Liver Resection (VDO)** *Rawisak Chanwat* **4. Tips and Tricks of Post Operative Care** *Vor Luvira*		**HPB 2** **Pancreatic Resection (VDO Session)** *Chairman: Sa-ard Treepongkaruna* *Co-Chairman: Chatchai Mingmalairak* **1. How to Reduce Pancreatic Leakage** *Paramin Muangkaew* **2. Radical Open Pancreatic Surgery (VDO)** *Jade Suphapol* 3. **Laparoscopic Pancreatic Resection (VDO)** *Sa-ard Treepongkaruna* **4. Robotic Pancreatic Resection (VDO)** *Prawej Mahawithitwong*
	Free Paper Presentation 1 *Chairman: Supakarn Techapongsatorn* *Co-chairman:Auttaporn Trakarnsanga*		**Free Paper Presentation 2** *Chairamn: Supakarn Techapongsatorn* *Co-chairman:Auttaporn Trakarnsanga*
	VDO Contest 1 *Chairman: Thawatchai Akaraviputh* *Co-chairman: Poochong Timratana* *(To be announced)* (Abstr. p. 219-230)		**VDO Contest 2** *Chairman: Thawatchai Akaraviputh* *Co-chairman: Poochong Timratana* *(To be announced)* (Abstr. p. 219-230)

18 July

Time / Room	08.30-10.00	10.00-10.30	10.30-12.00
Yellow Sapphire			

18 July

12.00-13.00	13.30-15.00	15.00-15.30	15.30-17.00
	Surgery Infection Society Thailand Sepsis and Intra-abdominal Infection *Chairman: Vitoon Chinswangwatanakul* *Co-chairman: Varut Lohsiriwat* **Critical Care for Surgical Sepsis: How to Maximize the Survival** *Chairat Paempikul* **MDR Outbreak in Surgical Ward: What We Can Do** *Susan Assanasen* **Difficult Source Control: Live or Let Die?** *Darin Lohsirswat*		**Surgery Infection Society Thailand Surgical Site Infection** *Chairman: Darin Lohsirswat* *Co-chairman: Pisake Boontham* **Surgical Site Infection: Back to Basic** *Pisake Boontham* **From Biochemical Knowledge to Antibiotic Usage: Do We Need Our Own Practice Guidelines?** *Varut Lohsiriwat* **Barrier, Protection, Prevention: How to Maximize the Efficacy** *Vitoon Chinswangwatanakul*

Time / Room	08.30-10.00	10.00-10.30	10.30-12.00
Chantaburi			

18 July

E-Poster contest Venue: Registration Hall *at* 13.30 hr.

RCST Family Night : *Diamond Room* (18.00-21.00)

12.00-13.00	13.30-15.00	15.00-15.30	15.30-17.00
	Vascular Surgery 1 *Chaiman: Pramook Mutirangura* *Co-chairman: Khamin Chindsakchai* **Surgery for Acute Limb Ischemia** - **Surgical Embolectomy** *Anucha Panoi* - **Thrombolytic Therapy** *Kritaya Kritayakirana* **Surgery for Critical Limb Ischemia** - **Artery Bypass** *Chumpol Wongwanit* - **Endarterectomy** *Pong Juntarapatin* - **Endovascular Surgery** *Suthas Horsirimanont* **Surgery for Vascular Trauma** - **Arterial Reconstruction** *Burapat Sangthong* - **Endovascular Surgery** *Banjerd Praditsuktavorn*		**Vascular Surgery 2** *Chairman: Ravi Pimolsarnti* *Co-chairman: Piyanut Pootracool* **Surgery for Abdominal Aortic Aneurysm** - **Open Repair** *Supapong Arworn* - **Endovascular Repair** *Frans L. Moll* **Surgery for Vascular Access** - **Arteriovenous Fistula** *Prasopchai Kongsakphaisal* - **Arteriovenous Bridge Graft** *Gorawee Tepsamrithporn* - **Venous Cacheterization** *Nunthapol Pongrattanaman* **Surgery for Varicose Vein** - **High Ligation, Vein Stripping & Avulsion** *Piyanut Pootracool* - **Endovenous Therapy** *Nuttawut Sermsathanasawadi*

18 July

Scientific Programme

Tuesday, 19 July 2016

Tuesday, 19 July 2016 (CME 3 หน่วยกิต)

Time / Room	06.00-07.00	08.30-12.00		
	Walk Rally			
Laemchabang	***09.30-11.30*** **ศัลยแพทย์กับความก้าวหน้าทางวิชาการ** *Chairman: ศ.นพ.สุชาติ จันทวิบูลย์* *Co-chairman: ศ.นพ.พรชัย โอเจริญรัตน์* **- เกณฑ์การประเมินเพื่อเลื่อนระดับทางวิชาการ** *ศ.นพ.ปริญญา สากิยลักษณ์* **- Routine to Research (R2R)** *ผศ.พญ.อรุโณทัย ศิริอัศวกุล* **- How to do it** *รศ.นพ.วรุตม์ โล่ห์สิริวัฒน์* **- How I do it** *นพ.ปริญญา สันติชาติงาม* บรรยายไทย			
Mabtapud	***08.30-10.00*** **Advances in CVT Surgery 2016 (3)** **Coronary Surgery** *Chairman: Sujit Banyatpiyaphod* *Co-chairman: Nuttapon Arayawudhikul* **- On Pump vs Off Pump** *Nuttapon Arayawudhikul* **- Post Infracted VSD** *Chaiwut Yottasurodom* **- Coronary with Valve** *Chawalit Wongbuddha* **- Redo Coronary Surgery** *Weerachai Nawarawong*	Coffee Break	***10.30-12.00*** **Advances in CVT Surgery 2016 (4)** **Thoracic Surgery** *Chairman: Somcharoen Saeteng* *Co-chairman: Punnarerk Thongcharoen* **- CA Lung** *Somcharoen Saeteng* **- VATS Update** *Punnarerk Thongcharoen* **- Single Lung Nodule: What to do** *Omchai Rattananont* **- Post Resection Empyema** *Voravit Chittitavorn*	

19 July

	Cholburi	***09.00-12.00*** **Financial Planning for Surgeons** **การวางแผนการลงทุนสำหรับศัลยแพทย์** *ผู้ดำเนินการอภิปราย: ธัญเดช นิมมานวุฒิพงษ์* - **ภาพรวมตลาดทุน** *ดร.ก้องเกียรติ โอภาสวงการ* - **ภาพรวมการลงทุนในไทย** *เทิดศักดิ์ ทวีธีระธรรม* *พบชัย ภัทราวิชญ์* *ชาญชัย พันทาธนากิจ* - **Fintech จะสร้างความเปลี่ยนแปลงในโลกการลงทุนอย่างไร** *รัชต์ โสตสถิต* - **Asset Allocation** *จีรภัทร พิมานทิพย์* บรรยายไทย
	Sriracha	***09.00-12.00*** **Vascular Surgery**

วันอาทิตย์ที่ 17 กรกฎาคม 2559

1. ห้องชลบุรี *สนับสนุนโดย* **บริษัท ร็อตต้าฟาร์ม ประเทศไทย จำกัด** (250 คน)

หัวข้อ **"เส้นเลือดขอดรักษาด้วยยาได้จริงหรือ ?"**

Moderator: ผศ.ดร.นพ. ณัฐวุฒิ เสริมสาธนสวัสดิ์

Speaker: ผศ.พญ.ปิยนุช พูตระกูล

2. ห้องจันทบุรี *สนับสนุนโดย* **บริษัท ทาเคดา (ประเทศไทย) จำกัด** (250 คน)

หัวข้อ **"Experts' Viewpoints: Doripenem in Complicated Surgery (Case Scenario)"**

Moderator: พ.อ. นพ. สมบัติ ลีลาสุภาศรี

Speaker: ผศ.นพ. ภิเษก บุญธรรม

3. ห้องมรกต *สนับสนุนโดย* **บริษัท เอ็มเอสดี (ประเทศไทย) จำกัด** (250 คน)

Surgical Approach in Intra-abdominal Infections

Speaker: รศ.นพ.บุญชู ศิริจินดากุล

ภาควิชาศัลยศาสตร์ คณะแพทยศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย

หัวข้อ **"Surgical Approach in Abdominal Laparoscopic Surgery: Optimizing Deep Paralysis and Insufflation Pressure"**

Speaker: พ.อ.นพ.สุทธจิต ลีนานนท์

กองศัลยกรรม โรงพยาบาลพระมงกุฎเกล้า

วันจันทร์ที่ 18 กรกฎาคม 2559

1. ห้องมรกต *สนับสนุนโดย* **บริษัท ทาเคด้า (ประเทศไทย) จำกัด** (250 คน)
หัวข้อ **"Optimizing Management of Peptic Ulcer Bleeding in Real Life Practice"**
Moderator: นพ.ทวี รัตนชูเอก
Speakers: รศ.นพ. สมชาย ลีลากุศลวงศ์
รศ.นพ.ชฎิล ธาระเวช

2. ห้องจันทบุรี *สนับสนุนโดย* **บริษัท เมดโทรนิค (ประเทศไทย) จำกัด** (250 คน)
หัวข้อ **Surgical Challenge in Using Electrosurgery and Vessel Sealing**
Opening Ceremony: *Vitoon Chinswangwatanakul*
Effectiveness and Safety of Control Bleeding
Sa-Ard Treepongkaruna
Shortening Operation Time by "LIGASURE"
Chucheep Sahakitrungruang

3. ห้องชลบุรี *สนับสนุนโดย* **บริษัท ดีเคเอสเอช (ประเทศไทย) จำกัด** (250 คน)
หัวข้อ **"ผลิตภัณฑ์แผ่นปิดแผลเคลือบสารสกัดเปลือกมังคุด"**
Speaker: ศาสตราจารย์ ดร.พิชญ์ ศุภผล

4. ห้องไพลิน *สนับสนุนโดย* **บริษัท คอนวาเทค (ประเทศไทย) จำกัด** (250 คน)
หัวข้อ **"Next-Generation Antimicrobial Dressing in Non-Healing Wound"**
Moderator: Assoc. Prof. Surajit Awsakulsutthi, M.D. FRCST
Speaker: Philip Bowler, MPhil. Microbiology

Abbreviations for Abstracts

S	=	Invited Speaker
O	=	Oral Presentation
		Gen., Ped., Plas.
P	=	Poster Presentation
RA	=	Resident Paper Award
YIA	=	Young Investigator Award
EPA	=	E-Poster Award
EP	=	E-Poster (non Completition)
ACS	=	ACS Award
ICS	=	ICS Inventor Award
PSA	=	Pisith Viseshakul Award
A-VA	=	Audiovisual Award

Abstracts

July 16, 17, 18, 2016

Laparoscopic Pancreaticoduodenectomy: How the Dream came True

Umaad Aegem, MD

Department of Surgery, Yala Hospital

Laparoscopic pancreatic surgery represents one of the most advanced applications for laparoscopic surgery currently in use. In the past, minimally invasive techniques were only used for diagnostic laparoscopy, staging of pancreatic cancer, and palliative procedures for unresectable pancreatic cancer. Recent advances in operative techniques and instrumentation have empowered surgeons to perform virtually all procedures in the pancreas, including the pancreatico-duodenectomy.

Laparoscopic techniques have been applied to a growing number of pancreatic surgeries since the early 1990s. The surgical management of pancreatic cancer has undergone a significant change in the past decade. The long-term results after laparoscopic resections for invasive pancreatic cancer, however, are still not well defined.

Laparoscopic pancreaticoduodenectomy for pancreatic cancer is a challenging procedure. The key success of advance laparoscopic surgery is teamwork.

KPH GI Bleeding Score: Academic Thinking in the Rural Hospital

Chaikitamnuaychok R* , Patumanond J**

*Department of Surgery, Kamphaeng Phet Hospital,

**Clinical Epidemiology Unit, Faculty of Medicine Thamasart University.

Backgrounds: Upper gastrointestinal hemorrhage (UGIH) is one of the most common emergency clinical manifestations. The definite patient risk stratification is not widely accepted. Emergency endoscopy for every patient is not possible in many medical centers.. Scoring tools to predict need for intervention, re-bleeding and mortality of upper gastrointestinal hemorrhage (UGIH) have been developed but simple guidelines to select patients for emergency endoscopy are lacking.

Objective: The aim of the present report is to develop a simple scoring system to classify upper gastrointestinal hemorrhage (UGIH) severity based on patient clinical profiles at the emergency departments and to compare the performances of the the Blatchford score, the Rockall score, and the KPH GI Bleeding Score (UGIH score 2014) on UGIH severity triage.

Material & Methods: A retrospective cohort study was conducted in Kamphaengphet hospital Thailand. Patients were criterion-classified into 3 severity levels: mild, moderate and severe. Clinical and laboratory information were compared among the 3 groups. Significant parameters were selected as indicators of severity. Coefficients of significant multivariable parameters were transformed into item scores, which added up as individual severity scores. The scores were used to classify patients into 3 urgency levels: non-urgent, urgent and emergent groups. Score-classification and criterion-classification were compared. The score performances were compared by diagnostic indices , discrimination curves between the KPH GI Bleeding Score (UGIH SCORE 2014) and the other two existing scoring systems.

Results: Significant parameters in the model were age ≥ 60 years,

pulse rate ≥ 100/min, systolic blood pressure < 100 mmHg, hemoglobin < 10 g/dL, blood urea nitrogen ≥ 35 mg/dL, presence of cirrhosis and hepatic failure. The score ranged from 0 to 27, and classifying patients into 3 urgency groups: non-urgent (score < 4, n = 215, 21.2%), urgent (score 4 - 16, n = 677, 66.9%) and emergent (score > 16, n = 121, 11.9%). The score correctly classified 81.4% of the patients into their original (criterion-classified) severity groups. Under-estimation (7.5%) and over-estimation (11.1%) were clinically acceptable. Focusing overall performances, the KPH GI bleeding Score (UGIH score 2014) classified patients non-significantly better than the Blatchford: 89.3% vs. 87.9% for mild ($P = 0.243$), 87.2% vs. 85.0% for severe ($P = 0.092$), but significantly classified better than the pre-endoscopic Rockall score: 89.3% vs. 76.4% for mild ($P < 0.001$), and 87.2% vs. 81.2% for severe ($P < 0.001$). The Blatchford score classified more patients into the mild categories, and less into the severe categories than the KPH GI bleeding Score (UGIH score 2014). In contrast, the pre-endoscopic Rockall score classified less patients into the mild categories but more into the severe than the KPH GI bleeding Score (UGIH score 2014).

Conclusions: The KPH GI bleeding Score (UGIH SCORE 2014) classified patients into 3 urgency groups: non-urgent, urgent and emergent, with clinically acceptable small number of under- and over-estimations. and demonstrated that the The KPH GI bleeding Score (UGIH score 2014) also classified patients into three severity levels to help indicate endoscopy more efficiently than the other two existing scoring systems.

Adenomatous Detection Rate (ADR) in Colonoscopy Screening Project for Colorectal Cancer (CRC), Thabo Crown Prince Hospital

Tuangpraj Srikoolwong, MD., Wattana Pareesri, MD., Chaloemphon Boonmee, MD., Somsak Boonharn, MD.

Back ground: Colorectal cancer now is the 2rd most common cancer in Thailand (2014) and increase in incidence. Early detection can prevent and reduced death rate. Colorectal cancer screening by colonoscopy was introduced by Thabo Crown Prince Hospital to detected the early stage of CRC and premalignant condition by using only age as criteria.

Object: To determined Adenomatous Detection Rate(ADR) in colonoscopy participants in Thabo Crown Prince Hospital and compared with other colonoscopic screening studies which used same or difference criteria .

Method: Colonic screening for CRC was performed in 178 participants age between 50-70 years old. Dermographic data, basic characteristic, procedure, and result were collected. The colonoscopic data was present by descriptive method. ADR result was compared to other studies with 95% confident interval.

Result: Adenomatous detection rate in this study was 20.22% (95% CI : 14.58 - 26.88) compared to other studies that use age as criteria screening, no statistic difference between that studies.

Conclusion: ADR in this study not difference from other studies which used age criteria for colorectal cancer screening and suitable for Thabo district population.

Rural Surgery: A Worldwide Issue

Tyler G. Hughes, MD FACS

Chair Advisory Council for Rural Surgery, American College of Surgeons; Clinical Assistant Professor of Surgery Kansas University School of Medicine

The impact of surgical access, the creation of the infrastructure necessary for essential surgical procedures, scope and limitations of surgery in the rural environment, and the training paradigms for rural surgeons are presented. With 5 billion people in the world without access to surgical care, it is vital that surgeons combine their efforts to develop the infrastructures necessary to bring care to remote and underserved areas. The issues of energy, water and transportation services are intrinsic to success in creating quality rural surgical care. Since the rural environment provides different challenges from urban care those differences are highlighted. Among these challenges are lack of specialty consultation, ancillary personnel support, and the need for training relevant to the population served are key.

Creating a Rural Surgery Program

Tyler G. Hughes, MD FACS

Chair Advisory Council for Rural Surgery, American College of Surgeons; Clinical Assistant Professor of Surgery Kansas University School of Medicine

The components of a rural surgical training program include both the surgeons, the model of practice and ancillary personnel needed to maintain a sustainable system. Various models from Scotland, New Zealand, Australia and the United States demonstrate various strategies for training and developing rural surgeons. In the United States examples from North Dakota, Texas, Oregon and Wisconsin are presented.

Essential Surgery: A Bridge to Rural Surgery

MICHAEL H. COTTON, MA (Oxon), FRCS (Eng), FACS, FCS (ECSA), FMH (Switz)

Although "Global Surgery" as a concept has gained wide interest and recognition, its definition remains imprecise. The Lancet Commission defines it as cost-effective intervention to provide the surgical needs of the majority of the population.

Various interventions from outside have been proposed and already exist, but none of these can systematically solve the surgical needs of the disadvantaged. The solution must be home-based.

Surgical need globally is self-evident. Surgery has been termed the neglected stepchild of primary care: the fairy godmother for this desperate child is urgently awaited!

In many places, access to surgery is difficult because of geography, poor facilities, great expense, and popular reluctance. However, in Thailand, there is good coverage of hospital care in rural areas, unlike its neighbor Myanmar. Nonetheless, despite incentives, there remains a lack of rural doctors, and particularly rural surgeons.

Why is this? A journey through the development of specialization and super-specialization will explain much of the problem. Surgical care is ever more provided by specialists working in a restricted field, with ever advancing technology.

Is high technology the answer? Decidedly, no! This can hardly ever provide cost-effective surgery. Surveys of surgery needed in low-income settings the world over portray the same needs despite differences in climate, social condition, population density, cultural tradition or religion.

Limited resource, low technology, low cost centres have been shown not only to be cost-effective, but also often better than sophisticated centres. Basic resources does not mean suboptimal practice, or unscientific care.

We must remember that at least 40% of the rural population is under 18 years. Typically such a population's surgical need is 60% Obstetric &Gynaecological, 20% Trauma (mainly from road traffic injuries), and 20% Septic. Even Thailand, alas, does not score well when it comes to Trauma statistics.

