CRITICAL SURGICAL ABDOMEN CONSENSUS CONFERENCE

Friday & Saturday, July 22nd - 23rd 2016

POST CONFERENCE SUMMIT

Monday 25th -Tuesday 26th Donegal

WSES

WSACS The Abdominal Compartment Society

DUBLIN IRELAND

www.wses.org.uk/congresses

WELCOME

It is our pleasure to welcome you and delegates from over 40 countries to Ireland to the exciting Critical Surgical Abdominal Consensus Conference. The World Society of Emergency Surgery is keen to ensure that your patients have better outcomes. Working together with the Abdominal Compartment Society and Donegal Clinical Research Academy the WSES will forge new treatment options and gain consensus on current optimal care.

The program will bring together those at the cutting edge of surgery and critical care to provide leading opinions and techniques on managing the critical abdomen. These opinions combined with the latest literature and scientific evidence will lead to consensus guidelines being produced. The organising committee, mainly WSES with some support from WSACS, welcome Acelity's major educational support on Friday 22nd and our other major sponsor for the rest of the conference.

The venue will be in the historic buildings of the Royal College of Surgeons in Ireland right in the heart of the Dublin's vibrant city centre. Please take the opportunity to attend the wonderful social program.

Fridays meeting will deal the evolution of the open abdomen, embracing new techniques in maintaining the abdominal domain, dealing with difficulty conditions particularly Pancreatitis and Tertiary Peritonitis. Experts will share their knowledge in how to obtain closure. Finally there will be a fistulae workshop to help deal with that difficult area.

We invite you to consider staying for Saturday's Intra-abdominal Infection Consensus Conference. There will also be two further exciting days next week in beautiful Donegal incorporating the development of key strategies for optimal care in Emergency Surgery. This will be followed o Tuesday with the popular Emergency Abdominal Surgery Course.

Organising Committee

Luca Ansaloni Fausto Catena Federico Coccolini Andy Kirkpatrick Massimo Sartelli Michael Sugrue

International Panel

Fikri Abu-Zidan (Arab Emirates)
Mark Bowyer (USA)
Federico Coccolini (Italy)
Salomone Di Saverio (Italy)
Ewen Griffith (UK)
Andrew K Kirkpatrick (Canada)
Ron Maier (USA)
Rita Melotti (Italy)
Ionut Negoi (Ireland)
Bruno Pereira (Brazil)
Massimo Sartelli (Italy)
Jean-Louis Vincent (Belgium)
Vanni Agnoletti (Italy)
Walter Biffl (USA)
Marc De Moya (USA)
Gustavo Fraga (Brazil)
Sam Huddart (UK)
Yoram Kluger (Israel)
Mark Malangoni (USA)
Dominique Monnet (France)
Mihai Paduri (Spain)
Amal Priyantha (Sri Lanka)
Kjetil Soreide (Norway)
George Velmahos (USA)
Luca Ansaloni (Italy)
Fausto Catena (Italy)
Cristian Eckmann (Germany)
Maddalena Giannella (Italy)
Jeff Kashuk (Israel)
Ari Leppäniemi (Finland)
Addison May (USA)
Philippe Montravers (France)
Federico Pea (Italy)
Sandy Rizoli (Brazil)
Michael Sugrue (Ireland)
Pierluigi Viale (Italy)
Marja Boermeester (Netherlands)
Osvaldo Chiara (Italy)
Jan De Waele (Belgium)
Giovanni Gordini (Italy)
Vladimir Khokha (Belarus)
Paula Loughlin (NI)
John Mazuski (USA)
Ernest E Moore (USA)
Andrew Peitzman (USA)
Boris Sakakushev (Bulgaria)
Jan Ulrych (Czech Republic)

WSES www.wses.org.uk

WSACS The Abdominal Compartment Society www.wsacs.org

RCSI www.rcsi.ie

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Prof. Fikri Abu-Zidan

Professor Fikri Abu-Zidan is a Consultant Surgeon (Acute Care Surgery and Disaster Medicine) who graduated (MD) from Aleppo University (Syria) in 1981 and was awarded the FRCS, Glasgow, Scotland in 1987. He achieved his PhD in Trauma and Disaster Medicine from Linkoping University (Sweden) in 1995 and obtained his Postgraduate Diploma of Applied Statistics from Massey University (New Zealand) (1999). He worked as a surgeon at Mubarak Al-Kabeer Teaching Hospital in Kuwait (1983—93), as a Trauma Research Fellow at Linkoping University, Sweden (1993-95), as a Senior Research Fellow at Auckland University (N.Z) (1996—2001), as a Trauma Fellow at Royal Perth Hospital, Perth, Australia (2001), and finally as a Professor at the Department of Surgery, College of Medicine and Health Sciences at UAE University (2001-till now). He has contributed to more than 280 publications in refereed international journals. More than 370 presentations and invited lectures have been presented at national and international meetings. He is serving as the Statistical Consultant of World Society of Emergency Surgery, World Journal of Emergency Surgery, Statistics Editor of Hamdan Medical Journal, and as an Invited Editor, member of Editorial board, and reviewer for several international journals. His clinical experience included treating war injured patients during the Second Gulf War (1990).

Mr. Paul Balfe

Graduate of Trinity College Medical School Dublin
Post-Grad Qualifications: Trinity College Dublin, Royal College of Surgeons in Ireland
Currently Consultant General and Gastrointestinal Surgeon, St. Luke's Hospital, Kilkenny Ireland

Dr. Cino Bendinelli

Dr Cino Bendinelli is an Italian graduate General Surgeon who specialises in Trauma surgery and Endocrine surgery. He gained extensive trauma surgical experience in war zones such as Afghanistan, Sierra Leone and Cambodia before settling in Australia in 2007. He was Trauma Fellow at Liverpool Hospital and then appointed Deputy Director of Trauma at John Hunter Hospital in 2008. Dr Bendinelli has a particular interest in traumatic brain injury and chest trauma and has published extensively in leading international scientific journals and book chapters. He has also published on Endocrine Surgery and was Endocrine Research Fellow at Brown University, USA.

Dr. Walter Biffl

Dr. Biffl earned his Bachelor of Science degree from Duke University, and Medical Degree from the George Washington University. He performed his surgical training at the University of Colorado Health Sciences Center, including a two-year NIH-sponsored Trauma Research Fellowship. Upon completion of residency he accepted a faculty position at Denver Health Medical Center with the University of Colorado. In 2002 he moved to Providence, RI, where he spent five years as Chief of the Division of Trauma and Surgical Critical Care at Brown Medical School. He returned to Denver Health in 2007 where he served as Associate Director of Surgery and Assistant Director of Patient Safety and Quality. He moved to Hawaii in November 2015 to serve as Medical Director of Acute Care Surgery at The Queen's Medical Center, and Professor and Associate Chair for Research in the Department of Surgery at the John A Burns School of Medicine of the University of Hawaii.

Prof. Marja Boermeester

Marja Boermeester is professor of surgery and a clinical epidemiologist at the Academic Medical Center (AMC) in Amsterdam, and principal investigator of many multicentre trials on diagnostics and treatment of abdominal infections (e.g. RELAP, OPTIMA, ESCAPE, OPTIMAP, DIABOLO). She received many grants (e.g. 10 national Health Care & Efficacy Research Grants) and trials were published in international high-ranked publications (NEJM, JAMA, Radiology, BMJ). Her core business in GI / HPB surgery is surgery of abdominal infections and intestinal failure surgery. She runs a successful Intestinal Failure Team in the AMC Amsterdam, with referrals from all over the country. She is member of the Academic Medical Center Research Council and Principal Investigator at the AMC, member of the writing committee of the Dutch Pancreatitis Study Group (DPSG), Principal Investigator of the DPSG section Chronic Pancreatitis, and member of several guideline committees (Antibiotics in Sepsis, Acute Diverticulitis, Peri-operative Patient Safety, and Diagnostics of Acute Abdominal Pain). Also national coordinator Pancreas Pearl at the String of Pearls Initiative (PSI); Councilor-at-large of the Surgical Infection Society Europe (SIS-E); member of the WHO Steering Committee on Global Guidelines for Surgical Site Infections. She has founded the SURgical Patient Safety System (SURPASS) checklist.

Prof. Mark Bowyer

Retiring after 22 years of active duty military service as a Trauma and Combat Surgeon, Dr. Bowyer remains the Chief of Trauma and Combat Surgery at the Uniformed Services University of the Health Sciences (the military medical school) in Bethesda, MD. In this role, he is responsible for the training of current and future military doctors learning to care for those in harms way. As a faculty member of Advanced Trauma Life Support, Definitive Surgical Trauma Care, Definitive Surgical Trauma Skills, Emergency War Surgery, Advanced Trauma Operative Management, and Advanced Surgical Skills for Exposures in Trauma (ASSET), Dr. Bowyer is an international force in trauma education. As one of the principle architects of the ASSET course he has shepherded it's promulgation to over 100 course sites over the last 6 years. His active practice of trauma surgery at the Washington Hospital Center in Washington DC, one of the busiest trauma centers in the United States, and experiences as "Trauma Czar" in Iraq, provide him with credible real life experiences that he enthusiastically brings to the classroom.

Dr. Fausto Catena

From 2000- 2011 Consultant General Surgeon at the Dept. of General, Emergency and Transplant Surgery with particular interest in emergency- trauma surgery, colorectal surgery, oncologic surgery, hernia surgery, kidney transplantation, sarcoma and carcinomatosis (HIPEC) and mininvasive surgery of the St Orsola- Malpighi University Hospital Bologna Italy. From 2012 Chief Department of Emergency and General Surgery Parma University Hospital ITALY. He wrote more than 600 scientific papers, (more than 200 on pubmed, H index = 32)) 22 book chapters and 5 Books (one Emergency Surgery Manual and 2 volumes Trauma Book Springer ed). Dr Catena won 19 national and international scientific prizes. He performed thousands medium-high level surgical procedures. (ICD 9 CM codified). He is Editor in Chief of the World Journal of Emergency Surgery (IMPACT FACTOR 1,47), Former Editor of European Surgical Research, Editor Open Cardiovascular and Thoracic Surgery Journal, Editor World Journal of Gastroenterology, Editor of the Turkish Journal of Trauma and Emergency Surgery, Editor Journal of Tumor, Editor Global

SPEAKER PROFILES

Journal of Surgery, Editor African Journal of Emergency Medicine, Editor di Transplantation Technologies and Research, Editor of Journal of Solid Tumors, Editor of Journal of Acute Disease, Editor Emergency Care Journal, Editor Edorium Journal of Transplantation , Editor BioMed Research International, Editor Turkish Journal of Surgery, Editor Journal of Infectious and Non Infectious Diseases, Editor Austin Journal of Infectious Diseases and Member of the Committee on Publication Ethics. Dr Catena was invited speaker in about 150 national and international Congress and chairman in about 70 national and international Congress; he was also teacher in about 70 Postgraduate Courses. He organized about 50 national-international Congress and Postgraduate Courses. He was contract Professor of the School of Specialization in General Surgery of Bologna University and Surgical Instructor for Residents in General Surgery. He was contract Professor in Emergency Surgery of the School of Specialization in Orthopedics of Bologna University. He performed 8 Surgical Stages in Foreign Countries. He is member of about 20 National and International Scientific Societies, Past President of the Italian Society of Young Surgeons, General Secretary of the World Society of Emergency Surgery, Member of the Executive Committee of the Italian Society of Surgical Physiopathology, Member of the Executive Committee of the Italian Society of Geriatric Surgery, past Member of the Executive Committee of the Italian Society of Digestive Pathology and Past President of ESYS- European College of Surgeons- Italian Chapter. From 2012 he is Fellow of Royal College of Surgeons UK. In 2013 he had the italian national certification as full professor of general surgery. Research activity is focused on emergency surgery (acute cholecystitis, adhesions, intrabdominal infections, trauma),renal transplantation (graft preservation), oncologic surgery (GIST and carcinomatosis- HIPEC), colorectal surgery (elective and emergency colorectal cancer, diverticular disease) and abdominal wall surgery (biological prostheses). Dr Catena is world opinion leader in emergency surgery: he wrote more than 10 guidelines- position papers in this scientific area.

Prof. Osvaldo Chiara

Graduated in Medicine at the State University of Milano, on july, 1978. Residency in General Surgery (five years) at the State University of Milano (1983). Residency in Thoracic and Cardiovascular Surgery (five years) at the State University of Siena (1989).

Hospital Career

From 1992 to 2002 dr Chiara has been Attending Surgeon at the Emergency Department of the University Hospital of Milano (IRCCS Ospedale Maggiore di Milano) and from 1996 Chief of Surgical Intermediate Intensive Care at the same Department. From January 2005 to September 2010 he has been Chief of Trauma Team at the Emergency Department of the Ospedale Niguarda Ca' Granda in Milano. From 2010 he is director of Trauma and Emergency Surgery at the Emergency Department of the Ospedale Niguarda Ca'Granda in Milano.

Academic Position

Since the academic year 1986/1987 dr Chiara is Professor of Surgery at the Postgraduate School of General Surgery of the State University of Milano with the teaching of Emergency and Trauma Surgery.

Dr. Federico Coccolini

SPECIALIST IN GENERAL and EMERGENCY SURGERY, with final grade of 70/70 cum laude, University of Milan Medical School, Milan, Italy. November 2011 — until now: permanent appointment as Medical Officer, Consultant Surgeon at the Unit of General and Emergency Surgery, at the Department of Emergency, General and Trasplant Surgery of the "Papa Giovanni XXIII" Hospital (former "Ospedali Riuniti" Hospital) of Bergamo (Italy). Particular interests: emergency surgery, trauma surgery, day-case surgery, advanced oncolgy, oncologic gastrointestinal surgery, laparoscopic and minimally invasive surgery, tissue engineering and experimental surgery, evidence based medicine and evidence based surgery. Principal investigator of some international trials (i.e. IROA-International Register of Open Abdomen, IRBP-International Register of Open Abdomen).

Dr. Jan De Waele

Jan De Waele is a surgery-trained intensivist with a specific interest in infections in critically ill patients and works at the surgical ICU of the Ghent University Hospital in Belgium. Clinical interests include infections and abdominal catastrophes such as the abdominal compartment syndrome. His research activities currently focus on optimizing antibiotic therapy in severely ill infected patients to improve outcome and combat resistance development. He is active in several societies: he is currently chairing the Infection Section of the ESICM and president of the Belgian Society of Intensive Care Medicine.

Dr. Marc DeMoya

After attending medical school at Temple University, he completed his General Surgical residency at St. Barnabas/Jersey City Medical Center in New Jersey. He went on to complete his trauma/critical care fellowship at the Ryder Trauma Center/Jackson Memorial Hospital in Miami and has been on faculty since completion of his fellowship in 2005 at the Massachusetts General Hospital. He is an Associate Professor and is the Trauma/Acute Care Surgery fellowship Program Director, Medical Director of the SICU, Clerkship Director for the Harvard Medical School Surgical clerkship, and Associate Program Director for the General Surgical Residency. He has published over 100 peer-reviewed articles and several chapters and has received numerous grants from the department of defense for trauma and simulation research.

