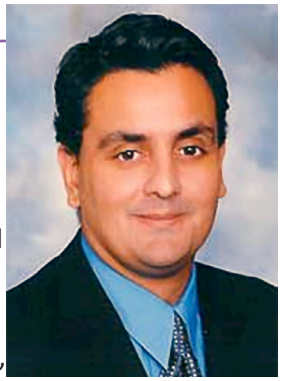
AASTDAILY MEETING NEWS

What is Happening Today – Wednesday September 26th, 2018

By – Jose Pascual Lopez, AAST Daily Editor



Welcome to San Diego! In this warm opening day for the 77 th Annual Meeting of the American Association for the Surgery of Trauma & the Clinical Congress of Acute Care Surgery, it is our pleasure to also join with The 4 th World Trauma Congress. A key session to look out for will the AAST presidential address of Dr. Michael F. Rotondo scheduled for 11:50 AM in Seaport D-H on the second floor, as well as 2 WTC panels, one on Hemorrhage Control for Complex Pelvic Fractures (Seaport D-H, second floor @ 10:40am) and the other on Traumatic Coagulopathy: Is it all the same? (Seaport D-H, second floor @ 5PM). Of course, as per tradition the top podium papers will be presented and discussed at Session I (Seaport D-H, second floor @ 8AM), moderated by Dr. Rotondo, and at Session V (Seaport D-H, second floor @ 2:15PM) papers on Trauma Systems, and moderated by Dr. Croce. Some interesting lunch sessions will also be available for registered participants at 1PM. At the same time, The Society of Trauma Nurses presents an afternoon discussion entitled Back to Basics: The Nuts and Bolts of Building Your Trauma Center. The day will end with the customary Professor Rounds where AAST/WTC posters will be presented (Harbor D-I, second floor @ 6PM). Lots of stimulating topics and discussions … Make sure you attend one or more of them!

Welcome to the 77th Annual Meeting of AAST & Clinical Congress of Acute Care Surgery and the 4th World Trauma Congress

Presented By: The American Assoiciation for the Surgery of Trauma & The World Coalition for Trauma Care

CME UPDATE

Rachel Sass – AAST Education Manager

The big event is here! Since my hire in March as the new Education Manager for AAST, I've been looking forward to attending our annual meeting and formally introducing myself to our members and meeting attendees alike. Please stop by the Education Booth to formally introduce yourself – I'd love to meet you!

This year we've put together an amazing program with the World Trauma Congress. Attendees are eligible to claim up to 40 AMA PRA Category 1 Credits™ (this includes attending a pre-session and both a Wednesday and Friday lunch session). A total of 12.50 self-assessment credits are available for certain sessions. Attendees will claim CME each day and will be prompted to do so from an email that will be sent at roughly 4:00 PM Pacific Daylight Time. If you don't receive the email or have problems claiming your CME, please stop by the Education Booth.

Have a wonderful time!

-Rachel Sass

Acute Care Surgery Maintenance of Certification Pre-Session

By Carlos Brown, MD – AAST Education Committee

The Acute Care Surgery, Maintenance of Certification session was held on Tuesday afternoon. The course started off with a trauma session with excellent presentations covering penetrating neck injuries, whole blood transfusion, and non-narcotic options for pain management. Dr. Kenji Inaba (Los Angeles, CA) shared his approach to the diagnosis and initial management of penetrating neck injuries. He emphasized the importance of physical exam in the diagnosis of penetrating neck injury. Those with hard signs of vascular injury or aerodigestive injury should be taken to the operating for exploration. Those without evidence of vascular or aerodigestive injury should be worked up with a CT angiogram, a study that has replaced the need for conventional angiography, pan-endoscopy, and contrast studies. Dr. Marty Schreiber (Portland, OR) then followed with an excellent presentation over the emerging use of whole blood in civilian trauma practice. He recommended the implementation of cold stored whole blood as the resuscitation fluid of choice for trauma patients presenting in hemorrhagic shock. Low titer blood type O (Rh- for women of child bearing age) may be used as universal donor whole blood. Dr. Andrew Bernard (Lexington, KY) closed the trauma session with a timely talk on the non-narcotic options for pain management of trauma patients. In the context of the opioid epidemic he recommended an obvious limitation of narcotics with a scaled approach of non-narcotic pain management, particularly emphasizing the use of the combination of acetaminophen and NSAIDs as well as the emerging role of ketamine infusion.