And of course there is the problem of migrants and refugees, of whom some 120,000 are estimated as living in Thailand.

Locals are needed to deal with the surgical problems of these! The days of the omniscient surgeon are long past. We need a revolution in surgical teaching and training, so that the locals can deliver surgery to the disadvantaged in a cost-effective manner.

This means adopting a programme of basic interventions that will save life or prevent severe lifelong disability. This we have defined as Essential Surgery and it consists of 15 interventions, in which locals can be taught and trained in a modular fashion. Such surgical education for rural surgical licenciates needs to be under the close of , and certified by, an august body such as the Royal College of Surgeons of Thailand.

New Technology Platforms in the Future of Urology: Robotics and Imaging

Prof. Stanley Duke Herrell

To date, the growth of robotics use in Urologic Surgery has adapted the only commercially available platform, the da Vinci robot, to a large variety of surgical procedures and anatomical locations supplanting standard laparoscopic approaches. However, like all non-autonomous robotic systems, the da Vinci at present represents simply a "tool" with the ultimate control, information processing, performance, and decision-making process of the surgery residing with the surgeon. The next steps for robotic surgical intervention will utilize development of alternative platforms, which allow for even more adaptable, less invasive, purpose-specific surgical robotics and the incorporation of advanced imaging technologies. Areas for discussion include potentially future commercially available systems, new experimental platforms, less invasive single site surgery platforms, and robotics in combination with image-guidance technologies.

Retroperitoneal Robotic Partial Nephrectomy: Approach and Technique

Prof. Stanley Duke Herrell

Robotic Assisted Partial Nephrectomy (RAPNx) has become a standard approach for the performance of minimally invasive partial nephrectomy. Posteriorly located tumors can be especially difficult and time consuming due to the need to mobilize the kidney to allow for visualization and proper arm angles for resection and sutured repair. Incorporation of the retroperitoneal approach can allow for improved direct access. The retroperitoneal robotic approach has been actively incorporated into our small renal mass management over the past several years. Key steps, patient selection criteria, equipment, and our early results will be discussed for this approach.

Kidney Transplantation in a Provincial Hospital: The Way to Success

Thanasak Tongbai MD

Buddhachinaraj Hospital, Phitsanulok

Background: ESRD has increased ending up in patients needing dialysis. Renal transplantation is the only way to improve their quality of life. But due to shortage of cadaveric donors, living related kidney transplantation is still needed. Buddhachinaraj hospital has been a leading provincial hospital in LRKT since 1995.

Objective: To encourage other provincial hospitals with the appropriate team (Nephrologist, Urologist, Vascular surgeon) begin renal transplantation.

Method: With the appropriate team in 1995, we began our first and second case with help from Professor Paibul Chitprapai and Professor Supot Wudhikarn. What we learned from these two experienced urologists gave us confidence to do renal transplantation until now.

Result: One hundred and eight cases of LRKT were performed from 1995-2015.We hope our experience can help stimulate urologist and increase the number of transplantation centers in provincial hospitals.

Functionality of the Abdominal Wall

Jan F. Kukleta, MD, FMCH
Zurich, Switzerland

Introduction: Functional changes of the abdominal wall (AW) arising from elective abdominal surgery or from AW-repairs are poorly understood. The musculoskeletal system of the trunk is a complex system. Its normal function is based on a balance between several muscle groups and the vertebral column. A simple movement of intact AW is a chain of various muscle activities. Synergy of this complex process requires balance.

Local or regional malfunction leads to dysbalance of the whole musculoskeletal system with functional deficits or chronic pain.

Ventral or incisional hernias lead often to minor or major anatomical changes causing difficulties of their treatment. An unloaded muscle cannot perform its usual action. It deposits collagen in the inactive muscle fibers with consecutive fibrosis, stiffness and loss of elasticity - disuse atrophy is the consequence.

Discussion:

1. The delay in repair of AW hernias impairs the chance of successful repair (restitution).

2. Is the delay one of the reasons for current unsatisfactory recurrence rate?

3. Intentional components separation leads to functional deficits of AW.

4. The BTA (Botulinum toxin A) induced temporary components relaxation facilitates

AW repairs without taking a permanent dysbalance in account.

Conclusion: AW disorders require a tailored repair. To be able to tailor (to choose the best available individual solution for each patient) we need to understand the AW better and have to adapt the treatment option to the pathology and not vice versa.

The World of Mesh

Jan F. Kukleta, MD, FMCH
Zurich, Switzerland

Introduction: Synthetic meshes became in the last two decades an indispensable part of groin- and abdominal wall repair world-wide.

There are more than 300 mesh devices in the market and they are not alike. The mesh behavior can be quite different from case to case, especially after the implantation.

The interaction between foreign body and the host tissue has besides possible individual reaction a predictable formation of inflammatory granuloma and scar tissue.

The primary objective of mesh use in hernia repair is the reinforcement. But the foreign-body response results in tissue-mesh complex compression (called previously "shrinkage"), stiffening (bridging), reduced elasticity, undesired nerve reaction and increased risk of infection.

Better understanding of these processes made optimization of mesh design possible. The life-long tensile strength of most meshes exceeds the necessary requirement. The effective porosity became the most important property, as it influences the extent of shrinkage and bridging. The total surface of the implanted device is finally the decisive factor of the optimized incorporation.

Conclusion: Despite the progress of technology and communication means which let the world appear smaller the World of mesh and its complexity grow bigger. This requires intensive dialogue between users and developers and a regular update of new achievements in order to improve patient's outcome.

Update on Burn Management

Stan MONSTREY, MD, PhD

Chairman, Department of Burn Centre, Plastic Surgery, University Hospital Gent, Belgium

Three important paradigm shifts have taken place over the past years which have significantly influenced the management of burn injuries.

The first paradigm shift puts more emphasis on the quality of survival rather than purely on survival only as to outcomes in burn management. Indeed the quality of life of the patients who sustained severe burn injuries has received much more attention in the past decennia with major emphasis on obtaining the best possible functional and aesthetic outcomes. To achieve this an objective assessment of the burn depth is of course crucial.

This brings us to the second paradigm shift where in the past 10 years Laser Doppler Imaging (LDI) has emerged as the most objective tool to assess wound healing potential and the depth of a burn wound. There is now a significant amount of evidence that LDI, with an accuracy of more than 95%, can determine whether a burn wound should be operated or treated conservatively.

The third paradigm shift consists of the new enzymatic debridement provided with Nexobrid. Several recent studies have demonstrated the advantages of Nexobrid in preserving deep dermal tissue thus avoiding unnecessary operations without increasing the risk of ending up with hypertrophic scars.

The diagnostic value of Nexobrid will be compared with Laser Doppler Imaging.

Back to the Basics with Robotic Surgery

Anusak Yiengpruksawan

When you hear of robotic surgery, you immediately visualize a scenario in which an automated robot-surgeon performing surgery on its own. That maybe true in the not-too-far future, but as of now, you maybe surprised to find out how not so sci-fi it actually is. As a matter of fact, the current robotic surgery is still human-operated surgery. The robot is just a tele-manipulated device that a human-surgeon controls via the computer. Although robotic surgery has many advantages over the traditional laparoscopic surgery, its downsides are cost, lack of haptic feedback, and somewhat inflexible platform. The latter two are the main focuses of this talk.

The discussion will be centered on the following two questions:

How do we compensate for the lack of tactile feedback and inflexibility of the system?

Why do the two disadvantages force a surgeon to go back to the basic principles of surgery?

This will be a visual presentation that consists mostly of pictures and video clips with no statistical information.

Artery-first Approaches to Distal Pancreatectomy

Kyoichi Takaori, MD, FACS

Division of Hepatobiliary-Pancreatic Surgery and Transplantation,
Department of Surgery, Kyoto University Graduate School of Medicine
54 Kawahara-cho, Shogoin, Sakyo-ku, Kyoto 606-8507, JAPAN

Artery-first approach to pancreatectomy is a technique to ligate the feeding artery before the division of the pancreas with intents to reduce the blood loss and to perform more oncologic resection. Accordingly, the splenic artery is ligated first during artery-first distal pancreatectomy. Potential merits of artery-first approaches include early determination of resectability in the setting of pancreatic cancer with possible involvement of splenic artery and/or celiac artery. However, due to difficulties in exposing the origin of splenic artery especially in open surgery, the artery-first approach distal pancreatectomy has been rarely performed. Thorough the experience of laparoscopic and robotic surgery, we have developed a technique of artery-first distal pancreatectomy by the "Tora-no-Ana" approach, which consists of posterior dissection of the pancreatic body thorough a division of the ligament of Treitz. A hanging maneuver of the pancreatic parenchyma with splenic artery and vein is another key for a successful artery-first distal pancreatectomy. By the hanging maneuver, the origin of splenic artery is well visualized and clearly identified either by open, laparoscopic, or robotic approach so that oncologic resection can be achieved. When involvement of the celiac artery is suspected, artery-first distal pancreatectomy with celiac artery resection is indicated. In conclusion, the artery-first approach to distal pancreatectomy is safe and feasible if the surgical principals by the Tora-no-Ana approach and hanging maneuver of the pancreatic body are adhered.

Update on the Standards of Care for Gender Dysphoria

Stan MONSTREY, MD, PhD, Britt COLEBUNDERS, MD, Griet DE CUYPERE, MD, PhD.

Chairman, Department of Burn Centre/Plastic Surgery, University Hospital Gent, Belgium

The Standards of Care of WPATH (World Professional Association of Transgender Health) are universally considered as the best guidelines for the treatment of gender dysphoria. Although version 7 has only been published 2 - 3 years ago, the Standards of Care are a continuous work in progress and recently at the WPATH meeting in Amsterdam, July 2016, new criteria for SRS have been discussed. The following issues will be further elaborated in this presentation.

1. Gender binary defying surgery

It is now universally accepted that gender dysphoria is more corresponding to a spectrum rather than dichotomy. There is an increase in acceptance of gender queerness and surgeons are getting more comfortable with pluralistic care options.

2. There is an increasing awareness of possible parenthood for transgender which has resulted in early counseling on the possibilities of gonadretention and fertility preservation.

3. It has always been a rule that one referral of a mental health professional is required for breast surgery and two are requested for genital surgery, however, there is no real evidence for this in the literature and there should be a balance between a paternalistic approach from the physician versus a more patient centered approach.

4. The minimal age of 18 years for sex reassignment surgery is also questioned by certain surgeons, especially in an area with a substantial increase of adolescence requiring treatment for their gender dysphoria, eventually with puberty blockers. The importance of a case by case approach and even more so by multidisciplinary treatment, is of utmost importance hereby.

5. Finally, some reflections will be given on the accreditation and certification of surgeons performing SRS as well as on the problems with reimbursement.

Future Trends in Phalloplasty

Stan MONSTREY, MD, PhD, Salvatore D'ARPA, MD, PhD

Chairman, Department of Burn Centre/Plastic Surgery, University Hospital Gent, Belgium

In female to male transsexualism the operative procedures are usually performed in different stages.

First the subcutaneous mastectomy which is often combined with a hysterectomy and ovarectomy, preferably endoscopically assisted.

In the next operative procedure for the genital sex reassignment usually a vaginectomy is combined with a reconstruction of the horizontal of the horizontal or fixed part of the urethra and a scrotoplasty in combination with a penile reconstruction.

The standard technique for phalloplasty is the radial forearm free vascularized flap which is often mentioned as the golden standard for penile reconstruction. The disadvantage of this flap however is the residual scar on the forearm.

Several alternative techniques for penile reconstruction have been performed by various surgeons and the advantages and disadvantages will be discussed in this presentation. The described techniques are anterolateral thigh ALT perforator flap in combination with a urethral reconstruction, bilateral gracilis flaps, reconstruction with a latissimus dorsi free vascularized flap, the fibula osteocutaneous flap and of course the metaiodoioplasty.

Locally Advanced Rectal Cancer

Martin R. Weiser, MD, Zhen Zhang, MD, PhD, and Deborah Schrag, MD, MPH

The year 2015 marks the 30th anniversary of the publication of NSABP-R01, a landmark trial demonstrating the benefit of adding pelvic radiation to the treatment regimen for locally advanced rectal cancer with a resultant decrease in local recurrence from 25% to 16%.

These results ushered in the era of multimodal therapy for rectal cancer, heralding modern treatment and changing the standard of care in the United States. We have seen many advances over the past 3 decades, including optimization of the administration and timing of radiation, widespread adoption of total mesorectal excision (TME), and the implementation of more effective systemic chemotherapy.

The current standard is neoadjuvant chemoradiation with 5-fluorouracil (5-FU) and a radiosensitizer, TME, and adjuvant chemotherapy including 5-FU and oxaliplatin. The results of this regimen have been impressive, with a reported local recurrence rate of less than 10%. However, the rates of distant relapse remain 30% to 40%, indicating room for improvement. In addition, trimodality therapy is arduous and many patients are unable to complete the full course of treatment. In this article we discuss the current standard of care and alternative strategies that have evolved in an attempt to individualize therapy according to risk of recurrence.

Head Injury: Neurosurgeons Think General Surgeons Do

Supachoke Chitvanich FRCST, FRCNST

Management of head injury patients in rural area are still major problem in Thailand. Data from Ministry of Public Health (WHO 2013) show that over 22,000 Deaths per year from road traffic accident and over 70% associated with severe head Injury. Data from Medical council of Thailand show that there are 450 alive qualified Neurosurgeons but only 350 of them are active and half of these neurosurgeons are working in Bangkok and neighbouring area. The Distribution of neurological service units are improper. There are 20 provincial general hospitals lack of Neurosurgeons and 13 general hospital have only 1 Neurosurgeons from 76 provinces and Bangkok.

Now by the advancement of Telecommunication system for example 4G or 3G mobile phone we can use for telemedicine consultation and direct communication between general surgeons who are caring the patients and remote consulting neurosurgeon so the head injury patient can be treated more properly and promptly.

Regionalization of neurosurgical service is my Recommendation because this system could consider Manpower needs, availability, Telecommunication, access and cost effectiveness. In truly regionalization system the patients with mild or moderate head injury could remain at outlying hospitals, thus freeing beds at regional referral centers for patients with more severe injuries. A great deal of planning and organization is needed if such systems are to be effective in the Thai Kingdom.

Scope and Limitations of Rural Surgery

Tyler G. Hughes, MD FACS

Chair Advisory Council for Rural Surgery, American College of Surgeons; Clinical Assistant Professor of Surgery Kansas University School of Medicine

Defining rural surgery is a difficult task because of the variation of need given the diverse types of rural surgical environments. The new American Board of Surgery definition of general surgery and its implications for rural surgeons is presented. Two models of rural surgery approaches are presented, the stand alone model and the systems model. The latter is expanded upon with a summary of the American College of Surgeons Advisory Council for Rural Surgery's Optimal Care Document which is intended to reflect an approach similar to Trauma Systems and create a regional approach to surgical problems in an integrated fashion.

Retention and Professional Development of Rural Surgeons

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No matter the commitment of a population to surgical access, the concept is not successful without the recruitment of surgeons of high quality and training to the rural world. The discussion of the characteristics of the persons likely to practice in rural areas is discussed as well as their training in their early years of development are presented. The factors which both attract and drive away surgeons from the rural environment will be presented as well. Once the surgeon is in the environment telemedicine and systemic support of the surgeon is essential. Examples from the United States in providing this sort of support is discussed.

Surgical Repair of Tricuspid Valve

Prof. Nguyen van Phan, PhD

Heart Institute, Viet Nam

Concomitant tricuspid regurgitation was presented in 50% of mitral valve disease and 30% of multi-valvular disease. Tricuspid valve repair should be done in the same operation with mitral valve procedure.

There are two groups of tricuspid valve incompetence: Functional TR and Organic TR.

From 1992 to 2008, 5425 patients with mitral valve and poly-valvular disease were operated at The Heart Institute, Viet Nam. Combined tricuspid correction was performed in 36% of them.

Surgical techniques: Ring annuloplasty (62%) and Posterior annuloplasty (38%).

Echo-cardiographic finding at the last examination showed: TR(0) = 74%, TR(1+) = 23%, TR (from 2+) = 3%.

Re-operation for severe TR = 3.6%.

Conclusion:

We do not have the exact method to evaluate the severity of tricuspid regurgitation.

Moderate TR should be corrected at the time of other valve surgery.

Prosthetic ring was absolutely necessary for organic TR.

Management of Locally Advanced Breast Cancer - an Indian Perspective

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Padma Shri awarded by Hon'ble President of India (2015)

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Introduction: By definition, a primary breast tumour that fulfils any of the following criteria in the absence of distant metastasis is considered to be Locally Advanced Breast cancer (LABC)

- Tumours more than 5 cm in size with regional lymphadenopathy.
- Tumours of any size with direct extension to the chest wall or skin, or both (including ulcer or satellite nodules), regardless of regional lymphadenopathy
- Presence of regional lymphadenopathy (clinically fixed or matted axillary lymph nodes, or any of infraclavicular, supraclavicular, or internal mammary lymphadenopathy) regardless of tumour stage

Assessment

Triple assessment, i.e., Clinical Breast Examination (CBE), bilateral mammogram, ultrasound guided core needle biopsy & biomarker expression (ER,PR & HER-2) must be indispensable gold standards in initial assmement of LABC. Management decisions must be guided by a Multidisciplinary Team. In view of the significant risk of metastatic disease, CT scan of chest & abdomen combined with Bone scan is mandatory (If facilities are available, PET scan as single staging test is ideal).

Treatment

Most patients with LABC require neoadjuvant chemotherapy. Anthracycline and Taxane based neoadjuvant Chemotherapy must be given

for inoperable Triple negative LABC patients. Anti HER-2 therapy should be given concurrently with Taxanes when HER-2 is positive, as there is evidence to suggest increased rates of pathological Complete Response (pCR) with this regimen.

In select post menopausal patients with luminal A type LABC, neoadjuvant endocrine therapy with aromatase inhibitors (letrozole) may be considered. The aim of surgical removal of lesion either as Primary therapy or after neoadjuvant chemotharapy should be clear resection margins. Mastectomy & axillary node clearance would be possible in the vast majority after completion of neoadjuvant systemic therapy (with or without radiotherapy).

When there is good response to neoadjuvant systemic therapy, some patients would be suitable for breast conservating surgery. In this era of Oncoplastic Breast Surgery, the use of plastic surgical techniques not only ensures feasilibility of Wide Local Excision with good cosmetic outcome, but also allows the surgeon to remove the tumour with greater volume of surrounding tissue, thus extending the boundaries of breast conserving surgery. Proper patient selection and careful planning after proper radiological and clinical assessment are the two essential prerequisites before undertaking oncoplastic breast conserving surgery. Axillary node clearance is the standard of care. However, if facilities & expertise is avilable, Sentinel lymph node biopsy can be considered in those who become clinically node-negative after neoadjuvant chemotherapy. It is mandatory for all Inflammatory LABC patients to have neoadjuvant systemic therapy. Furthermore, SNB & immediate breast reconstruction should not be performed in this subgroup of patients presenting with inflammatory breast cancer.

