Agenda

29 April 2026

6:00 pm - 9:00 pm
Younger Fellows & Trainees Section Dinner (Ticketed Event)

Speciality Dinner - Younger Fellows, Trainees Association

30 April 2026

8:00 am - 5:30 pm
Minimally Invasive Robotic and Laparoscopic Breast Surgery Workshop (Ticketed Event)

Workshop - Breast Surgery

Location: CTEC (Clinical Training and Evaluation Centre) at UWA (University of Western Australia)

30 April 2026

8:30 am - 10:00 am
LIVER TRANSPLANTATION

Scientific Session - Transplantation Surgery - Meeting Room M6

8:30 am
Liver transplant for Colorectal liver metastases
Dr Arul Suthananthan

8:45 am
Experience with OrganOx and donation after circulatory death (DCD)
Dr Ruelan Furtado

9:00 am
Complex liver transplant (Auxiliary Liver Transplant)
Prof Weilin Wang

9:15 am
Intestinal transplantation – National update
Dr Ruelan Furtado

9:30 am
Organ sharing in liver transplantation
Associate Professor Michael Fink

9:45 am
Discussion

8:30 am - 10:00 am
SKINNING THE CAT: CONTRASTING DIFFERENT NGO MODELS

Scientific Session - Global Health - Meeting Room M3

8:30 am
Rafiki: Establishing the East African Plastic Surgery Fellowship
Dr James Savundra

8:50 am
Operation Smile Australia
Associate Professor Richard Lewandowski, Associate Professor Richard Lewandowski

9:10 am
Operation Rainbow
Dr Ranjit Kunchur

9:30 am
Interplast Australia
Dr Kirstie Macgill

9:50 am
Discussion

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30 April 2026

10:00 am - 10:30 am
Morning Tea - Thursday

Catering - Transplantation Surgery, Global Health

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30 April 2026

10:30 am - 11:00 am
KEYNOTE LECTURE - Prof. Dr. Naimish N. Mehta (JAIPUR, INDIA)

Keynote Lecture - Transplantation Surgery - Meeting Room M6

10:30 am
Liver transplantation: Dual Lobe liver Transplantation - Update
Dr Naimish Mehta

10:30 am - 11:00 am
Keynote Lecture - Professor Annie Sparrow (NEW YORK CITY, USA)

Keynote Lecture - Global Health - Meeting Room M3

10:30 am
Missing in action at the World Health Organisation
Professor Annie Sparrow

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30 April 2026

11:00 am - 12:30 pm
Pancreas and Renal transplantation

Scientific Session - Transplantation Surgery - Meeting Room M6

11:00 am
Increasing Utilisation of Donated Kidneys by Emerging Technology machine perfusion
Dr Bulang He

11:15 am
Adult Dual kidney Transplants – technical aspects, challenges and relevance
Dr Santosh Olakkengil

11:30 am
Artificial Intelligence in Transplantation: Progress, Pitfalls and the problems of Trust
Dr Marwan Idrees

11:40 am
Paediatric Renal transplantation - Victoria
Dr Ruelan Furtado

11:55 am
Renal artery stenosis post transplantation – Prevention and management
Dr Suresh Navadgi

12:10 pm
Implementation of Japan's First Robot-Assisted Living Donor Kidney transplantation program: Protocol Based Early Outcomes
Dr Shota Akabane

11:00 am - 12:30 pm
TEACH A MAN TO FISH: TRAINING LOCAL SURGEONS ON OUTREACH PROGRAMS

Scientific Session - Global Health - Meeting Room M3

11:00 am
The Global Alliance for Surgical, Obstetric, Trauma and Anaesthesia (G4) - Part 1
Dr Neil Wetzig

11:15 am
Pathways Programme, Operation Smile International
Associate Professor Mark Lee

11:30 am
Surgical Teaching in Malawi
Dr Amanda Foster

11:45 am
Royal Australasian College of Surgeons(RACS) Global Health program enhancing breast cancer care at Bir Hospital in Nepal: Low Income Country(LIC) global collaboration model for need based local initiative
A/Prof Dr Anip Joshi
Purpose Nepal is a Low Income Country in South-Asia. In Nepal, breast cancer ranked first in female in 2022 as per Global Cancer Observatory(GLOBOCAN) (1) and Nepal Health Research Council. Bir Hospital is a Nepal government run academic hospital under National Academy of Medical Sciences in Kathmandu, Nepal. Breast cancer is the most common cancer in Bir Hospital. Methodology This is an observational study of LIC global collaboration model for need based local initiative of breast surgery capacity building at Bir Hospital in Nepal supported by RACS Global Health scholarships. RACS Katherine Edyvane Scholarship in Humanitarian Surgery has supported a surgeon in Bir Hospital for breast surgery training at Mater Hospital, Brisbane from July to August 2025 . Results There are 132 cases of breast cancer treated in Bir Hospital

maintained in database for outcome study. Following the RACS Katherine Edyvane scholarship training, the monthly breast cancer Multidisciplinary team(MDT) meeting has started in Bir Hospital as an initiative for shared decision making for breast cancer patients. There is improvement in breast cancer patient care by co-ordinated breast cancer treatment with effective communication among multi-disciplinary team members along with continuation of breast cancer surgery outcome research. There is an initiative to develop multidisciplinary breast cancer treatment clinical protocol in Bir Hospital. Conclusion The Bir Hospital LIC global collaboration model in Nepal for breast surgery capacity building has been successful in support with RACS Global Health program. This has led to uniform standard of breast cancer care by multidisciplinary team meetings and initiating standard breast cancer treatment protocols. This has also initiated interactions between Australian and Nepalese surgeons for further regional collaboration for breast surgical practice, training and research. References
1.https://gco.iarc.who.int/media/globocan/factsheets/populations/524-nepal-fact-sheet.pdf

12:00 pm
Capacity Building in Essential Surgical, Obstetric, Trauma, and Anaesthesia Care: A Practical Training Model in Eastern DR Congo
Dr Neil Wetzig

12:15 pm
Discussion

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30 April 2026

12:30 pm - 1:30 pm
Lunch - Thursday

Catering - Global Health, Transplantation Surgery

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30 April 2026

1:30 pm - 2:00 pm
KEYNOTE LECTURE - DR HENRY PLEASS (NSW, AUSTRALIA)

Keynote Lecture - Transplantation Surgery - Meeting Room M6

1:30 pm
National update on Simultaneous Pancreas and Kidney (SPK) transplantation
Dr Henry Pleass

1:30 pm - 2:00 pm
THE ROWAN NICKS LECTURE - PROFESSOR ANNIE SPARROW (NEW YORK CITY, USA)

Named Lecture - Global Health - Meeting Room M3

1:30 pm
Germ Wars: The real drivers of Antimicrobial Resistance – and the real solutions to combat the AMR crisis
Professor Annie Sparrow

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30 April 2026

2:00 pm - 3:30 pm
FREE PAPERS

Scientific Session - Transplantation Surgery - Meeting Room M6

2:00 pm
Psoas Muscle Index–Defined Sarcopenia Is Associated With Mortality After Kidney Transplantation
Dr Charis Kelly
Purpose Sarcopenia is an increasingly recognised marker of physiological vulnerability in surgical patients, yet its impact on outcomes after kidney transplantation remains unclear. This study evaluated the relationship between psoas muscle index (PMI)–defined sarcopenia and post-transplant outcomes, with a focus on patient survival. Methodology We performed a retrospective cohort study of 331 adult kidney transplant recipients transplanted between 2019 and 2025 at a tertiary centre. Pre-transplant CT-derived PMI at the L3 vertebral level was available for approximately 260 patients and indexed to height. Sarcopenia was defined using established sex-specific thresholds (≤6.6 cm^2/m^2 for males and ≤4.8 cm^2/m^2 for females). PMI was analysed as both categorical and continuous variables. The primary outcome was 12-month mortality. Secondary outcomes included graft-related outcomes, length of stay, and post-operative complications. Multivariable logistic regression adjusted for age, body mass index, frailty score, and dialysis duration. Results Sarcopenia was prevalent and associated with greater frailty and longer dialysis duration. Lower PMI as a continuous measure was associated with increased odds of 12-month mortality on both unadjusted and adjusted analysis, with a trend approaching statistical significance. On adjusted analysis, lower PMI as a continuous measure remained independently associated with mortality, along with dialysis duration. No significant associations were observed between sarcopenia and graft-related outcomes. Urinary and wound complications were the most common post-operative events among sarcopenic recipients. Conclusion PMI-defined sarcopenia identifies kidney transplant recipients at increased risk of early post-transplant mortality but does not predict graft outcomes. Routine assessment of muscle mass using pre-transplant imaging may improve peri-operative risk stratification and inform targeted optimisation strategies.

2:15 pm
Renal allografts with fibromuscular dysplasia – overcoming the string of beads
Dr Shirley Cai
Purpose: Fibromuscular dysplasia (FMD) is a non-atherosclerotic systemic arterial disease that is not infrequently discovered during kidney donor evaluation (approximately 2-6% of living kidney donors). This can be diagnosed pre-operatively in living donors or intra-operatively/post-operatively in deceased donor allografts. There are no guidelines on renal allografts with FMD. The short and long-term consequences remain uncertain, but it is hypothesised that FMD can cause early graft dysfunction due to renal artery stenosis or dissection. We review the literature on symptomatic renal allografts with FMD and the management techniques. Methodology: A literature review was performed in MedLine, PubMed, and Embase for search terms “fibromuscular dysplasia”, “kidney transplantation” or “renal transplantation”, and “renal artery stenosis”. All relevant articles were included. Results: 19 studies (17 case reports and 2 case reviews) were included and reviewed. Management of FMD in renal allografts were either prophylactically performed or for therapeutic purposes. Prophylactic techniques described include resection of affected segment +/- reconstruction with venous graft or arterial graft. Symptomatic FMD in renal allografts present as graft dysfunction such as hypertensive crisis or rising creatinine. Therapeutic techniques described include open surgical revision and endovascular treatment of renal artery stenosis. Follow up ranged from 1 week to 5 years. Primary outcomes were blood pressure and measured creatinine. Majority of studies showed stable allograft function post intervention, with two studies resulting in transplant nephrectomies. Conclusion: Renal allografts with FMD may have a role in renal transplantation, but clinicians and transplant surgeons must be wary of their potential complications. Both open surgical and endovascular techniques have been described to treat symptomatic FMD or prophylactically treat renal allografts with FMD. Successful treatment has been observed but little is known about long-term outcomes and further studies are warranted.

2:30 pm
Bridging or Becoming the Default? Three Years of Tunnelled Dialysis Catheter Use in a High-Demand Centre
Dr Frances Lee
Purpose Tunnelled dialysis catheters are intended as temporary access, yet in regions with high dialysis demand they frequently become the default rather than a bridge to definitive access. This reliance carries implications for patient outcomes, surgical workload and resource allocation. This study examines tunnelled dialysis catheter insertion over a three-year period at a high-volume centre, aiming to characterise

utilisation patterns, access pathways and clinically relevant outcomes. Methodology A retrospective review was undertaken of all tunnelled dialysis catheter insertions performed over a three-year period at a tertiary hospital servicing a high dialysis-burden population. Data collected included patient demographics, indications for catheter insertion, insertion site and setting, operator specialty, early complications, catheter dwell time and progression to definitive vascular access, including arteriovenous fistula or graft formation. Descriptive analysis was used to identify practice patterns and potential areas for service improvement. Results Tunnelled dialysis catheters were widely utilised for both urgent dialysis initiation and ongoing access in patients without immediate alternatives. Preliminary review suggests prolonged catheter dependence in a substantial proportion of patients, reflecting access delays, patient comorbidity and system constraints. While major procedural complications were uncommon, catheter-related morbidity remained clinically relevant. The procedural volume highlights the significant and sustained surgical workload associated with catheter-based access in high-demand settings. Conclusion: Prolonged permacath use was common in this cohort. While no association was observed with age or diabetes, prolonged catheter dependence was associated with delays in access creation and progression through the access pathway. These findings suggest that factors beyond patient characteristics may contribute to extended catheter use. In this context, tunnelled dialysis catheters may not consistently function as short-term bridging access and, in some cases, may represent an initial or sustained mode of dialysis access. Further work is required to better characterise where delays occur within the access pathway and to determine whether targeted system-level interventions may reduce catheter dependence and improve patient outcomes.

2:45 pm
Beyond Traditional Risk Indices: V-FIT—A Visceral Fat–Focused Donor–Recipient Score for Predicting Post-Liver Transplant Graft Outcomes
Dr Shabnam Islam
Introduction: Existing donor and composite liver transplant scores quantify perioperative risk but largely omit body composition and metabolic mismatch between donor and recipient. A novel VAT-focused donor–recipient scoring system (V-FIT: Visceral Fat and Frailty Index Threshold Score) has been developed to integrate key donor and recipient characteristics, as well as the donation pathway, with the aim of refining the prediction of graft outcomes, particularly early allograft dysfunction (EAD), biliary complications, and long-term survival. The proposed scoring system includes inputs such as donor VAT (high/low), age, steatosis (≥30%/<30%), and DCD/DBD pathway, in addition to recipient VAT, MELD (>20/≤20), age, and steatotic liver disease. Each variable is weighted (DCD = 2, steatosis ≥30% = 2; other adverse factors = 1), resulting in a 0–9 score stratified as low (0–3), medium (4–6), and high risk (7–9), with corresponding recommendations ranging from standard implantation to machine perfusion or graft avoidance. Unlike currently utilized scores, V-FIT is the first to prioritize imaging-defined VAT in both donor and recipient, directly addressing mechanisms such as ischaemia-reperfusion injury, biliary complications, and early allograft dysfunction that are biologically linked to metabolic phenotype rather than BMI alone. Results: The V-FIT Score is expected to show superior discrimination for graft loss and EAD, particularly in obese donors and DCD grafts, by capturing metabolic mismatch. High-risk combinations (for example, high donor and recipient VAT with DCD) are anticipated to be identified, which are associated with increased biliary and ischaemia-reperfusion injury risks, where standard scores may underestimate the danger. Conclusion: Current liver transplant scores quantify surgical and logistic risk but neglect donor–recipient metabolic mismatch. A VAT-based, bidirectional donor–recipient score delivers a novel, mechanistically grounded framework.

3:00 pm
Dual-Organ Renal Transplantation: Historical Context, Contemporary Evidence, and Implications for Prophylactic Kidney Transplantation
Dr Phil Lu
Background: Since early reports of combined thoracic–renal transplantation in the late 1970s, dual-organ heart–kidney and lung–kidney transplantation has emerged as a strategy to address irreversible chronic kidney disease (CKD) in thoracic transplant candidates, where calcineurin-inhibitor nephrotoxicity and pre-existing renal dysfunction confer excess mortality and dialysis dependence. Early series demonstrated technical feasibility and suggested lower rejection rates with same-donor concurrent transplantation. Methods: We reviewed contemporary international literature on combined heart–kidney and lung–kidney transplantation, focusing on survival, graft outcomes, and post-transplant dialysis. We also describe the Alfred Health experience (the major heart/lung transplant service in Australia) using Australasian Vascular Audit data from 2010-2025 with 292 renal transplants, including 3 heart–kidney and 3 lung–kidney procedures. Results: Registry and single-centre studies show that simultaneous heart–kidney transplantation improves survival compared with isolated heart transplantation in patients on dialysis or with pre-transplant GFR<40, with 5-year survival of ~70–75% and reduced cardiac rejection and allograft

vasculopathy. Lung–kidney transplantation is associated with improved 1–3-year survival and lower dialysis dependence versus isolated lung transplantation in recipients with eGFR<30 or pre-transplant dialysis, though kidney allograft loss is higher than in isolated kidney recipients. Evidence supports considering prophylactic renal transplantation at mGFR<40–50 in selected patients, balancing operative efficiency and renal benefit against graft attrition and allocation ethics. Conclusions: Dual thoracic–renal transplantation offers meaningful survival, immunologic, and renal benefits in patients with advanced cardiorespiratory failure and CKD. Emerging data support prophylactic kidney transplantation in those with mGFR<50 at highest risk of post-transplant renal failure.

3:15 pm
Ex Vivo Normothermic Machine Perfusion of Human Kidneys: A Scoping Review
Dr Qi Rui Soh
Purpose Ex vivo normothermic machine perfusion (EVNMP) provides a near physiological environment for assessment and reconditioning of kidneys prior to transplantation. Although early studies demonstrated feasibility in salvaging marginal donor kidneys, EVNMP protocols remain heterogeneous. This scoping review aimed to characterise human kidney performance during EVNMP and identify priorities for optimisation. Methodology Systematic searches of Embase, MEDLINE, and the Cochrane Library were conducted from 1960 to January 2026. Studies applying EVNMP to human kidneys in pre-clinical and clinical settings were included. Data were extracted on perfusion systems and parameters, perfusate composition, temperature, duration, biomarkers, viability assessment strategies, and transplant outcomes. Results 29 studies were included, 25 used customised circuits and four used commercial systems. Blood-based perfusates were used in 25 studies, with non-cellular perfusates in four. Perfusion strategies varied between pressure and flow controlled approaches, with urine output ranging from 10 to 500 mL/h. Biomarkers were assessed in 20 studies alongside macroscopic appearance and renal blood flow. EVNMP duration ranged from 1–2 hours to ≥24 hours. Approximately 224 discarded kidneys were used in pre-clinical research and 245 kidneys were transplanted following EVNMP, including kidneys that may otherwise have been discarded. Conclusion EVNMP enables human kidneys to function as metabolically active organs ex vivo and has progressed from experimental research to clinical application in kidney salvage for transplantation. Discarded human kidneys have been central to technique development. However, substantial heterogeneity persists across devices, perfusates, temperatures, perfusion parameters, biomarkers, and duration. This review identifies key knowledge gaps and provides a framework to guide EVNMP optimisation and future research.

2:00 pm - 3:30 pm
GLOBAL HEALTH: INNOVATION IN THE DEVELOPING WORLD

Scientific Session - Global Health - Meeting Room M3

2:00 pm
The Global Alliance for Surgical, Obstetric, Trauma and Anaesthesia (G4) - Part 2
Dr Neil Wetzig

2:15 pm
System-Level Barriers to Vascular and Endovascular Surgical Care in Oceania: A Cross-Sectional Survey
Dr Ashton Arthur
Background: Vascular disease prevalence and mortality are increasing across Oceania, yet access to vascular and endovascular surgical care remains highly inequitable, particularly in low- and middle-income countries (LMICs). Limited data exist on service availability and barriers to care, limiting efforts to strengthen vascular services in underserved regions. Method: The Global Vascular Companionship conducted a mixed-methods cross-sectional survey of surgeons, healthcare personnel, and health ministry representatives across Pacific Island countries in Oceania, also including all sovereign nations and non-sovereign territories with populations over 100,000. Contacts were identified through professional networks and public directories. Datapoints were collected on service availability, workforce capacity, and barriers to care, and supplemented by an online search. Descriptive and thematic analyses were performed. Results: Fifteen nations were identified, with hospital numbers ranging from one to more than ten per country. Forty-nine phone numbers and 137 email addresses were contacted, yielding responses from 30 individuals. Of these, 22 completed surveys, representing 16 hospitals. Only Fiji and Guam have full-time vascular surgeons; four countries rely on visiting surgeons, while ten have no access to vascular surgeons. Thematic analysis identified system-level constraints including shortages of trained specialists, limited diagnostic imaging and endovascular equipment, inconsistent access to consumables, inadequate theatre capacity, and insufficient

funding. Workforce training was most frequently identified as the intervention with greatest potential impact. Conclusion: Vascular surgical care across Oceania is profoundly inequitable, with most nations lacking sustainable local services. Targeted workforce-focused capacity building, supported by appropriate resources and regional collaboration, is urgently needed to improve equitable access to care in Pacific nations.

2:30 pm
The impact of artificial intelligence and robotics in surgery, the current landscape and future convergence
Dr Bayan Minasian
Purpose: To compare how artificial intelligence (AI) and robotics, both individually and in combination, are changing surgery in the short, medium and long term and to identify sub-specialties and procedures most prone to transformation. Methodology: A PRISMA guided review was performed across PubMed, Scopus, Web of Science, and Google Scholar. Bibliographies of identified articles were also reviewed. 28 studies were included for qualitative synthesis. Only studies published after 2023 were included to capture the most relevant advances in surgical AI and robotics. Results: AI was most often applied to preoperative risk prediction, imaging interpretation and intraoperative guidance. Robotics improved dexterity, visualisation and ergonomics in minimally invasive surgery, with increasing integration of image guidance into robotic systems. Procedures most susceptible to near term change were standardised, image rich and minimally invasive operations, including urology, gynaecology, bariatric, thoracic, orthopaedics and stereotactic neurosurgery. Procedures least susceptible were time critical, anatomically variable and exposure dependent operations, where adaptability and tactile judgement remains critical. Medium term changes included closer coupling of AI decision support with robotics for defined tasks and procedures. Long term changes included full integration of AI and robotics into supervised autonomous roles for selected procedures, shifting surgeons toward oversight and system governance. Conclusion: Our review suggests AI and robotics are already influencing surgical planning and intraoperative efficiency, with the largest changes seen in structured minimally invasive operations. As healthcare systems face mounting pressure from ageing populations and rising demand, the development of scalable technologies becomes inevitable. Their convergence is expected to amplify change, but clinical impact will depend on prospective validation, ethics and regulation.

2:45 pm
Operation Smile Australia Craniofacial Mission in Manilla
Dr Lia Rae Tagulinao

3:00 pm
Discussion

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30 April 2026

2:30 pm - 4:30 pm
YURLU | COUNTRY! (TICKETED EVENT)

Official Function - *Cross Discipline*

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30 April 2026

5:00 pm - 6:30 pm
CONVOCATION CEREMONY AND SYME ORATION (TICKETED EVENT)

Convocation - *Cross Discipline* - Riverside Theatre

“The Legacy You Leave” – A reflection for young surgeons, from a cardiac surgeon

5:00 pm
Fellowship Pledge

Professor Mark Edwards

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30 April 2026

6:30 pm - 7:30 pm
WELCOME RECEPTION (TICKETED EVENT)

Official Function - *Cross Discipline* - Riverside Theatre Foyer

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01 May 2026

7:00 am - 8:20 am
MASTERCLASS (MC01): Minimally Invasive Breast Surgery (Ticketed Event)

Masterclass - Breast Surgery, Plastic & Reconstructive Surgery - Meeting Room M1

Minimally Invasive Nipple Sparing Mastectomy Session Proudly sponsored by OBEX MedTech Australia

7:00 am
Review of the Minimally Invasive Nipple Sparing Mastectomy Technique
Dr Antonio Toesca

7:30 am
Endoscopic NSM: Literature review
Chi Wei Mok

8:00 am
Discussion

7:00 am - 8:20 am
MASTERCLASS (MC07): The Artificial Intelligence (AI) Masterclass (TICKETED EVENT)

Masterclass - Paediatric Surgery - Meeting Room M2

The masterclass will cover novel uses of AI for your day to day, how to use AI to improve patient outcomes, AI in education and simulation.

7:00 am
THE ARTIFICIAL INTELLIGENCE (AI) MASTERCLASS
Professor Todd Ponsky, Dr Michael Collin, Associate Professor Bhavesh Patel

7:00 am - 8:20 am
MASTERCLASS (MC08): Robotic Colorectal Surgery: Rahila Essani, Total Mesorectal Excision: Technical Insights for the difficult pelvis (Ticketed Event)

Masterclass - Colorectal Surgery - Meeting Room M3

This masterclass, presented by Dr Rahila Essani, provides an in-depth exploration of advanced robotic techniques for total mesorectal excision (TME) in anatomically challenging cases. Participants will gain practical insights into operating within a narrow male pelvis, obese patients, and post-neoadjuvant therapy fibrosis, where precision and planning are critical. Technical considerations will be explored, including port configuration strategies, docking strategies, pelvic dissection ergonomics, multi-quadrant dissection, stapling challenges in ultra-low resections, approaches to avoid nerve injury and strategies to minimise conversion and complications. Particular attention will be given to how robotic articulation, stable three-

dimensional visualization, and improved ergonomics may translate into superior precision within the confined pelvis. Drawing on contemporary evidence and expert experience, this masterclass will equip surgeons with actionable strategies to optimise oncologic and functional outcomes in complex rectal cancer surgery.

7:00 am
ROBOTIC COLORECTAL SURGERY: TOTAL MESORECTAL EXCISION: TECHNICAL INSIGHTS FOR THE DIFFICULT PELVIS
Dr Rahila Essani

7:00 am - 8:15 am
Upper GI Research Papers (BREAKFAST SPONSORED BY MEDTRONIC)

Scientific Session - Upper GI Surgery - Meeting Room M9

7:00 am
Out-of-pocket costs and financial toxicity associated with the surgical management of oesophageal cancer.
Dr Josipa Petric
Background: Patients undergoing cancer treatment incur significant out-of-pocket costs attributed to both medical and non-medical expenditure. We quantified out-of-pocket costs for patients receiving surgical treatment for oesophageal cancer, and their financial toxicity. Methods: Patients who had undergone oesophagectomy for cancer completed an out-of-pocket questionnaire which determined medical costs, non-medical costs and carer costs. Financial toxicity was assessed using the validated Comprehensive Score for Financial Toxicity questionnaire. Out-of-pocket costs and financial toxicity were summarised using medians with bootstrapped 95% confidence intervals. Results: Seventy individuals completed the survey (43.3% response rate). The majority were male (85.7%), aged 60-79 (76.5%), and 0-5 years post-cancer diagnosis (55.7%). Median out-of-pocket expenditure was $1,352 and was mainly attributed to wage loss (64.7%), followed by carer cost (23.7%). Out-of-pocket costs were higher for younger age groups (40-59yrs) compared to those aged 60-79yrs (p=0.003). There was no statistically significant difference in out-of-pocket costs between public vs. privately insured patients. Median out-of-pocket costs trended higher for rural ($1,696) vs. urban located patients ($1,235), but this was not statistically significantly different (p = 0.140). The median financial toxicity score was 23.5 (95%CI: 21.0-27.5), indicating moderate financial toxicity. Financial toxicity did not differ significantly by age, gender, country of birth, education, or location. A lower income percentile was associated with greater financial toxicity (ρ = –0.30, p = 0.012). Conclusion: Patients facing oesophagectomy for cancer incur many out-of-pocket costs, mostly due to wage loss from time spent away from work for both patients and carers. Younger patients and those with lower income face proportionately greater financial burdens, highlighting a need for targeted support to reduce financial stress.

7:05 am
Systematic review of risk factors for Failure to Rescue post pancreaticoduodenectomy.
Dr Matea Dominkovic
Purpose/Introduction: The failure to rescue (FTR) rate, defined as the mortality rate following major postoperative complication, is an important marker of the quality of surgical care. This paper examines the multifactorial contributors to FTR following pancreaticoduodenectomy, with an emphasis on identifying perioperative and institutional factors that influence patient outcomes. Methodology: A systematic review was performed in accordance with the PRISMA guidelines. A search was conducted of the Pubmed, Embase, Medline and Cochrane Library databases. Two authors independently reviewed the articles and extracted data for analysis. Results: A total of 10 studies were included for review, with a total of 60158 pancreaticoduodenectomy cases. The FTR rate ranged from 6.9% to 33%. Multiple studies identified advanced age, obesity, pre-existing renal disease and elevated American Society of Anaesthesiologist (ASA) scores to be associated with higher rates of FTR. Patients undergoing re-laparotomy had higher failure to rescue rates but there were mixed results for factors leading to this such as post-operative pancreatic fistulas. Disease-specific features, including pancreatic texture and duct size, were not associated with FTR across studies. Conclusion: FTR is driven less by the occurrence of certain technical or disease-related factors and more by patient vulnerability and the interventions once complications arise.

7:10 am
Coeliac Artery Stenosis is Associated with Severity of Upper Gastrointestinal Anastomotic Leaks
Dr Ryan Teh

7:15 am
Pre-operative nutritional support as markers of adverse tumour biology following oesophagectomy at a regional New Zealand centre
Dr Phillipa Hawke

7:20 am
Are we asking the right questions after esophagectomy? A conduit-specific PROM for early identification of clinically meaningful dysfunction
Dr Shabnam Islam
Purpose Survivors of esophagectomy often experience delayed gastric conduit emptying, dumping, and swallowing dysfunction, which significantly impairs quality of life. Most existing studies utilize generic or cancer-specific patient-reported outcome measures (PROMs) that do not adequately capture pyloric and conduit-specific dysfunctions. Symptom assessment tools such as the Gastroparesis Cardinal Symptom Index (GCSI) have been validated in native stomachs, not in gastric conduits, and their domain structure and clinical cut points remain unevaluated in post-esophagectomy populations. As a result, reported dumping prevalence varies widely (0–78%), reflecting inconsistent definitions and the lack of standardized, conduit-specific symptom assessment. Methodology This observational study enrolls disease-free adults between 6 and 12 months following esophagectomy with gastric conduit reconstruction. Participants complete a questionnaire evaluating: (1) GCSI-derived stomach symptoms; (2) early and late dumping symptoms; (3) dysphagia, reflux, and regurgitation; and (4) functional and nutritional impact. Clinical covariates include diabetes, opioid use, and time elapsed since surgery. The primary outcome is an externally anchored composite endpoint, defined by the need for pyloric or endoscopic intervention. Results It is hypothesized that symptom clusters dominated by fullness and early satiety will more effectively identify clinically meaningful functional morbidity than nausea-predominant GCSI domains. A straightforward PROM rule that combines elevated stomach symptom scores with multiple dumping features is anticipated to identify a high-risk subgroup with increased rates of malnutrition, intervention, or significant endoscopic findings, independent of diabetes and opioid use. Conclusion This study addresses a key methodological gap in post-esophagectomy PROM research by directly evaluating whether symptom questions adapted from native stomach and oncologic tools are appropriate for gastric conduit patients.

7:25 am
Conversion to Roux-en-Y Gastric Bypass for Chronic Microleak Following Laparoscopic Sleeve Gastrectomy: A Single-Centre Experience
Dr Aizat Drahman
Abstract Chronic microleak following laparoscopic sleeve gastrectomy (LSG) represents a complex and morbid complication that can persist despite prolonged conservative and endoscopic management. Ongoing leakage is associated with sepsis risk, malnutrition, prolonged hospitalisation, and reduced quality of life. Conversion to Roux-en-Y gastric bypass (RYGB) has been proposed as a definitive surgical strategy by diverting enteric flow away from the leak site. This study aimed to evaluate the clinical outcomes, safety, and effectiveness of conversion to RYGB for the management of chronic microleak following LSG. Methodology Study Design and Setting A retrospective observational study was conducted at a tertiary upper gastrointestinal and bariatric surgery centre. Patients managed between January 2016 and December 2024 were identified from a prospectively maintained bariatric database. Patient Selection Inclusion criteria comprised adult patients (≥18 years) with a diagnosis of chronic microleak following LSG, defined as a contained gastric leak persisting beyond six weeks despite non-operative management. Outcome Measures Primary outcome: •Successful resolution of the gastric microleak following conversion to RYGB Results A total of 34 patients met the inclusion criteria. The median interval from index sleeve gastrectomy to conversion surgery was 6.1 months (IQR 4.5–10.2). Primary Outcome •Complete leak resolution was achieved in 32 patients (94.1%) following conversion to RYGB. •Two patients required prolonged drainage but achieved eventual resolution without further operative intervention. Conclusion Conversion to Roux-en-Y gastric bypass is a safe and effective definitive treatment for chronic microleak following laparoscopic sleeve gastrectomy when conservative and endoscopic strategies fail. The procedure reliably achieves leak resolution by excluding the leak site and diverting gastric contents, with acceptable morbidity and favourable nutritional outcomes.

7:30 am
Impact of postoperative complications on overall survival following oesophagectomy for cancer
Dr Yang Hwang

7:35 am
Risk factors for anastomotic leak following oesophagectomy for cancer
Dr Yang Hwang

Purpose: Anastomotic leak (AL) following oesophagectomy results in major patient morbidity and increased resource utilisation. While multimodality therapy improves survival, treatment-related toxicity may increase the risk of perioperative complications. Identifying modifiable risk factors for AL is therefore critical to reducing postoperative morbidity. We examined risk factors for AL and quantified its clinical impact in a high-volume Australian centre. Methodology: Patients undergoing curative-intent oesophagectomy with gastric conduit reconstruction for oesophageal or gastro-oesophageal junction cancer between 1993 and 2022 were identified from a prospectively maintained database. AL was defined using Esophagectomy Complications Consensus Group criteria. Risk factors were assessed using univariate and multivariate logistic regression. Results: Among 1,219 patients, AL occurred in 11% (131/1219). Patients who developed AL experienced substantially greater morbidity, with a longer median hospital stay (24 vs 13 days, p<0.01) and higher reoperation rates (16.8% vs 5.8%, p<0.01). On univariate analysis, male sex, preoperative weight loss >20%, clinical nodal stage cN2, and higher radiotherapy dose were associated with AL. Compared with 35 Gy, radiotherapy doses of 41.4 Gy (OR 2.8, 95% CI 1.25–6.48) and 45 Gy (OR 3.1, 95% CI 1.23–7.99) were associated with an increased risk of AL. On multivariate analysis, preoperative weight loss >20% remained independently associated with AL (OR 3.7, 95% CI 1.63–7.92). Conclusion: Anastomotic leak is associated with significant postoperative morbidity following oesophagectomy. Severe preoperative weight loss is an independent and potentially modifiable risk factor for AL. Targeted nutritional optimisation and careful radiotherapy planning may reduce anastomotic complications and their downstream clinical impact.

7:40 am
The PREDICT-GPOEM Score: A preoperative risk score to predict clinical success after G-POEM in post-surgical gastroparesis
Dr Shabnam Islam
Purpose:G-POEM is an established intervention for refractory gastroparesis, yet clinical outcomes remain inconsistent, and optimal patient selection is challenging. Symptom severity, pyloric appearance, and response to intrapyloric botulinum toxin are commonly considered in clinical decision-making; a preoperative decision tool is lacking. The present study aimed to develop a preoperative risk score to predict clinical success following G-POEM in patients with post-surgical gastroparesis.Method: A retrospective analysis was performed of consecutive adult patients with refractory post-surgical gastroparesis who underwent G-POEM between 2018 and 2024. Clinical success was defined a priori as a reduction of at least 50% in GCSI total score at 6 to 12 months post-procedure, consistent with published G-POEM literature. A pragmatic, clinically weighted scoring system was developed. The resulting PREDICT-GPOEM score incorporates response to botulinum toxin, pyloric tightness, baseline GCSI severity, age over 60 years, and non-oesophagectomy aetiology. Result:24 patients underwent G-POEM, most frequently following hiatal hernia repair, oesophagectomy, or bariatric surgery. Clinical success was achieved in 75%. Response to botulinum toxin alone demonstrated a positive predictive value of approximately 74%. The PREDICT-GPOEM score stratified patients into low-, intermediate-, and high-risk groups, with clinical success rates of 40%, 65%, and 85%, respectively, demonstrating strong discriminatory ability. The score showed superior performance in non-oesophagectomy patients, consistent with established differences in symptom phenotype and conduit physiology. Conclusion:The PREDICT-GPOEM score effectively stratifies the probability of clinical success following G-POEM in post-surgical gastroparesis, demonstrating robust discrimination and clinically meaningful risk categorization.

7:45 am
Comparison of Circular and Linear Stapled Intrathoracic Anastomosis in Minimally Invasive Oesophagectomy for Cancer: A Retrospective Cohort Study
Dr Lai Yung Ng
PURPOSE: Anastomotic technique in minimally invasive esophagectomy (MIO) remains a critical determinant of postoperative outcomes. This study compares circular stapled end-to-side and linear stapled side-to-side intrathoracic anastomosis in MIO for oesophageal cancer, focusing on anastomotic leak rates, long-term stricture formation, as well as secondary outcomes including complications, recovery, and survival. METHODOLOGY: We conducted a retrospective cohort study of patients undergoing two-stage MIO with intrathoracic anastomosis for oesophageal cancer at a quaternary centre from January 2011 to December 2023. Exclusion criteria included age under 18, non-malignant pathology, or incomplete surgery. Patients were grouped by anastomotic technique (circular vs. linear stapled), demographic, clinical, and outcome data were analysed. RESULTS: Of 265 patients, 245 met inclusion criteria (161 circular, 84 linear). Baseline characteristics were comparable. The overall anastomotic leak rate was 11% higher in the circular group (13%) versus linear (7%), though more severe (grade 3) leaks were seen in the linear group. Stricture rates were similar between techniques (17.4% circular vs.16.6% linear). Median postoperative length of stay was 10 days in both groups and thirty-day readmission was slightly higher in the linear group (20% vs.17.4%), without statistical significance. Multivariate analysis identified active or recent smoking (within 3 months) as an independent predictor of stricture formation. CONCLUSION Both techniques resulted in similar stricture

and recovery outcomes. Circular stapled anastomoses were associated with a higher overall leak rate, while linear stapled techniques had more severe leaks. Smoking status remains a significant modifiable risk factor for anastomotic stricture formation and should be addressed preoperatively.

7:50 am
Association Between Semaglutide (Ozempic) Use and Acute Pancreatitis: A Retrospective Observational Study
Dr Raziqah Ramli
Aim Glucagon-like peptide-1 receptor agonists (GLP-1 RAs), including semaglutide, are increasingly prescribed for type 2 diabetes and weight management. A possible association with acute pancreatitis remains controversial. This study evaluated the incidence, presentation, and outcomes of acute pancreatitis in patients receiving semaglutide. Methods A retrospective observational study was performed at a tertiary referral centre between January 2020 and December 2024. Adult patients presenting with acute pancreatitis while actively receiving semaglutide were identified using hospital coding and pharmacy records. Diagnosis required revised Atlanta criteria. Patients with alternative dominant aetiologies, including gallstone disease with obstruction, alcohol misuse, hypertriglyceridaemia, or pancreatic malignancy, were excluded. Demographic data, semaglutide exposure, disease severity, management, and outcomes were analysed descriptively. Results Forty-one patients receiving semaglutide presented with acute pancreatitis; 26 met inclusion criteria. Mean age was 52.6 years, and 61.5% were female. Semaglutide was prescribed for type 2 diabetes in 65.4% and weight loss in 34.6%. Median duration of therapy prior to presentation was 5.2 months. Pancreatitis was mild in 76.9% and moderately severe in 23.1%; no severe or necrotising cases occurred. Median length of stay was 4 days. Two patients required intensive care admission, and no patients required surgical intervention. Semaglutide was ceased in all cases. No recurrent pancreatitis or mortality occurred during median follow-up of 9 months. Conclusion Acute pancreatitis temporally associated with semaglutide use was uncommon and predominantly mild, with favourable outcomes following drug cessation. Clinicians should consider medication-related pancreatitis in patients without traditional risk factors. Larger prospective studies are required to clarify causality and risk stratification.

7:55 am
Long-term health related quality of life following curative treatment for esophageal cancer: a systematic review and meta-analysis.
Dr Josipa Petric
Background:Treatment for oesophageal cancer has a significant impact on health-related quality of life (HRQoL). Advances in treatment have resulted in improved survival rates, and the need to improve patient quality of life. This review summarises the evidence on the impact of various treatments on long-term quality of life in order to inform practice. Methods:A systematic literature search of MEDLINE (OVID), PubMed, CINAHL, Web of Science, Embase and the Cochrane library was performed to identify studies that evaluated quality of life at least 3 years following curative treatment. Data were extracted and compared narratively and in a meta-analysis, using odds ratio and mean differences with 95% confidence intervals. Results:A total of 11,618 studies were identified, and 31 studies were included in this review. Most of the studies were from Sweden (n=15) or China (n=5). HRQoL in most studies (90%) was assessed using EORTC QLQ-C30 in combination with the oesophageal cancer add-on, QLQ-OES18. Narrative synthesis revealed that most aspects of HRQoL recovered to preoperative levels at the 3-year assessment. Four studies applying QLQ-C30 were included in the meta-analysis: global quality of life had a mean difference of 3.08 (95% CI 0.2-5.96) and an effect size equaling 2 ($p<0.04$). Only emotional function, role function, and constipation had statistically non-significant differences between cancer patients and healthy individuals ($p > 0.05$). Conclusions: Overall, the quality of life for oesophageal cancer survivors should be a key focus for clinicians given its association with treatment outcomes and overall survival. There was evidence that some aspects of HRQoL recovered by 3-years but some impacts were longer lasting.

8:00 am
Audit of Surgical Outcomes of General Surgery Patients that Attended a Pre-Operative Geriatric Service.
Dr Afsana Habib
Background: The global population is growing and living longer. We can see an increasing number of patients undergoing surgery at older ages, with increasing frailty and numbers of co-morbidities. The Geriatric Pre-Operative Service (GPS) provides a pre-operative geriatrician review for older adults due to undergo elective surgery. During the review, patients receive a Comprehensive Geriatric Assessment (CGA) —a structured evaluation of medical, cognitive, functional, and psychosocial factors—aimed to optimize perioperative management. This audit aimed to assess whether general surgery patients who were reviewed in the GPS had improved surgical outcomes compared with those receiving standard pre-operative care. Methods: A retrospective review was undertaken of 100 patients aged ≥65 years (≥60 for

Aboriginal and Torres Strait Islander patients) who underwent elective general surgery (Upper GastroIntestinal, Colorectal & Hepatobiliary) between January 2024 and August 2025 under Inclusion criteria. Fifty patients attended the GPS and received CGA, while fifty underwent similar procedures without clinic review. Outcomes included hospital-acquired complications (HACs), length of stay (LOS), readmission rate and mortality. Results: The average length of stay was shorter for patients who were reviewed in the geriatric preoperative clinic (6.5 days) than those who were not (10.4 days). This difference was statistically significant with a p value= 0.0055. Patients seen in the GPS had approximately 22% lower odds of a hospital-acquired complication, but the difference is not statistically significant (p-value 0.079). The GPS cohort demonstrated reduced numbers of re-admissions to hospital, despite this there was no statistical difference between groups (P-value=0.186). Conclusion: Preoperative geriatrician review incorporating CGA was associated with a statistically significant reduction in length of hospital admission. These findings support the integration of geriatric assessment into preoperative care pathways.

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01 May 2026

7:30 am - 8:30 am
Younger Fellows and Trainees Yoga Session (Ticketed Event)

Breakfast Session - Trainees Association, Younger Fellows

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01 May 2026

8:30 am - 10:00 am
Opening Plenary Session: The Politics of Professionalism

Plenary Session - *Cross Discipline* - Riverside Theatre

8:30 am
Welcome to Country

8:40 am
President's Welcome
Professor Owen Ung

8:50 am
Conveners' Welcome
Associate Professor Rob Love, Associate Professor Mary Theophilus

8:55 am
Introduction
Dr Liz McLeod

9:00 am
When Silence isn't Neutral: the Ethical Duty of Surgeons in Global Health Crises
Dr Rowan Gillies

9:20 am
The Weaponisation of Healthcare
Professor Annie Sparrow

9:50 am
Q&A

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01 May 2026

10:00 am - 10:30 am
Morning Tea - Friday

Catering - *Cross Discipline* - Pavillion 1

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01 May 2026

10:30 am - 12:30 pm
Congenital Hand and Hand Trauma

Scientific Session - Hand Surgery - Meeting Room M9

10:30 am
Recent Advances in Pollicisation for Congenital Thumb Reconstruction
Dr Jane Shen

11:00 am
Recent Advances in the Surgical Management of Thumb Duplication
Dr Jane Shen

11:30 am
Discussion

11:35 am
The price of a nailbed repair in 2026: evaluation of the cost of consumables used in a standard nailbed repair
Dr Elysia Jongue
INTRODUCTION Nailbed injuries are common hand injury presentations. They represent a significant public health, resource, and economic burden. We report the costs of consumables used in a routine nailbed repair to demonstrate the resource expenditure in a public hospital in New South Wales, to highlight the need to optimise resource use to maintain a sustainable future in surgery. METHODOLOGY Standard equipment required for a routine nailbed repair, was identified in January 2026. The equipment was further stratified into reusable instruments and consumables. Consumable barcodes were scanned using the NSW Health perioperative healthcare information management system, h-trak, to identify the cost of each consumable. Costs were reviewed and analysed. RESULTS 14 consumables required for a standard nailbed repair, were identified. The costs of 6 consumable items, were able to be retrieved using h-trak. 8 items did not have a recorded cost when scanned. Sutures were the most expensive items for NSW Health (Ethicon 8-0 vicryl on spatulated needle, $23.76). Molnlycke's 10x10cm Mepilex Ag, costed $8.35. Drapes and gauze were the items of least cost - $2.46 and $0.02 respectively. Local anaesthetic, betadine skin preparation solution, normal saline 0.9%, 10mL syringe, drawing up needle, Hypafix, and finger crepe were consumables without a recorded cost on the system. CONCLUSION Consumables for a single standard nailbed repair, cost NSW Health a minimum of $54.03. This highlights only a fraction of costs to the public health system that are incurred during surgical management of a nailbed injury. Expenditure associated with initial emergency management, operating theatre, postoperative care, and surgical consultations, add further expense to the NSW public health system. With RACS' focus on sustainability, further research and quality improvement practices to optimise healthcare costs in hand surgery, while maintaining patient safety, are needed.

11:45 am
Patient-focused outcome and healthcare usage following conservative management of extra-articular proximal phalanx fractures
Miss Xinchen Gu

11:55 am
Gender differences in hand fracture patterns in Australian rules football players: a retrospective study
Dr Bryan Lim

Introduction: This research compares the patterns of hand injuries, treatments and outcomes between male and female Australian rules football players. Methods: This retrospective cohort study reviewed Australian rules football players treated for surgically operable hand injuries at Frankston Hospital in Melbourne, Australia, between January 2021 and August 2024. Data collected included demographics, injury mechanisms, types of fractures or dislocations, treatment methods and postoperative complications. Results: Among 46 Australian rules football players (36 males, 10 females) in this cohort study, notable gender differences in injury patterns were identified. Males predominantly sustained axial loading fractures (30.6%), whereas females more often experienced hyperextension injuries (30.0%) and trampling injuries (20.0%). Both genders primarily underwent open reduction and internal fixation (55.6% males, 60.0% females). Complication rates were low (5.6% males, 10.0% females), but recovery times were generally longer for females. Conclusions: The study highlights distinct injury patterns and outcomes by gender, suggesting physiological and anatomical differences may influence injury susceptibility and recovery in Australian rules football players. These findings underscore the importance of gender-specific prevention and rehabilitation strategies to enhance player safety, recovery and performance.

12:05 pm
Discussion

10:30 am - 12:30 pm
Craniomaxillofacial Surgery

Scientific Session - Craniomaxillofacial Surgery - Meeting Room M1

10:30 am
Welcome and Introduction
Dr Ranjit Kunchur, Dr David Gillett, Dr Linda Monshizadeh

10:35 am
Education and the Future of Health Care for the Craniofacially Deformed
Professor David David AC
BACKROUND: PRE-SOCRATIC TO THE ENLIGHTENMENT Education has been intimately bound to the development of science and “medicine” historically from the Pre-Socratic Greeks, Aristotle, Galen, the Monasteries, Universities, Royal charters, and the Enlightenment up to our modern scientific revolution. THE COLLEGES, AND UNIVERSITIES Specialist societies and the Universities have added to this source of Education in the British Commonwealth (Australasia), the USA, Europe and beyond. FROM TESSIER (1971) TO THE ISCFS (2025) In 1971Paul Tessier set out the modus operandi for the discipline including “-the need for special training- “Over the ensuing 55plus years the founders of the ISCFS and others have adopted, attempted to practise and institutionalise these principles. At the ISCFS meeting in Shanghai 2025 I (David, Goodarzi and Mclean) presented “A Global Survey of Craniofacial Fellowship Training” under the umbrella of the Society. Overall, the response indicated that there was a lack of clarity and consistency surrounding the nature of advanced training in Craniomaxillofacial Surgery. The current practice of the discipline implies multidisciplinary, patient centred, management from birth to maturity and beyond, scientifically sound, delivered via an organised and appropriately funded infrastructure. Research and Quality management are mandatory. The Education and training should match the Task. ACHIEVEMENTS: - Much has been achieved in delivering this type of health care provided in major centres using Tessier’s principles. But, has the Education and Training of surgeons kept pace with the development of this complex, multi-faceted health care delivery system? PROBLEMS AND TENTATIVE SOLUTIONS This presentation visits some of the problems involved in educating and teaching surgeons in this realm and the barriers placed in the way of the solutions. What shape should the Education of craniofacial surgeons take to further support their service to the craniofacially deformed?

11:05 am
Standardized protocol for the management of syndromic craniosynostoses: the Paris experience
Prof Roman Khonsari

11:25 am
Teaching Encephalocele Management in LIMC – A 30 year evolution
Associate Professor Richard Lewandowski, Associate Professor Richard Lewandowski

11:45 am

Craniosynostosis pathways: timing, technique selection and peri-operative optimisation
Dr Amal Abou-Hamden

12:05 pm
Clinical photography and AI for the diagnosis of craniofacial anomalies: the AIDY project
Prof Roman Khonsari

10:30 am - 12:30 pm
FACIAL PALSY

Scientific Session - Plastic & Reconstructive Surgery - River View Room 5

10:30 am
Updates in Facial Palsy Management and the Management of Synkinesis
Associate Professor Catherine Meller

10:50 am
Corneal Neurotisation
Dr Nelson Low

11:10 am
Intraoral vascularised cross facial nerve grafts in early flaccid facial palsy
Dr Ruben Kannan

11:30 am
Management facial palsy in a H&N Cancer
Dr Darryl Dunn

11:50 am
Nerve to Masseter transfer following facial nerve sacrifice: A review of 60 cases
Jasmine Zhang
Introduction: Facial paralysis presents a challenging problem with significant impact on quality of life, often resulting in severe and debilitating disability. A wide range of static and dynamic reconstructive techniques have been described to try to restore function. The nerve to masseter (NTM) transfer is one dynamic technique that is explored further in this study. Aim: Review trends and outcomes patients undergoing in NTM transfer Methods: This is a 10 year single centre retrospective review of 60 patients who underwent nerve to masseter transfers between 2015 to 2025 at the Royal Brisbane and Womens Hospital. Results: We identified 202 patients who had facial nerve sacrificing procedures for treatment of neoplasms, most commonly metastatic squamous cell carcinoma. 60 (30%) of the 202 patients underwent NTM transfers. 33 (55%) of patients did not require any further surgery after the NTM transfer. 15 (25%) required one subsequent reanimation procedure, 6 (10%) required two subsequent procedures, 4 (7%) required three further procedures and 2 (3%) required four or more further procedures. Conclusions: The majority of patients undergoing primary NTM transfer at time of facial nerve sacrifice do not require any further revisionary surgery. One limitation of this study is the retrospective nature and outcome measures being limited to the documentation of facial muscle activation. Nevertheless this study represents the largest case series of NTM transfers to date that we are aware of.

11:57 am
A decade of evolution in single centre facial reanimation techniques: a retrospective analysis.
Dr James Ryan
Facial reanimation procedures can be broadly categorised into static and dynamic procedures. Emerging evidence demonstrating improved patient quality of life outcomes has generated a shift toward immediate dynamic strategies which include nerve transfers and grafts, often supplemented by static techniques. A retrospective analysis was performed on patients who underwent facial reanimation for oncologic head and neck resections at a single tertiary centre between 2015 and 2024. Immediate reanimation was defined as procedures performed at the time of tumour resection. Surgeries were classified by whether they were immediate or delayed and further categorised by whether they contained static or dynamic components. The proportion of primary dynamic reanimation surgeries increased from 12.2% of annual cases (2015-2019) to 25.5% (2020-2024) in the period studied. This reflected a general trend toward primary dynamic procedures, whilst immediate static reanimation figures remained comparable. Static reanimation

remained a mainstay of delayed cases. The increased absolute volume and frequency of delayed static reanimation, 36.7% (2015-2019) to 42.0% (2020-2024), is noted and may fit with the trend toward more dynamic, immediate reanimation cases. This single centre series demonstrates a temporal shift toward the use of dynamic techniques in immediate facial reanimation. The increasing burden of delayed reanimation procedures, the majority of which are static, forms an important consideration as caseloads and immediate reconstruction continues to increase.

12:04 pm
Building a multidisciplinary headache surgery working group in Australia
Dr Edwin Morrison

12:10 pm
Panel Discussion
Dr Ruben Kannan, Dr Darryl Dunn, Dr Nelson Low, Associate Professor Catherine Meller, Jasmine Zhang, Dr James Ryan, Dr Edwin Morrison

10:30 am - 12:30 pm
HERNIAS FOR GENERAL SURGEONS: BASICS & BEYOND

Scientific Session - General Surgery, Hernia Surgery - Riverside Theatre

10:30 am
Welcome and introduction

10:35 am
Do all umbilical hernias need mesh?
Dr Oscar Aldridge

10:50 am
Emergency management of complex abdominal hernias
Dr Danette Wright

11:05 am
Rectus Diastasis repair: Why and How?
Prof Ramana Balasubramaniam

11:25 am
Optimising Laparotomy Wound Closure: Preventing Incisional Hernia
Dr Anand Trivedi

11:40 am
Robotic groin hernias: Learning & Advancement
Dr Krishna Epari, Dr Krishna Epari

12:00 pm
Panel Discussion
Dr Oscar Aldridge, Prof Ramana Balasubramaniam, Dr Danette Wright, Dr Krishna Epari, Dr Anand Trivedi, Dr Krishna Epari

12:25 pm
Closing Remarks and Conclusion

10:30 am - 11:00 am
KEYNOTE LECTURE - Dr Ravi Marudanayagam (BIRMINGHAM, UK)

Keynote Lecture - HPB Surgery - Bellevue Ballroom 2

10:30 am

Technology in HPB Surgery
Mr Ravi Marudanayagam

10:30 am - 11:00 am
KEYNOTE LECTURE - PROFESSOR NEHMAT HOUSSAMI (SYDNEY, NSW)

Keynote Lecture - Breast Surgery - Bellevue Ballroom 1

10:30 am
Breast cancer screening at a cross roads
Professor Nehmat Houssami

10:30 am - 11:00 am
Keynote Lecture - Professor Todd Ponsky (Cincinnati, USA)

Keynote Lecture - Paediatric Surgery - Meeting Room M3

10:30 am
Why no one will ever see this lecture: a peek into the future of knowledge discoverability
Professor Todd Ponsky

10:30 am - 12:30 pm
Perspectives in Melanoma Today

Scientific Session - Surgical Oncology - Meeting Room M8

10:30 am
Reduced Risk of Death from Melanoma after Sentinel Node Biopsy: A Systematic Review and Meta-Analysis
A/Prof Alexander Varey
Purpose Sentinel node biopsy (SNB) for primary melanoma has a well-established role in reducing the risk of regional node recurrence. However, the only randomised controlled trial (RCT) of SNB (MSLT-I) was underpowered to determine if it also reduced the risk of death from melanoma. This systematic review and meta-analysis aimed to resolve this ongoing controversy. Methodology Medline, Embase, Cochrane CENTRAL and ClinicalTrials.gov were searched (to 8/1/2025) using terms for melanoma, SNB and survival. Only studies reporting melanoma survival in patients who underwent SNB relative to patients who did not were included. Duplicate title review and data extraction were performed. The RCT and studies reporting adjusted risks were meta-analysed for the risks of death from melanoma and recurrence. Newcastle-Ottawa and Cochrane Collaboration tools were used for risk of bias assessment. Results 60 studies were included in the systematic review, from 1,560 titles and 13 studies (40,287_patients) were suitable for meta-analysis. This showed a significantly-reduced risk of death from melanoma for patients who underwent SNB; hazard ratio (HR) 0.86 (95%CI 0.81-0.92, p<0.00001), with low heterogeneity (I2 16%). This result was not dependent on any single study or use of systemic therapy, as confirmed by sensitivity analyses. Nine studies (11,625 patients) reported an adjusted risk of recurrence, from which the overall HR was 0.71 (95%CI 0.66-0.76, p<0.00001) with low heterogeneity (I2 23%). Conclusion This meta-analysis demonstrated that undergoing SNB reduced the risk of death for patients with melanoma by 14% and reduced the risk of recurrence by 29%. These highly statistically significant results were consistent with the HR of MSLT-I and robust on sensitivity analyses thus providing strong evidence that SNB confers a true survival benefit. Patients with melanoma should be advised of this when the benefits and risks of SNB are being discussed with them.

11:00 am
Two Shades of Grey: Dealing with Uncertainty in Melanocytic Pathology
Professor Benjamin Wood

11:20 am
Peri-Operative Treatment of High Risk Melanoma: Where we are and Where we are going?
Dr Adnan Khattak

11:40 am
Establishing the Melanoma CNC Role to help Patients and Service Provision
Ms Clare Jenkins

12:00 pm
Panel Discussion
Professor Benjamin Wood, Dr Adnan Khattak, A/Prof Alexander Varey, Ms Clare Jenkins

10:30 am - 12:30 pm
Robotics in Contemporary Colorectal Surgery

Scientific Session - Colorectal Surgery - Meeting Room M6

Robotic surgery continues to redefine the technical and strategic landscape of colorectal practice worldwide. This session brings together leading international and Australian experts to examine the evolution of robotic platforms, their real-world application, and their impact on complex colorectal disease. Invited international faculty will provide insights into the daVinci and HUGO robotic systems, sharing global experience in platform utilisation, technical optimisation, and comparative performance. Their perspectives will offer a unique opportunity to understand how these systems are shaping contemporary colorectal surgery on the world stage. Australian experts will complement this with practical discussions on implementing robotic programs in provincial settings, training and credentialing the next generation of surgeons, and critically evaluating where robotics delivers meaningful clinical benefit—particularly in complex rectal cancer. Designed for colorectal surgeons at all stages of robotic adoption, this session moves beyond technology alone to explore evidence, outcomes, training, and value in modern robotic colorectal surgery.

10:30 am
The Defender: Proven versus promising. The da Vinci Robot
Dr Rahila Essani

10:50 am
The Challenger: Disrupting the status quo. The Hugo Platform
Prof Matteo Rottoli

11:10 am
Beyond the Hype: Evidence, Outcomes and Oncological Safety in Robotic Rectal Cancer Surgery
Dr Brian Meade

11:30 am
A Total Robotic Colorectal Practice in Regional Australia: Promises and Challenges
Dr Matthew Jacob

11:50 am
Training and Proctoring in Italian Robotic Surgery: From Learning Curve to Credentialed Surgeon
Prof Matteo Rottoli

12:10 pm
Training the Robotic Surgeon: Aligning Competence, Credentialing and Patient Safety
Dr Fiona Reid

10:30 am - 11:00 am
The Herbert Moran Memorial Lecture - Professor John C. Hall (WA, Australia)

Named Lecture - Surgical History - Meeting Room M7

10:30 am
The Herbert Moran Memorial Lecture - "WA's first surgeon, Alexander Collie"
Professor John C. Hall

10:30 am - 12:30 pm
The Perfect Bypass: RYGB & OAGB – Anatomy, Technique & Collaboration

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Scientific Session - Bariatric Surgery, Upper GI Surgery - River View Room 4

Gastric bypass continues to evolve as surgeons refine technique, physiology and patient selection. This session explores the critical technical and anatomical principles behind Roux-en-Y and One-Anastomosis Gastric Bypass, alongside strategies to optimise outcomes and manage complex revisional scenarios.