The second session covered a diverse mix of surgical critical care topics including end of life care, ARDS, and the use of ultrasound in the ICU. Dr. Chris Cocanour (Sacramento, CA) shared her expertise and experience on end of life care in trauma and surgical patients. When faced with the challenging situation of providing end of life care, she recommended a multidisciplinary approach to caring for the patient with a major emphasis on improving communication skills among health care providers talking with patient surrogates. Dr. Matt Martin (San Diego, CA) gave an update on the management of ARDS. He recommended the traditional low tidal ventilation but also advocated for more recent advances including neuromuscular blockade, proning, and possibly a course of steroids in early ARDS. In addition, he discussed some emerging favorable literature regarding ECMO for ARDS. Finally, Dr. Niels Martin (Philadelphia, PA) presented his experience with the application of ultrasound in the ICU. In particular, he presented the literature supporting

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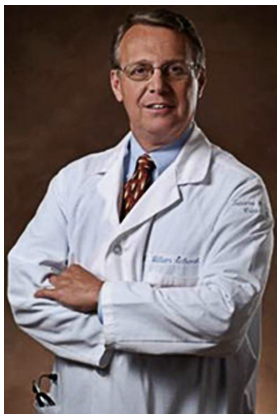
44th Fitts Orator

Interview with C.William Schwab, MD, FACS



The Fitts Lecture was established in 1974 by the AAST to honor Dr. William Fitts, Jr., who was an orthopedic surgeon. He trained at the University of Pennsylvania, had a distinguished military career during World War II, and went on to spend his entire career at the University of Pennsylvania, eventually becoming the Chair of Surgery there.

Anyone who is interested in learning more about Dr. Fitts, who was truly a fascinating person, should read the excellent review article in the Journal of Trauma written by Dr. Patrick Kim in 2007.

Patrick Reilly MD FACS: So this year's Fitts lecture will be given by a past President of EAST, AAST and IATSIC, C. William Schwab, MD, FACS. Dr. Schwab will be the 44th Fitts Orator and his talk will be on Friday, September 28 th . Dr. Schwab, some of our membership might not know the relationship you and the University of Pennsylvania have to Dr. Fitts. In fact, you were the senior author on a presentation at the 2006 AAST given by Carter Nance, as well as a subsequent publication in the Journal of Trauma and Acute Care Surgery that reviews Dr. Fitts' life career. Can you share with us any anecdotes about Dr. Fitt's career?

C William Schwab MD FACS: Thanks Dr. Reilly. It is a once in a lifetime experience and unique tribute to be the 44 th Fitts orator at this year's AAST. The Fitts lectureship is one of the most prestigious in trauma surgery. Dr. Fitts has been a very powerful force behind my professional career in trauma and surgery. I had the opportunity to meet with him when I was a resident and vividly recall our interactions and discussions. He was the personification of a surgical "giant" of those days: inspirational, charismatic, dogmatic and decisive. Speed ahead ten years, and I find myself joining the faculty of surgery in "his department" at the University of Pennsylvania. Many of the men and women who served with Dr. Fitts were on staff and some of his family living in Philadelphia. In an attempt to record some the highlights of his life, I convened a group to write a piece on Fitts (JTrauma. 2007;63, (1): 221-227). Key to this endeavor were involving Carter Nance, a past president of the AAST and resident under Dr. Fitts; Michael Fitts, his son, then the Dean of the law school at Penn and his brother Tom Fitts a surgeon in South Carolina. I would encourage all to read this article as is captures his journey from rural Tennessee as a boy, to his service in the Army medical corps in the jungles of Burma during World War II and onward to become the most impactful figure of the AAST and editor of our Journal during the formative years of the 1960s and 70s.

Reilly: That's a fascinating background for the talk and certainly helps explain your ongoing interest in military and civilian injury care that was at the heart of your Scudder Oration. Dr. Schwab can you tell us what it means for you to be the Fitts Orator this year?