Postoperative Radiotherapy improves survival & significantly reduces local recurrence. In ER/PR positive LABC patients, adjuvant endocrine therapy with aromatase inhibitor is superior to tamoxifen with evidence to suggest lower treatment failure rate and superior objective response rate.

Indian scenario - Facts

With over 150, 000 new cases being diagnosed every year, the incidence of Breast cancer has overtaken cervical cancer to become the most com-

mon cancer affecting women. Breast cancer is still a ùclosetû issue in most parts of rural India (60% of the Country's population). Due to lack of awareness and absence of an organized nationwide population based Breast Cancer Screening Programme, well over 60% present in advanced stages (LABC & metastatic). LABC accounts for some 30-35% of all cases of breast cancers diagnosed in the Country.

Compared to the West where breast cancer is common after the age of 50 years, the vast majority of breast cancers in the Country present a decade earlier, with peak incidence between 40 - 50 years. With some 70, 000 breast cancer related deaths per annum, a woman dies of breast cancer every ten minutes in India.

Whilst there are few Cancer Units offering multidisciplinary care on a par with the best centres across the world, by and large, breast cancer care in India is a lottery, with some getting excellent care, and most not. The reasons are - lack of uniform standardised treatment protocols, poor infrastructure & financial constraints. There is a huge variation in the survival rates of patients with breast cancer in the Country. The overall 5 year & 10 year survival rates of those presenting with LABC is around 55-60% & 30 - 35% respectively.

'Indian solutionû to the rising incidence of LABC

Although introduction of an organized nationwide population based Breast screening Programme using Mammography is the best proven way of detecting cancers in the impalpable stage, it is not a viable option for mass screening in India due to the enormous costs involved & huge variation in Mammographic reporting due to paucity of trained Breast radiologists. Moreover, more than 87% of India's population is under the age of 50 years, where screening by way of mammography is not effective at detecting early impalpable breast cancer (sensitivity of mammography is best over the age of 50 years).

Clinical breast examination (CBE), where trained Healthcare workers examine the breasts of women aged between 35 - 65 years, is relatively simple & inexpensive screening tool. There is considerable circumstantial evidence

to show that CBE is a viable option as a screening tool in Countries with limited resources. Although CBE will not be able to detect impalpable lesions that can be seen only on Screening mammography, it still has the potential to downstage cancer and thereby reduce mortality from the disease. More importantly, CBE presents an excellent opportunity for healthcare providers to empower women about the importance of early detection of breast cancer.

In an effort to find ùIndian solutionû for early detection of breast cancer, under the auspices of Ushalakshmi Breast Cancer Foundation (www.ubf.org.in), a Breast cancer Charity based out of Hyderabad (Capital city of Southern Indian State of Telangana), I have been overseeing the implementation of South Asia's largest population based Breast Cancer Screening Programme by way of Clinical Breast Examination (CBE) aimed at early detection of breast cancer.

Over the past four years (2012 - 2016), some 200, 000 underprivileged women spread across 3990 villages (rural India) in the Southern Indian States of Telangana & Andhra Pradesh have been screened for signs of early breast cancer by 3700 health care workers who have been trained in performing CBE. 210 early operable breast cancers have been detected through this initiative and all of them are being treated FREE of cost through the State Government funded Arogyasree scheme. One early breast cancer has been detected out of about 1000 women who underwent screening. This is in keeping with other established Breast Cancer Screening Programmes world over.

In the fullness of time, this community based Breast Cancer Screening Programme aimed at early detection of breast cancer would hopefully create the much needed awareness & minimize the number of women presenting with LABC. Equally, more lives would be saved & this innovative Programme has a potential to serve as a benchmark initiative for India and other South Asian Countries as well.

Resident Contest

Postoperative Pain Reduction After Additional Suction Following LC: A Prospective Randomized Controlled Study

Nisa Netcharussaeng, Akkaraphorn Deeprasertvit, Pichaya Deeprasertvit

Objective: To compare postoperative pain after laparoscopic cholecystectomy between conventional CO2 releasing method and additional suction using volume of PCA morphine consumption.

Background: Post-operative LC pain is an unwanted condition while the relationship between residual intraperitoneal CO_2 and pain level has not been clearly proved. There is an explanation about inflammation caused by CO_2 leading to pain stimulation, but not much research has been done to study about this. Moreover, pain score given by the patients using for pain measurement in most studiesis not quite accurate due to variable individual pain thresholds.

Methods: We did a single center, randomized, double blind study in Police General Hospital, Bangkok Thailand, from April 2015 to January 2016. Eligible patients were randomly assigned preoperatively to have either conventional CO_2 releasing method, or an additional 60 seconds of suction after LC. Randomization was done via a computer-generated permuted-block sequence.

Collected data including age, sex, BMI (kg/m^2), underlying diseases, ASA classification 1-3, diagnosis and indication for LC, postoperative pain by visual analog scale (0-10) at 6,12 and 24 hours, residual intraperitoneal pressure, operative time, intraoperative morphine amount, Morphine PCA amount in 24 hours, and postop complications, such as peritonitis, surgical site infection, and surgical wound bleeding. Patients who have been converted to open cholecystectomy or received ERCP within 30 days preoperatively or have contraindications for LC were excluded. Pain evaluation by PCA amount was designed to get more accurate primary outcomes.

Results: The patients were similarly distributed, with the number of females being approximately double the number of males in both groups. The most frequent diagnosis is symptomatic gallstones in 16 patients of both groups. Operative time in suction group was 73.8 ± 29.5 minutes and 91.5 ± 49.3 in non-suction group respectively (*p*-value 0.096). Residual intraperitoneal pressure was 4.1 ± 2.1 and 5.7 ± 3.5 mmHg with statistically significant difference. Morphine PCA amount in suction group was 0.085 ± 0.016mg/kg and in non-suction group was 0.104 ± 0.019mg/kg, which were not significantly different (*p*-value 0.464). Postoperative pain level at 6, 12 and 24 hours as secondary outcomes showed that suction group seemed to have slightly higher pain score at 6 and 12 hours but at 24 hours post LC, pain in suction group tended to be a bit lower than in non-suction group with *p*-value 0.093 which was not significantly different.

Conclusion: Additional CO2 suction in LC does not reduce postoperative pain. However, further study with a larger population was needed.

Predictive Model for Non-sentinel Lymph Node Metastases in Thai Breast Cancer Patients

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Background: Sentinel lymph node (SLN) biopsy is a standard procedure for axillary staging in breast cancer patients with clinically node negative. Several models were developed to predict the probability of non-sentinel lymph node (NSLN) metastases. However, differences in technique and setting may impact the accuracy of the models. We created a novel nomogram to predict NSLN metastases for Thai breast cancer patients.

Methods: Breast cancer patients who underwent SLN biopsy at the Division of Head Neck and Breast Surgery, Department of Surgery, Siriraj Hospital between January 2009 and October 2013 were recruited. All SLN biopsies were identified by blue dye and immediately examined by frozen section. All frozen SLNs were defrosted and confirmed by permanent section. The patients with positive SLN (either from frozen or permanent section) underwent axillary dissection. Associations between clinicopathological parameters and NSLN status were determined by Chi-square statistics. Logistic regression was performed to create predictive models.

Results: Four hundred and thirty breast cancer patients who had positive SLN and underwent axillary lymph node dissection were recruited. NSLN metastasis accounted for 48.37% of the patients with positive SLN. In frozen section model, tumor type, tumor size, lymphovascular invasion, and ratio of positive SLN were associated with NSLN status. Tumor type, tumor size, ratio of positive SLN, and presence of extranodal extension of SLN were associated with NSLN status in permanent section model. The area under the receiver operating characteristic (ROC) curve (AUC) = 0.71 for frozen section model and 0.781 for permanent section model. Validation of the model in 56 patients revealed AUC of 0.803 and 0. 831 in frozen and permanent section, respectively. Our models better predict NSLN metastasis, when compared to the previously published models,

Conclusion: We created two nomograms for frozen and permanent section of SLN which were reasonable and accurately predict NSLN status for Thai breast cancer patients.

Comparison of Postoperative Complication Between Diverting Loop Ileostomy and Colostomy Closure

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Background: Diverting ostomy can be achieved by either a loop ileostomy or loop transverse colostomy. It remains controversy which is better for feacal diversion from a colorectal anastomosis. Aim of this study to compare outcome between diverting loop ileostomy and colostomy after creation and closure.

Material &Methods: A retrospective review of medical records of 440 rectal cancer patients who operated with standard oncological resection and diverting ostomy at King Chulalongkorn Memorial Hospital (KCHM) between January 2004 and December 2014 was performed.

Results: Between January 2004 to December 2014, Of 440 patients who underwent surgical resection for rectal cancer with diverting ostomy, 340 patients (77.3%) and 100 patients (22.7%) had been perfomed diverting loop ileostomy and colostomy, respectively. The baseline demographic data in both groups were similar except lower rectal cancer surgery had higher rate of performing diverting loop ileostomy. The postoperative complication related to diverting ostomy between two groups was similar. The mean operating time was shorter in diverting ileostomy group (313 vs 335 min; $p = 0.048$). During follow-up, common causes of readmission were small bowel obstruction and dehydration .There were no difference between the two groups in diverting ostomy related complications during follow up period. Overall closure rate was 87.3% with a median interval time of 7 months. The operative blood loss and length of hospital stay were statistically significant lower in diverting colostomy group ($p = 0.012$ and $p = 0.010$, respectively). There was significantly higher incidence of readmission from small bowel obstruction after closure in the loop ileostomy (9.21% vs.1.26%; $p = 0.016$.), while 44.8% of patients with small bowel obstruction occurred within one month after surgery. Eight patients required surgical treatment after failed conservative management, which two cases caused from anastomosis stricture of ileum related to neoadjuvant chemoradiotherapy before cancer surgery.

Conclusions: Loop ileostomy closure was associated with higher complication in term of small bowel obstruction than closure of loop transverse colostomy. Therefore, closure of a loop ileostomy requires careful attention to detail to prevent obstruction. We recommend lysis adhesion under direct vision and carefully re-anastomose to prevent anastomotic stricture. Diverting loop colostomy is also recommended in the patients who received neoadjunvant chemoradiotherapy.

An Easy Method for Cartilage Dicing: Cartilage Grinder

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Background: The used of diced cartilage graft has recently increased over the past 10 years. Although technique of dicing cartilage has not been developed, diced cartilage had been used in rhinoplasty, forehead defects, and other facial contouring. This study was designed to develop a new cartilage grinder, which helped to make the cartilage in smaller pieces without loosing part of cartilage and lessen time.

Methods: After obtained approval from institutional review board, between January and December 2014, costal cartilages which obtained from ten patients were included. The cartilage was diced by conventional technique and by cartilage grinder. The specimens were processed by thin section histology stained with hematoxylin and eosin for their viability and architectural characteristics. Times between two techniques were compared.

Results: The mean chondrocyte viability rate for the conventional dicing and new grinding technique were 66.2% and 67.5% form the costal cartilage, respectively. The differences between the mean viability rates of conventional dicing and new grinding technique were not statistically significant (*P* value = 1.00). Mean used time of the conventional dicing (1.47mins/gm) was significant longer than new grinding one (0.24 mins/gm) (*P* value < 0.001).

Conclusion: The new cartilage grinder is efficient, fast and easy tool to make very fine cartilage without decreasing the cartilage viability. Moreover, this grinder can make very fine long strip cartilage, which helps in better molding and good for filling in every flaw.

Vascular Gel Model for Central Venous Catheterization Practice

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Background and Objective: Central venous catheterization provides a route for delivery of caustic or critical medications and allows measurement of central venous pressure. Ultrasound (US) guide puncture is now recommended for central venous catheterization procedures. The purpose of this study was to describe an inexpensive and simple educational model for US-guide central venous catheterization made with gelatin and mucillin powder, comparable in educational value to that of standard gel models available in the market.

Methods: A home-made educational gel model for central venous catheterization practice under US guide was described. Two model blood vessels were included, to simulate a vein and an artery at the area of catheterization. Sixty experience-naive trainees were included in study, and divided into two groups: those training with the home-made gel model (30), and those training with the standard gel model (30). Time to completion of the procedure was collected for each trainee, and compared between the two groups.

Result: The US images obtained using the home-made gel phantoms were of high quality and reliability, and were comparable to those obtained using the standard gel model. The time to completion of the procedure was not statistically different between the two groups ($p = 0.957$).

Conclusion: Home-made gel models can be used as an educational tool for simulating central venous catheterization under US guide for trainees, with comparable quality to standard gel models.

A Comparative Study Between Open and Laparoscopic Gastrectomy with D2 Lymph Node Dissection in Gastric Cancer

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Background: Gastric cancer is the 5th most common cancer, world-wide. However, its incidence in Thailand is much lower than that of other Asian countries. Laparoscopic gastrectomy with D2 lymph node dissection for the treatment of gastric cancer is popular among East Asian countries such as Japan, China and South Korea. Proven benefits of laparoscopic surgery include shorter hospital stay, faster recovery, and less blood loss. However, the advantages of laparoscopic surgery have not been confirmed in a country with low-incidence of gastric cancer. This study aimed to evaluate the safety profile of laparoscopic gastrectomy in Thai patients.

Objective: To compare early post-operative result of gastrectomy with D2 lymph node dissection between open (OG) and laparoscopic techniques (LG).

Methods: Data of 38 consecutive patients with gastric cancer who underwent D2 gastrectomy between the years 2010 and 2015 were reviewed. Twenty-two patients who underwent successful LG were compared with 16 patients who underwent OG. We compared early postoperative results in term of complications, intra-operative blood loss, operative time, length of hospital stay, and the number of harvested lymph nodes between the two groups.

Result: The clinicopathological characteristics of patients in the LG and OG groups were similar. The operative time was longer on average for the LG group (280 mins in OG and 390 mins in LG, $p = 0.01$), but the volume of blood loss was less (200 mL in LG and 500 mL in OG, $p = 0.002$). Volume of blood transfusion was also significant less in the LG group ($p = 0.012$). The hospital stay, time to oral diet, and number of harvested lymph nodes were not significantly different between the two groups. The incidences of postoperative death and complications were also not significantly different. There was one in-hospital death in the LG group due to aspiration pneumonia with ARDS.

Conclusions: Laparoscopic gastrectomy with D2 lymph node dissection was a safe procedure with morbidity and mortality comparable to those of open surgery.

Intravenous NSAIDs Administration to Prevent Post-ERCP Pancreatitis: A Randomized Control Trial

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Background and Objective: Post-ERCP pancreatitis (PEP) is a serious complication, which can range from mild to severe, with incidences between 3.5% to 5.4% of all procedures. Many prior studies evaluated the efficacy of NSAIDs in preventing PEP using various routes of administration, such as rectal suppository, and has proven it to be clinically effective. However, the efficacy of intravenous NSAIDs, which could be more convenient in terms of administration, in preventing PEP has never been conclusively proven. The objective of the present study was to evaluate the efficacy of intravenous Parecoxib in preventing post-ERCP pancreatitis.

Material and Methods: A randomized controlled trial was conducted from January 2015 to February 2016 on patients who were scheduled for ERCP. First-time ERCP patients with normal renal function and normal coagulogram were included. Those who were allergic to NSAIDS or sulfa drugs, who had pre-operative diagnosis of cancer, or active pancreatitis, or previous ERCP, or biliary stent placement were excluded.

The diagnosis of PEP was made if new symptoms of abdominal pain, increased serum amylase at least 3 times higher than baseline, and a prolonged hospital stay of more than 1 day, were observed.

Patients were randomly divided into the study or intravenous Parecoxib group, and the control or NSS group, all given before ERCP. Serum amylase levels before ERCP and post-ERCP at 4 and 12 hrs were collected. After the procedure, patients were observed for abdominal pain at 4 and 12 hrs, and the pain score was recorded. The length of hospital stay was recorded in all patients

Result: Nine patients were included in this study. There were no significant differences in the demographic data, baseline serum amylase (56 ± 18.28 vs 68.25 ± 39.78; p=0.555) and type of procedures between the two groups. Mean serum amylase levels at 4th and 12th hour postoperative were lower in the study group (153.8 ± 166.4 vs 103 ± 76.5, p = 0.593; and 129 ± 102.6 vs 98 ± 53.3, p = 0.604), but were not significantly different. Post-operative pain scores were also not significantly different between the two groups.

Conclusion: Intravenous NSAIDs may possibly lower the incidence of post-ERCP pancreatitis, since the serum amylase level in study group was lower on average. Due to the small sample size of this study, the results of the study did not demonstrate any significant difference. Further research is needed.

Outcomes of Perioperative Hypothermia in Colorectal Surgery Under Enhanced Recovery After Surgery (ERAS) Protocol

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Background and Objective: Perioperative hypothermia has been reported to be associated with poor surgical outcomes, such as increased wound infection and prolonged hospitalization. Enhanced recovery after surgery (ERAS) protocol is a modern multidisciplinary perioperative care pathway for many operations including colorectal surgery. However, whether perioperative hypothermia leads to worse outcomes in colorectal surgery under ERAS protocol is not known. The objective of this study is to determine the association between perioperative hypothermia and outcomes following colorectal surgery under the ERAS protocol.

Methods: A prospectively collected database of patients undergoing elective colorectal surgery under ERAS protocol at Siriraj Hospital from March 2011 to October 2015 was reviewed. Patients with incomplete or no record of core temperature during an operation were excluded. Hypothermia is defined as core temperature < 36˚C. Subsequently, patients were divided into 2 groups: hypothermic and normothermic groups. Short-term surgical outcomes were compared between the 2 groups.

Results: This study included 195 patients: 150 (77%) in the hypothermic group and 45 (23%) in the normothermic group. Patient's characteristics were comparable between groups. Rectal surgery (OR=4.3; 95%CI=2.1 to 8.8; *P*<0.001), multi-organ resection (OR=3.1, 95%CI=1.1 to 9.3; P=0.034), male gender (OR=2.6, 95%CI=1.3 to 5.3; P=0.006) and open surgery (OR=2.0, 95%CI=0.9 to 4.5; P=0.10) were more likely to experience hypothermia. Hypothermic patients had larger volumes of intraoperative IV fluid administration (1.7 L vs 2.4 L; *P*=0.001), more blood loss (324 mL vs 219 mL; *P*=0.074) and longer operating time (3.7 hours vs 3.1 hours; *P*=0.01). Hypothermic patients tended to have a higher rate of overall complications (23% vs 13%; *P*=0.15). One patient in the normothermic group died within 30 days of operation, while no patients died in the hypothermic group (*P*=0.12). Hypothermic patients had a longer time to normal diet intake (2.0 days vs 1.3 days; *P*=0.023) but a comparable time to first defecation (2.6 days vs 2.6 days; *P*=0.97). Hypothermic patients had a significantly longer hospitalization (5.7 days vs 4.4 days; P=0.048). On multivariate analysis, perioperative hypothermia - not other operative parameters - was a significant predictor of delayed time (>2 days) to normal diet intake (OR=2.9, 95%CI=1.2 to 6.9; *P*=0.01) and prolonged (>5 days) hospitalization (OR=2.6, 95%CI=1.0 to 6.6; *P*=0.029).