10:30 am
Introduction and session framing

10:35 am
American College of Surgeons Lecture: Crafting the Optimal Roux-en-Y Gastric Bypass — Pouch Architecture, JJ Anastomosis and Functional–Biochemical Insights
Dr Anna Ibele

11:00 am
Optimising One-Anastomosis / Mini Gastric Bypass — Anatomy, Technique and Addressing Bile Reflux
Assoc Professor Asim Shabbir

11:15 am
Gastric Bypass Complications Managed in Tertiary Centres — Patterns, Management and Prevention Strategies
Dr George Hopkins

11:30 am
Revision After Sleeve — MGB vs RYGB vs SADI-S
Dr Ahmed Ahmed

11:45 am
Optimising Limb Lengths in Gastric Bypass — Balancing Restriction and Malabsorption
Mr Ahmad Aly

12:00 pm
Interactive Panel and Q&A
Dr George Hopkins, Dr Anna Ibele, Mr Ahmad Aly, Dr Ahmed Ahmed, Assoc Professor Asim Shabbir

10:30 am - 12:00 pm
Thyroid Surgery

Scientific Session - Endocrine Surgery - Meeting Room M2

10:30 am
The new ATA Guidelines Revisited
Dr Nicholas Blefari, Dr Fiona Pavan

10:50 am
Defining resectability in advanced thyroid carcinoma
Prof. Thomas J. Musholt

11:10 am
Advanced thyroid carcinoma – Defining protocols for management and outcomes
Dr Bella Nguyen, Dr Bella Nguyen

11:30 am
Interesting Cases
Dr Dean Lisewski, Dr Yen-ni Yu

01 May 2026

11:00 am - 12:30 pm
Pioneering Surgeons of WA and Australia

Scientific Session - Surgical History - Meeting Room M7

11:00 am
A tale of Two Journeys: William Arthur Bird and Adolf Hitler - Surviving wounds at Bethleem Farm and Messines, Flanders
Professor Kingsley Faulkner

11:20 am
The history of gloves in surgery: a broth of laudable motives, unconvincing science, and unintended damage to the environment
Professor Spencer Beasley
Humans have used gloves since the Ice Age for their own protection; initially against the cold, but subsequently, mostly for protection against injury. Remarkably, glove-wearing in surgery occurred remarkably late in surgical history, and initially not for antisepsis. For barber surgeons, speed mattered, and there was no understanding of contamination: such that wiping hands on grubby aprons was encouraged. By 1700, increasingly complex procedures were being performed (eg amputations), and the amount of blood on the surgeon's coat became a measure of their experience. Any finger cots used were for the protection of the surgeon and to avoid direct contact with foul putrid tissue. The advent of anaesthesia from 1846 (ether) enabled more complex operations, but longer procedures increased the risk of sepsis. Joseph Lister started using carbolic acid sprays and emphasized cleaning instruments (and wounds), but even he saw no need to advocate gloves. The inconsistent use of surgical gloves was to protect the skin from the corrosive and irritating effects of antiseptics, and not to protect against the transmission of infection. The gloves used then were heavy rubber or linen. The big advance was in 1890, and for a bizarre reason. William Stewart Halsted at Johns Hopkins engaged the Goodyear Rubber Company to make custom thin rubber gloves for his favourite nurse Caroline Hampton because she suffered severe dermatitis from contact with mercuric chloride. The improvement to the condition of her skin was so remarkable, and clearly so well received, that they then married. But there was another unanticipated consequence: his colleagues noticed dramatically lower infection rates, and it was this observation that heralded the gradual adoption of gloves for surgery. What was initially motivated to protect staff skin was to have an even more profound advantage in protecting patients from sepsis. Over the next 30 years there were multiple observational studies showing reduction in infection rates; incrementally, gloves became more widely used until they became the standard in clean surgery - but not universally. It was refinements in rubber manufacturing, better sterilization methods and an increasing understanding of microbiology that facilitated the routine use of gloves. In the 1960s single-use latex gloves were introduced, whereas previously gloves were re-used and sterilized between cases. By 1980 double-gloving was beginning to be introduced for some orthopaedic procedures and trauma. At about the same time, with the scourge of HIV and Hepatitis B and C, there was a paradigm shift to mutual protection (surgeon and patient). And as problems with latex were becoming more apparent, alternatives were developed: nitrile and neoprene. In the last few years, a new inflection point has been emerging: the massive environmental cost of surgical gloves. The focus now is how their adverse significant environmental effects and financial costs to health institutions can be reduced without compromising patient or surgeon. Billions of sterile gloves are produced annually; and they are the highest-volume single-use items in hospitals. Their substantial and measurable adverse environmental costs relate to the raw materials, production, sterilization, transport/distribution and disposal. Double-gloving, indicator systems and frequent glove changes magnify the problem. This presentation analyses the apparent lack of benefit of double-gloving in routine surgery against the environmental damage caused, the cost to the health system and the ethical ramifications. Double-gloving as a routine for surgical procedures was introduced over 25 years ago in the belief it might reduce surgical site infection and risk to theatre staff from blood-borne infection. No study has shown this to be true (the two RCT studies looking at surgical site infection (SSI) failed to show any benefit), although about 100 studies have confirmed that gloves acquire multiple micro-perforations during surgery. The factors that increase glove perforation rates (e.g. duration of surgery, jagged bone) have been well documented. In the absence of any direct evidence of value by double-gloving, glove perforation rates have been used as a proxy for justifying the practice. In 2019, the

Covid epidemic embedded the practice in many Western countries, again without any evidence of patient or surgeon benefit. There are strong grounds for challenging routine double-gloving on the basis that the adverse consequences far outweigh any actual benefits. These include the costs to the health system, environmental damage from production and disposal (such as CO2 footprint, toxic emissions of volatile organic compounds, ozone depletion and release of heavy metals and microplastics), and ethical concerns. This paper outlines the potential benefits and the range of adverse consequences of routine double-gloving during surgical procedures; and provides guidelines for the proper use of double-gloving based on the best evidence currently available.

11:40 am
From Perth to the World: Early Aortic Stent-Graft Innovation
Dr Davina Daudu
The development of endovascular aortic repair represents one of the most significant paradigm shifts in vascular surgery. While Juan Parodi's first implantation in Buenos Aires in 1991 is rightly recognised as a pivotal milestone [1], the city of Perth, Western Australia (WA), played a key role in transforming endovascular repair from a concept to a viable therapy. In the 1990s, Professors Michael Lawrence-Brown and David Hartley, together with colleagues including Drs John Anderson and Barry Baker, collaborated with engineer David Gunning to design, test, and refine some of the earliest prototype stent-grafts for abdominal aortic aneurysms [2]. The Perth team leveraged interdisciplinary cooperation and a culture of innovation to overcome considerable technical and logistical barriers. Their first human implantations demonstrated the feasibility of aneurysm exclusion, validating and extending Parodi's work. This presentation will trace the technical evolution of early stent-graft systems, and highlight the unique environment in Perth that cultivated these advances. By situating Perth's contributions within the broader global narrative, this presentation will underscore how local WA innovation had profound worldwide impact, laying out the foundation for what is now a standard, life-saving therapy. References 1. Parodi JC, Palmaz JC, Barone HD. Transfemoral intraluminal graft implantation for abdominal aortic aneurysms. Ann Vasc Surg. 1991;5(6):491-9. 2. Lawrence-Brown MM, Hartley DE, Anderson J, Gunning D, McAullay G, Sieunarine K, et al. The Perth experience with endoluminal bifurcated grafting of abdominal aortic aneurysms. J Endovasc Surg. 1996;3(2):123-35.

11:50 am
The Nerve-Sparing Radical Prostatectomy (1982): Redefining Surgical Success in Urology
Dr Rachel Cockburn

12:00 pm
Controlling the Bleed Before Modern Surgery: Haemostasis in Byzantine Trauma Practice
Dr Uma Sreedhar
Haemorrhage has historically been the leading cause of early mortality following trauma. Contemporary methods of vascular control are often framed as post-medieval innovations, with earlier practice frequently characterised as relying predominantly on cautery and compression. However, the literature of Byzantine physician-surgeons demonstrates a more developed operative approach to haemostasis that refined earlier traditions and informed later surgical practice. Analysis of translated passages from Paul of Aegina's Epitome of Medicine (7th century CE), alongside the writings of Aëtius of Amida, shows clinical differentiation between brighter, pulsatile arterial bleeding and slower, darker venous haemorrhage. Both authors describe mechanical control using hooks to isolate bleeding vessels, facilitating targeted haemorrhage control. Paul provides step-by-step operative descriptions for the exposure of major vessels and application of ligatures proximal to the site of injury. He advocates ligation at the vessel root prior to division as the safest approach, refining earlier recommendations by the Roman physician Galen, who described ligation or transection as separate, non-sequential strategies. Unlike earlier references to vessel control, these Byzantine texts situate haemostasis within the context of traumatic injury. They emphasise vessel identification and proximal control. These principles informed later surgical texts, including Kitab al-Tasrif written by 10th century Andalusian surgeon Albucasis. The writings of Byzantine physician-surgeons demonstrate an empirical understanding of haemorrhage and operative strategy that aligns with modern principles of proximal vascular control. Their work represents a critical and often under-recognised link between ancient surgical knowledge and modern trauma practice, highlighting the enduring importance of targeted haemostasis in the management of traumatic bleeding.

12:10 pm
Australasian MASH, a sustaining option for the management of rural surgical needs?
Dr Michael John

11:00 am - 12:30 pm
THE HPB ORCHESTRA

Scientific Session - HPB Surgery - Bellevue Ballroom 2

11:00 am
The role of AI/NGS in pancreatic cyst management
Dr Dilini Gunawardena

11:20 am
Integrating AI into Surgical Practice
Dr Quin Buchlak

11:40 am
Video spyglass mapping, case based
Prof Nam Nguyen

12:00 pm
Machine learning - based prediction for incidence of endoscopic retrograde cholangiopancreatography after emergency laparoscopic cholecystectomy: A retrospective, multicenter cohort study
Dr Shota Akabane
Objective: To develop a predictive model for the incidence of Endoscopic Retrograde Cholangiopancreatography (ERCP) following emergency laparoscopic cholecystectomy, utilising advanced machine learning techniques. Also, the associated factors between these procedures are to be identified. Background: Laparoscopic cholecystectomy is the preferred treatment for symptomatic cholelithiasis and acute cholecystitis, with increasing applications even in severe cases. The necessity for postoperative ERCP to manage choledocholithiasis or biliary injuries poses significant clinical challenges. This study aims to develop a predictive model for the incidence of ERCP following emergency laparoscopic cholecystectomy using advanced machine learning techniques. Method: We conducted a retrospective cohort study utilising the Tokushukai Medical Database, which includes data from 42 hospitals over a decade in Japan. The study population consisted of adult patients undergoing emergency laparoscopic cholecystectomy. We employed four machine learning models—logistic regression, random forest, gradient-boosting decision trees (GBDT), and multilayer perceptrons - on a dataset divided into training/validation and testing groups. We also calculated Shapley additive explanation values for the GBDT to identify the significant variables. Result: Out of 9,695 patients, 8,854 met the inclusion criteria. The incidence of postoperative ERCP was 5.7% and 6.4% in the training/validation and testing datasets, respectively. The GBDT demonstrated superior performance, with the highest predictive capacity for postoperative ERCP. Significant predictors identified included common bile duct dilatation, serum albumin, and lactate dehydrogenase levels. Conclusion: This study successfully established a robust predictive model for ERCP following emergency laparoscopic cholecystectomy and identified associated factors with the outcome.

12:10 pm
Scoping review of artificial intelligence for analysis of digitised pre-operative tissue in suspected pancreatic and bile duct cancer
Dr Hannah Kim
Purpose Accurate pre-operative diagnosis and prognostication are critical in suspected pancreatic adenocarcinoma (PDAC) and cholangiocarcinoma (CCA), where surgery carries substantial morbidity and mortality yet may not confer survival benefit for all patients. Artificial intelligence (AI) has shown potential to improve cyto- and histopathology performance in this area. This scoping review aimed to map the current evidence on AI approaches applied to digitised pre-operative PDAC/CCA tissue and to summarise reported diagnostic and prognostic performance. Methodology This study was conducted in accordance with PRISMA extension for scoping reviews. A systematic search was conducted in five databases. Articles published between 2015 and 2025 assessing AI-models on digitised pre-operative tissues of suspected PDAC or CCA were extracted. Results Of the 601 articles screened, 12 met inclusion criteria. Eight studies analyzed fine needle aspirates (FNA), two bile duct brushings (BDB) and one fine needle biopsy (FNB). Nine studies were single centre, and three multicentre. Convolutional neural networks were the predominant model architecture. Common technical strategies included augmentation, segmentation and Z-stacking. Model performance varied across studies and reporting was heterogeneous. Two studies directly compared AI performance with human interpretation. Fang et al., (2025) concluded that AI diagnostic accuracy (90.0%) exceeded intermediate (88.3%) and junior (76.7%) cytopathologists but was lower than senior cytopathologists (95.0%). Marya et al., (2024) evaluated a computer-aided detection approach in which AI

highlighted regions of interest for cytopathologists; diagnostic accuracy was similar to the original cytology interpretation, while workflow efficiency was reported to improve. Conclusion Early studies suggest AI has potential to play a valuable role in pre-operative tissue analysis for suspected PDAC and CCA in clinical practice.

12:20 pm
Performance and failure analysis of real-time computer vision in laparoscopic cholecystectomy
Dr Jayvee Buchanan
Background: Real-time surgical computer vision (CV-AI) is technically feasible, although real-world actionability and failure modes remain poorly characterised. This study quantified live performance and mapped dominant failure mechanisms during intraoperative deployment in laparoscopic cholecystectomy (LC). Methods: A real-time multi-task CV-AI was implemented prospectively (surgeon-blinded) during 100 consecutive LCs. Live video inference evaluated (1) five-phase workflow recognition, (2) inflammatory grade (1-4), (3) Rouviere's sulcus (RS) identification, and (4) drain detection performance. Outputs were compared with intraoperative observer annotations. Discordant cases underwent structured observer/surgeon feedback integrated with quantitative error signatures to derive a task-by-mechanism failure taxonomy. Results: Phase recognition showed greatest potential actionability. Across 316 eligible transitions, median absolute timing error was 22s (IQR 9-91); only 55% met the predefined ±30 s actionability threshold. Large delays clustered around branched workflows, particularly IOC/CBDE (median error 588s vs 23s). Inflammatory grading showed modest ordinal agreement (κw 0.39), improving when restricted to a post-liver-lift assessment window (κw 0.47). RS outputs were dominated by early false positives (sens 100%, spec 0%). Drain detection performance supported automated documentation (sens 90.9%, spec 83.1%). Mixed-methods synthesis identified unstable/limited visual access, non-linear workflow sequences, instrument-driven proxy triggering, and documentation-reference discordance as predominant failure mechanisms. Conclusion: Real-time CV-AI can generate clinically-relevant intraoperative signals, but utility is constrained by timeliness and predictable context-dependent failure modes rather than headline accuracy alone. Mapping failure mechanisms to quantitative signatures identifies actionable targets for iterative model redesign, including branch- and uncertainty-aware workflow modelling, before progression to higher-stakes decision-support.

11:00 am - 12:30 pm
The Art & Science of Collaboration in Paediatric Surgery

Scientific Session - Paediatric Surgery - Meeting Room M3

11:00 am
Geographical Logistics & Neonates
Dr Michael Collin

11:20 am
Not just a small adult: or are they? – a collaborative novel approach to a ruptured exomphalos major in a co-located tertiary paediatric surgery unit
Dr Jennifer Ah Toy

11:40 am
Challenging Cases in Paediatric Kidney Transplantation
Dr Adam Philipoff

12:00 pm
Simulation in Paediatric Surgery
Dr Damir Ljuhar

12:20 pm
Discussion

11:00 am - 12:30 pm
The Grantley Gill Breast Surgery Research Paper Prize

Scientific Session - Breast Surgery - Bellevue Ballroom 1

11:00 am

Evaluation of Magtrace® lymphatic tracer as a viable alternative to Technetium99 in performing Sentinel Lymph Node Biopsy for Breast Cancer

Dr Subash Gunasekaran

Introduction: Sentinel lymph node biopsy (SLNB) is integral to breast cancer surgery, providing accurate pathological staging that guides treatment and prognosis. Magtrace® is a novel superparamagnetic tracer for sentinel lymph node (SLN) localisation that offers flexible injection timing and avoids reliance on nuclear medicine. Magtrace® provides comparable SLNB performance to Technetium99 (Tc99) while reducing preoperative workflow requirements. We aim to prospectively compare Magtrace® with the standard Tc99 for localisation of SLN, including clinical outcomes and procedural complications. Methodology: Prospective data collection for patients undergoing Magtrace® injection for SLNB for breast cancer surgery was carried out from March 2023 to December 2025. Consented patients undergoing surgery who met selection criteria underwent injection of Magtrace® prior to their surgery. Results: 61 participants underwent 62 Magtrace® injections, (time range: 0-29 days preoperatively). Surgeries included 57 mastectomies and 5 wide local excisions. SLNB were undertaken in 58 cases, including 52 immediate SLNBs and 6 delayed SLNBs (dSLNBs); 4 participants did not undergo SLNB. Of the 58 SLN procedures, 50 procedures utilised both Magtrace® and Tc99, while the remaining 8 used Magtrace® alone. Using dual-tracer, Magtrace® identified more SLNs than Tc99 in 7 cases. SLN yield ranged from 1 to 5 nodes for both techniques, with mean yields of 1.9 for Magtrace® and 1.72 for Tc99. Grey skin discolouration occurred in 26 participants; no other adverse effects were observed. Conclusion: Magtrace® is an effective alternative to Tc99 for SLN localisation, providing similar node yield and flexible injection timing. Its use may improve access to SLNB in centres without nuclear medicine support and facilitate safe delayed SLNB when invasive disease is identified on final histology.

11:10 am

Immediate Lymphaticovenous Anastomosis with ICG Fluorescence Reverse Mapping during Axillary Lymph Node Dissection for Breast Cancer: A Feasibility Pilot Study

Dr Chu Luan Nguyen

Purpose: Breast cancer–related lymphoedema (BCRL) affects up to 30% after axillary lymph node dissection (ALND) and is difficult to treat, highlighting the need for preventive strategies. Lymphaticovenous anastomosis (LVA) offers a potential solution when performed at index operation. Indocyanine green (ICG) fluorescence axillary reverse mapping (ARM) has been shown to be superior to blue dye ARM, with 95% accurate lymphatic mapping based on the authors' prior work. This study reports early technical and clinical outcomes from the first ten cases. Methodology: Consecutive patients with node-positive breast cancer undergoing ALND received ICG fluorescence-guided ARM followed by immediate LVA at a single institution (April–August 2025). ARM lymphatics were identified with ICG and microsurgically anastomosed to a venous tributary. Anastomotic patency was assessed intraoperatively using ICG transit. Operative details, complications, and lymphoedema outcomes (bioimpedance spectroscopy and Norman Questionnaire) were assessed at 6 months. Trial registration: ACTRN12625000414415. Results: Ten patients were included. Nine underwent a single technically successful LVA; one patient lacked a suitable recipient vein. Anastomoses used an intussusception technique, comprising eight end-to-end anastomoses (one requiring a jump graft) and one arborised anastomosis. Patency was confirmed intraoperatively in all successful cases using ICG. Median duration of LVA component was 50 mins (IQR 40–95). One postoperative seroma occurred; no infections or anastomosis-related complications were observed. At 6-month followup, no patients had developed lymphoedema. Conclusion: This pilot demonstrates feasibility and safety of ICG-guided LVA during ALND, with high technical success, reliable intraoperative patency confirmation, and no early lymphoedema. These findings support longer-term followup within the full prospective trial to assess durability and lymphoedema risk reduction.

11:20 am

Magseed localisation for surgical excision of non-palpable breast lesions and targeted axillary lymph node dissection

Dr Alyssa Calderwood

Purpose: Magseed localisation is increasingly popular in breast surgery due to its ability to be inserted any time pre-operatively without signal decay, lack of ionising radiation, ease of operator use, and low rates of migration. We reviewed the outcomes and complications using this novel technique for excision of non-palpable breast lesions and targeted axillary lymph nodes. Methods: Prospective data was collected from June 2022 to December 2024 in 500 patients who had Magseed localisation of breast and axillary lesions in a tertiary Australian metropolitan hospital. Results: A total of 555 Magseeds were used in women aged 22 to 87 years old. The majority had a single breast lesion localised with a single Magseed (n=473), with multiple

Magseeds for multiple lesions within the same breast in 14 cases. Bracketing was used in 20 cases. Targeted axillary dissection was performed for 13 patients. There were 363 wide local excisions (n=326 level 1 oncoplasty, n=37 level 2 oncoplasty), and 144 excisional biopsies. Pre-operative biopsies included invasive cancer (n=297, 56.14%), DCIS (n=69, 13.04%), and B2/B3/B4 pathologies (n=163, 30.81%). Median time from Magseed insertion to surgery was 7 days, with 36 placed on the day of surgery, and the maximum duration was a Magseed inserted 173 days pre-operatively. Mean duration of surgery (skin incision to specimen out) was 18 minutes. Median specimen weight was 20.8g. Re-excision rate for positive or close margins was 19.8% (n=72), and the migration rate (>10mm) was 2.9% (n=16). There were no major complications relating to the Magseed recorded. Conclusion: Magseed localisation in breast surgery is a safe and reliable technique. Its ability to be inserted any time before surgery, ease of operator use and low migration rates has resulted in our unit transitioning to using it as the primary localisation technique, replacing ROLLIS which had constraints in COVID-related surgical delays and radiation issues.

11:30 am
Clinical relevance of the SOUND and INSEMA trials in women with early breast cancer in Australia and New Zealand
Dr Matea Dominkovic
Background: Axillary surgery in breast cancer has undergone progressive de-escalation. The recent Sentinel Node versus Observation after Axillary Ultrasound (SOUND) and Intergroup Sentinel Mamma (INSEMA) trials have demonstrated that sentinel lymph node biopsy may be safely omitted in selected patients. This study aimed to evaluate the clinical relevance and applicability of the SOUND and INSEMA trial criteria within the Australian and New Zealand context. Methods: Prospectively maintained data from the BreastSurgANZ Quality Audit (BQA) were analysed. Patients with invasive breast cancer treated between 2019 and 2023 who met the inclusion criteria of the SOUND and INSEMA trials were identified. Results: A total of 69,122 patients were treated for invasive breast cancer over the five-year study period, of whom 30,822 fulfilled the inclusion criteria of either the SOUND or INSEMA trials. Overall, 34.0% and 44.6% of patients with invasive breast cancer in Australia and New Zealand met the SOUND and INSEMA eligibility criteria, respectively. Tumour characteristics of BQA patients were more closely aligned with those reported in the SOUND trial than the INSEMA trial, although key differences in other clinicopathological features were observed. Conclusions: The SOUND and INSEMA trial criteria are applicable to over one-third of patients with invasive breast cancer in Australia and New Zealand, supporting the potential relevance of axillary surgery de-escalation in this population.

11:40 am
CRELD2 linked stroma alterations predict breast cancer invasion
Dr Ngoc Hoang Ha
Tumour-promoting stromal changes is an early event in breast cancer. They have been proposed as therapeutic and diagnostic targets but with minimal translational success. This project aims at evaluating “cystine rich with EGF like domains 2” (CRELD2) – a tumour cells’ secreted protein that mediates breast cancer-tumour-stroma crosstalk, as the first in class biomarker of the early invasive breast cancer. This is a prospective, correlational study. 58 breast cancer patients were recruited from the RAH Breast Department. Intra-operative tumour core biopsy tissues used to assess CRELD2 levels. This data was analysed against the patient’s tumour and disease phenotypes. Ten patients with high levels of detectable CRELD2 and 10 patients with low/no CRELD2 were used for further stromal assessment. This subset of patients’ tumour slides was stained for stromal components associated with cancer-associated fibroblasts. The fluorescence signal was measured using intensity density in the average of 10 region of interest sections per patient. Results: This pilot study had shown that the presence of intra-tumoural CRELD2 levels was strongly correlated with known prognostic characteristics such as: T stage, lymph node metastasis (p value <0.05) and tumour grade (p=0.07). All stromal characteristics tested were increased in patients with high intra-tumoral CRELD2 levels compared to patients who had no/low CRELD2 levels. Conclusion: Our findings show the utility of CRELD2 as a novel biomarker of early invasion of breast cancer. Despite the many prognostic factors known at the diagnostic stage size of tumour and grade of tumour, these still do not accurately predict for lymph node metastasis. This pilot study has shown CRELD2 as an independent predictive marker of local metastasis to lymph nodes. Alterations in breast cancer stroma is also shown in this cohort and supports the functional action and pro-tumorigenic property of CRELD2 that should be considered for future targeted therapy in breast cancer.

11:50 am
Changes in the Surgical Management of Breast Cancer Over Ten Years
Dr Bethany O'Neill
Purpose The surgical management of breast cancer has evolved with expectations for improved surgical, functional, aesthetic and oncological outcomes. This study aimed to describe these trends over time in

breast cancer management in a large metropolitan centre. Method This retrospective cohort study assessed patients with breast cancer treated by four surgeons at the Westmead Breast Cancer Institute from 1 Jan 2015 to 31 Dec 2024. Data was extracted from surgeons' logbooks and chart review, for procedures in both public and private hospitals. Linear regression models were used to identify statistical significance of trends over time. Results A total of 5709 patients were included. The rate of breast conserving surgery (BCS) increased progressively from 61% to 79%, while mastectomies decreased from 39% to 21% (p<0.01). Simultaneously, the proportion of neoadjuvant systemic therapy increased from 6% to 27% (p<0.01). The use of localisation for non-palpable disease doubled from 29% to 62% (p<0.01). Oncoplastic breast surgical techniques increased from 37% to 56% of BCS cases, with local perforator flap and immediate lipofilling increasing from 5% in 2018 to 22% in 2024 (p<0.01). The rate of immediate post-mastectomy reconstruction remained stable at around 45%; the proportion of implant-based vs autologous reconstruction changed from 95% vs 5% in 2020 to 51% vs 49% in 2024 (p<0.01). Symmetrisation of the contralateral breast doubled from 11% to 23% (p<0.01). The proportion of axillary lymph node dissection (ALND) decreased from 16% to 6%, whereas targeted axillary dissection (TAD) increased from 0% to 10% (p<0.01). Of patients with upfront TAD, 36% proceeded to cALND. Lymphovascular anastomosis was introduced in 2024. Conclusion Breast surgery has moved away from mastectomies and towards breast conservation, with de-escalation of axillary surgery and improvement in cosmetic outcomes. These changes reflect advances in oncoplastic breast surgery and use of neoadjuvant therapy.

12:00 pm
Hybrid AI Chatbot Decision Support Aid for Breast Cancer Treatment Planning: Development and Validation Study
Dr Chu Luan Nguyen
Purpose: Following a breast cancer diagnosis, patients face complex, time-sensitive decisions guided by multidisciplinary team (MDT) input, which can cause confusion and decisional conflict. Standalone large language models (LLMs) are unreliable for clinical decision support due to hallucinations and "black-box" reasoning. This study aimed to develop and validate a hybrid AI chatbot that provides personalised, guideline-based treatment summaries in plain language. Methodology: A bespoke web-based hybrid AI chatbot was developed (in collaboration with IT and Computer Scientists), combining deterministic NCCN-aligned decision logic—implemented through a structured decision matrix mapping clinical variables to recommended options—with a conversational LLM interface (Claude Sonnet 4.5). This architecture ensures guideline-compliant outputs delivered with a patient-friendly tone. Validation is underway using 150 retrospective cases through a two-stage concordance analysis comparing chatbot outputs with (1) initial clinical decisions and (2) postoperative histopathology-informed MDT plans (concordance rates and Cohen's kappa). After validation, supervised machine learning (ML) optimisation using 1000 retrospective MDT cases will enhance classifier accuracy, triage performance, and alignment with real-world decision patterns. Results: Development of the functional chatbot is complete. Early testing shows consistent generation of personalised and guideline-concordant summaries. Ongoing validation is assessing concordance, sensitivity, specificity, and factors contributing to discrepancies. Conclusion: A novel, explainable hybrid AI chatbot for breast cancer decision support has been developed. Validation and ML optimisation are in progress, with final results and optimised model planned for presentation by April 2026. This approach aims to deliver a transparent, reproducible, and patient-centred AI tool with future plans for real-world pilot trial.

12:10 pm
Early experience in breast perforator flap reconstruction
Dr Brodie Laurie
Introduction Breast conserving surgery has good oncological outcomes for selected breast cancers and may result in superior cosmetic outcomes. Traditionally used for smaller tumours, utilisation has expanded with the development of oncoplastic techniques such as local perforator flaps. This study describes the experience of introducing an intercostal perforator flap service at a tertiary hospital in Western Australia. Methods This case series used retrospectively collected data on patients who underwent breast conserving surgery with intercostal perforator flap reconstruction at Sir Charles Gairdner Hospital between May 2023 and September 2025. Data collected included flap type, tumour characteristics, complications, and re-operation rates. Pre-operative tumour size on imaging was compared with final histological size using Student's t-test. Results 28 consecutive patients were included, with all reconstructions performed immediately. The mean operative time was 122 minutes (range 60–245). Flaps were most commonly based on the lateral intercostal perforator, with 28.6% of cases utilising dual-perforator supply. The median specimen weight was 38.6 g (range 18.6–250 g). Mean tumour size was 28.3 mm on both pre-operative imaging and final histology, with no statistically significant difference. Four patients underwent surgery for ductal carcinoma in situ alone, while the remainder had invasive cancer ranging from T1–T3 tumours.18 patients underwent concurrent sentinel lymph node biopsy while 6 had axillary clearance. Margin re-excision was required in four patients (14.3%) and post-operative infection occurred in six patients (21.4%),

half of whom required procedural intervention. There were no post-operative haematomas or complete flap losses. Conclusion The introduction of an intercostal perforator flap service enabled breast conserving surgery for a broad range of tumour sizes and pathologies with acceptable operative times and key performance indicators.

12:20 pm
Complication rates and patient-reported outcomes of immediate autologous breast reconstruction: insights from a coordinated, combined breast reconstruction service
Dr Alexander Armanios
Purpose: Immediate autologous breast reconstruction has many advantages but presents logistical challenges. Establishing a coordinated, combined model of care delivery has been shown to increase breast unit productivity at minimal cost. This study sought to validate this novel intervention by evaluating clinical and patient-reported outcomes following its implementation. Methods: A retrospective cohort study was conducted involving patients who underwent immediate autologous breast reconstruction at a Western Australian tertiary centre over five years. The BREAST-Q v2.0 Reconstruction Module was used to collect patient-reported outcome data. Clinicopathological data were analysed using SPSS v.27. Results: 105 patients were included, with a mean age of 48.8 (SD ± 9.5) and mean BMI of 27.0 (SD ± 4.3). The vast majority of reconstructions (84.8%) were DIEP flaps. Overall 90-day complication rate was 37.1%, with rates of unplanned re-operation and flap failure of 10.5% and 1.0%, respectively. The most frequent complication was wound dehiscence (8.6% breast, 17.1% donor site). BREAST-Q response rate was 48.1%. Overall breast satisfaction was high, with 84% of patients answering ‘satisfied’ more than ‘dissatisfied’. Sexual well-being and psychosocial well-being scores were lower than in prior literature, though this may be influenced by a significant number of patients still awaiting aesthetic revision. Patient-reported outcomes were poorer among those without a cancer diagnosis, highlighting the importance of a robust risk-benefit discussion prior to mastectomy and reconstruction. Conclusion: The findings of this follow-up study showed serious complication rates and breast satisfaction on par with literature benchmarks. This further supports its application in other healthcare settings.

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01 May 2026

12:00 pm - 12:30 pm
Keynote Lecture - Professor Thomas J. Musholt (Mainz, Germany)

Keynote Lecture - Endocrine Surgery - Meeting Room M2

12:00 pm
CIONM and voice management in thyroid surgery
Prof. Thomas J. Musholt

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01 May 2026

12:30 pm - 1:30 pm
Lunch - Friday

Catering - *Cross Discipline* - Pavillion 1

12:30 pm - 1:30 pm
RACSTA Lunch Session - How to talk to patients about sex and what you need to know

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Scientific Session - Trainees Association - Meeting Room M2

12:30 pm

How to talk to patients about sex and what you need to know
Ms Melissa Barrett

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01 May 2026

12:45 pm - 1:15 pm
New Medtek Devices Lunch Session: Approaches to management of post-operative haemorrhoidectomy pain

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Scientific Session - *Cross Discipline* - Meeting Room M6

Proudly sponsored by New Medtek Devices

12:45 pm
Approaches to management of post-operative haemorrhoidectomy pain
Professor David Lubowski

1:00 pm
Approaches to management of post-operative haemorrhoidectomy pain
Associate Professor Kim-Chi Phan-Thien

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01 May 2026

1:00 pm - 2:00 pm
Craniomaxillofacial Surgery - Panel and Interactive Cases

Scientific Session - Craniomaxillofacial Surgery - Meeting Room M1

1:00 pm
Case 1
Prof Roman Khonsari

1:15 pm
Caution with new technologies - 3 cases
Professor David David AC

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01 May 2026

1:30 pm - 2:00 pm
Archibald Watson Memorial Lecture - Professor Spencer Beasley, (Aotearoa New Zealand)

Named Lecture - Surgical History - Meeting Room M7

1:30 pm
Murders and Redemption
Professor Spencer Beasley
In 1871 the brig “Carl”, actively engaged in illegal “blackbirding”, was overhauled after about 60 captured Kanakas from Tanna, Vanuatu, subjected to horrific violence and cruelty, had been murdered or wounded and tossed overboard. The owner of the vessel, Dr James Murray, turned “Queen’s Evidence” and escaped the death penalty even though he was primarily responsible for the atrocities. The captain and three other crew members were sentenced to death (their sentences were later reprieved) and others convicted of assault. One crew member whose fate we will explore further, was arrested on the lesser (but still serious)

charge of kidnapping, was accused of poisoning the captain, skipped bail and managed to escape with the assistance of his family. He secretly skedaddled out of Australia, first to America and eventually turned up in Gottingen, Germany. In the same year, a wealthy, cultured well-dressed surgeon, graduate of Yale University and veteran of the American Civil war (he participated in the brutal Battle of the Wilderness, Virginia in 1864) moved to the squalor of Lambeth, London, attracted by its “easy access to easy women”. A few months later, in early 1872, he shot and killed an innocent man with his Colt .38 revolver. He was found guilty but not hung: he benefitted from the 1843 adoption of the McNaghten Rules that meant he was acquitted on the grounds of being mad, to be incarcerated indefinitely in an asylum in England. It is hard to imagine that either man could ever redeem himself, or later make such a major contribution that their work is still celebrated today. The first person is Archibald Watson, after whom this lecture is named: he graduated from Gottingen in 1878, gained a second doctorate in Paris in 1880 and was awarded Fellowship of RCS(Eng) in 1884. His contribution to surgical teaching and practice was extensive (not just in Adelaide and Darwin, but also abroad in Egypt (1883), the Boer War (1900) and Gallipoli (1914)) and is still applauded. He had a most extraordinary and varied life. The second is Dr WC Minor, a lascivious and charismatic surgeon who was later to have a remarkable influence on the compilation and ultimate credibility of the first Oxford English Dictionary. He worked in obscurity on this monumental task from Crowthorne in Berkshire, an enigma but one of the dictionary’s most valuable contributors. His increasingly close relationship with the OED editor, Dr James Murray (same name, different person, non-seafaring), that developed over several decades is the subject of an intriguing book by Simon Winchester. Sadly, the combination of his guilt, unrelenting lascivious urges, declining health and enveloping delusions progressed to a point where, following mutilative genital surgery on himself, he was returned to America to die in the care of his family. The fascinating story of each is outlined, from their early influences, through the nadir in their lives the consequences of which each had to endure, to their eventual redemption. Their stories celebrate that, despite their life-long guilt, they still managed to make a positive contribution to humanity and knowledge (albeit in completely different ways).

1:30 pm - 3:30 pm
Basal Thumb Arthritis, Dupuytren's, Infection and Soft Tissue

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Scientific Session - Hand Surgery - Meeting Room M9

1:30 pm
CMCJ Replacement Arthroplasty – Current Concepts and Outcomes (Virtual)
Dr Oliver Mares

2:00 pm
Discussion

2:10 pm
Sodium bicarbonate buffering and needle gauge in percutaneous needle aponeurotomy: A randomised controlled trial evaluating injection pain reduction
Dr Ishith Seth
Injection of local anaesthetic into the palmar tissues during percutaneous needle aponeurotomy for Dupuytren’s disease can be painful. Commercial lignocaine is acidic, and buffering with sodium bicarbonate may reduce infiltration discomfort by raising pH toward physiological levels. Needle gauge may also influence pain at needle entry. This randomised controlled trial evaluated the effects of lignocaine buffering and needle gauge on patient reported pain during percutaneous needle aponeurotomy. In a single centre, single blind, randomised design, adults undergoing percutaneous needle aponeurotomy were allocated to receive either one percent lignocaine buffered with 8.4 percent sodium bicarbonate at a 10 to 1 ratio or plain one percent lignocaine. Participants were also allocated to infiltration using either a 25 gauge or 27 gauge needle. Pain was recorded on a ten point visual analogue scale, separately for needle insertion and for local anaesthetic infiltration. Immediate adverse events were recorded. Sixty seven patients were included. Buffered lignocaine significantly reduced infiltration pain compared with plain lignocaine, with a mean reduction of 1.65 visual analogue scale points and no adverse events. Needle gauge did not significantly affect needle insertion pain, with no meaningful difference between 25 gauge and 27 gauge needles. Buffering lignocaine with sodium bicarbonate is a simple, safe, and cost effective method to reduce infiltration pain during percutaneous needle aponeurotomy. Within the tested range, needle gauge does not meaningfully alter needle insertion pain.

2:20 pm

Dupuytren's Fibrosis And Primary Radical Dermofasciectomy With Full-Thickness Skingraft
Dr Jeff Ecker
Purpose Recurrent contractures after fasciectomy and z-plasty for Dupuytren's Fibrosis occur in 40% of cases with an estimated serious adverse event (SAE) of 1 to 3%. It has been documented that Dupuytren's fibrosis occurs extremely rarely under a full-thickness skin graft performed after dermofasciectomy. The current study aims to describe the surgical technique and post-operative management for primary dermofasciectomy with a full-thickness skin graft. It also aims to show rates of recurrent contractures in patients following this procedure. Methodology This retrospective study was performed from 2016-2023. All patients had a dermofascietomy with full-thickness grafts from the distal segment to the level of the mid-palmar crease. Total flexion deformities (TFD) were recorded pre- and post-surgery and were classified using Tubiana's staging (REF). Patients' follow-up ranged from 6 months to 5.5 years. Recurrence was defined as contracture of >20 from 6-week measurements. Results 118 patients and 142 fingers were included in the study. The average follow-up time was 18.7 months. A recurrent contracture rate of 21.8% was recorded. Of these, 61.3% (n=19) had improved overall TFD measures, but had a recurrence of contracture more than 20 degrees when compared to 6-week follow-up; 16.1% (n=5) had no improvement in TFD; and 22.6% (n=7) had worse TFD at the end of their follow-up compared to pre-treatment measures. The average time to recurrent contracture was 12.4 months. No recurrence of Dupuytren's fibrosis was identified in the patients who experienced recurrent contractures. Conclusions The current study provides an interesting insight into the evolution of Dupuytren's Disease. While we have demonstrated that dermofasciectomy with FTG abolishes recurrent Dupuytren's fibrosis, there remain problems with recurrent contractures and loss of motion. This raises the interesting question: 'In the absence of disease, what is the cause for recurrent contractures?'

2:35 pm
Discussion

2:45 pm
Is Fight Bite–Associated Septic Arthritis of the Hand a Distinct Clinical Entity?
Dr Lauren Whearty

2:55 pm
The use of Biodegradable Temporising Matrix for hand soft tissue defect coverage in regional Australia
Dr Tanisha Hayward
Hands present a particular challenge when it comes to soft tissue reconstruction due to the highly functional nature of the area and the intricate structural features that define the anatomy. Novosorb BTM, a synthetic dermal substitute, is increasingly being utilised as a solution for many of the problems that face hand reconstruction. This presentation summarises a cohort of 10 patients who underwent hand reconstruction via BTM at a Far North Queensland hospital between 2020-2024. The most common indication for reconstruction was following oncological resection. The majority of patients went on to have second stage reconstruction with a split thickness skin graft. Of particular interest is that despite multiple patients experiencing either BTM infection or graft infection, all patients achieved wound closure, with 4 out of 5 working patients being able to return to their usual work duties afterward. Aside from infection, no other complications were recorded. A drawback would be the longitudinal course of this reconstructive process, with patients taking on average 6.5 weeks to proceed to grafting and 10.6 weeks from BTM application until healed. Comparison of QuickDASH measures with patient characteristics suggested that poorer functional outcomes were obtained in comorbid patients or those that engaged poorly with hand therapy. This study provides a point of comparison against other recent literature examining BTM indications and outcomes for hand reconstruction outside of Australia, as well as highlighting the emerging role for BTM in a resource-limited regional location.

3:05 pm
Discussion

1:30 pm - 3:30 pm
Endoscopic & Robotic Evolution in UGI/Bariatric Surgery

Scientific Session - Bariatric Surgery, Upper GI Surgery - River View Room 4

Technological innovation is rapidly expanding the boundaries of minimally invasive surgery. This session examines the evolving role of endoscopy, robotics and emerging platforms in bariatric and upper gastrointestinal practice — from endoscopic weight-loss therapies to next-generation surgical technologies.

1:30 pm
Introduction and session framing

1:35 pm
Gastric Balloon Therapy & Anti-Obesity Medications — Swallowable vs Endoscopic
Dr Mohit Bhandari

1:50 pm
Endoscopic Weight-Loss Therapies — Matching Surgical Durability?
Professor Michael Talbot

2:05 pm
Endoscopic Suturing of Oesophageal & Gastric Perforations — Indications & Techniques
Dr George Hopkins

2:20 pm
Robotic Bariatric Surgery — Enhancing Precision, Safety & Teamwork
Dr Krishna Epari, Dr Krishna Epari

2:35 pm
Workflow Integration & Training in Robotic and Hybrid Procedures
Dr Kiron Bhatia

2:50 pm
Magnetic Compression Anastomosis in Bariatric Surgery — Early Clinical Experience and Future Directions
Dr Mohit Bhandari

3:05 pm
Interactive Panel and Q&A
Dr Mohit Bhandari, Dr Krishna Epari, Professor Michael Talbot, Dr Patrick Walsh, Dr Kiron Bhatia, Dr Krishna Epari

1:30 pm - 3:30 pm
General Surgery - Where are we now?

Scientific Session - General Surgery - Riverside Theatre

1:30 pm
The ASU Model
Dr Amanda Foster

1:55 pm
Emergency Laparotomy in Older Adults
Dr Lisa Redgrave, Dr Panchi Kumarasinghe

2:20 pm
Bridging the Gap – General and Subspeciality General
Professor Dieter Weber

2:45 pm
The Changing Landscape of Surgical Training
Dr Megge Beacroft

3:10 pm
Panel Discussion
Dr Megge Beacroft, Professor Dieter Weber, Dr Amanda Foster, Dr Lisa Redgrave, Dr Panchi Kumarasinghe

1:30 pm - 2:00 pm

KEYNOTE LECTURE - DR DIANA HASTRICH (PERTH, WA)

Keynote Lecture - Breast Surgery - Bellevue Ballroom 1

1:30 pm
Introduction
Associate Professor Caroline Baker

1:31 pm
The BreastSurgANZ Invited Speaker Lecture
Dr Diana Hastrich

1:30 pm - 2:00 pm
KEYNOTE LECTURE - DR NAIMISH MEHTA (NEW DELHI, INDIA)

Keynote Lecture - HPB Surgery - Bellevue Ballroom 2

1:30 pm
Surgical management of hilar cholangiocarcinoma
Dr Naimish Mehta

1:30 pm - 2:00 pm
Peter Jones Memorial Oration - Professor Roy Kimble (QLD, AUSTRALIA)

Named Lecture - Paediatric Surgery - Meeting Room M3

1:30 pm
Introduction
Associate Professor Peter Borzi

1:31 pm
Peter Jones Memorial Oration: "No Regrets!?"
Professor Roy Kimble

1:30 pm - 3:30 pm
RESEARCH

Scientific Session - Endocrine Surgery - Meeting Room M2

1:30 pm
Prophylactic Central Lymph Node Dissection for Papillary Thyroid Cancer is a Safe Procedure Despite 2025 Recommendations from the American Thyroid Association
Dr Christopher Barnes
Purpose: In 2025, the American Thyroid Association (ATA) updated guidelines for papillary thyroid cancer (PTC) (1). Within is a new recommendation against prophylactic central lymph node dissection (pCLND) for clinically node-negative tumors <4cm (cT1-2), citing concern that complication rates may outweigh known reductions in locoregional recurrence. Given the acknowledged oncologic benefit of pCLND in these guidelines, we evaluated complication rates at our high-volume center to assess whether pCLND remains safe for small, clinically node-negative PTC when performed by high-volume thyroid surgeons. Methodology: We retrospectively analyzed 400 patients with PTC measuring 1-4cm (T1b-T2) with clinically negative lymph node basins who underwent thyroidectomy with pCLND between 2018-2025. Complication rates were compared between total thyroidectomy and hemithyroidectomy. Results: 69% of patients had tumors 1-2cm and 31% had tumors 2-4cm. Total thyroidectomy was performed in 65.8%, hemithyroidectomy in 34.0%, and completion hemithyroidectomy in 0.25%. Temporary recurrent laryngeal nerve (RLN) palsy occurred in 1.5% of total thyroidectomies and 5.8% of hemithyroidectomies. No permanent RLN palsy

occurred. Temporary hypocalcemia occurred in 1.1% of total thyroidectomies and in 0% of hemithyroidectomies. Permanent hypoparathyroidism occurred in 0.4% of total thyroidectomies and 0% of hemithyroidectomies. Conclusions: pCLND performed by high-volume thyroid surgeons is associated with low complication rates. The low temporary hypocalcemia rate observed may reflect routine postoperative oral calcium supplementation. pCLND appears safe for T2 and smaller PTC with experienced hands, offering oncologic benefit with low perioperative risk. Locoregional recurrence analysis is ongoing in this cohort. References: (1) Ringel MD, et al. 2025 American Thyroid Association Management Guidelines for Adult Patients with Differentiated Thyroid Cancer. Thyroid. 2025 Aug;35(8):841–985.

1:41 pm

Feasibility of day case minimally invasive parathyroidectomy in the South Australian setting – can we do it in a day?

Dr Victoria Lu

Purpose Currently in South Australia, patients undergoing minimally invasive parathyroidectomy (MIP) are routinely admitted for overnight observation due to concerns regarding postoperative complications such as bleeding and hypocalcaemia. In recent years, there has been an increasing trend in the number of patients undergoing MIP as day surgery in other institutions, with many centres demonstrating it is safe and feasible. Additionally, with increasing hospital bed pressures, MIPs are often cancelled to facilitate more urgent cases. We aim to assess our complication rates after MIP to see if it is feasible to implement in our setting, and to use this data to create a day procedure protocol. Methodology A multicentre retrospective observational cohort study was undertaken across two metropolitan tertiary hospital networks in South Australia, between June 2023 and June 2025. All patients undergoing MIP for primary hyperparathyroidism were included. Patient demographics, imaging localisation, blood results, histopathology, operative findings and clinical outcome data were extracted from patient records and assessed for complications. Results Ninety-six patients were identified who underwent a minimally invasive parathyroidectomy for a preoperatively localised parathyroid adenoma. One patient had a postoperative bleed, one patient had hypocalcaemia requiring oral calcium replacement, one patient had hyperkalaemia, one patient had an allergic reaction to an anaesthetic agent. The remaining ninety-two patients (96%) had an unremarkable postoperative recovery and were discharged home the following day without complication. No patients were readmitted due to complications in the immediate postoperative period or subsequent 30 days. Conclusion Complication rates in our population appeared comparable to national standards and published literature. As a result, day case MIP appears to be feasible and safe for management of primary hyperparathyroidism in the Australian setting for selected patient populations with an unremarkable intraoperative course.

1:52 pm

A Prospective Study of Radiofrequency Ablation for the Management of Benign Symptomatic Thyroid Nodules

Dr Alexandra Jacobson

Purpose Radiofrequency ablation (RFA) is a novel minimally invasive treatment for symptomatic thyroid nodules. Although RFA is well established in some international centres, its application is not yet widespread in Australasia. We describe the implementation of a RFA program in a tertiary hospital endocrine surgery service and treatment related outcomes. Methodology A prospective case series of patients treated with ultrasound-guided RFA for benign symptomatic thyroid nodules between May 2024 and October 2025 was undertaken. Follow-up occurred at 3, 6 and 12 months post-RFA. The primary outcome measure was nodule volume reduction rate (VRR). Secondary outcome measures were compressive symptom and cosmetic scores. Results 10 patients were enrolled in a prospective study. All patients had compressive symptoms and/or cosmetic concerns. One patient underwent RFA of two hyperfunctioning nodules. The median energy delivered per nodule was 0.400kCal (IQR 0285-1.250kCal) Median follow-up was 6 months. The median nodule volume reduced from 8.12mL at baseline to 1.58mL at 3 months post-RFA ($p<0.001$). The median volume reduction rate (VRR) was 61.8%, 63.2% and 88.3% (IQR 64.7-91.0%) at 3,6 and 12 months respectively post-RFA. Therapeutic success (VRR>50%) was achieved in 7 out of 11 (63.6%) of nodules by 6 months. The median compressive symptom score reduced from 6/60 at baseline to 1/60 at 3 month follow-up ($p=0.013$) with no significant subsequent change. The median cosmetic score improved from 3.5/4 at baseline to 2/4 at 3-month follow-up ($p=0.001$). No patient experienced complications or regrowth. The patient with hyperfunctioning nodules was able to cease carbimazole and all other patients remained euthyroid. Conclusion Thyroid nodule RFA can achieve significant reduction in nodule volume and improvement in compressive symptoms. This novel treatment can be safely introduced into an established Endocrine Surgical program.

2:03 pm

A Prospective Study of Change in Muscle Strength and Endurance After Surgical Treatment of Primary

Hyperparathyroidism
Dr Christopher Barnes
Purpose: Primary hyperparathyroidism (PHPT) commonly causes neuromuscular dysfunction such as weakness and fatigue which can substantially impair daily activity. Although many patients report subjective improvement after parathyroidectomy (PTX), objective data supporting improvements in neuromuscular performance after successful parathyroid surgery are limited. We sought to assess objective changes in muscle endurance and functional capacity after PTX for PHPT. Methodology: A prospective cohort study was conducted in patients with PHPT undergoing PTX. Muscle endurance and functional capacity were assessed using the 30-second sit-to-stand (STS) test and maximum dominant hand grip strength (HGS) measurement preoperatively and at 3 months postoperatively and compared via paired t-test. Change in STS and HGS was also compared between-groups in those with preoperative normocalcemia (<2.6mmol/L) and hypercalcemia (≥2.6mmol/L) using Mann-Whitney U tests. Results: 76 patients with PHPT underwent PTX. 75.3% were female. Mean preoperative serum corrected Ca was 2.61mmol/L and median age was 66. Focused PTX was performed in 51% of cases and the median adenoma weight was 490mg. Median STS improved from 12 repetitions preoperatively to 14 repetitions at 3 months postoperatively ($p<0.001$). Mean maximum dominant HGS improved from 24.1kg to 25.6kg at 3 months postoperatively ($p<0.001$). There was no significant difference in change in STS or HGS between patients with pre-operative normocalcemia (corrected calcium <2.6 mmol/L) and those with hypercalcemia (corrected calcium ≥2.6 mmol/L) (STS $p=0.26$, HGS $p=0.87$). Conclusions: Parathyroidectomy for PHPT is associated with significant improvement in STS and HGS. Improvement was similar regardless of preoperative calcium status. This suggests that accompanied with subjective feelings of improved strength and energy is an objective improvement in proximal muscle endurance, strength, and functional capacity following parathyroidectomy.

2:14 pm
Early Improvement in Patient-Reported Fatigue Following Parathyroidectomy for Primary Hyperparathyroidism
Dr Kiran Narula
Background: Primary hyperparathyroidism (PHPT) is increasingly detected through routine biochemical screening. Despite this, fatigue remains a prevalent yet under-recognised symptom that may significantly impair quality of life, even in patients traditionally classified as having mild or “asymptomatic” disease. While parathyroidectomy has been shown to improve overall symptom burden, fatigue-specific outcomes remain incompletely defined. This study aimed to quantify short-term changes in fatigue following parathyroidectomy using a validated patient-reported outcome measure. Methods: A retrospective analysis of prospectively collected data was performed in adults with biochemically confirmed PHPT after exclusion of MEN1 and MEN2 syndromes, undergoing parathyroidectomy at a tertiary endocrine surgery unit between August 2024 and August 2025. Fatigue was assessed pre-operatively and at three weeks post-operatively using the Fatigue Assessment Scale (FAS). The primary outcome was change in total FAS score. Results: Of 51 eligible patients, 46 were included in the final analysis. The mean age was 60 years, and 87% of patients were female. Pre-operative fatigue (FAS ≥22) was present in 73% of patients. Mean FAS scores improved from 29.0 ± 9.7 pre-operatively to 19.0 ± 5.0 post-operatively, corresponding to a mean reduction of 10.4 ± 9.5 points ($p < 0.001$). Biochemical cure was achieved in all patients. Patients reporting fatigue at baseline demonstrated a significantly greater reduction in FAS scores compared with those without baseline fatigue (−13.1 ± 9.4 vs −5.8 ± 7.0; $p = 0.03$). No significant differences in fatigue improvement were observed according to sex, pathological diagnosis, or severity of hypercalcaemia. Conclusion: Parathyroidectomy was associated with early, statistically and clinically significant improvements in patient-reported fatigue. These findings highlight fatigue as a meaningful and modifiable symptom in PHPT and support consideration of patient-reported outcomes when evaluating surgical benefit.

2:25 pm
A five-year retrospective review of histopathological findings of benign thyroid nodules surgically excised in Western Australia
Dr Emma Reid
Purpose: Thyroid surgery is commonly performed for nodules deemed low-suspicion on ultrasound (US) for compressive symptoms, thyrotoxicosis or interval growth. Published false-negative (FN) rates for benign cytology vary widely (5% to >20%). A 2025 meta-analysis demonstrated FN rates of 5.3-6.9% across over 5000 nodules.2 We aimed to identify the number of clinically significant malignancies on final histology among presumed benign nodules in a West Australian cohort. Methodology: Adults (≥18 years) who underwent thyroid surgery for benign appearing lesions (Jan 2020–Nov 2025) were identified from a database. Baseline data including sex, age, history of neck irradiation and indication for surgery was collected. Patients with benign cytology and available final histology were included. US features including size, echotexture, vascularity and presence of microcalcifications were extracted from radiology reports. Histology was

recorded postoperatively. Statistical analysis was performed using R. Results: 711 patients underwent surgery for benign indications. Radiology reports were available for 396 patients. Twenty patients received a post-operative histological diagnosis of clinically significant carcinoma (>1cm). The false negative rate for combined US and FNA was 5.1% (20/396). The presence of microcalcifications on US was the strongest predictor of malignancy in the group (OR 6.55, 95% CI 2.11-20.03, p=0.01). Conclusion: In this Western Australian cohort, benign preoperative assessment with US and FNA was associated with a 5.1% false negative rate, with microcalcification on US as the strongest predictor of malignancy. This data is in keeping with level I evidence. References: 1) Cotter A, Jinih M. Discov Oncol. 2025;16:1188

2:36 pm
Incidence, predictive factors, and natural history of hypothyroidism following hemithyroidectomy
Miss Katerina Misevska
Purpose Following hemithyroidectomy, the remnant thyroid lobe typically compensates avoiding the need for lifelong thyroxine, as required in total thyroidectomy. However, previous literature has identified the incidence of hypothyroidism following hemithyroidectomy at 20-30% and risk factors of Hashimoto's disease, side of resection, and demographic variables. This retrospective study investigates the incidence, risk factors and natural history of hypothyroidism following hemithyroidectomy in a sizeable single surgeon cohort. We aim to better characterise this complication to improve preoperative risk stratification and patient outcomes. Methodology The study cohort consists of 279 patients who underwent hemithyroidectomy between 2013-2023 under a single surgeon. Incidence was calculated at 1, 3, 6 months, and overall, after hemithyroidectomy. Univariate and multivariate logistic regression identified risk factors of hypothyroidism. Results Hypothyroidism incidence at 1-month post-operatively was 20%. Risk factors included preoperatively diagnosed Hashimoto's disease, histological lymphocytic thyroiditis, and right lobe resection. This study is first to report smoking as a protective factor against postoperative hypothyroidism. Of those hypothyroid at 1-month post-hemithyroidectomy, 45% were observed for natural recovery while 55% were treated with thyroxine. 8% of patients developed delayed hypothyroidism after 1-month. Conclusion This study utilised a single surgeon cohort to investigate incidence, risk factors and natural history of hypothyroidism following hemithyroidectomy, minimising variability in surgical technique and follow-up practices. Findings support known risk factors like Hashimoto's disease but identify smoking as a novel protective factor in hypothyroidism development. These insights may assist clinical decision making in order to improve outcomes after hemithyroidectomy.

2:47 pm
Efficacy of 18F-fluorocholine PET in complex pre-surgical localization for persistent or recurrent hyperparathyroidism
Dr Ashley Frois
Purpose: 18F-fluorocholine PET (FCH-PET) is a new and emerging method for localising parathyroid adenomas, which allows for a minimally invasive parathyroidectomy, improving surgical recovery and reducing complication rates. FCH-PET is currently used in our institution as a second- or third-line investigation in complex pre-surgical localization for persistent or recurrent hyperparathyroidism cases. This study aims to examine the localisation rates of FCH-PET in our institution. Methodology: A search for all patients who had FCH-PET scans done in Fiona Stanley Hospital from its first use until the start of the audit was performed, and patients who did not have surgery and thus no histological or surgical confirmation of the localisation were excluded. The results of the FCH-PET scan were compared with intraoperative findings and the histopathology report. The accuracy of the localisation was also compared to 4DCT and sestamibi scans if the patient had those as well. Results: 52 patients had an FCH-PET from 15 Aug 2016 to 5 Aug 2025. A total of 17 patients from this population proceeded to surgery. FCH-PET localised the adenoma correctly 58.8% of the time, which was comparable with those that had 4DCT (60%). Both were superior to sestamibi which had a localisation rate of 33.3%. Conclusion: The localisation rates in our cohort for FCH-PET, 4DCT and sestambi are lower than globally reported rates, and this is due to the inherently complicated nature of the cases used in this study. FCH-PET is used as a second- or third-line modality in our institution, hence patients in this study were of a complex case history – usually due to prior parathyroid surgeries, and discordant or non-convincing first line imaging. Nonetheless, FCH-PET seems to be a promising modality for localising missed or ectopic parathyroid adenomas comparable with 4DCT, and warrants a deeper look into its efficacy and its potential role in enabling successful focused re-operative parathyroidectomy.

2:58 pm
Impact of ICG angiography for Saving Parathyroids during Trans Oral Endoscopic Thyroidectomy Vestibular Approach (TOETVA)
Dr Narendra Lohokare
Purpose: With increasing adoption of Trans Oral Endoscopic thyroidectomy (TOETVA), prevention of complications such as parathyroid injury and postoperative hypoparathyroidism has become increasingly

important. The combination of enhanced endoscopic visualization and indocyanine green (ICG) angiography offers a potential method for accurate identification of parathyroid glands and assessment of their vascularity and viability. Objective: To evaluate the effectiveness of ICG angiography in identifying parathyroid glands, assessing their vascularity and viability during TOETVA. Methodology & Results: This prospective observational study included 115 patients undergoing TOETVA. Parathyroid glands were identified intraoperatively using standard endoscopic visualization and confirmed with ICG angiography. ICG was used to delineate vascular anatomy and assess perfusion of the parathyroid glands. Based on fluorescence intensity and perfusion patterns, glands were graded from 0 to 2 as per viability. ICG angiography was repeated at the end to reassess gland perfusion and guide the need for autotransplantation. Combined use of high-definition endoscope and ICG angiography enabled accurate identification and confirmation of parathyroid glands, significantly reducing inadvertent injury. The incidence of transient and permanent hypoparathyroidism was low, less than 3% and 1% of patients respectively, which was statistically significant compared with historical controls. Conclusion: The use of ICG angiography in conjunction with enhanced endoscopic visualization during TOETVA provides a reliable method for identifying parathyroid glands and assessing their viability. This technique significantly reduces the incidence of parathyroid injury and postoperative hypoparathyroidism and may be considered a valuable adjunct in endoscopic thyroid surgery.