Dr. Salomone Di Saverio

Dr. Salomone Di Saverio MD FACS FRCS is a young Consultant Surgeon with an extensive clinical and scientific experience. He is a Consultant Surgeon, performing elective General Surgery Procedures and Team Leader Consultant in Acute Care-Trauma Surgery. Clinical Head for Laparoscopy in Trauma Surgery in the Trauma Surgery Unit, Trauma Center Maggiore Hospital Bologna. Vice-Chairman of the Trauma Surgery Unit. He is currently involved as Editorial Board Member of several Scientific Journal including BJS and many others. He is an external Clinical Reviewer for NEJM, The Lancet, BMJ, Annals of Internal Medicine, Annals of Surgery, and many others peer reviewed journals. Leading Editor of not a Trauma Surgery book and Acute Surgery book published by Springer. Clinical Mentor and Teacher for residents and Trainees at University of Bologna, as well as faculty member in DSTC and other national and international surgical courses. Performed to date more than 3600 major surgical procedures, mainly as first operator,more than 1000 in laparoscopy. Described and published several original or innovative surgical techniques in both open and laparoscopic surgery. Leading author of several International WSES guidelines, including those on ASBO, Perforated and Bleeding Peptic Ulcers and Acute Appendicitis.

Ms. Anne Drake

Anne is currently the Director of Nursing & Midwifery at Letterkenny University Hospital, Republic of Ireland. Prior to joining the HSE Anne had extensive experience in the NHS. Anne has a PhD, MSc, BSc (Hons) and has a specialist interest in developing leadership capacity within the professions of Nursing & Midwifery.

SPEAKER PROFILES

Dr. Gustavo Fraga

Associated Professor of Surgery. Coordinator of Division of Trauma Surgery, School of Medical Sciences, University of Campinas.

Dr. Ewen Griffith

Mr Ewen A Griffiths graduated MB ChB from Dundee University, Scotland in 2000. He is a Fellow of the Royal Collage of Surgeons (Glasgow) and has completed training in General and Upper GI Surgery. His research in to 'hypoxia associated factors' in oesophagogastric cancer at Paterson Institute of Cancer Research, Christie Hospital, Manchester and Wythenshawe Hospital, Manchester led to many publications and the award of MD (Doctorate in Medicine) from Manchester University in 2006. He is a Consultant General Surgery / Upper Gastrointestinal Surgeon at University Hospitals Birmingham. He is the surgical NELA lead for his hospital. His research interests include oesophagogastric cancer, cholecystectomy / gallbladder disease, emergency surgery and gastrointestinal stents.

Dr. Ali Hallal

Dr Ali Hallal, is currently a an assistant professor of clinical surgery at the American University of Beirut Medical Center (AUBMC) where he works as Trauma , Upper GI surgeon and Intensivist. He is the program director for the trauma and surgical intensive care fellowship at the AUBMC. He had his Trauma and Critical Care fellowship training at Jackson Memorial Hospital Miami USA, and Upper GI training at ST Thomas' Hospital London. He worked as a consultant surgeon at King's College Hospital London where he developed the acute care service before joining the AUBMC in 2011. His main interests are surgical education, research in trauma system, sepsis and esophageal cancer.

Dr. Colm Henry

Dr Colm Henry is National Clinical Advisor for the Acute Hospitals Division in the HSE since 2014. Prior to this appointment, he was National Lead for the Clinical Director Programme in the HSE. He was Clinical Director of the Mercy University Hospital in Cork from 2009 to 2012 and was appointed as Consultant Geriatrician to the same hospital in 2002.

Prof. Tim Hodgetts

Brigadier Tim Hodgetts is an emergency physician with over 20 years of operational experience, leading the UK specialty of military emergency medicine from infancy to maturity and treating the victims of conflict in Northern Ireland, Kosovo, Iraq and Afghanistan. He has published and lectured extensively in the fields of pre-hospital emergency care, disaster medicine, and resuscitation of the critically injured, and has designed and propagated national and international curricula in these subjects. Brigadier Hodgetts' academic career includes the positions of inaugural Defence Professor of Emergency Medicine at the Royal College of Emergency Medicine, Honorary Professor of Emergency Medicine at the University of Birmingham, Visiting Professor in the School of Health Sciences at City University London, and Penman Professor of Surgery at the University of Cape Town. In 1999 he was made Officer of the Order of St John for services to humanity in Kosovo; in 2006 he was the UK national 'Hospital Doctor of the Year'; in 2009 he was made Commander of the British Empire for his contribution to combat casualty care; and in 2010 he received the Danish Defence Medal for Meritorious Service for his clinical leadership of the Danish-US-UK field hospital in Afghanistan. From 2004-2010 he served as the Queen's Honorary Physician. From 2011-2013 he was the Medical Director with NATO's Allied Rapid Reaction Corps. His current appointment is as Medical Director to the UK Defence Medical Services.

Dr. Li Hsee

Dr Li Hsee is a Fellow of Royal Australasian College of Surgeons and American College of Surgeons. He is a Consultant Trauma and Acute Care Surgeon and the head of Acute Surgical Unit at Auckland City Hospital, New Zealand. He is also the current chair of New Zealand Trauma Committee of RACS.

Dr. Sam Huddart

UK NHS Consultant Anaesthetist in Guildford, and post-graduate researcher (University of Surrey) with an interest in healthcare quality improvement in Emergency Surgery.

Dr. Nissanka Jayawardhana

Dr. Jayawardhana is presently employed by the Department of Health, Sri Lanka as a Consultant General Surgeon for fourteen years. During this period he has been working in District General Hospitals Trincomalee and Kegalle and District Base Hospitals Avissawella and Wathupitiwala — serving a wide area of the beautiful island country. He obtained the MBBS degree from North Colombo Medical College 1992. Later he obtained Master of Surgery Degree from University of Colombo and the fellowships of the surgical colleges of Edinburgh and Sri Lanka. He also worked as a specialist registrar in General surgery in James Paget Hospital NHS Trust, Great Yarmouth, UK before appointed as a consultant general surgeon in Sri Lanka upon his return to the island. His work include attending to various types of surgical abdominal emergencies both traumatic and non-trauma related, among many other areas as the head of the surgical team throughout this period. He is also engaged in training of general surgical trainees of the Postgraduate Institute of Medicine for more than ten years. He serves as an examiner in MD - Surgery Examination conducted by the Postgraduate Institute of Medicine of Sri Lanka and also in the International MRCS Examination of the RCS Edinburgh. He is a resource person for the National Trauma Management Course in Sri Lanka. Dr. Jayawardhana has been an active member of the specialty board for general surgery of the Post Graduate Institute of Medicine of Sri Lanka and a council member of the College of Surgeons of Sri Lanka from 2013 to date.

Dr. Prof. Andrew K Kirkpatrick

Dr. Kirkpatrick is a Professor in both the Departments of Surgery and Critical Care Medicine at the Foothills Medical Centre of the University of Calgary, and is the former Medical Director of Regional Trauma Services. Dr. Kirkpatrick graduated Magna Cum Laude from the University of Ottawa, with fellowships in Surgery and Critical Care at the University of Toronto with a Master's degree in Epidemiology at the University of British Columbia. He is President of the Abdominal Compartment Society and a past-President of the Trauma Association of Canada. Dr. Kirkpatrick has more than 350 peer-reviewed articles and book chapters, mainly concerning intra-abdominal hypertension, telemedicine, emergency sonography, hypothermia, aerospace medicine and occult pneumothoraces. He retains a reserve commision in the Canadian Forces and has served oversees on Unated Nations Missions on several occasions. He has consulted on Scientific Research to the Canadian Space Agency, NASA, and the National Research Council of Canada. He is a former Paratrooper and Flight Surgeon and currently maintains a current pilots license.

SPEAKER PROFILES

Dr. Jeffrey Kashuk

Jeffry Kashuk, MD,FACS is a senior surgeon at Assuta Hospital, Ramat HaChayal, Tel Aviv, and Herziliya Medical Center, Herziliya, Israel. He is a Professor of Surgery at Tel Aviv-Sackler School of Medicine, Tel Aviv, Israel. Born and raised in the United States, Jeff developed a noteworthy academic career in the USA before choosing to to emigrate to Israel. He is experienced in all areas of surgery and critical care, and has contributed to the development of the surgical subspecialty of Acute Care Surgery and Surgical Critical Care in the United States and worldwide. As a specialist in general surgery, he routinely performs all general surgery procedures, but is particularly skilled at caring for patients with acute surgical emergencies, and those patients who require surgical critical care. His research, which has emphasized problems associated with blood coagulation after injury, has been recognized world-wide; he is the author or co-author of nearly 100 peer-reviewed articles or book chapters.

Prof. Vladimir Khokha

Head Surgeon of Mozyr Medical Association, Deputy Head Doctor of Mozyr City Hospital in surgery, performing elective and emergency General Surgery Procedures. Performed more than 3000 major surgical procedures, mainly as first operator. Main fields of interest are currently Emergency Surgery either open or laparoscopic, Gastrointestinal Surgery, Colorectal Surgery, Abdominal Trauma Surgery, Emergency Surgical Oncology, emergency vascular surgery, emergency thoracic surgery, infection surgery. Member of Belarus Association of surgeons, member of the Board of Gomel surgical Association, member of Belarus pancreatic Club, 2012-2015 member of International Pancreatic Association and European Pancreatic Club, member of European digestive surgery society, member and national delegate of World Society of Emergency Surgeons. An important part of the activities is the implementation of modern methods of diagnosis and treatment of emergency surgical diseases in accordance with international standards.

Dr. Yoram Kluger

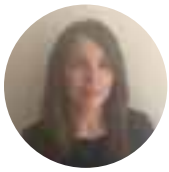
Dr. Kluger graduated from the School of Medicine of the Hebrew University in Jerusalem and completed his general surgery residency at Hadassah Medical Center. He further trained in surgery at the Allegheny Medical Center in Pittsburgh, PA, USA. Dr. Kluger was the founder and director of the Rabin Trauma Center at Tel Aviv Medical Center and the first in Israel to establish a dedicated hospitalization center for multiple injured patients. He is recognized worldwide for his research on medical preparedness and medical infrastructure management in mass casualty incidents. Dr. Kluger's main interests are surgical oncology and trauma surgery. He is the medical director of the pancreatic surgery service at Rambam Health Care Campus, and a clinical Associate Professor at the Ruth and Bruce Rappaport Faculty of Medicine of the Technion-Israel Institute of Technology. He was recently appointed Chairman of the department of surgery at the faculty of medicine.

Dr. Leo Lawler

Medical graduate UCD, House officer training MMUH/ SVUH/Mayo Clinic Rochester, Radiology residency Mallikrodt Institute/Washington University
Cross sectional fellow Johns Hopkins, Interventional fellow Johns Hopkins, Mater Misericordiae University Hospital 2006 – present, Honorary consultant OLHSC/Temple Street/Rotunda

Prof. Ari Leppaniemi

Ari Leppäniemi (MD, PhD, DMCC, Professor h.c.) is the Chief of Emergency Surgery at the Helsinki University Hospital Meilahti, Finland. His background training includes General and Gastroenterological Surgery with subsequent training and diplomas in Prehospital Medicine, Emergency Medicine, Disaster Medicine and International Health Care. He has worked as a Field Surgeon for the International Red Cross for civil wars of Cambodia, Sudan and Afghanistan, and as a Volunteer Surgeon for the United Nations Development Programme in Tuvalu and as Senior House Officer for the Department of Community Medicine in Zaria, Nigeria. He is the Past-President of the European Society for Trauma and Emergency Surgery (ESTES), Finnish Society of Surgery, International Association for Trauma Surgery and Intensive Care (IATSIC), and the Ambroise Pare International Military Surgery Forum (APIMSF). He is the Editor-in-Chief of the Scandinavian Journal of Surgery, Editor of the European Journal of Trauma and Emergency Surgery, and Associate Editor of the World Journal of Surgery. He has published over 160 original articles, more than 200 review articles, book chapters and dissertations, and more than 150 editorials, letters, commentaries and other articles, mostly on abdominal trauma, acute pancreatitis and abdominal compartment syndrome. His hobbies include fishing, badminton, and jazz.



Ms. Paula Loughlin

Paula Loughlin is a Consultant in General and Colorectal surgery in Altnagelvin Hospital in Derry/Londonderry. Having qualified from University College Dublin in 1996 she completed basic psychiatry training followed by a period of time working in Australia. Having completed her basic surgical training in Glasgow Paula did a period of research,with the late Professor Timothy Cooke, in Glasgow Royal Infirmary. She was conferred with an MSc in medical science from the University of Glasgow in 2009. Paula was appointed to the Northern Ireland higher surgical training scheme in 2007 and following completion obtained FRCSI in 2013. She was appointed to her consultant post in Altnagelvin in 2013. Altnagelvin is the only hospital in Northern Ireland which has been accredited by the BSGE as an endometriosis centre and Paula is the nominated colorectal surgeon. Her other interests include laparoscopic surgery, colorectal cancer and medical education. She is the undergraduate surgical tutor.

Dr. Peter MacMahon

Dr MacMahon obtained his subspecialist radiology training at Massachusetts General Hospital (MGH) in Boston USA, which included a clinical fellowship in the field of Emergency Radiology. This fellowship involved both the imaging of traumatic and non-traumatic emergency conditions in adults as well as in children. Currently he is a Consultant Radiologist at the Mater hospital in Dublin with specialist interests in Emergency, Musculoskeletal and Neuro imaging. Dr MacMahon has developed a range of clinician support tools with regards to appropriate emergency imaging and current research interests include methods of optimising the speed at which advanced imaging can be performed in the Emergency Department in the critically unwell patient.

Prof. Ron Maier

Dr. Maier is the Jane and Donald D. Trunkey Professor of Trauma Surgery, and Vice-Chair of the Department of Surgery at the University of Washington. In addition, he is the Director of the Regional Trauma Center, and Surgeon-in-Chief at Harborview Medical Center, the Level I Trauma Center in Seattle supporting four Northwest states representing one quarter of the landmass of the US.