Conclusions: The incidence of perioperative hypothermia in this series was unexpectedly high (77%), particularly in male patients and those undergoing open surgery, rectal operation, and multi-organ resections. Unintentional hypothermia led to delayed gastrointestinal recovery and prolonged hospitalization in patients undergoing colorectal surgery under the ERAS protocol. These results suggest that surgeons and their team should to focus detecting and preventing perioperative hypothermia.

Incidence of Esophageal and Gastric Pathology in Patients with Dyspepsia and Alarm Symptoms: Rajavithi Hospital Experience

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Background and Objectives: Upper gastrointestinal tract (UGI) cancer is a common cause of cancer-related death in Asia. Esophagogastroduodenoscopy (EGDS) is effective in detecting UGI cancers especially in symptomatic patients. Current guidelines recommend that any patient with dyspepsia and alarm symptoms (dysphagia, vomiting, weight loss, evidence of gastrointestinal bleeding, or anemia) should undergo EGDS. The purpose of this study was to relate endoscopic findings, such as esophageal and gastric cancer and other lesions, to risk factors such as age, gender, and the presence of alarm symptoms

Methods: A retrospective review of patients who underwent EGDS at Rajavithi hospital from 2010 to 2014 was done, using information obtained from medical records. Symptomatic patients over 18 years of age with no history of esophageal or gastric cancer were selected. Data collected included endoscopic finding, results of histological examination, final diagnosis, and details of management. All participants underwent biopsies for rapid urea test (RUT), and also further biopsies in the presence of any visible lesions for histopathological examination.

Results: During the study period, 2000 symptomatic patients (970 women, 1030 men) with a mean age of 55.5 years (range:18 to 93 years) underwent EGDS. H.pylori infection was detected in 27% of patients. EGDS revealed normal findings in 13%, mass lesions in 22%, ulcers in 20%, inflammation in 38%, and bleeding in 7% of patients. Results of pathological examination included inflammation in 16%, squamous cell carcinoma (SCC) in 11%, adenocarcinoma in 7%, and precancerous lesions in 1% of patients. Gastric adenocarcinoma and esophageal squamous cell carcinoma were seen in 7% and 11% of patients, respectively. Early stage, stage II, stage III, and advanced stage gastric and esophageal cancers were seen in 0.4%, 16.4% , 2.1%, and 0.4% of patients, respectively.

Conclusion: Presence of alarm symptoms was found to be significantly associated with the presence of H pylori infection (p-value < 0.05). Dyspepsia was found to be the most common presenting symptom (41%).

A Randomized Controlled Study of Oral Ciprofloxacin Versus Oral Cefixime in Preventing Transient bacteremia After Transrectal Prostatic Biopsy

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Objective: To compare the effectiveness of oral ciprofloxacin and oral cefixime in terms of the incidence of transient bacteremia, and other adverse events, in men undergoing transrectal prostatic biopsy.

Materials and Methods: One hundred patients with suspected prostate cancer who underwent out-patient transrectal prostatic biopsy at Ramathibodi hospital were randomly assigned to either oral ciprofloxacin or oral cefixime. Patients were monitored for transient bacteremia and other adverse events over a 14-day period.

Results: In the oral cefixime group, transient bacteraemia occurred in 2% of patients, while no bacteremia was observed in the oral ciprofloxacin group ($p > 0.05$). The frequencies of some adverse events, which included acute urinary retention, hematuria, rectal bleeding, vasovagal syncope, and hematospermia, were not significantly different between the 2 groups ($p > 0.05$). Only the frequency of dysuria was significantly different between the 2 groups ($p < 0.05$).

Conclusions: Oral cefixime was no better than oral ciprofloxacin in preventing post-transrectal prostatic biopsy transient bacteraemia, and appeared to be associated with a higher rate of dysuria. Until a more suitable, or more effective oral prophylactic agent is found, quinolone-based antibiotics should remain the prophylactic antibiotic of choice for men undergoing trans-rectal prostatic biopsy.

Chromosomal Abnormalities in Hypospadias and Cryptorchidism

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Background and Objective: Hypospadias and cryptorchidism are common congenital anomalies. There are many possible causes of hypospadias such as testosterone biosynthesis defects due to chromosomal anomalies. This study aimed to find the prevalence and types of chromosomal defects in patients with hypospadias and cryptorchidism seen at Songklanagarind Hospital.

Methods: Medical records of 842 hypospadias and cryptorchidism patients seen at Songklanagarind Hospital between 1 January 2005 and 31 December 2014 were reviewed. Data regarding genitalia abnormalities, age, nationality, and chromosomal study results were collected.

Results: Of the 842 patients, 476 had cryptorchidism, 301 had hypospadias, and 51 had both hypospadias and cryptorchidism. There were 90 of 842 patients (11%) who underwent chromosome studies, but one had missing chromosome data. Of these 89 patients, 21 had hypospadias with cryptorchidism, 43 had cryptorchidism only, and 25 had hypospadias only. Abnormal chromosome results were found in 20 of 89 patients (23%), including 47,XY+21 (Down syndrome; 30%), mosaicism (25%), abnormal autosomal and sex karyotypes, and 46,XX ovotesticular disorders of sexual development. Relating abnormal chromosome studies to abnormal genitalia, 8 of the 21 patients with hypospadias with cryptorchidism had abnormal chromosomes (38%), 9 of 43 cryptorchidism patients had abnormal chromosomes (21%), and 3 of 25 hypospadias patients had abnormal chromosomes (12%; P value = 0.008). Most of the patients with abnormal chromosomes, i.e.,10/20 (50%), had a posterior urethral opening.

Conclusions: These results suggest that chromosomal studies in hypospadias with cryptorchidism and posterior hypospadias patients can provide useful information for the attending physician.

A Preliminary Report on the Effect of Early Versus Standard Postoperative Feeding in Patients Undergoing Elective Colorectal Surgery: A Randomized Controlled Trial

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Background and Objective: It has been hypothesized that early oral feeding should decrease the inflammatory markers in postoperative colorectal patient and therefore enhances recovery and improves clinical outcomes. In this study, we aim to quantify the stress response elicited by early oral feeding compared to standard oral feeding both at a molecular level by measuring inflammatory markers IL-1, IL-6, and TNF-α, and at the clinical level by measuring clinical outcomes such as the length of hospital stay and the occurrence of anastomosis leakage.

Materials and Methods: A randomized controlled trial was conducted from November 2014 through March 2016. Patients from 18 to 85 years of age who underwent elective colorectal surgery by one surgeon were included. Patients enrolled were randomized in blocks into the early feeding (EF) group, with oral intake of liquid diet at 6 hours postoperatively, and the standard feeding (SF) group, with oral intake of liquid diet on postoperative day 4, according to standard practice at Songklanagrind Hospital. Primary outcome measures included serum levels of postoperative inflammatory markers IL-1, IL-6, andTNF-α. Secondary outcomes included length of hospital stay, and occurrence of anastomosis leakage

Results: A total of 17 patients were randomized, 9 to the EF group and 8 to the SF group. No significant differences in cytokines levels were observed between the two groups. Clinical outcomes such as length of hospital stay, anastomosis leakage, and other complications were also not significantly different between the two groups.

Conclusion: A preliminary analysis of the study seemed to suggest that there was no significant difference between early and standard enteral feeding after elective colorectal surgery in terms of inflammatory markers and postoperative complications.

Video-Assisted LIFT (VA-LIFT): A New Approach for Treatment of Complex Fistula in Ano

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Background and Objective: Ligation of the intersphincteric fistula tract (LIFT) procedure was proven to be the most effective procedure in the treatment of fistula-in-ano. In complex fistulae, curettage is still needed to remove the fistula tract and can sometimes impair sphincteric nerve function and results in incontinence. The video-assisted anal fistula treatment (VAAFT) was conceived as a sphincter-saving procedure under direct fistuloscopic visualization, but its use of a vascular staple instrument increases the costs of the procedure. The Video-Assisted LIFT (VA-LIFT) is a new approach that combines the benefits of LIFT and VAAFT, and might have practical uses in Thailand. The objective of the present study was to report the incidence of recurrent fistula and the incidence of postoperative fecal incontinence, in patients with complex fistula-in-ano who were treated with VA-LIFT.

Methods: Between October 2014 and December 2015, patients who were diagnosed with complex type of fistula-in-ano underwent VA-LIFT. The fistuloscope was inserted through the external opening to identify the fistula tract, which was then burned from the external opening to the internal opening, by cauterizing all fragments that adhere to the fistula wall, while avoiding damage to the sphincteric nerve. Postoperative follow-ups at 1 month, 3 months, and 6 months were conducted. Fecal incontinence was measured using Wexner's score.

Results: There were 29 patients: 11 patients had semihorseshoe-type fistula-in-ano, 9 patients had horseshoe fistula, and 9 patients had high transsphincteric-type fistula. After 6 months of follow-up, none developed fecal incontinence, and only three patients developed recurrent fistula. Postoperative wounds of VA-LIFT showed less scarring.

Conclusions: LIFT may not be the best choice for the treatment of complex fistula-in-ano. VA-LIFT might be a new, lower cost, effective, and safer treatment of complex fistula-in-ano that combines the practical benefit of the LIFT and a safe, visual approach of the VAAFT procedures.

COMPARISON BETWEEN LAPAROSCOPIC VERSUS OPEN REPAIR FOR PERFORATED PEPTIC ULCER

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Background and Objective: Peptic ulcer perforation is a common emergency abdominal condition. Exploratory laparotomy with simple suture is the current standard of treatment. Laparoscopic repair of perforated peptic ulcer has been used during last decade as an alternative procedure to the open repair. However, the benefits of laparoscopic approach remain controversial. The purpose of this study was to compare the open and laparoscopic approaches for the treatment of perforated peptic ulcer in terms of early postoperative results and complications.

Method: A retrospective study was conducted at Ratchaburi hospital, by reviewing the medical records of patients who underwent either open or laparoscopic repair for perforated peptic ulcer from September 2012 to December 2015. We excluded patients with incomplete data and patients who did not undergo surgery. We collected demographic data including age, sex, ASA, BOEY score, co-morbid conditions, history of peptic ulcer, NSAIDs use, alcohol use, smoking, and presence of free air on plain abdominal films. Intraoperative findings, postoperative complication, duration of nasogastric tube insertion, days till resumption of regular diet, and hospital stay were also collected.

Results: There were 165 patients in the study. 131 patients underwent exploratory laparotomy with simple sutures, and 34 patients underwent laparoscopic simple sutures. Demographic data were comparable between both groups. Free air on plain films was found in 82% in both groups. Operative time was significantly longer in the laparoscopic group. Postoperative intravenous analgesia use was lower in the laparoscopic group (1.1 vs. 5.1 doses, $P < 0.001$). Duration of nasogastric tube placement, days till resumption of regular diet, and hospital stay were not significantly different between both groups ($p = 0.279$, 0.273, and 0.911, respectively). There was no conversion from laparoscopic to the open procedure. Surgical site infection was significantly lower in laparoscopic group (0% vs. 16.8%, $P = 0.008$), but the frequencies of other complications were similar between groups.

Conclusion: Laparoscopic repair of perforated peptic ulcer was similar to open repair in term of duration of nasogastric tube placement, resumption of regular diet, and hospital stay. The laparoscopic group had lower rate of wound infection and lower requirement of post-operative intravenous analgesia when compared with the open group. Laparoscopic repair is a safe and effective alternative treatment of perforated peptic ulcer.

A Randomised Controlled Trial on the Outcome in Comparing Alginate Silver Dressing with Conventional Treatment of Necrotizing Fasciitis Wound

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Background and Objective: Necrotising fasciitis (NF) is a lethal and rapidly progressive soft tissue infection. NF has high morbidity and mortality, and consumes a significant amount of medical resources. Debridement of NF usually results in a large wound. It is still unclear regarding the best type of wound dressing. The objective of the present study was to compare the alginate silver dressing with conventional dressing for NF in terms of cost and effectiveness.

Patients and Method: A prospective randomised controlled trial was conducted at Maharaj Nakorn Chiang Mai Hospital. A total of 39 consecutive patients, who underwent debridement of NF between April 2013 and May 2016, were randomised to receive either silver dressing (group A) or saline dressing (group B). There were 3 main outcomes: the duration till wound closure (the duration until the wound bed was ready for skin grafting or closure), cost, and length of hospital stay.

Results: There were 25 men and 14 women. Group A consisted of 19 patients, group B, 20 patients. The mean wound area was not significantly different between the 2 groups (285.2 cm2 and 215.8 cm2 respectively; $P = 0.38$). The mean duration till skin closure was shorter in group A (21 days) than that in group B (32 days), but this trend was not statistically significant ($P = 0.057$). The mean costs of treatment in groups A and B were not significantly different (115,809 Baht and 92,673.6 Baht, respectively; $P = 0.434$). The lengths of hospital stay of the 2 groups were also not significantly different (29 days and 21 days, respectively; $P = 0.222$).

Conclusion: Although silver dressing seems expensive, the cost of treatment and the duration of hospital stay were not significantly different between the 2 comparative groups. However, the duration till skin closure showed a trend favoring the silver dressing group. More data is needed.

Pediatric Surgery

Free Paper

Treatment of Intussusception in a Limited Resource Hospital

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Background: Intussusception is a common emergency disease in infants and children. For an accurate diagnosis and treatment, specialty doctors and special equipment is needed. But, if resource is limited, the doctor can only use the available equipment in the hospital to investigate and treat the patient.

Objective: To review treatment modality and result of intussusception in Maharaj Nakhon Si Thammarat.

Material and Methods: The medical record of children 0 to 15 years with the diagnosis of intussusception , admitted at Maharaj Nakhon Si thammarat hospital ,from January 2012 to December 2015 were reviewed.

Results: There was a total of 42 patients ,of which 25 boys and 17 girls with 46 episode of intussusception. 69.6% were aged less than 1 year, only two patients of Peutz-Jegher syndrome with small bowel intussusception were more than 4 yr old. 42 patients (91.3 %) were referred from another hospital, 3 patients were from another province. Only 28.3% had an onset less than 24 hr. Symptoms of vomiting, bloody stool, abdominal pain and palpable abdominal mass were found 95.7%, 78.3% 65.2% and 47.8% respectively. 52.2% showed gut obstruction on abdominal X-ray. 27 patients received an abdominal ultrasound of which 26 patients demonstrated an abdominal mass. 2 patients had abdominal CT scan. Barium enema reduction was successful in 16 of 30 patients (53.33%). Ultrasound guided pneumatic reduction was successful in 9 of 11 patients (81.81%). 25 patient (54.3%) needed operation. 7 patients needed bowel resection due to bowel gangrene. 8 patients had a leading point. 5 episode of recurrence were noted and there were no casualties.

Conclusion: Intussuception is mostly diagnosed in children less than one year. Most of the cases were referred from other hospitals and often arrive late. The diagnosis is usually made by clinical signs and symptoms and abdominal X-ray. Ultrasound guided pneumatic reduction had a better success rate than barium enema reduction. About half of the patients needed an operation.

Prognostic Values of Serum Bilirubin at 7th Day Post-Kasai for Survival with Native Livers in Patients with Biliary Atresia

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Background: Biliary atresia (BA) is a serious liver disease with uncertain prognosis. The objective of this study was to investigate prognostic values ofthe >20% decrease in serum total bilirubin (TB) at 7th post-op day regarding early outcome and 5-year survival with native liver in BA.

Methods: BA patients undergoing Kasai operation between 2001 and2014 were reviewed. The ratio of serum TB at 7th post-op day to pre-op TB levels (TB7/TB0) was calculated for every patient.TB7/TB0 ratio of <0.8 indicated the >20% decrease in serum TB. At 6th month following Kasai operation, outcome of BA patients were categorized into good outcome (TB<2mg% or clinically jaundice-free) and poor outcome (TB>2mg% or clinically jaundice). For outcome analysis, logistic regression was used. For survival analysis, Cox regression was applied.

Results: There were 133 BA patients (M:F= 68:65) undergoing Kasai operation. Median age at surgery was 79 days. BA patients with TB7/TB0 ratio of <0.8 were found in 38%. Outcome at 6-month post-op could be evaluated in 126 patients (good: poor = 68:58).The 1-, 3- and 5-year survival rates with native livers were 85%, 70% and 65%, respectively. The median overall survival with native livers was 164 months. Median follow-up time was 87 months.

Logistic regression showed that gender and age at operation were not significant factors impacting on early outcome (P>0.05). However, TB7/TB0 ratio of <0.8 was an independent factor for good outcome (Odds ratio=3.0, P=0.006). Cox regressionanalysis demonstrated that5-year survival rate was significantly correlated with TB7/TB0 ratio of < 0.8(HR=0.46, 95%CI 0.23-0.91, P=0.025) and outcome at 6th month post-op (HR=0.05, 95%CI 0.01-0.15, P<0.001).

Conclusions: The >20% decrease in serum TB at 7thday post-Kasai is a predictor for good outcome. BA patients with TB7/TB0 of < 0.8 had 5-year survival with native livers significantlyhigher than those with the ratio of > 0.8.

Risk Factors for Postoperative Portal Vein Complications in Pediatric Patients Undergoing Living Donor Liver Transplantation: Initial Experience in Ramathibodi Hospital

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Background: Liver transplantation is the final treatment for patients with end-stage liver diseases. The living donor liver transplantation (LDLT) in pediatric age group has been started at Ramathibodi Hospital for about the third decade. This procedure in our institution has been successfully. Among the postoperative complications, vascular complications remain the major complications of LDLT, especially portal vein complications. The feasibility study of any associate factors developing portal vein complications after LDLT has to be challenge.

Purpose: The aim of this study is to find any risk factors associated with postoperative portal vein complications in patients undergoing LDLT at Ramathibodi Hospital.

Methods: Medical records of patients with end-stage liver diseases who underwent LDLT in Ramathibodi Hospital from March 2001 to August 2014 were retrospectively reviewed.

Results: Total 84 patients have undergone LDLT. There were 28 males and 56 females. Biliary atresia is the most common disease (79 in 84 patients.). Mean age at transplant was 2.23 years. Median PELD and CTP scores were 16 and 10, respectively. Mean weight was 10.8 kg in non-portal vein complications patients and 11.06 kg in portal vein complications patients. We found no significant difference between the 2 groups for weight. Thirteen patient (15.29%) developed portal vein thrombosis and 18 patients (21.18%) developed portal vein stenosis. Median warm ischemic time in portal vein complications group and non-portal vein complications group was 78.10 mins and 46.80 mins, respectively. Median portal vein size was 4 mm and median graft weight was 589 grams in patients who developed portal vein thrombosis after LDLT. Seven of 18 patients in post-LDLT portal vein stenosis group (38.9%) had acute graft rejection.