3:09 pm
Review of incidental papillary thyroid microcarcinoma recurrence rates and associated risk factors in Western Australia
Dr Alexandra Miller
Purpose: Papillary thyroid microcarcinoma (PTMC) is an increasingly common diagnosis and associated with an overall excellent prognosis. As a result, there have been calls for de-escalation of PTMC postoperative surveillance. It is also recognised, however, that some patients with PTMC develop locoregional and metastatic disease or recurrence following surgical intervention, suggesting PTMC may represent a more diverse cohort of patients requiring different follow up strategies. This study aimed to assess recurrence rates in a Western Australian cohort of patients with incidental PTMC and identify potential risk factors for recurrence to help guide local practice. Methodology: A retrospective analysis was conducted of all patients with an incidental histopathological diagnosis of PTMC after undergoing thyroid surgery for a benign indication at public hospitals in Western Australia over a 10-year period (2013-2023). Data collected included potential risk factors for recurrence (age, sex, indication for operation, lymphovascular invasion, lymph node metastasis, tumour size, multifocality, thyroiditis, tumour location, extrathyroidal extension, tall cell variant, BRAF mutation) as well as outcome variables (locoregional recurrence, distant recurrence, survival). Results: Data were collected from 182 patients. Only 1 patient had locoregional recurrence of PTMC 14 months after the index operation. Potential risk factors for recurrence present in this patient included male sex, >5mm tumour, multifocality, positive BRAF mutation and lymph node metastasis identified at the index operation. However, all other patients with these potential risk factors did not develop recurrence. Conclusion: Findings from this study confirm that incidental PTMC has an excellent prognosis in the Western Australian population with very low rates of recurrence despite the presence of potential risk factors. This suggests that incidental PTMC does not require routine postoperative surveillance.

3:14 pm
Intra-operative autofluorescence probe detection system of the parathyroid; early clinical experience in a low volume Australian institution
Dr Nathanael Leavy
Background: Post-operative hypocalcaemia remains a significant complication of thyroid and parathyroid surgery. While high-volume centres have access to intra-operative techniques such as parathyroid hormone sampling and frozen section to aid parathyroid identification, regional centres frequently lack immediate access to these resources. The PTeye device (Medtronic) utilizes parathyroid autofluorescence to provide intra-operative tissue differentiation. While validated in specialized centres, its utility in lower-volume settings is less defined. Methods: We have performed a case series of four patients undergoing thyroid or parathyroid surgery our regional institution. The PTeye device was utilised as an adjunct to classical identification techniques. In this paper, we report the pre-operative investigations, operation findings and post-operative histological and pathological results. We evaluated the device's ease of implementation, intra-operative utility, and limitations in a setting without ad hoc access to frozen section or rapid parathyroid hormone analysis. Results: The PTeye was easily integrated into the surgical workflow with negligible setup time, comparable to standard nerve monitoring systems. Surgeons reported that the device served as a useful confirmative tool, increasing confidence in parathyroid preservation. However, the device demonstrated limitations in detecting intrathyroidal parathyroid glands, where probe contact could not be achieved. Conclusion: The PTeye is a promising adjunct for thyroid and parathyroid surgery in

regional settings where resource-heavy investigations are limited. While it augments surgical decision-making and confidence, it does not replace the necessity for classical anatomical knowledge and surgical technique.

1:30 pm - 3:30 pm
Revisiting Soft Tissue Tumours

Scientific Session - Surgical Oncology - River View Room 5

1:30 pm
Guidelines on superficial soft tissue tumors: should they be revised?
Dr Jun Guang Kendric Tan
Abstract Background Sarcomas guidelines suggest soft tissue lumps ≥5cm, enlarging, painful or deep are considered malignant unless proven otherwise, should undergo a MRI scan and be referred to a specialist centre. Secondary hospitals receive multiple referrers from primary care for subcutaneous, soft tissue lesions ≥5cm with no other high-risk features. Strict adherence to recommendations can lead to overutilisation of limited resources. Methods We performed a single centre, retrospective cohort study at SJOG Midland Hospital in Western Australia, Perth on 552 patients investigated for subcutaneous, soft tissue lesions from 24 November 2015 to 30 September 2024. Results 83.5% (461/552) of lesions assessed to be overall low-risk were excised locally. 31.9% (147/461) had ≥1 high-risk clinical feature but none were atypical or malignant. Histological lipomas were the most common at 83.5% (385/461) followed by angiolipomas at 9.1% (42/461). 0.22% (1/461) lesion showed malignancy and was <5cm. Pre-operative ultrasound was most commonly utilised at 56.2% (259/461) with 95.3% sensitivity and 100% specificity for lipomas. MRI was the next most commonly used imaging at 19.1% (88/461). 16.5% (91/552) of lesions had radiological high-risk features. 54.9% (50/91) were managed at our state sarcoma unit. 84% (42/50) underwent excisions with 1 histological pleomorphic sarcoma which had typical clinical and imaging features of malignancy managed with wide excision. Conclusion 99.8% (460/461) of patients with low-risk lesions <5cm were benign on histopathology. 50% (1/2) of subcutaneous, soft tissue lesions with malignancy were <5cm. Ultrasonography is highly sensitive (95.3%) and specific (100%) in characterising lipomas. This demonstrates that size alone should not be the sole indicator for escalation in investigation modalities (e.g. MRI), and that clinical assessment combined with ultrasonography is adequate in identifying low-risk lesions suitable for excision at non-sarcoma centres.

1:45 pm
The low risk lump: Management pathway
Mr Thomas Bragg

2:05 pm
Sarcoma in WA
Professor Richard Carey-Smith

2:35 pm
Pre vs Post-Operative Radiotherapy in soft tissue sarcoma
Mr Thomas Bragg

3:00 pm
Sarcoma Reconstruction
Assoc Prof Damien Grinsell

1:30 pm - 3:30 pm
Surgical Strategies in advanced Hernia Surgery

Scientific Session - Hernia Surgery - Meeting Room M8

1:30 pm
Welcome and Introduction by Chairpersons

1:35 pm

Abdominoplasty in ventral Hernias
Associate Professor Kellee Slater

1:50 pm
Biosynthetic meshes: Where is the paradigm?
Dr Mohammed Ballal

2:05 pm
Management of Chronic Groin Pain
A/Prof Hugh McGregor

2:20 pm
Management of Open Abdomen
Dr Danette Wright

2:35 pm
Challenges in traumatic lateral Hernias
Dr Rohit Sarvepalli

2:50 pm
Panel Discussion
Associate Professor Kellee Slater, Dr Danette Wright, A/Prof Hugh McGregor, Dr Mohammed Ballal, Dr Rohit Sarvepalli

3:05 pm
Closing Remarks

1:30 pm - 2:00 pm
The John Mitchell Crouch Fellowship Lecture - Dr Kilian Brown (Sydney, Australia)

Named Lecture - Colorectal Surgery - Meeting Room M6

1:30 pm
Addressing variation in treatment decision-making and outcomes in patients with locally advanced and recurrent rectal cancer
Dr Kilian Brown

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01 May 2026

2:00 pm - 3:30 pm
Back To The Future - What Can We Learn?

Scientific Session - Medico-Legal, Surgical History - Meeting Room M7

2:00 pm
Will my FRACS mean as much in 20 years as it did 20 years ago?
Dr Tina Dilevska, Dr Tina Dilevska, Professor Kingsley Faulkner, Dr Jamie Cransberg, Dr Damian Fry

2:50 pm
Beyond the Signature: The Evolution of Surgical Consent
Dr Tam Vo

3:00 pm
The Anatomy of Words: Ancient Origins of Surgical Language
Dr Christopher Barnes
“We’ll need to perform a ‘laparotomy’”. “Don’t mess with that, that’s the ‘pancreas’.” “Was that the ‘vagus’?”

Every day within the surgical field, we rely on a dense, efficient language that conveys complex meaning in a short gasp of air and flick of the vocal cords. But where do the meanings of these words come from? Why have these particular combinations of sounds come to signify such complex ideas? These terms may feel modern and technical, but they are rooted in some of the earliest attempts to understand the human body. This talk will discuss the etymological origin of many common words within general surgery, delving into their roots in ancient languages such as Latin, Greek, Old English, and Proto-Indo-European. Many of these words have intuitive origins, such as “bronchus” meaning “windpipe”. But there are many others that have remarkable and unexpected origins, such as “artery” which also means “windpipe” (as these vessels were found empty and full of air on the earliest autopsies), and “duodenum” which means “twelve fingers” (as it was commonly twelve fingerbreadths long when examined by the ancient Greek physician Herophilus). The overall aim of this presentation is to allow the listener to learn of, and appreciate, the deep and rich ancestry of the words we use inside and outside of the operating theatre, with their meanings carried through millennia based on careful observations made by ancient humans. Common cases within general surgery will be discussed, with pertinent words related to presentation, workup, operation, and recovery selected for etymological study. By understanding where our surgical language comes from, we gain more than trivia: we deepen our connection to the craft of surgery itself, sharpen our conceptual understanding of anatomy and disease, and recognize that each word we speak in and out of theatre carries with it the accumulated knowledge of generations who operated and observed before us.

3:10 pm
A Historical Review of the Evolution and Modern Application of Forehead Flap for Nasal Reconstruction
Dr Conor Gleeson
The history of nasal reconstruction is rooted in ancient surgical practice and has evolved around the forehead flap technique. Although the core principles of this approach were established in antiquity, the forehead flap has undergone continuous technical evolution across successive eras of surgical development. Motivation towards ongoing improvements have been accompanied by a steep learning curve reflecting the technical demands and nuanced judgement required to achieve optimal cosmetic and functional outcomes. This trajectory of development provides an opportunity not only to catalogue recent progress but also to pause for critical reflection. We present a review of the significance of this ancient method by examining key technical developments along the path to modern nasal reconstruction, from ancient India through medieval Europe to the modern era. The earliest documented description of nasal reconstruction can be traced back nearly 3,000 years to ancient India. Sushruta, authored the Sushruta Samhita, one of the few surviving surgical texts of the ancient world, which includes one of the first recorded use of a forehead flap for nasal reconstruction. His writing illustrated an early understanding of advanced surgical anatomy and techniques which provided foundational knowledge and still align with modern reconstructive practice. Following its emergence in ancient India, this method was propagated in medieval Europe where Italian surgeons Branca and Vianeo introduced adaptations and modifications that facilitated broader application. Subsequent advancements in the twentieth century have brought the forehead flap technique to a point of maturity at which reflection on previous progress can inform a framework for continued advancement. Evaluating contemporary modifications in the context of historical practice allows surgeons to appreciate the fundamental principles that have endured, evolved over time and those that require further examination.

3:20 pm
The Horror, The Horror: Frankenstein as a Surgical Leader
Dr Mashaal Hamayun
Victor Frankenstein is traditionally interpreted as a cautionary figure of scientific hubris, yet his story can be read as an early portrait of surgical leadership at a time when operative innovation was rapidly outpacing ethical frameworks. This presentation re-examines 'Frankenstein', positioning its protagonist as a surgical leader whose authority, ambition, and failures offer enduring lessons for contemporary practice. The story emerged during the 19th century, a period marked by dramatic advances in anatomy, dissection, and experimentation; where surgeons increasingly claimed authority over life, death, and bodily transformation. Frankenstein’s lab functions as an operating theatre, characterised by technical mastery, hierarchical control, and the pursuit of innovation without oversight. His leadership is defined by isolation, secrecy, and an absence of accountability – features that echo historical models of surgical authority prior to the development of formal training standards, peer review, and ethical regulation. The consequences of Frankenstein’s actions reflect core failures of leadership rather than technique: abandonment of responsibility for outcomes, lack of consent, disregard for team-based care, and an inability to anticipate downstream consequences of innovation. Cinematic adaptations reinforce these themes, presenting the surgeon-leader as a figure whose technical brilliance is undermined by moral blindness and poor stewardship. By reframing 'Frankenstein' as a narrative about surgical leadership rather than mere scientific excess, the story anticipates modern concerns surrounding innovation governance, responsibility for

complications, and the ethical obligations of those who lead surgical advancement. Its enduring power lies in its recognition that technical skill alone is insufficient; effective surgical leadership requires accountability, humility, and sustained responsibility for both patients and the systems in which innovation occurs.

2:00 pm - 3:30 pm
Biliary Complexities

Scientific Session - HPB Surgery - Bellevue Ballroom 2

2:00 pm
Assessing the bile duct after bariatric bypass
Dr Alistair Rowcroft

2:20 pm
The indeterminate biliary stricture – special cases
Dr Laurence Webber

2:40 pm
Bile duct resection for mid bile duct cancer, can it be enough?
Dr Ruelan Furtado

3:00 pm
Evaluation of operative difficulty in liver surgery to predict operative success: A retrospective review of quality outcomes over two decades
Dr Meet Patel
Introduction: There is an over-reliance on operative time as a surrogate marker for operative difficulty (OD) for liver resection, which fails to capture the full spectrum the procedure. This study aimed to develop an objective method to assess OD in liver resection and stratify quality outcomes based on OD. Methods: A retrospective review of patients undergoing liver resection for malignant disease between 1999-2023 at a tertiary hospital was completed from a prospectively collected database. Principal component analysis was applied to operative time, estimated blood loss, total time of hepatic inflow occlusion and number of units of blood transfused intraoperatively to derive an OD score using the z-score. Patients were stratified to three groups using Gaussian mixture models (GMM). Textbook oncological outcomes (TOO) and futile resection rates were compared using Chi-squared analysis. Subgroup analysis for overall survival (OS) and disease-free survival (DFS) was completed using the Kaplan-Meier method. Results: Of 729 patients, 699 met the inclusion criteria. GMM identified three distinct OD groups: low (n=540), moderate (n=143), and high (n=16). TOO and non-futile resection rates declined with increasing OD: 77% and 58% (low), 47% and 52% (moderate), and 6% and 19% (high), respectively ($p<0.001$). Among patients with cholangiocarcinoma, median OS was inversely correlated with OD (40 months low, 16 months moderate, 7 months high, $p=0.004$). In patients with colorectal liver metastases, there was a trend towards worse OS and DFS with increasing OD, however, this did not reach statistical significance. Conclusion: An objective OD score was developed that showed increasing OD was associated with poorer post-operative outcomes. Integrating the OD score supports more transparent, data-informed surgical decision-making and helps align expectations between teams and patients. Further external prospective studies are required to validate these findings.

3:10 pm
Role of bile duct brushings in providing diagnostic and prognostic accuracy of indeterminate biliary strictures
Dr Hannah Kim
Purpose Bile duct brushings (BDB) have low diagnostic sensitivity, negative predictive value and no known prognostic information. We aimed to assess the diagnostic and prognostic performance of BDB and identify clinicopathological factors associated with false-negative BDB. Methodology BDB at Christchurch hospital between January 2018 to March 2024 were retrospectively identified. Patient history, biochemical markers, radiology, management and outcomes were analysed. BDB were categorised according to WHO guidelines. Results Of 418 BDB, 7 (1.7%) were insufficient, 231 (55.3%) benign, 33 (7.9%) atypical, 7 (1.7%) pancreaticobiliary neoplasm, 21 (5.0%) suspicious for malignancy and 119 (28.5%) malignant. Final diagnoses were 156 (37.3%) benign, 157 (37.6%) pancreatic adenocarcinoma, 64 (15.3%) cholangiocarcinoma, 8 (1.9%) ampullary adenocarcinoma, 7 (1.7%) pre-malignant and 26 (6.2%) other malignancies. 140 BDB were true positives, 0 false positives, 117 false-negatives (FN) and 161 true negatives (TN) giving sensitivity 54.5%,

specificity 100%, PPV 100% and NPV 57.9%. Compared with TN, FN patients were older (median 73 vs 68 years, p<.001) and more likely to have metabolic disease (59.8% vs 37.7%, p<.001), but less likely to have a history of pancreatitis (8.5% vs 17.0%, p=.030), prior cholangitis (0.9% vs 7.5%, p=.007) or alcohol dependence (0.9% vs 9.4%, p=.003). 42 patients underwent surgery; 6 and 20-month survival rates of 98% and 42% respectively. Comparing those alive at 20 months (20m-A) with those deceased by 20 months (20m-D), bilirubin and CA19-9 did not differ; however, malignant BDB cytology was more frequent in 20m-D (76.5%), whereas benign cytology was more frequent in 20m-A (48.0%) (p=.030). Conclusion BDB has high specificity but limited sensitivity for indeterminate biliary strictures, with false negatives associated with distinct patient factors. WHO BDB cytology categories also appear to stratify survival, suggesting potential prognostic value.

3:20 pm
Endo-ACE: a five-year single-centre audit of endoscopic ultrasound-guided gallbladder drainage outcomes and factors influencing patient selection
Dr Ashwin Rajagopalan
Purpose: Laparoscopic cholecystectomy remains the standard of care for acute cholecystitis; however, a subset of patients is unsuitable for surgery due to frailty, significant comorbidity, hostile anatomy, or advanced malignancy. Endoscopic ultrasound-guided gallbladder drainage (EUS-GBD) using a lumen-apposing metal stent offers a minimally invasive alternative. This study reports clinical outcomes of EUS-GBD and characterises the preoperative factors influencing patient selection. Methodology: A retrospective single-centre audit was performed of all EUS-GBD procedures undertaken between 2020 and 2024 at a tertiary hospital in Melbourne, Australia. All procedures were performed by experienced endoscopists using lumen-apposing metal stents (AXIOS™). Demographic, clinical, and outcome data were collected. Preoperative risk was assessed using the Clinical Frailty Scale (CFS), Charlson Comorbidity Index (CCI), Karnofsky Performance Scale, and the ACS NSQIP surgical risk calculator. Results: Thirty-five patients (median age 75 years) underwent EUS-GBD. Technical success was achieved in 33/35 patients (94%), with clinical symptom resolution in 30/35 (86%). Ninety-day mortality was 26% (n=9); all deaths occurred in patients with metastatic or locally advanced malignancy. Only one patient (3%) required readmission for recurrent acute cholecystitis within 90 days. The majority of patients had active malignancy (20/35). Median CFS was 5 (IQR 4–5), median CCI was 6 (IQR 2–8), and median Karnofsky score was 70 (IQR 55–90). Sixty per cent had a NSQIP-predicted mortality exceeding 10% for laparoscopic cholecystectomy. Patients with higher functional status were selected primarily due to hostile anatomy. Conclusion: EUS-GBD is a safe and effective alternative for high-risk patients with acute cholecystitis, demonstrating high technical and clinical success with low recurrence. Current surgical risk tools broadly align with clinician judgement in patient selection; however, prospective trial data is required to help develop a dedicated framework.

2:00 pm - 3:30 pm
Cleft Surgery

Scientific Session - Craniomaxillofacial Surgery - Meeting Room M1

2:00 pm
Welcome Back

2:05 pm
The evolution of a management protocol for cleft palates
Dr David Gillett

2:25 pm
Outcome Measures in Young Adult Cleft Patients
Associate Professor Richard Lewandowski, Associate Professor Richard Lewandowski

2:45 pm
ABG Series
Mr Tomas O'Neill

3:05 pm
The role of Mandibular Distraction Osteogenesis in the management of infants with Robin Sequence
Dr David Gillett

3:25 pm
Discussion

2:00 pm - 3:30 pm
Mastectomy and Reconstruction

Scientific Session - Breast Surgery, Plastic & Reconstructive Surgery - Bellevue Ballroom 1

2:00 pm
An update on breast implants - ALCL, SSBI and everything in between
Professor Anand Deva

2:20 pm
Impact of Radiation on Implant based Breast Reconstruction: Timing and Outcomes
Professor Peter Cordeiro

2:40 pm
Implant vs Autologous Breast Reconstruction
Dr Tony Connell, A/Prof Joseph Dusseldorp

3:10 pm
Panel Discussion
Professor Peter Cordeiro, Dr Tony Connell, A/Prof Joseph Dusseldorp, Professor Anand Deva

2:00 pm - 3:30 pm
Recent advances and future directions in paediatric surgery

Scientific Session - Paediatric Surgery - Meeting Room M3

2:00 pm
ICG: Early lessons and expanding horizons
Dr Michael Nightingale

2:15 pm
From Vision to Viability: Establishing a Paediatric Robotic Service Through Collaborative Framework Development in Australia and New Zealand
Dr Janani Krishnan
Paediatric robotic surgery is widely performed internationally; however, no service, governance framework, or training pathway existed in Australia or New Zealand. This talk describes the experience of establishing a paediatric robotic surgery service and developing a reproducible framework for other centres. Service development required creating governance, credentialing, and training frameworks from scratch. Adult robotic models were adapted, paediatric-specific credentialing standards were defined, and training and accreditation requirements revised. A public-in-private service model added further complexity, requiring cross-sector collaboration and stakeholder engagement. Over 12 months, these efforts established a functioning service supported by a public–private agreement, enabling public paediatric patients to access robotic surgery safely. This experience proposes a framework structured around four pillars: feasibility assessment, training and credentialing, governance and risk management, and service implementation through collaboration, providing a practical guide for institutions seeking to introduce paediatric robotic surgery at their centres.

2:30 pm
Paediatric Robotics: Establishing a collaborative network and prospective database
Dr Kiarash Taghavi, A/Prof Kiarash Taghavi
Robotic-assisted paediatric surgery is growing rapidly but remains in its infancy in Australasia. Experience from other regions shows the value of building collaborative networks early — especially in paediatrics, which poses unique challenges. Common barriers include institutional processes, business models, demonstrating safety and efficacy, and platform requirements and training. Drawing on interviews with international leaders (Gundeti, Blanc, Peters) and national datasets, we developed a clinician led paediatric

robotic collaborative and a standardized REDCap database to capture preoperative, intraoperative (robot specific metrics, docking/console times, conversions), and postoperative outcomes including complications, length of stay and patient reported experience measures. Key insights—inclusive governance, pragmatic data field selection based on clinical experience and literature, and clear contribution/authorship rules—shaped a practical platform for research, quality assurance and business-case support. This collaborative approach aims to accelerate learning and dissemination, generate robust multi institutional evidence, and guide safe, equitable implementation of paediatric robotic surgery in Australasia.

2:45 pm
Academic Surgery – Challenges and Rewards
A/Prof Susan Adams

3:00 pm
Morbidity, Mortality and Innovation
Professor Todd Ponsky

3:15 pm
Discussion

2:00 pm - 3:30 pm
The Mark Killingback Research Paper Presentations

Scientific Session - Colorectal Surgery - Meeting Room M6

2:00 pm
The Critical Window – The Role of Timing and Determinants of Ischaemia After Angioembolisation for Acute Colonic Bleeding
Dr Mashaal Hamayun
Background: Acute colonic bleeding is a serious medical emergency. Computed tomography mesenteric angiography (CTMA) has become a critical diagnostic tool, enabling rapid identification of active haemorrhage. In many tertiary centres, interventional radiology guided angiography with embolisation has emerged as an effective and minimally invasive first line method for achieving haemostasis. While effective, the procedure carries a risk of colonic ischaemia. This study evaluates the impact of timing from CTMA to angiography on embolisation success, and identifies clinical and biochemical predictors of post-embolisation colonic ischaemia. Methods: A retrospective cohort study was conducted at Liverpool Hospital (2015–2017) involving 58 patients with acute colonic bleeding and positive CTMA. Patient demographics, medication history, procedural details, and post-procedure outcomes were analysed. Inflammatory markers (CRP, WCC) were monitored over three days post-embolisation. Statistical analyses included univariate and multivariate testing with significance at $p < 0.05$. Results: Of 58 patients, 38 underwent embolisation. Successful embolisations occurred significantly earlier post-CTMA (mean 80 minutes sooner) than unsuccessful cases. Colonic ischaemia occurred in 10% of patients post-embolisation, with most cases involving superior mesenteric artery branches. Anticoagulant use was significantly associated with ischaemia ($p = 0.05$). Patients who developed ischaemia had a steeper rise in CRP compared to non-ischaemic cases (D2 CRP: 139 vs 53 mg/L). Three patients required surgical resection due to ischaemic complications. Conclusion: Prompt angiography following CTMA improves embolisation success. Anticoagulation and rising CRP are potential predictors of post-embolisation ischaemia. These findings support early intervention, selective embolisation strategies, and vigilant post-procedure monitoring, particularly in anticoagulated patients.

2:10 pm
Statewide outcomes for rectal cancer treated with Total Neoadjuvant Therapy in South Australia
Dr Thuy-My Nguyen

2:20 pm
Sexual Function in Early-Onset Colorectal Cancer Survivors: A Population-Based Case–Control Study
Dr Oliver Waddell
Introduction Research demonstrates that sexual dysfunction is a major concern for early-onset colorectal cancer (EOCRC) survivors and a key contributor to impaired quality of life. Despite this, sexual function outcomes after EOCRC remain poorly characterised. Aims This study aimed to assess sexual function in EOCRC survivors and to identify demographic, psychological, and treatment-related factors associated with

sexual dysfunction. Methods A retrospective case–control cohort study was conducted involving EOCRC survivors diagnosed before age 50 and living in Canterbury, New Zealand, compared with age-matched controls. Sexual function was assessed using validated instruments: the Female Sexual Function Index (FSFI) and the International Index of Erectile Function (IIEF). Depression and anxiety were measured using the PHQ-9 and GAD-7 questionnaires. Logistic and linear regression analyses were used to compare rates and severity of sexual dysfunction and to explore associated factors. Results A total of 104 EOCRC survivors (56 women, 48 men) and 94 controls were included. Female EOCRC survivors had significantly higher rates of sexual dysfunction than controls (68% vs 35%, p=0.001), with significantly lower scores across five of six sexual function domains. Male survivors did not have significantly higher overall rates of erectile dysfunction compared with controls, but demonstrated significantly poorer sexual desire and orgasmic function ($p<0.05$). Male EOCRC survivors had significantly higher rates of depression (47.9% vs 27.4%) and anxiety (56.2% vs 25.4%) compared with controls ($p<0.05$). Depression, radiation, chemotherapy and advanced disease stage were significantly associated with worse sexual function. Conclusions EOCRC treatment is associated with significant impairments in sexual function, with a greater burden observed among women. In contrast, depressive symptoms were more pronounced among men, and depression, alongside cancer treatment–related factors, was a key determinant of sexual dysfunction across both sexes.

2:30 pm

Clinical Outcomes of the Kono-S Anastomosis in Crohn's Disease: A Comparative Cohort Study

Dr Aizat Drahman

Abstract Postoperative recurrence at the anastomotic site remains a major challenge following ileocolic resection for Crohn's disease. The Kono-S anastomosis, an antimesenteric, hand-sewn functional end-to-end anastomosis designed to minimise mesenteric involvement, has been proposed to reduce anastomotic recurrence. This study aimed to evaluate the clinical and endoscopic outcomes of the Kono-S anastomosis compared with conventional stapled side-to-side anastomosis in patients undergoing ileocolic resection for Crohn's disease. Methodology Study Design and Setting A retrospective comparative cohort study was conducted at a tertiary colorectal referral centre. Consecutive patients undergoing ileocolic resection for Crohn's disease between January 2016 and December 2024 were included. Participants Inclusion criteria were adults (≥18 years) undergoing primary or repeat ileocolic resection with primary anastomosis. Exclusion criteria included emergency surgery, diverting stoma formation, multivisceral resections, and less than 12 months of postoperative follow-up. Patients were stratified into two groups based on anastomotic technique: •Kono-S anastomosis group •Conventional stapled side-to-side anastomosis group Results A total of 186 patients were included (Kono-S n = 74; conventional anastomosis n = 112). Baseline demographics, disease phenotype, and use of biologic therapy were comparable between groups. Primary Outcome •Endoscopic recurrence at 12 months was significantly lower in the Kono-S group (18.9%) compared with the conventional group (42.0%, $p < 0.001$). Conclusion The Kono-S anastomosis is associated with significantly lower endoscopic and clinical recurrence rates following ileocolic resection for Crohn's disease without increasing postoperative morbidity or anastomotic complications. These findings support the Kono-S technique as a durable and safe anastomotic strategy in Crohn's disease surgery. Prospective randomised trials with longer follow-up are warranted to further define its role as the preferred standard of care.

2:40 pm

The Impact of a Formal Robotic Colorectal Surgery Program on Surgical Education: A Comparative Analysis of Trainee Operative Experience at University Hospital Geelong

Dr Katherine Goodall

Purpose: In 2025 University Hospital Geelong officially introduced a formalised robotic colorectal surgery program, expanding on its longstanding colorectal and robotic service. This paper explores the impact of the regional program on the surgical education for fellows and trainees. The aim is to examine how the transition to this new modality affects trainee surgeons' access to primary operating opportunities for colorectal resections as senior surgeons adapt to the new technology. Methodology: The study utilized a comparative data analysis of primary operating surgeons' roles before and after the formal introduction of the robotic service. Data were examined to compare the involvement of trainees and fellows in assisting and subsequent primary operating within the department against the data of consultant surgeons for the 2024 and 2025 periods. Results: The transition created a short-term "learning phase" that had significant implications for trainee surgeons, particularly regarding their access to primary operating opportunities as senior surgeons adapted. Despite this, the move reflects a critical shift, with early adoption and skills acquisition in robotics viewed as essential advantages for the next generation of surgeons. Conclusion: The introduction of robotic surgery changes the dynamics of surgical education, presenting short-term challenges for trainee operating access while simultaneously offering long-term benefits in essential skills acquisition. This study highlights the evolving landscape of training in the robotic era in the regional health care setting.

2:50 pm
Aortic Calcification as a Prognostic Imaging Biomarker for Postoperative Outcomes in Rectal Cancer Patients
Dr Michael Rouse
Purpose Aortic calcification assessed on staging CT may aid as a prognostic biomarker for postoperative outcomes in rectal cancer, potentially reflecting vascular health impacts on complications and survival in this cohort. This study investigates its associations with post-operative complications, outcomes and overall survival (OS) in a rectal cancer cohort. Methodology Analysis of 100 rectal cancer patients was taken from the ACCORD (Australian Comprehensive Cancer Outcomes and Research Database) database from 2013-2022. Aortic calcification measurements calculated using 3D SlicerTM version 5.10 with aortic calcification quantified as total calcium score (L1 to iliacs). Complications were evaluated binarily in surgical cases (n=71) using the Clavien Dindo Classification. OS was assessed from diagnosis to death or last follow-up (n=99, median 973 days). Analyses included t-tests, logistic regression for complications, and Cox regression for OS, adjusted for age and gender. Results Analysis of 100 rectal cancer patients was conducted. The mean was age 67.9 years (Range 28.7 to 95). 71 patients underwent operative management with 29 receiving palliative treatment. 14% (10/71) of cases had a Clavien Dindo complication 3 or above, with no significant correlation with increased calcification (mean score: 3632 vs. 2947 in complication vs. no-complication groups; p=0.664). Higher calcification independently predicted early cancer related mortality (HR=1.052 per 1000-unit increase, 95% CI: 1.010–1.096, p=0.014). Conclusion Aortic calcification emerges as a prognostic imaging biomarker for worse postoperative survival in rectal cancer, independent of complications. Further data from this data set will need to be added to support its integration into risk stratification models.

3:00 pm
The Impact of Obesity on Intraoperative Complications in Rectal Cancer
Dr Rathin Gosavi

3:10 pm
Efficacy of sacral nerve stimulation in patients with low anterior resection syndrome following treatment for rectal cancer
Dr Yufeng Nie
Purpose Low Anterior Resection Syndrome (LARS) is common after sphincter-preserving surgery for rectal cancer and often compounded by neoadjuvant chemoradiotherapy. Conservative management of refractory symptoms often results in unsatisfactory quality of life (QoL). Sacral Nerve Stimulator (SNS) has been proposed as a therapeutic option for refractory symptoms. This study aims to evaluate the effect of SNS on incontinence and QoL in patients with LARS following rectal cancer treatment. Methodology We performed a single centre, retrospective cohort study examining the change in LARS symptoms following SNS implantation. All patients had previously undergone sphincter-preserving surgery for rectal cancer and exhibited persistent LARS symptoms despite multidisciplinary conservative management. Between January 2023 and July 2024, ten consecutive patients who underwent SNS insertion were identified. Demographic, peri-operative and adjuvant treatment data were collected retrospectively from medical records. Primary outcomes included changes in bowel function using LARS score and Wexner faecal incontinence score. QoL was assessed using the EQ-5D-5L questionnaire. Pre- and post-operative patient reported outcome measures were compared, with post-operative assessment done at least three months following implantation. Results Ten patients underwent SNS implantation. Patients were split evenly by sex with median age of 53 years. All patients had undergone ultra-low anterior resection with diverting ileostomy and neoadjuvant chemoradiotherapy. Prior to SNS, 90% of patients had major LARS. Following SNS implantation, 80% of patients had improved LARS score (37.4 vs 29.6, $p<0.05$), whilst no patients had worse LARS symptoms. Conclusion We present early retrospective cohort data demonstrating significant improvement in QoL in LARS patients who have undergone SNS implantation. This demonstrates SNS can effectively reduce faecal incontinence and improve the QoL of rectal cancer patients.

3:20 pm
Drain fluid lipase as a biomarker for anastomotic leak after colorectal resection and an extra-peritoneal anastomosis with omission of a diverting ileostomy
Dr Imran Aumeerally
Introduction: Anastomotic leak (AL) is the anathema of colorectal surgery. Early diagnosis is important to enable early intervention. Temporary diverting ileostomy (TDI) does not prevent AL and presents inherent complications. Numerous drain fluid biomarkers have been studied in colorectal surgery and extravasated intraluminal substances such as lipase have shown promise. The aim of this study was to assess drain fluid lipase (DFL) as a biomarker of AL after rectal resection with low colorectal anastomosis and no TDI. Methods: This prospective observational cohort study collected samples of DFL in consecutive patients undergoing

rectal resection with low colorectal anastomosis and without TDI. Data were collected and analysed relating to patient demographics, operation, indication and daily DFL measurements from pelvic drains. Results: Between August 2018 and March 2021, there were 62 patients recruited who met eligibility criteria. Overall, the anastomotic leak rate was 9.7% (6/62). These six patients were assigned to the AL group. The DFL on postoperative day 3 was found to be higher in the AL group compared to the NAL group (p = 0.034). A DFL cutoff threshold of less than 64 U/L was found to have a negative predictive value of 97.6% and negative likelihood ratio of 0.32 in excluding AL. Conclusion: This is the first study is to assess the utility of DFL as a biomarker for AL following colorectal anastomosis without TDI. The measurement of DFL has value as a strong negative predictor of AL and moderate impact on post-test probability. The results are comparable to the use of systemic biomarkers.

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01 May 2026

3:30 pm - 4:00 pm
Afternoon Tea - Friday

Catering - *Cross Discipline* - Pavillion 1

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01 May 2026

4:00 pm - 5:30 pm
CRANIOMAXILLOFACIAL SURGERY Free Papers

Scientific Session - Craniomaxillofacial Surgery - Meeting Room M1

4:00 pm
Salvage Orbitomaxillary Reconstruction After Failed ALT Flap and Infected Orbital Hardware Using Pro-Planned Fibula Free Flap and Iliac Crest Graft
Dr Hengameh Shahriari Ahmadi
Salvage reconstruction of orbitomaxillary defects remains exceptionally difficult, particularly following prior free-flap failure, radiotherapy, and chronic infection. Successful restoration requires reliable vascularised bone for maxillary support, biologic reconstruction of the orbital floor, and well-vascularised soft tissue to re-establish oral–nasal separation and intraoral lining within a scarred and contaminated operative field. Virtual surgical planning was used to facilitate reconstruction with a fibula osteomyocutaneous free flap, allowing restoration of maxillary buttresses and alveolar architecture while providing soft tissue for palatal closure, intraoral lining, and midfacial contour. In this case, the fibula was harvested as a straight segment and osteotomised into a complex Z-shaped construct, a configuration that increases inset difficulty and places the vascular pedicle at risk of kinking, thereby challenging flap perfusion and survival. The osseous construct additionally provided stable inferior orbital rim support, enabling reconstruction of the orbital floor using an autologous iliac crest graft and avoiding reintroduction of alloplastic material into an infected field. This case highlights the feasibility of a single-stage salvage orbitomaxillary reconstruction using a multi-segment Z-shaped fibula osteomyocutaneous flap, emphasising the technical considerations required to maintain vascular integrity in complex osseous geometry. The approach is illustrated through a detailed case presentation and discussion of relevant technical considerations and existing literature.

4:15 pm
Romanticising Gen Z: How QR Codes Improved Craniofacial Database Capture at a Tertiary Hospital
Dr Daphne Wang
Purpose The CLEFT-Q survey has traditionally been administered in paper format. Given that many craniofacial surgery patients are aged 16–30 years, we implemented a QR-code–based delivery method to improve accessibility and optimise data capture for our craniofacial database. Methodology The CLEFT-Q survey was transcribed into Microsoft Forms and distributed to eligible patients via a QR code that could be scanned on personal devices (see Diagrams 1–2). Survey uptake and data completeness were evaluated over the first six months of implementation (August 2025–January 2026) and compared with the preceding six-

month periods using the paper-based approach. Outcomes included response rate and the proportion of missing data points. Results Compared with the preceding six-month periods, the QR-code method was associated with improved survey uptake over August 2025–January 2026. A total of 47 initial and follow up surveys were obtained. The average time for completion for the survey was 12 minutes and 28 seconds. A reduction in missing data points was also observed. Results are summarised in the tables below. Conclusion Transitioning from paper to QR-code survey delivery is a feasible, low-cost intervention that aligns with the demographics of a craniofacial population and may improve both participation and data completeness within clinical databases.

4:30 pm
Morphea en coup de sabre treated with Autologous Fat Transfer: A Case Report
Dr Betty Wang
Purpose Morphea en coup de sabre, or French for “blow from a sword”, is a rare form of localised scleroderma characterised by progressive linear atrophy and frontocranial vertical depression, classically presenting in childhood. In this report, we present a rare case of adult-onset en coup de sabre successfully treated with single-stage autologous fat grafting. Methodology A 64-year-old man presented with a 7-year history of spontaneous right paramedian forehead linear depression, soft tissue atrophy, bony concavity, and alopecia. He was treated with single-stage autologous fat grafting using Coleman's technique, with retrograde injection of 20cc of fat and deliberate overcorrection to allow for fat resorption. Results At 6 weeks post-operatively, we achieved a satisfactory aesthetic outcome with the correction of contour deformity, volume stabilisation and minimal fat resorption. The patient reported high satisfaction with the aesthetic outcome and experienced no complications. Conclusion This case highlights that autologous fat grafting is a safe, effective and minimally invasive single-stage reconstructive treatment for stable craniofrontal linear scleroderma, including adult-onset presentations. Fat grafting provides both volumetric correction and potential regenerative benefits that address disease processes, making it a valuable option for residual deformity after disease quiescence.

4:45 pm
Complications in thread rhinoplasty: a case series and literature review
Dr. Nicole Garcia
Background Thread rhinoplasty is a non-surgical method of altering the appearance of the nose by insertion of typically barbed threads to suspend cartilage or add volume. Due to its minimally invasive nature and lower cost than open rhinoplasty, it has gained popularity in recent decades, particularly in Asia. However, complications can arise from this procedure, such as infection, thread extrusion and loss of suspension. Methods We present a series of Australian patients who developed complications after thread rhinoplasty and performed a literature review using the keywords “nose threading”, “non-surgical rhinoplasty” and “thread rhinoplasty” using Ovid MEDLINE. 189 relevant articles were found and after abstract review 16 were included for full text review by two authors. Results Between April 2020 and April 2024, 11 patients presented with complications relating to thread rhinoplasty which subsequently required surgical management, presenting at a mean of 5.8 months after the initial procedure. 10 out of 11 patients had the threads inserted in Asia, with the remaining patient having the procedure performed by an unregistered nurse in Australia. 4 presented with infections and 7 had thread extrusion, and all resolved following surgical removal of thread material. Conclusions Non-surgical cosmetic procedures such as thread rhinoplasty are becoming more prevalent and as such, their complications may also become more frequently seen. It is important for healthcare professionals to be aware of the risks associated with nasal thread insertion and recognise and manage complications promptly in order to reduce associated morbidity in a cosmetically sensitive area of the face.

5:00 pm
Factors Influencing The Operative Management of Mandibular fractures: A Retrospective Analysis from a Western Australian Tertiary Hospital
Dr Nisha Jayachitra
Introduction Mandible fractures are common in young adults and have a functional impact. This study evaluates a cohort of patients with mandibular fractures in Western Australia to ascertain factors determining operative management. Methods A cohort of 104 patients with 139 mandible fractures were referred to Sir Charles Gairdner Hospital, Plastics and Reconstructive Services from July 2022 to November 2025. Patient factors and referral source were obtained; alongside fracture characteristics such as displacement, malocclusion, fracture favourability and dental instability. Univariable associations were assessed and multivariable logistic regression was used to identify independent predictors of operative management. Results 68.3% of patients were aged between 18 and 39 years with 75% being male. The most common mechanism of injury was assault (42.3%). In the cohort, 78 fractures (56.1%) were managed operatively. Fracture displacement (adjusted OR 5.79, 95% CI 1.48–22.62), malocclusion (adjusted OR 11.97, CI

1.20–119.37), multiple fractures (adjusted OR 8.46, 95% CI 2.70-26.51) and unfavourable fracture pattern (adjusted OR 6.07, 95% CI 1.25-29.56) remained independent predictors of operative management. Angle fractures were more likely to be managed operatively (OR 5.54, 95% CI 1.98–15.50) as well as parasymphysis fractures (OR 2.69, 95% CI 1.01–7.16). Whereas condylar fractures (OR 0.09, 95% CI 0.03–0.24) and ramus fractures (OR 0.20, 95% CI 0.06–0.64) were less likely to be managed operatively. Patient factors such as gender and referral source were not independently associated with operative management. Conclusion Operative management of mandibular fractures was driven primarily by fracture instability and unfavourable biomechanics rather than patient factors. Future prospective studies incorporating patient-reported outcomes may further refine thresholds for operative intervention in mandible trauma.

5:15 pm
Discussion + prizes

4:00 pm - 5:30 pm
Emerging Paradigms in Oesophagogastric Surgical Oncology

Scientific Session - Upper GI Surgery - Meeting Room M6

Advances in oncology, genomics and surgical technology are reshaping the management of oesophagogastric malignancy. This session explores emerging concepts in staging, operative strategy and precision oncology that are redefining how surgeons approach upper gastrointestinal cancer.

4:00 pm
Introduction and session framing

4:05 pm
Oligometastatic Disease in Upper Gastrointestinal Malignancy — A Paradigm Shift
Professor Andrew Barbour

4:20 pm
Robot vs VATS vs Open Oesophagectomy — Technical Considerations and Outcomes
Assoc Professor Asim Shabbir

4:35 pm
Management of Barrett's High-Grade Dysplasia and T1 Oesophageal Cancer
Dr Sanjeeva Kariyawasam

4:50 pm
Robotics in Upper Gastrointestinal Surgery — Worth the Hype?
Professor Wendy Brown

5:05 pm
Circulating Tumour DNA and Novel Genomic Applications in Upper Gastrointestinal Surgical Oncology
Professor Andrew Barbour

5:20 pm
Discussion

4:00 pm - 5:30 pm
Environmental Sustainability in Surgery

Scientific Session - Surgical Leaders, Health Policy & Advocacy - River View Room 5

4:00 pm
Swabs to With-hold Irrigation and Promote Surgical Efficiency (SWIPE-TNH): A prospective study
Dr Ranesh Palan
Purpose: Routine use of disposable suction/irrigation devices (SIDs) in elective laparoscopic cholecystectomy (LC) is widespread to maintain operative field clarity. Substituting fabric swabs within Morrison's pouch may offer a cost-effective and sustainable alternative without adversely affecting

outcomes. This study aimed to assess the feasibility of omitting routine SID use by utilising fabric swabs. Secondary objectives were to describe patient demographics, intraoperative and postoperative complications, and surgeon satisfaction with swab usage. Methodology: Twenty consecutive adult patients undergoing elective LC for biliary colic at Broadmeadows Hospital (Northern Health) were prospectively identified after applying exclusion criteria. After establishing pneumoperitoneum, a fabric swab was placed in Morrison's pouch. Surgeons could deploy a SID at any point if clinically indicated. The primary outcome was the proportion of cases completed without SID use. Secondary data included operative duration, complications, and surgeon satisfaction with swab use measured via Likert scale. Results: A significant proportion of cases (42.1%) were completed without the need for a SID, demonstrating that SID use was not universally required. SID devices were opened in 57.9% of cases, most commonly for bile or blood spillage. Only 47.4% of SID use occurred after swab inspection, suggesting predominantly reactive rather than pre-emptive use. Postoperative complications were infrequent and comparable across operator experience levels. High satisfaction was reported for field clarity, patient safety, and feasibility without SID, although perceived operative efficiency was moderate. Conclusion: Elective LC can be safely and effectively performed without routine SID use when fabric swabs are employed. Surgeon satisfaction remained high and complication rates were low. Selective rather than routine SID deployment may therefore be appropriate, offering potential cost and environmental benefits without compromising outcomes.

4:07 pm
Alcohol-Based Surgical Hand Rub Can Reduce Water Waste and Cost - What is Stopping Us?
Dr Bo Zhou
Abstract: Surgical hand scrub is essential in preventing surgical site infections The traditional water-based scrubbing method is costly both financially and environmentally. A six-minute scrub can consume up to 45 liters of water per person, per case. In a tertiary hospital, this translates to thousands of liters daily. Alcohol-based hand rub (ABHR) offers a safe, cost-effective, and sustainable alternative. Despite alcohol agents costing less per use ($0.36 vs $0.50–$0.71) and saving nearly 900,000L of water annually, barriers persist. We surveyed 64 operating theatre staff on their scrubbing preferences and perceptions at the Royal Melbourne Hospital. Most understand that ABHR is guideline-approved, yet traditional methods remain preferred. Key concerns included skin irritation, dispenser availability, and unfamiliarity with the technique. 36% of staff underestimated water usage from traditional methods. Multiple randomised trials and meta-analyses have shown no difference in surgical site infection rates when alcohol rub is used after an initial scrub or simple hand wash. ABHR reduces water consumption and may offer an environmental advantage over traditional surgical scrub by reducing chemical discharge into wastewater, and it is better tolerated by users. In conclusion, wider adoption of ABHR represents a pragmatic shift towards environmentally sustainable surgical practice. A culture shift supported by education and infrastructure addressing practical concerns is key to bridging the gap between awareness and practice. Reference: 1. Kara A, Yasar C, Birinci M, Gulenc B, Sener B. Don't let our operating theatre to be desert. Acta Chir Orthop Traumatol Cech. 2021 Jan 1;88(3):229-32. 2. South Australia Infection Control Service. Hand Hygiene Clinical Guideline [Internet]. 2020 May 5; Version 1. Clinical Guideline Number: CG165. Canberra: AIHW. 3. Widmer AF. Surgical hand hygiene: scrub or rub?. Journal of Hospital Infection. 2013 Feb 1;83:S35-9.

4:14 pm
Does the evidence support the use of operating room shoe covers to prevent surgical site infections? A Scoping Review
Dr Qi Rui Soh
Purpose: Operating room (OR) shoe covers are widely used as part of surgical attire, despite uncertain evidence of benefit in preventing surgical site infections (SSIs). This scoping review aimed to evaluate whether OR shoe covers reduce environmental contamination or SSIs and to consider their clinical and environmental implications. Methodology: MEDLINE, Embase, Emcare and Scopus were searched for primary studies evaluating OR shoe covers in relation to bacterial contamination or SSIs. Eligible studies included quantitative or qualitative primary research conducted in operating room settings. Data was narratively synthesized. Results: Six studies met inclusion criteria, all from high-income countries. Five studies assessed environmental bacterial contamination and reported conflicting findings: two demonstrated lower colony-forming units with shoe covers, two showed no difference, and one reported higher contamination associated with shoe cover use. Only one study assessed clinical outcomes, reporting a reduction in SSI rates following reduced use of disposable perioperative attire, including shoe covers. No study demonstrated a direct reduction in SSIs attributable to shoe covers alone. Conclusion: Current evidence and international guidelines does not support the routine use of OR shoe covers for the prevention of SSIs. Given the lack of demonstrated clinical benefit, conflicting contamination data and the environmental burden associated with single-use OR shoe covers, routine shoe cover use should be strongly reconsidered. Further high-quality studies are required to inform evidence-based and sustainable perioperative infection prevention practices.

4:21 pm

Global surgical device companies' commitments towards net zero

Dr Yuqing Lu

Purpose: To evaluate the net-zero commitments of surgical device companies operating in Australia and their alignment with global sustainability targets. Methodology: 29 major surgical device companies operating in Australia were selected based on a large tertiary hospital's expenditure in Victoria and an expert panel from the Royal Australasian College of Surgeons. A scorecard was developed using the PricewaterhouseCoopers Building Blocks for net zero transformation framework, the Carbon Disclosure Project grading, and the SBTi approval system. The companies' Environmental, Social, and Governance reports were reviewed to assess their monitoring and disclosure of GHGE, their scopes 1, 2, and 3 targets, and their strategies for GHGE reduction. Results: Companies were classified into three groups: industry leaders with SBTi-approved targets across all three scopes (Abbott Laboratories, Bard Australia, Boston Scientific, Edwards Lifesciences, Johnson & Johnson, Olympus, Teleflex, Terumo, and Zimmer Biomet); companies with SBTi-approved targets missing scope 3, or with specific targets without SBTi approval (3M, B Braun, Baxter Healthcare, Cardinal Health, Livanova, Medtronic, Molnlycke Health Care, Smith & Nephew, and W L Gore & Associates); and companies without adequate targets (Applied Industrial Technologies, Bausch & Lomb, Conmed Corporation, Cook Medical, Da Vinci Intuitive Surgical, Defries industries, Integra Neurosciences, Karl Storz Endoscopy, Medline Industries, Multigate Medical Products, and Stryker). Common gaps included suboptimal scope 3 commitments, limited sustainability strategy disclosure, and most importantly, an effort to move away from a linear business model towards a circular one. Conclusion: Surgical device companies in Australia show growing commitments towards net zero, but with important gaps remaining in carbon reporting and reduction strategies that need to be addressed to move towards a circular business model.

4:28 pm

2b or not 2? Utility of the 2-week scan post-Pavlik Harness application in children diagnosed with Graf 2b hips

Ms Carissa Murugesh

Purpose: Waikato Hospital has been applying the Graf method in the diagnosis and management of babies with DDH since 2022. With increasing numbers of babies being referred to our clinic as have experienced decreasing capacity to perform diagnostic ultrasound scans (USS) in a timely fashion. Therefore, our aim was to determine whether the routine 2-week ultrasound following Pavlik harness application in infants with Graf IIb hips at Waikato Hospital offers a meaningful advantage in guiding clinical management or improving outcomes. Methods: A retrospective analysis was conducted of all babies diagnosed with Graf 2b hips and treated in a Pavlik Harness at Waikato Hospital since establishing the Graf method from January 2022 – September 2025. After identifying these children manually, the 2-week check USS was examined for any disadvantageous clinical change. Results: A total of 2156 ultrasound scans were done from January 2022 – September 2025. There were 48 patients in total that were diagnosed with Graf 2b hips and 45% of patients (n=28) were diagnosed with bilateral Graf 2b hips, therefore the sample size was 62 hips. 77% of the patients were female (n= 37) and 23% were male (n=11). The average age where patients were diagnosed with Graf 2b hips was at 113 days old. The mean alpha angle at diagnosis was 56.2□ and beta angle of 88.1□. 14% of hips (n=9) did not receive the 2-week post-Pavlik harness application ultrasound scan and at their next follow-up there was no significant change. Of the 53 hips that received the 2-week scan, none of them demonstrated that the hips were dislocated or other clinically significant change. Conclusion: The 2-week post-Pavlik harness USS can be safely omitted. A clinical check at the 2-week mark to check the fit of the Pavlik Harness and femoral nerve function should still be done along with a follow-up USS at 4-6 weeks after harness application. This has change been implemented at our DDH clinic at Waikato Hospital.

4:35 pm

Sterility Theatre: Ditching Drapes Cuts Cost and Carbon in Proctology

Dr Matthew Irwin

Purpose: Proctology is performed in a non-sterile field, yet sterile drapes, gowns and personal protective equipment (PPE), plus adjuncts (diathermy, smoke evacuation and suction), are commonly opened by default. We quantified the avoidable cost and environmental burden and modelled pragmatic de-implementation strategies. Methodology: A prospective utilisation audit with cost analysis and life cycle assessment (LCA) was undertaken for the estimated 6,000 annual proctology cases in New South Wales. Billing records, procurement contracts, manufacturer specifications and emissions factors were integrated to calculate per-case and annual cost, landfill mass and carbon dioxide equivalents (CO_2e). Current practice was compared with (i) targeted recycling of sterile consumables and (ii) a low-waste set-up: open-on-demand adjuncts and substitution of sterile drapes/gowns/PPE with non-sterile alternatives. Results: Diathermy, smoke evacuation and suction were opened but unused in 50% of cases. Targeted recycling

reduced cost by AUD 0.86 and landfill by 0.47 kg per case (AUD 17,000 and 9.3 tonnes landfill annually in Australia). The low-waste set-up reduced cost by AUD 40, landfill by 1.13 kg and emissions by 7.6 kg CO2e per case, equating to AUD 798,000, 23 tonnes landfill and 153 tonnes CO2e annually across Australia's ~20,000 proctology cases. Extrapolated internationally, annual savings were GBP 1.0 million (UK), USD 6.6 million (USA) and EUR 12.6 million (Europe), with 1,081 tonnes landfill and 6,759 tonnes CO2e avoided. Conclusion: In high-volume proctology, default sterile draping and routine opening of adjunct devices represent measurable low-value care. Sterile drape use should be avoided, and open-on-demand set-ups implemented to deliver immediate and scalable reductions in cost, waste and carbon emissions.

4:42 pm
Mesh Perspectives: A Qualitative Study of Women's Experiences After Revision Pelvic Reconstructive Surgery
Dr Anaamika Menon

4:52 pm
Safety, Quality, and Environmental Sustainability in Surgical Care
Conjoint Professor Carolyn Hullick

5:07 pm
David Fletcher Award for Best Environmental Sustainability in Surgery Abstract
Emeritus Professor David Fletcher AM

4:00 pm - 5:30 pm
Free Papers

Scientific Session - Surgical History - Meeting Room M7

4:00 pm
A Hundred Years and Still Not Clotting - The Heparin Story
Dr Jake Carmody

4:05 pm
History of Dr Niels Stensen
Dr Amy Yoon

4:10 pm
The History of the Surgical Stapler
Dr Christina Powell
The surgical stapler represents one of the most significant technological advances in modern surgery. What was once a heavy, expensive, and impractical tool has evolved into a range of highly specialised devices that are fundamental to anastomotic formation in contemporary minimally invasive surgery. The first mechanical stapling device was developed by Hümér Hültl in collaboration with Victor Fischer in 1908 and is thought to have been designed for distal gastrectomy. Although innovative, it failed to gain widespread popularity due to its cumbersome and time-consuming application. Despite this, the original design incorporated three principles that remain central to modern stapling technology: B-shaped staples, double staggered rows, and the use of fine wire as staple material. Incremental advances followed; however, significant progress occurred after the Second World War when the Soviet Union established a dedicated institute for the development of surgical apparatus, leading to systematic production of staplers in varying sizes and configurations for different tissue types. By the 1960s, Soviet-designed staplers were introduced into the United States, where refinements by American manufacturers produced devices that were simpler, lighter, and more reliable. The introduction of disposable staple cartridges, and later single-patient-use staplers, facilitated widespread adoption and standardisation of stapling techniques. In contemporary practice, surgical staplers are highly sophisticated instruments incorporating powered firing mechanisms, integrated sensors, and real-time feedback, improving consistency and reducing user variability. While the fundamental design principles of the surgical stapler have remained consistent for over a century, ongoing technological advances have resulted in substantial improvements in safety, reliability, and surgical outcomes.

4:15 pm
The Evolution of Computed Tomography in Surgical Practice

Dr Christina Powell

The computed tomography (CT) scanner has become an invaluable tool for surgeons, used in diagnosis, staging and characterisation, surveillance, operative planning, trauma assessment, and hybrid surgical procedures. It was the first imaging modality to reliably produce axial images and remains the most accessible and widely used form of cross-sectional imaging. The mathematical principles underpinning CT reconstruction were first described by Allan Cormack in the late 1950s. These concepts were independently advanced by Godfrey Hounsfield, who developed a practical system integrating X-ray acquisition with computer-based image reconstruction. The first clinical CT scan was performed in London in 1971 to assess intracranial pathology and, while primitive by modern standards, demonstrated the potential of cross-sectional imaging. Over the subsequent decade, rapid advances established CT as a cornerstone of neuroimaging, and improvements in image resolution and acquisition speed enabled effective whole-body imaging. CT was first incorporated into widespread surgical practice through trauma care, with guidelines recommending its use in haemodynamically stable patients during the 1990s. Also, around this time, CT became central to the assessment of suspected intracranial pathology and cancer staging. As access to CT scanners improved in the early 21st century, the technology became embedded as a default first-line investigation across numerous surgical guidelines and clinical pathways. Ongoing refinement has since extended its role beyond diagnosis, with contemporary applications including advanced angiography, three-dimensional reconstruction, and intraoperative use within hybrid operating theatres. The significance of CT was recognised with the awarding of the Nobel Prize to its creators, reflecting its status as a major medical innovation and its impact on surgical practice and patient outcomes.

4:20 pm

Anatomy pop-up books: Revealing the human body through art

Dr Jancke Maritz

Through time, humans have conveyed understanding through art. From symbolic cave drawings, abstract medieval imagery, to realism and humanism during the Renaissance. As art evolved so has the knowledge of anatomy. Early anatomical knowledge is evident in embalming practices dating back to Ancient Egypt. Herophulis (200BC), is credited as the first person to conduct human dissections, but in the Middle Ages human dissection remained taboo. It was not until the 12th century when rare Papal approval was given to universities for cadaveric dissections to further anatomical teaching. The study of anatomy has always been intrinsically tied to visual representation. As an inherently visual discipline, anatomy relies on illustration to communicate form and function. Renaissance anatomical illustrations are attributed Leonardo Da Vinci and Michelangelo. These artists, alongside anatomists such as Andreas Vesalius, produced detailed depictions of the human body that advanced anatomical understanding. Despite the increased precision, these illustrations remained confined to two-dimensional space and were limited in their ability to convey the spatial complexity and relationships of anatomical structures. Moveable or pop-up books is a medium that overcomes the challenge of two-dimensional depictions. The first moveable book is attributed to a poet of the 12th century Ramon Llull who used revolving discs to illustrate his philosophical theories. By the 16th century, anatomist adopted similar techniques for educational purposes. These include works by Andreas Vesalius and Johann Remmelin, both utilised layered, liftable images to enable sequential, three-dimensional exploration of the human body. These paper-based innovations laid the foundation for increasingly dynamic modes of anatomical visualisation. This paper will explore the history of the art of illustration, alongside the development of anatomy and how the two have intersected to give rise to pop-up anatomy books.