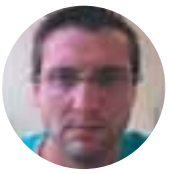
SPEAKER PROFILES

Prof. Mark Malangoni

Mark A. Malangoni, MD, FACS is Associate Executive Director of the American Board of Surgery. Dr. Malangoni received an undergraduate degree in Zoology cum laude from Indiana University and his Doctor of Medicine degree from the Indiana University School of Medicine. He completed a residency in Surgery at the Indiana University School of Medicine and is certified by the American Board of Surgery in Surgery and Surgical Critical Care. Dr. Malangoni is an Adjunct Professor of Surgery at the University of Pennsylvania School of Medicine and was formerly Professor of Surgery at the Case Western Reserve University School of Medicine and Chairman of the Department of Surgery at MetroHealth Medical Center in Cleveland, Ohio, positions he held for more than 20 years. Dr. Malangoni is a member of the Board of Regents of the American College of Surgeons. He has been Chair of the Advisory Council for General Surgery and Chair of the Board of Governors of the American College of Surgeons, as well as Vice-Chair of the Residency Review Committee for Surgery. Dr. Malangoni is a Past-President of the Central Surgical Association, Surgical Infection Society, Ohio Chapter of the American College of Surgeons, and the Cleveland Surgical Society; has served as Vice President of the American Association for the Surgery of Trauma, is a past Chair of the American Board of Surgery and serves as a Senior Director of both the American Board of Surgery and the American Board of Emergency Medicine.

Dr. Manu Malbrain

Manu Malbrain (1965) qualified as MD from the Catholic University of Leuven, Belgium in 1991. He is married to Bieke Depré and they have 3 sons: Jacco, Milan and Luca. As of May 1st 2013 he became the medical hospital director of the ZNA "Ziekenhuis Netwerk Antwerpen" Stuivenberg and ZNA St-Erasmus hospitals in Antwerp, Belgium. He is the manager and director of the Medical and Surgical ICU, the High Care Burn Unit and a hyperbaric oxygen chamber of the ZNA Stuivenberg/St-Erasmus. He is a critical care physician (qualified in 1996) with a basic training in internal medicine (qualified MD in 1991). He is actively involved in the European Society of Intensive Care Medicine (ESICM) where he chaired the Working group on abdominal problems (WGAP) within the POIC section (2009 -2013) and studied the effects of raised intra-abdominal pressure (IAP) in general ICU patients for the last 20 years. He finished the Patient Acute Care Training (PACT) module on abdominal problems together with Jan De Waele. He was the Scientific program Chair together with Michael Sugrue of the 2nd World Congress on Abdominal Compartment Syndrome, Noosa, Australia, Dec 6-8 in 2004. He was the chairman of the 3rd WCACS in Antwerp, Belgium, March 22-24 in 2007 (www.wcacs.org). He is the founding President and Executive Committee member since 2004 and actually the Treasurer of the World Society on Abdominal Compartment Syndrome (WSACS at www.wsacs.org). Together with Niels Van Regenmortel, he is co-founder of the International Fluid Academy (www.fluid-academy.org) and co-chaired the first 5 iFAD meetings end of November each year. Besides IAP, his favourite topic is less invasive (hemodynamic) monitoring and fluid management and he enjoys his active involvement in (bedside) teaching and education of medical trainees and students. He is member of the Medical Advisory Board of Pulsion Medical Systems for the last 10 years. In 2003 he was the first ESICM Chris Stoutenbeek Award winner in Amsterdam with a study protocol on different intra-abdominal pressure measurement methods and he successfully defended his PhD doctorate's thesis in 2007 on the same topic (KU Leuven). He is author and co-author of more than 250 peer-reviewed articles, reviews, editorials, book chapters and even two complete books on ACS.



Dr. Ignacio Martin-Loeches

Dr Martin-Loeches is full time Intensive Care Medicine physician and lead of Research in Intensive Care Medicine at St James's Hospital. Elected Vice-Director of Intensive Care Medicine acting as a Lead in Intensive Care Medicine within the department of Anaesthesia in St James's Hospital. PhD in the discipline of Infectious diseases & Internal Medicine. Dr Martin-Loeches is internationally recognize and as executive member of the European Diploma in Intensive Care Medicine, member of the executive committee of research at the European Society of Intensive Care Medicine and principal investigator of the European Network in Respiratory Infections and member of the Clinical Trials of Health Research Board in Ireland.

Prof. Addison May

Dr. Addison May is a Professor of Surgery and Anesthesiology in the Division of Trauma and Surgical Critical Care at Vanderbilt University Medical Center in Nashville, Tennessee, USA. He is the Director of Surgical Critical Care, the Program Director for Vanderbilt University Medical Center's Surgical Critical Care and Acute Care Surgery Fellowship, and the Director of Research for the Division. He has a specific clinical and research interest in surgical infectious diseases and is currently the Secretary/Treasurer of the Surgical Infection Society – North America. Dr. May's practice includes acute care surgery, trauma, and surgical critical care and he maintains ongoing funded research in surgical infectious diseases and critical care.

Prof. John Mazuski

John E. Mazuski, MD, PhD is Professor of Surgery at Washington University in St. Louis, Missouri in the Section of Acute and Critical Care Surgery in the Division of General Surgery. He received his medical degree from the University of California, Los Angeles in 1981. He completed surgical residency at the University of Minnesota, Minneapolis in 1990. He also received a PhD degree in biochemistry from the University of Minnesota. Following surgical residency, Dr. Mazuski completed a fellowship in surgical critical care, also at the University of Minnesota. He is board certified in surgery and in surgical critical care by the American Board of Surgery. Dr. Mazuski was a member of the surgical faculty at St. Louis University from 1991 to 2002, then joined the faculty of Washington University School of Medicine in 2002, where he has been Associate Professor and then Professor of Surgery. Dr. Mazuski's clinical responsibilities include trauma and emergency general surgery, surgical critical care, and hyperbaric oxygen therapy. He is co-director of the Surgical Intensive Care Unit at Barnes-Jewish Hospital. His research interests focus on surgical infections. He chaired or co-chaired task forces from the Surgical Infection Society (SIS) and the Infectious Diseases Society of America (IDSA) that published guidelines on the management of intra-abdominal infections in 2002, 2003, and 2010, and is the current chair of an SIS task revising those guidelines. Dr. Mazuski was elected President-Elect of the Surgical Infection Society in 2015, and will assume the presidency in 2016.

Mr. Ken Mealy

Consultant General Surgeon Wexford General Hospital, Ireland, Joint Lead National Clinical Programme in Surgery, Clinical Director of the National Office of Clinical Audit, Vice President Royal College of Surgeons in Ireland.

SPEAKER PROFILES

Dr. Dominique Monnet

Dominique L. Monnet joined ECDC in October 2007 to lead ECDC's Disease Programme on Antimicrobial Resistance and Healthcare-Associated Infections. He is also representing ECDC in the EU-US Transatlantic Task Force on Antimicrobial Resistance (TATFAR). Before joining ECDC, he worked in French hospitals, at the US Centers for Disease Control and Prevention (1993-1995) and at the Danish Statens Serum Institut (1997-2007) where he was coordinating surveillance of antimicrobial resistance and antimicrobial consumption in humans in Denmark. His research interests include surveillance of antimicrobial resistance and antimicrobial consumption, the relationship between consumption of antimicrobials and resistance, and the factors that affect antimicrobial usage, both in hospitals and in primary care.

Prof. Philippe Montravers

University Professor - Hospital Practitioner. Head of the Department of Anaesthesiology and Surgical Intensive Care Unit. Bichat Claude Bernard University Paris Diderot Teaching Hospital. Assistance Publique Hopitaux de Paris.

Dr. Ernest E Moore

Ernest E. "Gene" Moore, M.D. has been the Editor of the Journal of Trauma and Acute Care Surgery since 2012, and was the Chief of Trauma at the Denver General Hospital for 36 years, Chief of Surgery for 28 years, and the first Bruce M. Rockwell Distinguished Chair in Trauma Surgery. He continues to serve as Vice Chairman for Research and Professor of Surgery at the University of Colorado Denver. Under Dr. Moore's leadership, the Rocky Mountain Regional Trauma Center at Denver General became internationally recognized for innovative care of the injured patient, and its trauma research laboratory has been funded by the NIH for 25 consecutive years. Dr. Moore has served as president of nine academic societies, including the Society of University Surgeons, American Association for the Surgery of Trauma, International Association for the Trauma and Surgical Intensive Care, and the World Society of Emergency Surgery. His awards include the Robert Danis Prize from the Society of International Surgeons, Orazio Campione Prize from the World Society of Emergency Surgery, Philip Hench Award from the University of Pittsburgh, Florence Sabin Award from the University of Colorado, the Lifetime Achievement Award from the Society of University Surgeons, the Lifetime Achievement Award for Resuscitation Science from the American Heart Association, the American College of Critical Medicine Distinguished Investigator Award, the Distinguished Service Award from the Shock Society, and the Lifetime Service Award from the International Association for Trauma and Surgical Intensive Care. He has honorary fellowships in the Royal College of Surgeons of Edinburgh, the Royal College of Surgeons in Ireland, the Royal College of Surgeons of Thailand, and the American College of Emergency Physicians; and is an honorary member of the Brazilian Trauma Society, Colombian Trauma Society, Eastern Association for the Surgery of Trauma, European Society for Trauma and Emergency Surgery and Trauma Association of Canada. Editor, Journal of Trauma.

Ionut Negoi

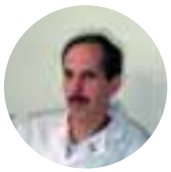
General Surgery, Surgical Oncology, Hepatobiliopancreatic Surgery

Dr. Maurice O'Kane

Dr O'Kane graduated in medicine at the University of Edinburgh and undertook postgraduate training in Scotland, N. Ireland and France. He has been a consultant chemical pathologist in Altnagelvin Hospital since 1996. Dr O'Kane is visiting professor at Ulster University and Director of Clinical Practice at the Association for Clinical Biochemistry and Laboratory Medicine. He is Director of Research at the Western Health and Social Care Trust and Chief Executive of the Clinical Translational Research and Innovation Centre. His research instruments include point-of-care testing and clinical biochemical aspects of diabetes mellitus and genetic lipid disorders.

Mr. Mihai Paduraru

Mr. Mihai Paduraru, PhD, MSc, MD, is a Consultant Surgeon specializing in General and Emergency Surgery, currently working in a General Hospital in Castilla - La Mancha, Spain. Following Masters Degrees from Carol Davila University — Bucharest, Zaragoza University — Spain and Cardiff University — UK, and a Doctorate from Carol Davila University and Complutense University — Spain, with research and development focus in Geriatric Emergency Surgery, he is currently coordinating a European Society of Trauma and Emergency Surgery (ESTES) Project. He has international teaching experience in Emergency Surgery with the Modular UltraSound ESTES Course team and membership of professional bodies in Spain and the UK, including European and Spanish Association of Endoscopic Surgery.



Prof. Andrew Peitzman

Mark M. Ravitch Professor of Surgery
Executive Vice-Chairman, Department of Surgery
University of Pittsburgh

Dr. Bruno Pereira

PH.D., Master Degree in Surgery, Associate Professor of Surgery & Surgical Critical Care - University of Campinas - Brazil, Director, Disasters Committee - Pan American Trauma Society, WSACS Ambassador, FACS, FCCM

Mr. Amal Priyantha

Consultant Gastrointestinal Surgeon, Teaching Hospital, Colombo South. Past president, Gastroenterological and Endoscopic Society of Sri Lanka. Chair person, Board of Study in Gastrointestinal Surgery, Postgraduate Institute of Sri Lanka.

Dr. Massimo Sartelli

Dr Massimo Sartelli is Consultant Surgeon at the Department of Surgery, Macerata Hospital, Italy. He is author and co-author of 8 manuals of general-emergency surgery. In the last years he has devoted his updating to the study of surgical sepsis. He is deputy editor of the "World Journal of Emergency Surgery" and member of the Board of Directors of the "World Society of Emergency Surgery" (WSES). In last years he coordinated WSES guidelines for management of intra-abdominal infections and soft tissue infections. He designed and coordinated three prospective studies describing the epidemiological and treatment profiles of patients with cIAIs worldwide.

SPEAKER PROFILES

Prof. Kjetil Soreide

Kjetil Soreide MD, PhD is specialising in General and Gastrointestinal surgery at the Stavanger University Hospital in Stavanger and is a professor at the Department of Clinical Medicine at University of Bergen, both in Norway. Since 2010 he has been an editor with the BJS, the premier surgical journal in Europe. He is the past co-Editor-in-chief for the Scand J Trauma Resusc Emerg Med, a position he held since the inaugural launch of the journal and for 11 years up until 2015. He currently serves on the editorial board of several journals. His main research interests include gastrointestinal surgical disease, with a strong focus on translational gastrointestinal oncology and emergency surgery. He has published over 180 peer-reviewed papers, reviews, editorials and book chapters.

Mr. Michael Sugrue

A Fellow of both the Irish and Australasian College of Surgeons. He qualified in 1981 from University College Galway in 1981 with many undergraduate honours and awards. Michael obtained his MD in 2002 for his work on Intra-abdominal Pressure and Renal Failure, on which he has published widely. He is ex-president of World Society Abdominal Compartment Syndrome and was convenor of the 2nd and 4th World Congress on the Abdominal Compartment Syndrome He has achieved many awards for pursuit of educational initiatives included the ESR Hughes Medal from Australasian College of Surgeons in 2008. He was a Consultant Surgeon for 15 years at Liverpool Hospital in South West Sydney and Professor of Surgery at UNSW Sydney. He was a cornerstone in the development of DSTC and had taught on over 20 courses around the world. He enjoys patients and surgery the most and is a very hands-on, technically interested surgeon. He has published over 200 articles. Michael Sugrue is currently General and Breast Surgeon in Letterkenny University Hospital and Galway University Hospital Ireland. He works on call 1 week in 5 in a busy general on call position. He has developed two recent courses in Emergency Surgery EASC which has now been run in 4 countries and the Open Abdomen course. He lives with Pauline in historic Ramelton in Donegal. He enjoys a surf. He is Co-convenor of the Critical Surgical Abdomen Conference July 22-26th 2016 hopes you might attend this exciting 4 day meeting in Dublin and Donegal.

Dr. Scott Thomas

Dr. Thomas received his medical degree from Indiana University School of Medicine and completed his residency in general surgery at St. Joseph Mercy Hospital in Ann Arbor, Michigan and The Royal North Shore Hospital in Sydney, Australia. He also completed his trauma fellowship at The Royal North Shore Hospital in Sydney. Board certified in surgery, Dr. Thomas is Chair of the Committee on Trauma for Indiana, Chief of Trauma Services for Beacon Health System and Medical Director of Trauma services at Memorial Hospital of South Bend, Indiana.

Dr. Jan Ulrych

Jan Ulrych was born in 1974 in Prague. Ulrych received his medical degree at 2nd Medical Faculty of Charles University in Prague. Ulrych has been practicing since 2000, last 10 years at 1st Department of Surgery of General University Hospital in Prague. He is board-certified surgeon with surgical oncology subspecialty, especially hepatopancreatobiliary surgery. Ulrych interest also includes surgical infections. He is author of national recommendations for treatment of skin and soft tissue infections and treatment of intra-abdominal infections. He is responsible for education of surgery at First Medical Faculty of Charles University in Prague. He has participated in many research projects and grants. He is author of chapters in several books and many publications in scientific journals. He is married. He lives with his wife in small town near Prague and they bring up two children.