Conclusions: Prolonged warm ischemic time is a significant risk factor for postoperative portal vein thrombosis patients. Small portal vein size, large for graft weight and diminishingly amount of crystalloid and albumin transfusion during surgery trend to be associated with portal vein thrombosis. As for the patients with portal vein stenosis, the presence of acute graft rejection may predict the development of portal vein stenosis after LDLT.

Postnatal Prognostic Factors of Neonates with Congenital Diaphragmatic Hernia

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Background: Congenital Diaphragmatic Hernia (CDH) is one of the complex congenital diseases in pediatric surgery with a high mortality rate. Most patients are neonates presenting with respiratory distress shortly after birth. The overall outcome is still not satisfactory.

Objective: The aim of this study is to analyze the prognostic factors that affect the survival of neonates with CDH in our institute during a 5-year period.

Material and Methods: Retrospective study of all neonates with the diagnosis of CDH whom were treated at Queen Sirikit National Institute of Child Health from January 2010 to December 2014. Data collection included demographic data, associated anomalies and outcome. Statistical analysis was done using Chi-square test with the p-value less than 0.05.

Results: There were 51 patients (30 males and 21 females) with CDH treated at our institute. Male to female ratio was 1.5:1. Forty-three patients (84%) developed respiratory distress within the first 6 hours of life and 8 cases died before any surgical correction could be done. Of the 43 cases, 21 (49.9%) survived after surgical correction. The remaining 8 patients developed symptoms later than 6 hours after birth and all survived (100%). The diaphragmatic defects in 42 cases (83%) were at the left side and 9 cases (17%) at the right side. The survival rate of patients with the left diaphragmatic defects was significantly better than the right side (71.4% vs 22.2%, P=0.039). Of all 35 patients whom underwent surgical correction of the diaphragmatic defects, 13 cases were noted to have the hernia sac but only 10 survived (77%), whereas 22 cases had no hernia sac and 19 survived (86%). There was no significant difference of the survival rate between presence and absence of hernia sacs (p=0.42). The most common associated anomaly was congenital heart diseases. The major cause of death was pulmonary hypertension. The overall survival rate was 58.8% and the survival rate of the patients who underwent surgical correction was 67.4%.

Conclusion: The prognostic factors that affect the survival of neonates with CDH in our institute are onset of the symptoms presenting over 6 hours after birth, absence of pulmonary hypertension and congenital heart disease. The left diaphragmatic defect had better survival rate than the right sided defect.

Biliary Atresia in Infancy : An Analysis of Diagnosis, Prognostic Factors and Outcomes of Treatment

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Purpose: The aim of this study was to evaluate the diagnosis, prognostic factors and outcomes of treatment of biliary atresia in infancy.

Patients and Method: Medical records of patients with biliary atresia whom were treated between 2006 and 2015 at Queen Sirikit National Institute of Child Health were reviewed. All of the patients underwent the operative procedures such as intraoperative cholangiography (IOC), liver biopsy, hepatic portoenterostomy or hepatic portocholecystostomy. Data collection included age at operation, types of operation, diameter of bile ductules at the porta hepatis, and outcomes after treatment depending on jaundice disappearance, serum bilirubin levels and effects of steroid administration.

Results: One hundred and twenty patients were treated during the study period. They were categorized into type I, II and III in 3 (2.5%), 28 (23.3%) and 89 cases (74.2%), respectively. Twenty-four patients (20%) underwent only mini-laparotomy, IOC and liver biopsy because of progressive cirrhosis was seen during the operation. Roux-en-Y hepatic portoenterostomy was performed in 90 cases (75%) of all types with the ratio of functionalized to defunctionalized limb of 20±4.0 cm : 40±5.1 cm. Hepatic portocholecystostomy was performed in 6 cases (5.0%) in type II. Rate of jaundice disappearance after operation was 43%. The factors significantly influenced jaundice disappearance were age at operative approximately 60 days (P=0.043, RR=1.154, 95% CI=1.08-2.11). The diameter of bile ductule at the porta hepatis less than 50 microns effected the persistence of bilirubin level and appearance of jaundice (P=0.002, RR=1.81, 95% CI=1.29-2.54).There was no statistical relationship between corrected age of operation, type of operation, stage of liver fibrosis, bile ductular proliferation, steroid usage, cholangitis to jaundice disappearance. The total and direct bilirubin level had significant increased above 2.5 g/dl in patients with diameter of ductule of porta hepatis < 50 microns (P=0.006, RR= 1.578, 95% CI=1.18-2.11). There was no statistical relationship between corrected age of operation, types of operation, stage of liver fibrosis, bile ductular proliferation, steroid usage, cholangitis to normal bilirubin level.

Conclusion: The prognostic factor of jaundice disappearance and normal total and direct bilirubin level was the diameter of ductule of porta hepatis. Age of operation was significant only in jaundice disappearance.

The Relationship Between Clinical Outcomes After Kasai Operation and Related Factors in Infants with Biliary Atresia

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Background: Biliary atresia (BA) has unclear etiology, leading to cholestasis and cirrhosis. Kasai portoenterostomy has been accepted worldwide as the primary treatment for establishing biliary drainage. Successful Kasai operation increases the survival and postpones subsequent liver transplantation. Several prognostic factors have been related to the results of this procedure.

Objective: To study about the relationship between clinical outcomes after Kasai operation and related factors in infants with BA

Design of study: Retrospective charts review

Material and Methods: A retrospectively reviewed of 48 infants with BA who underwent Kasai operation in division of pediatric surgery at Siriraj hospital (January 1st, 2006 to May 31st, 2015). Ten patients were excluded due to the incomplete clinical data. Finally, 38 patients enrolled in this study.

The variables from clinical, laboratory database, radiologic findings, operative findings, and post-operative conditions were chosen for study.

Result: The median onset of visible jaundice was 4 (0-16) weeks. The median age at Kasai operation was 82 (34-204) days. There were 25 (65.8%) cases who could achieved post-operative jaundice clearance. The evidence of post-operative cholangitis were 30 (78.9%) cases.

The age at the time of Kasai operation has significant impact on post-operative jaundice clearance (*P* value = 0.028). The cut-off age, defined by the ROC curve analysis, was 90 days (*P* value = 0.042). Odds ratio for age at the operation (90 days was 4.78 (95% CI 1.13 - 21.32).

Conclusion: The age at the time of the Kasai operation has significant impact on the ability to achieve post-operative jaundice clearance. The patients whose age at the operation > 90 days have significant risk for delayed clearance of jaundice compare with the age of (90 days.

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Intussusception in Premature Baby; Unusual Cause of Bowel Obstruction and Perforation: A Case Report and Literature Review

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Intussusception in a premature baby is a rare condition. We report a male preterm infant, birthweight 1190 grams delivered by Cesarean section at 29 weeks of gestation. A literature review was conducted of 22 neonatal intussusception cases. While abdominal distension was found in all of the cases, bilious emesis was found in 94.4%. An abdominal mass was only found in 36.4%. The presentation of preterm cases mimicked necrotizing enterocolitis (NEC) whereas term cases presented with obstruction and were associated with bowel atresia. Small bowel obstruction and perforation can also found on the plain abdominal radiography. Ultrasonography and contrast enema did not archive for the diagnosis in most cases. Only 13.6% of cases could demonstrate intussusception by abdominal ultrasonography. Surgical treatment was the recommended treatment in neonatal intussusception.

Associated Genitourinary Abnormality in Low Type Anorectal Malformations and Urologic Investigation

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Background: Urogenital anomaly has been considered as the most common associated condition to anorectal malformation (ARM). There were recommendations for urogenital anomaly survillance. The goal of this study was to evaluate the benefit of screening tools for urogenital anomalies in ARM patients, especially low-type malformations, in our institution.

Methods: A retrospective review of 183 ARM patients in Siriraj hospital during January 2004 - December 2014 was performed. Demographic data included age, sex, type of anorectal malformation, type of surgery, and other associated anomaly. Basic screening methods are ultrasonography and voiding cystourethrography. Further investigations included diuretic renogram, intravenous pyelogram, DMSA scan, magnetic resonance urography, cystoscopy, and retrograde pyelogram. Symptoms, types of anomaly, and treatments of urinary tract anomaly were recorded.

Results: All 183 patients data were reviewed. Low type malformation accounted for 51 patients. 153 were scheduled for KUB ultrasonography as a screening protocol with 42 abnormal results. Most common anomaly was vesicoureteric reflux followed by renal agenesis. Thirteen low-type ARM patients had abnormal screening results. After follow up, 4 from 11 hydronephrosis and pelviectasis patients appeared normal in later years. For the genital abnormality, hypospadias was predominated in low-type ARM with urinary tract anomaly patient. This correlation was not found in non low-type patients.

Conclusion: In case of low-type ARM, hydronephrosis was predominated and some of them spontaneously resolved, expectant management was preserved in selected cases. Noninvasive screening test should be encouraged and performed in all ARM patients.

Plastic Surgery

Free Paper

Augmentation Rhinoplasty with ePTFE: How I Do It?

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Background: Augmentation rhinoplasty is one of most common aesthetic surgical procedures in Thailand by personal observation. The convention procedures involved silicone implantation, still commonly employed in the majority of cases. However, the silicone prosthesis induces long term capsular contracture and tissue erosion. Moreover, long term infection is not uncommon. The expanded polytetrafluoroethylene (ePTFE) prosthesis was used for nasal implantation to reduce complications and achieve more natural appearance.

Purpose: To describe the surgical procedure of augmentation rhinoplasty with carved ePTFE material.

Methods: There were 352 cases performed augmentation rhinoplasty with ePTFE material at Kamol hospital between January 2013 and December 2015. The surgical procedures were performed under local or general anesthesia by the author. The operation time was approximately 1-2 hour. The follow up time were between 1 week and 2 years.

Results: The majority of patients were satisfied with the aesthetic results. The external appearance looked natural. Post-operative complications were infection and implant migration. There were 12 cases requested for secondary revision for aesthetic purpose.

Conclusions: The overall patients were satisfied with the aesthetic results. The expanded polytetrafluoroethylene (ePTFE) prosthesis is an alternative implant material for augmentation rhinoplasty. However, patient selection, surgeon's knowledge and manual skill are important to achieve the goal.

General Surgery

Free Paper

Comparison of the Surgical Wound Infection Rate and Length of Hospital Stay in Complicated Appendicitis Between Primary Closure and Delayed Primary Closure

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Background: Delayed primary closure (DPC) have been applied in complicated appendicitis in Hatyai hospital. Recently, many papers support the good outcome of primary closure (PC) in complicated appendicitis. The aim of this study was to compare the difference in the surgical wound infection rate and length of hospital stay between PC and DPC in cases of complicated appendicitis in adults.

Methods: This cross sectional study was conducted at the Hatyai hospital in two periods of time. The adult patient (>15 years old) of both gender who underwent appendectomy through Gridiron or Lanz incision and having complicated appendicitis (ruptured, incidental ruptured, gangrenous appendicitis) in Hatyai hospital were enrolled. A total of 50 patients from 1st October 2015 to 31st May 2016 were in PC group and 83 patients between 1st October 2010 and 30th September 2011 were in DPC group. The rate of surgical wound infection and the length of hospital stay were recorded. Data was analyzed using chi-square test and t-test, p value was calculated.

Results: 133 patients, 77 (57.89%) male and 56 (42.10%) female were included in the study. The mean age of patients was 39 + 17 years old and the average onset of symptoms was 31 hours. The surgical wound infection was developed 5 (10%) patients in the PC group and 3 (3.61%) patients in the DPC group. The data was analyzed with the Chi-Square test and there was no significant difference of wound infection between PC and DPC group (p value > 0.05). But the difference in length of hospital stay were significant with the T-test (p value < 0.01), showing superiority of PC (3.2 days) over DPC (6.1 days).

Conclusion: There was no significant difference of the wound infection rate between PC and DPC group but in PC group had significant decrease the length of hospital stay compared with DPC group.

Comparing the Cost-effectiveness of Minimally Invasive, Hybrid, and Open Esophagectomy for Esophageal Cancer

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Background: Esophagectomy is regarded as the only curative option for resectable esophageal cancer. Many studies have reported that minimally invasive esophagectomy(MIE) had improved short-term outcomes such as decreased post-operative pneumonia and pain compared to open esophagectomy, however, MIE also had increased operative cost and time. To solve the problem of high cost and long operation time, we have experimented with hybrid esophagectomy instead of total MIE.

Objectives: The objective of this study was to compare the cost-effectiveness of MIE, open esophagectomy, and hybrid esophagectomy.

Methods: Between January 2007 and December 2014, 83 thoracic esophageal cancer patients underwent a 3-phase esophagectomy. Surgical techniques included (1) open esophagectomy; open right thoracotomy and open laparotomy in 54 patients, (2) hybrid esophagectomy; right thoracoscopic surgery and open laparotomy in 16 patients, and (3) MIE; right thoracoscopic and laparoscopic surgery in 13 patients. A chart review was performed to identify the costs and clinical data of each technique for cost-effectiveness analysis.

Results: MIE was estimated to totally cost 210,971.46 baths, hybrid esophagectomy 164,089.69 baths, and open esophagectomy 148,926 baths with p=0.152. MIE took 596.46 minutes, hybrid esophagectomy 455.31, and open esophagectomy 429.35 minutes with P=0.002. No significant differences were found between the three groups in terms of early postoperative complications, blood transfusion, length of ICU stay, or length of hospital stay.

Conclusion: Hybrid esophagectomy is effective compared to MIE and open esophagectomy. According to this economic study we recommend hybrid esophagectomy for esophageal cancer because this technique may allow the reduction of cost and operative time.

Endoscopic Drainage of Pancreatic Pseudocysts : Short-Term and Long-Term Assessment of Outcomes and Complications in Rajavithi Hospital

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Background: Endoscopic drainage is minimal invasive alternative management for pancreatic pseudocyst , which has become the treatment of choice in many reference centres. However data on the clinical outcome and complication rate are conflicting. This retrospective study the short-term and long-term outcomes and complication. The predictor for potential of pseudocyst resolution or complications.

Purpose: Our study evaluates endoscopic drainage for pancreatic pseudocyst in a short-term and long-term follow up with clinical and procedure outcomes, including procedure-related adverse event and re-intervention.

Methods: This retrospective study for symptomatic pancreatic pseudocyst patient from January 2005 to December 2014 for endoscopic drainage pancreatic pseudocyst at Rajavithi Hospital. Follow-up data were obtain by medical record. The patient's chart were review demography data , cause and management. The preprocedure abdominal image in the study was review by radiologist.

Results: All 65 patients were included (43 male and 22 female)Most common cause of pseudocyst was alcohol 36.9%. The symptom that indicated drainage were abdominal pain 89.2%, early satiety 35.4% and mass 27.7%. Most common were single pseudocyst 78.5.% and located in the head of the pancreas 44.6%. Short term follow up (1-month) : clinical success rate 73.8%, procedure success rate 83.1%, mortality rate 1.5% and complication rate 18.5%. Then remain pseudocyst at 1-month are 56 patient (86.2%) after follow up to the 12-month period showed clinical success rate 90.8%, procedure success rate 89.2% and complication rate 9.3%. Remain pseudocyst at 12-month follow up were 9 patient (13.8%), 8 patient (12.3%) used a longer period than 12 months was resolve. 4.6% was recurrence pseudocyst after follow up more than 12-month. Pancreatic pseudocyst decrease size after 1-month and 12-month follow up was significantly ($P = 0.00$).

Conclusions: Endoscopic drainage for symptomatic pseudocyst is an effective treatment in both short term and long term , which is not successful in all case but has high long term success rate, less invasive than surgery and avoid the need for external drainage, improve QoL. Most of the complication require supportive treatment or minimal invasive surgical treatment.

A Comparison on Early Outcome of Per-oral Endoscopic Myotomy (POEM) and Laparoscopic Heller Myotomy (LHM) in Achalasia Patients

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Background: Achalasia is a rare esophageal motility disorder. The gold standard of treatment is Laparoscopic Heller myotomy (LHM). Per-oral endoscopic myotomy (POEM) is a novel endoscopic treatment. There had only been a few studies comparing POEM with LHM.

Objective: The aim of this study is to report the early outcomes ofPOEM compared with LHM .

Materials and Methods: A retrospective review of patients who underwent POEM and LHM in Rajavithi Hospital from April 2007 to January 2016. The data was collected by chart review and phone interview. Eckardt symptom score was collected preoperatively, 3 and 6 months postoperatively. The primary outcome was Edkardt score improvement compared in both groups. The secondary outcome was rate of complications.

Results: There were 57 achalasia patients included, 19 patients underwent POEM, 38 patients underwent LHM. The median age, operative time and duration of symptom were compared between the POEM and the LHM group with the result of 39.7 yr (20-59) vs 49 yr (27-75) P=0.01, 142 min (40-295) vs 165 min (80-450) P=0.2, 39 mo (3-144) vs 52 mo (6-480) P=0.5. Comparison of the mean Eckardt score between the POEM and the LHM group at preoperatively, 3 months and 6 months postoperatively were 7.3±2.1 vs 7±1.4(*P*=0.64), 0.9±1.0 vs 1.5±1.2 (*P*=0.03), 1.4±1.1 vs 1.3±1.3 (*P*=0.21). Treatment success (Eckardt score _3) in the POEM group and the LHM group were 94.7% and 97.4% at 6 months follow-up. GERD symptoms presented postoperatively in the POEM group in 2 patient (10.5%) while LHM with fundoplication in 2(6.8%) and LHM without fundoplication in 4/9 (44%) patients. Rates of minor complications in the POEM vs LHM group were 26% and 10.5%. There is one esophageal wall necrosis in POEM group which improved with conservative treatment. Capnoperitoneum was found in 2 patients (20%), successful treat with needle decompression. One patient (4%) in LHM group had an esophageal mucosal tear which was repaired intraoperatively. Minor complications in the POEM and LHM group were15 vs 10.5% respectively withoutpostoperativemortality.

Conclusions: POEM is comparable with LHM in safety and effectiveness of achalasia treatment within postoperative 6 month follow-up period. Minor complications can be resolved by conservative treatment without short term morbidity and mortality.

Management of Abdominal Gunshot Wounds: Predictor for Therapeutic Laparotomy

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Background: Management of abdominal gunshot wounds (AGW) has been shifted from mandatory exploration to selective non-operative management (SNOM). However, there is no uniform consensus regarding the criteria of SNOM and there is little information about the predictor for therapeutic laparotomy.

Purpose: The authors examined the outcomes SNOM of AGW patients in our institution and the predictor for therapeutic laparotomy that could be obtained at the emergency department (ED).

Methods: A retrospective study was performed on AGW patients from January 2004 to December 2014 at King Chulalongkorn Memorial Hospital. Laparotomy was done in 1) all patients presenting with shock and/or peritonitis, and 2) Stable patients with suspected peritoneal penetration (PP) from physical examination and/or radiographic findings, with the exception of isolated right upper quadrant (RUQ) AGW. SNOM was attempted in 1) all patients with no PP (tangential AGW), and 2) Stable patients with RUQ AGW who had isolated solid organ injury demonstrated by computed tomography. Data collection included demographic data, emergency department parameters, details of AGW, and outcomes in terms of mortality and non therapeutic laparotomy rate. Stepwise logistic regression of the ED parameters was performed to identify mutually independent predictors for therapeutic laparotomy.