Schwab: William T. "Billy" Fitts was a visionary, and long before many others Fitts spoke, wrote and showed by his example the need for highly organized and functional trauma teams and the requirement for specially trained surgeons to improve the care of the injured and advance the science of injury. In addition, he sought to unify the surgical disciplines necessary for trauma care under a single banner, the AAST. And lastly, his early military experiences made him a strong advocate for the synergisms between military and civilian surgery and the key role that should play in addressing mass casualty events. As I said, this is a tremendous honor and at the same time, it is daunting to think that I am following in the shadow of Dr. Fitts and the previous orators, and therefore, have the responsibility to deliver a lasting and impactful message.

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DON'T FORGET TO SIGN UP FOR A TABLE AT THE ANNUAL BANQUET!

Banquet sign-up is MANDATORY.

Please visit the banquet sign-up desk in Seaport Foyer and select your table ASAP. Banquet sign-up ends at 10:00 am on Friday, September 28 th .

Fitts Orator — Continued from page 3

Reilly: Can you tell us the title of your Fitts Oration?

Schwab: The title of my Fitts Oration is Damage Control and Firearm Death: The Tale of Two Cities.

Reilly: Could you give us a little insight into what you're going to talk about without necessarily giving away the whole story of your lecture?

Schwab: Dr. Rotondo asked me to reflect back on the last 25 years of work done at the University of Pennsylvania to study and direct public policy in an effort to lower the toll of firearm death and injury in America. I became interested in this shortly after coming to Penn in the late 80s as our trauma center became saturated with victims and gun wounding from handguns. Though exciting for surgeons and trauma teams, the death and devastation was uncontrollable and emotionally overwhelming. Nevertheless, we needed new approaches as so many of these young men were dying on our operating tables, and
to our distain, many died after we had controlled the bleeding and fixed all their injuries. Learning from others, many of whom will be attending the meeting, brought us to the Damage Control approach.

But medical care had no effect on the violence epidemic. In an attempt to characterize the problem, we began to look for the root causes. Our efforts

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MAKE SURE TO VISIT THE EXHIBITORS AND VIEW THE AAST & WTC POSTERS TODAY!

Exhibit Hall opens at 5:00 PM.
Opening Reception and Poster Session will start at 6:00 PM

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Fitts Orator — Continued from page 4

did heighten the awareness about the problem, especially within the medical community, but sadly, was ineffectual to gain a foothold at creating any effective or sustainable policy within the federal government.

My job in the upcoming Fitts oration will be to identify the important lessons learned from the past and attempt to give some insights into a way forward.

Reilly: I look forward to your talk, and I think it will be well received. As you know, the ACSCOT and the prevention committees of ASST, EAST and the WTA have all again weighed in on these issues in recent months, and all agree that funding of sound scientific studies in a public health approach to firearm injury is sorely needed. Now recently, you've also had an opportunity to be involved in the NASEM report that looked at the future of trauma systems and specifically military-civilian collaboration. Can you just give us a couple of thoughts on that experience and how you think it may move injury care forward in the next number of years?

Schwab: Let me just say that the National Academy of Sciences, Engineering and Medicine's report on creating a national trauma system by combining the military and civilian trauma sectors is a "page turner!!!" Similar to the National Research Council's report on Accidental Death and Disability of 50 years ago, the NASEM committee was moved by the data, evidence and testimony that showed our country still lacks a comprehensive trauma system and is ill prepared to respond disaster and mass casualty events. These mass casualty responses have become an almost daily responsibility of the emergency, and in particular, the surgical professions. Of interest our committee was not formed in response to these challenges but rather to identify ways to learn from the Military Health System its advances in trauma care learned in Iraq and Afghanistan. During the same time period, civilian trauma systems had not developed uniformly and most continued to lack integrated and comprehensive data for prehospital care, from non-trauma center hospitals, medical examiners and about longer term outcomes. Our committee felt that the best way to eliminate the 25,000-30,000 preventable deaths annually in the US was to partner both systems as one national trauma system and in that way, assure the military lessons were adopted by the civilian sector, guarantee bidirectional learning in the future and provide military trauma surgeons access to civilian training platforms to assure combat surgical readiness. Although I won't be speaking on the NASEM report specifically the linkage between the escalation of mass casualty shootings, need to prepare all hospitals to respond to these, and the findings of the NASEM report coalesce to give insight as to how we must respond to the new face of firearm violence.