Manvydas Varzgalis

Manvydas Varzgalis qualified from the Lithuanian University of Medical Science, in 2005 with honours degree. He undertook his surgical training in Lithuania. Moved to Ireland in 2011 where he further specialised in General, Endocrine and Breast Surgery. His main interests are surgical education, emergency surgery and breast surgery. Manvydas is actively involved in undergraduate teaching in NUIG and is running Basic Surgical Skills Modules for medical students.

Prof. George Velmahos

George C. Velmahos, MD, PhD, MSEd received his medical degree and a doctorate from the University of Athens Medical School in Athens, Greece. He is a Fellow of the American College of Surgeons, American College of Critical Care Medicine, Royal College of Surgeons of Edinburgh, and Royal College of Physicians and Surgeons of Glasgow. Dr. Velmahos is the John F. Burke Professor of Surgery at Harvard Medical School and Chief of Trauma, Emergency Surgery, and Surgical Critical Care at Massachusetts General Hospital, both in Boston, Massachusetts. He is the Trauma Program Leader for the Center for Integration of Medicine with Innovative Technology (CIMIT), and is the Founder of the Center for Early Trauma Research at Massachusetts General Hospital. Dr. Velmahos is a member of the American Surgical Association, Society of University Surgeons, American Association for the Surgery of Trauma, Society of Critical Care, Society of Clinical Surgery, Surgical Biology Club, Western Surgical Association, New England Surgical Society, International Society of Surgery, and many others. He is the Chair of the International Committee of the American College of Surgeons as well as serving on many executive committees and held office in numerous societies and professional medical organizations. Recipient of multiple teaching awards from the University of Southern California & Massachusetts General Hospital, he is the Associate Editor of the World Journal of Surgery, serves on the Editorial Board of Surgery, Archives of Surgery, World Journal of Emergency Surgery, and Journal of Trauma. He is a reviewer for nearly all major surgical and critical care journals. He received the honorary title of Master of Critical Care from the Critical Care Society.

Dr Jean-louis Vincent

Dr Vincent is Professor of intensive care medicine at the University of Brussels (Université Libre de Bruxelles) and intensivist in the Department of Intensive Care at Erasme University Hospital in Brussels. He obtained his PhD degree at the University of Brussels in 1982. He is President of the World Federation of Societies of Intensive and Critical Care Medicine (WFSICCM) and a Past-President of the European Society of Intensive Care Medicine (ESICM), the European Shock Society (ESS), the Belgian Society of Intensive Care Medicine (SIZ), and the International Sepsis Forum (ISF). He was a Council member of the Society of Critical Care Medicine (SCCM) from 2011-2013. He is member of the Belgian Royal Academy of Medicine. Dr. Vincent has signed more than 900 original articles, some 400 book chapters and review articles, 1000 original abstracts, and has edited 102 books. He is co-editor of the "Textbook of Critical Care" (Elsevier Saunders) and the "Encyclopedia of Intensive Care Medicine" (Springer). He is the editor-in-chief of Critical Care, Current Opinion in Critical Care, and ICU Management & Practice and member of the editorial boards of about 30 other journals, including Critical Care Medicine (senior editor), the American Journal of Respiratory and Critical Care Medicine (AJRCCM), PLoS Medicine, Lancet Infectious Diseases, Intensive Care Medicine, Shock, and the Journal of Critical Care. Dr Vincent has received several awards: the Distinguished Investigator Award of the Society of Critical Care Medicine, the College Medalist Award of the American College of Chest Physicians, the

SPEAKER PROFILES

Society Medal (lifetime award) of the European Society of Intensive Care Medicine, the prestigious Belgian scientific award of the FRS-FNRS (Prix Scientifique Joseph Maisin-Sciences biomédicales cliniques), and the Lifetime Achievement Award of the Society of Critical Care Medicine. He was awarded the title of Baron by King Albert II of Belgium in 2013. His name appears more than 1000 times in Pubmed, and his work has been cited more than 110,000 times; his H-index is 140.

Dr. Liam Woods

A native of Dublin, Liam is a UCD graduate and a qualified Chartered Accountant. Prior to joining the health services, he worked in the private sector in an accounting and consultancy organisation. He joined the health services in 1999 as Financial Director of the Eastern Regional Health Authority, serving in this post until the ERHA became part of the Health Service Executive in January 2005. Liam has been the Director of Finance of the HSE for an eight year period, Director of Health Business Services for a year and appointed as National Director of Acute Hospital Services (Interim) in January 2015.

VENUE
ROYAL COLLEGE OF SURGEONS IN IRELAND

MEET – DINE – CELEBRATE – TEACH

Dating back to 1784, the Royal College of Surgeons in Ireland (RCSI) combines the historic with the modern to offer a truly unique and elegant venue in the heart of Dublin's city centre.

From open fires & high ornate ceilings, the original building has an air of luxury and warmth whilst the new side of the building offers a selection of rooms with a multi-purpose design within a prestigious setting.

CRITICAL SURGICAL ABDOMEN CONSENSUS CONFERENCE

FRIDAY JULY 22nd 2016, DUBLIN, IRELAND

MOVING FROM OLD TO NEW

RCSI

VENUE

ROYAL COLLEGE OF SURGEONS IN IRELAND

RCSI

CRITICAL SURGICAL ABDOMEN CONSENSUS CONFERENCE

FRIDAY JULY 22nd 2016, DUBLIN, IRELAND

CRITICAL SURGICAL ABDOMEN CONSENSUS CONFERENCE

FRIDAY JULY 22nd 2016, DUBLIN, IRELAND

WSES/WSACS Sponsored by Acelity

INDICATIONS AND BENEFITS OF OPEN ABDOMEN IN NON-TRAUMA PATIENTS

TIME	SESSION TITLE
0805	**Welcome** Professor John Hyland, President, Royal College of Surgeons in Ireland
0805-0815	**Introduction** F Coccolini GP Fraga
	OA Indications and Techniques
0815-0825	**Open Abdomen in Peritonitis** M DeMoya
0835-0845	**Open abdomen in vascular emergencies** W Biffl
0855-0905	**Open Abdomen in Pancreatitis** A Leppäniemi
0915-0935	**Case Scenario Panel** B Sakakuskev
0935-0945	**Optimum technique for temporary abdominal closure in non-trauma patients?** M Boermeester
0955-1030	**Case Scenario Panel** M Sugrue
1030-1100	**Morning Tea Coffee**
	Re-exploration and definitive closure Chair: F Catena Y Kluger
1100-1110	**Planning re-exploration before definitive closure in non-trauma patients?** A Kirkpatrick
1120-1130	**Optimal Closure Timing in Non-trauma patients?** A Peitzman
1140-1150	**Non-mesh mediated techniques** B Pereira
1200-1210	**Mesh mediated techniques for closure** L Ansaloni
1220-1230	**Strategy to close abdomen after trauma?** EE Moore
1240-1300	**Case Scenario Panel** J Kashuk
1300-1400	**Lunch - Poster Round**
	OA Nutritional Management and Complications Chair: E Moore A Kirkpatrick
1400-1410	**Which nutritional support is indicated in open abdomen** R Maier
1420-1430	**Which is the best treatment for EA fistulas?** Y Kluger

TIME	SESSION TITLE
1440-1530	**Acelity Fistulae Isolation Workshop** Bowyer Pereira Catena Abu-Zidan Maier Kirkpatrick
1530-1600	**Afternoon Coffee and Tea**
1545-1630	**Free Paper Session** Chair: L Ansaloni A Kirkpatrick
1600-1610	**Do we have to leave the abdomen open when using negative pressure wound therapy in peritonitis? A feasibility study.** O Jannasch P Ihle
1610-1620	**Opportunities of negative pressure wound therapy to patients with severe abdominal sepsis.** S Shlyapnikov A Demko I Batyrshin
1620-1630	**Flatology as a cause of Compartment Syndrome?** A Tamas
1630-1640	**Single center experience of the open abdomen** JG Lee YU Choi SH Lee
1640-1650	**A stepwise approach in managing enteroatmospheric fistulae in a frozen abdomen - A prospective study with two year follow up** O Jannasch J Tautenhahn H Lippert P Mroczkowski
1650-1700	**Open abdomen: an old technique with new indications** Z Bodnar E Tidrencze
1700-1710	**A Protocol Combining Open Abdomen and Staged Abdominal Closure Provides Effective Treatment for Acute Pancreatitis Complicated with Early Multiple Organ Failure** KC Yuan YC Wong CY Fu SC Kang SY Wang CH Liao CH Yang Y Hsu
1710-1720	**The European open abdomen registry Introduction of the Data Set and Initial Results of Procedures and Procedure-Related Complications** R Schwab C Güsgen A Willm
1730	**Influence of intra-abdominal hypertension on the marker-presepsin sCD14** YM Turgunov DN Matyushko ZM Koishibayev AA Nurbekov AE Alibekov DK Kaliyeva LM Koishibayeva
1735	**Conference Closure**
1915	**Reception, Board Room** (included in Dinner ticket)
1945	**Presentation of Honorary Fellowship RSCI** Professor EE Moore
2015	**Dinner, College Hall** (Music by Clan Mhic Rhuairi) **Presentation of Prizes** L Ansaloni A Kirkpatrick

EXPLORE IRELAND

Outdoors lovers will find lots to be excited about in Ireland, with acres of wild and windswept countryside, cute-as-a-button villages and hair-raising coastal cliffs making up the country's surprisingly varied scenery. From mesmerizing UNESCO World Heritage sites to unique vistas that beg to be photographed, these are 10 of the most beautiful places to visit in Ireland.

Cliffs of Moher

Ireland's mighty Cliffs of Moher reign strong as one of the country's most visited natural attractions - towering 214 meters over the Atlantic Ocean in western Ireland. The iconic cliffs run from near the village of Doolin for around 8km to Hags Head in County Clare and host the country's most spectacular coastal walk. Carved out by a gigantic river delta around 320 million years ago, the imposing cliffs also offer incredible views, stretching over Galway Bay, the distant Twelve Pins mountain range and the northern Maumturk Mountains

Ring of Kerry

Ireland's most scenic tourist trail, the Ring of Kerry, runs 120 miles through some of southwestern Ireland's most jaw-dropping landscapes. A patchwork of lush meadows, glacial lakes and heather-topped mountains, the Ring of Kerry includes highlights like the rugged Beara Peninsula and the Kerry Way - Ireland's longest and oldest walking route. Stop off on route at the Killarney National park, a UNESCO World Heritage biosphere reserve, home to the 15th century Ross Castle and a herd of wild red deer.

The Giants Causeway

Northern Ireland's only UNESCO World Heritage-listed site, the Giant's Causeway is proof that Mother Nature provides the most dramatic tourist attractions. The natural wonder is comprised of around 40,000 polygonal basalt rock columns, formed by the ancient volcanic landscape and stretching along the coastline like a series of gigantic stepping stones. A Giants Causeway Day Trip from Belfast is one of the country's most popular excursions, with visitors taking the unique opportunity to walk one of nature's most peculiar pathways.

Skellig Islands

Ireland's magnificent UNESCO World Heritage Skellig Islands make a worthy side trip from the popular Ring of Kerry tourist trail, a pair of small rocky mounds that rise up from the sea off the coast of Portmagee. Not only are the two islands - Skellig Michael and Little Skellig - home to a fascinating 6th-century monastic complex perched on the 230-meter high cliff top, but they also host an impressive array of birdlife. Look out for Gannets, Black Guillemots, Cormorants, Razorbills and Herring Gulls as you climb the hair-raisingly steep 600-step climb to view the monastic remains.

Aran Islands

Famous for their traditional knitted 'Aran sweaters' (sold all over the UK) and car-free roads, the Aran Islands are one of few places left where you can experience a traditional Irish village, unmarred by the modern developments of the mainland. Here, many locals still speak Gaelic as their first language, live in small farming communities and drive pony traps. The countryside is equally enchanting - historic forts teetering on cliff tops, endless sandy beaches and miles of rugged coastline.

Glenveagh National Park

Ireland's second-largest National Park at 14,000 acres, Glenveagh is County Donegal's number 1 attraction, drawing hikers and fishermen from all over the country. While you're taking in the mountaintop views, enjoying afternoon tea in the 19th century Glenveagh Castle or fishing for salmon and trout in the glittering lakes, keep a lookout for the park's rare wildlife. The formerly extinct Golden Eagle was reintroduced to the park in 2000 and they share their habitat with Ireland's largest herd of red deer.

The Burren

A mind-boggling landscape of ruts, fissures and rocky mounds, walking across the Burren has been likened to walking on the moon. Sculpted through thousands of years of acid erosion, the karst landscape appears like a giant jigsaw of grikes (fissures) and clints (isolated rocks jutting from the surface), teetering 300-meters above the ocean on the coast of County Clare in western Ireland. Be sure to take a closer look as you trek over the rocks, too - the rocky terrain nurtures a surprising variety of rare plants and insects (around 700 different species), with colorful wildflowers blooming between the cracks throughout the spring.