Results: Eighty AGW patients were included in the study. Thirty-two patients with shock/peritonitis underwent immediate operation, all had therapeutic laparotomy. All 28 tangential AGW patients underwent successful SNOM. Of the 20 stable AGW patients with PP, 15 underwent laparotomy (1 was non therapeutic), while SNOM was attempted in 5 patients (4 RUQ AGW with isolated solid organ injuries and 1 delayed presentation) with 1 subsequent laparotomy required due to delayed bleeding from a kidney injury. Successful SNOM was carried out in 32 patients (40%). The non therapeutic laparotomy rate was 2% (1 in 47 patients undergoing laparotomy). Six patients who underwent immediate laparotomy died from exsanguinations (mortality rate 7.5%). The mutually independent predictor for therapeutic laparotomy was a positive focused assessment sonography for trauma (FAST) result (Odds ratio 21.7, 95%CI 2.7-172.7, p <0.001).

Conclusions: SNOM could be performed safely in patients with tangential AGW and stable patients with isolated RUQ AGW. Laparotomy in patients with shock/peritonitis and in patients with PP other than isolated RUQ AGW is still a safe approach carrying a low non therapeutic laparotomy rate. FAST may be helpful in predicting therapeutic laparotomy in AGW patients.

Military and Civilian Injuries During Low-Intensity Armed Conflict Areas: A New Paradigm in Military Medicine

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Background: A low-intensity armed conflict has been occurring for more than a decade in southernmost region of Thailand resulting in destruction of life and property. However, the epidemiology of military and civilian-related injuries is poorly defined.

Purpose: To analyze mechanisms and severity of injuries to advance treatment strategies and inform public health policies.

Methods: The Songklanakarind Hospital Trauma Registry and Hospital Information System (HIS) were queried for all individualssustained injuries in the southernmost region of Thailand and transferred to Songklanagarind Hospital between the years 2009 and 2014. Mechanisms of wounding were recorded. Injuries were analyzed using Injury Severity Score (ISS) as were treatment required and outcomes.

Results: A total of 572 soldiers and civilians were transferred to Songklanakarind Hospital. Most of victims were male (81.5%), mean age for the group was 40 years old (range 4-92). Civilians were victimized more than military personnel (64.9% vs. 35.1%, respectively). Blunt mechanism accounted for 206 (36.0%) of the injuries, blast injury 179 (31.3%) and penetrating mechanism 164 (28.7%). The mean Injury Severity Score (ISS) was 14.5. Two hundred nineteen (38.3%) were major trauma (ISS > 15). Proportion of patients with major trauma was increased annually. The proportion of victims with major trauma was highest among victims transferred from Pattani followed by Narathiwas, and Yala, respectively. Most patients (79.9%) required surgical treatment. Surgery for orthopedic conditions was the most frequently performed (35.9%) followed by surgery for wounds and soft tissue (17.1%), and laparotomy (13.6%). One hundred sixty-three patients (28.5%) suffered with post traumatic complications in which infection (62.6%) was the most frequent. Overall mortality was 33 patients (5.8%).

Conclusions: Significant number of patients referring from southernmost region of Thailand insurgency sustained major trauma. Despite a very low mortality rate, post traumatic complications were high especially infectious complication. More efforts and researches on this area are warranted.

Clinical and Pathological Staging in Immediate Breast Cancer Reconstruction

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Background: Immediate breast reconstruction after mastectomy has an advantage of a single-stage operation and also provide a good cosmetic results. It is suitable for patients who have early stage breast cancer. When adjuvant radiotherapy was planned, breast reconstruction should be delayed due to the worse cosmetic outcomes. Accurate clinical staging in patients with tumor staging 0,1,2 and nodal stage 0 who don't require adjuvant radiotherapy is important for immediate reconstruction.

Purpose: Aim of our study was to identify correlation between clinical and pathological staging for patients who are candidate for immediate reconstruction.

Methods: A retrospective study was performed in patients who operated for immediate breast cancer reconstruction after mastectomy from January 2009 - July 2014 at King Chulalongkorn Memorial Hospital. Immediate reconstruction was performed in clinical T1,T2, node negative, T0 (DCIS) lesions patients in 81 patients (93%). Mismatch of clinical and pathological staging was reviewed and calculated for correlation. Adjuvant radiation was recorded.

Results: Among total 107 patients who underwent immediate reconstruction, only 87 patients whose recorded for both clinical and pathological staging were completed.Seventy-two patients diagnosed with invasive cancerstaging ranging from T1-T4 and N0 - N2 stage. Other 15 breasts are classified as premalignant lesion or benign diseases. Mismatch of clinical and pathological staging found in 39 patients. But only 20 of 39 patients need additional adjuvant radiotherapy. Statistical calculation was done in the correlation of T staging and N staging by using weighted kappa test. For T staging, liner-weighed kappa test show 0.7 with 95% CI (0.54-0.85). For N staging, linear-weighted kappa test shows 0.17 with 95% CI (0-0.4).

Conclusions: Accuracy of clinical staging in breast cancer patients who choose the immediate reconstruction plays as important role for adjuvant radiotherapy. This data can guide the possibility of adjuvant radiation which immediate reconstruction should be avoided because it results in poor cosmetic outcome.From out study, T staging has a good result of correlation between clinical and pathological staging, However, N staging show a worse correlation between clinical and pathological staging. Imaging study additional with conventional study such as MRI and ultrasound-guided fine needle aspiration of suspected axillary lymph node may give better preoperative staging.

Damage Control for Thoracic Trauma: King Chulalongkorn Memorial Hospital Experience

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Background: Damage control surgery is a well established principle of treatment for severely injured patients especially abdominal injuries but there a few reports about its perspective in thoracic trauma.

Purpose: To evaluate outcomes of damage control for thoracic trauma in King Chulalongkorn Memorial Hospital.

Method: A retrospective data were collected from medical records of patients, admitted in King Chulalongkorn Memorial Hospital from January 2012 to January 2016, who underwent damage control for thoracic trauma including chest wall injury, tracheobronchial injury, lung parenchymal injury, thoracic vascular injury and cardiac injury. The primary outcomes are survival and causes of death, other accumulated data are demographic data, mechanism of injury, vital signs, injury scores, initial arterial blood gas values, operation procedures and complication.

Results: There were 14 patients underwent damage control for thoracic surgery, Thirteen of them were male and 1 patients was female. Blunt injury was more frequent mechanism of injury (57%). Five patients survive (36%). Mortality was 64%, major causes of death are exsanguination (67%) and organ failure (33%). Median systolic blood pressure at emergency department was 78 mmHg, median pH was 7.088, median lactate is 11.45 mmol/L and median INR was 1.28. Median ISS was 37.5. The surgical incisions were median sternotomy (14%), Left anterolateral thoracotomy (21%), Right anterolateral thoracotomy (21%) and Clamshell thoracotomy (44%). Twelve patients (86%) required thoracic packing and temporary chest closure. Mean ventilator day was 10.8 days and mean ICU stay was 12.6 days. Complications were pneumonia (29%), Empyema thoracis (14%) and surgical site infection (7%).

Conclusion: Damage control for thoracic trauma resulted in very high mortality because most of patients were moribund but it might be the last resort to save their life.

Comparative Study of Primary Repair of Traumatic Colonic Wound versus Diverting Colostomy

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Background: The management of colon injury remains controversial. This study investigated the efficacy and safety of each types of treatment for colonic injury.

Purpose: To determine the outcomes stratified by types of treatment for colonic injury and risk factors associated with unfavorable outcomes.

Methods: We conducted a retrospective study from a prospective collected database, in which all adult patients with colonic injuries admitted to Songklanagarind hospital, an academic Level I trauma center in Thailand, from 2010 to 2014, were reviewed. Statistical analysis was used to compare the results ofeach types of treatment and multivariate logistic regression was applied to identify independent risk factors for the development of unfavorable complications.

Results: Over the five years study period49,567 patients with trauma were seen 7,318 patients (14.8%) were admitted. Eighty-seven patients were identified as having colonic injury. Sixty-nine patients (79.3%) had primary repair for colonic wound, 6 patients (6.9%) had resection and primary anastomosis, and 12 patients (0.1%)had diverting ostomy done. The overall intra-abdominal infection was 29.5% (primary repair, 25.8%; resection and anastomosis, 33%; diverting ostomy 50%; $P = 0.15$). The overall colonic suture line leak was 5.1% (primary repair, 4.8%; resection and anastomosis, 16.7%; diverting ostomy 0%; $P = 0.34$). The overall mortality was 10.3% (primary repair, 10.1%; resection and anastomosis, 0%; diverting ostomy 16.7%; $P = 0.65$).Multivariate analysis revealed age> 45 years as an independence risk factor for colonic suture line leak (odds ratio, 14.66; confidence interval, 1.28 to 168.36).

Conclusions: Our study suggested the types of treatment (primary repair, resection and anastomosis, diverting ostomy) for colonic injury do not affect postoperative complication rate. Age of patient is an independent risk factor for colonic suture line leak.

Surgical Outcome of Perihilar Cholangiocarcinoma in King Chulalongkorn Memorial Hospital

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Introduction: Perihilar cholangiocarcinoma isan adenocarcinoma arising from biliary confluence. At present, this tumor is still consider to be difficult to cure. Complete resection with margin negative resection is the only potential curative treatment of patient.

Objective: The primary objective is to evaluate the results of surgical management of perihilar cholangiocarcinoma. And the secondary objective is to evaluate prognostic factor of overall survival in King Chulalongkorn Memorial Hospital.

Materials & Methods: Retrospective review of medical records of 55 patients underwent surgical resection for Perihilarcholangiocarcinoma at King Chulalongkorn Memorial Hospital between 1 May 2003 to 30 April 2014. was performed.

Results: Between 1 May 2003 to 30 April 2014. There were 55perihilar cholangiocarcinoma patients underwent surgical resection in King Chulalongkorn Memorial Hospital. The 3 and 5 years survivals rate are. 60.52% and 31.17%. The multivariate analysis identified R0 resection (HR= 1.76 ,95 % CI 1.05-2.93, p = 0.03),vascular invasion (HR=1.32, 95 % CI 0.52-3.14,p=0.05) and lymph node metastasis (HR=3.21, 95 % CI .1.40-7.32, p<0.05) were independent prognostic factors for overall survival .

Conclusions: Complete resection remains the most efficient treatment with prolonged quality survival. In this study, margin negative resection,absence of lymph node metastasis and vascular invasion are the main prognostic factors after curative-intent surgery for perihilar cholangiocarcinoma.

Treatment Outcome of Pancreatic Head Cancer in King Chulalongkorn Memorial Hospital: Classified by Resectability Status

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Background: Most of pancreatic cancers were diagnosed at an advanced stage. As surgical resection remained the only curative treatment, more aggressive surgery had been performed to increase resection rates, especially cancer in the pancreatic head that frequently invaded the portal vein and the extrapancreatic nerve plexus. This type of tumor required portal vein resection and extrapancreatic nerve plexus dissection to obtain a negative resection margin. Nowadays, National Comprehensive Cancer Network (NCCN) classified pancreatic cancer into 3 groups according toresectability status; resectable, borderline resectable, and unresectable. In Thailand, there was few data about treatment outcome of each group of pancreatic cancer.

Purpose: The aim of this study was to evaluate treatment outcome of pancreatic head cancer classified by resectability status of NCCN.

Materials and methods:Retrospective review of medical records of patients who were diagnosed pancreatic head cancer at King Chulalongkorn Memorial Hospital between January 2009 and June 2014 was conducted. Among 108 patients with pancreatic head cancer, 16 patients were resectable group(R), 26 patients were borderline resectable group (BR), and 66 were unresectable group (UR).

Results: Patients in the resectable group had significant better survival time (median survival time (MST) = 13months) than those in borderline resectable (MST= 7months) and unresectable group (MST= 3months) (p=0.001). In BR group, standard pancreatoduodenectomy (PD) was performed in 11 patients (42.31%), PD with vascular resection (VR) was performed in 4 patients (15.38 %), bypass surgery was performed in 6 patients (23.08%), and tissue biopsy without palliative surgery was performed in 2 patients (7.69%). Survival in BR group, PD with VR group(MST = 12 months) was better than PD without VR group (MST = 10 months) and bypass surgery group (MST = 6 months), but tissue biopsy group had the worst prognosis (MST = 1 month) (p = 0.12).

Conclusions: Resectable pancreatic cancer has the best prognosis, but borderline pancreatic cancer has better prognosis than unresectable group. Multidisciplinary treatment including resection was required for borderline resectable pancreatic cancer.

Clinical Characteristics and Factors Influencing Outcomes in Adult Soft Tissue Sarcomas

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Background: Soft tissue sarcomas (STS) are rare tumors classified into multiple histological subtypes. Complete surgical resection is the mainstay of curative therapy. However, the success of surgery varies with the site, histologic grade, depth, and size of the tumor. Generally, the prognosis of disease remains poor.

Purpose: The aim of the study was to define clinical characteristics and factors that influence outcomes of treatment in adult STS.

Methods: Records review identified 385 patients with STS treated from January 2002 to July 2015 at Songklanagarind hospital. Patient features, tumor characteristics, factors influencing surgical outcomes including adjuvant radiotherapy were analyzed.

Results: Mean age at diagnosis was 51 (16-94). No difference in gender in diagnosis of STS (M:F = 1:1). The most common site was extremity (42.9%) followed by retroperitoneum (14.8%), trunk (12.5%), visceral organs (11.7%) and head & neck (11.2%). Median tumor size was 10.5 cm (1-40). Seventeen percent presented with stage IV at diagnosis. Almost 20% of patients had no surgery either unresectable or metastatic disease. Closed and involved margins were factors that influence local and distant recurrence.

Conclusions: Extremity remains the most common site of STS. The patients usually present with large tumor size (> 5 cm) which difficult in getting adequate margins, resulting in poorer outcomes.

The Level of Vitamin A, Vitamin B1, Vitamin B12, Vitamin D, Vitamin E and Folate in the Short Bowel Syndrome Patients with Total Parenteral Nutrition

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Background: Intestinal failure had results an inadequate digestion and absorption of nutrients. Patients will required the long term total parenteral nutrition. The most common of short bowel syndrome in children was occurred from NEC. Also, we study the level of vitamin A, B1, B12, D, E and folate in the short bowel syndrome patients at before and after receive total parenteral nutrition.

Methods: Twelve short bowel syndrome patients were prospectively studied. Routine and study blood samples is taken before total parenteral nutrition is started at the first and second admission dates. Total parenteral nutrition was adjusted according individual patients and then follow up study blood samples were taken after completion of TPN for a total of 5 days and 2 days of rest. We compare the differences of vitamin level A, B1, B12, D, E and folate of before and after receive total parenteral nutrition.

Results: From June 2013 to December 2015, twelve SBS patients were 5 boys (41.6%) and 7 girls (58.4%) with age range of 1 year to 12 years. All twelve patients need total parenteral nutrition(TPN). A weighted mean of SBS patients was 14.9 kg. Most of the patient's weight was less than the 25th percentile, and there for classified as malnutrition. Ten cases were free of ileocolic valve and two cases had ileocolic valve.The length of remaining intestine was more than 75 cm in 3 patients and less than 75 cm in 9 patients. All patient had vitamin deficiency and were given for oral vitamin supplement at home. Different from the result of pre and post given the TPN, it increases a vitamin A ($p < 0.004$), E ($p < 0.001$), D2 ($p < 0.001$) and D3 ($p < 0.04$) significantly. Although the serum levels of vitamin B1, vitamin B12 and folate in the SBS group intend to increased, but were not significantly different.

Conclusion: SBS patients had the vitamin deficiency. These findings suggest that the total parenteral nutrition were significant improve for vitamin A, E, D deficiency and that individual adjustments are needed depending on the patient's vitamin status.

Young Investigator Award

Body Composition Change After Bariatric Surgery

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Background: Bariatric surgery is one of treatment choices for morbid obesity patients because of its effective weight loss. To improve positive effects on metabolic risks, this weight loss should be primary from body fat mass (BFM). The aim of this study is to analyze the body composition for determining FFM, BFM, and basal metabolic rate (BMR) before and after bariatric surgery

Method: Patients performed bariatric surgery in King Chulalongkorn Memorial Hospital University between September 2014 and October 2015 were prospectively collected. Patients' weights and body compositions were recorded by using bioelectrical impedance analysis (BIA) (Inbody 720). Weight, BFM, FFM, and BMR were measured before and 1, 3 and 6 months after bariatric surgery. The changes in body composition were analyzed

Result: A total of 43 patients were included with at least 6 months follow up, 25 for LRYGB and 18 for LSG. There were 25 females and 19 males with an average age of 37.09 years old. The average BMI before surgery was 49.08 kg/m^2 and 6 months after surgery was 36.78 kg/m^2. The average %EWL was 53.04%. The average of BFM before surgery and 6 month after surgery were 68.42 ± 18.72 and 43.41 ± 15.59kg ($P < 0.001$) respectively. The average of FFM before surgery and 6 month after surgery were 65.85 ± 15.50 and 57.03 ± 12.59 kg ($P < 0.001$) respectively.

In 6 months after surgery, patient had lost33.83 of body weight (25.01 kg of BFM and 8.81 kg of FFM). We mainly found a decrease in BFM (36.96 ± 12.49%) whereas FFM was slightly reduced (12.93 ± 6.44%).

The significant decrease in BMR (1791.93 ± 334.90vs1673.31 ± 309.83 Kcal $P < 0.001$) was observed only from before surgery to 1 month after surgery. Thereafter, there was no significant change in BMR at 3 and 6 months (1629.44 ± 300.55, 1601.47 ± 271.89). Between these two operations, LSG and LRYGB do not differ in term of body composition.

Conclusion: The weight loss after bariatric surgery is mainly due to a reduction in BFM with less impact on the FFM (39.49% vs 14.76%). BMR was significantly decreased in 1 month after surgery.

Benefits inPreservation of the IMA during Laparoscopic Sigmoid Colectomy: A Case-Matched Comparative Study

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Background: In curatively intended resection of sigmoid cancer, ligation of the root of the inferior mesenteric artery (IMA), high tie, is considered necessary for wide lymph node dissection. IMA ligation compromises blood flow to the anastomosisand maydamage to the autonomic nerve nearby, which may increase the leakage rate and cause postoperative impaired anorectal function. Accordingly, some surgeons employ a technique of preserving the IMA for increase blood flow and decrease postoperative bowel complications. But these technique was reported to need longer time in laparoscopic surgery due to technical difficulties and the adequate of lymph nodes clearance and benefitsin postoperative anorectal function are unclear.

Objectives: To compare theoperative results of two methods in laparoscopic sigmoid colectomy (with or without preservation of the IMA) in term of operative time, blood loss, lymph nodes clearance, complications, postoperative anorectal function and recurrence rate.