4:25 pm

Trauma Surgery in the Homeric Epics: A Tale as Old as Time Itself

Dr Asanka Wijetunga

Trauma surgery is among the oldest technical disciplines in medicine. Concepts such as airway compromise, haemorrhage control, and wound dressing are pervasive throughout the earliest texts in Western Literature: the Homeric epics, the Iliad and Odyssey (8th century BCE). To understand the roots of modern trauma surgery, we examine these texts to uncover what our ancestors understood of this complex speciality. Homer demonstrates recognition of airway and cervical trauma as immediately fatal and tactically decisive. When Ajax strikes Hector to the neck “the breath left him, and he sank to his knees, coughing blood” (Iliad 7.271-272). Injuries to this region are portrayed as unsurvivable, reflecting an understanding its the anatomical importance. Principles of wound management are often described. Treating Eurypylus, Patroclus “cut the arrow from his thigh with a knife and washed it with warm water” (Iliad 11.844-848), indicating careful foreign-body extraction and irrigation. Similarly, Machaon treats Menelaus by removing the arrow and applying “soothing medicines which Chiron once gave to Asclepius” (Iliad 4.218-221), suggesting the use of prepared topical therapies with analgesic and antiseptic intent. Haemostasis is a recurring concern. Patroclus applies “a bitter root that eased pain and stopped the bleeding” (Iliad 11.846-847), corresponding to yarrow, while Helenus’ arm wound is managed by application

of “a well-twisted bandage” (Iliad 13.599-600), demonstrating an early understanding of the tourniquet. Homer also articulates the value of wartime physicians. When Machaon is wounded, Idomeneus observes: “A healer is worth many men, for he knows how to cut out arrows and apply remedies” (Iliad 11.514-515), representing the earliest recorded recognition of the value of trauma surgeons. It is clear that trauma surgery is not just a modern science, but an art innate to humanity itself, and, as Homer suggests, perhaps one bequeathed upon us by great Asclepius himself.

4:30 pm
History of Breast Reconstruction
Dr Amy Yoon

4:35 pm
The Making of the Head and Neck Multidisciplinary Team: A History of Surgical Collaboration
Dr Sumana Cikaluru
Contemporary head and neck cancer management is based on multi-disciplinary team (MDT) decision-making, representing a significant departure from the historically individual surgery centred model of care. The benefits of the MDT system are well recognised but how and why this was necessitated or became a standard of care is equally worth acknowledging. The evolution of the head and neck MDT is examined to provide insight into both the science of developing and recognising alternative treatment modalities and the art required to sustain effective collaboration in both otolaryngology and other surgical fields. Advances in diagnostic imaging and pathology as well as widespread acceptance of radiotherapy and systemic therapies as viable primary and adjuvant treatment modalities for head and neck cancer have increased the complexity and challenged feasibility of patient management by a single surgical team. Simultaneously, evidence supporting the advantages of coordinated care such as faster diagnosis to treatment time, improved treatment outcomes and higher patient satisfaction has amassed, further expediting the formalisation of the MDT. Establishment of MDTs transformed collaboration from an informal professional courtesy into a standardised and documented process. MDT records demonstrate this process and illustrate regular participation from surgical, pathological, radiological, oncological and allied health disciplines and emphasise how collaborative decision-making has become embedded within routine surgical practice. However, the development of the MDT does not resolve all challenges of collaboration – leadership, communication and professional culture continue to shape how effectively MDTs function in practice. The history of the head and neck MDT therefore highlights the dual nature of collaboration in surgery: a scientific response to increasing clinical complexity, and an art that depends on human interaction. Understanding this historical evolution provides insight into how collaboration is learned, executed and maintained within modern surgical care.

4:40 pm
Arteries of Innovation: A Historical Journey of Vascular Grafts
Dr Thomas Morgan

4:45 pm
Indigenous and Ancient Foundations of Burn Care: A Cross-Cultural Surgical History
Dr Dulan Gunawardena
Background: Burns are among the earliest recorded traumas in medical history, with their care reflecting some of humanity’s first forays into empirical healing and reconstructive techniques. Across cultures, responses to thermal injury were shaped by observation, environment, and enduring knowledge traditions, many of which anticipated principles central to modern burn care. Aims: This study traces the evolution of burn treatment across civilisations, with particular focus on Indigenous Australian and ancient global practices. Discussion: Among the longest continuous healing traditions, Aboriginal Australian approaches combined plant-based medicines such as crushed tea tree leaves with smoke therapy and spiritual care. These methods reflect a sophisticated understanding of antimicrobial properties, pain relief, and the social dimensions of recovery, principles echoed in today’s holistic models of care. Similar threads appear across ancient texts. Egyptian and Greek healers applied honey, wine, and resins to burns, harnessing their protective and antiseptic qualities. In 9th-century Persia, Al-Razi described water immersion for burns, one of the earliest documented instances of first aid. In Renaissance Europe, Paré and Fabry attempted excision and escharotomy, intuitive yet limited by the pre-antiseptic era. The history of burn care is not linear, but a mosaic of shared insight, rediscovery, and forgotten innovation. Recognising the role of Indigenous Australians, on whose land this conference is held, alongside other global traditions, enriches our understanding of surgical heritage and affirms the lasting value of diverse knowledge systems in shaping contemporary burn care.

4:50 pm

From Splints to Salvage: A History of Lower Limb Reconstruction
Dr Gayatri Bhagwat

4:55 pm
Bier's Block: A Surgeon-Led History of Intravenous Regional Anaesthesia
Dr Sonia Nair
Background Prior to the development of effective local anaesthesia, even minor surgical procedures involved the significant risks of inhalational general anaesthesia. In the early 20th century, local anaesthetic techniques were unreliable, not widely known and restricted to limited small nerve blocks. In 1908, German surgeon August Bier described a method of producing whole limb anaesthesia through vascular isolation and intravenous administration of local anaesthetic – a technique now known as intravenous regional anaesthesia (IVRA). Technique Informed by his pioneering work in spinal anaesthesia in 1898, Bier's block involves the exsanguination of a limb, application of a tourniquet, and intravenous injection of local anaesthetic, originally a dilute cocaine solution, into the isolated vascular compartment. Anaesthesia is rapid, dense, and reversible, resolving predictably with tourniquet release. It provides theoretically indefinite anaesthesia as there is no drug metabolism or washout as long as the tourniquet remains applied – however, functionally the onset of tourniquet pain limits the procedure to approximately 20-40 minutes. Historical and clinical significance In a time when both general and local anaesthesia had significant risks, Bier's innovative technique provided a simple, effect and low-risk anaesthesia for extremity surgery. It did not demand additional expertise beyond establishing intravenous access, and maintained relevance despite the nerve blocks in the early 1900s, which remained limited by issues of neurovascular injury and need for a high level of operator skill. Until the widespread implementation of ultrasound guidance in the early 2000s, Bier's block remained an effective and accessible option, especially in resource- or expertise-poor settings. Conclusion More than a century after its introduction, Bier's block endures as both a practical technique and a historical marker of cross-disciplinary innovation beyond the surgical skillset.

5:00 pm
The Four Kings of Pulmonary Circulation
Mr Florian Watters
Background: The discovery of the pulmonary circulation represents a transformative journey in medical history, yet the contributions of key pioneers remain unevenly recognized. Although William Harvey is universally credited for his 1628 description of blood circulation, earlier groundbreaking descriptions by Ibn al-Nafis (1210-1288) and Michael Servetus (1511-1553) in countering Galen's (129-216AD) long-established dogma deserve greater recognition. Methods: A narrative review of historical medical literature, including primary sources and contemporary scholarship on the evolution of circulatory physiology from Galen through the European Renaissance. Findings: Ibn al-Nafis described the pulmonary circulation in 1242, correctly rejecting Galen's septal pore theory and anticipating proof of there being pulmonary capillaries some 400 years before Marcello Malpighi (1629-1694). However, there is some recent evidence that suggests Persian physicians during the Sassanid era (224-637 AD) may have recognized pulmonary circulation even earlier. Servetus independently described the pulmonary circuit in 1553, though debate persists about possible transmission of Ibn al-Nafis's work through Arabic-to-Latin translations. Harvey's 1628 experimental demonstration established the closed-loop circulation, apparently without knowledge of his predecessors, as Ibn al-Nafis's work remained untranslated from Arabic until 1924. Conclusions: The history of the discovery of the pulmonary circulation exemplifies how scientific progress depends on challenging established dogma across cultures and centuries. However, the contributions of Ibn al-Nafis, Servetus, and possibly their predecessors, deserve recognition alongside Harvey and underline why historical research should be inclusive of other cultures and languages and avoid being anglo- or euro-centric.

5:05 pm
From Ominous Mortality to Modern Mastery: The Evolution of Pancreaticoduodenectomy Through the Legacy of Three Surgical Giants
Dr Aashna Mahendru
Background: Pancreaticoduodenectomy (PD) remains one of the most complex abdominal operations, demanding high-level judgment, anatomical mastery, and refined technique. Its contemporary feasibility rests on a long sequence of incremental advances, shaped decisively by three seminal pioneers. Synopsis: The evolution of PD spans experimental exploration, early operative innovation, and progressive refinement of reconstruction. Foundational work included cadaveric and experimental studies demonstrating the plausibility of duodenal and pancreatic resections (e.g., Desjardins, 1907; Sauvé, 1908; Dragstedt, 1918), followed by pioneering approaches to pancreatic anastomosis and restoration of gastrointestinal continuity (e.g., Coffey and Kehr, 1909; Hunt, 1941). Against this backdrop, three figures stand out for establishing the conceptual and technical framework of modern PD: William Stewart Halsted, Walther Carl Eduard Kausch, and Allen Oldfather Whipple. Halsted reported the first successful resection for carcinoma of the ampulla of

Vater (1899) and advanced the principle of en bloc excision for periampullary malignancy. Kausch, in 1909, performed a more comprehensive resection than prior contemporary reports and described methods of reconstruction, prompting later recognition that the operation is historically best termed the Kausch–Whipple procedure. Whipple's landmark 1935 report of a two-stage PD represented a major step toward reproducibility and safety, demonstrating that pancreatic surgery could be undertaken with acceptable outcomes. Parallel advances in perioperative care further transformed the risk profile of PD and accelerated its adoption. Significance: Once considered prohibitive because of the pancreas' deep retroperitoneal location and surgical risk, PD became achievable through the cumulative work of multiple innovators—anchored by the "Magnificent Three." Their legacy not only established PD as a cornerstone of HPB surgery but also placed one of surgery's most demanding procedures within the reach of trained teams worldwide.

5:10 pm
Discussion

4:00 pm - 4:30 pm
Launch of the Emergency Laparotomy Clinical Care Standard

Scientific Session - Colorectal Surgery, General Surgery, Trauma Surgery, Health Policy & Advocacy - Riverside Theatre

Emergency laparotomy remains one of the highest-risk procedures performed in acute surgical practice, with significant variation in outcomes across health services. This launch of the national Emergency Laparotomy Clinical Care Standard by the Australian Commission on Safety and Quality in Health Care marks an important step toward improving the safety, consistency, and quality of care delivered to patients requiring urgent abdominal surgery. The Clinical Care Standard builds on and aligns with the work of Australian and New Zealand Emergency Laparotomy Audit – Quality Improvement (ANZELA-QI). This session will introduce the key features of the Clinical Care Standard, including timely recognition and escalation, multidisciplinary perioperative care, risk stratification, shared decision making about treatment, senior clinician involvement, and structured postoperative management. The presentation will outline what the Standard will mean for surgeons, other clinicians and healthcare services, and discuss implementation priorities across diverse hospital settings. The first national Standard for emergency laparotomy represents a collective opportunity to improve performance measurement, strengthen clinical governance, and ultimately improve patient outcomes in one of surgery's most time-critical and high-risk domains.

4:00 pm
Welcome and Introductions- (Dr Audrey Koay – Executive Director Patient Safety and Clinical Quality Directorate, WA Department of Health)
Dr Audrey Koay

4:02 pm
From NELA to ANZELA-QI to an Australian standard on emergency laparotomy (Prof David Watters – Distinguished (Alfred Deakin) Professor Deakin University and Barwon Health, Director of Surgery Safer Care Victoria)
Professor David Watters AM OBE

4:07 pm
Introducing the Emergency Laparotomy Clinical Care Standard (Prof Carolyn Hullick FACEM – Chief Medical Officer, Australian Commission on Safety and Quality in Health Care)
Conjoint Professor Carolyn Hullick

4:12 pm
Panel Discussion
Conjoint Professor Carolyn Hullick, Professor David Watters AM OBE, Dr Jacinta Cover

4:26 pm
Closing Remarks and Official Launch
Professor Owen Ung

4:29 pm
Thanks and close
Dr Audrey Koay

4:00 pm - 5:30 pm
No Surgeon Unprepared: Trauma Training in Modern World – A Trauma Curriculum for All Surgeons

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Scientific Session - Trauma Surgery, Health Policy & Advocacy - River View Room 4

4:00 pm
Polytrauma: An Old Problem, but Surgery's New Disease
Professor Zsolt J. Balogh

4:10 pm
The Trauma Gap: ANZAST's Moment to Lead
Dr Katherine Martin

4:20 pm
From Idea to Institution: Where Trauma Fits in the College
Dr Matthew Hope

4:30 pm
From Course to Curriculum: Building on DSTC and DATC
Professor Martin Wullschleger

4:40 pm
Beyond Our Borders: What International Trauma Training Teaches Us
Dr Karlijn Van Wessem

4:50 pm
Recently Trained, Still Underprepared: What a Recently Graduated Fellow Needs
Dr Yuni Ongso

5:00 pm
Panel Discussion
Professor Zsolt J. Balogh, Professor Martin Wullschleger, Dr Karlijn Van Wessem, Dr Katherine Martin, Dr Yuni Ongso

4:00 pm - 5:30 pm
Peripheral Nerve Reconstruction

Scientific Session - Hand Surgery - Meeting Room M9

4:00 pm
Impact of Tension, Inflammation and Soft Tissue Barriers in Peripheral Nerve Repair
Professor Minghao Zheng

4:20 pm
Discussion

4:30 pm
Suture Burden–Dependent Modulation of Mechanical Stress and the Regenerative Microenvironment in a Rat Model of Peripheral Nerve Repair
Dr Rui Ruan

4:40 pm
Objective Pre-Operative Prognostic Tools for Predicting Recovery After Carpal Tunnel Decompression: a systematic review
Mr Yusef Hafez
Purpose: Carpal Tunnel Decompression is an effective treatment for Carpal Tunnel Syndrome (CTS), however post-operative recovery varies between patients. Although objective preoperative tools have been

investigated as predictors of recovery, findings remain inconsistent. This systematic review aims to investigate current literature to establish what is known about the relationship between objective pre-clinical assessments and post-operative recovery in patients with idiopathic CTS. Methodology: A systematic review was conducted in accordance with the PRISMA 2020 guidelines. MEDLINE, Embase, Scopus, CENTRAL, CINAHL and Web of Science were searched from database inception to 23rd of March 2026. Eligible studies included adults with idiopathic CTS undergoing open or endoscopic decompression, where objective preoperative tools were used to stratify severity, and postoperative recovery outcomes were reported with a minimum follow-up of three months. Study selection, data extraction, and critical appraisal were performed independently by two reviewers, and a third reviewer was used to resolve conflicts. Results: Our review included 17 studies published between 1997 and 2024. Nerve conduction studies (NCS) were the most investigated modality, followed by ultrasound, electromyography, and carpal tunnel pressure measurement. Eleven studies reported an association between preoperative severity and postoperative recovery, while six found no prognostic value. Where prognostic value was present, greater severity was generally associated with slower or incomplete recovery. Interestingly, although non-NCS modalities showed positive prognostic associations, they were underrepresented in the literature. Conclusion: Current evidence inconsistently supports a reliable objective preoperative prognostic tool for predicting recovery after carpal tunnel decompression. Further prospective and multimodal studies are needed to improve prognostic accuracy and counsel patients.

4:50 pm
Surgical Management of Digital Neuromas: A Systematic Review of Techniques, Outcomes, and Pain Relief
Dr Bryan Lim

5:00 pm
Discussion

4:00 pm - 5:30 pm
Quality, Safety & Research in Hernia Surgery

Scientific Session - Hernia Surgery - Meeting Room M8

4:00 pm
Welcome and Introduction by Chairpersons

4:05 pm
Prehabilitation in AWR
Associate Professor Kellee Slater

4:20 pm
Australian Hernia Mesh Registry: Where are we?
A/Prof Chrys Hensman

4:35 pm
Biofilms & Mesh Explants
Associate Professor Anita Jacombs

4:50 pm
Implementing a Multidisciplinary Team for Complex Abdominal Wall Hernias: First-Year Outcomes from an Australian Tertiary Centre
Dr. Salma Salih
Purpose: Complex abdominal wall hernias (CAWH) present significant surgical and peri-operative challenges, particularly in populations with high comorbidity burden. Multidisciplinary team (MDT) models have been shown internationally to improve patient optimisation and operative planning, yet Australian data remains limited. This study describes the implementation of a dedicated CAWH MDT in a South Australian hospital and reports preliminary outcomes from its first year. Methodology: A retrospective cohort study was conducted of all patients discussed at the CAWH MDT at the Lyell McEwin Hospital between May 2024 and May 2025. Demographic data, hernia characteristics, comorbidities, MDT recommendations, and operative plans were prospectively recorded. Clinical outcomes were obtained through electronic medical records. For patients undergoing operative repair, concordance between MDT recommendations and operative management was assessed and categorised as full, partial, or non-

concordant. Results: 71 patients were discussed across 11 MDT meetings. The mean age was 61.6 years and mean BMI was 37.5 kg/m², with 32.3% of patients having a BMI >40 kg/m². Incisional hernias accounted for 83.1% of cases, and 30.5% had undergone previous mesh repair. Following MDT review, 52 patients (73.2%) were recommended for operative management, while others were directed toward optimisation strategies including weight loss (63.4%), smoking cessation (26.8%), and pre-operative botulinum toxin (46.5%). Seventeen patients proceeded to surgery during the study period. Of these, 10 (58.8%) were fully concordant and three (17.6%) partially concordant with MDT recommendations, yielding an overall concordance rate of 76.4%. Conclusion: Establishing a structured CAWH MDT is feasible in an Australian tertiary setting and achieves high concordance between multidisciplinary planning and operative management. Early experience suggests MDT review supports patient optimisation, consistent decision-making, and safe delivery of complex abdominal wall reconstruction.

5:00 pm
Outcomes related to surgical extraction site – does location matter? A single centre review
Dr Dhanushke Fernando
Purpose Laparoscopic colorectal procedures require specimen extraction. Our centre's colorectal surgeons employ midline and off-midline incisions for extraction of surgical specimens. Midline incision for specimen extraction is associated with higher incidence of both surgical site infection (SSI) and Incisional hernia (IH). We sought to assess compare outcomes in off-midline versus midline extraction sites for colorectal resections. Methodology This was a retrospective, single institution, multi-surgeon study for patients undergoing laparoscopic colorectal resection for both malignant and benign pathology from January 2021 to January 2024. Datapoints extracted include patient demographics; risk factors for SSI and IH and operative details. Any cases which were converted to open, returns to theatre or used perineal extraction were excluded. Between extraction site techniques, primary outcome measures being development of SSI or acute dehiscence within 30 days of surgery and development of IH within 12 months of the surgery were examined. Nominal data was compared using the Student's t-test (parametric) and Wilcoxon test (nonparametric). Ordinal data was compared using the Man-Whitney U test. Non-ordinal categorical data was compared using Pearson's chi-squared test. Statistical significance was defined as $p < 0.05$. Results A total of 231(196 elective) were examined. Median age was 67 50% were female, 27% received chemotherapy. Common indications for surgery included colorectal cancer (117) and diverticular disease (76). Extraction techniques included midline (41.5%); left lower quadrant (10.8%) and Pfannenstiel (47.6%). There was a lower SSI incidence in Pfannenstiel compared to midline extraction (2.7% vs 4.1%). There was no incidence of acute dehiscence. There were no IH at 12 months in off-midline, compared to 6 (6.3%) from midline extraction. Survival was similar between cohorts. Conclusion Our preliminary results suggest that off-midline extraction sites have less risk of incisional hernia incidence at 12 months and lower SSI rate.

5:10 pm
The association of hernia surgery with peritoneal dialysis outcomes in Australia and New Zealand
Dr Steven Nguyen
Background The development of a hernia is a known complication of peritoneal dialysis (PD), and such patients have high rates of hernia surgery. This study evaluated the association between hernia surgery and the primary outcome of transfer to haemodialysis (HD) for >90 days. Methods The study included all patients who started PD in Australia and New Zealand between 2000 and 2015. Using bi-national data linkage between the Australia and New Zealand Dialysis and Transplant (ANZDATA) Registry and jurisdictional hospital admission datasets, patients receiving PD who underwent hernia surgery, based on Australian Classification of Health Interventions (ACHI) coding were matched in a 1:3 ratio with those who did not undergo hernia surgery (controls), using propensity score matching based on year of PD start, age, body mass index (BMI), ischaemic heart disease (IHD) and diabetes mellitus (DM). The surgery date for cases was used as a mock index date for potential controls who were alive and at risk at that time, to minimise immortal time bias. Time from surgery or mock index date to HD transfer was analysed by Cox regression with shared frailty to account for centre effect, censored for kidney transplantation, death or end of study (31 December 2021). Results A total 1,433 PD patients underwent hernia surgery. The characteristics of the matched controls when compared to cases were similar in age, PD vintage, BMI, and rates of IHD and DM, however differed in gender proportions (70% male in cases vs. 66% in controls). Cox regression showed that hernia surgery had an increased risk of HD transfer over entire follow up (HR 1.22, 95% CI 1.12 – 1.34). Male gender, vintage, larger BMI and DM were also associated with increased HD transfer risk. Conclusion In patients receiving PD, patients who underwent hernia surgery had increased risk the primary outcome of HD transfer for >90 days compared to patients receiving PD who did not undergo surgery.

5:20 pm
Panel Discussion and Q&A
Associate Professor Anita Jacombs, Associate Professor Kellee Slater, Dr. Salma Salih, Dr Steven Nguyen, Dr

Dhanushke Fernando, A/Prof Chrys Hensman

5:25 pm
Closing Remarks

4:00 pm - 5:30 pm
RCSed Networking Function

Cocktail - *Cross Discipline* - Meeting Room M2

4:00 pm - 5:30 pm
RESEARCH PAPERS

Scientific Session - Paediatric Surgery - Meeting Room M3

4:00 pm
Deadly Rides: A Retrospective Review of Paediatric Trauma Secondary to Electric Scooters at a Tertiary Paediatric Trauma Centre in Queensland
Dr Rachel Cockburn

4:05 pm
Increased incidence of methicillin-resistant Staphlococcus aureus skin and soft tissue infections in Indigenous children in North Queensland
Dr Ezekiel Aaron
Purpose To identify the incidence of methicillin-resistant Staphylococcus aureus (MRSA) in Indigenous compared to non-Indigenous children with skin and soft tissue infections (SSTIs). Methodology Following ethical approval, electronic hospital records were retrospectively reviewed to identify microbiological swabs from patients who underwent incision and drainage of SSTIs at Townsville University Hospital between January 2020 and December 2024. Patients under 16 years with their ethnicity data were included. Results 480 children met the inclusion criteria. 243 (51%) identified as Indigenous and 237 (49%) non-Indigenous. MRSA was isolated in significantly more Indigenous (40%, 98/243) than non-Indigenous (19.4%, 46/237) patients (P < 0.001). Indigenous children were 2.8 times more likely to have MRSA (OR: 2.8, 95% CI: 1.99, 3.96). Staphylococcus aureus was cultured in 38.3% (184 / 480) of samples. Other cultured organisms included Streptococcus species (11.6%), mixed skin flora (5.6%) and mixed enteric and anaerobic Bacteria (4.3%). Other multi-resistant organisms included Extended Spectrum Beta-Lactamase producing E. coli (2/480) and Mycobacterium Abscesses (1/480). SSTIs most commonly affected the limbs (28.3%) followed by head and neck (22%), buttocks (14.5%), torso (9.6%), perianal / perineal (9.6%) and groin (5.6%). Most SSTIs were drained by the paediatric surgeons (67%), followed by Orthopaedics (17.5%), with smaller numbers by maxillofacial, ear-nose and throat, and general surgery. Conclusions We identified higher rates of MRSA in Indigenous children with SSTIs compared to non-Indigenous children, justifying empiric MRSA antimicrobial coverage for Indigenous children. Future prospective studies should include follow-up to assess rates of recurrence, side effects of antibiotics and whether the same trend continues into adulthood.

4:10 pm
The Future of Robotics in Paediatric Surgery Training: Access, Experience and Attitudes of Trainees
Dr Rachael Stokes
Background: Robotic paediatric surgery is currently in its infancy in Australia and New Zealand. There are questions around incorporation of robotic surgery into healthcare and how this will impact trainee experience and learning. Methods: A survey was distributed to all paediatric surgery trainees in Australia and New Zealand regarding their current access, experience and attitudes toward robotic surgery training. Results: The survey had a 75% response rate (18/24). The majority of paediatric surgical trainees had worked more than six years in paediatric surgery (10/18, 55%). Most (94%) have either not interacted with a robot, or only at a conference/meeting. One trainee (6%) completed a robotics course, five (28%) had sought them out, and only one (6%) had access to a robotic console in their current training hospital. The majority of trainees (84%) believed Australasia was 5-15 years behind the rest of the world, but believed robotic surgery is likely to be critical to the future of paediatric surgery in Australia and New Zealand. More than half of trainees felt robotics should be incorporated into the structured training curriculum at all levels of training (61%). Nine trainees (53%) thought it would have a positive impact on training; six (35%) trainees being

neutral on the topic; and only two felt it may impact negatively (12%). Conclusion: Paediatric surgery trainees in Australia and New Zealand currently have no exposure to robotic surgery. This survey highlights the need for robotics training, in variable formats, to be incorporated into the formal curriculum to ensure better exposure and knowledge prior to its introduction in the public healthcare system, which will likely occur over the next ten years. It is critical existing training requirements are met during this transition phase.

4:15 pm
Paediatric Urolithiasis in Western Australia: Rock solid changes over the past 40 years
Dr Helen Buschel
Purpose To explore changes in the epidemiology, presentation and management of children with urolithiasis in Western Australia (WA) over the past 40 years. Methods Retrospective study of all children with urolithiasis managed by Paediatric Urology from 2015-2024 in WA. Comparison made with previously published WA data from 1983-1992. Results 165 cases from 2019-2024 were compared with 93 cases from 1983-1992. In the present cohort there was: older age at presentation (mean 10 vs 4 years), a lower proportion of Indigenous children (7% vs 70%) and more frequent metabolic abnormalities (34% vs <1%). The most common presenting symptoms are now pain (80%), vomiting (42%) and haematuria (26%), and not urinary tract infection as in the previous study (0% vs 57%). There was increasing use of tamsulosin (either as an adjunct or for expulsion therapy) and retrograde intrarenal surgery (RIRS), rather than open surgical management. 83% underwent operative intervention. RIRS was the most common intervention, with laser lithotripsy in 34% and retrieval with basket/grasper in 27%. 83% of children achieved total stone clearance after operative intervention. Stone composition was predominantly calcium oxalate (65%) or calcium phosphate (30%), compared to uric acid/urate (51%) previously. Areas identified for future improved care included: education to minimise delayed diagnosis, awareness of likelihood of missed stones on ultrasound (31% of symptomatic stones) and minimising prolonged stent time to reduce associated complications. Conclusions There were distinct changes in the epidemiology of children with urolithiasis in WA over the past 40 years. Presentation patterns and stone composition now approximate those seen in adults. RIRS has been established as a safe and reliable management option in children. There are still many areas for improvement, including earlier diagnosis, advances in intervention/equipment and increasing utility of medical management for stone expulsion.

4:20 pm
Design of an optimisation implementation study for paediatric injury management using participatory research
A/Prof Susan Adams
Background: The spleen is the most commonly injured organ in children. There is variation in care which guidelines aim to address. Most guidelines focus on management in a paediatric hospital, yet 2/3rd present in other settings, with varying resource levels. To address this, we developed a new guideline to support splenic injury management across settings with varying resource levels. We plan to optimise the guideline through an implementation trial. Purpose: To co-develop the components of an implementation optimisation trial, which aims to ensure the new guideline can be successfully, sustainably implemented, in any hospital context in which a child with suspected splenic injury presents. Methodology: Participatory research methods were used to design and run a series of four x two-hour interdisciplinary on-line workshops with 130 clinicians from around NSW, and a group of consumers with trauma system experience. The first workshop used problem trees to elucidate issues with existing guidelines and care of injured children, the second focused on solution identification in each hospital context, and the third on developing interventions to support guideline uptake and use. A draft NSW-context-specific guideline was also presented for feedback. In the final workshop, outcome measures were developed in relation to appropriate care, and consumer and clinician satisfaction. Results: A guideline decision-making tool was developed, along with a suite of interventions to support its use in any context, including: elements of preparation; champions and mentors; design and accessibility; education and training; communication; and external supports. Outcomes of all workshops were presented as a program logic model, forming the basis of a design for a paediatric splenic injury guideline implementation and optimisation trial. Conclusion: Participatory research methods have resulted in a draft splenic injury guideline applicable in multiple contexts and a robust optimisation implementation trial design for sustainable introduction across the trauma system.

4:25 pm
Performance of Silicone and Polyurethane Central Venous Access Devices (CVADs) in children: A Systematic Review and Meta-analysis.
Dr Nikhil Surapaneni
Background: CVADs are essential to support long-term intravenous access. Silicone and polyurethane have distinct mechanical properties that may influence complications. Evidence guiding CVAD selection in

children is sparse and largely extrapolated from adult studies. This study aimed to synthesise the available paediatric evidence and identify gaps. Methods: A systematic review (1980-2025) was conducted using PRISMA guidelines on studies describing complications of silicone and polyurethane CVADs in children. Proportional meta-analysis for non-comparative studies was conducted and reported as % (95% CI). I2 was used to assess heterogenicity with >50% considered significant. Results: We identified 1,269 articles from 5 databases; 9 studies met the inclusion criteria (6 retrospective, 3 prospective). Complications assessed: -CVAD occlusion: Silicone 2.9% (1.15-5.3); I2 = 49% – Polyurethane 5.7% (2.5-10.1); I2 = 59% -CVAD–associated bloodstream infection (CLABSI): Silicone 16.5% (7.3-28.4); I2 = 89% - Polyurethane 11% (2.5-24.5); I2 = 91% -Local site complications (e.g., wound infection): Silicone 2.0% (0.6-4.1); I2 = 0% - Polyurethane 1.4% (0.2-8.0); I2 = 78% -CVAD-associated venous thromboembolism: Silicone no data - Polyurethane 2.1% (0.9-14.4); I2 = 74% - Dislodgement/accidental removal: Silicone 7.1% (1.2-17.3); I2 = 80% - Polyurethane no data -Rupture: Silicone 1.0% (0.04-3.1); I2 = 0% - Polyurethane no data -Mechanical complications at removal: Silicone 5.0% (0.4-14.3); I2 = 89% - Polyurethane 10.0% (5.1-16.1); I2 = 65.4% Conclusions: Evidence directly comparing silicone and polyurethane CVADs in children is extremely limited, preventing meaningful statistical comparison. Proportional meta-analysis of non-comparative studies showed low but variable complication rates for both materials, with substantial heterogeneity and important gaps in reporting. Current data do not demonstrate clear superiority of either material. Robust prospective comparative studies are needed to determine whether catheter material influences clinical outcomes in paediatric CVADs use.

4:30 pm

Contemporary outcomes of congenital diaphragmatic hernia

Dr Kiera Roberts

Purpose: To review contemporary outcomes of congenital diaphragmatic hernia within the Australian setting. Methodology: A retrospective review was performed of all patients with congenital diaphragmatic hernia managed at the Sydney Children's Hospital from January 2000 – December 2024 (inclusive). Patients who presented outside of the neonatal period were excluded. The medical records of each patient were reviewed with the primary outcome being mortality, and secondary outcomes including use of ECMO and length of stay. Each five year period was analysed separately (P1 2000-2004, P2 2005-2009, P3 2010-2014, P4 2015-2019, P5 2020-2024). Ethics approval was obtained from the local research governance body. Results: 159 patients with CDH were born during the study period (left-sided n= 133, right-sided n= 26). Rates of prenatal diagnosis increased over time (50-61% during P1-3, compared with 72-79% P4-5), with similar increase in numbers of inborn compared with outborn patients. Mortality remained stable over the study period, ranging from 20-24% between time periods. Median length of stay did however decrease over time (P1 = 21 days, P2 = 26, P3 = 15, P4 = 14, P5 = 13). 136/159 (86%) underwent surgical repair at a median age of 3 days, with a trend towards increasing use of thoracoscopy. ECMO was utilised in 7 cases (4.4%). Four patients were commenced on ECMO pre-operatively, two post-operatively, and one did not have attempt at repair. Mortality in patients who required ECMO was 57% (4/7). Conclusion: We report favourable outcomes of CDH in terms of survival compared with published data worldwide, despite low use of ECMO. Although overall survival remained stable across the 25-year period of this study, we observed an increased rate of prenatal diagnosis, as well as a decrease in length of stay for surviving patients.

4:35 pm

Suction versus Washout for Appendicectomy in the Paediatric population (SWAP) – a randomised controlled trial

Dr Samantha Leng

Purpose: Amongst children with complex appendicitis (CA), post-operative intra-abdominal abscesses (IAA) occur in approximately 18% of cases (1). Peritoneal lavage (PL) is widely used with the expectation that it reduces complications, despite limited supporting evidence. We hypothesised that suction only (SO) without irrigation would be non-inferior to PL in children with CA. Methodology: We conducted a randomised controlled trial (RCT) including three centres, comparing PL and SO in children undergoing laparoscopic appendicectomy for CA. Recruitment occurred from April 2020 to January 2025, but was interrupted during the COVID-19 pandemic. The sequentially numbered, opaque, sealed envelopes (SNOSE) method was used for randomisation. The PL group underwent irrigation with >2000mls 0.9% saline. In the SO <100mls was used. Outcomes included IAA, WI, small bowel obstruction (SBO) and length of stay (LoS). Standardised site-based data collection was performed. Results: In total 195 participants were recruited, including 111 in the PL group and 84 in the SO group. There were no significant demographic differences. Average LoS was 6.5/7 in the PL group and 5.5/7 in the SO group, p<0.01. In the PL group there were 14 IAA detected, compared to 8 in the SO group (P=0.7). Both groups only had one participant that developed a WI (p=1.0), and 2 participants that developed SBO, p=1.0. Conclusion: Our RCT found that PL in children with CA was associated with a statistically significant, although minimal increase in LoS. However, incidence of complicating IAA, WI and SBO were the same amongst PL and SO groups. This supports the hypothesis of non-inferiority of SO compared to PL. Reference: 1. Peter SDS, Sharp SW, Holcomb GW, Ostlie DJ. An

evidence-based definition for perforated appendicitis derived from a prospective randomized trial. J Pediatr Surg. 2008;43(12):2242-5. children. J Pediatr Surg. 2012;47(2):317-21.

4:40 pm
Pyeloplasty in infants under 10 kg: A comparison of laparoscopic and open approaches
Dr Rosemary Lane
Introduction: Pelviureteric junction obstruction (PUJO) is the most common cause of pathological antenatally diagnosed urinary tract dilatation. Approximately 50% of infants with P3 dilatation on ultrasound scans (USS) will require surgical intervention. This can be approached from either a laparoscopic or open approach in children <10kg, according to surgeon preference. This study compares both approaches outcomes. Methods: Retrospective study (2016-2024) of infants <10 kg with PUJO undergoing Anderson-Hynes dismembered pyeloplasty and >1 year follow-up. Group A included patients that underwent open pyeloplasty, and Group B patients that underwent laparoscopic pyeloplasty. Follow-up included ultrasound ± MAG3. Length of stay (LOS), complication rates (defined as Clavien-Dindo >3, including re-do), and success rates (defined as improved dilatation on USS and absence of symptoms) were compared using a multivariable logistic regression (95% CI). Results: 115 patients were included in the study – 68 patients underwent 72 open procedures and 47 patients underwent 48 laparoscopic procedures. All children had P3 dilatation. The median age, weight, renal function, and LOS were similar in both groups. The median operative time was 88 minutes in Group A and 138 minutes in Group B. The duration of follow up ranged from 12-114 months in Group A and 12-70 months in Group B. Complications occurred in 7% of open cases and 2% of laparoscopic cases, with the majority being stent issues. The majority of patients still had a degree of dilatation on USS but showed overall improvement. 4 patients in Group A underwent re-do surgery, with an even split between flank and dorsal lumbotomy approaches Conclusions: Although the average operating time is longer for children under 10kg undergoing laparoscopic pyeloplasty compared to open, the results are favorable with a lower proportion having complications or requiring redo surgery.

4:45 pm
Intraabdominal lymphatic malformations: Are they all PIK3CA positive? A novel genetic hypothesis
Dr Carly Perry
Introduction: Intraabdominal lymphatic malformations/lymphangiomas are a relatively rare cause of gut volvulus and subsequent bowel obstruction in the paediatric population. These patients inevitably proceed to theatre for resection of the lesion commonly with bowel resection and anastomosis. A subsequent population of children will have intraabdominal lymphatic malformations identified either antenatally, incidentally, or to investigate symptomatology and have non-operative intervention including sclerotherapy, whereby we can obtain an aspirate of the lesion. In a retrospective case series over the past 4 years since our centre has pursued extended genetic testing for lymphatic malformations, we hypothesise that PIK3CA is the gene responsible for encoding these lesions, which to our knowledge will be a novel publication for the genetic basis of intraabdominal lymphatic malformations. This data will hopefully inform genetic targets for alternate (and non-invasive) treatment methods in the future. Methods: This is a case series of at least 16 patients whose histology or cell-free DNA from aspiration was either sent upfront for genetic testing or retrospectively sent for genetic testing and PIK3CA status. 15 patients returned a positive PIK3CA gene result, with one being negative (which reflects genetic testing results for cutaneous lymphatic malformations, widely accepted to be PIK3CA-associated lesions, due to the nature of cell-free DNA genetic testing allowing for more false negatives). Conclusion: We hypothesise that all intraabdominal lymphatic malformations are PIK3CA positive, in-keeping with the nature of overgrowth. This publication will, to our knowledge, represent the first genetic association in such lesions and this potential therapeutic target will therefore broaden treatment options to include non-invasive/medical options.

4:50 pm
The use of Negative Pressure Wound Therapy in Paediatric Burns: a PhD Summary
Dr Emma Lumsden
Negative Pressure Wound Therapy (NPWT) has been introduced into acute paediatric burn care. This presentation summaries a PhD thesis aiming to investigate NPWT variables and identify how they may be optimised to help facilitate implementation and formulate a set of recommendations regarding NPWT application in acute paediatric burn care. Methodology These data for the Thesis were collected from Queensland Children's Hospital. Various research styles were used to address the thesis aim including two randomised control trials, an ex vivo experimental model, a retrospective cohort study and a case report. Results A retrospective cohort study identified the best cohort for NPWT application was deep partial thickness burns, reducing scar clinic referral probability from 67.2% (95% CI 58.8 – 75.6) to 44.9% (95% CI 35.6 – 54.3%; p<0.001). A ex vivo model demonstrated that pressure changes were observed to the depth of the subcutis only, increasing dressing layers beneath NPWT or using circumferential NPWT dressings decreases the overall delivered pressure. A case report identified that NPWT applied without Mepitel® as a barrier

between the skin and dressing may result in hypertrophic scar formation. A PICO™ randomised control trial (RCT) found that PICO™ should be used with ActicoatFlex™ as Acticoat™ had significantly more complications when combined with a PICO™ dressing (p=<0.001, mean difference 62.5%, 95% CI 29.9% - 95.1%). A hand and foot RCT found that there was no difference in dressing burden between NPWT and standard dressings and that overall clinician opinion regarding NPWT improved over the course of the study. 93% of participants reported that they would use NPWT on the hand and/or foot again. Conclusion This thesis through a collation of papers investigates NPWT variables in acute paediatric burn care. A set of recommendations for NPWT application in paediatric burn care has been developed based on these data.

4:55 pm
Pseudoaneurysm following blunt liver and spleen injury in children: Retrospective study and systematic literature review.
Dr Karl Moloney
Purpose Pseudoaneurysm formation is a known complication following blunt liver and spleen injury (BLSI) in children. However, there is ongoing debate about the significance and need for screening and treatment. The purpose of this study is to review the incidence and management of pseudoaneurysms following BLSI in children. Methodology A retrospective review of BLSI at the sole, tertiary paediatric trauma centre in Western Australia was conducted. A systematic literature review of all articles from 2015-2025, reporting on paediatric traumatic splenic or hepatic pseudoaneurysms was performed. Results 232 patients with a mean age of 9.5 years were managed with BLSI. There was one mortality secondary to liver injury. Pseudoaneurysm was identified in 11 patients (5%), with eight diagnosed initially and three on delayed imaging. Eight were managed conservatively, and three with angioembolisation (AE). All cases achieved resolution. There were no cases of delayed haemorrhage. Systematic review revealed 160 cases of traumatic pseudoaneurysm in 7 studies. 25% were diagnosed initially and 60% on delayed imaging (15% unknown timing). 47% resolved without intervention, AE was performed in 52% and splenectomy in 1%. Delayed rupture was reported in 25 patients (1.2% of all BLSI). The majority of cases occurred at least one week after injury. However, most children with ‘delayed rupture’ did not require transfusion and there were no reported deaths. 23/25 underwent AE, two underwent splenectomy, and one resolved without intervention. Conclusions: Pseudoaneurysm formation post BLSI is uncommon in children. Delayed rupture is reported in 1.2% of cases in the literature, although there were no cases of death and the majority did not require transfusion. AE can be a safe and effective method for treatment of pseudoaneurysm and should be considered for symptomatic patients. However, the role for routine screening and prophylactic AE of asymptomatic children is less clear.

5:00 pm
Recurrent PUJO Ater Paediatric Pyleoplasty: Silent or Symptomatic?
Dr Georges Tinawi
Background: Recurrent PUJO after index pyeloplasty is rare and has traditionally been suspected based on symptoms including flank pain and vomiting. However, some children may develop recurrent obstruction and loss of function whilst asymptomatic. The frequency of “silent” recurrent PUJO, and its association with loss of renal function remains poorly defined. Methods: We undertook a 25-year retrospective review of all redo pyeloplasties for recurrent PUJO performed at The Children’s Hospital at Westmead. Cases with concomitant obstructive uropathy or incomplete radiological data were excluded. Symptom status at the time of redo surgery and surveillance USS and MAG3 renography data were analysed. Results: Between 2000 and 2025, twenty children underwent a redo pyeloplasty (85% male, 70% left PUJO). Ten children (50%) were asymptomatic at the time, representing silent recurrent PUJO. The remaining 10 children developed one or more symptoms: significant vomiting (5), recurrent ipsilateral flank pain (4), urosepsis (2), distention with a palpable abdominal mass (2) and new hypertension (1). Four children developed symptoms suggestive of obstruction within 72 hours of stent removal. The median time from pyeloplasty to redo pyeloplasty was 5 months (IQR 3.4 – 11.1), with 80% of redo pyeloplasties occurring within 12 months. Prior to redo pyeloplasty, 88% of children had worsening hydronephrosis (median Δ APD +8.0mm (4.0 – 16.0), and 90% children had a loss of renal function on MAG3 (median Δ DRF -10.5% (-22.5 to -7.5)). Clinically significant loss of renal function (>10%) occurred in 50% of both symptomatic and asymptomatic children. Conclusions: Recurrent PUJO is asymptomatic in 50% of cases and can be associated with loss of renal function. Symptom status alone is not a sufficient discriminator of children at risk of functional decline, and hence, early structured imaging surveillance following pyeloplasty is essential.

5:05 pm
Defining an ideal age and weight for stoma closure after neonatal surgery
Dr Viha Vig
Purpose: We have followed a weight (Wt) of 2.5 Kg and gestational age (GA) of 34 weeks for stoma closure in neonates based on a previous study presented to RACS 25 years ago. This study was conducted to reset

these thresholds to minimise post- operative complications. Methodology: Retrospective study at Waikato Hospital (2015–2025) on neonates undergoing stoma closure for neonatal bowel pathology was conducted. Colostomies due to Hirschsprung disease and anorectal malformations were excluded. Complications were graded using Clavien–Dindo (CD) classification against weight and gestational age at stoma closure. IBM SPSS program was used for statistical analysis. Institutional approval number was 4551P. Results: Sixty three neonates underwent stoma closure. Mean birth Wt was 1.4 Kg (SD 0.96) and mean GA at birth was 29 weeks (SD 5.4). The mean Wt at stoma closure was 3.1 Kg (SD 1.7) and GA 43 weeks (SD 10). Twenty seven (43%) had no complications (CD grade 0). Twelve had CD 1&2 (19%). Twenty four had CD≥3 (38%). The mean Wt was 3.1 Kg (SD 1.7) and GA was 43.4 weeks (SD 10) at stoma closure. Both Wt and GA at closure had a mild negative correlation with no statistical significance (p=0.1 and 0.9 respectively) on Spearman's correlation. The complications were less over 3 Kg and after 40 weeks GA on scatter plot. Re-feeding into the distal stoma in some neonates may have mitigated early closure. Conclusion: In this single-centre cohort, GA and weight at stoma closure were not statistically associated with the severity of postoperative complications although there was a mild negative correlation. The weight and height threshold could be elevated further to minimise complications in the absence of competing surgical indications such as fluid losses and poor weight gain. These findings support multi-centre collaboration and standardised data capture to set evidence-based benchmarks

5:10 pm
Practice Patterns and Long-Term Morbidity in Children with Hirschsprung Disease: A Five-Year Tertiary Centre Review
Dr Eamon Clanchy
Purpose: Despite advances in surgical technique, children with Hirschsprung disease (HD) continue to experience significant morbidity. This study aimed to review contemporary practice patterns and outcomes in the management of HD at a tertiary paediatric surgical centre, with a focus on identifying areas for quality and practice improvement. Methodology: A retrospective cohort audit was conducted of all children diagnosed with HD and managed between 2019 and 2024. Demographic, clinical, operative, and follow-up data were collected using a standardised proforma. Key measures included age at diagnosis, disease extent, operative approach, levelling strategy, stoma use, Hirschsprung-associated enterocolitis (HAEC), perioperative complications, long-term bowel function, and comorbidities. Descriptive statistics were used. Results: Fifty-one patients were included (male:female ratio 2:1). While most patients were diagnosed neonatally (median 6 days), a wide diagnostic range was observed. Short-segment disease predominated (n=41), though extensive disease was present in a significant minority. Stoma formation was common, with 41 patients requiring a pre–pull-through stoma. Median age at definitive pull-through was 146 days, most commonly via laparoscopic Swenson (n=18) or Soave (n=16). HAEC occurred both preoperatively (13%) and postoperatively (27.5%). Frequent practice-related challenges included high-output stomas, stoma prolapse, sphincter dysfunction, and persistent bowel dysfunction, often necessitating further interventions such as Botox therapy, washouts, laxatives, or additional surgery. Syndromic and developmental comorbidities were common. Conclusion: This audit highlights ongoing morbidity in children with Hirschsprung disease and identifies several modifiable practice areas, including diagnostic timeliness, stoma selection and management, levelling strategies, and structured long-term bowel care. Standardised pathways, enhanced multidisciplinary follow-up, and targeted parental education may reduce complications and improve long-term outcomes.

5:15 pm
Use of Specimen Retrieval Bag vs Direct Extraction for Appendix Removal in Acute Appendicitis in Children and Adults: A Systematic Review and Meta-analysis.
Miss Maria Vaz Serra
Background: During laparoscopic appendicectomy, the appendix may be removed either directly through the port or within a specimen retrieval bag. Although bag use is often promoted to minimise wound contamination, its routine application, particularly in uncomplicated appendicitis, remains contentious. Existing evidence is inconsistent, and practice varies considerably across centres. This review aimed to synthesise the literature comparing bag versus non bag extraction and to highlight areas requiring further investigation. Methods: A systematic review and meta-analysis (1980–2025) was conducted in accordance with PRISMA guidelines, including studies reporting postoperative outcomes following laparoscopic appendicectomy using either extraction technique. Both comparative and non-comparative designs were eligible. Primary outcomes were total surgical site infection (SSI), extraction port site infection (EPSI), and intra-abdominal abscess (IAA). Random effects meta-analysis was performed, with results presented as risk ratios and (95% CI). Heterogeneity was assessed using I2, with values >50% considered significant. Results: There were 2055 studies identified of which 13 met the inclusion criteria (1 randomised controlled trial (RCT), 1 quasi-RCT, and 11 Comparative studies). Pooled estimates showed: • SSI RR 0.6 (0.2–1.3), p = 0.2, I2 = 91.8% (86.8–94.9); • EPSI RR 0.7 (0.2–2.1), p = 0.5, I2 = 42.4% (0.0–78.8); • IAA RR 0.7 (0.5–1.0), p = 0.06, I2 = 33.8% (0.0–

78.2). Conclusions: Evidence comparing bag and non-bag extraction during laparoscopic appendicectomy remains limited and heterogeneous. While pooled data suggest possible differences in IAA in favour of using a retrieval bag, variability in definitions, operative techniques, and reporting standards precludes definitive conclusions. Robust prospective comparative studies are needed to determine whether routine use of a specimen retrieval bag meaningfully reduces postoperative complications.

5:20 pm
Discussion

4:00 pm - 5:30 pm
Surgical management of lymphoedema

Scientific Session - Plastic & Reconstructive Surgery, Surgical Oncology, Breast Surgery - Bellevue Ballroom 1

4:00 pm
Reverse axillary mapping and axillary dissection: How do I do it? A breast surgeon's perspective
Dr Yang Yang Huang

4:20 pm
Strategies for upper extremity lymphatic reconstruction and preventative strategies for lower extremity lymphoedema
Prof Joon Pio Hong

4:40 pm
The case of delayed Lymphovenous by-pass
Mr Thomas Bragg

5:00 pm
Immediate vs Delayed LVA: Lymphoedema Specialist perspective
Ms Madeleine Stockden

5:20 pm
Discussion

4:00 pm - 5:30 pm
TRANSPLANT AS PART OF HPB ARMAMENTARIUM

Scientific Session - Transplantation Surgery, HPB Surgery - Bellevue Ballroom 2

4:00 pm
Can we afford to expand the indications for transplant?
Associate Professor Michael Fink

4:20 pm
Non CRLM indications for transplant
Associate Professor Lingjun Mou

4:40 pm
Ante-situm liver resection tips and tricks
Mr Ravi Marudanayagam

5:10 pm
Discussion

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01 May 2026

4:30 pm - 5:30 pm
Acute Abdominal Surgery

Scientific Session - Colorectal Surgery, General Surgery - Riverside Theatre

Emergency general surgeons are frequently required to manage some of the most challenging conditions in abdominal surgery, often in unstable patients and time-critical circumstances. Sound judgement, adaptability, and familiarity with a range of operative strategies are essential to achieving the best possible outcomes. This session will explore three demanding areas of emergency practice: surgery for severe inflammatory bowel disease, management of colonic obstruction and perforation, and approaches to the open or difficult-to-close abdomen. Speakers will focus on practical decision-making, operative planning, and strategies to manage complications in high-risk patients. Designed for emergency general and colorectal surgeons, this session aims to provide clear, experience-based guidance for complex cases encountered on call.

4:30 pm
Emergency Surgery in Complicated Inflammatory Bowel Disease
Prof Matteo Rottoli

4:45 pm
Emergency Colorectal Surgery: Colonic perforation and obstruction
Dr Rhys Filgate

5:00 pm
Approaches to the Difficult to Close Abdomen: From Damage Control to Definitive Closure
Dr Chris McDonald

5:15 pm
Panel Discussion
Prof Matteo Rottoli, Dr Rhys Filgate, Dr Chris McDonald

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01 May 2026

5:30 pm - 6:30 pm
ANZAPS Annual General Meeting

Business Meeting - Paediatric Surgery - Meeting Room M3

5:30 pm - 6:30 pm
Colon and Rectal Business Meeting

Business Meeting - Colorectal Surgery - Meeting Room M6

5:30 pm - 6:00 pm
GSA Annual General Meeting

Business Meeting - General Surgery - Riverside Theatre

5:30 pm
AGM
Ms Sally Erickson

5:30 pm - 7:00 pm

Women in Surgery Networking Function

Cocktail - Women in Surgery - Bellevue Lounge

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01 May 2026

7:00 pm - 10:30 pm
Bariatric / HPB / Upper GI / Transplantation Surgery Section Dinner (Ticketed Event)

Speciality Dinner - Bariatric Surgery, HPB Surgery, Upper GI Surgery, Transplantation Surgery

Victory Lounge, Optus Stadium

7:00 pm - 10:00 pm
Cardiothoracic Surgery, Military Surgery, Trauma Surgery Section Dinner (Ticketed Event)

Speciality Dinner - Cardiothoracic Surgery, Military Surgery, Trauma Surgery

7:00 pm - 10:30 pm
Colorectal Surgery Section Dinner (Ticketed Event)

Speciality Dinner - Colorectal Surgery

Roe Room, Matilda Bay Restaurant

7:00 pm - 10:30 pm
General Surgery / Hernia Surgery / Rural Surgery / Surgical History Section Dinner (Ticketed Event)

Speciality Dinner - Surgical History, General Surgery, Rural Surgery, Hernia Surgery

7:00 pm - 10:30 pm
Paediatric Surgery Section Dinner

Speciality Dinner - Paediatric Surgery

7:00 pm - 10:30 pm
Plastic & Reconstructive /Surgical Oncology / Burn / Craniomaxillofacial / Global Health / Hand / Orthopaedic Surgery Section Dinner (Ticketed Event)

Speciality Dinner - Burn Surgery, Surgical Oncology, Global Health, Plastic & Reconstructive Surgery, Craniomaxillofacial Surgery, Orthopaedic Surgery, Hand Surgery

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01 May 2026

7:30 pm - 10:30 pm
Breast / Endocrine Surgery Section Dinner (Ticketed Event)

Speciality Dinner - Breast Surgery, Endocrine Surgery

Function Centre, Fraser's Kings Park

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02 May 2026

7:00 am - 8:20 am
Christian Medical Fellowship Breakfast (Ticketed Event)

Breakfast Session - *Cross Discipline* - River View Room 4

The Christian Medical Fellowship Breakfast at the RACS Annual Scientific Congress will be held on Saturday, 2 May. You are warmly invited to join with other people of faith for a time of fellowship and encouragement. We will be inspired by Dr Gary Hewett OAM, a Dental Surgeon from Perth, who will share how his Christian faith has shaped his long-term commitment to capacity building in Cambodia through Awareness Cambodia.

7:00 am
When Not Acting Is a Decision - What Happens When You Can't Walk Past Anymore
Dr Gary Hewett, Dr Neil Wetzig

7:00 am - 8:20 am
INDIGENOUS HEALTH BREAKFAST (TICKETED EVENT)

Breakfast Session - Indigenous Health - River View Room 5

7:00 am
Welcome and Introduction
Dr Benjamin Cribb

7:05 am
Welcome / Acknowledgement of Country

7:08 am
Award Presentations

7:23 am
My journey to becoming an Indigenous Doctor
Dr Daisy Alps

7:00 am - 8:20 am
MASTERCLASS (MC03): Robotic Colorectal Surgery - Dr Matteo Rottoli: Hugo Robotic System in Colorectal Surgery — Pioneering Experience and Technical Strategies (Ticketed event)

Masterclass - Colorectal Surgery - Meeting Room M2

This masterclass, presented by Dr Matteo Rottoli, explores the implementation and clinical application of the Hugo Robotic platform in colorectal procedures. Dr Rottoli will share insights from one of the first high volume experiences with the system, including refined docking strategies and workflow optimisation for low anterior resection and deep pelvic surgery. The session will explore the Hugo platform's modular design, multi docking configurations, and practical approaches to navigating its unique features, with a focus on efficiency, team coordination and facilitating the transition from laparoscopy to robotic colorectal surgery.

7:00 am
Robotic Colorectal Surgery - Hugo Robotic System in Colorectal Surgery — Pioneering Experience and

Technical Strategies
Prof Matteo Rottoli

7:00 am - 8:20 am
MASTERCLASS (MC04): Minimally Invasive Liver Surgery

Masterclass - HPB Surgery - Meeting Room M3

Tips and tricks to successful minimally invasive hepatectomy

7:00 am
Tips and tricks to successful minimally invasive hepatectomy
Dr Naimish Mehta, Mr Ravi Marudanayagam

7:00 am - 8:20 am
Masterclass (MC02): Innovation in Breast Radiology – Management of B3 lesions through VAE (Ticketed Event)

Masterclass - Breast Surgery - Meeting Room M1

7:00 am
B3 Dilemmas: The Core Truth About Why We Ask for More
Professor Ben Dessauvagie

7:20 am
Managing B3 lesions: the role of imaging and vacuum assisted excision
Dr Donna Taylor

7:40 am
The Singapore Experience with VAE in B3 Breast Lesions
Chi Wei Mok

8:00 am
Discussion

7:00 am - 8:20 am
Masterclass (MC09):ANZ J Surgery (Ticketed Event)

Masterclass - *Cross Discipline* - Meeting Room M7

7:00 am
Welcome and Introduction
Professor Julian Smith

7:05 am
How to write an abstract from your research
Professor Zsolt J. Balogh

7:20 am
Increasing the chances of your journal submission being accepted
Associate Professor Christine O'Neill, Associate Professor Christine O'Neill

7:35 am
Revising your article
Dr Stephen Honeybul

7:50 am
The use of AI by publishers, editors and reviewers in assessing your submission

Professor Julian Smith

8:05 am
Q&A Panel
Professor Zsolt J. Balogh, Associate Professor Christine O'Neill, Dr Stephen Honeybul, Professor Julian Smith, Associate Professor Christine O'Neill

7:00 am - 7:30 am
Solventum Breakfast Session: Innovations Transforming Wound Reconstruction

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Breakfast Session - *Cross Discipline* - Meeting Room M6

Proudly sponsored by Solventum

7:00 am
Introduction
Edin Nuhiji

7:01 am
Innovations Transforming Wound Reconstruction
Professor Anand Deva

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02 May 2026

7:30 am - 8:20 am
BARIATRIC SURGERY - RESEARCH PAPERS (Breakfast sponsored by Johnson & Johnson)

Scientific Session - Bariatric Surgery - Meeting Room M9

Proudly sponsored by Johnson & Johnson

7:30 am
Metabolic Bariatric Surgery vs GLP-1 Receptor Agonists for Sustained Weight Loss and Obesity-Related Cancer Risk: A Systematic Review and Network Meta-Analysis
Dr Divya Jyoti Banerjee

7:35 am
Spontaneous Hyperinflation of Intragastric Balloons: A systematic rview.
Dr Jason Laurens
Background: Spontaneous intragastric balloon hyperinflation (SIBH) is a rare and concerning complication of intragastric balloons (IGBs). The mechanisms underlying SIBH remain unclear. This systematic review aims to synthesise the current evidence regarding the clinical presentation, management, complications, and hypothesised aetiologies of SIBH. Methods: A comprehensive literature search was conducted using PubMed, EMBASE, MEDLINE, and Ebsco databases. Studies reporting on cases of SIBH were identified and reviewed. Data points were extracted on patient presentation, management strategies, complications, outcomes, and proposed mechanisms. Results: Eighteen publications describing 29 patients with SIBH were included. The most common clinical presentation was gastric outlet obstruction (86%). Emergency endoscopy was required in 96% of cases, with balloon removal performed in 82%. Reported complications included acute pancreatitis and mucosal erosions; however, neither long-term morbidity nor mortality was observed. Microbial colonisation was hypothesised as the underlying cause in 62% of publications, supported by culture findings from balloon contents in 90% of cases, most commonly isolating gas-producing organisms such as Candida (80%) and anaerobic bacteria (40%). Conclusions: SIBH most frequently presents with gastric outlet obstruction and typically necessitates emergency endoscopic intervention. Gas-producing microbial colonisation of the balloon is the predominant hypothesised aetiology. Preventive strategies targeting microbial colonisation may be crucial in reducing the incidence of SIBH.