Reilly: Great. Just going to finish up with a few last questions. You 've been involved in the training of more than 100 Fellows here at Penn Medicine and some of the AAST membership might not realize that your very first fellow here at Penn was our own AAST President Michael F. Rotondo. Do you have any anecdotes about Dr. Rotondo's time as a fellow or faculty member you'd like to share with the organization?

Schwab: Dr. Reilly, that is a loaded question!! Yes, I have many anecdotes, some even printable! Mike Rotondo was our first Penn fellow and started in 1989. Between 1988 and 1996 the City of Philadelphia suffered under a rapidly escalating siege of gun wars. The sheer number of dead, dying and horrendously wounded patients arriving at our center increased exponentially. The wounding patterns were unlike anything that I had encountered in the military. At the time, there were just three faculty trauma surgeons, Drs. Don Kauder, Mike McGonigal and myself. We quickly became overwhelmed. We needed help--- Solution? Early "field promotion!" Dr. Rotondo became "faculty" on the spot!! And in typical Rotondo fashion, took on the challenge with great vigor. We all learned exponentially from one another, and it was obvious that MFR was destined for great things! Oh, and did I mention that we four shared a profoundly warped sense of humor? That "Band of Brothers" was forged from the carnage of the streets of Philadelphia and to this day, the four of us remain great friends and "partners" for life.

Reilly: Dr. Schwab any final thoughts as we conclude this interview?

Schwab: The history of Bill Fitts and all that he brought to this organization, its Journal and to the advancement of our field, puts a tremendous spotlight on this oration. I will try and do my best and make Dr. Fitts proud. It's the penultimate honor, and I thank you, and the AAST.

AAST PANEL SESSION:

Thursday, September 27, 2018, 8:50–10:00 AM

How Should We Position Acute Care Surgery in the Landscape of Healthcare Economics

Topics:

Setting the Stage – Us Economics Trends

Kristan Staudenmayer, MD, MSc

Macroeconomic trends in US healthcare

Workforce Scope of ACS

The Devil is in the Details – What is Affecting Our Practice Now

Jay Doucet, MD, MSc

RVU and global compensation

The ACA, capitation, and value-based care

Other factors affecting our patients—surprise bills

Local Economics – Advocating Value and Meeting Local Needs

Andrew Bernard, MD

Benefit of ACS for outcomes

Advocating value in your department in the RVU-based world

Balancing act—reimbursement from non procedural revenue vs. procedures

Wrap-Up

Joseph Minei, MD, MBA

Summarize strategy for AAST and academic organizations

Recommended Research Areas on which to focus

WTC PANEL SESSIONS:

Wednesday, September 26, 2018, 10:40–11:40 AM

Hemorrhage Control for Complex Pelvic Fractures

Moderators: Ingo Marzi, MD, and Clay Cothren Burlew, MD

Role of Fixation: Ingo Marzi, MD

Role of Pelvic Packing: Clay Cothren Burlew, MD

Role of Endovascular Techniques: Ryosuke Usui, MD

Wednesday, September 26, 2018, 5:00–6:00 PM

Traumatic Coagulopathy: Is it All the Same?

Moderators: Yasuhiro Otomo, MD, PhD, and Mitchell Cohen, MD

European Bleeding Guidelines: Radko Komadina, MD

DIC or Trauma-Induced Coagulopathy?

*Western Perspective: Bryan Cotton, MD

*Eastern Perspective: Yasuhiro Otomo, MD, PhD

Thursday, September 27, 2018, 11:15 AM – 12:15 PM

Pro/Con Debate

Moderators: Ari Leppaniemi, MD, PhD, and Zsolt Balogh, MD, PhD

Laparoscopy in Trauma

*Pro: Selman Uranus, MD

*Con: David Feliciano, MD

Grade IV Splenic Injury with Blush

*Splenectomy: Andrew Peitzman, MD

*Angio/Emobolization: Federico Coccolini, MD

Acute Care Surgery — Continued from page 2

the use of ultrasound for the evaluation of hemodynamics. He really drove home the fact that ultrasound is a dynamic, non-invasive, and inexpensive tool to evaluate the hemodynamic status and intravascular volume of a patient in the ICU.