Materials and Methods: A 1:2 Case-matched comparative study were applied and retrospectively analysed 27 patients (19 female and 8 male, mean age 63± 9.44 years) with sigmoid tumor,who underwent surgery between January 2012 and December 2015. Laparoscopic sigmoid colectomy with preservation of the IMA was performed in 9 patients, and ligation of the IMA with sigmoidectomy was carried out in 18patients. Bowel function follow-up was performed at6 and 12 months after surgery.

Results: Lymph nodes around the IMA were dissected with preservation of the IMA in 9cases (group A). And the IMA was ligated in 18 cases (group B). Mean operative time was 194.44 (+28.77), 178.89 (+55.52) min for group A and B, (P=0.349). Respective blood loss 94.44 (+52.71), 79.44 ml (+58.15), (P = 0.51) and mean numbers of harvested LN were 14.56 (+3.74) and 17.56 (+7.64), (P = 0.183). Three patients of the IMA-ligated group had a short period of incontinence (1-2weeks postoperative). No leakage or bleeding or recurrent tumorwere found in both group. None of the operative results of groups A and B were different statistically.

Conclusions: Laparoscopic sigmoid colectomy with preservation of the IMA in 9cases allows equivalent laparoscopic lymph node dissection to the high tie technique without excessive operative time or bleeding and may lowers the frequency of postoperative impaired anorectal function.

Enhanced Recovery After Surgery (ERAS) Helpselderly Maintain their Activities of Daily Living and Improve Quality of Life Following Major Colorectal Surgery - with Comparable Surgical Outcomes to Younger Patients

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Objective: This study aimed to evaluate surgical and functional outcomes following the application of enhanced recovery after surgery (ERAS) in elderly undergoing colorectal resection.

Methods: A prospectively collected database of elderly patients (age ± 75 years) undergoing elective colorectal surgery under ERAS pathway in Siriraj Hospital from 2011 to 2015 was reviewed. Surgical outcomes of such patients were compared to those of younger patients. Patient-reported outcome measures were compared between their preoperative status and postoperative status by activities of daily living (ADL) using modified Barthal index (MBI: 0= totally independent to 100 = totally dependent) and health-related quality of life (HR-QoL) using 100-mm visual analog scale.

Results: This study included 30 elderly patients with median age of 78 years,Charlson Comorbidity Index of 7 and CR-POSSUM predicted mortality of 3.5%. Compared toyounger patients, the elderly had non-significant higher rate of complication (31% vs 15%; p=0.06) and longer postoperative stay (5 days vs 4 days; p=0.12) but comparable time to tolerate solid diet and time to first defecation. AverageADL-MBI was following: 99 at baseline vs 96, 97, 97 and 98 at 1, 3, 6, and 12 monthsafter surgery, respectively. HR-QoL showed a recovery to an extent equal to or better than theirpreoperative scores: 56 at baseline vs 55,59,64 and 72 at 1, 3, 6, and 12 months after surgery, respectively.

Conclusions: Although the elderly were inherited to significant comorbidities and high predicted mortality, the application of ERAS in such patients resulted in comparable surgical outcomes to younger patients. Additionally, the elderly could maintain their ADL and exhibit better HR-QoL after surgery.

ACS Award

Should Electrocautery be Used for Hemostasis of Sleeve Gastrectomy Staple Line or ot? This Study Concerns Histological Alteration of the Gastric wall After Electrocauterization on Staple Line

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Introduction: Sleeve gastrectomy has become more popular in a surgical procedure to treat patients with morbid obesity. An essential part of the procedure is the hemostasis on the staple line. Electrocautery must be applied to staple line precisely. It is still a controversial issue whether postoperative leakage around the staple line would occur.

Method and Procedures: After sleeve gastrectomy was performed,the divided part of the stomach which was used as a surgical specimen was studied. Three specimens from three different patients were used in the study. Different spots on the staple line of each specimen wereelectrocauterized by a monopolar hook in a different period of time: spot cautery, one second, two seconds, three seconds, four seconds and five seconds. A systematic study was conducted; each electrocauterized spot on the staple line was studied in 3 dimensions: two lateral sides, two longitudinal sides and thermal injury in depth to evaluate tissue injury on the staple line.

Results: Eighty-five pieces of tissue,five on each of seventeen slides, were studied macroscopically and microscopically. Macroscopically, the tissue injury did not exceed the staple line. Microscopically, submucosa and intramuscular hemorrhage and cellular swelling were found in both electrocauterizedand non-electrocauterized areas; nevertheless, neither cell death nor structural change was found.

Conclusions: Precisely and carefully performed electrocautery on sleeve gastrectomy staple line is effective for hemostasis and as it has been proved to be safe in this histological study.

ICS Inventor Award

Vascular Gel Model for Central Venous Catheterization

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Background: Central venous catheterization provides a route for delivery of caustic or critical medications and allows measurement of central venous pressure. Ultrasound guide puncture is now recommended in central venous catheterization procedure. The purpose of this study is to describe an inexpensive material (gelatin, mucilin powder) and simple method to create ultrasound-imaging models for the purpose of education and practice using, comparable with standard gel model

Method: 60 non-experience trainees were included in study and subjected to two groups, homemade and standard gel model. Procedural times were collected and compare between the two groups.

Result: Homemade ultrasound phantom we produced contains two vessel lumens. The images obtained using the phantom were high reliance quality and comparable to standard gel model. When compare the two groups, time to complete procedure was no statistic significant (p=0.957)

Conclusion: Homemade gel model can used as simulator in central venous catheterization for trainees and comparable to standard gel model.

Pisith Viseshakul Award

Use of Diagnostic Peritoneal Lavage for Detecting Hemoperitoneum in Blunt Abdominal Trauma with Hypotension Despite Being a Negative Result of FAST Examination

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Background: Massive hemoperitoneum is one of the major sources of bleeding in blunt trauma with hypotension. Diagnostic peritoneal lavage (DPL) is a very sensitive and effective means for detecting hemoperitoneum in hemodynamically unstable patients. However, most trauma centers now used focused assessment sonography in trauma (FAST) for initial evaluation and triage trauma patient because FAST is non invasive, easy to perform, repeatable and has a high sensitivity.

Objective: To determine benefit of DPL in blunt trauma patients with hypotension and negative result of FAST examination.

Materials and Methods: From April 2012 to March 2015, blunt trauma patients who presented with systolic blood pressure ≤ 90 mmHg were recruited from Songklanagarind trauma registry. Patient older than or equal to15 years who came directly to Songklanagarind trauma center with a negative result of initial FAST examination and performed a DPL at the emergency room were enrolled to this study. Demographic data, result of DPL and operative record were review and descriptive reports.

Results: In 48 months study period, 119 adult trauma patients presented with hypotension. Sixty-nine patients had a negative result of FAST examination. Diagnostic peritoneal lavage was performed in 27 patients and only 4 patients (14.29%) had a positive result. Exploratory laparotomy was performed in all patients with positive DPL. Non therapeutic laparotomy occurred in 1 patient (25%).

Conclusion: About 14% of blunt trauma patients presented with hypotension and had a negative result of FAST examination had a hemoperitoneum that can detected by DPL. Seventy five percent of these patients need emergency laparotomy for bleeding control.

Initial Hematocrit as a Predictor for Emergency Operation or Intervention

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Background: Severe trauma is the first cause of death in a developing country. Hemorrhage or hypovolemic shock is the main problem in these patients. It is believed that the initial hematocrit (Hct) cannot accurately predict blood loss. We challenge that belief by investigating the predictive value of an initial Hct.

Methods: The data were a retrospectively collected from a prospective collection regristry that included 131 trauma patients following trauma activated criteria of Songklanagarind Hospital from January 2014 to December 2014. Emergency operation or intervention was defined as procedures needed to improve hemostasis within 4 hours. Categorical data were compared. Logistic regression was used to measure the relationship between dependent and one or more than independent variables.

Results: The study population was 81.7% male. The median age was 33 years. The most frequent mechanism was blunt injury (78%). The initial Hct was not related to an emergency operation. Injury severity score > 26 (p<0.039), respiratory rate > 25(p=0.039) and Age > 46 (p=0.004)were predictors for emergency procedures.

Conclusion: Although initial Hct dose not correlate OR emergency or intervention in first 4 hours but respiratory rate, FAST, INR, age, ISS and mechanism of injury are other factors that relate to an emergency operation in first 4 hours.

Incidence and Management of Occult Hemothorax in Blunt Chest Trauma

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Background: Increasing use of computed thoracic tomography for blunt chest trauma evaluation has led to an increase in the occult hemothorax identification. The natural history of occult hemothorax is still not known. This research aimed to study the characteristics of patients who had progression of occult hemothorax until delayed pleural decompression was performed.

Methods: This is a retrospective review of blunt chest injury patients from a prospective institutional trauma registry. The review included patients who had occult hemothorax defined by a negative CXR with presence of hemothorax in CT chest or abdomen verified by a radiologist. Data collected included demographics, injury sustained and characteristics of the hemothoraces from the CT scans such as thickness of the hemothorax, Hounsfield units (HU) and the treatments of hemothorax were also recorded.

Results: Of the 244 patients who had blunt chest injury, 30 (12.2%) had occult hemothorax during the 1-year study period. The mean injury severity score (ISS) was 16. Delayed hemothorax occurred in 19 patients (63.3%) and pleural decompression was performed in 11 patients (36.6%). Patients with pleural decompression tended to have higher ISS, more associated chest injury and thicker hemothorax.

Conclusions: Occult hemothorax occurs in a significant proportion of blunt chest trauma patients. It is important to be aware of the progressions and pleural decompression maybe considered in multiple and severely injured patients.

E-poster Competition

Effects of 8-Year Treatment of Long-acting Testosterone Undecanoate on Metabolic Parameters, Urinary Symptoms, Bone Mineral Density and Sexual Function in Men with Late Onset Hypogonadism

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Introduction: The long term effects of long acting testosterone undecanoate (TU) and the Androgen receptor (AR) CAG repeat lengths in Thai late onset hypogonadism (LOH) men has not yet been reported.

Objective: This study analyzed the 8-year follow-up effects of intramuscular TU therapy on metabolic parameters, urinary symptoms, bone mineral density (BMD), and sexual functionand investigated the CAG repeat lengths in LOH men.

Methods: We reviewed the medical records of 428 LOH men who had been treated with TU and a total of 5 patients were diagnosed with prostate cancer during TU. There were 120 patients (mean age 65.6 ± 8.9) who had 5 - 8 years continuous TU supplementation and sufficiently completed records for analysis. Genomic DNA was extracted from peripheral blood and the CAG repeat region was amplified by PCR. Fragment analysis, sequencing, electropherogram and chromatogram were performed. The main outcome measure was dynamic parameter changes during testosterone supplementation.

Results: TU did not improve all obesity parameters. A statistically significant decline was found in waist circumference, % body fat, HbA1c, cholesterol, LDL and International Prostate symptom Score ($p < 0.05$). TU did not produce differences in body mass index (BMI), HDL, triglyceride and the Aging Male Symptoms score from the base line. However, a statistically significant increase was demonstrated in the level of testosterone, PSA, hematocrit, International index of erectile function score and both vertebral and femoral BMD ($p < 0.05$). No major adverse cardiovascular events and prostate cancer in this study. The CAG repeat length was between 14 and 28 and the median CAG length was 22. There was no association between the CAG repeat length and any of the anthropometric measurements.

Conclusions: Long-term TU treatment in LOH men for up to 8 years durations appears to be safe, tolerable and effective in improving obesity parameters.

Outcome of Planned Esophagectomy in Clinical Responders Following Chemoradiation in Locally Advanced Squamous Cell Esophageal Cancer

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Background: Due to high operative mortality after chemoradiation treatment (CRT), definitive chemoradiation (dCRT) has been gaining in popularity for treatment of locally advanced squamous cell esophageal cancer. However, incidence of locoregional recurrence was high but number of salvage surgery was low. To date, no test can accurately detect micro residual disease. We consider that watchful waiting until disease is obvious is too late after dCRT. We hypothesized that significant number of clinical complete responders have microscopic residual disease after dCRT which worth undergoing esophagectomy. To our knowledge no study has investigated clinicopathological outcome of planned esophagectomy after dCRT in locally advanced squamous cell esophageal cancer. We conducted this prospective study to test our hypotheses.

Methods: Patients with locally advanced squamous cell esophageal cancer (T3-T4/N0-1/M0) were included. All patients had tranthoracic esophagectomy with 2-field lymphadenectomy 4 months after concurrent 50-60 Gy of radiotherapy with 2 cycles of 5FU and cis-platin. Clinical complete response (cCR) was defined when no dysphagia, negative endoscopy/biosies and unremrkable CT+/-PET 3 months after dCRT.Contraindications for esophagectomy included patients with unresectable, poor performance status/severe co-morbid diseases and declining surgery. Clinicopathological outcome was examined.

Results: Of 70 dCRT, 51 clinical complete responders (cCRs) underwent esophagectomy with 2-field lymphadenectomy. Operative mortality was 1.9%. R-0 resection was 89%. Incidence of pathological complete response (pCR) was 45% and 55% had microscopic residual tumor. Five-year survival was 31.5% (50% for pCR and 20% for non-pCR, p=0.04). Locoregional recurrence was identified in 24% of cCRs with esophageal resection. Endoscopic findings, CT or PET-CT can not accurately detect pCR or microscopic residual disease.

Discussion: More than 50% of advanced squamous cell esophageal cancer with clinical complete response after dCRT had microscopic residual disease. Planned esophagectomy after dCRT was safe. Resection and R-0 rate was high. Operative mortality and locoregional recurrence was low. Five year survival was more than 30%. Until an accurate marker for residual disease detection is established, planned esophagectomy, rather than salvage surgery should be an optional treatment in fit patients after dCRT for locally advanced squamous cell esophageal cancer.

Congenital Pyloric Atresia : A Rare Congenital Anomaly

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Introduction: Congenital pyloric atresia (CPA) is a very rare congenital anomaly of the pylorus that was first described by Calder in 1979***. CPA is presented less than 1% of gastrointestinal atresias with the incidence of 1:100,000 live births***. It is classified into 3 anatomical types; pyloric web or diaphragm, segmental atresia or solid cord and pyloric atresia with atretic gap***. CPA may occur as an isolated lesion or in association with other congenital or hereditary anomalies. It has frequently been reported with epidermolysis bullosa***. However, commonly CPA only presents with abdominal distension and non-bilious vomiting. This is our experience with 3 cases within 4 years of this very rare congenital anomaly, focusing on the diagnosis, associated anomalies and the management.

Case 1: A 4-day-old female baby born term at 39 weeks of gestation with the birth weight of 2,900g, was transferred to us with the history of non-bilious vomiting. Feeding was initiated on day2 of life and since then she has been vomiting after every feed. Physical examination revealed slight epigastric distension but the abdomen was soft without tenderness. Plain abdominal film showed a large gastric dilatation with decreased distal bowel gas. Upper gastrointestinal study(UGIS) showed gastric dilatation and a long narrowed pyloric canal. Preoperative diagnosis was gastric outlet obstruction, suspected hypertrophic pyloric stenosis. On laparotomy, the stomach was distended down to the pylorus and the bowel distally was collapsed. A nasogastric tube was pushed down to identify the obstruction site, resistance was found at the pylorus. A longitudinal incision was made through the pylorus and a pyloric web was found. The web was excised and Heineke-Mikulicz pyloroplasty was performed. Histopathology of the web confirmed gastric tissue including the mucosa and submucosal layer. Feeding was initiated on postoperative day 5. The baby was discharged uneventfully on day14. A follow-up UGIS 3 months later, showed a normal passage of the stomach.

Case 2: A 2-day-old female baby born prematurely at 35 weeks of gestation

with the birth weight of 2,040g, was transferred to us with a prenatal diagnosis of duodenal atresia. The prenatal ultrasonography found gastric dilatation with maternal polyhydramnios. Physical examination revealed epigastric distension. Plain abdominal film (figure6) showed dilatation of the stomach and what thought to be the duodenal bulb. Preoperative diagnosis was duodenal atresia with the obstructed site at the first part of the duodenum. On laparotomy, pyloric atresia with a short cord was found therefore gastroduodenostomy with end to side anastomosis was performed.Feeding was initiated on postoperative day 10 and the baby was discharged uneventfully on day15.

Case 3: A 10-day-old female baby born prematurely at 33 weeks of gestation with the birth weight of 1,900g, was transferred to us with multiple clear blisters on the trunk and extremities, abdominal distension and history of respiratory distress syndrome. Feeding intolerance and abdominal distension started on day 4 of life. Physical examination revealed epigastric distension but the abdomen was soft without tenderness. Plain abdominal film (figure7) showed a single bubble appearance without distal bowel gas. Preoperative diagnosis was pyloric atresia. On laparotomy, pyloric atresia with an 1.5cm in length of solid cord was found. Pyloric resection and end to end gastroduodenostomy (BillrothI) was performed. Feeding was initiated on postoperative day 7 and the baby was discharged uneventfully on day17. She also has been confirmed with the diagnosis of epidermolysis bullosa.

Conclusion: CPA is a rare congenital anomaly. However our experience of 3 cases within a 4 year period demonstrates that it is not that rare. CPA should be a differential diagnosis of any newborn with gastic outlet obstruction especially in the association of epidermolysis bullosa. The diagnosis is done by plain abdominal film with the finding of single bubble appearance without distal bowel gas. CPA can be prenatally diagnose with the findings of gastric dilatation without distal bowel gas. Surgical management is mandatory and can be done safely. For pyloric web, excision of the web and Heineke-Mikulicz pyloroplasty should be done. For other types of CPA, resection of the pylorus and gastroduodenostomy should be done. Gastrojejunostomy should be avoid due to high morbidity in children.

Effect of Endoscopic Linear Stapler Technology in Sleeve Gastrectomy Specimens

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Background: Sleeve gastrectomy is the one of standard bariatric procedure. The stapler line leakage after sleeve gastrectomy are important cause of morbidity and mortality. Technical stapling failure associated with increased risk of leakage. The precision and appropriated B-shape staple formation are essential for safe anastomosis.

Objectives: Aim to evaluate the effect of Gripping Surface Technology endoscopic linear stapler compare with powered endoscopic linear stapler.

Methods: The body and fundus portion of sleeve gastrectomy specimens were divided with each type of endoscopic linear staple side by side. For identify each part of stomach, every specimen was located by intracoporeal stitch mark during the operation. The study was start immediately in operating room after specimens retrieved. Use the Echelon Flex Powered Plus stapler and 60 mm. blue cartridge Gripping Surface Technology (GST) reload compare with Echelon Flex Powered stapler and 60 mm. blue cartridge non-GST reload. Measure tissue slippage distance after firing endostapler and evaluate the B-shape staple formation of each firing.

Results: Total stapler firing with 24 blue cartridges (12 GST and 12 non-GST) in 3 sleeve gastrectomy specimens. All stapler line is in optimal shape formation. There was no difference in the optimal staple formation between each type of the staple line. Significant less mean tissue movement after firing of GST endostapler is 0.38 mm. versus 1.0 mm. of non-GST powered endostapler ($p = 0.04$).