WSES INTRA-ABDOMINAL INFECTION CONSENSUS CONFERENCE

SATURDAY JULY 23rd 2016, DUBLIN, IRELAND

VENUE

ROYAL COLLEGE OF SURGEONS IN IRELAND

WSES INTRA-ABDOMINAL INFECTION CONSENSUS CONFERENCE

SATURDAY JULY 23rd 2016, DUBLIN, IRELAND

TIME	SESSION TITLE
0700	**Board meeting WSES/WJES**
	ROOM A
0800	**Introduction** Massimo Sartelli (Italy) Luca Ansaloni (Italy)
0810	**Lecture: Certainties and controversies in the management of intra-abdominal infections** Mark Malangoni (USA)
	First session: Classification diagnosis and risk factors **Chairs:** Ernest E Moore (USA) Andrew Peitzman (USA)
0830	**Classification** Massimo Sartelli (Italy)
0845	**Diagnosis** Fikri Abu-Zidan (Arab Emirates)
0900	**Peritoneal swabs: when and how** Jan Ulrych (Czech Republic)
0915	**High-risk patients** Kjetil Soreide (Norway)
0930	**The role of prognostic scores to predict mortality in intra-abdominal infections** Ewen Griffith (UK)
0945	**Discussion** **Invited to Discussion:** Ari Leppäniemi (Finland)
1000	**Case presentation** Michael Sugrue (Ireland)
	Second session: Source control **Chairs:** Yoram Kluger (Israel) Ron Maier (USA)
1020-1050	**Morning Coffee and Visiting Sponsors**
1050	**Principles of source control** John Mazuski (USA)
1105	**Laparoscopic approach to intra-abdominal infections** Salomone Di Saverio (Italy)
1120	**Relaparotomy strategy** Marja Boermeester (Netherland)

TIME	SESSION TITLE
1135	**Damage control surgery strategy in patients with severe sepsis** Fausto Catena (Italy)
1150	**Discussion** **Invited to Discussion:** Vladimir Khokha (Belarus)
1205	**Case presentation** Jeffry Kashuk (Israel)
1220	**Lunch**
	Third session: Antimicrobial therapy **Chair:** Ron Maier (USA) Mark Malangoni (USA)
1300	**Principles of antimicrobial therapy** Maddalena Giannella (Italy)
1315	**Antimicrobial resistance in intra-abdominal infections** Cristian Eckmann (Germany)
1340	**Intra-abdominal candidiasis. Impact and treatment** Philippe Montravers (France)
1335	**Duration of antimicrobial therapy** Federico Coccolini (Italy)
1350	**Interventions to improve antibiotic prescribing practices for patients with intra-abdominal infections** Addison May (USA)
1405	**Discussion** **Invited to Discussion:** John Mazuski (USA)
1420	**Case presentation** Osvaldo Chiara (Italy)
1440	**Lecture** **Antimicrobial resistance in Europe** Dominique Monnet (European Centre for Disease Prevention and Control ECDC)
	ROOM B **Chairs:** Walter Biffl (USA) Gustavo Fraga (Brazil)
	Concurrent Free paper and Mini Poster Session
1300	**Surgical intervention in acute pancreatitis: timing and coordination are the key** I Negoi S Paun S Hostiuc A Moldoveanu M Beuran

WSES INTRA-ABDOMINAL INFECTION CONSENSUS CONFERENCE

SATURDAY JULY 23rd 2016, DUBLIN, IRELAND

TIME	SESSION TITLE
1310	**Costs of admission for adhesive small bowel obstruction** P Krielen MWJ Stommel H van Goor RPG ten Broek
1320	**Use of adhesion reduction device in colorectal surgery: a modeling study of the cost-effectiveness** MWJ Stommel P Krielen C Strik H van Goor RPG ten Broek J Grutters
1330	**Laparoscopic surgery for intra-abdominal infections in Japan** Tomo Oka

Mini paper 3 min presentation (3 slides) + 2 min discussion (poster to be displayed separately)

1340	**Clostridium perfringens's necrotizing acute pancreatitis: a case of success** R Castro J Mendes L Amaral R Quintanilha T Rama A Melo
1345	**Non-operative management for high grade hepatosplenic trauma associated with cerebral, thoracic, pelvic and limb traumatic lesions** F Sousa A Pinho J Preto R Bessa de Melo C Fernandes F Resende L Graça J Costa Maia
1350	**Management of a severe gunshot trauma during hunting** E Cocozza M Berselli V Quintodei L Livraghi L Latham L Farassino G Borroni J Galvanin
1355	**Under pressure: can a better understanding of emergency intra-operative decision-making processes improve surgeons' performance?** A Bradley
1400	**Perforated giant duodenal ulcer; the surgeon's dilemma** A Che Jusoh N Shukri N Yahya
1405	**Extracellular bovine-derived peritoneum matrix: the new biological graft for abdominal wall reconstruction** N Abatov M Tussupbekova R Badyrov K Abugaliev A Abatova
1410	**The effect of vacuum-assisted closure In the management of highly contaminated wound** K Sekiya T Oka Y Otomo
1415	**Mycotic splenic vessel aneurysm leading to massive GI bleed: abstract** L Casey J Kelly J Conneely
1420	**Implications of Left sided gallbladder in Acute Cholecystitis** H Abonga F Catena

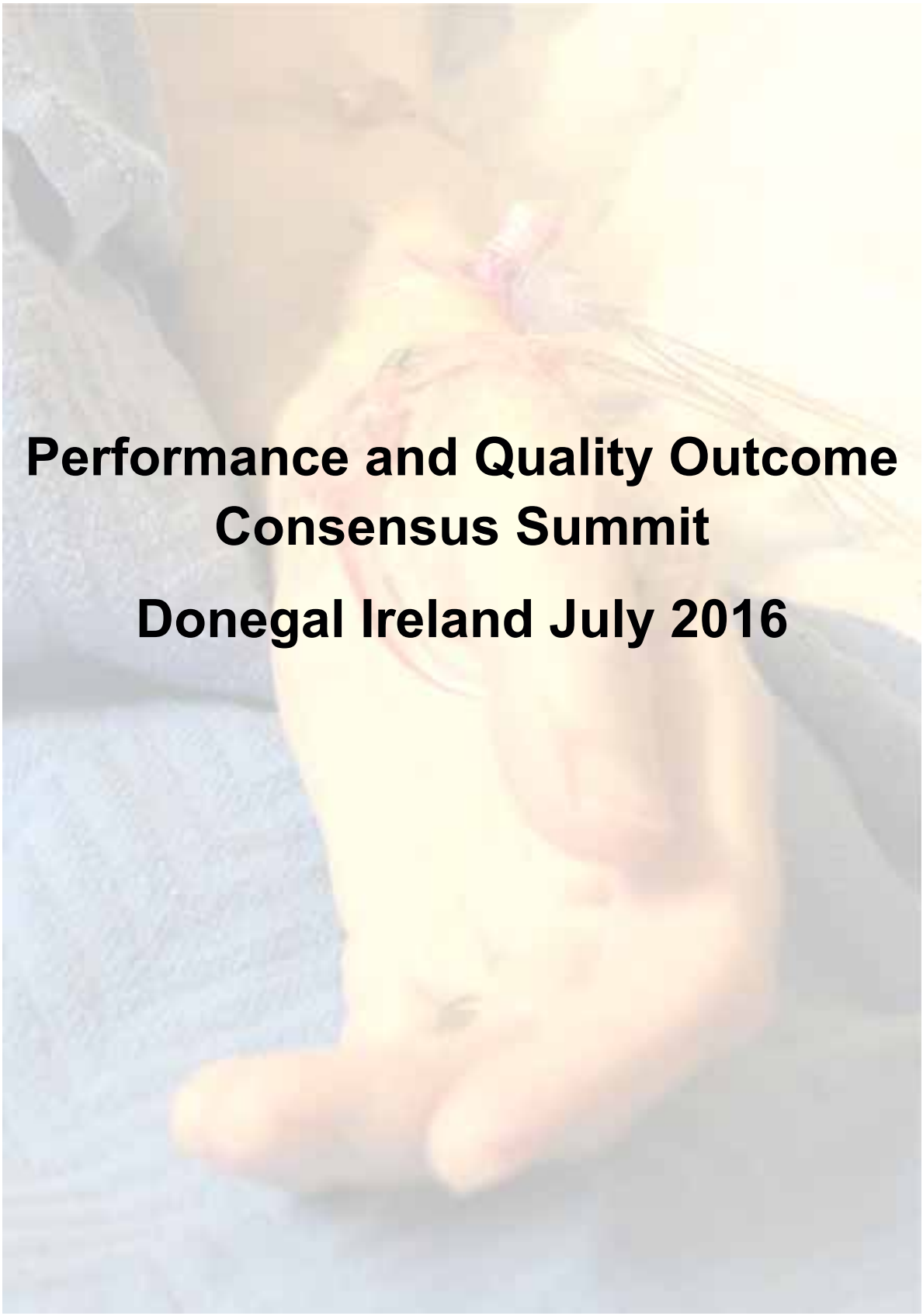
TIME	SESSION TITLE
1425	**Diverticulitis. Resection and Colorectal Anastomosis with or without diverting ostomy or resection and end-colostomy?** D Soriero F Costanzo E Cartesegna E Caratto M Caratto C Sticchi R Fornaro
1430	**Acute cholecystitis – the best treatment** F Sousa L Pinto C Fernandes R Bessa de Melo L Graça J Costa Maia
1435	**Normal appendix on histology at emergency appendicectomy: is it avoidable?** V Cubas S Martin K Wheatley
1500-1530	**Afternoon Coffee**

Fourth session: Critically ill patients

Chairs: George Velmahos (USA) Luca Ansaloni (Italy)

1545	**Intra-abdominal infections in the intensive care unit: determinants of outcome** Jan De Waele (Belgium)
1600	**Appropriate antimicrobial therapy in critically ill patients** Ignacio Martin-Loeches (Italy)
1615	**Management of abdominal sepsis** Jean-Louis Vincent (Belgium)
1630	**Role of the Adjunctive therapies** Massimo Girardis (Italy)
1645	**Inflammatory mediators in intra-abdominal sepsis** Andrew K Kirkpatrick (Canada)
1700	**Discussion** **Invited to Discussion:** Ignacio Martin-Loeches (Ireland)
1715	**Case Presentation** Michael Sugrue (Ireland)
1735	**Wining Free paper and mini presentation**
1745	**Close of meeting** Massimo Sartelli Luca Ansaloni
1900	**Wound Optimization** The latest bundle approach including NWPTi smith&nephew
1945	**Pre Dinner Reception and Dinner in Historic Royal College of Physicians in Ireland, Kildare Street, Dublin**

Resources for Optimal Care of Emergency Surgery



Performance and Quality Outcome Consensus Summit

Donegal Ireland July 2016

WSES EMERGENCY SURGERY PERFORMANCE QUALITY AND OUTCOME CONSENSUS SUMMIT

MONDAY JULY 25th 2016, LOUGH ESKE CASTLE, DONEGAL, IRELAND

TIME	SESSION TITLE
0800	**Welcome and Introduction** M Sugrue L Ansaloni G Velmahos
0805-0815	**Resources and Designation of Emergency Surgery Service** Hsee Velmahos Crowley Mealy
0825-0835	**Acute Care Unit Structure** Ansaloni Maier E Moore
0845-0855	**Reception and Triage** Hodgetts Coccolini Soreide Balfe
0905-0915	**Data systems, registry and evaluation** Velmahos Boermeester Peitzman Coccolini
0925-0935	**Interaction and connectivity with Laboratory, Radiology OR ICU Gastro** Leppaniemi (OR) 2min each presenter 5 key points MacMahon (Radiology) O Kane (Laboratory) Malbrain (ICU) Steele (Gastroenterology)
0945-0955	**Quality Assurance and Performance improvement and Innovation** Huddart Hodgetts Malbrain Woods
1015-1045	**Morning Tea**
	Chairs: E Moore M Boermeester L Wood
1045-1055	**Sepsis control in Emergency Room** Coccolini Sartelli Kluger Malangoni Vincent
1105-1115	**Research in Acute Care Surgery** Catena Kirkpatrick Maier Coccolini
1125-1135	**Education** Sugrue Bowyer Lawler Martinez
1145-1155	**Patient related outcomes measures** Drake Maier Bendinilli Murphy
1205-1230	**Future discussion planning for framework of KPI 's in Acute Care Surgery** **Chairs:** Pietzman Maier Henry KPI's will have been circulated as part of Summit Proceedings prior to meeting. Each topic will have 5 Key Performance indicators KPI's. These will have been reviewed the attendees prior to meeting. They are not intended to be definitive rather act as the start of a new era in Emergency Surgery Care Improvement.

TIME	SESSION TITLE
	Disease Specific Process and Outcome KPIs **Session 2:** Overview only; There will be NO individual presentations
	Di Saverio Appendicitis Ansaloni Cholecystitis Leppaniemi Pancreatitis Soreide Perforated Ulcer Kelleher Upper GI Bleeding Steele Lower GI Bleeding Pereira Small Bowel Obstruction Sugrue Large Bowel Obstruction Balfe Diverticulitis Kashuk Mesenteric Ischaemia Thomas Abdominal Vascular Moore Coagulation Kashuk Pneumothorax and Empyema Sartelli Septic shock in Emergency De Waele Septic shock in ICU Malbrain Fluids in septic shock Sugrue Abdominal Compartment Syndrome Paduraru Geriatric Emergency Care Biffl Paediatric Emergency care Maier Triage O Kane Laboratory (Bloods) Malbrain Fluids MacMahon Radiology Steele/Sugrue Gastroenterology (Bleeders) Vincent ICU (Admission) Leppaniemi Emergency Theatre Boermeester Health Care Systems
1230	**Synopsis of the Meeting** Catena
1245	**Future direction** E Moore R Maier (5 min each)
1255	**Close of Meeting**
1300	**Lunch** Afternoon free for relaxation and explore beautiful Donegal
1930	**Pre Dinner Tour of Doengal Castle** Catena
2000	**Dinner** Donegal Town Old Castle Bar

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11th EMERGENCY ABDOMINAL SURGERY COURSE

TUESDAY JULY 26TH 2016, LOUGH ESKE CASTLE, DONEGAL, IRELAND

VENUE

LOUGH ESKE CASTLE, DONEGAL

11th EMERGENCY ABDOMINAL SURGERY COURSE

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TIME	SESSION TITLE
0800	**Welcome and Introduction** M Sugrue
0810-0825	**Imaging for the Acute Abdomen** M Boermeester
0825-0845	**Appendicitis The latest** S Di Saverio
0845-0905	**Case Scenario** Boermeester Coccolini MacMahon Catena
0905-0925	**Diverticulitis Keys to Management** A Pietzman
0925-0945	**Case Scenario** Mealy Leppaniemi MacMahon Periera
0945-1000	**Management of LBO** P Loughlin
1000-1030	**Case Scenario** Jayawardana Lawler Bendinelli Balfe
1030-1100	**Morning Tea**
1100-1120	**Pancreatitis** A Leppananiemi
1120-1140	**Case Scenario** Hallal Moore Steele Lawler Thomas
1140-1200	**Complicated Cholecystitis** L Ansaloni
1200-1230	**Case Scenario** Maier Pereira Steele MacMahon
1230-1245	**Perforated Duodenal Ulcer** F Catena
1245-1330	**Lunch** Meet the Sponsors

TIME	SESSION TITLE
1330-1350	**Management Upper GI Bleed** Li Hsee
1350-1410	**Case Scenario** Steele Priyantha Lawler Kashuk
1410-1430	**Appendicitis The latest** S Di Saverio
1430-1450	**Case Scenario** Boermeester Coccolini MacMahon Catena
1450-1505	**Diverticulitis Keys to Management** A Pietzman
1505-1530	**Case Scenario** Mealy Leppaniemi MacMahon Periera
1550-1610	**Management of LBO** P Loughlin
1610-1630	**Case Scenario** Jayawardana Lawler Bendinelli Balfe
1630-1645	**Afternoon Tea**
1645-1700	**Pancreatitis** A Leppananiemi
1700-1730	**Case Scenario** Hallal Moore Steele Lawler Thomas
1730-1750	**Complicated Cholecystitis** L Ansaloni

The Summit wish to thank the following for their tremendous support
Presentation EASC recognition award
Tim Ryan and Neville Couse

ABSTRACTS – OPEN ABDOMEN CONSENSUS

Do we have to leave the abdomen open when using negative pressure wound therapy in peritonitis? A feasibility study.