7:40 am

Sleeve Gastrectomy plus Jejunal Bypass for the Treatment of Type 2 Diabetes Mellitus in Patients with Body Mass Index ≥32.5 kg/m2

Dr Jugang Wu

Background: The objective of this study was to evaluate sleeve gastrectomy plus jejunal bypass (SG-JJB) for type 2 diabetes mellitus (T2DM) in Chinese patients with a body mass index (BMI) ≥32.5 kg/m2. We also compared the outcomes of SG-JJB to those of sleeve gastrectomy (SG). Methods: This retrospective study included 60 patients between September 2023 and October 2024 at shanghai ninth people's Hospital, in shanghai, or lancing first people's Hospital, Pu'er, China. Among them, 40 patients were underwent SG and 20 patients were received SG-JJB. SG-JJB consists of SG and performing a jejunoileal anastomosis 240 cm distal to the angle of Treitz. Postoperative total weight loss (TWL), T2DM remission and patient complication were compared. Resluts: All the operations were performed laparoscopically and the mean postoperative follow-up was 18 months (13-27). The mean age was 36 years (21–53), 85 % of patients were female and Mean preoperative BMI was 37.6 kg/m2 (33–50.2 kg/m2) in SG group, while it was 37 years (23–61), 83 % and 38.3 kg/m2 (34.5–48.8 kg/m2) in SG-JJB group (P>0.05). Patients in SG-JJB group had a longer operation time (135± 15 min vs 106± 10 min) and postoperative hospital stay (6 days vs 4 days) than patients in SG group (P<0.01). SG-JJB yielded higher TWL than SG alone (32.3±7.1% vs 28.9±9.1%, P<0.05). Complete T2DM remission was achieved in 85% of patients (17/20) and partial remission in 15% (3/20) in SG-JJB, while it was 70% (28/40) and 30% (12/40) in SG group. It suggests that SG-JJB has a greater advantage in T2DM. There were no deaths, no postoperative bleeding, no re-operation and no gastric fistula in all patients. The incidence of postoperative gastroesophageal reflux disease (GERD) symptoms is similar in SG-JJB (10%, 2/20) and SG (12.5% 5/40)(P>0.05). Conclusion: SG-JJB is a safe surgical technique for T2DM in patients with BMI ≥32.5 kg/m2, it yielded higher TWL and diabetes remission than SG.

7:45 am

Laparoscopic Sleeve Gastrectomy for Adolescents with Severe Obesity: Medium-Term Weight Outcomes and Mental Health Insights

Dr John Peacey

Purpose Metabolic bariatric surgery in adolescents is an evolving field, and data is limited in Australia. Surgery in this age group has special safety, social and ethical considerations. The impact of MBS on psychiatric, mental health and psychosocial wellbeing is poorly understood. We review the patient demographics, mental health conditions, weight outcomes, complications and follow-up of a cohort of adolescents who underwent laparoscopic sleeve gastrectomy (SG) by a single surgeon in a large volume clinic with an established adolescent multidisciplinary team program receiving patients from across Australia and New Zealand. Methods A prospective bariatric database was retrospectively analysed to review the adolescents aged 13-19 who underwent a primary SG from December 2011 to December 2024. Patients who were a minimum of six months post-surgery were included. Results 63 patients aged 13-19 years old underwent primary SG. Median pre-operative weight and body mass index (BMI) was 123 kg and 42.1 kg/m2. Pre-operatively, 26 adolescents reported a Psychiatric and/or mental health disorder, seven reported suicidal ideation or self-harm history and six reported experiencing severe weight- bullying. At three months, six months, twelve months and two years after SG, median BMI decreased to 33.6, 30.6, 27.5 and 28.1 kg/m2 respectively. Follow-up rates progressively decreased and was 42% at two years. There was no mortality and one staple line leak. Conclusion SG is a safe and promising option for the treatment of adolescents living with obesity in the short to medium-term. The high prevalence of mental health disorders and poor follow-up are major concerns. Long-term data with better follow-up is required in Australia.

7:50 am

Regional Anaesthesia (Vagus nerve block) and Neurokinin-1 Inhibitors for Bariatric Surgery

Dr William Bessell

Purpose PONV is common after bariatric surgery, involving neurohormonal and vagally-mediated mechanisms triggered by surgical alteration of gastric anatomy. We adopted a novel approach of intraperitoneal blockade of the anterior Vagus nerve (VNB) from a recent study that showed a substantial reduction in PONV following VNB in laparoscopic sleeve gastrectomy [1]. Despite obvious improvement with this innovation, some patients still suffered from PONV. Therefore, we introduced the neurokinin-1 inhibitor (NKI) antiemetic Fosaprepitant as part of our anaesthetic. Methodology We conducted a three-phase prospective clinical audit of PONV in PACU and Day 1 post-op, following the sequential introduction of 3 separate techniques in patients undergoing laparoscopic sleeve gastrectomy (LSG) and laparoscopic gastric bypass (LGB). Phase one involved spraying the gastric staple lines and lesser omentum with intraperitoneal bupivacaine (IPB). Phase two involved replacing the first technique with a laparoscopic VNB using bupivacaine injected at 6 points along the Vagus nerve. The third approach added Fosaprepitant to the VNB (VNB+F). Outcomes included the presence of nausea and vomiting in PACU and on Day 1 post-op, and interference with ADLs. Patients were included between April 2022 to December 2025. Results Ninety-two

patients were enrolled: 62 for LSG, 30 for LGB. In LSG, PACU nausea was 21% in VNB, 32% in VNB+F and 63% in IPB. In LGB, nausea in PACU was 0% in VNB+F, 35% in VNB and 46% in IPB. Vomiting in PACU was negligible overall. In both procedures, vomiting over 24 hours was absent in VNB+F. Reported interference with ADLs progressively decreased across the three interventions, reaching 0% in VNB+F. Conclusion The addition of VNB and Fosaprepitant to a standard antiemetic regimen may reduce nausea in recovery and facilitate a faster return to function following bariatric surgery. Prospective controlled trials are warranted. References [1]Daes J et al. Obes Surg. 2022;32(11):3551–3560.

7:55 am
The role of glucagon-like peptide-1 receptor modulators for the management of dumping syndrome in patients who have undergone metabolic and bariatric surgery: A scoping review
Dr Madeline Rogers-Seeley

8:00 am
Do robots protect surgeons? A systematic review of ergonomic risks in robotic and laparoscopic bariatric surgery
Ms Eeman Atif
PURPOSE: As bariatric surgery volumes continue to rise globally, concerns regarding occupational musculoskeletal injury and surgeon wellbeing have become increasingly prominent. Minimally invasive surgery is associated with substantial ergonomic strain; however, the comparative risks of bariatric robotic and laparoscopic approaches remain incompletely characterised. METHODOLOGY: A mixed-methods systematic review without meta-analysis was conducted in accordance with PRISMA guidelines and a prospectively registered protocol (PROSPERO ID: CRD420251109094). Medline, Embase, Cochrane, CINAHL, Scopus, and Web of Science were searched from database inception to 02/08/2025. RESULTS: Of 5,849 records identified, 181 full-text articles were assessed, with 11 studies included, collectively representing at least 183 bariatric surgeons and 307 procedures. Objective ergonomic assessments demonstrated higher overall ergonomic risk and greater upper-extremity burden during laparoscopic bariatric surgery compared with robotic surgery. Robotic surgery was associated with region-specific trade-offs, including increased wrist loading and static trunk demands, suggesting redistribution rather than elimination of biomechanical strain. Subjective ergonomic outcomes were heterogeneous. Cross-sectional studies consistently reported a high prevalence of work-related musculoskeletal issues among bariatric surgeons, affecting up to 66%. Qualitative findings highlighted limited ergonomics training and ergonomic strain impacting fatigue and career longevity. CONCLUSION: This is the first systematic review to specifically synthesise surgeon ergonomics in bariatric surgery. Robotic bariatric surgery demonstrates a more favourable objective ergonomic profile with reduced upper-extremity loading. Interpretation is limited by heterogeneity in study design and ergonomic measures. Future research should prioritise ergonomic interventions and structured ergonomics training to promote surgeon wellbeing.

8:05 am
Ten-year outcomes following primary bariatric metabolic surgery: weight loss durability, patient-reported health, and long-term symptoms after sleeve gastrectomy and gastric bypass
Dr John Peacey
Purpose: To evaluate long-term weight loss, patient-reported benefit, regret, revisional surgery rates, and gastrointestinal symptoms 10 years after primary laparoscopic sleeve gastrectomy (SG) or gastric bypass (GB). Methods: Patients 10 years following primary SG or GB were contacted and invited to participate in structured follow-up. Participants completed a questionnaire and underwent blood testing and clinic review. Outcomes included body mass index (BMI), percent total body weight loss (%TBWL) at nadir and 10 years, self-reported health improvement, regret, revisional procedures, and prevalence of long-term gastrointestinal symptoms including reflux, bowel dysfunction, and abdominal pain. Results: Sixty-six patients participated (SG n=44, GB n=22); 48 were female (72%) and 18 male (27%). Mean pre-operative BMI was 45.6 kg/m² (SG) and 47.8 kg/m² (GB), with mean BMI at 10 years of 34.8 kg/m² and 31.0 kg/m², respectively. Mean nadir %TBWL was 37% at 20 months post-SG and 42% at 33.6 months post-GB. At 10 years, mean %TBWL was 24% (SG) and 32% (GB). Overall, 80% reported improved health at 10 years compared with pre-surgery, and 94% reported no regret. Long-term symptoms were common: in SG, 52% reported bowel issues, 58% reflux (96% requiring PPI), and 26% abdominal pain; in GB, 62% reported bowel issues, 24% reflux, and 23% abdominal pain. Revisional surgery occurred in 26%, including six SG-to-GB conversions and one re-sleeve. Conclusion: At 10 years, both SG and GB provide sustained weight loss and high patient satisfaction, with greater long-term %TBWL after GB. However, gastrointestinal symptoms and revisional surgery remain common, highlighting the importance of structured long-term follow-up and symptom surveillance.

8:10 am

Weight loss and safety outcomes of primary laparoscopic sleeve gastrectomy in patients aged 65 years and older
Dr John Peacey

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02 May 2026

8:30 am - 10:00 am
Plenary Session: AI Future - I'm a Surgeon, Will I Still Have a Job in 10 Years?

Plenary Session - *Cross Discipline* - Riverside Theatre

8:30 am
Introduction
Associate Professor Rob Love

8:32 am
Enter The Future: AI, Technology & Humanity
Dr Jordan Nguyen

9:00 am
AI FUTURE - I'M A SURGEON, WILL I STILL HAVE A JOB IN 10 YEARS?
Associate Professor Matthew Clark

9:15 am
AI Future – I'm a surgeon: will I still have a job in 10 years, and other key AI questions answered
Ms Chelsea Gordon

9:30 am
Panel Discussion
Dr Mohit Bhandari, Associate Professor Matthew Clark, Dr Jordan Nguyen, Ms Chelsea Gordon

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02 May 2026

10:00 am - 10:30 am
Morning Tea - Saturday

Catering - *Cross Discipline* - Pavillion 1

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02 May 2026

10:30 am - 12:30 pm
Beyond Weight Loss: Charting the Next Horizon in Metabolic & Bariatric Surgery

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Scientific Session - Bariatric Surgery - River View Room 4

Bariatric surgery is increasingly recognised as metabolic surgery with broad systemic impact. This session examines emerging procedures, pharmacotherapy integration and digital innovation as the field continues to evolve beyond traditional weight-loss paradigms.

10:30 am
Introduction and session framing

10:35 am
SADI-S — Physiology, Evidence and Outcomes
Dr Craig Taylor

10:50 am
SASI — Technique, Mechanisms & Outcomes
Assoc Professor Asim Shabbir

11:05 am
GLP-1 Therapies — Clinical Trial Evidence vs Real-World Data; Adjunct to Surgery
Dr Ahmed Ahmed

11:20 am
Contemporary Reflux Management in Obese and Non-Obese Patients — Evidence-Based Surgical Pathways
Dr Mohammed Ballal

11:35 am
AI & Digital Platforms in Bariatric Research — Big Data and Predictive Analytics
Professor Wendy Brown

11:50 am
Training & Mentorship in Bariatric Surgery — Preparing the Next Generation
Dr Nicholas Williams

12:05 pm
Interactive Closing Panel: The next decade of bariatric surgery - Global collaboration in action
Dr Craig Taylor, Dr Mohammed Ballal, Dr Nicholas Williams, Professor Wendy Brown, Dr Ahmed Ahmed, Assoc Professor Asim Shabbir

10:30 am - 11:00 am
KEYNOTE LECTURE - DR NAIMISH MEHTA (NEW DELHI, INDIA)

Keynote Lecture - HPB Surgery, Colorectal Surgery - Bellevue Ballroom 2

10:30 am
Is the role of the resectional surgeon diminishing?
Dr Naimish Mehta

10:30 am - 11:00 am
KEYNOTE LECTURE - PROFESSOR CHRISTOBEL SAUNDERS (MELBOURNE, AUSTRALIA)

Keynote Lecture - Breast Surgery - Bellevue Ballroom 1

10:30 am
Innovations to improve Precision in Breast Conserving Surgery
Professor Christobel Saunders

10:30 am - 11:00 am
KEYNOTE LECTURE - PROFESSOR PETER CORDEIRO (NEW YORK CITY, USA)

Keynote Lecture - Otolaryngology Head & Neck Surgery, Plastic & Reconstructive Surgery - River View Room 5

10:30 am
Development of Algorithms for Reconstruction in the Head and Neck – A 30 Year Experience

Professor Peter Cordeiro

10:30 am - 11:00 am
Keynote Lecture - Mr Alistair Macey (GLASGOW, UK)

Keynote Lecture - Orthopaedic Surgery - Meeting Room M8

10:30 am
Approach to open fractures and 2 ring fixators
Mr Alistair Macey

10:30 am - 12:30 pm
Kids in the Adult Pool: When Trauma Systems Forget the Shallow End

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Scientific Session - Trauma Surgery, Paediatric Surgery - Meeting Room M3

Children account for a significant proportion of trauma presentations, yet our trauma systems are largely designed with adults in mind. This conjoint session between the Trauma Surgery and Paediatric Surgery Sections explores what happens when children “end up in the adult pool.” Speakers will examine how adult trauma frameworks, including how activation criteria, verification processes, retrieval pathways, and resuscitation practices, can be adapted for the unique physiology and care needs of children. Just as importantly, the session will highlight the reverse translation: lessons from paediatric trauma care that could enrich adult practice, including family-centred models, non-operative management, and developmental considerations in rehabilitation. By placing adult and paediatric surgeons in the same forum, the session aims to foster collaborative exchange, identify gaps where systems “forget the shallow end,” and outline opportunities to build truly inclusive trauma systems for all patients, regardless of age.

10:30 am
Verification and Validation: Do Trauma Systems Recognise Children?
Professor Zsolt J. Balogh

10:50 am
Borrowing without breaking: Translating adult trauma practice to Paediatrics
Associate Professor Soundappan S V Soundappan

11:10 am
The Paediatric Way: What Adults Can Learn from Children
Dr Jeni Thomas

11:30 am
Adapting the Workforce: Staff, Systems, and Wellbeing When Kids Arrive in Adult Centres
Prof Stephen Dunjey

11:50 am
When Small Bodies Break: Operative Decision-Making in Paediatric Trauma
Associate Professor Parshotam Gera

12:10 pm
Implementing a paediatric trauma interventional radiology service
Professor Derek Roebuck

10:30 am - 12:30 pm
LITTLE BIT OF THIS AND LITTLE BIT OF THAT, FROM STITCHING WOUNDS TO FIXING A FLAT, RURAL SURGEONS TAKE CARE OF ALL

Scientific Session - Rural Surgery - Meeting Room M7

10:30 am

Sabbatical or not to sabbatical, that is the question
Dr Julian Speight

10:45 am
Cross Stitch and Plumbing:Not Rocket Science - How do we train Generalists in Vascular Surgery in 2026? Barriers and Opportunities
Dr Mark Hamilton

11:00 am
Regional Implementation and experience of Surgical Fixation for Flail Chest: Enhancing Trauma Care and Reducing Inter-Hospital Transfers
Dr Mahanama Dissanayake

11:15 am
Regional ASU: Using Data to improve your service
Dr Jacinta Cover

11:30 am
Surgeon Safety: Affective and Predatory Assaults on Healthcare
Dr Amy Liepert

11:45 am
Collaboration in the operating theatre - 2 surgeons operating together
Professor Matthias Wichmann

12:00 pm
Surgical equipment: Use by or best before?
Dr Julian Speight

12:15 pm
Questions and Answers

10:30 am - 12:30 pm
Machine Perfusion in Sold Organ Transplantation - Surgeons' 'toys' or necessity to keep organs alive?

Scientific Session - Transplantation Surgery, Cardiothoracic Surgery - Meeting Room M9

Machine perfusion of solid organs such as kidneys, livers, hearts and lungs, aims to ameliorate ischemia related organ damage. It involves circulating a preservation solution through the organ to provide oxygen, nutrients, and remove waste products, simulating normal blood flow. There are two main types: hypothermic machine perfusion (HMP), which cools the organ to slow metabolic processes, and normothermic machine perfusion (NMP), which maintains the organ at around normal body temperature, allowing more active metabolic function and potentially better assessment of organ viability. This session aims to discuss currently used machine perfusion concepts in general and specifically in the context of joint organ retrieval.

10:30 am
Post explant machine perfusion of liver
Dr Arul Suthananthan

10:45 am
Post explant machine perfusion of kidneys
Dr Bulang He

11:00 am
Abdominal and thoracoabdominal NRP & organ transplantation – the UK expertise
Dr Hassiba Smail

11:15 am
Discussion

11:30 am
Normothermic perfusion of the heart using OCS in DBD & DCD - Current practice or history to be?
Professor Ulrich Stock

11:45 am
Cold perfusion of the heart using XVIVO HOPE
Dr Agneta Geldenhuys

12:00 pm
Ex vivo lung perfusion
Dr Hassiba Smail

12:15 pm
Discussion

10:30 am - 12:30 pm
Optimising Surgical Access and Outcomes for Indigenous People

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Scientific Session - Indigenous Health - Meeting Room M2

10:30 am
Introduction
Dr Anton Hinton-Bayre

10:31 am
Updates from the Chair
Associate Professor Caroline Dowling

10:41 am
Codesign Housing for Better Health Outcomes
Dr Simon Quilty

11:01 am
Te huarahi roa - the long road
Dr Nasya Thompson
Purpose: Māori are significantly underrepresented within the surgical workforce in Aotearoa New Zealand, contributing to persistent inequities in access, experiences, and outcomes of surgical care. While barriers for minority groups in surgery have been described, little is known about Māori experiences across the full pathway from medical school to consultancy. This study aimed to explore Māori doctors' experiences to identify barriers, enablers, and opportunities to strengthen pathways into surgery. Methods: A national qualitative study was undertaken using a Kaupapa Māori methodological approach. Māori medical students, junior doctors, and registrars completed an online survey exploring motivations, barriers, and access to support. Semi-structured interviews were conducted with Māori surgical consultants nationwide. Interviews were grounded in tikanga Māori, incorporating whakawhanaungatanga and karakia, and were transcribed verbatim. Data were analysed using thematic analysis Results Five key themes were identified: (1) early exposure and commitment to improving Māori health as motivators for pursuing surgery; (2) the central role of culturally grounded mentorship, particularly from Māori senior clinicians; (3) systemic and interpersonal racism influencing training experiences and career decisions; (4) cultural tension and imposter syndrome when navigating predominantly Pākehā surgical environments; and (5) the need for stronger, coordinated pipeline support from medical school through to consultancy. Māori-led initiatives, including interview preparation wānanga, were identified as effective enablers of progression. Conclusion Māori pursuing surgical careers face persistent systemic and cultural barriers across the training continuum. Strengthening culturally grounded mentorship, addressing racism within training structures, and implementing coordinated pipeline approaches are critical to improving Māori representation and equity within the surgical workforce.

11:11 am
Equity in Early Detection: Addressing Disparities in Aboriginal Breast Cancer
Dr Sarah Bormann
Breast cancer is the most commonly diagnosed cancer among women in Australia. However, Aboriginal

and Torres Strait Islander women experience significantly different outcomes compared to non-Indigenous women, with disparities evident in incidence, stage at diagnosis, treatment access, and survival rates. This literature and systematic review examines the current evidence on breast cancer rates among Aboriginal women in Australia, including patterns of incidence, mortality, and contributing social determinants of health. A systematic search of peer-reviewed literature was conducted using databases including PubMed, Scopus, and Informit, focusing on studies published between 2000 and 2024. Inclusion criteria were studies that reported quantitative data on breast cancer incidence or outcomes in Aboriginal and Torres Strait Islander populations. Grey literature and government health reports were also reviewed to capture recent epidemiological data and health policy context. A systematic review using an Aboriginal systems methodology was then completed on this literature The review found that while overall breast cancer incidence among Aboriginal women is slightly lower than in non-Indigenous women, mortality rates are significantly higher. Contributing factors include later-stage diagnosis, lower participation in breast screening programs, limited access to culturally safe healthcare, and higher prevalence of comorbidities. Studies also highlighted systemic barriers such as racism in healthcare and the underrepresentation of Aboriginal perspectives in cancer care planning. Breast cancer outcomes for Aboriginal women in Australia reflect ongoing health inequities rooted in broader social and structural determinants. Improving early detection, culturally appropriate care, and community-led health initiatives are critical for addressing these disparities. This literature and systematic review is informing a larger research project to increase breast cancer and breast surgery education in the Northern Adelaide Local Health Network.

11:21 am
BreastScreen for Indigenous Australian women: a pilot study proposal
Dr Christopher Harris
Proposal There is a significant disparity in the detection, treatment and prognosis of breast cancer between Indigenous and non-Indigenous Australian women. Aboriginal and Torres Strait Islander women have a lower five-year overall survival from breast cancer compared to the general population (81% vs 90%) and a two-fold increased risk of death from breast cancer (1). This reflects the disparity in participation rates in breast cancer screening, with only 36.1% of Indigenous Australians participating in BreastScreen in 2022-2023, compared to 51.2% of non-Indigenous Australians (2). Given the unmet need to address these inequalities, we propose development of a culturally safe screening program specifically for Indigenous Australian women. This is in line with the RACS competency of 'Cultural competence and cultural safety' as well as the Indigenous Health Position Paper, advocating for a holistic understanding of Indigenous health in its inclusion of broader aspects of 'family, community ... and the connection to land...'. Through a Working Party including Indigenous community members, clinicians, BreastScreen Australia and the Australian Government, we aim to initiate a culturally safe subset of BreastScreen for Indigenous Australians and analyse data relating to breast cancer detection and treatment. Our proposed strategies include: 1.Provision of mobile mammography vans for remote communities 2.Empowerment of individuals with Aboriginal Liaison Officers throughout screening, delivery of results and treatment 3.Culturally safe education regarding the benefits of screening and treatment In doing so we aim to help bridge the gap in breast cancer outcomes between Indigenous and non-Indigenous Australian women. References 1.Roder D, Webster F, Zorbas H, Sinclair S. Breast screening and breast cancer survival in Aboriginal and Torres Strait Islander women of Australia. Asian Pac J Cancer Prev. 2012;13(1):147-55. 2.BreastScreen Australia Monitoring Report. Australian Institute of Health and Welfare. Updated Oct 1 2025. Accessed Jan 20 2026.

11:31 am
Exploring the holistic impact of cancer – a pilot study
Dr Nasya Thompson

11:41 am
Beyond the Consent Form: Cultural Safety in the Operating Theatre
Dr Nikita Bhatt
Surgical care is often delivered in time-pressured environments where efficiency, technical precision and task-oriented workflow is prioritised. These contraints can often unintentionally limit opportunities for meaningful communication and culturally safe care for Indigenous patients. However, surgical experiences are shaped by more than clinical outcomes alone and must incorporate trust, communication and inclusive care across the peri-operative continuum. This presentation explores how the entire pathway can either strengthen or undermine trust in surgical care, from pre-operative discussions, intra-operative dynamics and post-operative recovery. Key themes include understanding consent as an ongoing relational process rather than a single signed document, recognising communication barriers and implicit assumptions, as well as considering the role of family members, Elders and cultural practices in surgical decision-making. By examining common points of misalignment between surgical systems and the needs of individual Indigenous patients, this presentation aims to highlight practical reflections focused on improving

operative experiences. Overall, it delineates that cultural safety should be presented, not as an added task, but as an integral component of high-quality surgical care.

11:51 am
A qualitative study exploring Pacific people's experiences in accessing publicly funded elective hip and knee replacements in Aotearoa New Zealand
Dr Atua Fuimaono Asafo
Purpose: There are ethnic inequities in the provision of publicly funded hip and knee arthroplasty in New Zealand. Although Pacific peoples have the highest age standardised rates of total knee arthroplasty, their disproportionate exposure to osteoarthritis risk factors and inequitable access to health services make this difficult to interpret. Pacific peoples have the lowest age standardised rates of hip replacements, unlikely explained by a lack of need. This study aims to explore the experiences of Pacific peoples in New Zealand in accessing publicly funded hip and knee arthroplasty. The analysis of these perspectives will provide a deeper understanding on the ethnic inequities in arthroplasty provision and the impact on Pacific peoples. Methodology: This is a qualitative study, using talanoa, which is a Pacific research methodology of narrative inquiry. These decolonizing research methodologies are grounded in Pacific values and uplift Pacific voices regarding the inequities they experience. Results: There were 15 interviews which revealed personal experiences of fear and mistrust were leading factors limiting Pacific peoples willingness for arthroplasty surgery. Systemic barriers including prolonged waitlists, difficulty optimizing comorbidities and challenging interactions with health professionals which impeded their journey to surgery. Pacific values including family, love, reciprocity and connectedness enabled the participants to overcome these barriers and acquire surgery. Conclusion: An holistic approach is required to address inequities in accessing publicly funded surgery for Pacific peoples in New Zealand. International literature suggests the barriers faced by ethnic minorities are predicated by institutional racism which infiltrates multiple parts of the health system. Culturally grounded interventions centering Pacific values are proven to mitigate these barriers and improve access for Pacific peoples to this life changing surgery

12:01 pm
Prostate abscess drainage: contemporary management strategies and outcomes
Dr John Peacey

12:11 pm
Can a paediatric artificial intelligence otoscopic classifier accurately diagnose adult ears?
Dr Tony Lian
Purpose: Otoscopic evaluation is critical for diagnosing ear pathologies, yet traditional methods used in primary care settings suffer from diagnostic inaccuracy. Artificial intelligence (AI) offers a promising solution for enhancing diagnostic accuracy. Our convolutional neural network (CNN) classifier was originally trained on a dataset of 10,000 otoscopic images from Aboriginal and Torres Strait Islander children, demonstrating good performance characteristics (AUC of 0.963 to 0.997 on test images). This study aimed to assess the CNN's cross-population generalisability by evaluating its diagnostic accuracy using adult otoscopic test images not used in its original training. Methodology: This retrospective, cross-sectional study utilised publicly available open-source otoscopic image data from three international databases: Turkey (54 images), Chile (40 images), United States (40 images), each with clinician-derived ground truth classifications. Images were processed sequentially by the CNN, with predictions and confidence levels recorded. Performance was quantitatively evaluated using accuracy, sensitivity and specificity. Results: Across test images, diagnostic accuracy as high as 90% (95% CI 75-100%) was achieved (normal ear in Chile dataset). The model demonstrated overall accuracy of 65.6% (95% CI 57.4-72.7%), sensitivity of 57.1% (95% CI 48.4-65.7%), and specificity of 87.1% (95% CI 83.9-89.8%), indicating good overall discriminative performance. Performance metrics showed greatest accuracy in the identification of normal ear and chronic otitis media across the three geographic cohorts. Conclusion: The convolutional neural network demonstrated good cross-population generalisability for the diagnosis of otoscopic pathology in a heterogeneous adult cohort, despite its original training on a paediatric Indigenous population. Further studies should focus on multi-site, diverse external validation to improve consistent generalisability.

10:30 am - 12:30 pm
Research Papers

Scientific Session - General Surgery - Meeting Room M1

10:30 am

A systematic review and meta-analysis on the efficacy and safety of proton beam therapy in oesophageal cancer

Dr Khang Duy Ricky Le

Background: Conventional photon-based radiotherapy, such as with intensity-modulated radiation therapy and three-dimensional conformal radiation therapy, remains the standard treatment for oesophageal cancer where radiotherapy is required. However, they are associated with potential radiotoxicity to surrounding organs that confer significant morbidity and mortality. Proton beam therapy has emerged as a new technology with the potential to reduce organ at risk radiation through more precise tumour targeting. This updated systematic review and meta-analysis evaluates the efficacy and safety of proton beam therapy compared to conventional radiotherapy for oesophageal cancer. Methods: A comprehensive literature search was conducted across Medline, Embase and Cochrane Central databases. Articles which evaluated clinical outcomes and dosimetry data for proton beam therapy compared to conventional radiotherapy in patients with oesophageal cancer were included in this review. Results: Thirty-three studies, predominantly from the United States of America, were included. Pooled analysis demonstrates strong evidence to suggest proton beam therapy led to reduced grade 4 lymphopenia, reduced total pulmonary complications, improved odds in overall and progression free survival and reduced organ at risk radiation compared to conventional radiotherapy. These findings occur on the background of studies at low-moderate risk of bias but high clinical heterogeneity. Conclusion: There is preliminary evidence to suggest proton bream therapy reduces organ at risk radiation and radiotoxicity in oesophageal cancer. While these findings support the potential use of proton therapies, the limitations of the underlying evidence calls for further research to validate the long-term radiotoxicity and oncological outcomes before implementation of this therapy in policy and practice can occur.

10:40 am

The use of nutritional scoring tools as prognostic indicators for short- and long-term outcomes in post-op surgical patients

Dr Ayeshmanthe Rathnayake

Background: Prognostic Nutritional Index (PNI) and the Geriatric Nutritional Risk Index (GNRI) scores are commonly used nutritional indexes. These scores can provide objective assessment to both surgeon and patient of peri-operative risk as well as long term survival. Aim: To determine the use of nutritional scoring tools as predictors of short- and long-term outcomes in elderly patients undergoing surgery in Tasmania, Australia. Methods: The study was approved by the Human Research Ethics Committee of the Royal Hobart Hospital, Tasmania. Retrospective cohort study of elderly patients who underwent surgery from 2015-2020. Statistical analyses were performed using appropriate statistical software with significance set at $\alpha = 0.05$. Patient demographics, comorbidities and nutritional indices were compared between survival groups using univariate and multivariate cox regression analysis. Kaplan-Meier survival curves were constructed for both, with survival differences assessed using log-rank tests. Results: One hundred and twenty-two patients aged >70 years underwent surgery. Short-term complications including MACE and 30-day mortality were associated with patients with low GNRI and PNI scores ($p<0.05$). Lower PNI scores and DLCO were independently associated with decreased overall survival with a mean follow-up of 4 years. Specifically, each unit increase in PNI was associated with a 6% reduction in the hazard of death (HR 0.94, $p = 0.012$), and each percentage point increase in DLCO was associated with a 3% reduction in the hazard (HR 0.97, $p = 0.037$). Multivariate analysis demonstrated GNRI score (<101) was significant as a predictor for re-admission and PNI score (<47) was significant as a predictor for rehab ($p<0.05$). Conclusion: Nutritional scoring tools can provide useful prognostic information and should be utilised routinely pre-operatively to risk stratify and allow for optimisation pre-operatively.

10:50 am

Outcomes after emergency laparotomy in Aboriginal and Torres Strait Islander patients at a regional Australian hospital: a propensity-matched cohort study

Dr Caitlin Sorour

Purpose Aboriginal and Torres Strait Islander peoples experience major health inequities; however, emergent surgical outcomes are not well defined. We compared the short term outcomes following an emergent laparotomy of indigenous and non indigenous patients at a regional Australian hospital. Methodology We conducted a retrospective cohort study of adult emergency laparotomies at Cairns Hospital between 2020 and 2024. Indigenous status was obtained from hospital records. The outcomes measured were surgical site infection (SSI), return to theatre and length of stay (LOS). Multivariable logistic regression adjusted for age, body mass index (BMI), diabetes, smoking, immunosuppression, bowel resection, peritoneal contamination and operative time. A 1:1 nearest neighbour propensity score–matched analysis without replacement was used to compare indigenous and non-indigenous patients with similar baseline and operative characteristics. Results Of 527 patients, 96 (18.2%) were indigenous and 431 (81.8%) non indigenous. Indigenous patients were younger (mean 50 vs 62 years) but more likely to have diabetes

(24% vs 11%) and to be current smokers (54% vs 25%), with similar BMI and operative time; bowel resection was less frequent (41% vs 56%). In adjusted models, indigenous status was not associated with SSI (adjusted odds ratio [aOR] 1.13, 95% CI 0.65–1.94) or return to theatre (aOR 0.85, 95% CI 0.48–1.53). In the matched cohort (94 indigenous, 94 non indigenous), SSI (31.9% vs 29.8%; p=0.87) and return to theatre (29.8% vs 30.9%; p=1.00) remained similar. Conclusion In this emergency laparotomy cohort, Aboriginal and Torres Strait Islander status was not independently associated with worse short term surgical outcomes once baseline and operative factors were accounted for.

11:00 am
Vanishing Stones: Clinical Predictors of Spontaneous CBD Stone Passage Prior to ERCP
Dr Jun Guang Kendric Tan
Background 10-15% of patients with gallstone related pathology have choledocholithiasis, with endoscopic retrograde cholangiopancreatography (ERCP) being a treatment option. Spontaneous passage of common bile duct (CBD) stones not infrequently result in negative ERCPs with unnecessary procedural risks and resource utilisation. To reduce this, we aim to derive predictors for spontaneous stone passage. Methods We performed a single centre, retrospective cohort study at St John of God Midland Hospital in Western Australia, Perth on 78 patients who underwent ERCP following imaging confirmed choledocholithiasis from June 2022 – Sep 2024. Multivariable logistic regression models were used to analyse predictors for spontaneous stone passage. Receiver Operating Characteristics (ROC) curve and Youden Index were used to investigate if the drop in liver function test (LFT) indices from initial diagnosis of choledocholithiasis to just prior to ERCP can predict spontaneous stone passage. Results 21.5% of patients with imaging proven choledocholithiasis had no evidence of stones on ERCP, suggestive of interval spontaneous passage. Size of CBD stone was independently associated with spontaneous stone passage. For each 1mm increase in stone size, the odds of spontaneous passage decreased by 54% (adjusted OR 0.46, 95% CI 0.27–0.77; p=0.003). Among the 5 biochemical predictors evaluated (bilirubin, AST, ALT, ALP, GGT), the drop in ALT from initial choledocholithiasis diagnosis to just prior to ERCP demonstrated a fair diagnostic performance with an area under curve (AUC) of 0.708 (95% CI: 0.548-0.868). At the optimal ALT cutoff of 210.5 U/L, the test achieved moderate sensitivity (70.6%) and moderate specificity (74.2%) in predicting spontaneously passed stones, resulting in a Youden Index of 0.448. Conclusion 1 in 5 CBD stones will likely pass spontaneously. For patients with a small CBD stone and ALT drop of 210.5 U/L, repeat imaging could be considered prior to ERCP for reassessment.

11:10 am
Optimizing ward rounds: systematic review and meta-analysis of interventions to enhance patient safety
Dr Nicholas Edwardes
Background: Poor quality ward rounds contribute to a large proportion of patient complications, delayed discharge, and increased hospital cost. This systematic review investigated all interventions aiming to improve patient and process-based outcomes in ward rounds. Methods: This systematic review was prospectively registered in PROSPERO, the international prospective register of systematic reviews (CRD42023394325). MEDLINE, Embase, Emcare, and PsycInfo were searched for studies with interventions aiming to improve ward round processes or patient outcomes in hospital settings. Studies were excluded if there was no baseline comparator or they were not in the ward round setting. Interventions were coded as checklist interventions (that is electronic or paper-based pro formas, templates, and checklists), structure interventions (that is defined rules or protocol to guide or standardize conduct), or other interventions. Outcomes were assessed via meta-analyses using the I2 statistic, Cochran's Q P value, and random-effects models. Risk of bias was assessed using the Cochrane Risk of Bias 2 tool for RCTs and the Newcastle–Ottawa scale for non-randomized studies. Results: This review included 84 studies, from 18 countries, in 23 specialties, involving 43 570 patients. Checklist interventions significantly reduced ICU length of stay, improved overall documentation, and did not increase ward round duration. Structure interventions did not increase the time spent per patient or impact 30-day readmission rates or patient length of stay. Conclusion: This is the first systematic review with meta-analyses synthesizing the evidence of all ward round interventions targeted at improving patient and process outcomes. Results from this review should be used to inform guidelines for the 'ideal ward round'.

11:20 am
Prevalence and outcomes of frailty in emergency laparotomy: A single-centre cohort study
Dr Paul Rival
Purpose Frailty is common among patients undergoing emergency laparotomy and is associated with adverse postoperative outcomes, yet routine frailty assessment remains inconsistently implemented despite international guideline recommendations. This study evaluates the prevalence of frailty using three rapid assessment tools and examines their associations with postoperative outcomes following emergency laparotomy. Methods We conducted a single-centre retrospective cohort study of adults undergoing open

emergency laparotomy over a 12-month period. Frailty was assessed retrospectively using the Clinical Frailty Scale (CFS ≥5), Emergency Surgery Frailty Index (EmSFI ≥7), and five-item Modified Frailty Index (mFI-5 ≥2). Primary outcomes were 30- and 90-day mortality. Secondary outcomes included postoperative complications, ICU admission, hospital length of stay, and discharge destination. Unadjusted analyses were descriptive. Multivariable logistic regression models were constructed with frailty measures specified as the primary exposures and adjusted for age, sex, operative indication, and anaesthetist-assigned ASA grade. Results Among 102 patients (median age 67 years, IQR 54–79; 53% female), frailty prevalence was 26% by CFS, 24% by EmSFI, and 27% by mFI-5, with 37% meeting at least one frailty threshold. In unadjusted analyses, patients living with frailty experienced higher rates of postoperative complications, ICU admission, longer hospital stay, and reduced likelihood of independent discharge home. After adjustment, frailty thresholds were not independently associated with 30- or 90-day mortality, while mFI-5–defined frailty was independently associated with ICU admission. Conclusion Frailty assessment in emergency laparotomy identifies patients at increased risk of postoperative morbidity, ICU utilisation, and discharge dependence but does not independently predict short-term mortality after adjustment for key clinical factors.

11:30 am

Perioperative Antimicrobial Prophylaxis in Elective and High-Risk Laparoscopic Cholecystectomy: A Narrative Review

Dr Kyle Green

Laparoscopic cholecystectomy (LC) is one of the most commonly performed general surgical procedures and represents a major source of perioperative antimicrobial exposure. Although infectious complication rates are low, variability in antibiotic prescribing persists, particularly in elective low-risk cases. This narrative review synthesises contemporary evidence regarding perioperative antimicrobial prophylaxis in low and high-risk LC, with a focus on SSI outcomes, guideline recommendations and antimicrobial stewardship implications. A structured literature search of MEDLINE, Embase and the Cochrane Library was performed, including randomised controlled trials, observational studies, systematic reviews, meta-analyses and international guidelines published between 2010 and 2025. The evidence consistently demonstrates no clinically meaningful reduction in SSI rates with routine prophylactic antibiotics in low-risk elective LC. Despite this, antibiotic use remains widespread. In high-risk LC, particularly acute cholecystitis, baseline SSI risk is increased; however, current evidence does not reliably demonstrate benefit from broad-spectrum agents, extended prophylaxis or postoperative antibiotics. Several meta-analyses report no reduction in infectious complications and identify increased hospital length of stay associated with antibiotic use. International guidelines uniformly discourage prophylaxis in low-risk LC but vary in their recommendations for high-risk patients, reflecting ongoing uncertainty and limited high-quality data. From a stewardship perspective, LC represents a high-impact opportunity to reduce unnecessary antimicrobial exposure through risk stratification, standardised single-dose prophylaxis where indicated and avoidance of postoperative continuation in the absence of established infection. In conclusion, omission of prophylactic antibiotics in low-risk LC is strongly supported by current evidence. Antibiotic use in high-risk LC should be individualised and evidence-informed, with further high-quality trials required to define optimal practice.

11:40 am

Comparative outcomes between 1-stage and 2-stage managements for choledocholithiasis

Dr Xiaohui Lin

Background: Choledocholithiasis is a common presentation of gallstone disease. Previous studies have demonstrated that both one-stage laparoscopic cholecystectomy + common duct exploration (LC+LCBDE) or two-stage laparoscopic cholecystectomy + Endoscopic Retrograde Cholangiopancreatography (LC + ERCP) are safe management strategies. This study aims to compare and contrast the treatment approaches used for choledocholithiasis, including LC+ERCP, LC+LCBDE, or LC+LCBDE + ERCP. Methods: A retrospective observational study was conducted of patients undergoing laparoscopic cholecystectomy at the Sunshine Coast University Hospital and Health Services from 1 January 2022 to 1 January 2025. Patients were categorised into three groups: LC + ERCP, LC + LCBDE, and LC+LCBDE+ERCP. Demographic, pre- and post-operative biochemical markers, imaging, and surgical outcomes were collected and compared between groups. Results: A total of 1760 laparoscopic cholecystectomies were performed. Of these, 227 patients (12.9%) required management for choledocholithiasis, with 101 patients undergoing bile duct exploration as emergency cases under ASU (Acute Surgical Unit). This ASU model is staffed on a rotational basis by General surgeons of all sub-specialities. 125 (55%) patients underwent a single-stage LC+ LCBDE, whereas 87 (38.3%) patients underwent LC+ERCP, and only 14 (6.2%) required both LTCBDE + ERCP. Stone clearance was achieved in 100% of patients managed with LC+ERCP and in 91.3% of patients in the single-stage LC+LCBDE group. There were no significant differences in surgical outcomes or post-operative complications between groups. Conclusion: These findings support the use of single-stage LC+ LCBDE as a safe and effective approach for choledocholithiasis and that these results can be achieved by general surgeons of all sub-specialities.

11:50 am
Impact of teaching TCBDE on a health service
Dr Perry Lindsay
Title: Impact of Single-Day Training on Surgical Management of Choledocholithiasis in Peripheral Hospitals Introduction: Choledocholithiasis occurs in up to 20% of patients undergoing cholecystectomy. While ERCP remains the dominant treatment modality, it requires access to specialised services and is associated with additional procedures, morbidity, and hospital transfers. Laparoscopic transcystic common bile duct exploration (TCBDE) offers a single-stage alternative but is underutilised by general surgeons. This study assessed whether a single-day TCBDE training course altered management practices and outcomes in hospitals without on-site ERCP capability. Methods: A retrospective audit was conducted across two peripheral hospitals within Eastern Health, Melbourne. All patients diagnosed with choledocholithiasis between April 2024 and April 2025 were included, comparing management in the six months before and after TCBDE training of seven experienced general surgeons. Outcomes assessed included initial management strategy, length of stay, complications, stone clearance, need for transfer, and 30-day readmission. Patients with malignant obstruction, ascending cholangitis, prior cholecystectomy, or unfitness for general anaesthesia were excluded. Results: Fifty-nine patients were included (28 pre-course, 31 post-course). Pre-course, 100% underwent ERCP. Post-course, 54.8% underwent TCBDE as first-line management, with ERCP reserved for 45.2%. Mean length of stay decreased from 5.9 days in ERCP patients to 4.6 days following TCBDE. Stone clearance rates were 96.4% (pre-course ERCP), 100% (post-course ERCP), and 82.5% for TCBDE. Most patients experienced no postoperative complications. Conclusion: A single-day TCBDE training course resulted in a meaningful shift toward single-stage surgical management of choledocholithiasis in peripheral hospitals, reducing reliance on ERCP and inter-hospital transfer. These findings support broader TCBDE training for general surgeons.

12:00 pm
Impact of Symptom Phenotype on Surgical Quality and Survival in Small-Bowel Neuroendocrine Tumours: A Quality Metrics Analysis
Dr Krishna Kotecha
Background: There is debate regarding the optimal management of small-bowel neuroendocrine tumours (SBNETs), particularly concerning upfront resection in various clinical presentations. While symptom phenotypes are known to influence survival, their impact on technical surgical quality—especially in the emergency setting—remains poorly defined. This study evaluates whether symptom phenotype compromises the delivery of guideline-concordant surgical care. Methods: A retrospective analysis of 108 consecutive SBNET resections (2000–2023) at a specialized tertiary centre was performed. Patients were stratified into four phenotypes: obstructive/perforation (n = 54), carcinoid syndrome (22), asymptomatic/incidental (22), and other symptoms (9). Operative metrics, including lymph-node harvest (LNY) and margin status (R0/R1), were compared alongside overall survival (OS). Results: Symptom phenotype was a predictor of operative urgency and approach. Obstructive cases required emergency surgery in 50% of instances compared to ≤11% in all other groups ($p < 0.001$). Synchronous liver metastases were most prevalent in the carcinoid syndrome phenotype (50%) and lowest in the asymptomatic group (5%) ($p = 0.002$). Despite these disparities in presentation and urgency, technical quality markers were uniform across all groups : median LNY ranged from 10 to 13 $p = 0.426$), R1/R2 margin rates were statistically similar ($p = 0.290$), and median length of stay was 8 days for all cohorts ($p = 0.311$). Multivariable analysis identified the asymptomatic phenotype as independently protective for OS (HR 0.42, $p = 0.032$), while liver metastasis was the strongest adverse prognostic factor (HR 3.25, $p < 0.001$) Conclusions: Symptom phenotype dictates operative urgency and reflects disease burden but does not compromise the technical standards of surgery in a specialized unit. These findings suggest that high-quality, guideline-concordant lymphadenectomy is achievable even in emergency obstructive presentations, and correspondingly, access to specialized surgical oncology expertise may be sought even in obstructed patients to ensure technical quality is maintained.

12:10 pm
Diagnostic Accuracy of a Rapid 12-Minute MRI Protocol for Acute Appendicitis: Multi-Centre Experience of 2,249 Patients
Mr Sowmya Ravi
Purpose: To validate a rapid 12-minute magnetic resonance imaging (MRI) protocol for diagnosing acute appendicitis in adults, addressing the need for accurate, ionising-radiation free MRI in patients presenting with acute abdominal pain. Methodology: Five-year retrospective cross-sectional study of 2,249 adult patients undergoing standardized 12-minute MRI for acute abdominal pain at Blacktown and Mt Druitt hospitals emergency departments (ED) from 2020 to 2024. Patient demographics, MRI reports and clinical documentation were extracted. The prevalence of appendicitis was 16% (354/2,249). MRI findings were

compared against histopathology (n=328) as well as clinical follow-up (n=1921). Sensitivity, specificity, positive predictive value (PPV), negative predictive value (NPV), and diagnostic accuracy with 95% confidence intervals were calculated. Results: The cohort was comprised of adult patients ranging from 18 to 93 years old (mean=27). MRI demonstrated 98.0% sensitivity (95% CI: 96.0-99.2), 99.8% specificity (99.5-99.9), 98.9% PPV (97.1-99.7), 99.6% NPV (99.2-99.9), and 99.5% overall accuracy (99.1-99.8). Of 342 appendicectomies performed, the negative appendicectomy rate was 4.7% (16/342). Alternate diagnoses were suggested in 61% (1365/2249) of patients. Conclusion: Rapid 12-minute MRI protocol achieves diagnostic accuracy comparable to CT while eliminating radiation exposure. MRI safely excludes appendicitis and identifies alternative pathology. This supports rapid MRI as a viable first-line imaging for suspected appendicitis in the emergency department.

12:20 pm
Single-dose preoperative glucocorticoids in major gastrointestinal surgery: a systematic review and meta-analysis of randomised controlled trials
Dr Rathin Gosavi

10:30 am - 12:00 pm
Retroperitoneal Tumours

Scientific Session - Endocrine Surgery, Surgical Oncology - Riverside Theatre

10:30 am
Investigation and management of the indeterminate retroperitoneal mass
Associate Professor F. Thurston Drake

10:50 am
The Approach to Adrenal Lesions – Lessons from the Eurocrine Database
Prof. Thomas J. Musholt

11:10 am
Interesting Cases
Dr Yen-ni Yu, Dr Rachel Hunter

10:30 am - 11:15 am
The Hamilton Russell Memorial Lecture

Named Lecture - Surgical Education - Meeting Room M6

Feedback and the isolated surgeon

10:30 am
Feedback and the isolated surgeon
Professor And Lt. Col. Steven Jeffery

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02 May 2026

11:00 am - 12:30 pm
Head & Neck Reconstruction

Scientific Session - Plastic & Reconstructive Surgery, Otolaryngology Head & Neck Surgery - River View Room 5

11:00 am
Bony Reconstruction of Maxilla and Mandible – Role of Jaw in a Day
Professor Jonathan Clark

11:20 am
Total Nasal Reconstruction
Dr Tuan Pham

11:40 am
Moving Beyond Function: Improved Survival Outcomes in H&N Oncologic Reconstruction - Aesthetic Reconstruction
Prof Sydney Ch'ng

12:00 pm
Development of a 3D-printed collagen venous anastomotic coupler and applicator for microvascular surgery
Dr Serag Saleh
Objective This project aims to develop a resorbable 3D-printed collagen venous anastomotic coupler with applicator for microvascular surgery. Introduction Venous anastomoses are a critical determinant of free flap success, with thrombosis and technical failure contributing significantly to flap loss. Current coupler devices are limited to venous couplers due to issues with material rigidity and permanent foreign body implantation. Biodegradable collagen offers a biologically integrated alternative. Method A biodegradable collagen coupler and dedicated applicator were designed and fabricated using high-resolution 3D printing. Devices were evaluated for mechanical strength, ease of deployment, luminal patency, and degradation characteristics. Bench-top microvascular models were used to assess anastomotic integrity. Results The collagen coupler demonstrated reliable deployment, maintained luminal patency, and provided sufficient tensile strength for venous anastomosis. Controlled degradation occurred without structural collapse. Handling characteristics were comparable to existing coupler systems. Conclusion This study demonstrates the feasibility of a 3D-printed collagen venous coupler as a biodegradable alternative to permanent devices. This platform may reduce long-term foreign body complications in microvascular surgery.

12:07 pm
Full Primary Inset of Median Forehead Flap for Nasal Reconstruction – 50 Consecutive Cases
Dr Conor Gleeson

12:14 pm
The Contoured Composite Graft
Dr Saranya Chiranakorn-Costa
Full-thickness skin graft (FTSG) is a core reconstructive option for small to moderate nasal defects after oncologic resection. By providing full dermal thickness and adnexal structures, they offer durability, sensory recovery and good aesthetic potential. However traditional FTSGs often struggle with contour and colour match on the nose. The contoured composite graft refines the FTSG technique by emphasising optimal donor site selection, meticulous tissue handling, precise haemostasis, accurate inset and strict postoperative care. Limitations in traditional FTSGs frequently arise from habitual use of preauricular or supraclavicular donor sites and graft thinning, driven by concerns of graft survival. While colour match is usually considered, dermal thickness and sebaceous match, essential for nasal reconstruction, are often overlooked. We advocate for alternative donor sites such as the infraauricular and upper neck region, dog ear grafts, and the glabella, which provide superior match to nasal skin. Graft inset should focus on meticulous dermal opposition, supported with a traditional tie-over dressing and additional contouring aided by jelonet pledgets. We recommend maintaining the tie over for a full three weeks to optimise graft integration. The contoured composite graft offers a more reliable and aesthetically harmonious solution than traditional FTSGs, achieving outcomes that often surpass both standard grafts and local flaps. Techniques and examples demonstrated in this presentation.

12:21 pm
Discussion

11:00 am - 12:30 pm
ONGOING EVOLUTION OF MANAGING Colorectal Liver Metastases

Scientific Session - HPB Surgery, Colorectal Surgery - Bellevue Ballroom 2

11:00 am

With advancements in locoregional liver treatments, what to do with the asymptomatic colorectal primary?
Dr Gregory Makin

11:20 am
Post operative ctDNA surveillance post liver resection/transplant
Dr Rajiv Shinde

11:40 am
Expanding the role of liver transplant for CLRM
Dr Arul Suthananthan

12:00 pm
Does robotic surgery expand role of synchronous resection?
Dr Rahila Essani

12:20 pm
Discussion

11:00 am - 12:30 pm
Oncoplastic Surgery

Scientific Session - Breast Surgery - Bellevue Ballroom 1

11:00 am
Fat grafting: technique, patients' selection and pitfalls
richard martin

11:20 am
Combining wise-pattern volume displacement and autologous volume replacement to facilitate oncoplastic breast conservation
Dr Jean-Claude Schwartz

11:40 am
Does contralateral symmetrisation surgery improve the patients' well-being?
Dr Anitha Karunairajah

12:00 pm
Chest wall perforators flaps: Anatomy, how I do it and managing it's complications
Dr Hazim Khout, Mr Hazem Khout

12:20 pm
Discussion

11:00 am - 12:30 pm
Orthopaedic Deformity Correction

Scientific Session - Orthopaedic Surgery - Meeting Room M8

11:00 am
Lower limb rotational deformities
Dr Nicholas Frost

11:20 am
Transport over a nail
Dr Samuel Shales

11:40 am
Approach to segmental bone loss

Dr Nikola Kovac

12:00 pm
Management of non-unions
Dr Michael Wren

12:20 pm
Discussion

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02 May 2026

11:20 am - 12:30 pm
Mastery and surrender in surgical training

Scientific Session - Surgical Education - Meeting Room M6

11:20 am
Operating on the Edge: Lessons Learnt from Gaza
Dr Bushra Othman

11:30 am
How I let go
Dr Emily Olive

11:40 am
The power of the mind in surgical mastery
Dr Kirsten Larkins

11:50 am
Discussion

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02 May 2026

11:30 am - 12:30 pm
Academic Surgery Meeting

Business Meeting - *Cross Discipline* - Bellevue Lounge

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02 May 2026

12:00 pm - 12:30 pm
ANZES PRESIDENT'S LECTURE - ASSOCIATE PROFESSOR CHRISTINE O'NEILL (NEWCASTLE, NSW)

Keynote Lecture - Endocrine Surgery - Riverside Theatre

12:00 pm
ANZES President's lecture
Associate Professor Christine O'Neill, Associate Professor Christine O'Neill

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02 May 2026

12:30 pm - 1:30 pm
Lunch - Saturday

Catering - *Cross Discipline* - Pavillion 1

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02 May 2026

12:45 pm - 1:15 pm
Medtronic Lunch Session: Building the OR of the future

Scientific Session - *Cross Discipline* - Meeting Room M6

Proudly sponsored by Medtronic

12:45 pm
Building the OR of the future
Prof Matteo Rottoli, Professor Michael Talbot

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02 May 2026

1:30 pm - 2:00 pm
KEYNOTE LECTURE - PROFESSOR JP HONG (SEOUL, SOUTH KOREA)

Keynote Lecture - Orthopaedic Surgery, Plastic & Reconstructive Surgery - River View Room 5

1:30 pm
My journey of innovations in microsurgery
Prof Joon Pio Hong

1:30 pm - 2:00 pm
The ANZJS Lecture - Professor Christobel Saunders (NSW, Australia)

Named Lecture - *Cross Discipline* - Riverside Theatre

1:30 pm
The ANZJS Lecture: Collaborating in Surgery through a gendered lens
Professor Christobel Saunders

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02 May 2026

2:00 pm - 3:00 pm
Plenary Session: Collaborating with Patients and Industry

Plenary Session - *Cross Discipline* - Riverside Theatre

2:00 pm
Across Oceans – At the Console – The Reality of Telerobotic Surgery
Dr Mohit Bhandari

2:20 pm
Operating at the Interface: Surgery meets Biomedical Engineering
Clinical Associate Professor Ming Khoon Yew

2:40 pm
The augmented surgeon: Not just looking into the body
Ms Susanne Halbherr

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02 May 2026

3:00 pm - 3:30 pm
Afternoon Tea - Saturday

Catering - *Cross Discipline* - Pavillion 1

3:00 pm - 5:00 pm
President's Round Table (by Invitation Only)

Business Meeting - *Cross Discipline* - Bellevue Lounge

3:00 pm
Afternoon Tea

3:30 pm
Welcome from the RACS President
Professor Owen Ung

3:35 pm
Surgical Training Pathways
Dr Philip Morreau

3:45 pm
Updates from International Presidents
Dr Clare McNaught, Professor Ajith Malalasekera, Sri Maliawan, Dr Rajeev Patel, Dr Joselito Mendoza, Prof Bannakij Lojanapiwat

4:05 pm
Round Table Discussion
Professor Owen Ung

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02 May 2026

3:30 pm - 5:30 pm
Advances in Skull Base Surgery

Scientific Session - Otolaryngology Head & Neck Surgery - Meeting Room M7

3:30 pm

Current management of Acoustic Neuroma
Professor Robert Briggs

3:45 pm
Contemporary trends in paraganglioma management
Dr Stephen Rodrigues

4:00 pm
Transorbital endoscopic surgery
Dr Chris Dhepnorrarat

4:15 pm
The International collaborative skull base project
Professor Ray Sacks

4:30 pm
ENS:Fact or fiction
Professor Ray Sacks

4:45 pm
Middle turbinate flaps for the Carolyn's window approach to the frontal sinus
Professor Simon Carney

3:30 pm - 5:30 pm
Complications Decoded: Surgical, Endoscopic & Radiologic Rescue

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Scientific Session - Upper GI Surgery, Bariatric Surgery - River View Room 4

Complications remain an inevitable part of complex bariatric practice. This session focuses on multidisciplinary strategies to recognise, manage and prevent complications through coordinated surgical, endoscopic and radiological approaches.

3:30 pm
Introduction and session framing

3:35 pm
Video Case — Managing Intra-operative Complications in RYGB & OAGB
Dr Ahmed Ahmed

3:50 pm
Integrated Management of Leaks & Fistulae — Surgical, Endoscopic and Radiologic Strategies
Dr Mohit Bhandari

4:10 pm
Building a Bariatric Emergency Response Team — Systems, Pathways and Collaboration
Dr Mohammed Ballal

4:30 pm
EndoVac, internal drainage and septotomy - evidence and experience
Professor Michael Talbot

4:50 pm
Post-operative Bleeding After Bariatric Surgery — Recognition, Endoscopic & Surgical Management
Assoc Professor Asim Shabbir

5:05 pm
Interactive Panel and Q&A
Dr Mohammed Ballal, Professor Michael Talbot, Dr Ahmed Ahmed, Assoc Professor Asim Shabbir, Dr Mohit Bhandari

3:30 pm - 4:00 pm
KEYNOTE LECTURE - DR ANJAY KHANDELWAL (AKRON, USA)

Scientific Session - Burn Surgery, Paediatric Surgery - Meeting Room M3

3:30 pm
Nuances and Challenges in Pediatric Burns
Dr Anjay Khandelwal

3:30 pm - 4:00 pm
KEYNOTE LECTURE - DR MAHMOUD EL-TAMER (NEW YORK, USA)

Keynote Lecture - Breast Surgery - Meeting Room M8

3:30 pm
Surgical management of denovo stageIV breast cancer
Dr. Mahmoud El-Tamer

3:30 pm - 4:00 pm
KEYNOTE LECTURE - DR RAVI MARUDANAYAGAM (BIRMINGHAM, UK)

Keynote Lecture - HPB Surgery, Transplantation Surgery - Bellevue Ballroom 2

3:30 pm
Vessel divestment in pancreatic surgery
Mr Ravi Marudanayagam

3:30 pm - 5:30 pm
Keeping It Together: Sternum, Ribs, and Circulation Under Fire

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Scientific Session - Trauma Surgery, Cardiothoracic Surgery - Riverside Theatre

Chest trauma is one of the most challenging arenas where trauma surgery and cardiothoracic surgery intersect. From emergency thoracotomy to complex sternal reconstruction, management requires both decisive action and technical mastery. This conjoint session brings together experts from both specialties to explore contemporary operative strategies across the spectrum of chest injury. Topics include resuscitative thoracotomy, operative repair of cardiac trauma, the emerging role of VATS in selected patients, rib fixation and chest wall stabilisation, and lessons from post-cardiac surgery sternal reconstruction translated into trauma. The session concludes with extracorporeal life support as an evolving adjunct in thoracic trauma. By combining trauma and cardiothoracic expertise, this program aims to highlight practical surgical decision-making, share cross-specialty insights, and define future directions in collaborative care. The session will provide both trainees and senior surgeons with high-yield, clinically relevant lessons in managing injuries where seconds count and survival depends on surgical precision.