The final session covered several aspects of emergency general surgery including the use of laparoscopy, care of the pregnant patient, and management of the open abdomen in emergency general surgery. Dr. Andre Campbell (San Francisco, CA) started the session with a video-based talk describing minimally invasive techniques in trauma and emergency surgery. He particularly recommended the use of diagnostic laparoscopy in the hemodynamically stable patient with penetrating abdominal trauma to determine peritoneal violation. Dr. Ali Salim (Boston, MA) followed with current recommendations for the management of emergency surgery diseases in the pregnant patient. He emphasized becoming familiar with the anatomic and physiologic changes in pregnancy, realize there are two patients but the mother is the priority, radiology can be obtained as needed, and laparoscopy is safe in all three trimesters. Finally, Dr. Paula Ferrada (Richmond, VA) presented her approach to management of the challenging scenario of an open abdomen in the emergency general surgery patient. Best option is to avoid open abdomen all together. If abdomen is left open then recommendations include temporary abdominal closure followed by sequential closure and eventual primary closure. Ideally you would like to close as soon as the patient is ready and preferably within one week.

Firearm Injury Prevention: It Starts with a Conversation

By M. Margaret Knudson MD, FACS and Deborah Kuhls MD, FACS

Hosted by the Injury Prevention and the Pediatric Trauma Committees of the AAST, the pre-session on firearms focused on prevention strategies including discussions between surgeons and at-risk patients. The session was opened by Dr. Richard Falcone who set the stage and described the sad case of a 4 year old twin who found his father's service weapon and accidentally and fatally shot his twin brother. It appears that homicide rates are decreasing in the pediatric population while suicides are increasing. Getting the data on guns in the home is difficult. Of note, children can't often tell the difference between toy guns and real guns. The epidemiology of firearm injuries among adults was reviewed by Dr. Ronald Stewart who has facilitated extremely important prevention initiatives for the American College of Surgeons. He demonstrated that homicide rates are actually increasing in the adult population in contrast to children. Also increasing in recent years are mass shootings especially in the Americas compared to the rest of the world. Dr. Stephanie Boone discussed the link between domestic violence and guns suggesting that the presence of a gun in a domestic situation increases the risk of a woman being murdered by a factor of 5. Dr.Peter Masiakos reminded the audience that mass shootings account for less than 1% of firearm related deaths, while suicides account for 63%, emphasizing the importance of safe storage laws to protect children and adolescents. Dr. Zara Cooper discussed the risk to older adults of having a gun at home, particularly when dementia sets in and advocated for a plan to "retire" firearms for geriatric patients. Dr. Dorian Lamis described a method of Means Safety Counseling for at-risk patients, emphasizing that poisoning/overdoses among those attempting suicide are only 2% fatal, while using firearms for this purpose results in an 84% fatality rate. Dr. Brendan Campbell reminded us that 30% of households contain guns and 13% have them stored where they are accessible to children. Parents have unrealistic views of what children understand about guns. The COT has initiated a table based firearm safety project aimed at parents. Dr. Eric Kuncir is a retired Navy surgeon and opined that military veterans are comfortable with having loaded weapons around due to their combat training. He outlined various methods of safe gun storage and smart guns that are capable of recognizing the gun's owner. Dr, Kuhls summarized the survey results from the ACS demonstrating that ACS members overwhelmingly support the role of surgeons in promoting gun safety for their patients. Drs. Rochelle Dicker and Thomas Duncan outlined the lethal triad affecting violent injuries which includes mental illness, substance abuse, and poverty. Lack of social capital is another risk factor for violence. A successful hospital-based violence prevention program can decrease recidivism by 25%. Dr. Eileen Bulger, the current Chair of the ACS/COT, described methods of advocating for firearm safety at the state and local level, focusing on firearm injuries as a public health problem and recognizing that states with the strictest guns laws have lower rates of gun-related deaths and injuries.

THING TO DO IN SAN DIEGO!

Go to a Padres Game!

Experience the USA Today #1 MLB ballpark with your fellow 2018 AAST Conference attendees. To purchase discounted tickets click here and enter the password: AAST18. For more information or to purchase groups of 10 or more please contact Logan Washburn at 619.795.5137 or lwashburn@padres.com

Gaslamp Quarter

A lively downtown neighborhood known for its nightlife set in a 16 square-block mixture of Victorian-era buildings and modern skyscrapers. From shopping to museums, there is plenty to do on your own or with family. Learn more.