Olof Jannasch[1], P.Ihle[2]
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[2]Department of General, Abdominal, Thoracic Surgery and Proctology, Hufeland hospital, Mühlhausen, Germany

Aim: Negative pressure wound therapy (NPWT) is established in therapy of abdominal sepsis. Prolonged use of NPWT may lead to non-closure of the abdominal fascia and development of further complications and ventral hernia formation. The aim of this study was evaluation of the Closed Cavity Vacuum Sealing (CVS) - a modification of the usually used NPWT in patients with peritonitis.

Methods: From 1st August 2011 to 30th September 2013 the CVS-Abdomen was used for treatment of secondary and postoperative peritonitis. In contrast to the usually applied NPWT an adhesive mesh and 1-2 drains are placed between two polyurethane foams. Drains are diverted laterally of the laparostomy wound. Afterwards the abdominal wall is closed over the foams. For application of NPWT a novel universal adapter ensures compatibility with every commercially available suction device.

Results: CVS-Abdomen was used in 14 patients. Duration of treatment ranged from 7 to 25 days. Time interval for changing of dressing and foams was 3 to 5 days. Fascia and skin closure was achieved in all patients. Surgical reinterventions for bleeding, intraabdominal abscess or injury of internal organs were not necessary. We did not observe formation of an intestinal fistula. In 2 year follow up no patient was diagnosed with a ventral hernia.

Conclusions: CVS-Abdomen is an interesting alternative for treatment of peritonitis using NPWT. The device can be combined with commercially available NPWT systems using the universal adapter. Main advantage is prevention of fascial retraction during therapy compared to conventional open abdomen management or classic NPWT in abdominal sepsis.

Opportunities of negative pressure wound therapy to patients with severe abdominal sepsis.

S.Shlyapnikov, A.Demko, I.Batyrshin
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Saint-Petersburg, Russian Federation

Aim: Investigate the possibility of applying negative pressure wound therapy (NPWT) in patients with severe abdominal sepsis (SAS), assess the impact of NPWT on the outcome of treatment, the development of a local and systemic complications .

Material. The prospective study of 77 patients with SAS in the period 2013-2015 was made. Inclusion criteria - patients with SAS, SOFA>4, MPI - 25-29 . Treatment of patients of the main group (n- 48) was performed using NPWT. The control group (n- 29) was performed in accordance with the traditional approach: "relaparotomy on demand". Evaluation of the different approaches was carried out from the perspective of 28 day mortality and the incidence of postoperative complications.

Results:

1. 28 day mortality rate in the study group was - 41.7 %, 75.9 % in the control

2 Early postoperative complications such as acute ulcers of the intestine , complicated perforations in the main group - 11 (23 %), in the control group - 16 (55.2%); bleeding from the tissues of the abdominal wall developed in 3 (6.3%) in the main group , the control group this complication has not been received , the development of surgical site infection in the study group were registered in 3 (6.3%) in the control group - 25 (86.2 %) , the formation of postoperative ventral hernia in the main group was 36 (75 %), in the control group - 12(41.4 %). In the control group also noted the eventration development - 6(20.7%).

Conclusions:

1. Application of NPWT can reduce the level of 28 -day mortality in patients with SAS requiring the "open abdomen treatment" .

2 . Surgical approach using NPWT can significantly reduce the number of early postoperative complications such as acute ulcers of the small intestine, but increase development of postoperative ventral hernias .

3 . Application of NPWT can reduce the number of repeated abdominal debridement.

Flatology as a cause of Compartment Syndrome?

A.Tamas, JP McGrath Department of General Surgery of Our Lady's Hospital, Navan, Ireland

Introduction: We present a rare case of fatal flatology.

Clinical Case: A 33 year old man in residential care with intellectual disabilities presented to Our Lady's Hospital, Navan with coffee ground vomitus, abdominal pain and distension. He was noted to be anuric. His background was significant for long standing constipation, epilepsy and gastritis. In ED he received a phosphate enema as an initial attempt to address his constipation but deteriorated dramatically over a period of an hour with increasing abdominal distension and a combined metabolic and respiratory acidosis.

A CT scan revealed a large bowel dilated to rectum full of faecal residue and small bowel dilated with faecalisation. He was transferred to theatre where underwent a laparotomy. He had a massively distended gaseous colon with ischemia involving colon from splenic flexure to terminal ileum. A subtotal colectomy with end ileostomy was performed. The patient did not survive.

Discussion: We believe the long standing constipation was the background to an acute presentation of a closed loop obstruction with complete obstruction and a massive and fatal build up of flatus leading to progressive distension and intra abdominal hypertension . The combination of the these clinical features make it an important but rare complication of severe constipationentity to

Conclusion: Intra-abdominal hypertension and abdominal compartment syndrome are increasingly recognized in both medical and surgical critically ill patients and are predictive of death. Prompt recognition and intervention to decrease the intra-abdominal pressure and improve vital organ perfusion are essential.

Single center experience of the open abdomen

Jae Gil Lee, Young Un Choi, Seung Hwan Lee
Department of Surgery, Yonsei university college of medicine

Purpose: To review the single center experiences of the open abdomen
Methods: Medical records for 59 patients who managed by open abdomen after laparotomy were reviewed retrospectively from March 2009 to December 2015 at tertiary university hospital. The indications for the open abdomen were followed;
1) traumatic hemoperitoneum requiring massive transfusion,
2) uncontrolled intraabdominal infection,
3) bowel infarction requiring second look laparotomy, and
4) impending risk of abdominal compartment syndrome such as non-traumatic intra-abdominal bleeding.
Patients who died within 48 hours after initial open abdomen were excluded from the analysis. Statistical analysis were performed by using IBM SPSS ver. 20.0.
Results: Forty-seven patients were included for this study. Mean age was 52.2 2±16.7 years old, and men were 37 (78.7%). The leading cause of open abdomen was traumatic abdominal injury in 23 (48.9 %), and followed by bowel perforation (10, 21.3%), non-traumatic bleeding (7, 14.9 %), and bowel infarction (6, 12.8 %). Preoperative shock was accompanied by 37 patients (78.7 %). Abdominal wall was closed in 38 patients (80.9 %), and median times for dressing changes were 0 (IQR 0 ~ 1). Abdominal wall was closed by primarily in 21 patients (44.7 %), and followed by fascial closure using artificial mesh technique (12, 25.5 %). Length of ICU and hospital stay were 12.0 days and 32.0 days, respectively. Time interval to abdominal closure was 4 days (IQR 2 ~ 10.3 days) after open abdomen. Complications were developed in 27 patients, including uncontrolled sepsis (21.3 %), entero-atmospheric fistula (19.1 %), ventral hernia (8.5 %), bleeding (4.3 %), and lateralization (4.3 %). Overall mortality rate was 44.7 % in all patients, and main cause of the death was sepsis (61.9%)
Conclusion: The major cause of abdomen was traumatic intraabdominal bleeding, and closed primarily in most patients. However, complications are occurred frequently, resulting in poor outcome. Further analysis for the risk and benefits of the open abdomen is required.
Keywords: open abdomen, intraabdominal hypertension, hemoperitoneum, intraabdominal infection

A stepwise approach in managing enteroatmospheric fistulae in a frozen abdomen - A prospective study with two year follow up

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[2]Department of Vascular Surgery, Municipial hospital, Magdeburg, Germany
[3]Department of General, Abdominal and Vascular Surgery, University hospital, Magdeburg, Germany

Aim: Formation of an intestinal fistula in an open abdomen is considered as one of the most serious complications. Prolonged treatment and development of a frozen abdomen often marks the end for surgical treatment of the fistula. A variety of procedures exist to separate the fistula and assure healing of the surrounding wound. However, existing therapies often lead to long treatment periods or do not solve the problem at all. Aim of this study was analysis of a stepwise approach including the use of the fistula adapter (FA) in managing enteroatmospheric fistulae (EAF).
Methods: This prospective study concerned all patients with open abdomen and EAF treated from April 2005 to June 2014 in a university hospital. Patients with a frozen abdomen and inability of surgical revision were evaluated for management with the FA and negative pressure wound therapy. The FA used (diameter 1.5, 3.0 and 4.5 cm, respectively) was selected in relation to size, number and location of the EAF. Follow up covered a period of at least 2 years after the initial formation of the EAF.
Results: Of 55 patients included in this study 28 developed a frozen abdomen with accompanying EAF. 21 were managed with the FA. We used up to 4 FA simultaneously in one patient. 3 of the 21 patients died in hospital. One fistula closed spontaneously. One patient underwent surgical revision after 3 months. The remaining 16 patients were discharged with a conventional ostomy bag. In follow up 6 patients underwent surgical closure of the fistula, in one patient a low volume fistula closed spontaneously, 6 patients live with an ostomy and 3 died still having their fistula.
Conclusions: We present a stepwise approach in treating patients with a frozen abdomen and accompanying EAF. In most cases a reliable separation of the fistula was achieved with the FA. The system can be easily applied and supports early mobilization and oral feeding. Most patients could be discharged for outpatient treatment with a conventional ostomy bag.

A Protocol Combining Open Abdomen and Staged Abdominal Closure Provides Effective Treatment for Acute Pancreatitis Complicated with Early Multiple Organ Failure.

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1. Division of Trauma and Emergency Surgery Department of Surgery
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2. Division of Emergency and Critical Care Radiology, Department of Medical Imaging and Intervention, Chang-Gung Memorial Hospital, Linkou, Taiwan

Background: Early multiple organ failure in acute pancreatitis is still challenging. Abdominal compartment syndrome is crucial for this critical condition. This study is to evaluate the efficacy of our multi-discipline protocol in management for acute pancreatitis with early multiple organ failure.
Material and methods: This a prospective protocol directed observation study. Decompressive laparotomy with open abdomen was arranged immediately if acute pancreatitis complicated with abdominal compartment syndrome and multiple organ failure was confirmed. Bogota bag was the choice for temporary abdominal closure. Organ supportive measurements as renal replacement therapy, ventilator, vasoactive agent or extracorporeal membrane oxygenation were arranged if indicated. Early enteral feeding via nasogastric tube was done as early if feasible. Retroperitoneal abscess evacuation was performed if it had been confirmed by computed tomography. After condition improved, staged

operation combined with plasty surgeon for abdominal domain reconstruction was achieved. Data collection includes demographic data, Ranson score, SOFA score, length of ICU stay, complications and final result.
Results: Since 2015/05, there were 15 patients admitted to Chang Gung Memorial Hospital, due to severe form acute pancreatitis complicated with early multiple organ failure.
All patients received contrast CT study initially. The Balthazar grade were all E and the average CTSI was 9.4. The area of pancreatic necrosis was >50% for 8 patients and >80% for 7 patients. The average RANSON score for acute pancreatitis was 6.7 and he average preoperative SOFA score was 12.9. After operation and ICU treatment, 12 patients survived with an average length of hospital stay 44.2 days. Three patients died so the mortality rate is 20% now. 12 patients developed retroperitoneal abscess and received multiple operations. After treatment, 12 patients achieved stable condition with a length of hospital stay about 44.2 days. 9 patients had successful abdominal domain reconstruction with an average duration of open abdomen for 84.1 (2-298) days.
Conclusions: This protocol including open abdomen, surgical critical care, and delayed abdominal domain reconstruction seems feasible for acute pancreatitis complicated with early multiple organ failure. Mortality rate is much lower than that predicted by scoring system. More patients should be enrolled in the future for efficacy evaluation.

The european open abdomen registry - Introduction of the Data Set and Initial Results of Procedures and Procedure-Related Complications

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German Armed Forces Central Hospital

Introduction: Open abdomen management has become a well-established strategy in the treatment of serious intra-abdominal pathologies. Key objectives are fistula prevention and high fascial closure rates. The current level of evidence on laparostoma is insufficient. This is due to the rareness of laparostomas, the heterogeneity of study cohorts, and broadly diversified techniques. A standardised, multicentre registration is necessary to draw up evidence-based guidelines.
Material and methods: In order to improve the level of evidence on laparostomas, the implementation of a laparostoma registry has been initiated by CAMIN (Chapter for Military and Emergency Surgery) of DGAV (German Society for General and Visceral Surgery). It was implemented as the Open Abdomen Route by EuraHS. Key objectives include collection, quality assurance, standardisation of therapeutic concepts and the development of guidelines. Since 1 May 2015, the registry is available as an online database called Open Abdomen Route of EuraHS (European Registry of Abdominal Wall Hernias). It includes 11 categories for data collection, including 3 scheduled follow-up examinations.
Results: Within this pilot study all entries of the first 120 days have been analysed resulting in a review of 82 patients. At 44%, secondary peritonitis is the predominant indication. Mortality is 22%. Comparing methods with / without fascial traction reveals fascial closure rates of 67% / 25% (intention to treat analysis, $p<0.03$). Inert visceral protection has been used in 67% of patients and achieved a small bowel fistula incidence of only 5.5%.
Discussion: Technical optimisation of laparostoma management to reach low fistula incidence and high fascial closure rates is possible. A method that grants the best possible outcome, measured by current evidence, would include fascial traction, visceral protection and negative pressure. The laparostoma registry is a useful tool to generate, in the short term, sufficient evidence for open abdomen treatment.

Influence of intra-abdominal hypertension on the marker-presepsin sCD14.

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Background: One of the most frequent and heavy complications associated with intra-abdominal hypertension (IAH) is development of the septic state. Now this marker-presepsin sCD14 is considered as the earliest marker of bacterial and fungic systemic infections: increasing of its level means disturbance of barrier function of intestine and the beginning of bacterial flora circulation in blood.
Objective: To evaluate the influence of IAH on the marker-presepsin sCD14.
Material and methods: The experimental research: male rats of the same age, weight, diet (n=100). Among them: a control group (n=10) - intact animals without affecting; comparison group (n=90) - animals, which was artificially created by IAH of different degrees (15, 25, 35 mm Hg) and different exposure times (3, 12, 24 hours). In all animals we investigated the marker-presepsin sCD14.
Results: Results of experiment are presented in Table 1.

Table 1.
Results of investigation of sCD14 in the experiment.