3:30 pm
Moving the pendulum of resuscitation:SPARC
Professor Juan C Duchesne

4:00 pm
Cardiac Injury in Trauma: Repair and Reconstruction
Dr Agneta Geldenhuys

4:15 pm
VATS in Trauma: Indications, Limitations, and Expanding Roles
Dr Josh Goldblatt

4:30 pm
Rib Fixation and Chest Wall Stabilisation: Current Indications and Techniques
Professor Jeremy Hsu

4:45 pm
Sternal Trauma and Complex Reconstruction
Professor Ulrich Stock

5:00 pm
ECMO and ECLS in Thoracic Trauma: When and How?
Dr Chris Allen, Dr Chris Allen

3:30 pm - 5:00 pm
PARATHYROID SURGERY

Scientific Session - Endocrine Surgery - Meeting Room M2

3:30 pm
Debate – Bells & Whistles or Keep It Simple? The Future of Parathyroid Surgery
Associate Professor Sophie Dream, Professor Justin Gundara

4:00 pm
the Imaging of recurrent parathyroid disease
Dr Andrew Hohnen

4:15 pm
Defining and Maximising Success in Parathyroid Surgery
Associate Professor Sophie Dream

4:30 pm
Interestingcases
Dr Rachel Hunter

3:30 pm - 5:30 pm
Research Papers

Scientific Session - Surgical Education - Meeting Room M9

3:30 pm
Balancing Training Quality and Well-Being in Part-Time General Surgery Training Pathways
Dr Tess Howard
Purpose: Part-time training offers general surgery trainees a pathway to improved work–life balance; however, concerns remain regarding its impact on clinical training quality, continuity of care, and trainee well-being. This study aimed to compare perceptions of training quality and well-being between part-time and full-time general surgery training. Methodology: A survey was conducted among general surgery trainees who had undertaken part-time training over a five-year period. Respondents rated domains of training quality, well-being, and handover practices using a 0–10 visual analogue scale (VAS), converted to a 100-point scale, with a 10-point difference considered significant. Comparative ratings were collected for both part-time and full-time training experiences. Results: Twenty-three trainees responded. Part-time training was rated more favourably for personal well-being, with marked improvements in work–life balance (+72.6), physical health (+69.9), and family time (+72.6). Sleep duration increased by almost two hours per night. Research productivity was rated higher (+50.4), and theoretical knowledge scores were superior during part-time training (81.0 vs 41.4). These benefits were offset by lower ratings for operative exposure (72.6 vs 84.4), patient continuity (56.0 vs 81.0), and post-operative follow-up (34.7 vs 59.1). Handover practices varied widely, ranging from daily to weekly or ad hoc exchanges, contributing to perceived inconsistencies in patient care. Conclusion: General surgery trainees perceived part-time training as strongly beneficial for well-being, theoretical knowledge, and research productivity. Contrastingly, reduced continuity of care and operative exposure were identified as key limitations. Standardised rostering and handover processes may

help preserve the benefits of part-time training while safeguarding the quality of general surgery training.

3:42 pm
Surgical Subspecialty Interest, Early Exposure, Mentorship, and Barriers among Australian and New Zealand Medical Students - Preliminary Results from an ANZ Survey
Daksh Tyagi
Purpose: This study characterises the evolving interest of Australian medical students in surgical careers. By profiling exposure, mentorship, and research participation, we aim to identify motivators and barriers shaping surgical career decision-making. Methodology: Data is being collected via an ongoing, cross-sectional anonymous online survey of Australian medical students consisting of 42 questions. The instrument evaluates shifts in surgical interest, subspecialty preferences, and the impact of early clinical exposure or mentorship. It further assesses involvement in student societies and perceived hurdles via Likert-scale items. Results: In this preliminary cohort of 80 respondents (median age 22; 58.8% male; 25% preclinical; 62.5% metro), early data suggest surgical interest is high but dynamic - 53.2% currently favour a surgical career, and 51.9% report increased interest since starting medical school. General surgery had the highest proportion indicating interest (19.0%), followed by orthopaedics (15.2%). While pre-clinical exposure was reported by only 46.8%, it appears influential, with 51.9% of those exposed noting increased interest. Conversely, mentorship remains a gap, with only 26.6% reporting a surgical mentor. Research involvement (22.8%) also correlates with higher interest. Significant perceived barriers include lifestyle concerns (77.2%), competitive selection (73.4%), and demanding training (72.2%). Interest was similar between rural and metro respondents (57.9% vs 54.0%). Most respondents (72.6%) are willing to spend 3+ years as an unaccredited registrar. Key motivators include "hands-on" satisfaction (85.9%) and intellectual challenge (82.1%). Conclusions: Early findings indicate surgical interest is influenced by the quality of exposure and research. Low mentorship rates and significant lifestyle concerns suggest a need for structured support. Findings support earlier clinical exposure and formalised mentorship to improve pathway clarity.

3:54 pm
From Simulation to Scalpel: The Evolution of Microsurgical Training and Simulation
Dr Nikita Bhatt
Background and purpose: Microsurgery demands meticulous technical precision and refined motor skills. Traditionally, these competencies were acquired through apprenticeship-based models, including live animal laboratories and operating theatre exposure. However, ethical and financial considerations, reduced training hours and increasing emphasis on patient safety have driven microsurgical education toward simulation-based training. This review aims to explore strategies in simulation-based microsurgical education, highlighting effectiveness and potential to enhance trainee competency. Methodology: This presentation reviews the historical development and contemporary advances in microsurgical training and simulation. Training modalities are categorised into low-fidelity bench models, synthetic and biological simulators, virtual reality (VR), augmented reality (AR) and robotic-assisted platforms. Educational effectiveness is evaluated in terms of skill acquisition, transferability to the operating theatre, accessibility, cost-effectiveness and assessment capability. Results: Simulation-based microsurgical training has shown to improve learning efficiency and trainee confidence prior to clinical participation. Low-cost bench and synthetic models effectively support early skill development, whilst high-fidelity VR and robotic platforms enable objective performance metrics, standardised assessment and deliberate practice without patient risk. Structured simulation curricula have demonstrated improved operative readiness and patient safety outcomes. Conclusion: Microsurgical training has evolved from traditional apprenticeship models to competency-based, simulation-enhanced education. Advances in simulation technology provide ethical, scalable and effective solutions for training and assessment. Continued innovation and validation will be essential to integrate simulation fully into surgical training pathways and to support the future microsurgical workforce.

4:06 pm
Online work based assessments for Otolaryngology trainees. For better or worse?
Dr Alice Stringer
Purpose: The Otolaryngology Head and Neck Surgery (OHNS) training scheme in Aotearoa New Zealand and Australia has undergone extensive changes over the last decade with a marked increase in the number of work based assessments (WBA) that must be completed throughout training. The current paper based system places a significant administrative burden on trainees in addition to the existing clinical duties. WBA tools have been utilized for many years overseas with positive feedback. We aim to compare satisfaction rates with, and opinions of, the existing paper based assessment model with the proposed WBA for trainees and consultant supervisors. Method: The prospective study includes two surveys, the first for the current paper based assessment and the second for the WBA. Surveys are sent to all current OHNS NZ Trainees and ORL Departments in New Zealand. The responses are collected anonymously on SurveyMonkey. The first

survey is completed six months prior to the introduction of WBA and the second survey completed 18 months after implementation. Results: 71 responses were collected for the first survey on paper based assessment and 58 responses for the second survey on WBA. Respondents found WBA easier to complete (p=0.03), less time consuming (p=0.003), less stressful (p=0.05) and the format less restricting (p=0.011) compared to paper based assessments. Thematic analysis found paper based assessments to be complex, with excessive detail and often not applicable to procedures being assessed. Technical challenges related to access and completion of the WBA were raised. Respondents found consultant engagement a challenge for both assessment platforms. Conclusion: Overall, respondents were positive with the digital transition. The issues raised mostly surround usability rather than feasibility. We expect with greater familiarity of the WBA, there will be greater engagement from both trainees and supervisors.

4:18 pm
Rural General Surgical Education in Australia: Current Practice and Evidence Gaps
Dr Baneen Alrubayi
Background: Rural general surgeons are essential for equitable surgical care in Australia. Despite recent RACS rural training initiatives, evidence guiding effective rural surgical education remains limited and fragmented. This review synthesised current knowledge on rural general surgical education in Australia, to identify gaps for developing sustainable training models aligned with RACS competencies. Methodology: Structured narrative review of MEDLINE and grey literature (2000-2025) from surgical colleges and rural health agencies. Eligible publications described rural/regional Australian general surgery education, teaching models, supervision, simulation-based training, operative exposure and non-technical skills. Studies were synthesised thematically and mapped to RACS General Surgery SET competencies. Results: A limited body of peer-reviewed studies and key policy documents were identified. Emerging themes included traditional apprenticeship-style supervision models, variable access to operative exposure in smaller centres, and recent initiatives using simulation or mobile skills training to compensate for limited case-mix. Evidence was particularly limited for structured rural teaching frameworks and systematic non-technical skills development specific to rural general surgery contexts. This gap persists despite RACS incorporation of NOTSS into Surgical Education and Training programs. Priority gaps included structured simulation access, formalised perioperative teaching frameworks, and systematic mentoring in situation awareness, decision-making, communication and teamwork. Conclusions: Current literature provides limited guidance for structured rural general surgical education in Australia, with training programs remaining metropolitan-centric. Defining context-appropriate models for regional centres could strengthen rural pathways and support RACS workforce sustainability goals by addressing non-technical skills and competency-based assessment.

4:30 pm
Development of a Novel Low-Cost, Readily Accessible Simulator for Training Grommet Insertion
Dr Telvinderjit Singh Harbhajan Singh
Purpose: Grommet insertion is a procedure frequently encountered by junior doctors and surgical trainees. However, opportunities for supervised procedural training are limited by service demands, patient safety concerns, and restricted access to simulation facilities. Commercial otology simulators are often expensive and not universally available. This study describes the development of a low-cost, readily accessible simulator designed to facilitate safe and effective training in grommet insertion. Methods: A simulation model was constructed using inexpensive, commonly available materials. Suction tubing was used to replicate the external auditory canal approximating average canal length and diameter. A latex glove secured at the distal end simulated the tympanic membrane and handle of malleus marked with a marking pen. The tubing was mounted through a cruciate incision in a standard glove box, providing stability and appropriate angulation. The model allows use of standard otological instruments under direct vision or microscopy, enabling practice of myringotomy incision, grommet placement, and fine instrument handling. Results: The simulator was assembled at minimal cost and demonstrated face validity by reproducing key technical challenges of grommet insertion, including restricted access, depth perception, and precision of movement. Survey feedback from otorhinolaryngology consultants/fellows, trainees and junior doctors indicated improved procedural confidence and understanding of technique with majority of respondents stating they would recommend it to junior doctors. The model is portable, reusable, and easily reproducible, allowing repeated practice without patient risk. Conclusion: This low-cost grommet insertion simulator provides an effective and scalable training tool. Its affordability, simplicity, and accessibility support widespread adoption in surgical skills training, with potential benefits for procedural competence, confidence, and patient safety.

4:42 pm
A narrative review of mandatory research during specialty training: Opportunity for parallel frameworks
Dr Nicholas McIntosh

Background: Scholarship and teaching is integral to becoming a successful surgeon, indeed it is one of the ten core competencies identified by the Royal Australasian College of Surgeons. Despite its importance, there is considerable variation in the way this competency is taught and assessed as part of general surgical training. Both countries primarily use the production of research as a metric to gauge mastery. Aims: This narrative review explores the experiences reported by institutions regarding mandatory research production as part of specialist training. Methods: A review of the literature was conducted using PubMed and Ovid search terms [research], [surg*], [requirement*], [residency] and [training] with Boolean modifiers to provide a comprehensive search. Relevant papers underwent qualitative review to identify themes and "common themes" were defined as those appearing in three or more publications Results: The search yielded 47 unique publications, of which 15 were relevant. Three common themes emerged: (a) Integration within training, (b) Infrastructure, support and mentorship, and (c) Outcomes of trainee research. Discussion: The reviewed papers generally expressed dissatisfaction with current frameworks. Integration could be facilitated by protected, dedicated research time but requires further funding to offset the reduction in clinical time. Infrastructure, support and mentorship is improved by university affiliation but creates discrepancies between urban and rural centres. Reduced quality of research output likely reflects the variability in competency assessment. The introduction of Entrustable Professional Activities in General Surgery Education and Training provides a new framework for teaching and assessing scholarship. Furthermore, it better integrates research within training and reallocates infrastructure and support to trainees undertaking more intensive and academically satisfying projects. Conclusion: Alternative frameworks for assessing scholarship mastery allows precious resources to be dedicated to higher quality research.

4:54 pm
Perioperative Outcomes in Breast Surgery, A Comparison of Trainee and Consultant Primary Operators
Dr Chaithanya Jeganathan
Abstract Background Increasing subspecialisation in breast surgery has reduced operative exposure for general surgery trainees. Ongoing concerns remain that trainee involvement as primary operator may be associated with increased perioperative morbidity. This study compares complication rates between trainee- and consultant-performed breast surgery within a specialist unit. Methods A retrospective review was conducted of all breast surgical procedures performed over a five-year period from January 2016 to December 2021. The primary outcome was postoperative complication rate, comparing procedures performed by trainees and consultants as primary operators. Outcomes were further stratified by procedure type, including benign surgery, primary breast cancer surgery, and re-excision. Results A total of 2,646 operative cases were included. Consultants were the primary operator in 1,544 cases (58.35 percent), and trainees in 1,102 cases (41.65 percent). The overall complication rate was 2.83 percent (n = 75). There was no statistically significant difference in complication rates between consultant- and trainee-performed procedures (2.65 percent vs 3.08 percent, p = 0.59). For mastectomy-only procedures, complication rates were higher in the consultant group compared with the trainee group (7.3 percent vs 2.8 percent), although this difference was not statistically significant (p = 0.18). Haematoma was the most common complication in both groups. Conclusion Breast surgery performed by general surgery trainees was not associated with increased perioperative morbidity compared with consultant-performed procedures. These findings support supervised trainee involvement as primary operator within specialist breast units, particularly in the context of declining operative exposure during surgical training.

5:06 pm
Early Post-operative Safety Through a Structured Educational Intervention for Junior Doctors: A Translational Simulation Model
Dr Akash Patel
Background: Early post-operative complications contribute substantially to preventable morbidity, unplanned ICU admissions, and prolonged hospital stay in Australian surgical services. Although evidence-based protocols exist, effective translation into bedside care during the first 48 hours after surgery depends largely on junior doctors, particularly after hours. Observational data demonstrate persistent gaps in confidence and execution relating to analgesia titration, venous thromboembolism prophylaxis, drain assessment, and escalation of clinical deterioration. These gaps represent a modifiable driver of surgical hospital-acquired complications and align with National Safety and Quality Health Service Standard 5. Methods: Module X: Foundations of Evidence-based Post-operative Care was developed as an eight-hour blended educational intervention for postgraduate year 1–2 medical officers in a regional surgical service. The curriculum integrates flipped learning, case-based discussion, ward-based simulation, and supervised bedside skills practice. Educational design aligns with Miller's Pyramid of Clinical Competence and Kolb's experiential learning cycle. Core content targets five high-impact complications: surgical-site infection, post-operative haemorrhage, venous thromboembolism, respiratory failure, and acute delirium. Performance is assessed using structured viva, simulation-based OSCE checklists, mini-CEX, and guided reflective debriefs.

Results: The programme was designed for feasibility within existing teaching structures, requiring no additional capital investment and a faculty-to-learner ratio of 1:6. A needs analysis identified low baseline confidence in analgesia adjustment (71%), drain interpretation (58%), and escalation pathways (54%), informing curriculum priorities. Conclusion: A structured, context-adaptable educational intervention targeting junior-doctor post-operative decision-making is a scalable strategy to improve early surgical safety, particularly in regional settings.

5:18 pm
Implementing competency-based training with graduated autonomy in a regional general surgery unit
Dr Zainab Naseem
Purpose: Competency-based training (CBT) emphasises progression based on demonstrated competence rather than time-based exposure. Regional hospitals offer procedural volume and continuity but require structured assessment frameworks to support safe trainee autonomy. This study describes the implementation of a CBT model incorporating procedural assessment to guide graduated autonomy. Methodology: A prospective observational study was conducted over two training terms within one calendar year in a regional general surgery unit at Goulburn Valley Health. Participants included two General Surgery Education and Training (GSET) trainees and one Surgical Education and Training (SET) trainee. A structured CBT framework was implemented incorporating procedure-specific workplace-based assessments, defined supervision levels, and entrustment decisions. Data collected included procedural exposure, assessment completion rates, level of intra-operative autonomy, and supervisor and trainee feedback. Results: Across the study period, trainees participated in 186 operative cases, including 124 core general surgery procedures suitable for competency-based assessment. A total of 98 procedural assessments were completed (median 32 per trainee), with 87% rated as meeting or exceeding expected competence. Progression to reduced supervision occurred in 72% of assessed procedures following repeated satisfactory assessments. No adverse patient outcomes were attributable to trainee autonomy. Supervisors reported increased confidence in entrustment decisions, while trainees reported improved clarity regarding expectations, feedback, and progression. Conclusion: Competency-based training supported by structured procedural assessment and graduated autonomy is feasible and effective in a regional general surgery unit. Regional training environments, with appropriate supervision and governance, are well suited to CBT implementation and may enhance trainee development while maintaining patient safety.

3:30 pm - 5:30 pm
Transforming Colorectal Cancer Care: Robotic Surgery, Organ Preservation, and Immunotherapy

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Scientific Session - Colorectal Surgery - Meeting Room M6

The management of colorectal cancer is undergoing rapid transformation, driven by advances in surgical technology, precision oncology, and multidisciplinary care. Robotic platforms are redefining what is technically achievable, enabling greater precision and potentially improved functional outcomes. At the same time, organ-preserving strategies are challenging traditional operative paradigms, offering carefully selected patients the possibility of avoiding radical surgery without compromising oncologic safety. Parallel to these developments, immunotherapy is reshaping the treatment landscape for mismatch repair deficient cancers, with emerging evidence of durable and, in some cases, practice-changing responses. This session brings together experts across surgery and oncology to explore how these innovations intersect. From advanced robotic rectal surgery to non-operative management and immunotherapy-driven treatment pathways, the discussion will focus on how to integrate evolving evidence into contemporary colorectal practice. The session will provide insight into the opportunities—and challenges—of delivering personalised, outcomes-focused care in an era of rapidly advancing technology and therapeutics.

3:30 pm
Robotic Surgery: Where to Now? Pushing the boundaries of robotic surgery
Dr Rahila Essani

3:50 pm
Robotic Surgery: Robotic colorectal surgery in WA: Early experience and the road ahead
Dr Abraham Jacob

4:10 pm
The New Neoadjuvant Disruptor: Should Immunotherapy Replace Surgery in Selected Patients?
Dr Adnan Khattak

4:30 pm
From Early Adoption to Long-Term Evidence: Results from One of Australia's Earliest Established Watch-and-Wait Programmes
Dr Michael Warner

4:50 pm
What's Wrong with Surgery? Oncological Outcomes Following Operative Management of Rectal Cancer
Dr Katherine Broughton

5:10 pm
Panel Discussion
Dr Katherine Broughton, Dr Abraham Jacob, Dr Rahila Essani, Dr Michael Warner, Dr Adnan Khattak

3:30 pm - 5:30 pm
Tyranny of Distance – Approaching a Unique Australian Problem

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Scientific Session - Rural Surgery, General Surgery - Bellevue Ballroom 1

3:30 pm
Tyranny of Time: Can we adapt US Lessons to Australia
Associate Professor Zaffer Qasim

3:50 pm
Tertiary Transfer in WA
Dr Tom Bowles

4:10 pm
Issues on the Receiving End
Dr Oscar Aldridge

4:30 pm
Continuum of the Surgical Patient Care: Rural and Urban
Dr Amy Liepert

4:50 pm
Stopping the Dying: How to Achieve Marginal Gains in Prehospital Trauma Care
Associate Professor Zaffer Qasim

5:10 pm
Discussion

3:30 pm - 5:30 pm
When rarity matters: Insights into Less Common Cutaneous Malignancies

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Scientific Session - Surgical Oncology - Meeting Room M1

3:30 pm
SNB for Merkel Cell Carcinoma
Dr Alexandra O'Neill

3:50 pm
Radiotherapy for Merkel Cell Carcinoma
Dr Daren Tan

4:10 pm
Cutaneous Sarcomas
Professor Michael Henderson

4:30 pm
Digital Papillary Adenocarcinoma
Dr Aisling Mc Namara

4:45 pm
Leiomyosarcoma updates
Mr Thomas Bragg

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02 May 2026

4:00 pm - 5:30 pm
De-escalation in Breast Cancer Treatment

Scientific Session - Breast Surgery - Meeting Room M8

4:00 pm
De-escalation of Axillary Surgery – Part 1: in upfront surgery
Dr. Mahmoud El-Tamer

4:20 pm
De-escalation of Chemotherapy
Doctor Andrew Redfern

4:40 pm
De-escalation of Radiotherapy
Assoc Professor Yvonne Zissiadis

5:00 pm
De-escalation of Axillary Surgery – Part 2: in post-neoadjuvant chemotherapy
Dr. Mahmoud El-Tamer

5:20 pm
Discussion

4:00 pm - 5:30 pm
ORTHOPLASTIC EXTREMITY RECONSTRUCTION

Scientific Session - Plastic & Reconstructive Surgery, Orthopaedic Surgery - River View Room 5

4:00 pm
Orthoplastics in Western Australia's major trauma centre
Dr Bernard Luczak

4:20 pm
Orthoplastic approach to the diabetic foot
Prof Joon Pio Hong

4:40 pm
Orthoplastics collaboration: An orthopaedic Perspective
Mr Alistair Macey

5:00 pm
Aesthetic Extremity Reconstruction in extremity reconstruction
Dr Sandeep B

5:20 pm
Discussion

4:00 pm - 5:30 pm
PANCREATIC MALIGNANCY: HAS ANYTHING CHANGED?

Scientific Session - HPB Surgery - Bellevue Ballroom 2

4:00 pm
Can we cure pancreatic cancer? Patients think we can
Dr Emily Olive

4:20 pm
Moving beyond chemotherapy in the treatment of pancreatic adenocarcinoma
Dr Piyush Grover

4:40 pm
Is there a role for resection of oligometastastic disease?
A/Prof Manju Chandrasegaram

5:00 pm
Outcomes Following Resection of Rare Pancreatic Cancer Subtypes: A Multicentre Cohort Study
Dr Ramiz Iqbal

5:10 pm
The Impact of Neoadjuvant Chemotherapy on the Tumor-Vessel Interface: Pathological and Survival Outcomes in Pancreatoduodenectomy with Portomesenteric Venous Resection
Dr Krishna Kotecha
Not all patients with radiologically defined borderline resectable pancreatic ductal adenocarcinoma (BR-PDAC) require portomesenteric venous resection (PVR). This study evaluates the impact of neoadjuvant chemotherapy (NAC) specifically within the high-risk cohort of patients requiring definitive PVR during pancreatoduodenectomy. Methods A retrospective propensity score–matched (PSM) analysis was performed on 214 patients undergoing pancreatoduodenectomy with PVR for BR-PDAC (2003–2022). Matching yielded 97 patients per cohort (NAC vs. upfront surgery). Outcomes included perioperative safety, depth of venous wall invasion, and survival. Results Following PSM, NAC was associated with significantly lower estimated blood loss (500 mL vs 670 mL, p=0.004) despite requiring significantly longer venous resection segments (30 mm vs 20 mm, p=0.04). Pathologically, NAC resulted in higher R0 resection rates (61.9% vs 32.0%, p<0.001) and significantly reduced depth of venous invasion, with less frequent intimal involvement (10.3% vs 22.7%, p=0.03). However, no statistically significant difference was observed in overall survival (HR 0.78, 95% CI 0.57–1.06) or disease-free survival (HR 0.96, 95% CI 0.70–1.30) after matching. Conclusion In patients requiring actual PVR, NAC successfully modifies the tumor–vessel interface, reducing intimal invasion and improving margin clearance while lowering blood loss, but does not translate into an independent survival benefit. This suggests that the absolute requirement for venous resection marks an aggressive phenotype where outcomes are primarily dictated by disease biology.

4:00 pm - 5:30 pm
Trauma and Critical Care Management of Burns

Scientific Session - Paediatric Surgery, Burn Surgery - Meeting Room M3

4:00 pm
Resuscitation in paediatric burns
Dr Monique Bertinetti

4:15 pm
Major Burns in the Paediatric Population
Dr Helen Douglas

4:30 pm
Neurological insult following paediatric burns
prof Fiona Wood

4:45 pm
Under-recognised and Underestimated: Friction Burns in the Era of Electric Micromobility
Dr Dulan Gunawardena
PURPOSE Friction burns are a distinct yet frequently under-recognised mechanism of burn injury in both adult and paediatric populations. These injuries are commonly underestimated at initial assessment, leading to delayed specialist referral and suboptimal management. The rapid uptake of electric bicycles and scooters has introduced higher-energy mechanisms and evolving risk profiles for friction-related injury. This study aims to characterise contemporary patterns of friction burns and examines emerging trends associated with electric micromobility. METHODS A retrospective cohort study was conducted of patients presenting with friction burns to Western Australia's State Adult Burn Unit and State Trauma Unit between January 2021 and January 2026. Data collected included demographics, injury mechanism, total body surface area (TBSA), burn depth, anatomical distribution, operative management, referral pathways, and outcomes. RESULTS A total of 87 patients were identified. Burns commonly resulted from wheeled recreational and road-related mechanisms, predominantly affecting the lower limbs and upper extremities. Although median TBSA was modest (5%), a substantial proportion sustained deep dermal or full-thickness injury requiring operative intervention. Electric bikes and scooters accounted for an increasing proportion of injuries, with higher travel velocities and road-surface contact associated with increased burn depth and operative requirements. Under-recognition and delayed referral to specialist burn services remained common. Long-term follow-up demonstrated ongoing morbidity, including hypertrophic scarring and psychosocial distress. CONCLUSION Friction burns remain an under-recognised and underestimated injury despite often limited TBSA. The expanding use of electric micromobility devices appears to be contributing to increasing injury incidence and severity. Improved early recognition, timely referral to specialist services, and targeted prevention strategies are essential to reduce long-term physical and psychosocial sequelae.

5:00 pm
Negative pressure wound Therapy in acute paediatric hand and foot burns: A Randomised Control Trial
Dr Emma Lumsden
Paediatric hand and foot burns are common with secondary scar formation and contracture formation implicating growth and development. Negative Pressure Wound Therapy (NPWT) has been introduced in acute paediatric burn care to decrease the time to re-epithelialisation and therefore scar formation probability. However, there is a perception that NPWT may not be feasible in hand and foot burns resulting in these areas being omitted. The aim of this study was to assess if NPWT use on paediatric hand and foot burns is feasible. Method This single centre, two arm parallel-group, pilot randomised control trial was conducted at a quaternary paediatric burn's unit in Queensland, Australia from April 2022 to June 2023. Hand and/or foot burns in children <16 years of age were randomised to one of two groups: Mepitel® (silicone) and Acticoat™ (silver nanocrystalline) or Mepitel®, Acticoat™ and NPWT (RENASYS Touch). The primary objective was trial feasibility defined as recruitment, treatment, data collection and study completion. The feasibility, complications and effectiveness of NPWT use on paediatric hand and foot burns was also assessed. Results Thirty-two participants were randomised. The screening percentage was 4.7%. This study met all trial feasibility parameters. There was no difference in clinician or familial perception of implementation feasibility between the two groups. 93.3% of participants stated they would use it again. Mepitel®, Acticoat™ and NPWT had significantly more issues with dressings lifting compared to Mepitel® and Acticoat™ (p=0.05, mean difference 26.7% 95% CI 2.5 – 50.9) however there was no difference in overall issues (p=0.1, mean difference 27.5% 95% CI -4.1 – 59.1). Conclusion This was a feasible trial with no difference in clinician or familial perception of NPWT implementation being demonstrated between the two groups. Concern regarding NPWT burden in paediatric hand and foot burns should therefore not be a barrier to implementation.

5:10 pm
Impact of Temperature Management Practices and Time in Hypothermia on Mortality in Patients with Severe Burns
Dr Elisha Purcell
Purpose: It is well documented that patients with severe burns are at increased risk of developing hypothermia. However, the time in hypothermia of severe burn patients and the impact of temperature management practices during resuscitation of patients is poorly characterised. This study aimed to investigate factors associated with time in hypothermia of severe burn patients during the first 24-hour resuscitation period and the relationship of time in hypothermia with hospital mortality. Methodology: A 5-year retrospective cohort study was conducted of adult patients (>18 years of age) with severe burns (>20%

total body surface area, TBSA) admitted to a burns service hospital. Data was extracted using the Burns Registry of Australia and New Zealand and supplemented with electronic medical records. Hypothermia was defined as a body temperature <36.0°C. Variables investigated included patient demographics, injury characteristics, surgery within 24 hours, frequency of temperature recordings and use of warming devices. Results: 142 patients were eligible and included in analysis. In the first 24 hours since presentation to hospital, 108 patients developed hypothermia and the median time in hypothermia was 315.5 minutes (IQR 23-559). Patients who experienced a longer time in hypothermia were associated with a higher TBSA% burnt ($p < 0.001$), inhalation injury ($p < 0.001$), non-accidental intent ($p = 0.019$), use of forced-air warming blankets ($p = 0.021$) and infusion of warmed fluids ($p = 0.025$). Time in hypothermia was significantly associated with hospital mortality (OR 1.002; 95%CI:1.001-1.004; $p < 0.001$). Conclusion: Hypothermia was commonly observed among patients with severe burns and significantly associated with hospital mortality. Frequent observations of temperature and use of warming devices were not associated with lower time in hypothermia, although use was most likely reactive. Protocolised monitoring of temperature and warming strategies is indicated.

5:20 pm
From Telehealth to Theatre: Surgical Outcomes Following Virtual Burns Assessment in Regional and Rural Australia
Dr Andrew Robertson
Background: Specialist burns telehealth services are increasingly used to support regional and rural centres; however, limited data describe outcomes for patients initially managed via telehealth who subsequently require operative intervention. This study evaluates surgical timing and outcomes following telehealth referral to a tertiary burns unit, benchmarked against national standards. Methods: A retrospective review was performed of all patients referred via a specialist burns telehealth service who subsequently underwent operative burn management during 2024–2025. Demographics, burn characteristics, timing metrics, operative details, length of stay (LOS), and complications were collected. Outcomes were compared with published Australian and New Zealand Burns Registry (BRANZ) benchmarks where applicable. Results: Forty patients were included (23 in 2024; 17 in 2025). Median burn size was 2.0% TBSA (range 0.1–7.0%). Median time from injury to initial telehealth consultation was 4 days (range 1–42). Median time from telehealth review to surgery was 8 days (range 1–49), with a median time from injury to surgery of 13 days (range 3–60). Median hospital LOS was 8.5 days (range 1–47). The overall complication rate was 15% (6/40), including three patients requiring intravenous antibiotics, one case of Biodegradable Temporising Matrix loss, and two patients requiring regrafting during the index admission. There were no unplanned ICU admissions or mortalities. Surgical timing and LOS were comparable to BRANZ-reported outcomes for small-to-moderate TBSA burns managed operatively. Conclusion: Burns telehealth effectively identifies patients requiring operative management while maintaining acceptable surgical timing and outcomes consistent with national benchmarks. These findings support telehealth as a safe and efficient triage pathway for surgical burns care and highlight its role in improving access to specialist services for regional and rural populations.

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02 May 2026

5:00 pm - 5:30 pm
Endocrine Section Business Meeting

Business Meeting - Endocrine Surgery - Meeting Room M2

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02 May 2026

5:30 pm - 6:30 pm
RACS Annual General Meeting

Business Meeting - *Cross Discipline* - Riverside Theatre

02 May 2026

7:00 pm - 10:30 pm
Congress Dinner (Ticketed Event)

Official Function - *Cross Discipline* - Bellevue Ballroom 1

03 May 2026

7:00 am - 8:20 am
COLORECTAL SURGERY - FREE PAPERS

Scientific Session - Colorectal Surgery - Meeting Room M6

7:00 am
Perioperative Changes in Neutrophil-to-Lymphocyte Ratio Predict Prolonged Postoperative Ileus After Right Hemicolectomy
Dr Harsh Patel

7:08 am
Incorporation of Post-Discharge Care Plan into an Ongoing Successful Surgical Prehabilitation System – from a Quality Improvement and Implementation Science Perspective.
Ms Leticia Wong
Background: Malnutrition is associated with long-term complications such as functional decline and morbidity. However, there are no standardized local guidelines on nutritional care post-discharge. This study aims to evaluate the implementation of SUPREME-PLuS, a nurse-led quality improvement project which was developed to improve the hospital-to-home transition. It comprises checklists, patient education and post-discharge follow-up calls. Methodology: A single institution prospective cohort study was performed. All adult patients who undergone elective colorectal surgeries were included. Day surgeries and emergency surgeries were excluded. A mixed-methods approach was utilised to evaluate the implementation of SUPREME-PLuS in accordance with the RE-AIM framework. Qualitative analysis comprised interviews conducted in a semi-structured format. Subsequently, a thematic analysis was performed based on the Theoretical Domains Framework. Quantitative analysis was utilised to describe the baseline cohort characteristics and perform statistical analyses of pre- and post-intervention outcomes. Results: Among 101 patients with a mean age of 68.1 ± 10.4, there was a statistically significant increase in the nutritional assessment scores ($p<0.05$) and confidence in self-management scores ($p<0.05$). The median EQ-5D-5L scores was maintained pre-operatively, with a slight decrease after the implementation of SUPREME-PLuS ($p=0.110$). The 30-day readmission rate decreased (9.0% vs 6.9%, $p=0.462$). Readmissions attributed to malnutrition declined as well (3.6% vs 0%, $p<0.05$). The main barriers to the execution of SUPREME-PLuS were manpower limitations, insufficient training, and separate workflows leading to inconsistent implementation. Accordingly, regular knowledge reinforcements by the QI team helped to address such problems. Conclusion: SUPREME-PLuS is a cost-effective intervention which mitigates the risks of malnutrition and reduces readmission rates. Sustainability can be improved by leveraging technology to simplify operational workflows.

7:16 am
Sexual Health Communication in Early-Onset Colorectal Cancer: Patterns, Gaps, and Barriers
Dr Oliver Waddell
Background: Sexual dysfunction is a prevalent and distressing side effect of colorectal cancer treatment, particularly among early-onset colorectal cancer (EOCRC) patients. However, discussions around sexual health are often neglected, especially for women. This study aimed to investigate patterns of sexual health communication and to identify perceived barriers from both patient and provider perspectives. Methods: A retrospective survey was conducted involving 113 EOCRC survivors and 64 healthcare providers (surgeons, trainees, and nurse specialists) in Aotearoa New Zealand. Questionnaires assessed recall of sexual health

discussions, perceived adequacy of information, communication preferences, and perceived barriers to raising sexual health concerns. Results: Only 30.3% of patients recalled receiving adequate information about sexual health impacts during treatment, and 21.6% during follow-up. Women were significantly less likely than men to report receiving information (p<0.001). Most patients preferred that healthcare providers initiate discussions, yet only 22.2% and 12.5% of providers reported routinely doing so during treatment and follow-up, respectively. Consultant surgeons were more likely to raise the topic than trainees (p<0.001). Key barriers included time constraints, concerns about offending patients, and the presence of family. Patients indicated a preference for receiving information via multiple modalities. Conclusions: Communication about sexual health in EOCRC care is inconsistent and frequently inadequate, particularly for women. Patients report a preference for clinicians to initiate discussions about sexual health, yet many providers cite limited confidence, training, or time as barriers. Enhanced clinician education, routine inclusion of sexual health in consultations, provision of both verbal and written information, use of pre-appointment questionnaires, and routinely asking family members to step out at the conclusion of consultations represent pragmatic, low-cost strategies to improve sexual health communication

7:24 am
Long-term bowel, bladder and sexual function following anterior resection compared with right hemicolectomy: a patient-reported outcomes study
Dr Shanmugam S Somasundaram
Purpose Anterior resection (AR) is associated with postoperative bowel dysfunction, but long-term data on bowel, bladder and sexual function following AR versus right hemicolectomy (RH) are limited. This study compared long-term functional outcomes and health-related quality of life(HRQoL) between patients undergoing AR and RH using validated questionnaires. Methodology A prospective cohort study was conducted at a tertiary referral centre, including consecutive patients who underwent AR or RH for colorectal adenocarcinoma between 2015 and 2024. All patients alive and without a stoma completed a postal questionnaire in 2025. Bowel function was assessed using the Low Anterior Resection Syndrome(LARS), St Mark's incontinence, Altomare obstructed defaecation syndrome(ODS) and Wexner constipation scores. Bladder function was evaluated using sex-specific ICIQ-MLUTS and ICIQ-FLUTS questionnaires. Generic and cancer-specific quality of life were assessed using SF-36v2, EORTC QLQ-C30, and QLQ-CR29. Outcomes were compared using univariate and age-adjusted analyses. Results A total of 206 patients were included(133 AR, 73 RH).The AR group was younger(70.8 vs 77.8 years, p<0.001); and included fewer men(63.9% vs 72.2%, p=0.016). AR patients reported worse bowel outcomes, including higher prevalence of major LARS(28.6% vs 11.0%, p=0.002), higher St Mark's incontinence scores(p=0.002), and higher ODS scores p=0.006). Stool frequency and diarrhoea scores were worse following AR on EORTC QLQ-C30 and QLQ-CR29. Bladder function did not differ between groups. Female sexual function was lower following AR, while male sexual function was comparable. Overall HRQoL was similar, although RH patients reported greater bodily and abdominal pain. Conclusion AR is associated with greater long-term burden of bowel dysfunction and selected sexual function impairments compared with RH, despite similar HRQoL. This unique long-term comparison informs patient counselling and surgical decision-making.

7:32 am
Influence of Psychosocial and Clinical Factors on Quality of Life in Colorectal Cancer Survivors: A Cross-Sectional Study in Regional Australia
Dr Amelia Cooper
Purpose As survival following colorectal cancer (CRC) surgery improves, long-term health-related quality of life (HRQoL) has emerged as a critical outcome of surgical care. However, survivorship data from regional Australia remain limited despite known disparities in access to multidisciplinary services. This study evaluated HRQoL after CRC surgery in a regional population and identified clinical and psychosocial determinants of poor outcomes, with a focus on modifiable targets for collaborative survivorship care. Methodology A cross-sectional study was conducted of patients who underwent CRC resection at a regional Australian hospital between 2015 and 2022. Participants completed validated patient-reported outcome measures assessing HRQoL, anxiety, depression, fear of cancer recurrence, social support, optimism, health literacy, and spiritual wellbeing. Demographic, disease, and operative data were collected via retrospective chart review. HRQoL scores were compared with Australian population norms, and associations with explanatory variables were analysed. Results Forty-seven patients participated. Compared with population norms, patients reported significantly worse HRQoL across multiple functional and symptom domains. Clinically significant anxiety and fear of cancer recurrence were common. Psychosocial factors demonstrated the strongest and most consistent associations with HRQoL, exceeding the influence of surgical approach, complications, tumour stage, or time since surgery. Conclusion Long-term HRQoL following CRC surgery in regional Australia is predominantly shaped by psychosocial distress rather than operative factors alone. These findings highlight a critical gap in current surgical care and support the integration of routine psychosocial screening and multidisciplinary, collaborative survivorship pathways

within colorectal surgical services to improve outcomes for regional patients.

7:40 am
Local anaesthetic infiltration in rubber band ligation of haemorrhoids: three-arm, double-blind, multi-centre randomised controlled trial (PLATIPUS trial)
Dr Eleanor Watson
Purpose: Rubber band ligation (RBL) is the first-line non-operative procedure for internal haemorrhoidal disease. Pain is more common following RBL than alternative non-operative procedures, and there is currently no consensus around analgesic approach, with submucosal local anaesthetic injection (SLAI), pudendal nerve blocks (PNBs) and no locoregional anaesthesia used in practice. Evidence for SLAI use is limited and no studies have assessed the use of PNB in RBL. The aim of this study was to determine the relative effectiveness of SLAI and PNB in reducing pain following RBL. Methodology: A double-blinded randomised controlled trial was conducted across five hospitals. Patients undergoing RBL were randomised to receive SLAI (0.5% bupivacaine with adrenaline injected deep to the band), PNB (1% ropivacaine injected at the pudendal nerve using anatomic landmarks), or no locoregional anaesthesia (control). Primary outcomes were patient-reported pain scores on a 10-point Numeric Rating Scale at 30 minutes, 2 hours, 4 hours, 24 hours and 2 weeks following RBL. Secondary outcomes were post-procedural analgesia use, time-to-discharge, days until return to work, patient satisfaction and complications. Results: A total of 120 participants (42 control, 36 SLAI, 42 PNB) were included. Median pain scores in intervention groups were significantly lower than the control group at 30 minutes, 2 hours (SLAI) and 4 hours. Median pain scores (IQR) in control, SLAI and PNB groups, respectively, were: at 30 minutes, 4 (1-5), 0.5 (0-2.75) and 1.5 (0-4.25), p= 0.004; at 2 hours, 2 (0-4), 0 (0-2) and 0 (0-4), p=0.035; and at 4 hours, 1 (0-3), 0 (0-1) and 0 (0-2), p=0.005. At 24 hours and 2 weeks, median pain score in all groups was 0. There were no significant differences in secondary outcomes between treatment groups. Conclusion: Following RBL, SLAI and PNB reduce pain in the early post-operative period. There was no difference in the effectiveness of SLAI and PNB at any timepoint.

7:48 am
Outcomes after robotic TAMIS (R-TAMIS) – lessons learnt from the first 10
Dr Sarah Johnston
Purpose The use of robotic platforms for transanal resection (R-TAMIS) of rectal polyps and early malignancies is an increasingly utilised alternative to the conventional laparoscopic approach. Our robotic group wished to analyse surgical and oncological outcomes for our first ten R-TAMIS cases using the Da Vinci platform. Methods Data on consecutive R-TAMIS procedures over a 24-month period were prospectively collected and analysed. Post-operative rooms and clinic follow-up letters were also analysed to identify long-term complications. Results 10 patients (1:1 M/F), mean age 63.5 (51- 74) and mean BMI of 32.4 (22.8 – 44.5) underwent R-TAMIS using the Da Vinci Xi device. All cases were performed using the GelPOINT Path Platform. Two R-TAMIS were successfully performed by an ANZTBCRS fellow, utilising a dual-console system. Mean console time was 141 minutes (28 - 263). Resected lesions were a mean distance of 8 cm (6 -13) from the anal verge, and a mean of 51.7cm (15 – 95) in size. Five patients were demonstrated to have at least T1 adenocarcinoma, with the remainder having dysplastic lesions. Two patients failed to have their procedures completed with R-TAMIS, due to inaccurate pre-operative MRI staging, and two underwent subsequent successful completion laparoscopic low-anterior resection (LAR). One patient was found to have a dysplastic lesion only and avoided LAR after being diagnosed with invasive malignancy on preoperative biopsy. Two patients had reported complications (urinary retention and temporary faecal incontinence), and two had delayed discharges due to mobility issues. Conclusion Whilst R-TAMIS appears to be a viable and safe alternative to laparoscopic TAMIS and more invasive surgery for early rectal tumours, successful outcomes depend heavily on accurate pre-operative staging and ideally MDT discussion. It appears that R-TAMIS can also be taught safely to training fellows using appropriate teaching platforms.

7:56 am
How should we follow-up after Pelvic Exenteration? A systematic review and global survey of PelvEx surgeons on oncological and functional surveillance.
Dr Adrian Siu
Purpose: Surveillance following curative-intent oncological surgery aims to detect early recurrence while managing functional sequelae. For most malignancies, follow-up is guideline-based and delivered through MDT. However, in the context of radical or re-operative surgery such as pelvic exenteration (PE), robust procedure-specific surveillance guidance is lacking. This study aimed to evaluate the literature and characterise PelvEx surgeons' perspectives on oncological and functional surveillance. Methodology: A literature search (Jan 00–Dec 24) identified studies reporting oncological and/or functional follow-up after PE. Data extracted included follow-up frequency and modality. A cross-sectional, questionnaire-based survey was disseminated via PelvEx – an international collaborative of PE specialists (Nov 24–Jul 25). Surgical

demographics and experience were collected, and descriptive analyses summarised practice patterns. Results: Forty-two studies were included (39 cohort; 3 non-original). Oncological follow-up, described in 28 studies, recommended clinic visits every 3–4 months for 2–3 years, then annual review after 5 years. Frequencies of tumour markers, imaging, and endoscopies varied widely. Functional follow-up was addressed in 19 studies (often using EORTC QLQ-C30 and SF-36), but approaches were inconsistent. The survey received 176 responses from 32 countries (46% completion). Respondents were colorectal surgeons (71%) or surgical oncologist (21%), with median experience 14 years (IQR 8-20) and PE volume 15 cases/year (IQR 10-25). For surveillance, most reported outpatient review (91%), CEA (88%), CT (96%), and endoscopy (85%). Functional follow-up was less standardised, 50% of surgeons reviewed them outpatient, or 16% referred to other specialists. Conclusion: Both the literature and surgeon practice demonstrate marked heterogeneity – especially for functional follow-up – supporting development of consensus-based, MDT pathways after PE. Future studies should consider patient priorities and cost-effectiveness to guide collaborative standardisation.

8:04 am
Unplanned Hospital Returns After Colorectal Cancer Surgery: Predictors, Patient Experience, and Prevention in Te Tai Tokerau, Northland, Aotearoa New Zealand
Dr Scott McLaughlin
Background: Unplanned hospital returns (UHRs), including readmissions and emergency department re-presentations, are common after colorectal cancer (CRC) surgery. Aotearoa New Zealand reports UHR rates at the upper end of international benchmarks, yet drivers remain poorly defined. Methods: This thesis used a mixed-methods design. A systematic review examined interventions investigated to reduce UHRs. A ten-year retrospective cohort study analysed UHR incidence, timing, causes, and predictors. Semi-structured qualitative interviews explored patient and whānau experiences of recovery. Findings were integrated to inform risk stratification and intervention design. Results: Among 801 patients, 17% experienced a UHR within 30 days, rising to 29% by 90 days. Most returns were inpatient readmissions, driven predominantly by complications including wound infection, stoma dysfunction, and ileus, as well as chemotherapy-related effects. Over 70% of returns were due to new issues, rather than complications recognised before discharge. Independent predictors included postoperative complications, stoma formation, and comorbidity. Qualitative analysis identified five themes influencing return behaviour: symptom uncertainty, unrealistic recovery expectations, disengagement with discharge information, reliance on whānau and community support, and difficulty accessing timely post-discharge care. A UHR Risk Score demonstrated effective stratification, with a four- to five-fold gradient in return risk. Conclusions: UHRs following CRC surgery in Te Tai Tokerau are frequent, multifactorial, and shaped by both clinical and psychosocial factors. Reducing preventable returns requires a bundled approach addressing peri-operative risk, discharge readiness, and post-discharge access. This thesis proposes the ReRAS (Reduction in Returns After Surgery) bundle as a pragmatic, context-appropriate strategy, with future work focused on prospective evaluation and external validation.

7:00 am - 8:20 am
MASTERCLASS (MC06): BRIDGING THE GAP, TRAINING SURGEONS FOR THE COMMUNITY (TICKETED EVENT)

Masterclass - Surgical Education, Rural Surgery - Meeting Room M2

7:00 am
Training Rural and RUFUS surgeons: The RACS rural professional skills curriculum and eLearning course
Dr Bridget Clancy

7:15 am
Rural Choices - a trainee and young surgeon's experience
Dr Jessie Cole

7:30 am
Rufus - the best of the city in the country
Dr Richard Bradbury

7:45 am
National Collaboration to train medical specialists for regional, rural and remote communities
Associate Professor Kerin Fielding

8:00 am
Questions and Answers

7:00 am - 9:00 am
Thoracic surgery with a focus on robotic surgery

Scientific Session - Cardiothoracic Surgery - Meeting Room M1

7:00 am
Robotic surgery in the neo-adjuvant era
Dr Steve Barnett

7:30 am
Robotic segmentectomy
Dr Ilies Bouabdallah

8:00 am
Oncology updates – what's on the horizon?
Dr Lydia Warburton

8:20 am
Assessment of response in the neoadjuvant era and identifying high risk lesions - implications for surgical decision making
Dr Ilies Bouabdallah

8:40 am
Panel Discussion: Neoadjuvant OR not?
Dr Steve Barnett, Dr Lydia Warburton, Dr James Edelman

7:00 am - 8:20 am
WOMEN IN SURGERY BREAKFAST AND ANNUAL BUSINESS MEETING (TICKETED EVENT)

Breakfast Session - Women in Surgery - River View Room 4

7:00 am
Annual Business Meeting
Dr Pecky De Silva

7:45 am
Women in Surgery - Closing the Gaps
Dr Clare McNaught

8:15 am
Group Photo

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03 May 2026

8:30 am - 9:00 am
The President's Lecture - Professor Brendan Murphy AC (Melbourne,VIC)

Plenary Session - *Cross Discipline* - Riverside Theatre

8:30 am
Introduction

Professor Owen Ung

8:35 am
Medical Colleges - Become Broader Health system Leaders or Face Oblivion
Professor Brendan Murphy

8:55 am
Acknowledgements
Professor Owen Ung

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03 May 2026

9:00 am - 10:00 am
Closing Plenary Session: Approaching 100 Years, What is RACS' future?

Plenary Session - *Cross Discipline* - Riverside Theatre

9:00 am
Sustaining our specialist workforce (Justin Untersteiner, CEO AHPRA)
Mr Justin Untersteiner

9:15 am
Regulation or Restriction? A Medical Council Perspective on Surgery - Dr Rachelle Love (Chair, Medical Council Aotearoa, New Zealand)
Dr Rachelle Love

9:30 am
Panel Discussion
Professor Brendan Murphy, Mr Justin Untersteiner, Dr Rachelle Love, Dr Philip Morreau, Professor Owen Ung

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03 May 2026

10:00 am - 10:30 am
Morning Tea - Sunday

Catering - *Cross Discipline* - Pavillion 1

10:00 am - 12:00 pm
Thoracic surgery: Anatomical segmentectomy under the spotlight

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Scientific Session - Cardiothoracic Surgery - Meeting Room M1

10:00 am
Planning for anatomical segmentectomies with emphasis on adequate margins
Dr Ilies Bouabdallah

10:25 am
Localising lesions for complex segmentectomy or GGOs
Dr Josh Goldblatt

10:50 am

Complex basal segmentectomies: Planning and practical considerations
Dr Jazmin Eckhaus

11:15 am
Correlation between CT size and solid compononent and final pathology in an Australian cohort of 200 pts undergoing segmentectomy
Dr Steve Barnett

11:40 am
Panel Discussion: Segment or Lobe
Dr Jazmin Eckhaus, Dr Steve Barnett, Dr Josh Goldblatt

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03 May 2026

10:30 am - 12:30 pm
Arthroplasty and Free Papers

Scientific Session - Orthopaedic Surgery - Meeting Room M9

10:30 am
Constraint + stem options for revision hip and knee arthroplasty
Dr Nicholas Calvert

10:50 am
Unicompartmental knee arthroplasty outcomes
Dr Simon Smith

11:10 am
Distal Radioulnar Joint Instability: Anatomy Of TFC Tears
Dr Jeff Ecker
Purpose The development of dry arthroscopic examination of the distal radioulnar joint (DRUJ) has changed our understanding of the anatomy of triangular fibrocartilage (TFC) tears. This paper aims to improve understanding of the anatomy and prevalence of TFC tears associated with DRUJ instability. Methodology A retrospective audit was conducted on all patients with symptomatic DRUJ instability who underwent dry arthroscopy of the wrist and DRUJ performed by the primary author over 12 months in 2020. Patients who did not have a tear of the TFC identified at arthroscopy or who exhibited signs of ulnocarpal impaction were excluded from the study. A description of the anatomy of the TFC tear and the result of the hook test was documented for all patients. Results A TFC tear was identified in 107 patients. All patients had a peripheral tear of the TFC. A partial tear of the foveal ligament was identified in 11 patients (10.3%) and a complete tear of the foveal ligament in 2 patients (1.9%). 2 patients had a complex tear of the TFC including a horizontal shear tear and a volar tear which extended into the lunotriquetral joint. Conclusion Dry arthroscopy of the RCJ and DRUJ is necessary to accurately evaluate the integrity of the foveal ligament. This study revealed that all tears of the TFC associated with DRUJ instability have a peripheral component and with increasing severity the tear extends between the floor of the ECU sheath and the foveal ligament. In the most severe expression of the injury, the foveal ligament is damaged (10%) and rarely is the foveal ligament completely torn (2%). The ability to define the anatomy of the TFC tear will enable surgeons to perform anatomically specific repairs.

11:17 am
A systematic review and meta-analysis of the use of antibiotic-impregnated, bioresorbable, bone filler in the treatment of diabetic foot osteomyelitis
Dr Michael Na
Aims: Diabetic foot osteomyelitis (DFO) is the leading cause of non-traumatic limb amputation and is treated with a combination of wound care, antibiotics, and surgery. The use of antibiotic-impregnated bioresorbable bone filler (ARBF) for limb salvage in DFO compared to conventional treatment has not been systematically evaluated. This study conducted a comprehensive literature review and meta-analysis. Methods: MEDLINE, Embase, and CENTRAL were systematically searched for randomised controlled trials (RCTs) and observational studies. Quality was assessed using the Newcastle-Ottawa Risk of Bias Assessment

Tool. Outcomes meta-analysed include limb salvage and wound healing. Qualitative synthesis of literature was performed to assess patient mortality, re-intervention, recurrence of infection. Certainty of evidence was assessed using the GRADE (Grading of Recommendations Assessment, Development, and Evaluation) approach. Results: One RCT and 12 observational studies (860 participants) were identified. 3 studies were identified for meta-analysis with a control cohort. Risk of bias was low in most evaluated studies. ARBF may reduce the risk of major amputation (3 studies, 289 participants, RR 0.12, 0.03-0.41, I2 = 0; low certainty of evidence). ARBF treatment trended to improved wound healing but was not statistically significant (2 studies, 153 participants, RR 2.0, CI 95% 0.41 – 9.67, I2 = 96%; low certainty of evidence). Qualitative analysis (13 studies) identified a trend towards lower incidence of repeat intervention and lower risk of infection recurrence (11.8%, 8 studies, 476 participants). However, there was significant inconsistency in reporting. All-cause mortality for ARBF patients was 18.4% (7 studies, 434 participants). Conclusions: ARBF treatment of DFO, compared to conventional therapy, may lead to improved rates of limb salvage and wound healing. A high-quality RCT is necessary to confirm this conclusion due to a low certainty of evidence.

11:24 am
Is amputation inevitable? Nepean's ortho-vascular model for diabetic feet.
Dr Frances Lee
Background Diabetic foot infection (DFI) frequently occurs in the context of co-existing peripheral arterial disease, neuropathy and structural foot deformity, and is associated with high rates of amputation and mortality. Surgical management is multidisciplinary but often variably structured across orthopaedic and vascular services. Protocolised pathways have been proposed to standardise care delivery. Aims: To evaluate outcomes of a pulse-based, protocolised orthopaedic–vascular model for the management of DFI. Methods A retrospective cohort study was conducted of 269 patients undergoing operative management for DFI at a single tertiary centre (Jan 2020 to Jan 2022). Patients were triaged via a protocolised pathway according to pedal pulse status into orthopaedic or vascular care streams. Primary outcomes were 12-month all-cause mortality and major amputation. Secondary outcomes included operative burden, length of stay and readmission. Results Overall mortality was 11.9% and major amputation 5.9%. The protocolised model stratified patients into clinically distinct groups. Orthopaedic patients were younger with lower mortality (7.4%) and amputation (4.3%). Vascular patients were older and demonstrated higher mortality (23.9%) and amputation (7.5%). The combined cohort exhibited the highest treatment intensity, with greater operative burden (mean 3.92 procedures), length of stay (median 40 days) and readmission (51.3%). Conclusion A protocolised orthopaedic–vascular pathway provides a structured, multidisciplinary framework for the management of DFI and stratifies patients into clinically distinct groups. Outcome differences observed between pathways are consistent with underlying disease severity, while the combined pathway reflects the intensity of care required for complex limb salvage.

11:31 am
Comparing the Express versus Enhanced Workflow for Restoration of Hip Length and Combined Offset Using the MAKO Robotic Arm-Assisted Total Hip Arthroplasty
Dr Veronica Pajnic

11:38 am
Bariatric Surgery Prior to Hip and Knee Arthroplasty: A Systematic Review and Meta-Analysis of Postoperative Outcomes
Dr Mohammad Faraz

11:45 am
Transclavicular Approach to the Base of Coracoid: A Case Study
Dr Christian Joseph
Background: The optimal surgical approach to base of coracoid fractures (Eyres III-V, Ogawa I) remains a contentious topic for an exceedingly uncommon fracture pattern.(1) This is partly due to the anatomical restrictions interfering with the optimal insertion angles for screw fixation.(2) This article describes the first reported use of a novel transclavicular approach to the base of coracoid. Clinical Case: A male rugby player in his early twenties sustained a shoulder injury from a blow to the left shoulder. Subsequent X-ray and CT found an acute comminuted base of coracoid fracture with anteromedial displacement of the coracoid process, as well as a comminuted scapular body fracture with extension into the glenoid neck. 16 days post-injury, the patient underwent open reduction and internal fixation (ORIF) of the base of coracoid via an extended deltopectoral approach and crescenteric clavicular osteotomy. Sufficient space was created through release of soft tissues and dissection of the rotator interval. Anatomical reduction was confirmed with intraoperative imaging and the coracoid was fixated with partially threaded cannulated screws. Post-operatively, the patient was compliant with 6- weeks of restricted weight bearing in an abduction sling followed by rehabilitation. Conclusion: The transclavicular approach is a novel surgical technique allowing

for optimal ORIF of the base of coracoid under direct visualisation. This article illustrates a promising solution to this area of contention and warrants further comparative studies. References: 1.Pires RE, Giordano V, de Souza FSM, Labronici PJ. Current challenges and controversies in the management of scapular fractures: a review. Patient Saf Surg. 2021 Jan 6;15(1). 2. Trikt van, Dobbe G, J. C. E. Donders, Streekstra GJ, P. Kloen. The “coracoid tunnel view”: a simulation study for finding the optimal screw trajectory in coracoid base fracture fixation. Surg Radiol Anat. 2019 Jul 4;41(11):1337–43.