La Jolla Cove

One of the most photographed beaches in Southern California, La Jolla Cove has water visibility that can at times exceed 30 feet. Surrounded not only by sandstone cliffs but by plenty of restaurants and activities. Learn more.

Cabrillo National Monument

From hiking to tidepooling, Cabrillo National Monument is a seaside park located at the southern tip of the Point Loma Peninsula. Learn more.

Belmont Park

A beachside amusement park in Mission Bay, Belmont Park has plenty of rides and attractions for people of all ages. Parking and admission is free, you pay as you play! Learn more.

SAGES: Hands-On Laparoscopic Common Bile Duct Exploration

By Matthew Bloom, MD, MSEE, FACS

The AAST and SAGES partnered together to present a Hands-On Laparoscopic Common Bile Duct Exploration Course prior to the start of the 77th Annual Meeting of AAST and Clinical Congress of Acute Care Surgery and 4th World Trauma Congress.This oversubscribed course was moderated by Dr. Matthew Bloom of Cedars-Sinai who showed data demonstrating a median decreased length of patient stays of 2 days, and a close to 40+% direct and total cost savings of performing a single procedure vs cholecystectomy with separate ERCP. Dr. Eric Hungness of Northwestern University spoke about the performance and interpretation of the cholangiogram, and alternative methods of safe dissection of the gallbladder in difficult cases. He emphasized the importance of obtaining the critical view of safety, and the importance of routine cholangiography as a means to identify stones, clarify anatomy, and recognize iatrogenic injury early. Dr. Ezra Teitelbaum of Northwestern discussed the proper method of transcystic duct exploration, and tricks to optimize success. He showed operative videos demonstrating the technique, and suggested inclusive criteria of patients with less than 6 stones, maximal stone size of less than 1 cm, and an absence of hepatic ductal stonesDr. Fernando Santos demonstrated videos of difficult cases, and methods of choledocoscopy. He suggested that surgeons begin with simple, single stone cases, and proceed with more difficult cases as their experience increases, knowing that post-operative ERPC still remains an option.Dr. Dennis Kim, who recently started a LCBCE program from the trauma/acute care service at Harbor/UCLA, discussed his experience with the residents and staff regarding the new program. He stressed the importance of including the nursing staff in the training and making it clear how beneficial the single procedure is to patients. His residents have enjoyed learning the procedure and actively participate in the cases.In the hands-on laboratory portion, each student had the chance to practice laparoscopic common bile duct exploration with clearance of the common bile duct using a video choledochoscope and basket extraction techniques on a simulator. A 1:3 ratio of instructors to students enabled the surgeons to have multiple opportunities to perform the procedure. In a separate session, proper back table equipment setup was reviewed, as well as the composition of a dedicated ready-to-grab LCBDE cart for operating room staff to use. Participants also learned how to deploy laparoscopic antegrade biliary stents and their indications. “Taking back the management of common duct stones from our colleagues in GI medicine makes both clinical and economic sense. Shorter lengths of stay and decreased direct and total healthcare costs are realized when choledochal stone disease is treated in a single operation”, said Dr. Bloom. “Besides,...clearing the duct is the most fun you’re going to have during a cholecystectomy.”

MORE THING TO DO IN SAN DIEGO!

Sunset Cliffs

As the name suggests, the view of the sunset from Sunset Cliffs is second to none. Sunsets are not the only thing to see at the beach, however, California gray whales and other sea life can also be seen from time to time. Learn more.

Ferry to Coronado Island

Skip the drive and catch a ferry from downtown San Diego to Coronado Island and spend the day exploring everything the island has to offer. Learn more.

San Diego Zoo

One of the largest zoological membership associations in the world, the San Diego Zoo is one of the few zoos in the US that houses the giant panda. The zoo is home to 3,500 animals representing 650 species. Learn more.

Old Town

The historic heart of San Diego, Old Town was created in 1769 and was California’s first settlement. In the Old Town San Diego State Historic Park you can experience life from the early Mexican-American period, blacksmith and all. The historic park is located in the center of Old Town which itself is nestled in the heart of San Diego. Learn more.