Control group (intact rats), n=10, sCD14=19,42 ng/ml									
Comparison group (rats with IAH), n=90									
	15 mm Hg, n=30			25 mm Hg, n=30			35 mm Hg, n=30		
	3 hours (n=10)	12 hours (n=10)	24 hours (n=10)	3 hours (n=10)	12 hours (n=10)	24 hours (n=10)	3 hours (n=10)	12 hours (n=10)	24 hours (n=10)
sCD14	23,55 ±0,82	42,08 ±1,35*	42,85 ±1,94*	37,04 ±1,85*	145,36 ±4,01*	148,33 ±2,44*	37,7 ±1,02*	209,3 ±3,97*	213,3 ±4,86*

ABSTRACTS – OPEN ABDOMEN CONSENSUS

* p<0,01

The sCD14 concentration in blood linearly increases to rising of the abdominal pressure in an . At the same time, there is statistically significant difference in groups with IAH and control group. The insignificant increasing of sCD14 concentration is noted only in group 15 mm Hg + 3 hours. IAH 25 and 35 mm Hg causes almost double rising of sCD14 concentration even in 3 hours, and further at IAH duration till 12-24 o'clock there is a sharp jump of sCD14 (at 7-10 times) in blood plasma. There are very insignificant differences between the 12-hour and 24-hour sCD14 concentration in all three groups.
Conclusions: sCD14 protein can be considered as the early biomarker of the preseptic state at the intra-abdominal hypertension demonstrating enterogenous translocation of microorganisms to the blood system.

Open abdomen: an old technique with new indications

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Department of Emergency Care, Torrevieja University Hospital, Torrevieja, Spain[2]

The open abdomen (OA) management is still a frequently used and useful process in the surgeons' hand.
The history of OA management is very similar to the history of other innovations of medicine: describe, forgotten, re-discovered, and faced with skepticisms but finally has been accepted as "truth". The OA management was firstly described probably in 1897, re-introduced in 1940, but only during the last decades became a widely used and accepted technique. The early indications were trauma and/or the septic abdomen. The main concept was to control the bleeding, to control contamination and to leave the abdominal cavity open to decompress or facilitate return at planned relaparotomy. Nowadays the technique itself is the same but the indications are different. The most important indications are: trauma, damage control surgery, critically ill surgical patient, septic surgical patient, catastrophic abdomen, intra-abdominal hypertension (IAH), abdominal compartment syndrome (ACS), multicompartment syndrome (MCS) and the giant abdominal wall defects. The importance of the correct indication is extremely high because the OA is still a high morbidity procedure.
The authors review the different indications presenting a typical clinical case of each.

ABSTRACTS – INTRA-ABDOMINAL INFECTION

Laparoscopic surgery for intra-abdominal infections in Japan

Tomo Oka
Tokyo Medical and Dental University Hospital of Medicine, Trauma and Acute Critical Care Medical Center

Background: Laparoscopic surgery is not only an accepted procedure for digestive surgery but also an emerging technique in emergency general surgery in Japan, such as cholecystectomy and appendectomy. We have known that Laparoscopic surgery has the advantages of minimally invasive procedure.
Material and Method: Our department is Trauma and Acute Critical Care Medical Center. We have performed only emergency surgeries without elective surgeries and provided intensive care for postoperative patients in ourselves. In our field, the surgeons having an interest in laparoscopic surgery certificated their boards and had performed laparoscopic procedures for emergency general surgeries with intra-abdominal infection including acute peritonitis. We would like to show the change of laparoscopic surgeries in our department, and actually the videos of our laparoscopic procedures and the photographic images of postoperative wounds.
Result: The numbers of laparoscopic surgeries have been increasing in our department year after year. The number of surgeries was more than 250 per year and then the proportion of laparoscopic surgeries was more than 17%. We show the videos of laparoscopic procedures and the photographic images of postoperative wound (i.e. Appendectomy, Hartmann' operation).
Conclusion: Laparoscopic surgery has spread in our field. I think that laparoscopic surgery is more useful than conventional open surgery (e.g. wound infection, length of hospital stay), if patients have appropriate indications, such as hemodynamic stable. In the future, with the improvement of their device and surgeon experience, laparoscopic surgery will be needed in the field of acute care surgery.

SURGICAL INTERVENTION IN ACUTE PANCREATITIS: TIMING AND COORDINATION ARE THE KEY

Ionut Negoi[1,2], Sorin Paun[1,2], Sorin Hostiuc[3], Alin Moldoveanu[4], Mircea Beuran[1,2]

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Introduction: Severe acute pancreatitis (AP) continues to be associated with significant morbidity and mortality, despite the nowadays pancreatic surgical techniques and intensive care refinements [1-3].

Objective: The aim of the current study is to correlate the timing of surgery with morbidity and mortality in patients with acute pancreatitis, stratified according to Atlanta 2012 classification, in the current era of intensive care and minimally invasive technologies.

Method: Retrospective study of patients admitted in a tertiary emergency center, between November 2012 and Nov 2015. Selection criteria: (1) acute pancreatitis; (2) open or minimally invasive surgical approach.

Results: 624 patients were selected, with mild in 337 (54%), moderate severe in 243 (39%) and severe AP in 44 (7%) patients. The etiology was biliary in 250 (40%), alcohol in 108 (17.3%), hypertriglyceridemia in 31 (5%) and ERCP in 12 (2%) patients. The mean time to surgery was 9.8±3.7 days and 26.43±9.1 days in patients with moderately severe and severe AP, respectively. In patients with severe AP, the indication for surgery was infected (proved or suspected) necrosis in 18 (63%) of cases, lack of clinical progression in 10 (23%) and progressive multiple organ dysfunction in 6 (14%) patients. Patients with moderate-severe AP and a surgical procedure earlier than 28 days presented predominant class I-II complications, according to Clavien-Dindo scale, while patients with severe AP had class IV-V complications (p Chi-square=0.022). Mortality was 0 in patients with moderate-severe AP, and 42% in patients with severe AP (p Chi-square=0.01). In patients with severe AP, surgical intervention earlier than 28 days was associated with a significantly higher mortality (p Log Rank=0.026). **Conclusions**: In patients with severe acute pancreatitis, surgical intervention earlier than 28 days is associated with significant majore complication and mortality rate. Nowadays combinations of intensive care and minimmaly invasive techniques may buy precious time for these patients.

Key words: acute pancreatitis, morbidity, mortality, surgery.

Acknowledgement: This work was supported by a grant of the Romanian National Authority for Scientific Research and Innovation, CCCDI UEFISCDI, project number 9831 (https://www.eurostars-eureka.eu/project/id/9831).

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Costs of admission for adhesive small bowel obstruction

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[1]*Department of Surgery, Radboud University Medical Center, Nijmegen, The Netherlands*

Objective: To provide an accurate cost estimate of the in-hospital costs for treatment of adhesive small bowel obstruction (ASBO) using micro- costing methods.

Background: Previous research on the costs of treatment ASBO is outdated and often based on reimbursements, rather than the true costs of admission an related intervention. Treatment and surgery for ASBO has changed and protocolized during recent years. An accurate estimate of the true costs of treatment is necessary to understand healthcare burden and model cost-efficacy of anti-adhesion measurements.

Methods: Consecutive patients admitted for ASBO to the Radboud University Medical center from November 2013 to November 2015 were included. An episode of ASBO was defined as an readmission for SBO with operative confirmation of adhesions or after radiological exclusion of other causes for SBO. For the purpose of generalization we used the costs of medication and interventions as provided by the Dutch Health Authority whenever possible. If these were not available local hospital costs were used. We evaluated costs separately for operative treatment for ASBO and non-operative treatment.

Results: A total of 185 patients developed SBO, of which 39 patients had at least 1 episode of ASBO. Fourty-six consecutive admissions were reviewed, 7 of them were transferred to other hospitals providing no complete admission data and are therefore excluded, leaving 39 admissions for ASBO during the study period. An operative treatment was required in 19 patients (48.7%).

Mean hospital stay for ASBO with operative treatment was 16.0±11 days versus 4.0±2.0 days for non-operative treatment (P=0.003)

Overall costs for an admission for ASBO with operative treatment were €16.090,88 (SD €2.505,52), and for non-operative treatment € 2.277,27 (SD € 265.34) (p = <0.005). The costs made for an operative treatment for ASBO consist mostly of ward costs (mean €7.855, 74, SD

€6881.54), operation costs (mean €2684.71, SD €1434.29), ICU costs (mean €2183.00, 74, SD €4304.93) and feeding costs (mean €1797, 37, SD €2069.71).
Conclusion: The costs of an admission for ASBO are much higher than previously thought. These costs can be used to guide development of cost-effectiveness model for anti-adhesion barriers.
Keywords: colorectal surgery, SBO, surgery, adhesions

Table 1 Comparison of Costs for Operative vs. Non-operative treatment for ASO

	Operative		**Non operative**		**Independent sample T-test**
	Mean	SD	Mean	SD	
Operation	€ 2684.71	€ 1434.29	€ 0	€ 0	
Medication	€ 634.13	€ 816.08	€ 99.34	€ 93.17	P = 0.011
Radiology	€ 510.00	€ 467.70	€ 154.92	€ 159.88	P = 0.003
Laboratory	€ 324.49	€ 223.20	€ 69.82	€ 38.94	P = 0.00
Microbiology	€ 69.70	€ 98.10	€ 11.06	€ 37.34	P = 0.023
Ward	€ 7855.74	€ 6881.54	€ 1850.47	€ 913.92	P = 0.001
ICU	€ 2183.00	€ 4304.93	€ 0	€ 0	
Feeding	€ 1797.37	€ 2069.71	€ 91.65	€ 288.56	P = 0.002
Blood products	€ 31.74	€ 100.79	€ 0	€ 0	

Use of adhesion reduction device in colorectal surgery: a modeling study of the cost-effectiveness
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Objective: To determine the cost-effectiveness of the use of adhesion barriers in colorectal surgery, regarding to prevention of adhesive small bowel obstruction (ASBO) and reduction of complication in reoperations.

Background: Despite the burden of postoperative adhesions, adhesion barriers are seldom applied in colorectal surgery. Data on the effectiveness of adhesion barriers are published in recent literature but a cost-effectiveness analysis of the use of adhesion barriers lacks.

Methods: A decision tree model was developed to determine the cost-effectiveness of the use of anti-adhesion barriers such as Seprafilm® in colorectal surgery. Different strategies were compared, open versus laparoscopic colorectal surgery either with or without the use of an anti-adhesion barrier. Pubmed, Medline and the Cochrane database were searched for the best available evidence regarding the probabilities needed for the decision tree model. Outcome of this model were the provider of healthcare costs, which included only direct healthcare costs, for all treatment strategies.

Results: The costs for all different treatment strategies in both open and laparoscopic surgery were compared. Anti-adhesion barriers can be applied cost-effectively. A sensitivity analysis will be performed to take in account the uncertainties concerning the probabilities used in the model.

Conclusion: We hope to support the hypothesis that the use of adhesion barriers in colorectal surgery is not only effective but also cost-effective in the prevention of adhesion related problems following colorectal surgery.

Keywords: colorectal surgery, cost-effectiveness, surgery, adhesions

ABSTRACTS – MINI POSTER SESSION

CLOSTRIDIUM PERFRINGENS´S NECROTIZING ACUTE PANCREATITIS: A CASE OF SUCCESS

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Necrotizing pancreatitis caused by *Clostridium perfringens* is a rare condition that is associated with high morbidity and mortality. Initial presentation on CT scan with pneumoperitoneum and pneumoretroperitoneum is even more unusual.

The authors report a 62-year-old man with medical history of hypertension, dyslipidemia and previous coronary stent placement. He came to the emergency department with upper abdominal pain with few hours of onset and vomits. The initial serum amylase was 2306U/l. The first CT showed signs of a non-complicated acute pancreatitis. He remained under surveillance and suffered clinical deterioration with progressive abdominal pain and tenderness and for this reason he was admitted to the intensive care unit where he progressed rapidly to multiple organ failure in less than 24 hours. A new CT scan was performed that showed pneumoperitoneum and pneumoretroperitoneum. This sudden worsening raised the suspicion for visceral perforation versus clostridium necrotizing pancreatitis reason why empiric antibiotherapy with Meropenem and Metronidazole were initiated and exploratory laparotomy was proposed. We performed a pancreatic necrosectomy and vacuum pack laparostomy. He returned on the immediate post operative period to the intensive care unit (for 37 days) with ventilatory, transfusional and inotropic support needed. Intraoperative peritoneal fluid culture was positive for *Clostridium perfringens* confirming the diagnosis. Nineteen days after surgery a method of mesh mediated fascial traction was applied. He was submitted to several laparostomy reviews (10 in total) on the operating room, with mesh gradual closure combined with laparoscopic assisted necrosectomy. A low debit pancreatic fistula developed and was oriented to the left hypochondrium. Inaugural diabetes was registered too and nowadays he is insulin dependent. Nevertheless, the fascial layer was completely closed in 4 weeks and good cosmetic results were achieved. He was discharged from hospital after 61 days. He is now on the 15th month of follow-up.

This condition is often fatal and an early diagnosis with prompt surgical treatment and adequate resuscitation are the key for success, making it possible to survive clostridium perfringens necrotizing pancreatitis.

Non-operative management for high grade hepatosplenic trauma associated with cerebral, thoracic, pelvic and limb traumatic lesions

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Introduction: The effectiveness of non-operative management for high grade hepatosplenic trauma remains unclear with an overall failure rate of 4,9%. Non-operative management for these patients may be efficient and may increase organ salvage rates and decrease blood transfusions requirements, nontherapeutic laparotomy rates, septic complications and mortality rates.

Case Report: A 20-years old healthy male patient was admitted to the emergency department after a violent motor vehicle accident. Initial assessment revealed: A – no airway obstruction, cervical spine was immobilized; B – no respiratory distress or subcutaneous emphysema. Normal breath sounds with a pulse oximeter reading of 100% (venturi mask 28%). C – Blood pressure 72/54 mmHg and heart rate 87 bpm. Abdomen examination was unremarkable. Pelvis was unstable. Two catheters were placed and 2L of normal saline solution was administered. It was applied a pelvic binder. The patient was hemodynamically normal after fluid ressuscitation. D – Glasgow Coma Scale Score was 15. E - Deformity of right upper limb and slight external rotation of left lower limb.

Blood samples revealed hemoglobin of 9.8 g/dl. Urinary cannabinoids were positive. It was documented a hepatosplenic trauma (grade 3/4), chest trauma with pneumothorax and pulmonary contusion requiring thoracic drainage, brain contusion and intracraneal hemorrhage, pelvic trauma (fracture of sacrum, ileopubic and ischiopubic tract and symphysis diastasis) and cubital shaft fracture with elbow dislocation.

He was decided medical treatment and patient was admitted to an intensive care unit with a favorable evolution. and discharge hospital after 3 weeks. Two months after no permanent lesions were observed and abdominal CT scan revealed complete resolution of the hepatosplenic trauma.

Conclusion: This patient demonstrates a successful case of non-operative management of high grade hepatosplenic trauma associated with other non-abdominal trauma. Non-operative management has higher rate of success in younger patients with no comorbidities, but is only indicated for those hemodinamically normal or responsive to fluid resuscitation.

MANAGEMENT OF A SEVERE GUNSHOT TRAUMA DURING HUNTING

Eugenio Cocozza, Mattia Berselli, Valeria Quintodei, Lorenzo Livraghi, Lorenzo Latham, Luca Farassino, Giacomo Borroni, Jacopo Galvanin.