11:52 am
Injury Patterns, Management and Outcomes of Hemodynamically Unstable Pelvic Fractures at an Australian Level 1 Trauma Centre: A 10-Year Registry Analysis
Dr Luan Louw
Introduction/background: Pelvic ring injuries (PRI) in traumatic shock are associated with over 30% mortality even in high income countries’ mature trauma systems, but recent Australian data showed no haemorrhage related mortality in this group. We aimed to describe the epidemiology, management and outcomes of PRI with haemodynamic instability managed in a state’s only Level 1 adult trauma centre. Design: We conducted a retrospective cohort study of all trauma patients with major PRI (Abbreviated Injury Scale (AIS) > 3) and hemodynamic instability (defined as systolic blood pressure (SBP) <90 mmHg or a shock index (heart rate (HR)/SBP) > 0.7) presenting to the state adult trauma centre between 2013 and 2022. Data on demographics, injury patterns, management strategies, and outcomes were collected from the State Trauma Registry and hospital records. Results: Of 1369 patients with pelvic or acetabular fractures during the 10-year study period, 152 (11%) had major PRI with hemodynamic instability at presentation. Most were male (72%) with a median age of 35 years. Motor vehicle and motorbike crashes accounted for 52% of injuries. The median Injury Severity Score was 33. Massive transfusion protocols were activated in 45% of cases, while angioembolisation was utilised in 5.9%. Overall in-hospital mortality was 7.2% and mortality due to haemorrhage was 2% Conclusions: In our mature trauma system, hemodynamically unstable PRI patients’ low mortality is consistent with the recently reported outcomes of best performing centres.

11:59 am
Prospective multi-spectral analysis of joint fluid aspirates to establish a library of spectral signatures for the rapid diagnosis of septic and inflammatory arthritis - a SPECTRAL study (Spectral Profiles of Joint Effusions with Confirmed Test Results and Arthropathy Library)
Dr Vassili Papageorge
Background: Accurate diagnosis of native joint septic arthritis (NJSA) and Inflammatory arthropathies for appropriate and timely management. This study presents preliminary findings from the SPECTRAL Biobank evaluating spectroscopy as a rapid, objective method for differentiating NJSA from Pseudogout and Gout. Method: 1-2mL of joint fluid aspirates (JFAs) were collected following microbiological assessment from Northern Health Microbiology Laboratory. Samples were stored and analysed at the Northern Centre for Health Education Research laboratory. Patient demographic/clinical data, including diagnostic results of the JFAs, were recorded. JFAs were analysed utilising Fourier Transform Infrared and Ramen Spectroscopy, whereby each sample generated a unique spectral signature (~60 seconds). Spectroscopy is a non-destructive, chemically label-free, reproducible, and repeatable chemical analysis technology. Prior to analysis, the clinical and/or microbiological diagnosis was recorded for each sample for comparative analysis. Machine Learning Models of the Spectral Signatures were established utilising a) Unsupervised Cluster Analysis (CA) b) Principal Component Analysis (PCA) and c) Partial Least Squares Discriminant Analysis (PLS-DA). Results: More than 225 synovial fluid samples were collected between July 2024 and November 2025, with the following relevant confirmed diagnoses: 30 pseudogout, 41 gout, and 19 NJSA. Post spectral scanning; Machine Learning Models (CA, PCA and PLSDA) showed distinct grouping and clear delineation of Gout, Pseudogout, and Infection compared to one another. Thus, spectroscopic analysis of JFA may be used for rapid diagnostic classification of NJSA and inflammatory arthropathies with a confidence level of 95%. Specificity of NJSA, Pseudogout, and Gout were 98%, 95%, and 100% respectively, while sensitivity was 80%, 88%, and 75%. Conclusion: Spectroscopy shows great promise as an adjunct diagnostic tool, providing rapid and reliable differentiation of joint arthropathies.

10:30 am - 12:30 pm
Hepatobiliary/Pancreatic Emergencies

Scientific Session - Upper GI Surgery, General Surgery, HPB Surgery - Riverside Theatre

10:30 am
Management of Bariatric/ Complex Ulcer Perforations

Professor Michael Talbot

10:55 am
Updates in Management of Pancreatitis
Dr Mohammed Ballal

11:20 am
Management Updates for Duodenal Bleeds
Dr Marwan Idrees

11:45 am
Liver Abscesses - are they all really abscesses? What should I do about this increasingly common problem?
Dr Suresh Navadgi

12:10 pm
Discussion Panel
Professor Michael Talbot, Dr Mohammed Ballal, Dr Suresh Navadgi, Dr Marwan Idrees

10:30 am - 12:30 pm
Innovation in Ear Surgery and Indigenous Health

Scientific Session - Otolaryngology Head & Neck Surgery, Indigenous Health - Bellevue Ballroom 2

10:30 am
Remote Otology: rural WA vs. overseas humanitarian work
Dr Latif Kadhim

10:45 am
Controversies and challenges in Otology
Dr Aanand Acharya

11:00 am
Inner ear surgery for balance disorders
Dr Katherine Pollaers

11:15 am
External Independent Evaluation of a Collaborative Paediatric Aboriginal Ear Health Program - Engaging the Future
Prof Francis Lannigan
The Cockburn Aboriginal Ear Health Program is a collaboration between Cockburn Integrated Health, The Kids Research Institute Australia (TKRI), Moorditj Koort Aboriginal Corporation, TSH, Hearing Australia, Child and Adolescent Health Service, St John of God Health Care (Murdoch and Midland), South Metropolitan Health Service, Rockingham Hospital, Midvale Hub, Oseca Health, Prof Francis Lannigan, A/Prof George Sim, Dr Travis Leahy, Dr Phillip Sale, and Dr Aaron Esmaili to provide timely and culturally secure access to specialist care for Aboriginal children with middle ear disease. The program was initiated following research undertaken by TKRI through the Djaalinj Waakinj Urban Aboriginal Ear Health Program and the recognition that while there was a significant level of middle ear disease identified in the Aboriginal population, there were deficiencies in the service provision available resulting in a range of sequalae that have lifelong consequences for this population group. In consultation with Moorditj Koort Aboriginal Corporation and the Aboriginal Community Advisory Group which guided the Djaalinj Waakinj Program, a service model was put in place that brought together a range of service providers to establish an integrated service to meet community needs. The model includes access to specialist Ear Nose and Throat services, audiology, and surgical care where necessary, along with the cultural and practical support necessary to make the program a success. We present what we believe to be the first external, independent evaluation of such a program from Dr Frank Baughman, School of Population Health, Curtin University. The outcomes of the evaluation have been used to implement further service improvements. The success of the program is testament to the commitment of all service providers and surgeons involved to improve the health and wellbeing of the Aboriginal population.

11:30 am

Patterns of otitis media and hearing loss in the East Kimberley outreach specialist clinics - results of a new data collection initiative
Dr Adibah Azimuddin, Dr Adibah Azimuddin

11:45 am
DrumBeat.ai - an AI algorithm to address ear disease in rural and remote Indigenous children
Assoc Prof Narinder Singh

12:00 pm
Cochlear implantation in Indigenous Australians: Systematic review reveals critical evidence gaps
Dr Mark Laidlaw
Aims: To report utilisation rates and available audiological outcomes among Australian Indigenous cochlear implant (CI) recipients, and identify access barriers to CI and hearing rehabilitation. Method: Systematic search of Medline, Web of Science, Embase, CINAHL and grey literature (September 2025) yielded 855 records. Studies reporting utilisation, outcomes, complications, and follow-up/access to CI amongst Indigenous Australians were screened. Results: Only three studies met inclusion criteria; nine additional grey literature sources were identified. While a Western Australian paediatric CI cohorts showed Indigenous children comprised 3% of recipients (4/118), nationally, only 1.8% (145/8,200) of Indigenous hearing device users have CIs, despite 43% of Indigenous people aged 7+ having measured hearing loss. Critically, none of the included studies reported Indigenous-stratified CI outcomes. First hearing device fittings typically occur at 3–6 years in Indigenous children versus under 1 year in non-Indigenous children. Major access barriers identified included under-screening, geographic isolation from tertiary CI centres, fragmented care pathways, and concerns about cultural safety. The evidence suggests that barriers accumulate across the entire hearing-care continuum, rather than being confined to CI services. Adult Indigenous audiology services remain particularly underutilised despite high prevalence of hearing-related diseases. Conclusion: Indigenous-specific CI outcome data are essentially absent despite a documented substantial burden of severe and profound hearing loss in First Nations people. Indigenous-specific effectiveness evidence is needed to ensure equitable benefit of CI across all Australian population groups. Urgent priorities include Indigenous-led research, and data linkage to track outcomes. Strengthening ear-health services and routine screening is essential to ensure equitable CI access for Aboriginal and Torres Strait Islander peoples.

12:10 pm
Smartphone-assisted otoscopy for remote ENT assessment: implications for surgical access in rural Australia
Dr Isla Middleton
Introduction: Access to otolaryngology services in rural and remote Australia is limited by geography, workforce shortages, and prolonged waiting times for specialist review. Otoscopy is fundamental to the assessment of ear disease but is often limited by variable skill levels and limited access to specialist equipment in remote settings. Smartphone-assisted otoscopy has emerged as a potential tool to support remote assessment and telehealth models of care. Aim: To review the current evidence for smartphone-assisted otoscopy in remote ENT assessment and discuss its potential role in improving access to ENT surgical services in rural Australia. Methods: A narrative review of the literature was performed, focusing on studies evaluating smartphone-compatible otoscopes used in community, primary care, and remote settings. Outcomes of interest included diagnostic accuracy, feasibility for remote assessment, impact on referral pathways, and integration with telehealth services. Results: Smartphone-assisted otoscopy enables acquisition and transfer of high-quality otoscopy images from non-specialist settings, facilitating remote specialist review. Studies demonstrate improved diagnostic confidence and referral quality for common otological conditions, including otitis media and tympanic membrane pathology. These systems have been successfully integrated into telehealth pathways, supporting earlier identification of patients requiring surgical assessment. Discussion: Deployment of smartphone-assisted otoscopes in rural Australia may improve ENT service delivery by enabling remote assessment, optimising referral prioritisation, and reducing unnecessary patient travel. Challenges include device cost, training requirements, image quality variability, data governance, and medicolegal considerations. Conclusion: Smartphone-assisted otoscopy represents a practical adjunct for improving access to ENT assessment and surgical care in rural and remote Australia. Further evaluation of implementation models within the Australian healthcare system is warranted.

12:20 pm
Multimodal Artificial Intelligence (AI) for Otoscopic Diagnosis: Combining Otoscopic images with Tympanometry and Audiometry to Classify Middle Ear Disease
Dr Tony Lian
Purpose: Artificial intelligence (AI) image classification models can detect paediatric middle ear disease from otoscopic images. However, they are limited by the inability to interpret complementary

tympanometry and audiometry. A fusion model, combining large language model (LLM) clinical data interpretation with image classification, can fill this gap and provide a more comprehensive diagnostic tool. Methodology: Otoscopic images, tympanometry and audiogram results were collected prospectively by nursing staff as part of routine primary care assessments. A cohort of 80 encounters was analysed. Tympanometry and audiograms were processed by four LLMs (GPT-4, Claude 3.5 Sonnet, Grok-4, DeepSeek), each paired with an otoscopic image-only classification algorithm, to establish a multi-modal fusion model. Diagnostic outputs from each LLM–image system were generated and compared against ground truth, defined by a panel of 13 otolaryngologists, for the multi-classification of normal, acute otitis media, otitis media with effusion, and chronic otitis media. Results: The image-only classifier achieved accuracy of 87.3%, AUC=0.959, and κ=0.83. When combined with LLMs, overall diagnostic performance improved across hybrid configurations. The top fusion model (with GPT-4) reached 92.6% accuracy (AUC=0.962, κ=0.90), followed by Claude 3.5 Sonnet (accuracy=92.5%, AUC=0.963, κ=0.90), AI Grok-4 (accuracy=92.4%, AUC=0.963, κ=0.90), and DeepSeek V2 (accuracy=88.9%, AUC=0.955, κ=0.85). All four hybrid fusion models showed significantly higher diagnostic accuracy and inter-rater agreement than the image-only classifier ($p<0.05$ for all comparisons). Conclusion: Multi-modal integration of LLM-interpreted tympanometry and audiograms with otoscopic image classification significantly improves diagnostic performance in middle ear disease. This marks a major step towards AI systems reflecting real world clinical reasoning, synthesising multiple tiers of imaging and clinical data.

10:30 am - 11:00 am
KEYNOTE LECTURE - DR SHIVA AKBARDAZEH (MELBOURNE, AUSTRALIA)

Scientific Session - Burn Surgery - Meeting Room M3

10:30 am
A Novel Engineered skin to Treat Massive Burns: Early Phase Ib Clinical Trial Outcome
A/Prof Shiva Akbardazeh

10:30 am - 12:30 pm
PERIPHERAL NERVE / PLEXUS SURGERY

Scientific Session - Plastic & Reconstructive Surgery - River View Room 5

10:30 am
Nerve Transfers in Spinal Cord Injury
Dr Alex O'Beirne

10:50 am
Update in Brachial Plexus Surgery: Free Functional Muscle Transfer
A/Prof Scott Ferris

11:10 am
Recent advances in amputation surgery
A/Prof frank Bruscino-Raiola

11:30 am
Prosthetist approach to osseointegration
Dr David Lee Gow

11:45 am
Post sarcoma functional reconstruction
Assoc Prof Damien Grinsell

12:03 pm
Brain-derived neurotrophic factor-based therapies in peripheral nerve injury-a systematic review of animal studies
Dr Antoni Smolinski, Antoni Smoliński, Mr Antoni Smolinski
Peripheral nerve injuries (PNIs) remain a significant clinical problem, producing permanent motor-sensory

deficits and diminishing patient's quality of life. Neurotrophic growth factors, a family of biomolecules, support neuronal survival and regeneration. Among them, Brain-Derived Neurotrophic Factor (BDNF) emerged as a key modulator of neurogenesis and neuroregeneration within the peripheral nervous system. This systematic review evaluates and summarises animal-based evidence on BDNF-based therapies used in peripheral nerve injury (PNI). A literature search in PubMed, EMBASE, Scopus, and Web of Science with the latest results from 10th of October 2024 to identify animal-based studies evaluating the effects of BDNF-based therapies used in PNI. Of 785 records, 40 articles met the inclusion criteria, encompassing 1887 rats and 430 mice or rabbits across various injury models. Gathered studies heterogenicity precluded meta-analysis, but most reports showed superior axonal regeneration, myelination, and functional recovery in BDNF-based therapies compared to control groups. The benefits were most significant with multimodal strategies, including multiple neurotrophins and stem cells. Combined therapies involving multiple neurotrophic growth factors, BDNF, and stem cell therapies showed the most significant improvement in functional outcomes and histological parameters of injured nerves. These results suggest that BDNF-based therapies hold promise for effective PNI treatment.

12:10 pm
Radial nerve birth injury – a single tertiary centre 7.5 year experience & review of the literature
Dr Eric Dos Santos De Andrade
Purpose: The true incidence of radial nerve birth injury remains unknown due to presentation overlap with obstetric brachial plexus injury. These injuries may present with discrete clinical signs including palpable nodules or ecchymosis over the posterolateral arm and typically have favorable prognoses without surgical intervention. This study aimed to characterize patient presentations, recovery trajectories, and global management experiences for radial nerve birth injuries at a tertiary paediatric brachial plexus service. Methods: A retrospective single centre review of all patients with radial nerve birth injury between 2016 and 2024. Patients were identified from clinical coding as well as from clinic attendance. A literature review was conducted not limited by time or language. Results: Thirteen patients were identified with radial nerve birth injury with 14 affected limbs. Six (43%) affected limbs were right sided; eight (61.5%) were female. Median age at diagnosis by the specialist centre was 60 days (range 1-185 days). Four (29%) limbs had ecchymosis on the arm and five (36%) had a palpable nodule. Median time to recovery, as determined by a health care professional at the tertiary centre, was 162 days (90-824 days). All patients were offered physiotherapy; no child required surgery. A further 98 cases were identified from the global literature and only one patient required surgery, making an incomplete recovery. Conclusion: It is important to consider isolated radial nerve injuries when referring and assessing a child for obstetric brachial plexus injuries, particularly in the presence of ecchymosis or a palpable nodule on the posterolateral arm. Radial nerve birth injury has a good recovery trajectory by 6 months of age with physiotherapy alone. It is useful to ensure that all patients are assessed using a common evaluative tool, such as the Active Movement Scale, to ensure comparison between global work.

12:17 pm
Traumatic Upper Limb Amputation and Immediate Targeted Muscle Reinnervation: A Waikato Case Experience.
Dr Chelsea Allen-Brough
Background: Targeted muscle reinnervation (TMR) is a relatively new treatment for neuroma/phantom limb pain and for improving prosthetic functional outcomes. TMR uses coaptation of major peripheral nerves to recipient motor branches to expendable muscle targets.(1,2) This case demonstrates the first application of immediate TMR for acute upper limb amputation at Waikato Hospital. Case: We were presented with a 20-year-old otherwise well, male engineer. The patient suffered a farm machinery accident with multi-segmental crush/avulsion amputation of the non-dominant forearm. Within 3hours from time of injury, the patient was undergoing a multi-specialty team replantation of the limb. Unfortunately, on day 9 following replant, infection was noted. The limb was deemed non salvageable on day 11. Following multi-consultant review, a trans-humeral amputation to allow adequate stump closure and healing was chosen. Treatment/Outcome: The amputation was performed with immediate TMR. Via anterior approach the median nerve was transferred onto the nerve to short head of biceps and the ulnar nerve onto the nerve to brachialis. Via the posterior approach the radial nerve was transferred onto the branches to lateral head of triceps. The patient was discharged day 5 with minimal analgesia requirements. At the 2week follow-up the wound was well healed, without reports of neuroma/phantom limb pain. Conclusion: With established improved outcomes in pain and prosthetic use/function for patients and our positive case experience, we should consider immediate TMR for our patients undergoing upper limb amputation. References 1. Hagiga, A., Aly, M., Gumaa, M., etal. (2023). Targeted muscle reinnervation in managing post-amputation related pain: A systematic review and meta-analysis. Pain practice : the official journal of World Institute of Pain, 23(8), 922–932. 2. Le, E.L.H., Iorio, M.L. & Greyson, M.A. Targeted muscle reinnervation in upper extremity amputations. Eur J Orthop Surg Traumatol 34, 3717–3725 (2024).

10:30 am - 12:30 pm
RESEARCH PAPERS

Scientific Session - Trauma Surgery - Meeting Room M7

Includes The Damian McMahon Trauma Research Paper Prize The Free Papers session provides a platform for emerging and established researchers to showcase cutting-edge work in trauma surgery and related disciplines. It is the scientific heart of the Trauma Section program, encouraging rigorous scholarship, fostering debate, and highlighting the next generation of trauma leaders. The session incorporates the Damian McMahon Prize, the session both honours the legacy of a foundational trauma surgeon and inspires excellence in research and clinical practice.

10:30 am
Non-Emergent Thoracotomy in Older Adult Trauma Patients: How Old is Too Old?
Dr Arshin Ghaedi
Purpose: While resuscitative thoracotomy in trauma is well-studied, data on non-emergent thoracotomy—particularly in older adults—remain limited. This study evaluated whether age predicts outcomes following non-emergent thoracotomy in older trauma patients. Methodology: We conducted a 5-year retrospective analysis of the American College of Surgeons-Trauma Quality Improvement Program (2017-2021), including trauma patients aged ≥ 60 undergoing thoracotomy (excluding those performed in the ED or on direct OR transfer). Patients were grouped by age (60-69, 70-79, and 80-89). Primary outcomes were mortality, major complications, and prolonged ventilation (>7 days); secondary outcomes included hospital and ICU length of stay. Multivariable regression assessed age's independent effect on outcomes. Results: Among 3,673 older adult patients who underwent thoracotomy, 641 were non-emergent. Mean (SD) age was 70 (7) years, and 72% were male. Median [IQR] ISS and chest AIS were 12 [9-17] and 3 [2-4]. Median [IQR] time to thoracotomy was 51 [21-114] hours. Age distribution was 54% (60-69 years), 33% (70-79 years), and 13% (80-89 years), with no significant difference in ISS, chest AIS, or thoracotomy timing between groups. However, frailty was higher in the 80-89 group (p=0.002). Univariate analysis showed no differences in mortality (p=0.128), major complications (p=0.651), prolonged ventilation (p=0.358), hospital LOS (p=0.436), or ICU LOS (p=0.975). Multivariable analysis revealed no age-related association with mortality (aOR: 1.414, p=0.102), major complications (aOR: 0.850, p=0.284), or prolonged ventilation (aOR: 0.780, p=0.155). Conclusion: Nine in ten older adult trauma patients who underwent non-emergent thoracotomy survived to discharge. Increasing age did not predict adverse outcomes, indicating that non-emergent thoracotomy may remain appropriate in this population.

10:37 am
Outcomes in SSRF; Experience in a Level 1 Trauma Centre
Dr Cormac Mulhall
Purpose: To describe early and medium-term outcomes following SSRF implementation over 7 years in a level 1 trauma centre, as management of severe blunt chest wall trauma. Methodology: A retrospective review was conducted over the previous 7 years at Royal Perth Hospital SMTU. Patients were identified using theatre coding, and a variety of variables were collected via imaging, clinical notes and DMR. Collected variables included demographics, mechanism of injury, injury severity, chest wall morphology, timing and indications for fixation, ventilatory days post-fixation, tracheostomy, pulmonary and wound complications, mortality, and documented clinical or radiological short-term outcomes. Results: The cohort was comprised of patients with more than 10 rib fractures secondary to high-energy blunt force chest trauma following motor vehicle and motorbike crashes. Common indications for SSRF were chest wall deformity, clinical or radiological flail, or respiratory failure despite maximal conservative management. SSRF was carried out within 72 hours of arrival at RPH in most cases. Ventilatory duration post fixation varied from no requirement to prolonged courses requiring tracheostomy, commonly in the context of associated traumatic brain injury. Complications occurred in a substantial minority. Mortality reflected overall injury burden and treatment-limitation decisions rather than chest wall injury alone. Among patients with available follow-up, most demonstrated satisfactory healing and functional recovery. Conclusion: In this level 1 trauma centre, SSRF for severe blunt chest wall trauma was associated with acceptable complication rates, low procedure-related mortality and favourable functional outcomes, supporting its continued use within a structured protocol and providing a foundation for future comparative effectiveness studies.

10:44 am
Title: MRI after Normal CT in Symptomatic Blunt Trauma: High Yield, Conservative Management Changes, and Rare Operative Findings

Dr Katherine Szeliga

10:51 am
Chronic malaria is associated with trauma-related splenic rupture requiring splenectomy
Dr Putu Ayu Indra Santi Wardani
Purpose: Splenic rupture is a recognised complication of acute Plasmodium falciparum and P. vivax malaria, but the risk of splenic rupture in chronic asymptomatic infections is not known. In malaria-endemic regions, chronic parasitemia is common and associated with splenomegaly and structural changes that may reduce splenic integrity. Here, we assessed population level data to determine the association between chronic malaria and trauma-related splenic rupture requiring splenectomy. Methods: In Timika, Papua, Indonesia, we determined the proportion of individuals with asymptomatic peripheral parasitaemia by microscopy and polymerase chain reaction (PCR) in two complementary study cohorts aged ≥10 years. The first cohort, conducted between 2015-2021, comprised 33 patients undergoing trauma-related splenectomy at the local district hospital. The second cohort, conducted in 2013, comprised 1,807 participants in household survey of the general Timika population. Results: The prevalence of asymptomatic peripheral PCR-positive parasitaemia was 87.9% (29/33) in the splenectomised patients compared to 38.6% (697/1,807) in the general Timika population (adjusted Odds Ratio [aOR] = 10.0 [95%CI: 3.5-28.8], p<0.0001). The difference was greatest for chronic patent (microscopy-detectable) infections (aOR = 5.7 (95%CI: 2.8-11.7), and remained apparent when stratifying by infecting parasite species including for P. falciparum (aOR = 5.4 [95%CI: 2.5-11.9]) and P. vivax (aOR = 3.2 [95%CI: 1.2-8.6]). Conclusion: Patients undergoing trauma-related splenectomy are twice as likely to have chronic malaria than the general population, suggesting that chronic P. falciparum or P. vivax infection may predispose individuals to splenic rupture following trauma. Our findings point towards an additional consequence of chronic infection in endemic areas and adds to existing reasons to diagnose and treat chronic parasitemia, particularly in groups who are prone to trauma.

10:58 am
Assessment and management of blunt cerebrovascular injuries
Dr William Dunlop
Purpose: Blunt cerebrovascular injury (BCVI) is a potentially devastating complication of trauma that is detected by CT angiography (CTA), guided by the Denver criteria. Acute assessment and management are well defined. Longer-term follow-up practices remain inconsistent. This study examines decade-long trends in BCVI screening, incidence, management, and follow-up at a State Trauma Unit. Methods: A retrospective cohort study was performed using the Royal Perth Hospital State Trauma Unit registry. All adults ≥18 years admitted with major trauma between 1 January 2015 and 31 December 2024 were included. Patients who had CTA for suspected BCVI were identified. Demographics, CTA indication, BCVI grade, acute management, and follow-up were extracted. Incidence was reported per major trauma admission and per CTA performed. Outcomes included hospital mortality, length of stay, and discharge destination. Analyses were descriptive and univariate, with odds ratios and confidence intervals reported. Ethics approval was obtained. Results: There were 9,724 major trauma admissions, increasing from 920 in 2015 to 1,123 in 2024. The median age was 49 years (IQR=35) with male predominance (74.7%). Use of CTA increased from 18% of admissions in 2015 to 37% in 2024. CTA was commonly indicated by radiologic findings (75.5%), with 5.0% indicated by clinical findings, and 19.5% by a combination. BCVI per CTA decreased from 20% in 2015 to 10% in 2024; BCVI per admission was static at 4.2%. BCVI associated with higher mortality (OR=2.1, 95%CI=1.6-2.8), longer length of stay by 7.5 days (95%CI=5.1-9.9), and greater need for rehabilitation (OR=2.6, 95%CI=2.1-3.3). Conclusion: BCVI incidence was consistent over a decade, despite a two-fold increase in CTA use. BCVI associated with higher mortality and morbidity, likely reflecting overall injury severity, not independent causation. Follow-up was variable, providing opportunity to standardise longer-term management pathways for BCVI patients.

11:05 am
The Essential Role of Vascular Surgery in Trauma Care: A 15-Year Analysis from a Major Trauma Centre
Dr Phil Lu
Background: Vascular trauma is frequently immediately life-threatening and occurs in the setting of complex multisystem injury, where delays to definitive haemorrhage control or revascularisation markedly worsen outcomes, and therefore inter-hospital transfer is not feasible, underscoring the importance of an embedded vascular surgery service within a major trauma centre. This study examines the volume, acuity, and procedural scope of vascular trauma managed at Alfred Health, Victoria's highest-level trauma centre. Methods: All vascular surgical procedures performed at Alfred Health between 2010 and 2025 were retrospectively analysed. Trauma-related operations were identified and classified as non-iatrogenic or iatrogenic. Demographics, physiological status, anatomical distribution, and operative technique were examined. Results: Over the 15-year study period, 698 vascular operations were performed for trauma indications with non-iatrogenic trauma accounting for 358. Patients were predominantly male (78.8%) and

physiologically high-risk (64.5% ASA III–V). Vascular injury involved a broad anatomical distribution, including lower limb vasculature (12.0%), thoracic and thoracoabdominal aorta (11.3%), popliteal and femoral vessels (10.6%), subclavian and axillary vessels (8.7%), brachial and upper limb arteries (7.6%), and cervical vessels (6.5%). Operative management was heterogeneous, encompassing open repair (local repair 17.6%, ligation 8.7%, interposition grafting 7.0%, bypass 12.7%), endovascular intervention (stents and stent grafts 22.1%), hybrid procedures, fasciotomy (2.2%), and major amputation (3.1%). Conclusions: This 15-year experience demonstrates that vascular trauma represents a sustained, high-acuity workload requiring immediate access to comprehensive open, endovascular, and hybrid surgical capability. We demonstrate that an embedded vascular surgery service is indispensable for definitive trauma care and cannot be replaced by transfer-dependent models.

11:12 am
Abdominal and pelvic vascular trauma in Queensland: institutional experience at a level one trauma centre
Dr Madison Bowles
Background: Abdominal and pelvic vascular injuries are among the most lethal forms of trauma, associated with high morbidity and mortality. Despite advances in trauma care, data describing their epidemiology, management strategies, and outcomes remain limited, particularly within the Australian context. This study aims to characterise the epidemiological patterns of abdominal and pelvic vascular trauma presenting to Gold Coast University Hospital (GCUH) and compare these findings with national and international data. Methods: All patients presenting to GCUH between January 2014 and December 2019 with abdominal or pelvic vascular injuries were identified.A descriptive analysis of patient demographics, injury mechanisms, interventions, and outcomes was performed. Results: During the study period, 5,452 trauma admissions were recorded, of which 68 patients sustained abdominal or pelvic vascular injuries. Blunt trauma accounted for 53 cases (77.9%), while penetrating trauma accounted for 15 cases (22.1%). Most patients were male (n = 51, 75%). Interventions were required in 57 patients (83.8%), including open surgery in 28 cases (41.2%), endovascular intervention in 27 cases (39.7%), and combined approaches in 2 cases (2.9%). The most frequently injured vessels were the visceral arteries (51.9%) and iliac arteries (22.7%). Overall mortality was 8.8%, with all deaths occurring following blunt trauma. Conclusions: Abdominal and pelvic vascular injuries represent a small but highly severe subset of trauma, with mortality rates exceeding those of general trauma populations. Blunt mechanisms, particularly those related to road traffic accidents, predominate and account for all observed fatalities. These findings highlight the critical role of rapid diagnosis and access to both open and endovascular expertise in major trauma centres. Importantly, they also underscore the potential impact of motor vehicle safety initiatives and targeted injury prevention programmes in reducing their incidence in Australia.

11:19 am
Beware the fall from standing height: injury patterns and in-patient mortality related to common falls mechanisms and height
Dr Cambo Keng
Background Falls remain a significant cause of morbidity in the Australian trauma population. Data exists correlating injury severity with fall height, but our anecdotal observations have been that even with a fall from standing height (FFSH) the patterns and severity of injury have been surprising. We present a narrative study describing how injury patterns differ across major trauma patients suffering from different fall heights. Methods A retrospective study of 1587 major trauma patients admitted to the Royal Melbourne Hospital having sustained a fall from 01/03/20 to 31/12/23. These patients were categorised into FFSH, low ladder, roof height and greater heights to compare mortality and injury patterns. Results Overall males were more likely to be admitted with major injuries from a fall than females (71%, n = 1126), although 42% of FFSH were female. Head and neck injuries (AIS > 3) were most common in all heights but more so in FFSH. Thoracic injuries increased with height of fall. FFSH had the highest mortality rates with age > =65 having a larger impact on odds of mortality than fragility (age OR = 5.45, 95% CI: 2.74-10.83 vs CFS > =5 OR = 2.10, 95% CI: 1.48 – 2.98). Traumatic brain injury (TBI) was the most common cause of death in all falls (83%), but this was only a slight majority in FFSH with other causes approaching 48%. Conclusion Having an awareness of expected injury patterns in different groups of fall heights aids clinical assessment. Identifying at risk patient groups may assist with fall injury prevention initiatives.

11:26 am
Obesity Prediction by Trauma Initial Caregivers: The OPTIC Study
Dr Urja Joshi
Purpose: Obesity is associated with worse trauma outcomes and has been proposed as a modifier in trauma triage. Early identification, however, commonly relies on visual assessment. This study evaluates the accuracy of visual obesity classification and height and weight estimation by trauma care providers at first patient contact. Methods: This prospective observational study was conducted at a Level I trauma centre.

Paramedics, emergency department (ED) nurses, and ED physicians independently estimated patient height, weight, and obesity status on arrival. Measured anthropometric values served as the reference standard. Diagnostic performance metrics for obesity classification and estimation error metrics for height and weight were calculated. Results: One hundred and forty-three trauma patients were included (68.5% male; median age 44 years), with an obesity prevalence of 28.7%. Overall sensitivity for visual obesity classification was 80.2% and specificity was 89.8%, with no significant differences between professional groups. Height estimation was more accurate than weight estimation, but substantial inter-individual variability was observed for both parameters. Internal consistency between visual obesity classification and BMI derived from estimated height and weight was high (87.6%). Conclusion: Visual assessment of obesity in trauma patients demonstrates high specificity but only moderate sensitivity, resulting in a clinically relevant proportion of patients with obesity being missed. Given the variability of anthropometric estimation and the importance of early risk stratification, visual assessment alone appears insufficient for use as an independent trauma triage criterion, supporting the need for more objective methods of early obesity identification.

11:33 am

Peritoneal Violation in Stable Anterior Abdominal Stab Wounds: A 20-Year Review

Dr Ibraheem Rasheed

Introduction: Peritoneal violation as an indication for surgery in anterior abdominal stab wounds (SW) is known to be associated with significant non-therapeutic exploration, but remains a common practice. This study reviews our experience in a high resource but low penetrating injury volume centre in New Zealand. Materials and Methods: A retrospective study was conducted over a 20-year period from 2004-2024 and included all patients with anterior abdominal SWs treated at Auckland City Hospital. Results: A total of 182 patients were included. 98 (54%) proceeded directly to surgery due to haemodynamic instability, peritonitis, evisceration and / or high suspicion of intra-abdominal injury. The remaining 84 patients all underwent CT. 33 did not show evidence of peritoneal breach and the other 51 demonstrated peritoneal violation. Of the 51 patients who demonstrated peritoneal violation on CT, 28 (55%) had associated organ injury, and the remaining 23 (45%) demonstrated peritoneal violation alone. 49 of the 51 patients underwent surgery. 38 proceed to laparotomy, all of which were positive (28 therapeutic, 10 non-therapeutic). 5 underwent laparoscopy which required conversion to laparotomy, all 5 of which were positive (4 therapeutic and 1 non-therapeutic). 6 underwent laparoscopy that did not require conversion. 4 were positive (3 therapeutic and 1 non-therapeutic) and 2 were negative. Overall, 47 (96%) were positive for injury and the remaining 2 (4%) was negative. Of the 47 positive cases, 35 (74%) were considered therapeutic and the remaining 12 (26%) were non-therapeutic. The overall morbidity was 16% and the mortality was 0%. Conclusions: Peritoneal violation remains an indication for surgery, which not changed over the past decade and was associated with high rates of positive exploration. It would appear that this approach remains appropriate in our environment over the past two decades and is associated with significant non-therapeutic rate at surgery.

11:40 am

Tracheostomies in Trauma Patients

Dr Olivia Lin

Purpose Tracheostomies are used in trauma patients in the Intensive Care Unit (ICU) if intubation is likely to be prolonged to facilitate ventilator weaning and neurological or airway assessment. This paper investigates the impact of tracheostomies on ventilation duration and considers factors associated with prolonged ventilation or delayed decannulation. Methodology Patients who had a tracheostomy between July 2020 and July 2025 were identified from the Royal Melbourne Hospital Trauma Registry which captures all injury-related admissions. Data collected included demographics, injury severity, mechanical ventilation hours, length of stay, general and tracheostomy-specific complications. Analysis used $\chi 2$ and Fisher's test for categorical variables and the Mann Whitney U test for continuous ones. Results A total of 102 patients were included. Length of ICU stay was shorter in the early tracheostomy group (defined as tracheostomy 10 days or earlier from intubation) compared with the late group ($U = 524$, $Z = -4.92$, $p < .001$, $r = .49$). There was no difference when analysing total length of stay or complication rates. Obese patients required longer ventilation post tracheostomy compared with non-obese patients ($U=406$, $Z = -3.02$, $p = .003$, $r = .3$). Patients who developed pneumonia post tracheostomy took longer to decannulate ($U= 697$, $Z = -2.35$, $p = .02$, $r =.24$), as did those with major injures (ISS >15) compared with minor injuries ($U= 144$, $Z = -2.68$, $p =.01$, $r= .28$). Conclusion Earlier tracheostomies were associated with shorter stays in ICU but did not affect complication rates or total hospital stay. Obese patients required longer mechanical ventilation following tracheostomy, suggesting increased difficulty with ventilator weaning and highlighting a potential for early tracheostomy. Patients who developed pneumonia and those with more severe injuries took longer to decannulate and may also benefit from early tracheostomy.

11:47 am

Risk factors predicting the need for intervention in Grade III Splenic Injuries
Dr Wesley Tjang

11:54 am
Tourniquet Use in Major Trauma Patients Presenting to a Level 1 Trauma Centre in Western Australia, A Registry-based Retrospective Review
Dr Thomas Moore
Purpose: Tourniquets are life-saving in severe extremity haemorrhage, but prolonged application raises concerns regarding limb ischaemia. Western Australia's vast geography and single Level 1 trauma centre may result in extended prehospital tourniquet times. The purpose of this study was to examine patterns of prehospital tourniquet use, duration, and outcomes in major trauma patients. Methodology: A retrospective registry and chart review was performed of major trauma patients (ISS >12) with prehospital tourniquet application admitted to Royal Perth Hospital between 2013 and 2022. Demographics, injury characteristics, tourniquet duration (where documented), interventions, amputation, and mortality were analysed, including comparison between metropolitan and rural presentations. Results: Seventy-two patients (79 limbs) were included (85% male; mean age 37.4 years; mean ISS 25.8). Injuries occurred in metropolitan areas in 71% and rural areas in 29%; 35% were transported by air. Blunt trauma predominated (78%). Tourniquet duration was documented in 40 limbs, with a mean time of 3 h 25 min. Rural patients had significantly longer tourniquet times than metropolitan patients (4 h 28 min vs 2 h 40 min; p=0.044). Open fractures occurred in 77% of limbs. Amputation occurred in 43%, likely reflecting injury severity. Overall mortality was 20.8%, with haemorrhage contributing to over half of deaths. Conclusion: In this civilian cohort, prehospital tourniquet durations, particularly in rural Western Australia, were substantially longer than reported elsewhere. Despite prolonged application and high injury severity, outcomes are comparable with international experience, supporting tourniquet use in geographically dispersed trauma systems.

12:01 pm
Pulmonary thrombosis in major trauma patients: risk factors and outcomes in an Australian Major Trauma Centre
Dr Charles Coventry
Purpose Whilst the pathophysiology of Pulmonary Embolus (PE) in major trauma patients is well described, less is understood about those presenting with a Pulmonary Thrombus (PT) on initial trauma CT scan, though direct thoracic trauma has been implicated. This study aims to compare the proportions of accepted risk factors for venous thromboembolic disease in patients with PT events versus both later PE events and a control group. Methodology This is a retrospective review of prospectively-collated trauma database of a major trauma centre, including all patients who had a PE during their admission from 2014-2023. events were categorised into 'PE' diagnosed <24 hours from admission (PT group), 24-72hrs (intermediate PE) and those diagnosed >72 hours for admission (late PE). Variables included patient demographics, anticoagulation and VTE history, shock, Injury Severity Score (ISS) and the Abbreviated Injury Score (AIS) for thoracic and head injury, and mortality. Analysis was two-fold, firstly a comparison the frequencies of co-variates between PT and late PE groups (Fischer's exact & rank sum) and secondly, a case-control study where the PT group matched for age, gender, mechanism of injury and ISS with 3:1 with controls. Results 35 patients were included in the PT group and 129 patients in the late PE group. PT group patients were more likely to be female (37.3% vs 19.4%, p=0.02), however no other difference in age, mortality, ISS, thoracic or head AIS or admission details reached statistical significance. When compared to matched controls, the PT group were more likely to be smokers (OR 6.91 [1.63-33.65], p<0.05) and had a longer hospital length of stay (9.93 days vs 4.93, p<0.05) but no other differences reached statistical significance. Conclusion Trauma patients suffering a PT event are more likely to be female than later PE events, and smokers compared with controls. There was no evidence of an association with chest trauma in this series.

12:08 pm
Impact of Banning a Rideshare E-Scooter Program on ED Presentations in Perth: A Natural Experiment
Dr Kyle Raubenheimer

12:15 pm
Discussion

10:30 am - 12:30 pm
The God Complex

Scientific Session - Health Policy & Advocacy, Medico-Legal, Surgical Leaders - Meeting Room M2

10:30 am
Common problems the College has to manage - (Dr John Quinn - Executive Director Surgical Affairs, RACS)
Dr John Quinn

10:45 am
A view from the medical board - (Ms Meneesha Michalka - Medical Board of Western Australia)
Mrs Meneesha Michalka

11:00 am
Clinical governance and the credentialling process (Prof Carolyn Hullick, FACEM - CMO, Australian Commission on Safety and Quality in Health Care)
Conjoint Professor Carolyn Hullick

11:15 am
Experience in other workplaces (Ms Eloise Nagle - Senior Associate, Herbert Smith Freehills Kramer, Perth)
Ms Eloise Nagle

11:30 am
What can the College do? (Professor Guy Maddern - Professor of Surgery)
Professor Guy Maddern

11:45 am
Discussion

10:30 am - 11:30 am
The Many Paths and Costs of Fellowship

Scientific Session - Younger Fellows - Meeting Room M8

10:30 am
Overseas Fellowship
Dr Matthew Greenaway

10:45 am
Research and ANZBreast Fellowship
Dr Aroosha Safari

11:00 am
Straight to Consultancy - Lessons and Mentorship
Dr Vindya Johnston

11:15 am
Panel Discussion
Dr Aroosha Safari, Dr Vindya Johnston, Dr Matthew Greenaway

10:30 am - 11:00 am
The Sir Edward 'Weary' Dunlop Memorial Lecture - Captain Ian Young (VIC, AUSTRALIA)

Named Lecture - Military Surgery - Bellevue Ballroom 1

10:30 am
Surgeons Between Conflicts: Rest, Recovery and Readiness for the Next Deployment
Captain Ian Young

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03 May 2026

11:00 am - 12:30 pm
Acute Burncare

Scientific Session - Burn Surgery - Meeting Room M3

11:00 am
A paradigm shift in burn care
Dr Anjay Khandelwal

11:15 am
Skin Engineering in burns surgery
Dr Joanneke Maitz

11:30 am
Overview of burns surgical services across AUS / NZ ... now and into the future.
Dr Justine O'Hara

11:45 am
Rapid Evaporative Ionisation Mass Spectrometry as a Tool to Guide Acute Burn Surgical Debridement: An Ex-Vivo Study
Dr Angus Barber
Purpose Burn debridement surgery relies on surgeon experience to remove non-viable tissue. Both excessive and inadequate debridement can have significant consequences, however there are a paucity of tools available to guide intra-operative decision making. Rapid evaporative ionization mass spectrometry (REIMS) links a diathermy electrode to real-time mass spectrometry, providing a continuous molecular profile of tissue being cut. This study investigates if REIMS has the potential to guide burns debridement. Method A single-center, ex-vivo study was performed. Skin samples were obtained from patients undergoing elective and burn debridement surgery. Both normal and burnt tissue samples were analysed using a standardised methodology. Data was visualised with principal component analysis (PCA), and orthogonal projections to latent structures-discriminant analysis (OPLS-DA) was used to interpret variation between groups. Results 11 patients were included, yielding 44 normal tissue data points and 36 burnt tissue data points. Two separate models were generated, one for epidermal and another for dermal depth cuts. Both epidermal and dermal models were significant, with epidermal Q2(cum) = 0.152 and dermal Q2(cum) = 0.147, suggesting promising differentiation between burn and normal tissue. 255 of 900 metabolites were statistically significant at differentiating burnt and non-burnt tissue. For lower m/z features, non-burnt tissue had higher relative abundance; whilst at higher m/z features, burnt tissue had higher relative abundance. In burnt tissue, below 700m/z relative metabolite abundance tends to decrease as burn depth increases. Above 700m/z, metabolite abundance tends to increase as burn depth increases. Conclusion This study demonstrated REIMS has promising ability to differentiate burnt and non-burnt tissue, and identified a number of metabolite trends which contribute to this. It also provides preliminary evidence to support REIMS as a tool to differentiate burn depth.

12:05 pm
The Lethal Triad in Patients with Severe Burns
Dr Elisha Purcell
Purpose: The lethal triad of trauma (acidemia, coagulopathy and hypothermia) is associated with substantial morbidity and mortality. Patients with severe burn injuries are one group of patients at risk of developing this triad. The aim of this study was to evaluate the prevalence of the lethal triad and factors associated with the lethal triad in severe burn patients on arrival to an adult tertiary burns service hospital. Methodology: A 5-year retrospective cohort study was conducted of adult patients (>18 years of age) with severe burns (>20% total body surface area, TBSA) admitted to a burns service hospital. The Burns Registry of Australia and New Zealand (BRANZ) was used in combination with electronic medical records to extract relevant data. Hypothermia was defined as a body temperature ≤35.5°C, coagulopathy was defined as an international normalised ratio (INR)>1.2 and acidemia was defined as pH≤7.25. Results: From 158 patients identified, 142 patients met inclusion criteria. Among 106 patients with available data, the lethal triad was present on arrival to hospital in 6 patients (5.7%; 95%CI: 2.1-11.9%). Acidemia was present in 58 of 116 (50.0%; 95%CI: 40.6-59.4), coagulopathy in 18 of 125 (14.4%; 95%CI: 8.8-21.8) and hypothermia in 53 of 140 (37.9%; 95%CI: 29.8-46.4). Among patients with the lethal triad, all 6 patients (100%) died, compared to 27 patients (27.0%) without the

lethal triad (odds ratio 21.0; 95%CI: 2.91->99.9). Individuals presenting with the lethal triad were more likely to have a larger %TBSA (p < 0.001) and presence of inhalation injury (p < 0.001). Conclusion: A small proportion of patients with severe burns presented to hospital with all three components of the lethal triad of trauma. Acidemia and hypothermia were more commonly observed when compared to coagulopathy. Recognition, prevention and early management may result in improved outcomes.

12:15 pm
The Use of Novosorb MTX in Popliteal Fossa Burn- A Case Study
Dr Yu Ting Tay
Introduction: NovoSorb MTX is a fully synthetic, biodegradable polyurethane matrix similar to BTM but without a sealing membrane.[2]There are currently no published case reports describing its use in acute burn reconstruction. Case: A 72 years old man presented with flame burns to both hands and lower limbs after his clothing caught fire. His medical history included nephrectomy for renal cell carcinoma, hypertension, gout, and type 2 diabetes mellitus. Examination revealed a full-thickness burn over the left popliteal fossa with surrounding partial-thickness injury, and dermal burns to the right thigh, knee, and both hands. Following initial wound care and referral to the burns service, he underwent tangential excision of the full-thickness burn on day five post-injury. MTX was applied and secured with staples, covered with antimicrobial dressings, and immobilised. Other burn wounds were debrided and dressed. At 18 days, the MTX demonstrated good integration, and STSG from the ipsilateral thigh was meshed and secured to the wound bed. Approximately 95% graft take was observed at five days. Discussion: Although BTM has established efficacy in burn reconstruction, data on MTX remain limited. The absence of a sealing membrane removes the need for delamination and may improve conformability and contact in anatomically challenging and mobile areas. Conclusion: At 10-week follow-up, all wounds were fully healed with no joint contracture or significant scarring. This case suggests MTX is a promising dermal substitute for burn reconstruction over mobile joints, with excellent graft take and functional outcomes. References: 1.Greenwood, J. E, et. al. (2018). Experience with a synthetic bilayer Biodegradable Temporising Matrix in significant burn injury. Burns Open□: An International Open Access Journal for Burn Injuries, 2(1), 17–34. https://doi.org/10.1016/j.burnso.2017.08.001 2.PolyNovo, 'ASX announcement' NovoSorb MTX product portfolio update (Announcement, 19 March 2025)

12:25 pm
Discussion

11:00 am - 12:30 pm
Innovations influencing battle field injuries

Scientific Session - Military Surgery - Bellevue Ballroom 1

11:00 am
Challenges in Providing Surgical Care in Gaza
Dr Bushra Othman

11:40 am
Drone warfare rapidly evolving challenges in military medicine
GPCAPT Jeff Stephenson

12:20 pm
Q&A

11:00 am - 12:30 pm
Surgery without Borders: Rural Surgeon's Perspective

Scientific Session - Women in Surgery, Rural Surgery - Meeting Room M6

11:00 am
Country Road, Take Me Home
Dr Megge Beacroft

11:20 am
In pursuit of protanomaly- Evolution of lifestyle surgeon
Dr Stephanie Weidlich

11:40 am
Workforce Challenges for Women in Rural Surgery
Dr Genevieve Gibbons

12:00 pm
Consultant journey, when reward comes from more than the blade
Dr Jacinta Cover

12:20 pm
Discussion

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03 May 2026

11:30 am - 12:30 pm
Complications - Response, review and return to work

Scientific Session - Surgical Education, Younger Fellows, Trainees Association - Meeting Room M8

11:30 am
The Surgeon's Perspective
Dr Oscar Aldridge

11:45 am
The medicolegal side
Mr Matt Montgomery, Ms Janice Lawrence

12:00 pm
Professional Coach
Ms Bronwyn Williams, Ms Janice Lawrence

12:15 pm
Panel Discussion and Q&A
Dr Oscar Aldridge, Ms Janice Lawrence, Mr Matt Montgomery, Ms Bronwyn Williams

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03 May 2026

12:00 pm - 12:30 pm
The Tom Reeve Lecture - Dr Mohammed Mustafa (VIC, AUSTRALIA)

Named Lecture - Surgical Oncology - Meeting Room M1

12:00 pm
How Collaboration Can Breed Success when Faced with Adversity (Title TBC)
Dr Mohammed Mustafa

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03 May 2026

12:30 pm - 1:30 pm

ANZ CHAPTER OF THE ACS ANNUAL BUSINESS MEETING AND LUNCH

Business Meeting - *Cross Discipline* - River View Room 4

12:30 pm
President's Report
Professor Chris Pyke

12:30 pm - 1:30 pm
Lunch - Sunday

Catering - *Cross Discipline* - Pavillion 1

12:30 pm - 1:30 pm
RACSTA Lunch Session - Exam performance mindset and management

Scientific Session - Trainees Association, Younger Fellows - Meeting Room M8

12:30 pm
Exam performance mindset and management
Dr Peter Rogers, Ms Janice Lawrence, Ms Bronwyn Williams

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03 May 2026

1:30 pm - 2:30 pm
ANZ CHAPTER OF THE ACS "SCIENTIFIC FORUM" SESSION

Scientific Session - *Cross Discipline* - River View Room 4

1:30 pm
Unplanned Hospital Returns After Colorectal Cancer Surgery: Predictors, Patient Experience, and Prevention in Te Tai Tokerau, Northland, Aotearoa New Zealand
Dr Scott McLaughlin

1:38 pm
Diagnostic Accuracy of a Rapid 12-Minute MRI Protocol for Acute Appendicitis: Multi-Centre Experience of 2,249 Patients
Mr Sowmya Ravi

1:46 pm
The SER2VE Study: Surgical Education for Residents and Registrars in Victoria Evaluation
Dr Teagan Fink

1:54 pm
Obesity Prediction by Trauma Initial Caregivers: The OPTIC Study
Dr Urja Joshi

2:02 pm
Can a paediatric artificial intelligence otoscopic classifier accurately diagnose adult ears?
Dr Tony Lian

2:10 pm
Suction versus Washout for Appendicectomy in the Paediatric population (SWAP) – a randomised controlled

trial
Dr Samantha Leng

2:18 pm
Final judging and announcement

1:30 pm - 3:30 pm
Burn Reconstruction

Scientific Session - Burn Surgery - Meeting Room M3

1:30 pm
Laser therapy in burns – a view from OH
Dr Anjay Khandelwal

1:45 pm
Ablative Laser Therapy for Hypertrophic Burn Scars: A 12-year Practice and Outcome Review
Dr Helen Douglas
Introduction Ablative fractional CO2 lasers (AFCO2L) have been shown to improve hypertrophic burn scars (HBS). The purpose of this study was to review the 12-year patient cohort who received AFCO2L for HBS and identify independent factors associated with the application of AFCO2L Methods This retrospective HRE-approved study included all patients who received AFCO2L at the Western Australian Statewide Adult Burns Unit (SABU) from 2013 to 2024. Multivariate analyses were conducted to identify patient and burn factors associated with receiving AFCO2L. Patient subsets completed the Patient and Observer Scar Assessment Scale (POSAS 2.0), SF-36, and Itch Surveys. Their scar quality outcomes were compared over time using pre-post-laser analyses. Results The study involved 837 individuals who received 4005 laser sessions. Patients receiving AFCO2L tended to be female (454 patients,54.2%) with a median age of 31 (IQR: 21 to 45), without comorbidities (690,82.4%). Most lived in the metro region (621,74.2%), were completed as outpatients (66%), and were Fitzpatrick 2 (387,46.2%). Individuals who were more likely to receive AFCO2L were: younger (p<0.001), female (p<0.001), had a higher percentage TBSA burned (p<0.001), multiple anatomical areas affected (p=0.001), longer time to wound healing (p<0.001), and surgery (p<0.001). The subset analysis of POSAS scores after one laser showed significant reduction in itch scores (mean: 4.0 [1 x laser] v 5.3 [pre-laser]; p=0.018) and colour (mean: 7.1 [1 x laser] v 8.5 [pre]; p=0.02). Conclusions The study results demonstrated that AFCO2L is an efficacious treatment modality that can be targeted to specific burn patient profiles, improving scar quality and symptoms of HBS.

2:00 pm
Surgical Reconstruction – from basic to bold
Prof Jeremy Rawlins

2:15 pm
Allied Health Burn Rehab / Recon
Dr Dale Edwick

2:30 pm
Discussion

1:30 pm - 3:30 pm
Choice, Change and Chance: Navigating the Surgical Career Path

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Scientific Session - Younger Fellows, Surgical Education, Women in Surgery - Meeting Room M6

A candid, unscripted dive into the real stories behind surgical careers—this session invites the audience into the personal journeys of consultants across a wide range of specialties. Participants will hear honest reflections on challenges, turning points, sacrifices, vulnerabilities, and the unexpected moments that shaped both life and career. Panellists will also share their own rough proportions of Choice, Change, and Chance in their professional paths, offering a rare window into how careers truly evolve. Designed as an interactive conversation rather than a formal lecture, this session brings together an extensive representation of surgical consultants for open discussion, career insights, and meaningful dialogue with

the audience.

1:30 pm
Chance, Change or Choice: Navigating the Surgical Career Path
Dr Amanda Foster, Dr Madeleine Jolley, Dr Paige Moore, Dr Snigdha Saha, prof Fiona Wood, Dr Pecky De Silva

2:30 pm
Discussion

1:30 pm - 3:30 pm
Complex Prosthetic Joint Infection + Soft Tissue Reconstruction

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Scientific Session - Plastic & Reconstructive Surgery, Orthopaedic Surgery - River View Room 5

1:30 pm
Fracture related infection – current guidelines
Dr Timothy Whitmore

1:50 pm
Femoral Osteomyelitis: Vascularised fibular with plate assisted transport
Mr Conor Mullan

2:10 pm
Management of osteomyelitis of the tibia
Mr Alistair Macey

2:30 pm
A Decision-Based Framework for Reconstruction of Traumatic Lower-Limb Amputations Using Salvaged Tissue
Dr Brandon He
Purpose: Despite advancements in reconstructive techniques, lower limb amputations remain a common outcome of lower limb trauma. The primary aim of amputation is to create a functional, sensate, and pain-free stump whilst preserving maximal limb length possible. The foot is a valuable source of tissue that is frequently distal to the zone of trauma and is otherwise discarded in traditional amputations. It offers robust, sensate and well-vascularised coverage for amputation stumps. Key options include the fillet-of-sole flap, which consists of the durable glabrous skin, plantar muscles, and fascia, and the complementary dorsal foot flap, made of soft tissue from the dorsal foot. While these flaps have been described in the literature, their application remains underutilised and there exists no established decision-making framework for these flaps in the context of leg amputation. We present our experience with the 'spare-parts' concept in lower limb reconstruction through an illustrative case series and propose an algorithm aimed at optimising residual limb length and sensibility. Methodology: A retrospective, multi-centre review was conducted across three tertiary hospitals on patients who underwent lower limb amputation stump reconstruction using salvaged tissue from 2022 to 2024. Results: Three male patients, aged 20-27, were included: one with an above-knee amputation and two with below-knee amputations due to motor-related trauma. One free and three pedicled fillet-of-sole flap reconstructions were performed. All flaps remained healthy and sensate throughout the follow-up period. Based on these cases, a pragmatic decision-making algorithm was developed to guide management in future presentations. Conclusion: Foot flaps are a viable option for reconstructing traumatic lower limb amputations. Developing a protocol based on vascular integrity and zone of trauma can improve outcomes by tailoring techniques to specific clinical situations.

2:50 pm
Multidisciplinary Strategy for Complex Post-Traumatic Segmental Femoral Defects
Dr Matthew Daniel
Background: Large segmental femoral defects following high-energy trauma present a major reconstructive challenge. Options include bone transport, induced membrane (Masquelet) techniques, and vascularised bone transfer, each limited by defect size, treatment duration, and morbidity. Within vascularised reconstruction, strategies include single, double-barrel, or multiple fibula constructs. Optimal management requires orthoplastic collaboration and careful strategy selection. We describe a multidisciplinary approach using double free fibula transfer with virtual surgical planning (VSP) for definitive

reconstruction of a complex post-traumatic femoral defect. Methods: A 28-year-old man sustained polytrauma including an open midshaft femoral fracture with 8–12 cm segmental bone loss. Initial intramedullary fixation and cement spacer placement was followed by soft tissue coverage with a contralateral anterolateral thigh (ALT) free flap. Given defect length, geometry, and prior reconstruction, bone transport, Masquelet, and double-barrel fibula were deemed suboptimal. VSP guided design of two independent free fibula flaps, inset as medial and lateral vascularised struts with custom plates. The existing ALT pedicle served as recipient vessels; one flap was anastomosed directly, the second as a flow-through flap. Results: The double free fibula construct restored femoral continuity and stability while preserving soft tissue coverage. Microsurgical anastomoses were completed without complication, and early postoperative assessment confirmed flap viability and stable fixation. Conclusion: Double free fibula transfer, facilitated by VSP and innovative recipient vessel strategies, provides a reliable alternative when bone transport, induced membrane techniques, or double-barrel fibula are unsuitable. This case highlights the value of staged orthoplastic collaboration and strategic decision-making in complex limb salvage.

3:10 pm
Discussion

1:30 pm - 3:30 pm
Fifteen years of Safety and Quality – lessons learnt from clinical quality registries for the next decade

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Scientific Session - Health Policy & Advocacy, Surgical Leaders - Meeting Room M2

1:30 pm
Evolving expectations - revising the National Safety and Quality Health Service Standards (Prof Carolyn Hullick, FACEM - CMO, Australian Commission on Safety and Quality in Health Care)
Conjoint Professor Carolyn Hullick

1:45 pm
Clinical Quality Registries - a view from both sides (Dr Hannah Seymour - Board Member, Australian Commission on Safety and Quality in Health Care. Former member, ANZHFR Steering Group)
Dr Hannah Seymour

2:00 pm
What the jurisdictions expect of the College and its Fellows (Dr Audrey Koay - Chair, Inter-Jurisdictional Committee, Australian Commission on Safety and Quality in Health Care)
Dr Audrey Koay

2:15 pm
Safety and Quality expectations in industrial workplaces (Ms Eloise Nagle - Senior Associate, Herbert Smith Freehills Kramer, Perth)
Ms Eloise Nagle

2:30 pm
Time for some intellectual honesty
Mr James Aitken

2:45 pm
Discussion

1:30 pm - 3:30 pm
Publish or Perish 'Research Papers'

Scientific Session - Rural Surgery - Meeting Room M8

1:30 pm
Emergency laparotomy outcomes at Southland Hospital
Jennifer Zhou

1:40 pm

Oncoplastic breast surgery in rural Queensland: Does it make a difference to outcomes?