Conclusions: Gripping Surface Technology endoscopic linear stapler decrease tissue slippage of sleeve gastrectomy specimens with optimal B-shape formation. It seems to reduce the stapler reload usage in sleeve gastrectomy procedure due to less tissue slippage, need the further large number in randomized controlled trial.

E-poster (non Competition)

At Registration Hall

Chylothorax After Blunt Chest Trauma: A Case Report

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Traumatic chylothorax after blunt chest trauma alone is considered rare and still has many hypothesis of mechanism of injuries. Mainly describing from hyperextension of spine, it cause thoracic duct stretching and result in duct injury. Our patient was a 27-year-old female who sustained in motorcycle crash and had a multiple injuries, blunt-only thoracic injuries and had traumatic thoracic aortic and left vertebral artery injuries with T2 vertebrae subluxation. She was underwent TEVER without any thoracic or spine surgery. On post operation day 7 her chest drain content was milky-white like fluid with confirmation of chyle leak. The patient underwent conservative treatment with NPO and IV nutrition for 2 weeks. After that the lymphatic scan was performed and showed no thoracic duct injury. The patient was safely chest drain remove and recovered. Though it's found to be rare it can be managed safely with conservative treatment.

Phlegmasiaceruleadolens with Compartment Syndrome

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Venous thromboembolism (VTE) is a major health care problem resulting in significant mortality, morbidity, and expenditure of resources. The incidence of VTE is approximately 100 per 100,000 people per year in the general population. The VTE compounds with pulmonary embolism and deep vein thrombosis (DVT). The complication of DVT has many conditions.The extensive DVT of the major axial deep venous channels of the lower extremity causes a condition called phlegmasia cerulea dolens which is a complication of DVT. Phlegmasiaceruleadolens (PCD) is an uncommon but potentially life-threatening complication of acute DVT characterized by marked swelling of the extremity with pain and cyanosis, which in turn may lead to arterial ischemia and ultimately gangrene with high amputation and mortality rates. There is no consensus for treatment and treatment methods reported are usually suboptimal. The key in treating such patients is to provide quick and effective treatment to save the limb and the patient.Besides, this case report is very rare condition because this patient had phlegmasiacerulaedolens with compartment syndrome whichhad been reported only 15 cases. Timely restoration of the venous circulation is important in order to save limbs. We would like to present a patient who developed lower extremity DVT secondary to femoral vein compression syndrome, progressed rapidly to PCD.

Laparoscopic Assisted Excision of Choledochal Cyst and Roux-en-Y Hepaticojejunostomy : Preliminary Report of 3 Cases

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Background: The first laparoscopic choledochal cyst excision performed in a child was reported in 1995 by Farello and colleagues and eventually has increasingly gained acceptance as an alternative to open excision in children.

Objective: To report the preliminary results of laparoscopic assisted excision of CDC and Roux-en-Y hepaticojejunostomy in children performed in QSNICH.

Patients: The patients' age were 3mo,2.6 yr and 2.8 yr. The weight were 5.1,11 and 18 kgs. ,respectively.

There were all type I ,according to Todani's classification

In these three cases, one presented with jaundice and the other two with the abdominal pain.

Operative technique:

- A 5 mm port was introduced through the umbilicus for the telescope.
- Three additional 5 mm ports are then used for the working instruments.
- Carbon dioxide pneumoperitoneum was maintained at a pressure for 8-12 mmHg.
- Endotracheal intubation general anesthesia was standard without epidural analgesia.
- Intraoperative cholangiography via the gallbladder were performed in all cases.
- The duodenum was retracted downward using a fan retractor through the left upper port.
- The cyst was dissected, begin at the mid portion and then opened.
- The cyst wall was then dissected from the portal vein and hepatic artery while viewing the cyst from inside and outside.

- The cephalad portion of the cyst was excised after identifying the orifice of the right and left hepatic ducts, leaving a stump approximately 5mm from the bifurcation of the hepatic ducts.

- The distal portion was dissected from the pancreatic tissue and then was divided and sutured with 4/0 vicryl.

- Calculi within the cyst were removed and washed out.

- The jejunum was exteriorized, and the jejunojejunostomy was performed extracorporeally.

- The Roux limb was passed through a window in the transverse mesocolon to the porta hepatis.

- The hepaticojejunostomy was performed by interrupted sutures of 4/0 vicryl.

- The gallbladder and the cyst were removed through the umbilicus.

- The operative field was washed with warm saline and a subhepatic closed suction drain was left.

Results: The average operative time was 8 hours .There was no operative complication and no conversion. The blood loss was minimal. The average hospital stay was 8 days. The follow up time ranged from 2 month to 3.2 years. No complication was detected at the follow -up visits.

Conclusion: Laparoscopic excision of choledochal cyst and Roux-en-Y hepaticojejunostomy in children,even in neonate,is both feasible and safe. The disadvantage,as on the learning curve,was the longer operative times but no adverse outcomes were observed.

DVD Contest

A Case Series in Thailand : Bilateral Transareolar Endoscopic Sistrunk Operation for the Treatment of Thyroglossal Duct Cyst

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Aims: The standard treatment of thyroglossal duct cyst is Sistrunk operation. Nevertheless, the advanced of endoscopic surgery technology have supported an opportunity for patients to undergo minimally invasive surgery. After we developed a novel endoscopic Sistrunk operation to selectively access the neck space using the bilateral transareolar (BT) approach which is feasible, safe, and gives good cosmetic results. We continued to operate more transareolar endoscopic sistrunk operation cases.

Methods: Three cases of thyroglossal duct cyst in female patients aged 45, 15, and 18 years old were selected. Endoscopic Sistrunk operations were performed on the patients by the bilateral transareolar approach; using bipolar energy device, hook scissors, and metallic clips to carry out the surgical procedures in concordance with the conventional Sistrunk operation.

Results: A complete thyroglossal duct cyst and hyoid bone resection was performed in the patients. The total operative time was 180, 140, and 150 minuteswith estimated blood loss of 20, 10, and 10 mL, respectively. There was no any complications occurred during the operation or afterward in the cases. Minimal operative scars by BT endoscopic method on the areola were observed.

Conclusions: The BT endoscopic sistrunk operation was impressively simple to perform. Access and feasibility of BT endoscopic Sistrunk operation could be shown. This technique can be an alternative choice for patients who prefer endoscopic surgery with a satisfied cosmetic result.

Laparoscopic Endoscopic Cooperative Surgery for Gastric Gist Resection: Our Technique and Experience in Vajira Hospital

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Background: Laparoscopic endoscopic cooperative surgery (LECS) for gastric GIST was firstly reported by N. Hiki et al in 2008. This technique is applied for submucosal tumor resection which lesions are closed to important structure e.g. EG junction or pylorus. Here we present our technique to perform LECS for gastric GIST resection.

Aims: To report our early experience of laparoscopic endoscopic cooperative surgery.

Methods: History and operative record of patients who underwent LECS at Vajira hospital from August 2014 to March 2016 were reviewed. The pictures were captured from operative video.

Result: There were 3 patients who underwent LECS, 1 tumor located nearesophagogastric junction, 1 tumor was near pylorus and 1 tumor was at the lesser curvature.There was no conversion. All patients were underwent complete R0 resection and there was no complication. Here we present details of our procedure.

Conclusions: LECS technique is feasible treatment option for gastric GIST. In addition this technique is applied to the tumor vicinity to EGJ and pylorus and can preserve function of these structures.

Laparoscopic Pancreaticoduodenectomy

Amarit Tansawet, Wisit Kasetsermwiriya, Thada Yongpradit, Issaree Laopiumthong, Suphakarn Techapongsatorn.

Vajira Minimally Invasive Surgical Unit (VMISU)

Background: Open pancreaticoduodenectomy (Whipple's operation) has been the standard treatment for periampullary cancer since 1930. However, in the era of minimally invasive surgery, this complex procedure can be performed with less invasive technique and still achieve impressive results.

Purpose: To demonstrate our laparoscopic pancreaticoduodenectomy technique

Methods: Our first laparoscopic pancreaticoduodenectomy was performed in a Thai 76-year-old female patient, who suffered from ampullary cancer. The procedure followed the same steps as the open counterpart, which included 1) infra-pyloric dissection and gastroduodenal artery transection 2) transection at the neck of pancreas 3) hepatoduodenal ligament dissection and common bile duct transection 4) transection of the antrum 5) Kocherization, mobilization and transection at the duodenojejunal junction 6) mobilization of the uncinate process 7) duct to mucosa pancreaticojejunostomy 8) choledochojejunostomy and 9) gastrojejunostomy. All steps were performed laparoscopically. A specimen was retrieved via a mini-laparotomy incision. Closed-suction drains were placed in the surgical area.

Results: Our patient recovered uneventfully. Near normal ambulation can be achieved on post-operative day 3. She was discharged from our hospital safely on day 10 after operation.

Conclusion: In high-volume minimally invasive surgical center, good results can be achieved from laparoscopic pancreaticoduodenectomy. Good patient selection and complete pre-operative evaluation are also the key factors for success.

Laparoscopic Spleen-preserving Distal Pancreatectomy with Conservation of Splenic Artery and Vein

Hathaiwan Moungthard

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Background: Spleen-preserving distal pancreatectomy with conservation of splenic artery and vein is considered as safe and practical for treatment of benign or low-grade malignant tumors in the body and tail of the pancreas.Splenic loss causes either changes in the peripheral blood count, infection or sepsis Some authors have also stressed the potential immunosuppression related to splenectomy. Two major spleen-preserving procedure have been presented by Kimura and Warshaw procedure. Among the concern of the Warshaw technique adversed related outcome was splenic infarction. We would like to demonstrate Kimura procedurewhich preserve the spleen with splenic vessels.

Objective: To present our preoperative evaluation and surgical technique.

Material and Method: 53-year-old female patient came to our hospital with abdominal painfor 2 weeks.MRI showed 2- cm hypervascular nodule in pancreatic body. Also the contrast enhancement doppler endoscopic ultrasound was reviewed hypervascular enhancement lesion. The surgical procedures included:1) the gastrocolic and gastrosplenic ligament dissection; 2) inferior edge of the pancreas dissection to expose the splenic vein; 3) superior edge of the pancreas dissection to expose the splenic artery; 4) dividing the pancreas ; 5) resecting the pancreatic body and tail and 6) removing the specimen.

Result: Patient underwent with successful operation and minimal blood loss. She started her diet postoperative day 2. Postoperative hospital stay was 7 days. The hospital course was uneventful.

Conclusion: Laparoscopic spleen-preserving distal pancreatectomy with conservation of splenic artery and vein is feasible and safe procedure.

Laparoscopic Sigmoidectomy with Transanal Specimen Extraction: Step by Step

Narong Boonyagard, Prapawan Teerasart, Punthita Aimsupanimitr, Panya Thaweepworadech, Ittiphol Viratanapanu, Dome Charoenthong, Supakit Chartchaiyarerk, Somkiat Ussavarojpong, Chaiyaporn Suwitchakul

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Traditional laparoscopic colectomy for colorectal cancer requires a mini-laparotomy for specimen extraction. This increases a postoperative wound complication including pain, incisional hernia, and wound infection. To decrease the incidence of wound complications,Natural Orifice Specimen Extraction (NOSE) wasdeveloped to avoid additional incisions through the abdominal wall.

However, Published experience remains limited. Early data suggest equivalent oncologic and safety profiles to traditional laparoscopic colectomy. Recently, reports have shown that NOSE has the lower postoperative pain and fewer wound complication. However, the detail of these techniques is still evolving

In this VDO, we describe a technique for laparoscopic sigmoidectomy of malignant polyp in a 67-year-old female followed by transanal specimen extractionin Bangkok Metropolitan Administration (BMA) General Hospital Bangkok, Thailand. This video demonstrates a technique for operative field setup, port placement, and step of operation.

Laparoscopic Transhiatal Approach in the Treatment of Epiphrenic Esophageal Diverticulum: Step by Step

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Epiphrenic esophageal diverticulum is a relatively rare disorder of the esophagus.This diverticulum is defined as mucosa and submucosa herniation through the muscular layers of the esophageal wallat the lower third of the esophagus. This disease is usually associated with underlying motility disorder of esophagus. The primary symptoms are dysphagia and regurgitation in the majority of patients. Symptomatic patients required surgical intervention. Standard treatment of the epiphrenic diverticulum includes diverticulectomy, esophageal myotomy, and fundoplication.

In this VDO, we describe a technique for laparoscopic diverticulectomy, hellermyotomy, and Dor fundoplication ofMultipleepiphrenic diverticulum in a 64-year-oldmalein King Chulalongkorn Memorial Hospital (KCMH) Bangkok, Thailand. This video demonstrates a technique for operative field setup, port placement, and step of operation.

Laparoscopic Low Anterior Resection with Total Mesorectal Excision: The Beginner's Steps to Avoid Complications

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Introduction: Rectal carcinoma is one of the most common cancer and cause of death nowadays. Surgical resection is the principal curative treatment from early to advance stage with or without adjunctive chemo-radiation therapy. Currently, total mesorectal excision becomes a standard technique worldwide since proved for significant increase survivals. Laparoscopic low anterior resection with total mesorectal excision is one of the most challenging procedures for colorectal surgeons. With benefits of oncologic outcome and minimally invasive surgery, this procedure is considered as an excellent option for both benign and malignant disease. Complication regarding the surgical error can lead to severe complications such as anastomosis leakage, nerve injury, ureteric injury or low anterior syndrome.

Results: This report and video present the standardized techniques in steps by steps to help the beginners to perform this complicated laparoscopic operation and show how to avoid many pitfalls along the way.

Laparoscopic Transhiatal Approach in the Treatment of Lower Thoracic Esophageal Leiomyoma

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Esophageal Leiomyoma are rare. The incidence varies from 0.005 to 5.1%. Leiomyomas arise from smooth muscle cells. and are generally solitary, well encapsulated submucosal tumors, mainly located at the middle or lower third part of the esophagus. More than half the patients are asymptomatic. Indication for surgical resection are unremitting symptoms, Increase in tumor size, Atypical finding and to obtain histopathologic diagnosis. The technique for surgical removal of Leiomyoma is enucleation. There are a variety of surgical approaches. The appropriate approach is depend on tumor size,tumor location and patient condition. For tumor of the lower one-third intrathoracic esophageal leiomyoma, Left thoracotomy or thoracoscopy are appropriate surgical approaches.

In this case,we performed laparoscopic enucleatoin for lower esophageal leiomyoma via transhiatal approach. In this VDO, we describe a technique for laparoscopic enucleation in a 38-year-old female in King Chulalongkorn Memorial Hospital (KCMH) Bangkok, Thailand. This video demonstrates a technique for operative field setup, port placement and step of operatio

Laparobotic Duodenal Diverticulectomy: A Case Series and Operative Technique

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Duodenal diverticulum was first reported by Chomel in 1710. The true incidence of duodenal diverticula is unknown. However, published literature quote incidences ranging from 0.16% to 22%, depending on the diagnostic method.

Most of duodenal diverticula are asymptomatic; only 5% of patients experience symptoms resulting from complication. Surgical treatment is recommended for symptomatic or complicating diverticulum.

Several reports have described a laparoscopic approach for duodenal diverticula, with either diverticulectomy or an inversion procedure. However, because of the deep-seated and posterior location of the lesion and inherent disadvantages of laparoscopic approach that includes 2-D image, counter intuitive movement, and limited degree of freedom of movement of the instruments, these procedures can be frustrating and difficult. The advent of the daVinci Robotic Surgical System with a stable work platform, a magnified 3-dimensional image, and articulated instruments has provided an alternative MIS approach that allows more complex procedures to be performed with efficiency and safety.

We present the operative technique and surgical steps of laparobotic duodenal diverticulectomy.

Adult to Adult Living Donor Liver Transplantation with Modified Right Lobe Graft; Chiang Mai Experience

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Adult to adult living donor liver transplantation(ALDLT) is a very complex operation regards to preoperative planing, cutting edge surgical techniques and postoperative management. The recipient is 54 years old man who has had chronic hepatitis B cirrhosis with multiple hepatocellular carcinoma. His 49 years old spouse is the donor who had 667 ml3 of right lobe which was calculated to 1.06 of graft to body weight ratio of the recipient. The operation was started with cholangiogram through cystic duct to determine the the bile duct anatomy. Subsequently, Right hepatic artery and right portal vein was temporary occluded for demonstrating the demarcated line between right and left lobe of liver. Parenchymal transection was performed with the cavitron ultrasonic aspiration (CUSA) device along right side of the middle hepatic vein.The V5 and V8 branches of middle hepatic vein were well preserved at the graft side for back table process. Inferior mesenteric vein from the donor and left portal vein from explant specimen were used as the conduit for V5 and V8 reconstruction. The modified right lobe liver graft was implanted by piggy back technique. Right portal vein was anastomosed to main portal vein with the 1cm of a growth factor. Right hepatic artery was anastomosed to right hepatic artery under operative microscope and Right intrahepatic bile duct was anastomosed to common hepatic duct. The warm and cold ischemic time was 56 minutes and 2 hour 40 minutes respectively. The operative time was 9 hours 30 minute with 3 unit of pack red cell transfusion. The recipient was discharged on day 14 without any complication. He recoved well and showed no signs of recurrence disease 1 year after transplant.

Epiphrenic Diverticulectomy with Long Myotomy and Dor Fundoplication in Recurrent Dysphagia

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Epiphrenic diverticula are a rare disease, it is a pseudodiverticulum of pulsion type located in the distal 10 cm of the esophagus and frequently associated to achalasia. The symptoms and the pathophysiology of achalasia and EED may overlap, leading to the speculation that achalasia may be responsible for the symptoms. Similarly to patients with achalasia without EED, a careful preoperative evaluation is essential in patients with EED. Endoscopy and an esophagram are mandatory in the workup of these patients, while esophageal manometry confirms the associated motility disorder. Treatment is indicated in all patients fit for an operation except those who are asymptomatic with a small EED and no prior history of aspiration. Laparoscopic Heller's myotomy and partial fundoplication is the most adequate therapy. Diverticulectomy must be added to the procedure in large diverticula. Experience with endoscopic therapy is very limited.

This video shows the case of a 72-year-old woman with a 20-years of recurrent dysphagia and 10-kg weight loss caused by an epiphrenic diverticulum associated with esophageal achalasia. She underwent multiple sessions of botulinum toxin injection and balloon dilation.A preoperative barium swallow showed a dilated esophagus with a 6-cm epiphrenic diverticulum. Esophageal manometry confirmed the absence of peristalsis in the esophageal body. We performed a laparoscopic diverticulectomy and a 10-cm distal esophageal myotomy with a Dor fundoplication. The postoperative course was uneventful. On the third postoperative day a barium swallow showed no leak, and the patient started oral intake. She was discharged home 4 days after the operation free of symptoms and tolerating a soft diet. Twelve months after surgery, she was asymptomatic and had gained 8 kg. A barium swallow showed a normal-size esophagus with regular emptying.

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