Introduction: The emergency surgery management of a gunshot trauma is a challenge chapter. The case of a 64-years old man taken to DEA by helicopter and admitted for a severe gunshot trauma (shotgun during hunting) is reported.

Methods: A CT scan revealed: multiple birdshots in the abdomen, large hepatic loss of substance at VI segment, right kidney hematoma, free peritoneal fluids, burst fracture of the right iliac bone, IX, X, XI ribs and loss of substance of the right side and posterior part of the abdominal wall.

Results: Patient underwent to explorative laparotomy, ileal resection, abdominal packing with effective hemostasis and Bogota-bag laparostomy. Periodic revision of the abdominal cavity were performed. In 10 POD the definitive abdominal closure was carried out with a biological prosthesis and a VAC therapy device. During ICU recovery kidney failure and multi-resistant infections occurred. The patient was treated with antibiotics and dialysis. After 2 months he underwent to plastic surgery in order to cover the abdominal loss of substance with a graft from his right thigh.

Conclusions: The patient was discharge in good condition from ICU department to our department in 42 POD. In 74 POD he was transferred to rehabilitation clinic.
Emergency laparotomy, VAC therapy, delayed abdominal closure with the use of riassorbable prosthesis are milestones in the centralized treatment of major abdominal traumas.

Under Pressure: can a better understanding of emergency intra-operative decision-making processes improve surgeons' performance?

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Introduction: Non-Operative Technical Skills in Surgery (NOTSS), a fundamental aspect of which is decision-making skills, has gained precedence in contemporary surgical training. Good decision-making skills are particularly pertinent in emergency surgery. However, with changes in working patterns many trainee surgeons perceive a lack of exposure limits experience from which such skills are developed. Current research on intra-operative decision-making, particularly in emergency surgery, is limited. Few studies explore intra-operative decision-making processes. Analogies with pilots' decision-making are overemphasized considering the technologies supporting aviation decision-making compared to those supporting the surgeon in emergency theatre.
Aims: To establish: 1) decision-making processes employed in emergency surgery, 2) how these processes are applied, 3) factors that impact these processes, 4) what surgeons perceive as good and poor decisions.
Methods: An anonymous questionnaire combining quantitative and qualitative data collection was distributed to doctors working within the general surgery departments of two tertiary level district general hospitals in Scotland. The questionnaire underwent satisfactory testing of validity, reliability and psychometric properties (Chronbach's α coefficient scores 0.7-0.9 for each section).
Results: Following senior/colleague advice was the most common decision-making process employed in an emergency (62.5%; n=15). Factors impacting decision-making were rated from 5: highest impact, to 1: no impact. Perceived level of risk had the highest impact (96% score 5; n=24). Whether a complication was unexpected was the second highest (67%, n=18, score 4/5). Time available to make a decision and whether the complication was perceived as preventable were joint third most important factors (59%; n=16, score 4). Significant personal factors included how the individual perceived their own abilities (26%, n=7, score 5; 48%, n=13, score 4) and stress/fatigue (26%, n=7, score 5; 41%,n=11, score 4). 48% gave score 4 to impact of blame versus supportive culture. Good decision-making was defined as: calmly considered, safe, decisive, knowledge-based and clearly communicated. Poor decision-making was defined as: misplaced confidence, unsatisfactory patient outcome, lacking knowledge/experience and communicated poorly.
Conclusion: A better understanding of intra-operative decision-making during emergency surgery can improve surgical training in this area. However more research must be undertaken to better understand this complex multi-factorial process and how it can better be taught and developed.

Perforated Giant Duodenal Ulcer; The Surgeon's Dilemma.

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Abstract: Duodenal ulcer is the commonest cause of peptic ulcer perforation. Most were < 1 cm in diameter which can be effectively managed by an omental patch or pexy technique. Perforated ulcer with size of > 2 cm poses a management dilemma to surgeon as variety of operative techniques described but with lack of clinical evidence. This review is done for two main objectives which are to propose standardize definition of giant perforation and to recommend operative options for such condition. Both issues have not received an international interest due to its rarity despite of known significant morbidity and mortality compared to a much smaller ulcer. All relevant clinical papers published were identified and analyzed. Inclusion criteria were any surgical procedure done for large or giant peptic duodenal perforation sized > 2 cm. Trauma or malignancy related perforations were excluded. A total of nine papers which fulfilled the criteria were identified with majority (55%) retrospective in nature. Most authors agree to define giant ulcer for those > 2 cm in diameter whether it perforates or not. Until conclusive definition made and to avoid confusion, we suggest current definition remains. Operative options can be divided into resection or non resection approaches. The duodenal defect has to be closed for the former and resection is quite challenging as adjacent area typically indurated and inflammed. However it is preferred in stable patients with short duration of peritonitis (< 24 hours). Four options available are antrectomy with or without laparostomy, gastric disconnection (antrectomy and three tube ostomies), gastric body partition and duodenectomy with gastrojejunostomy. On the other hand, in hemodynamically unstable patient non resection technique is advocated. It is further subdivided into either omental based (patch, plug or free plug type), jejunal based (serosal patch or duodeno-jejunostomy) or tube based repair. Each of those techniques is discussed. In conclusion, based on current evidences non resection omental plug approach with or without three tube ostomies is advisable for duodenal defect size 2-3 cm (level 2b evidence, grade B recommendation). Resection approach preferably reserved for a larger defect (> 3 cm) or as a salvage procedure and obviously stages resection is favoured.

Extracellular bovine-derived peritoneum matrix: the new biological graft for abdominal wall reconstruction.

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Introduction: The extracellular bovine-derived peritoneum matrix represents a promising new fascial substitute for abdominal wall defects repair. The aim was to investigate the structural changes of the anterior abdominal wall upon a contact with xenoperitoneum implant under a 4-week period in the rat model.

Materials and Methods: Open abdominal wall defect repair was performed in 24 white non-linear rats, weight 180-225g. The extracellular bovine-derived peritoneum matrix was 1,0*1,0 cm per one animal. Observation periods were 7, 21, 30 days (n=8 in each group respectively). Macroscopical assessment was included the infection existence in implantation area, adhesion and seroma formation. Microscopical criteria were performed by an inflammatory response, neovascularization and the connective tissue maturation. The technique of staining with H&E, Van Gieson's stain with pikro-fuchin.

Results: Upon autopsy, macroscopically, in all cases no seroma formation or infection was observed. Adhesion formation at the margins of implants and suture sites were occasionally registered in 12% cases. By the 7th day the microscopic data showed the granulation tissue and new thin-walled blood vessels formation in the implantation area, the suture-line reactive inflammation and giant cell infiltration. On the 21st day there was granulation tissue maturation, around of the implantation area moderate lymphocytes infiltration and singular plasmocytes were fixed. At the 30th day connective tissue maturation was registered, inflammatory response was not observed.

Conclusion: The extracellular bovine-derived peritoneum matrix in the early stages of the experiment has been showed an adequate biocompatibility with the recipient body, without causing severe post-implantation inflammation. These data is allowed to use this new biological graft for abdominal wall reconstruction perspectively.

The effect of Vacuum-Assisted Closure In the management of highly contaminated wound.

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Background: The Vacuum-Assisted Closure (VAC) may play an important role in improving surgical site infection (SSI) .In Japan, the use of VAC system for highly contaminated wound following laparotomy is not common. We introduce our experience of using VAC system.

Case: 53-year old women who was diagnosed colorectal perforation, transported to our hospital. Her past histories were high blood pressure, cholelithiasis and Cesarean section. We performed emergency operation. Hartmann's procedure was performed for rectal perforation, but it took more than 3 hour because of the adhesion in her pelvis, highly contamination and obesity (BMI 34).Primary wound closure was thought to be the high risk of SSI, so we decided to use VAC system. We sutured only fascia and supra-aponeurotic prosthesis was applied. Wound dressing including the exchange of the prosthesis was done within 3 days after the surgery. Finally wound suture was done in 4 and 5 POD. After the wound closure, we continued VAC system from the top of the skin. In spite of the highly contaminated wound and Thick subcutaneous fat, she got well without any abdominal and wound infection

Conclusion: Since 2007, we experienced 70 cases of colorectal perforation, and unfortunately 39 patients suffered from SSI. We continued to improve the management of contaminated wound, and it will be the useful option. After the introduction of VAC system, 6 patients were applied and their results were better than conventional management.

Mycotic Splenic Vessel Aneurysm Leading to Massive GI Bleed: Abstract.

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Background: Whilst immunosuppression is a known risk factor for infected aneurysm, the most common offending organisms remain *Staphylococcus* and *Salmonellla* species. Splenic artery aneurysm is the most common visceral aneurysm, however, splenic vein aneurysm is far less observed. Mucormycosis is an infection by the Mucorales order of fungus, for which immunosuppression is also a risk factor. We present the case of a 48 year-old immunocompromised woman with mycotic abscess causing ruptured splenic vessel pseudoaneurysm.

The case: A 48 year- old woman presented to the emergency department one month post double lung transplant for idiopathic pulmonary fibrosis with massive and unstable upper GI bleed. She underwent an emergency exploratory laparotomy which revealed gastric ulceration eroding into the splenic hilum. She then underwent enbloc distal gastrectomy + splenectomy with gastrojejunostomy formation. Histology showed a mycotic abscess involving the splenic hilum and eroding into the splenic vein, confirmed as Mucormycosis by Periodic Acid Schiff staining.

Discussion: True mycotic aneurysm refers to those that originate from septic vegetations in the heart, or those caused by fungi. Mucorales order in particular is ubiquitous in nature, but mostly poses threat to immunocompromised or diabetic patients. Though it has a propensity for vascular invasion, rhino-orbital and respiratory infections are far more often described. The source of mucormycosis is unclear in this patient, but is assumed to be nosocomial. Splenic vein aneurysm is extremely rare, with increased portal pressure the proposed main underlying

mechanism. The presentation of the disease is varied with rupture in this case. Treatment involves removal of risk factors, infected tissue removal and targeted anti-fungal agents such as amphotericin B. Removal of immunosuppression in transplant patients increases risk of organ rejection, thereby complicating treatment.
Conclusion: Mycotic aneurysms of the splenic vasculature caused by mucormycosis are exceedingly rare. Nonetheless, they pose a life-threatening risk when present and in the case of solid-organ transplant patients present a therapeutic challenge as reducing immunosuppression increases risk of rejection.

IMPLICATIONS OF LEFT-SIDED GALLBLADDER IN ACUTE CHOLECYSTITIS

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Background: Left-sided gallbladder without situs viscerum inversus (LSG-woSVI) is considered to be a very uncommon congenital anomaly. Clinical features and routine pre-surgical imaging including ultrasounds could miss the anomalous position thereby producing complications during surgery. Infact, in the majority of the cases, the abnormal position of the gallbladder is discovered at surgery. Laparoscopic cholecystectomy can be performed safely, but bile duct injury can have higher incidence than orthotopic gallbladder.

Methods: We present an 18 years retrospective review of all scientific literature for diagnosed cases of LSG-woSVI undergoing cholecystectomy from 1996 to mid 2014. We carried a comprehensive search of the Pubmed using medical subject headings “left sided gallbladder”, “right-sided ligamentum terese” “situs viscerun inversus”, “preoperative diagnoses”, “cholecystectomy” and “bile duct injury”. We considered in our review a classification of the LSG-woSVI in two groups: True LSG-woSVI (T-LSG) and LSG-woSVI in patients with Right-sided ligamentum terese (R-LSG). The details of the diagnostic and operative procedure were analyzed, and particular attention was paid to the method of cholecystectomy and related complications.

Objectives: Our objectives were to outline empirical top tips for a safe cholecystectomy in incidentally diagnosed LSG.

Results: Our retrospective review revealed 14 cases of LSG-woSVI undergoing cholecystectomy for acute cholecystitis up to 2014. More than half of the cases (8/15= 51%) were reported in the last five years. Mean age was 54 years, M/F ratio was approximately 1:1 (6M) and the clinical presentation was pain in the right upper abdominal quadrant in 75.5% of the cases. Pre-operative diagnoses of LSG was reached in 14.3% of the cases. T-LSG was the most frequent type of LSG as it was diagnosed in 92.8% (13/14) while R-LSG was found in 7.2% of the cases in the literature. Laparoscopic cholecystectomy was performed in 85.7% (12/14) of the subjects and open cholecystectomy in the other 14.3%. Bile duct injury (BDI) occurred in 7.1%. All cases subjectected to cholecystectomy through the fundus first tecniche were free from BDI. Also, BDI did not occure in any of the cases subjected to intra-operative cholangiography.

Conclusions: LSG-woSVI is a rare congenital presentation of the gallbladder diagnosed incidentally during surgery in the majority of the cases. The incidence of BDI in this type of cholecystectomy is higher compared to that of the orthotopic gallblader. Preoperative diagnoses of LSGB could be difficult to reach in an emergency setting. Howevere intraoperative colangiography and fundus firsrt cholecystectomy shoul be considered as safe and razionale evidennced based procedures to reduce BDI during incidental intraoperative findings of LSGB.

Keywords: Left sided gallbladder, Right-sided ligamentum terese, Situs viscerun inversus, Preoperative diagnoses, Cholecystectomy, Bile duct injury

DIVERTICULITIS. RESECTION AND COLORECTAL ANASTOMOSIS WITH OR WTHOUT DIVERTING OSTOMY OR RESECTION AND END-COLOSTOMY?

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Introduction: Once the diseased colon is resected, the surgeon may complete the operation by performing a colorectal anastomosis with or without a diverting colostomy or ileostomy, or by constructing an end-colostomy.
Methods: The authors conducted a literature review of the last 20 years and a critical analysis of the results of their own experience.
Results/Discussion: The surgical literature is replete with non-randomized studies supporting the idea that primary anastomosis, in comparison with end-colostomy, is not associated with worse morbidity and mortality and may be associated with significantly improved morbidity and mortality rates. Nearly all of this literature is retrospective and suffers from an indeterminate degree of selection bias. One of the largest single-institution retrospective reviews described a “diverticulitis disease propensity score” estimating the likelihood of patients undergoing primary anastomosis versus end-colostomy and found that strong predictors of nonrestorative surgery included urgent or emergent cases, BMI ≥ 30, Mannheim peritonitis index ≥ 10, immunosuppression, and Hinchey grade 3 or 4. These patient factors are frequently recognized in the literature as predictors of end-colostomy formation. In one of the few prospective studies addressing the issue of primary anastomosis, patients with a higher Mannheim peritonitis index were much more likely to undergo end-colostomy. Because of the shortcomings of the literature, the clinician must weigh the risks associated with anastomotic failure and of prolonging the operation, while recognizing that end-colostomies created under these circumstances are often permanent. Parameters generally favoring proximal diversion include patient and

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