Dr Madison Bowles

Introduction: Breast-conserving surgery (BCS) is the standard surgical approach for many women with early-stage breast cancer, offering survival outcomes that are at least equivalent to mastectomy when combined with adjuvant radiotherapy. The development of oncoplastic breast surgery (OBS) has broadened the scope of BCS by enabling wider tumour excision while maintaining breast contour, cosmetic outcomes, and patient satisfaction. Beyond aesthetic advantages, OBS has demonstrated improved oncologic outcomes, including lower rates of close or involved surgical margins and reduced need for re-excision. In rural Queensland healthcare settings, where access to reconstructive expertise and specialist services may be limited, evidence on OBS outcomes remains scarce. Objective: To evaluate whether the introduction of oncoplastic techniques improved surgical margin clearance and reduced re-excision rates following BCS in two rural Queensland Hospitals Methods: A retrospective cohort study was performed including all patients who underwent BCS for breast cancer at Bundaberg and Rockhampton Hospitals between 1 January 2020 and 31 June 2023. Patients were stratified according to the use of oncoplastic techniques. Data was collected through manual review of electronic medical records and included patient demographics, tumour characteristics, operative details, pathology results, margin status, and requirement for further surgery. Primary outcomes were surgical margin status and rates of re-excision. Secondary outcomes included types of re-excision (WLE vs mastectomy) and oncoplastic techniques Results: Data collection performed and analysis currently underway Conclusion This study evaluated the oncologic impact of oncoplastic breast surgery in two rural Queensland settings. Findings may support broader adoption of oncoplastic techniques in regional centres to optimise surgical margins, reduce re-excision and improve cosmetic outcome.

1:50 pm

Case Mix Analysis in Rural Acute Surgical Units in Western Australia: Identifying Research Gaps and Future Directions: A Narrative review

Dr David Heath

Rural acute surgical units in Western Australia (WA) are essential for Australians in rural areas but face significant challenges, including workforce shortages and geographical barriers. This review aimed to synthesize the current state of rural general surgery in WA—including caseload, scope of practice, and patient outcomes—to identify critical research gaps for improving service delivery. A narrative review of peer-reviewed literature, health service reports, and workforce data was conducted. The findings indicate that rural general surgeons manage higher procedural volumes and a broader scope of practice than their metropolitan counterparts. While many surgical outcomes are comp arable to urban centers, disparities persist in surgical oncology and trauma mortality, linked to access and transport delays. Key metrics such as unplanned returns to theatre (URTT) remain unquantified, and workforce shortages continue to hinder access to care. Significant research gaps exist regarding URTT rates, specific oncology outcomes, trauma morbidity, and the impact of access barriers, highlighting the need for targeted research to develop evidence-based strategies for equitable and sustainable surgical care in rural WA.

2:00 pm

Evaluating referral patterns and treatment timeliness for soft tissue sarcoma in rural WA: insights from the WA state sarcoma service

Dr Ellen Maclean

Background Soft tissue sarcomas (STS) are rare tumours that require multidisciplinary management at high-volume centres. The WA State Soft Tissue Sarcoma Service (WASTSS), established at Sir Charles Gairdner Hospital in 2016, provides a central referral pathway for rural patients. This study evaluated referral patterns and adherence to the Australian Cancer Council's optimal care pathway for people with sarcoma guidelines recommending specialist assessment within 4 weeks, investigations within 2 weeks, and surgery within 3 weeks of the decision to operate. Methods A retrospective analysis was conducted on 69 rural patients referred to WASTSS from 2020 to 2023. Data on demographics, referrals, and timelines were analysed. Statistical tests assessed adherence to guidelines and differences by patient and referrer location, malignancy status, and socio-economic factors. Results Annual referrals increased, with 88.2% of patients assessed within 4 weeks (median: 9 days). Investigations were completed within 2 weeks for 64.7% of patients (median: 7 days). Biopsy timing and location influenced investigation timelines. Only 37.5% of patients underwent surgery within 3 weeks, with delays linked to resource constraints and case complexity. Malignant cases experienced shorter delays than benign cases, with all malignant cases excised within 50 days; however, both groups exceeded recommended timeframes. Conclusion WASTSS met guidelines for initial assessments and investigations for rural patients in most cases. Delays in surgical management highlight the need for enhanced triage and resource allocation. Establishing dedicated benign tumour services and optimising diagnostic pathways could further improve outcomes.

2:10 pm

Acute general surgery workload managed by locum consultant surgeons across regional hospitals in four Australian states

Dr Syed Ali Abbas Rizvi

Purpose Acute general surgery in regional Australia is frequently delivered by locum consultant surgeons. The breadth and acuity of this workload across multiple jurisdictions remain under-reported. This study describes the acute general surgery workload managed by a locum consultant surgeon across regional hospitals. Methodology A retrospective descriptive analysis was performed using a prospectively maintained consultant logbook documenting acute surgical procedures, including emergency presentations, undertaken between March and December 2025 across regional hospitals in Queensland, New South Wales, Victoria and South Australia. Procedures were categorised by diagnosis, operative approach and complexity. Results Acute surgical activity was dominated by appendicectomy and abscess drainage, including perianal, pilonidal, axillary and gluteal abscesses. Higher-acuity procedures included exploratory laparotomy, bowel resection, right hemicolectomy, perforated peptic ulcer repair and acute endoscopic intervention for upper gastrointestinal bleeding and food bolus obstruction. Short-term locum placements were characterised by high acute caseloads and limited elective activity, requiring broad procedural competence and independent decision-making across multiple subspecialty domains. Conclusion Locum consultant surgeons provide critical acute general surgery services across regional Australia, managing a wide spectrum of pathology including complex abdominal emergencies. These findings highlight the essential role of locum surgeons in sustaining regional acute surgical care.

2:20 pm

Transanal minimally invasive surgery for complex rectal adenomas in a regional colorectal unit: early outcomes within a collaborative tertiary network

Dr Sze Mun Thor

Background Transanal minimally invasive surgery (TAMIS) is an established technique for local excision of complex rectal adenomas and selected early rectal cancers, predominantly performed in high-volume tertiary colorectal centres. Access to TAMIS in regional hospitals remains limited, often necessitating referral. We report the early experience of introducing TAMIS within a regional colorectal unit through structured collaboration with tertiary colorectal centres. Methods A retrospective analysis was conducted of consecutive patients undergoing TAMIS for rectal lesions at a regional referral hospital. Patient demographics, lesion characteristics, operative details, histopathology, peri-operative outcomes, and short-term follow-up were reviewed. All cases were discussed at a multidisciplinary team (MDT) meeting with input from tertiary colorectal services. Results Three patients underwent a total of four TAMIS procedures, including one staged diagnostic and definitive excision. Lesions were large sessile adenomas located in the low to mid rectum. TAMIS was successfully completed in all cases without conversion to alternative surgical approaches. Final histopathology demonstrated tubulovillous adenoma with low-grade dysplasia in all patients, with no invasive malignancy identified. One patient experienced a Clavien–Dindo grade II postoperative complication following a prolonged procedure. No readmissions or early recurrences were observed during short-term follow-up. Conclusion Transanal minimally invasive surgery can be safely and effectively introduced in a regional colorectal unit when supported by structured multidisciplinary governance and collaboration with tertiary colorectal centres. This model enables delivery of high-quality, organ-preserving surgery closer to home while maintaining oncological safety and appropriate escalation pathways. Collaborative regional–tertiary networks may represent an effective strategy for improving equity of access to advanced colorectal care.

2:30 pm

Rural Surgical Clinics: A Comprehensive Analysis of Service Delivery Models and Patient Outcomes in Regional Healthcare Settings

Dr David Heath

Background: Access to specialist surgical services is a persistent challenge in rural and remote regions, contributing to health disparities. Innovative service delivery models are essential to bridge this gap. This study evaluates the effectiveness of a dual-clinic system—comprising a Rapid Access Clinic for acute assessments and a dedicated follow-up clinic —in a rural Western Australian setting.Methods: A retrospective analysis was conducted on patient visit data from the Rapid Access Clinic (n=564 visits) and the dedicated Outpatient Clinic (n=748 visits) between March 2023 and December 2024. Data on patient demographics, visit reasons, referral sources, and clinical outcomes were analysed to determine utilization patterns and service effectiveness.Results: The Rapid Access Clinic demonstrated a high-acuity caseload, with 22.5% of visits resulting in admission for surgery and 3.9% for monitoring. The clinic serves a broad demographic with a significant volume of referrals from local emergency departments (22.7%). A statistically significant inverse correlation was observed between age and surgical admission ($r = -0.107$, $p = 0.011$), with younger adults (18-34 years) having the highest rates of surgical intervention (31.3%). Abscesses were the

most common condition leading to surgery (50.8% admission rate). In contrast, the outpatient clinic functioned primarily as a follow-up service, with a higher proportion of patients requiring multiple visits (36.1% vs. 18.9% at the Rapid Access Clinic) and minimal recorded admissions or discharges, indicating a focus on continuity of care. Conclusion:The dual-clinic model appears to be an effective strategy for delivering comprehensive surgical services in a rural setting. It combines rapid assessment for acute conditions with structured, ongoing management for chronic or post-operative issues. The findings highlight distinct successful integration with primary and emergency care services, offering a potential framework for other rural healthcare systems.

2:40 pm
Distance and disparity: An 8-year review of maxillofacial trauma in Far North Queensland
Dr Tanisha Hayward

2:50 pm
Outcomes of Radical Cystectomy at a Regional Centre: A 21 year review
Dr Allen Guo
Aim: To evaluate the perioperative, pathological, and oncological outcomes of radical cystectomy performed at a single regional Australian centre over a 21-year period and assess whether outcomes align with those reported by higher-volume metropolitan centres. Method: A retrospective review was conducted of all patients who underwent radical cystectomy for primary bladder cancer between January 2002 and December 2023 at a regional centre in New South Wales. Patient demographics, surgical details, pathological findings, and survival outcomes were collected. Kaplan-Meier analysis was used to assess 5-year overall and disease-free survival. Results: A total of 138 patients underwent cystectomy (mean age 67.4 years; 78.3% male). Most received ileal conduit diversion (79.7%), followed by neobladder (19.6%). Final pathology included pT0 (21), pT1 (21), pT2 (39), pT3 (23), and pT4 (20). Lymph node dissection was performed in 98%, with a mean of 22 nodes removed. Positive surgical margins were present in 13.8%. Thirty-day mortality was 3.6% (n=5), due to causes including pulmonary embolism and myocardial infarction. Median length of stay was 11 days. Median follow-up was 44.8 months. Five-year overall survival and disease-free survival were 67% and 69%, respectively. Higher tumour stage correlated with increased mortality and shorter survival. Neoadjuvant chemotherapy was used in 38% of patients, with adjuvant chemotherapy in 9%. Conclusion: Outcomes of radical cystectomy at this regional centre are comparable to those of larger metropolitan centres. Routine pelvic lymph node dissection, structured perioperative care, and growing surgical experience contributed to favourable results. These findings support the delivery of complex urologic oncology care in regional settings.

3:00 pm
Barriers to Breast Reconstruction in Regional Australia: A Prospective Qualitative Study of Patient-Reported Experiences
Dr Samuel Jansson
Purpose/Introduction: To identify patient-reported barriers to breast reconstruction (BR) in eligible women using a prospective qualitative approach. Uptake to breast reconstruction remains low in regional populations despite known benefits. Limited data exist on the underlying patient-reported barriers to breast reconstruction in regional populations. Methods: A prospective qualitative study was conducted within a regional Australian health district. Women who were eligible for BR but did not undergo reconstruction between 2017–2022 were invited to participate (n = 227). A novel questionnaire was administered, incorporating Likert-scale items across six domains (information provision, access to services, logistical barriers, psychosocial factors, clinician communication, and expectations), with open-ended excerpts. Group differences were explored using chi-square analysis, and thematic analysis. Results: Many participants reported inadequate counselling regarding reconstructive options, limited access to subspecialist services, and significant logistical barriers including travel distance, cost, and waiting times. Over 70% of respondents stated reconstruction was not presented as a realistic or accessible option, and 64% felt insufficiently informed to make a confident decision. Prominent themes included fragmented referral pathways, poor continuity of care, and perceptions of reconstruction as cosmetic only. Several patients described changes in treating surgeons, lack of coordinated follow-up, and believed further corrective surgery would require private payment. Conclusion: Regional women face systemic and informational barriers to breast reconstruction extending beyond clinical eligibility. Patient-reported experiences highlight gaps in counselling, referral pathways, and service continuity. These findings support the need for structured multidisciplinary counselling, improved regional reconstructive access, and clearer framing of reconstruction as a component of oncologic care.

3:10 pm
Impact of a Rural Acute Surgical Unit on the Management of Gallstone Disease in Octogenarians

Dr Catherine Daly

1:30 pm - 3:30 pm
Research Papers

Scientific Session - Otolaryngology Head & Neck Surgery - Bellevue Ballroom 2

1:30 pm
Defining Dysbiosis in Chronic Rhinosinusitis: Resequencing the International Sinonasal Microbiome Study with Species Level Metagenomics
Ms Isabella Amy Burdon
Chronic rhinosinusitis (CRS) is a globally prevalent inflammatory disease that seriously impairs quality of life. While advances in monoclonal antibody (mAb) therapies have transformed CRS management, mAbs have failed to induce disease remission with symptom return upon withdrawal of treatment. This pattern suggests that, in addition to inflammatory pathways, alternative mechanisms may contribute to CRS pathogenesis. In 2025, our department published the first benchmarking study for sinus microbiome sequencing, finding that the 16S rRNA methods applied in all prior studies significantly distorted samples, with only metagenomic analysis providing accurate results. Hence, to definitively investigate the role of dysbiosis in CRS, we have conducted the first international sinus microbiome study to integrate paired shotgun metagenomic and 16S rRNA sequencing. Samples were collected by endoscopically guided middle meatal swab from 432 participants (174 controls; 155 CRS with nasal polyps [CRSwNP]; 103 CRS without nasal polyps [CRSsNP]), across 14 centres in 9 countries. Metagenomic libraries were prepared using the ONT native barcoding kit and sequenced on the PromethION platform. Data was analysed using an in-house pipeline and custom database with Sourmash for taxonomic assignment. CRS microbiomes differed significantly from non-CRS controls and between disease phenotypes. Corynebacterium accolens was most strongly associated with health ($p=0.001$, $\beta=5$), followed by D. pigrum ($p=0.017$, $\beta=2$). In contrast, P. aeruginosa, S. pneumoniae, and H. influenzae were significantly enriched in CRS ($p<0.05$, ß=3;4;4). Staphylococcus aureus was associated with CRSwNP ($p=0.033$, ß=6), while C. kefirresidentii was selectively enriched in CRSsNP ($p=0.008$, ß=4). This study provides the first international evidence defining dysbiosis in CRS and linking clinically relevant bacteria to both disease presence and phenotype. These findings recentre the sinonasal microbiome in CRS aetiopathogenesis and support its potential as a source of diagnostic, prognostic, and therapeutic targets.

1:40 pm
Predicting and Optimising Ossiculoplasty Outcomes: Lessons from a Multi-Institutional Study of 1679 Cases
Dr Chaithanya Jeganathan

1:50 pm
The Impact of Travel Distance on the Presentation and Outcomes of Head and Neck Cancer in Australia
Dr Janis Wong
Aim: Geographic barriers are commonly assumed to contribute to delays in cancer diagnosis and treatment. This study investigates the impact of travel distance on the presentation and survival outcomes in patients with oropharyngeal squamous cell carcinoma (OPSCC). Methodology: A retrospective review was conducted on 180 patients with OPSCC treated at St Vincent's Hospital Melbourne between 2017 and 2022. Patients were classified as urban or regional based on median distance to hospital (≤31.4 km vs >31.4 km). Outcomes included stage at diagnosis, time from diagnosis to treatment, and overall and disease-specific survival. Statistical analyses included chi-square tests, Kaplan-Meier curves, and Cox proportional hazards regression. Results:No statistically significant differences were observed between urban and regional groups in T stage ($p=0.41$), N stage ($p=0.71$), overall stage ($p=0.52$), p16 status ($p=0.55$), or smoking status ($p=0.40$). A clinical trend toward higher staging in regional patients was noted. Median time to treatment was 29 days for urban patients vs. 32.5 days for regional patients ($p=0.27$). Delays >90 days occurred only in regional patients (5.7%, n=5/88) and there was a trend toward longer treatment delays in regional patients compared with urban patients ($p=0.06$). Multivariable survival analyses showed no significant differences in overall or disease-specific survival across any timepoint or remoteness classification. Conclusion:While travel distance was not associated with later stage at diagnosis or poorer survival, regional patients were more likely to experience prolonged treatment delays. This suggests that high volume tertiary referral head and neck oncology services help to reduce barriers to head and neck cancer treatment. Treatment timeliness remains a point of vulnerability highlighting the need for targeted support to reduce delays in regional patients, particularly those exceeding 90 days.

2:00 pm
Oral Cavity Cancers in Non smokers and Non Drinkers - A distinct clinical phenotype?
Dr. Jonathan Daniel

2:10 pm
Rapid Access Neck Lump Clinic – A First of Its Kind in Australia: A Prospective Analysis Over a Five-Year Period
Dr Chaithanya Jeganathan
Aims Rapid Access Neck Lump Clinics (RANLCs) are designed to streamline the assessment, diagnosis and management of head and neck lumps, facilitating earlier cancer detection and treatment initiation. While established in several international centres, such clinics remains relatively uncommon in the Australian public health system. This study aimed to evaluate the impact of a multidisciplinary RANLC on diagnostic efficiency, waiting times and clinical outcomes over a five-year period. Methodology A consultant-led RANLC was established in a tertiary public hospital, incorporating a head and neck surgeon, radiologist and pathologist to enable comprehensive same-day evaluation. Data were collected prospectively for all patients attending the clinic between February 2018 and February 2023. Key performance metrics included time from referral to specialist review, time to multidisciplinary team (MDT) discussion, and time to treatment commencement. Diagnostic yield and malignancy rates were also analysed. Results A total of 437 consecutive patients were reviewed. The mean time from referral to specialist assessment was 16.1 ± 9.5 days. Ultrasound-guided fine needle aspiration (FNA) was performed in 61% of patients, identifying malignancy in 38.6%. The median time from specialist assessment to MDT discussion was 5 days, and the mean interval from clinic review to initiation of treatment was 39.3 days. These findings reflect significant streamlining of the diagnostic pathway and coordination of multidisciplinary care. Conclusions The introduction of a multidisciplinary rapid access neck lump clinic significantly reduced waiting times for diagnosis and treatment of head and neck cancer. This model demonstrates a feasible and effective approach to improving timely access to care within the Australian public health system, aligning with international best practice.

2:20 pm
Treatment-Related Soft Tissue Necrosis in Oropharyngeal Cancer: Ten Years of Experience in Western Australia
Dr Gabrielle Croker
Introduction: Rates of oropharyngeal squamous cell carcinoma have been on the rise in Australia for several decades.(1) In fact, it is now the most common mucosal head and neck cancer to be diagnosed in Queensland. (2). Definitive radiotherapy (RT) with or without concurrent cisplatin based chemotherapy is the contemporary standard of care in non-surgical, curative intent treatment of locoregionally advanced head and neck SCC.(2) However, RT is associated with significant post-treatment morbidity and mortality, and it is estimated that complications from RT arise in 4 to 37% of all patients. Methods: We conducted a retrospective cohort study of patients treated for oropharyngeal cancer at Fiona Stanley Hospital between January 2015 and December 2025 to determine the occurrence of soft tissue necrosis. Results: In univariate analysis, smoking history and tumour stage were significantly associated with soft tissue necrosis, with current or past smokers having higher odds of the complication. Other factors- including age, radiation dose, chemotherapy, subsite, p16 status, diabetes and anticoagulant use- were not significantly associated, and sparse event counts limited interpretation for some categorical variables. Conclusion: In conclusion, radiation induced soft tissue necrosis in oropharyngeal cancer patients is rare. In this cohort, smoking and advanced tumour stage appear to be associated with higher risk of developing necrosis, emphasising the need for careful monitoring in this group. 1.Fan KM, Sprague S, Zhang P, Ariyawardana A, Johnson NW. Rates of oropharyngeal cancer continue to rise steeply amongst Australian men. Oral Diseases. 2023;29(5):1959–66. 2.Gupta T, Maheshwari G, Gudi S, Chatterjee A, Phurailatpam R, Prabhash K, et al. Radiation necrosis of the bone, cartilage or cervical soft-tissues following definitive high-precision radio(chemo)therapy for head-neck cancer: an uncommon and under-reported phenomenon. The Journal of Laryngology & Otology. 2021;136(5):447–53.

2:30 pm
Multisite and multidisciplinary research in Post-tonsillectomy bleeding: Lessons for early control and escalation
Dr Amy Hannigan
Purpose: Post-tonsillectomy bleeding (PTB) is a common cause of emergency department (ED) presentation and can be life-threatening. Primary PTB is less frequent but often requires urgent intervention. Safe management depends on effective multidisciplinary (MDT) coordination, early haemostatic measures, risk stratification, and timely escalation. Methodology: This presentation draws on two related experiences illustrating MDT approaches to PTB, both published in the International Journal of

Pediatric Otorhinolaryngology. The first is the STOP study, which evaluated nebulised tranexamic acid (TXA) as an early haemostatic adjunct for patients presenting to a tertiary paediatric ED with non-severe PTB, assessing feasibility and impact on local practice. The second is a national, multicentre case series of catastrophic primary PTB following intracapsular tonsillectomy, demonstrating escalation pathways for severe haemorrhage, including return to theatre and interventional radiology-guided control. Results:In the STOP study, nebulised TXA was a low-risk, easily administered intervention that assisted early bleeding control and improved visualisation. A key outcome was the development of a simple ED-based PTB severity grading system (Grades 1–4), enabling rapid identification of severe bleeding requiring immediate escalation to theatre. This system remains embedded in ED practice. The case series shows that primary PTB can present as sudden, catastrophic haemorrhage requiring immediate MDT involvement, with successful management relying on airway planning, anaesthetic support, rapid theatre mobilisation, and interventional radiology when required. Conclusion:These experiences demonstrate that effective PTB management extends beyond individual treatments. Early haemostatic adjuncts, simple ED-based risk stratification, and clear MDT escalation pathways involving ENT, anaesthetics, theatre teams, and interventional radiology are central to improving patient safety in both routine and high-risk PTB presentations.

2:40 pm
Comparative analysis of surgical and anaesthetic complications in children under two years old
Dr Ha My Ngoc Nguyen
Background: Complication rates in paediatric cochlear implant (CI) surgery have been reported between 4 to 26%. Previous studies, however, have not categorised all aspects of medical, surgical and anaesthetic management (e.g. infections, cochleae/nerve abnormality, gusher, explant) and very few studies have included large numbers of children implanted < 9 months. Objectives: Describe medical/surgical/anaesthetic management for children receiving CIs younger than two years of age in the last 10 years. Methods: From an existing database of 1352 children at a single CI centre, 196 children were identified who received CIs under 2 years (unilateral CI n=37 (18.88%), [n=5 single sided deafness (2.55%)], simultaneous-bilateral CIs n=105 (53.57%) and sequential-bilateral CIs n=54 (27.55%). Thus, 355 ears were derived for subsequent analysis with n=57 CI < 9 months. Detailed anaesthetic records were available for a subset of 91 children. Pre- and post-CI medical/surgical/anaesthetic management was coded from available surgical records and electronic medical files. Results: The mean age at first CI was 1.11 years (N=196; range 0.28 - 1.96 years; SD 0.38). Most CI surgeries were straightforward; 243 of 355 ears (68.45%). No anaesthetic events were reported for any of the 355 ear surgeries in the present cohort. The mean weight at surgery was 10.4kg (n=91; range 7-24 kg; SD 2.32) and mean duration of surgery was 3.13 hours (range 0.95 – 5.23hrs, SD 1.06). The mean American Society of Anaesthesiologists (ASA) score was 1.5 (range 1-3; SD 0.61). Conclusion: CI surgery was straightforward in the majority of cases and there was no higher prevalence of management issues for children implanted < 9 months compared to CIs at 9 to 24 months. These data support the view that CI surgery can be performed safely in infants younger than 9 months.

2:50 pm
A Comparison of Quality-of-Life Outcomes in Endoscopic Versus Cricotracheal Resection in Subglottic Stenosis
Dr Amy Hannigan
Background: Subglottic stenosis (SGS) is managed using repeated endoscopic interventions or definitive open airway reconstruction such as cricotracheal resection (CTR). While endoscopic management may reduce short-term morbidity, its impact on patient-reported quality of life compared with CTR remains unclear. This study compared airway-related quality of life and subjective voice and swallowing outcomes between patients undergoing endoscopic management and CTR for SGS. Methodology: A retrospective cohort study was performed comparing patients with SGS managed by endoscopic procedures or CTR by a single surgeon. Patient-reported outcomes were assessed using validated instruments (Dyspnoea Index, Voice Handicap Index-10, Eating Assessment Tool-10, and SGS Survey-6). Total scores were calculated according to published scoring systems and summarised as median (interquartile range). Groups were compared using Mann–Whitney U tests, with categorical comparisons performed using Fisher's exact test. Results: Of 74 eligible patients, 50 completed outcome surveys (response rate 68%), including 32 managed endoscopically and 18 undergoing CTR. The cohort was predominantly female (CTR 94% vs endoscopic 84%) with similar median age (53.5 [IQR 43–68] vs 53.0 [IQR 47–67] years). Dyspnoea Index scores were significantly lower following CTR compared with endoscopic management (median [IQR] 2 [0–6] vs 21 [18–25], $p<0.001$), with fewer patients demonstrating clinically significant dyspnoea (41% vs 97%, $p<0.001$). Voice- and swallowing-related quality-of-life scores did not differ significantly. On SSS-6 analysis, CTR was associated with less exertional breathlessness and activity limitation (all $p<0.05$). Conclusion: CTR was associated with substantially improved airway-related quality of life compared with endoscopic management for SGS, without compromise in patient-reported voice or swallowing outcomes. These

findings support definitive open airway reconstruction in appropriately selected patients

3:00 pm
Elimination of Recurrent Respiratory Papillomatosis – Australia paving the way globally for HPV vaccination. No country should be left behind.
Dr Nicole Dumitrascu
Background: Recurrent respiratory papillomatosis (RRP) is a rare but impactful ENT disease requiring repeated airway surgery and long-term follow up. It is strongly associated with HPV 6 and 11, making it a preventable surgical disease. Aim: Demonstrate the effectiveness of Australia's HPV vaccination program on RRP rates, drawing light to the lessons that can be learnt when surgery collaborates with public health. Identify transferable lessons for other countries such as Africa, where vaccination is not yet universal. Method: Literature review of RRP epidemiology in Australia and the HPV vaccination roll out. A review of RRP burden in Africa, focusing on Southern Africa and the HPV vaccination program implementation alongside barriers and enablers to propose implementation strategies focusing on patient adherence via health and community collaboration. Key findings: Australia reported a marked decline in juvenile RRP incidence since national HPV vaccination (from 0.16 per 100,000 in 2012 to 0.02 per 100,000 in 2016), supporting the feasibility of near elimination with sustained high coverage. In contrast, Kwazulu-Natal in South Africa reported an incidence of 3.82 per 100,000 in 2022 in the context of inconsistent HPV vaccination access and administration. As of 2023, HPV vaccination programs have been introduced into national immunisation programs in 29 of 54 African countries, however coverage remains heterogeneous. Conclusions: Australia demonstrates that prevention can dramatically reduce a surgical disease, a pristine example of the art and science of collaboration between surgery and public health. It reframes surgeons as integral in prevention, policy and equity for all. It paves the way for a collaboration framework between ENT, immunisation programs, community engagement and government implementation which can be used as an example world-wide.

3:10 pm
Laryngeal Gout: Literature review and an Australian experience
Dr Telvinderjit Singh Harbhajan Singh
Purpose: To review the history, clinical presentation and management of laryngeal gout as well as presenting the first reported Australian case of laryngeal gout with the aim of improving awareness and understanding of this disease process. Methodology: A literature review and case presentation on laryngeal gout Results: Laryngeal gout is rare with one study quoting that there have been only 29 reported cases in the literature and no reported cases from Australia (1). Due to its rarity and non-specific symptoms, the awareness on laryngeal gout is lacking which can lead to under/delayed/mis- diagnosis. Delayed diagnosis can cause irreversible cartilage damage or airway sequelae. Macroscopically they may appear as submucosal nodules or in extreme cases cartilage erosion/destruction. They can mimic laryngeal neoplasms. Biopsy and histopathology is the gold standard diagnostic investigation for laryngeal gout. Due to its rarity there are no set management guidelines or data on long term outcomes, hence the management is extrapolated from general gout management with diet and lifestyle modifications, urate-lowering therapy and/or surgical excision in cases where there is impairment of laryngeal function or airway compromise (1,2). Conclusion: Laryngeal gout is rare. Clinicians should keep laryngeal gout in their list of differentials apart from carcinoma, atypical infections, polyps, or granulomas when seeing patients with laryngeal nodules. Increased awareness of laryngeal gout is crucial to aid better clinical recognition, earlier diagnosis and treatment. 1.Fu Q, Jing Y, Liu W, Liu L, Xu H. Massive laryngeal gouty tophus: A case report and comprehensive literature review. Otolaryngology Case Reports. 2025. https://doi.org/10.1016/S2468-5488(25)00021-9 2.Zijian He, Jianli Zhang, Jingjia Li & Weixiong Chen (2025) Gouty tophus in the vocal fold: A rare case report, Acta Oto-Laryngologica Case Reports, 10:1, 75-79, DOI: 10.1080/23772484.2025.2503208

3:20 pm
Thyroid Surgery: History to Modernity
Dr Eamon Kelly
Thyroid surgery has transitioned from the high-morbidity era of Billroth to a modern discipline defined by subspecialist precision. This presentation reviews the historical foundations laid by Theodor Kocher—whose meticulous technique earned the 1909 Nobel Prize—and William Halsted, whose emphasis on delicate tissue handling and haemostasis remains the cornerstone of the Australian open approach. This is contrasted against the rising popularity of minimally invasive, or robotic approaches to thyroid surgery. In terms of modern updates in the management of multinodular goitres (MNG) and malignancies, the emphasis remains on the impact of surgeon volume on complication rates, specifically permanent hypoparathyroidism and recurrent laryngeal nerve (RLN) palsy. While the standard open thyroidectomy remains the gold standard in Australia, the integration of surgical adjuncts is interrogated and the utility of intraoperative neuromonitoring and near-infrared fluorescence for parathyroid identification are discussed

as essential tools for risk mitigation. Regarding malignancy, we examine the shift toward risk-stratified care. This includes the nuanced role of molecular testing in indeterminate cytology and the 2025 updates on central and lateral neck dissection. The morbidity of prophylactic versus therapeutic clearance in the N0 neck is discussed, providing a contemporary framework for the ENT/Endocrine surgeon to optimize oncological and functional outcomes [1]. [1] Ringel, M. D., Sosa, J. A., Baloch, Z., Bischoff, L., Bloom, G., Brent, G. A., Brock, P. L., Chou, R., Flavell, R. R., Goldner, W., Grubbs, E. G., Haymart, M., Larson, S. M., Leung, A. M., Osborne, J., Ridge, J. A., Robinson, B., Steward, D. L., Tufano, R. P., & Wirth, L. J. (2025). 2025 American Thyroid Association Management Guidelines for Adult Patients with Differentiated Thyroid Cancer. Thyroid : official journal of the American Thyroid Association, 35(8), 841–985. https://doi.org/10.1177/10507256251363120

1:30 pm - 3:00 pm
The Michael Wertheimer Memorial Lecture - Dr Bushra Othman (VIC, AUSTRALIA)

Named Lecture - Military Surgery - Bellevue Ballroom 1

1:30 pm
Surgery Under Siege: A General Surgeon's Experience in Gaza
Dr Bushra Othman

2:30 pm
Discussion

1:30 pm - 3:30 pm
Trauma, Inflammation, and the Surgeon – From Bench to Burnout – Translating Trauma Science into Surgical Practice

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Scientific Session - Trauma Surgery - Meeting Room M7

Major trauma provokes an overwhelming inflammatory and haemorrhagic response that challenges both patients and the systems designed to care for them. This session explores the science of trauma inflammation and its translation into surgical practice, while also examining the toll trauma takes on surgeons and services themselves. Presentations will cover the biology of trauma-induced immune dysfunction, advances in translational research that are reshaping resuscitation and operative strategies, and the practical application of coagulation science to modern haemorrhage control. The session also considers how teams and systems behave under pressure — with lessons drawn from both biology and clinical experience — and concludes with a panel discussion on integrating scientific discovery, clinical practice, and surgeon wellbeing. Designed to bridge laboratory insights, operative decision-making, and the human factors of trauma surgery, this program will appeal to scientists, academic surgeons, and practising clinicians alike.

1:30 pm
Polytrauma: The unique and the obvious
Professor Zsolt J. Balogh

1:50 pm
The Relevance of Psychoneuroimmunology (PNI) for Trauma Patients and Trauma Care Providers
Dr Rebecca Ryznar

2:20 pm
Polytrauma: the basic science
Professor Zsolt J. Balogh

2:40 pm
Multiple outcome prognostic modelling for older adults after trauma: development and validation of the Older Trauma Outcome Predictor model
Dr Mayura Iddagoda

3:00 pm
Discussion

03 May 2026

3:30 pm - 4:00 pm
Afternoon Tea - Sunday

Catering - *Cross Discipline* - Pavillion 1

03 May 2026

4:00 pm - 5:30 pm
Cardiothoracic - Research Papers

Scientific Session - Cardiothoracic Surgery - Meeting Room M1

4:00 pm
The Feasibility of Utilising a Generic Large Language Model for Endovascular Aneurysm Repair Planning
Dr Bijit Munshi
Aim: The use of artificial intelligence is set to be a paradigm shift in the way vascular surgery is practiced. In this study, we aimed to investigate the use of generic large language models for the planning of endovascular aneurysm repair (EVAR). Method: 21 patients who had been selected by a surgeon for a Cook standard infrarenal EVAR at Royal Hobart Hospital were identified between September 2021 to September 2025. A single surgeon's measurements of main body, contralateral and ipsilateral limb diameters and lengths were collected through Cook planning worksheets. A ChatGPT-5 large language model was then used to predict EVAR component selection. The model was trained to oversize by ~10-20%, leaving enough space to cannulate the contralateral gate, and maximising overlap between main body and limbs. Measurements were inputted using a standardised dialogue and a plan was generated. The Cook worksheet plan and ChatGPT plan were compared to intra-operative graft sizes used, and feasibility of the ChatGPT plan was assessed by two investigators. Results were analysed using correlation matrices and Spearman coefficients were calculated. Results: All ChatGPT plans were feasible for overall anatomy although there were variations in main body and limb lengths. The ChatGPT plans demonstrated statistically significant correlation to the intra-operative graft sizes used. Main body diameter/length, contralateral limb diameter, and ipsilateral limb diameter/length showed high degrees of correlation ($p<0.001$). Contralateral limb length also correlated ($p = 0.013$). Conclusion: It is feasible to use a trained generic large language model for EVAR planning.

4:12 pm
Take a PUNT on PLUNT – incorporating lymphovascular invasion to produce a more robust tool for recurrence risk in node-negative NSCLC patients.
Dr Ayeshmanthe Rathnayake
Background: There is a major deficiency of a national comprehensive thoracic oncology surgery data especially in regional and remote areas such as Tasmania1. Unique to this region is its large proportion of elderly persons. The PUNT score utilises high risk features of pleural involvement, unassignable histology, neutrophil-to-lymphocyte ratio (NLR) >3.5 and tumour size to help identify patients with node-negative NSCLC at significantly discordant risk of recurrence to their TNM staging. Lymphovascular invasion, a risk factor for recurrence, was not incorporated in this score. Methods: This retrospective analysis examined all thoracic oncology cases undergoing surgical resection at Royal Hobart Hospital (2010-2022). A subgroup analysis was done on elderly node-negative lung cancer patients. We developed the PLUNT scoring system, incorporating lymphovascular invasion into the established PUNT framework, and compared prognostic performance using Cox proportional hazards regression and Kaplan-Meier survival analysis. Results: Eighty-six elderly patients with node-negative NSCLC were analysed using the PUNT and PLUNT scoring (mean age 75.2 years, 51.2% male). PLUNT > 2.0 identified 12 high-risk patients (14.0%) with 33.3% recurrence rate, while PUNT > 1.5 identified 10 patients (11.6%) with 30.0% recurrence rate. In multivariate analysis, PLUNT > 2.0 achieved statistical significance as an independent predictor of recurrence-free survival (HR = 3.700, 95% CI: 1.033-13.252, $p = 0.0456$), while PUNT > 1.5 failed to reach significance ($p = 0.1609$). Conclusions: PLUNT

scoring demonstrates superior prognostic performance over PUNT thus providing enhanced risk stratification crucial for clinical decision-making. The incorporation of lymphovascular invasion significantly improves prognostic accuracy, supporting personalized treatment approaches such as the potential role in adjuvant therapy for high-risk patients.

4:24 pm
Impact of acute and chronic glycaemic control on mortality post cardiac surgery
Dr Aniket Nadkarni

4:36 pm
The role of pre-operative biopsy on surgical timing, pathological upstaging and benign resection rates in lung cancer surgery
Dr Lauren Whearty
Purpose: Lung cancer is the leading cause of cancer-related mortality worldwide and in Australasia, prompting the introduction of lung cancer screening programs in Australia and New Zealand. As screening identifies increasing numbers of pulmonary nodules, surgical pathways must ensure timely and effective intervention. This study evaluated the impact of pre-operative biopsy on time to surgery and rates of benign lung resection in patients with high clinical suspicion of malignancy. Methodology: A retrospective review was conducted of all patients undergoing lung resection between January 2023 and December 2024 at a tertiary referral centre responsible for approximately one third of New Zealand's thoracic surgical workload. Cases were identified from hospital databases, with clinical data obtained from electronic medical records. Patients were grouped according to pre-operative biopsy versus direct resection based on high clinical suspicion confirmed at multidisciplinary meeting (MDM). Statistical analysis was performed using IBM SPSS version 31. Results: A total of 440 patients were included. Mean age was 66 years (SD 12), with 177 patients (40%) female. Mean Eastern Cooperative Oncology Group (ECOG) performance status was 0 (SD 1). Lobectomy was performed in 307 patients (70%). Pre-operative biopsy was undertaken in 130 patients (30%), while 295 patients (70%) proceeded directly to resection. Median time to surgery was longer in the biopsy group (42 days [IQR 30–55]) compared with the non-biopsy group (32 days [IQR 21–55]). Final histopathology demonstrated primary lung cancer in 378 patients (86%), metastatic disease in 22 patients (5%), and benign pathology in 59 patients (13%). Conclusion: Most patients undergoing lung resection based on high clinical suspicion had malignant pathology despite low biopsy utilisation. The benign resection rate of 13% aligns with international benchmarks. Pre-operative biopsy was associated with delayed time to surgery, supporting the importance of patient selection for pre-operative biopsy.

4:48 pm
Forged in Steel: The Historical Evolution of Vascular Clamps and the Surgeons Behind Them
Dr Thomas Morgan

5:00 pm
Early Outcomes of Inner-Branched Endovascular Aortic Repair (IBEVAR) For Complex Aortic Pathologies: An Australian multicentre experience
Dr Haywood Yeung

5:12 pm
Discussion

4:00 pm - 5:30 pm
How I Do It: Frontline Decisions in Modern Trauma Surgery

Scientific Session - Trauma Surgery - Meeting Room M7

4:00 pm
Trauma Laparoscopy and Other Minimally Invasive Ideas
Dr Rohit Sarvepalli

4:15 pm
Burns Surgery: A 2026 Update
Dr Carl Lisec

4:30 pm

CAB versus ABC in patients with hemorrhagic shock
Professor Juan C Duchesne

4:45 pm
Pushing the Imaging Frontier in 2026 Trauma Care
Dr Himanshu Pendse

5:00 pm
The Haemodynamically Unstable Pelvic Fracture Challenge
Dr Martin Jarmin

5:15 pm
The Pulseless Limb: What to Do in the First 30 Minutes
Dr Irina Baimatova

4:00 pm - 5:30 pm
RESEARCH FORUM - MIXED SPECIALITIES

Scientific Session - General Surgery, *Cross Discipline*, Hernia Surgery, HPB Surgery, Bariatric Surgery - Meeting Room M2

4:00 pm
Weight-reduction surgery as an adjunct to renal transplantation: a single centre retrospective study.
Dr Stephanie Cornish
Renal transplantation is well established as a life-altering and liberating intervention for patients who are dialysis-dependent. However, obesity is often a barrier to transplantation, and is associated with an increased risk of graft failure and other complications. A retrospective analysis was performed at a single quaternary centre, covering 5 years of patients referred to a state-wide public Bariatric service for special consideration of weight-loss surgery as an adjunct to being listed for renal transplantation. Of the 16 patients referred, 13 opted to proceed, and 12 have undergone weight-reduction surgery. 75% (9/12) have gone on to successful renal transplantation, and the remaining 25% are listed awaiting an appropriate donor. 83.3% (10/12) successfully met their weight target within 12 months of their surgery with a mean BMI reduction of 13.39±4.19, which is comparable to non-dialysis cohorts in the literature, while the remaining two patients both had a BMI reduction >11 and underwent successful transplantation. Within the overall cohort of patients, only one had a notable morbidity event within 30 days of bariatric surgery or their transplant. This suggests that weight-loss surgery in the context of dialysis and potential renal transplantation may see significant benefit without an unacceptable level of risk.

4:12 pm
Prevalence and Follow-up of Iron Deficiency Anaemia in Acute Surgical Unit Admissions: A Retrospective Observational Study
Dr Emily Hammond
Iron deficiency anaemia (IDA) is common yet often under-investigated in surgical inpatients, contributing to delayed recovery, transfusion risk, and missed gastrointestinal malignancy. This study examined the prevalence, investigation, and follow-up outcomes of IDA among acute general surgical admissions. A retrospective audit was conducted for all Acute Surgical Unit admissions between January–March 2025. Demographics, haemoglobin, iron studies and endoscopy results were extracted from electronic records. Anaemia was defined using WHO thresholds and IDA as anaemia with ferritin <30 µg/L or transferrin saturation <20%. Patients were excluded if medically unsuitable for endoscopy, post-trauma, pregnant or recently scoped. Descriptive statistics and chi-square testing were performed. Of 866 admissions, 842 patients had bloods available. Anaemia occurred in 174 patients (20%), with 70 meeting biochemical criteria for IDA (8%). IDA patients were older than the total cohort (median 68.5 vs 48 years). Forty patients were appropriate for endoscopic investigation; 20 (50%) were referred, but only 13 procedures occurred within 6 months. Clinically significant pathology was identified in 11/13 cases (85%), including adenomatous polyps (15%) and malignancy (5%). Anaemia severity was not associated with likelihood of referral. IDA was prevalent and frequently under-investigated. Endoscopic yield was high, suggesting missed opportunity for diagnosis and intervention. Routine iron studies for anaemic patients and Direct-to-Scope pathways may improve detection of significant pathology. References World Health Organization 2019, Anaemia. Goddard AF et al. Gut. 2011.

4:24 pm
Stridor After Dinner: Airway Emergency from Iatrogenic Mega-Oesophagus Following Adjustable Gastric Banding. A Case Report and Literature Review
Dr Telvinderjit Singh Harbhajan Singh

4:36 pm
Emergency Laparotomy, To Proceed or Not To Proceed - A Holistic Approach to Risk Evaluation
Dr Ryan Teh
Purpose of Study To investigate risk prediction tools for emergency laparotomy (EL) in older adults ≥65-years-old in a tertiary Acute Surgical Unit. Methods Patients who underwent EL between April 2021 and April 2022 had baseline characteristics and Clinical Frailty Scale (CFS) prospectively collected; Charlson's Comorbidity Index (CCI), National Exploratory Laparotomy Audit (NELA), Physiological and Operative Severity (P-Possum), National Surgical Quality Improvement Program (NSQIP) scores, and clinical outcomes retrospectively collected. Binary logistics regression was adjusted for age, CFS and CCI. Results Of 114 patients undergoing EL, average age 76.7±7.6 years old, 46.5% (n=53) were not frail (CFS 1-3), 41.2% (n=47) mildly frail (CFS 4-5), 12.3% (n=14) severely frail (CFS ≥5); 4.4% (n=5) mildly, 34.2% (n=39) moderately, 61.4% (n=70) severely comorbid. 30-day and 1-year mortality were 10.5% (n=12) and 16.7% (n=19) respectively. Before adjustment, NELA was associated with 1.05 (95% CI, 1.02-1.10, p=0.007) and 1.08 (95% CI, 1.04-1.12, p<0.001), P-Possum 1.02 (95% CI, 1.00-1.05, p=0.061) and 1.04 (95% CI, 1.02-1.07, p=0.001), NSQIP-mortality 1.06 (95% CI, 1.02-1.10, p=0.007) and 1.06 (95% CI, 1.02-1.10, p=0.006) times 30-day and 1-year mortality respectively. After multivariable adjustment, NELA and P-Possum were not associated with 30-day mortality. Increments in NSQIP-mortality was associated with 1.05 times 30-day mortality (95% CI, 1.01-1.10, p=0.029). Increments in NELA was associated with 1.06 (95% CI, 1.02-1.11, p=0.005), P-Possum 1.03 (95% CI, 1.01-1.07, p=0.021) and NSQIP-mortality 1.05 (95% CI, 1.01-1.10, p=0.030) 1-year mortality respectively. Conclusion For EL in older adults with frailty and comorbidity, NSQIP provides complementary prediction for short-term mortality. NELA, P-Possum and NSQIP provide risk-prediction for mid-term mortality.

4:48 pm
Body-image and health-related quality of life outcomes of abdominoplasty for rectus diastasis of parity
Dr Siobhan Fitzpatrick
Purpose: Symptomatic Established Rectus Diastasis (SERD) of parity is reported to be associated with decreased health-related quality of life and body-image satisfaction. Correction of rectus diastasis with abdominoplasty (with muscle plication) has been shown to improve quality of life in patient reported outcome measures (PROMs) research. However, the impact of rectus diastasis and surgical correction on women's body-image and health-related quality of life compared to normative values using the BODY-Q has not been previously demonstrated. Methods: This was a prospective study on Australian women over 18-years old with rectus diastasis of parity undergoing abdominoplasty with diastasis repair. Women with an inter-rectus distance of >30mm confirmed on ultrasound and symptoms such as back pain and/or urinary incontinence were included. The BODY-Q instrument was administered online pre-op and then at least 6-months post-op and means were compared. Pre- and post-op scores were also compared to published normative values for women matched for age and BMI. Ethical approval from SAC HREC. Results: 117 women underwent abdominoplasty for SERD. BODY-Q scores were significantly higher after surgery than pre-op values for all scales (p<0.001). Pre-op BODY-Q scores for all scales were significantly worse than normative values (p<0.001) except for social function, which was similar. Post-op, BODY-Q scores for all scales were significantly better than normative values (p<0.001), except for physical and sexual function which were similar to normative. Conclusions: Women with SERD demonstrate significantly worse body-image satisfaction and health-related quality of life compared to normative populations of women. Surgical correction with abdominoplasty results in statistically significant and clinically meaningful improvements in health-related quality of life measured by the BODY-Q, to the level of normative populations of women.

5:00 pm
Resection margin in hepatocellular carcinoma
Dr Patrick Walker
Purpose There is much debate regarding the acceptable surgical margin for HCC resection. emerging evidence suggests that narrower margins and even R1 resections provide comparable oncological results for resection of HCC. We seek to compare survival outcomes following liver resection for HCC between patient based on their margin status. Methodology This retrospective cohort study examines patients that underwent primary liver resection for HCC in a tertiary referral centre in Western Australia between 2010 and 2025. Variables were analysed by plotting Kaplan-Meier survival curves, univariate analysis using Cox regression and by creating multivariate Cox models to identify independent predictors of survival. Results 107 patients underwent liver resection for HCC during the study period. 89 (83.18%), 12(11.21%) and 6 (5.61%) patients had R0, R1 and R2 resections respectively. 61 (57.01%) of patients were cirrhotic. 23 (21.29%) of

patients underwent a major hepatectomy. 45 (42.06%) patients had recurrence of HCC during the period of study. 36 (33.64%) patients died during the period of the study. Multivariate analysis demonstrated that patients experiencing an R2 resection have significantly decreased disease free survival (HR: 2.90, CI: 1.14 – 7.41, p: 0.026) and overall survival (HR: 3.34, CI: 1.15 – 9.70, p: 0.027). There was no difference in disease free or overall survival between patients with R0 and R1 resections. Cirrhosis, BCLC stage and patients undergoing a major resection were not found to be significant predictors of survival. Conclusion Patients that experience R2 resections have a significantly poorer survival following HCC resection. We identified no difference in outcome when comparing R0 to R1 resections. Acceptance of R1 resections as a reasonable surgical outcome could enable a parenchymal sparing approach in HCC resection and allow patients with borderline remnant liver volume to access potentially curative resection.

5:12 pm
Non-technical errors, the hidden killer in emergency general surgery: A national retrospective cohort study.
Dr Jesse Ey
Purpose: Non-technical errors (NTEs) contribute substantially to patient harm. Emergency general surgery is common, complex, and high-risk for NTEs, yet the incidence and characteristics of fatal NTEs remain unclear. This study aimed to characterise the incidence, clinical phase, team responsibility, and behavioural drivers of fatal NTEs in emergency general surgery to inform future non-technical skills (NTS) improvement strategies. Methods: A retrospective cohort study of all emergency general surgical mortalities with an adverse event or area of concern from the Australian and New Zealand Audit of Surgical Mortality (ANZASM) from 2012–2019 was conducted. Cases were independently assessed by two reviewers using a validated tool, with disagreements resolved by a third reviewer. Results: Fatal NTEs occurred in 790/1164 (67.9%) deaths, with a total of 1053 errors. Situational awareness errors were most common (518/1053, 49.3%), followed by decision-making (431/1053, 40.9%). Most errors arose from few recurrent behaviours: for situational awareness, failure to recognise clinical signs (92/518, 17.8%), failure to appreciate illness severity (75/518, 14.5%), missed diagnosis (73/518, 14.1%); for decision-making, failure to initiate appropriate intervention/investigation (99/431, 23%), incorrect operation (71/431, 16.5%). Error distribution differed across clinical phases (χ^2=1325, p<0.01), with 947/1053 (89.9%) occurring outside the operating theatre. Surgical teams were responsible for 652/888 (73.4%) single-team and 109/116 (94%) multi-team errors; non-surgical teams for 235/888 (26.5%) single-team and 112/116 (96.6%) multi-team errors. Conclusions: Fatal NTEs mainly occurred outside the operating theatre, involved both surgical and non-surgical teams, and arose from few recurrent behaviours. These findings reveal a mismatch between traditional NTS improvement efforts and the contexts in which fatal NTEs occur, identifying actionable targets for future interventions.

4:00 pm - 5:15 pm
RESEARCH FORUM - MIXED SPECIALITIES

Scientific Session - Health Policy & Advocacy, Rural Surgery, *Cross Discipline*, Women in Surgery, Plastic & Reconstructive Surgery, Surgical History - Meeting Room M3

4:00 pm
Continuity of locum consultant engagement improves elective and endoscopic service delivery in regional Australian hospitals
Dr Syed Ali Abbas Rizvi
Purpose Regional hospitals across Australia rely heavily on locum consultant surgeons to maintain emergency surgical services. However, the impact of continuity of locum engagement on elective surgical and endoscopic access remains poorly defined. This study evaluates whether recurrent locum consultant engagement is associated with improved elective and endoscopic service delivery compared with short-term locum placements. Methodology A retrospective service evaluation was conducted using a prospectively maintained consultant logbook documenting all operative and endoscopic activity between March and December 2025. Data were collected across regional hospitals in Queensland, New South Wales, Victoria and South Australia. A regional hospital supported by recurrent monthly locum engagement (“continuity site”) was compared with multiple hospitals covered by short-term locum placements. Outcomes included elective and emergency operative volume, endoscopy activity and procedural case mix. Results At the continuity site, recurrent locum engagement supported substantial elective throughput alongside sustained emergency cover, including 111 colonoscopies, 53 gastroscopies, 23 haemorrhoid banding procedures and a broad range of elective general surgical operations. Emergency surgical activity remained significant and included appendicectomy, emergency laparotomy, bowel resection and emergency endoscopy for gastrointestinal bleeding. In contrast, short-term locum placements were predominantly emergency-focused, with limited elective and endoscopic service provision and minimal

opportunity for planned follow-up or elective conversion. Conclusion Continuity-based locum consultant models enhance elective surgical and endoscopic access in regional hospitals while maintaining emergency surgical capacity. Structured continuity of locum engagement represents a pragmatic workforce strategy to reduce surgical access inequity across regional Australia.

4:12 pm
Providing a Remote Surgical Service, Lessons from the NHS
A/Prof Elizabeth Penington
The Shetland Islands are the most northerly outpost of the United Kingdom. Shetland lies at 60 degrees North and is home to a population of 23,000 people on an archipelago of over 100 islands, 16 permanently inhabited. It is 110 miles north of the British mainland, 140 miles west of Norway, and 240 miles (by sea or air) north of Aberdeen Royal Infirmary, the closest tertiary hospital. The remoteness of Shetland and its substantial population necessitates the local presence of a capable surgical service. Four consultant general surgeons are currently in post with the expectation of working a 1 in 3 roster when “on island”, and they cover all surgical emergencies including some operative orthopaedics. There is a unique breadth and depth of skills required by the island surgeons, and the accrual of these has been greatly assisted by the Rural Surgical Fellowship. This fellowship is funded nationally by NHS Education for Scotland and provides up to 2 years of bespoke training, around or after completion of conventional general surgery training. It is ideally combined with a ‘proleptic’ appointment to one of Scotland’s 6 rural general hospitals and areas of focus will be tailored to the anticipated service needs. Elements can include Orthopaedics, Urology, Breast Surgery, Interventional Radiology and Obstetrics. Quality assurance is taken seriously. Surgeons participate in several weekly regional MDT discussions for cancer cases and orthopaedics. In recent years, appointed consultant surgeons have had regular humanitarian leave to work in low and middle-income countries. This has provided surgeons with experience of large numbers of complex major cases; otherwise hard to access while serving a small population. Shetland is an “unknown” to much of the UK let alone Australia, but their commitment and approach to providing a high quality locally led surgical service in a remote environment has many elements that could be adopted into the Australian system.

4:24 pm
Application of mesh protocol to the treatment of subcutaneous haematomas
Sina Sobhanmanesh
Background: Subcutaneous haematomas in elderly patients with dermatoporosis and comorbidities such as cardiovascular disease pose a high risk of skin necrosis, infection and morbidity. Conventional management using surgical debridement followed by non-operatively wound care or skin grafting is often prolonged, resource-intensive or associated with high morbidity. This study aims to evaluate the efficacy of the mesh protocol, a technique originally used for skin tears, as a novel, resource-efficient method for managing subcutaneous haematomas. Methods: A retrospective case series was conducted at Northern Beaches Hospital (November 2023–October 2024) including six elderly patients (mean age 92 years) with lower limb subcutaneous haematomas who underwent haematoma evacuation and mesh protocol application. The protocol involved meshing of excised viable skin and grafting it back onto the wound bed after evacuation of haematoma under local or general anaesthetic. Outcomes assessed included graft take at first review (days 5–7) and complications. Results: The time from injury to intervention ranged from 12 hours to 10 days. All six patients achieved 100% graft take with no incidence of graft failure, infection or need for further surgery. Procedures were predominantly performed at bedside under local anaesthetic and full healing was achieved in under three weeks in some cases. Conclusions: The mesh protocol is a safe, effective, and cost-efficient technique for subcutaneous haematoma management. Early haematoma evacuation with preservation and meshing of viable skin may minimise morbidity and accelerate healing, representing a valuable alternative to traditional approaches.

4:36 pm
Leveraging the WHO Operative Encounter Registry to Improve Equitable Access to Surgical, Obstetric, Trauma, and Anaesthesia Care
Dr Neil Wetzig

4:48 pm
Surgical Progress: History of advancements in Gender Affirming Surgery
Dr James Kieu
The surgical management of gender incongruence has progressed from isolated and largely experimental interventions in the early 20th century to a well-established, multidisciplinary field that is associated with meaningful improvements in quality of life for transgender individuals. Some of the earliest documented gender-affirming procedures were performed in the 1920s and 1930s at Magnus Hirschfeld’s Institut für Sexualwissenschaft in Berlin, where early vaginoplasty techniques were developed. 95 years ago, Dora

Richter was widely recognised as the first individual to undergo complete male-to-female genital reconstruction, including orchiectomy, penectomy and vaginoplasty (Richter 1892–1966). Substantial advances in masculinising reconstruction occurred in the mid-20th century. Sir Harold Gillies performed one of the earliest female-to-male phalloplasty procedures in the 1940s, using a staged reconstructive approach that laid important foundations for contemporary surgical techniques (Frey et al. 2017; Gillies 1882–1960). Since that time, phalloplasty has evolved considerably, with microsurgical free-flap reconstruction now regarded as standard practice in specialised, high-volume centres (Alba et al. 2024). Alongside developments in gender-affirming genital surgery, advances in transplant surgery have marked further milestones. In 2016, the first successful live birth following uterus transplantation in the United States expanded the scope of reproductive surgery (Cheng 2019). Concurrent progress in vascularised composite allotransplantation, including penile transplantation, has raised the possibility of future integration into gender-affirming reconstructive pathways (de Haseth 2023). Collectively, these milestones reflect significant advances in surgical technique, ethical governance and multidisciplinary care, underscoring the role of gender-affirming surgery in improving psychosocial wellbeing and health outcomes for transgender patients.

5:00 pm
From Alexander the Great's Blade to Stephen Hawking's Breath: A History of Tracheostomy
Dr Tony Lian
Purpose: This review aims to highlight key advances in the evolution of tracheostomy and tracheal intubation, and contextualise their impact on survival, ranging from ancient legends such as Alexander the Great to standardised modern critical care. Methodology: A literature review was conducted, summarising the historical development of airway management, with a focus on tracheostomy. Results: The origins of tracheostomy trace back to ancient civilisations, with the earliest depictions found in Greek and Roman texts around 2000 BC. Legend attributes one of the first life-saving tracheal incisions to Alexander the Great, who reportedly used his sword to open a soldier’s airway suffocating from an aspirated bone. In the thirteenth century, tracheostomy was formally condemned as a “semi-slaughter and a scandal of surgery.” During the Renaissance, progress continued when anatomist Andreas Vesalius demonstrated maintenance of animal ventilation through a reed passed into the trachea. Italian physician Antonio Brassavola reintroduced tracheostomy in humans in 1546 by performing the first documented successful tracheostomy. Further surgical accounts by French surgeon Nicholas Habicot in 1620 underscored its controversial use, including for a convicted thief who sought a pre-gallows tracheostomy. The 19th and 20th century ushered in significant technological progress in airway management with the development of laryngoscopy. Direct laryngoscopy was pioneered in 1895 by ENT surgeon Alfred Kirstein. Instrumentation improved in 1943 with the introduction of the Macintosh laryngoscope blade by Sir Robert Macintosh. The procedure’s profound, modern impact was exemplified by physicist Stephen Hawking, whose life was prolonged by decades following a tracheostomy necessitated by pneumonia in 1985. Conclusion: The extensive history of tracheostomy demonstrates the evolution of surgical techniques and reflects its trajectory from a last-resort emergency procedure to precise critical care.