A Message from the Chair...

The 2010-11 academic year holds tremendous promise for the Department of Surgery as we capitalize on the achievements of the last few years and look forward to expanding services throughout the department and surgical services as a whole. Tulane surgery has taken a leadership role in areas as diverse as international rural trauma and pre-hospital care initiatives; evaluating the interaction of stem cells and breast cancer metastasis; to the development of novel surgical techniques such as robotic transaxialary total thyroidectomy. The Faculty, Residents and Staff of the department continue to work tirelessly to promote advances in surgical science and surgical patient care.

A new addition to the department is Matthew Cowell, who takes the reigns as the department's Practice Development Manager. Matthew is working with University, Medical School and HCA leadership to encourage strategies to promote Tulane Department of Surgery locally, regionally and nationally. In addition to practice development, Matthew and his team (Monique LeCompte and Caroline Barber) are renewing a commitment to alumni relations and we look forward to having more interaction with our alumni than ever before.

In the last newsletter I mentioned the implementation of the Surgical Services concept at Tulane. This organizational construct enables the surgery departments to work more closely together to better manage surgical initiatives in the areas of patient care, research and education. Dean Sachs provided guidance in setting up the Surgical Services concept and the affiliated board. The Surgical Services concept is based upon an understanding that in the modern economic environment flexibility and responsiveness is critical to success. By putting the Chairs and Section Chiefs of the surgical departments and divisions together, Tulane Surgery as a whole can plan more effectively, utilize resources with greater effectiveness, and ensure areas of collaboration are maximized. By consolidating shared services such as surgical education and clinical research infrastructure the surgical services team is better able to meet the needs of all surgical Faculty. In addition, the collaboration embodied in the Surgical Services concept allows for greater consistency and higher quality.

We are excited to see Surgical Services evolve and strengthen and are confident it will be a model that will be replicated in many academic medical centers throughout the country.

Douglas P. Slakey, M.D., M.P.H.
Professor & Chair
**Department Update**

**Dr. Ernest Chiu's** research project, “The Use of Adipose Stem Cells in Breast Surgery: Friend or Foe?, has been chosen as the recipient of an Aesthetic Surgery Education and Research Foundation Grant in the amount of $40,000.

**Dr. Anil Paramesh** was recently awarded a grant from the American Organ Procurement Organization (AOPO) to study the use of lymph nodes vs. serum for transplant crossmatching.

**Dr. Jim Korndorffer** recently received a patent on a laparoscopic camera training device that will be used by the Fundamentals of Laparoscopic Surgery program of the ACS and SAGES.

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**Did you know?**

The Department of Surgery has received 626 resident applications this year for 4 spots.

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2010
American College of Surgeons Clinical Congress Reception
Washington, DC

*On October 4, 2010 the LSU, Ochsner and Tulane Departments of Surgery held an reception during the American College of Surgeons Clinical Congress in Washington, DC.*

At the conference, Dr. Emad Kandil presented his experience with robotic transaxillary thyroid surgery with intraoperative nerve monitoring. He also presented his data on robotic adrenal surgery with intraoperative endoscopic ultrasound.
“Watch and Wait”
Safe for Many Incisional Hernias
For Patients at Low Risk, Incarceration Rare
Over Two-year Follow-up

Although there is little support for it in the surgical literature, a pilot study has confirmed what experts say is a common practice among surgeons: It is safe to simply observe many patients who have asymptomatic incisional hernias.

Studies to support the approach of “watchful waiting” for incisional hernias are important on several levels, experts say, from avoiding surgical complications and lowering health care costs to protecting surgeons legally.

The single-institution study was performed at the Michael E. DeBakey VA Medical Center in Houston, and results were presented at the 2010 annual meeting of the American Hernia Society (AHS).

Although incisional hernia operations are elective, surgeons are taught that these hernias, even if asymptomatic, should be repaired to avoid a later complication like bowel strangulation. Consequently, more than 200,000 repairs are performed annually at a cost of approximately $2.5 billion, with rates of complications including infection as high as 44% in some reports of open repair, according to Charles Bellows, MD, associate professor and chief of general surgery at Tulane University, in New Orleans, and the study’s lead author.

In addition, among those patients who have underlying comorbidities like chronic obstructive pulmonary disease and heart and liver disease, the high risk for a difficult-to-manage mesh infection tips the risk-benefit ratio toward watchful waiting.

“As the risk of complications after incisional hernia repair increases, the benefits from surgery become unacceptable,” said Dr. Bellows.

Although many surgeons put off an operation in a patient with an asymptomatic incisional hernia because of the high risk for complications, there are few data on the natural history of these hernias and how patients fare when left untreated.

“What Dr. Bellows is trying to do is prove that it’s safe [to observe], and I think it was a very logical thing to do,” said Robert Fitzgibbons Jr., MD, professor and chief of general surgery at Creighton University in Omaha, and a leading author of studies on watchful waiting in patients with inguinal hernias.

In the VA study, 42 men with incisional hernias were enrolled in a watchful-waiting trial over 11 months in 2005 and 2006. These patients were asymptomatic, refused surgery or were deemed “high-risk” for surgical complications.

Patients were told to watch for hernia symptoms with physician follow-up scheduled at two, six and 12 months. Main outcome measures were pain and discomfort interfering with usual activities as measured by the Activity Assessment Scale (AAS) and physical function and quality of life as measured by the SF-36 Health Survey. Secondary measures included patient-reported pain and complications like incarceration.

In the VA study population, average age was 64 years and mean body mass index (BMI) was 32 kg/m². Average hernia size was 205 cm² (range, 16-870 cm²), and patients had an average of 2.4 previous repairs.

Thirty-eight patients completed the study. During the 12-month period, there were 33 emergency room (ER) visits, but only eight were for hernia-related issues. Of these ER visits, four resulted in a hospital admission (three patients). Two of the patients were admitted for bowel obstruction, and one patient was admitted twice for hernia-related pain. Acute hernia accident/incarceration occurred in one patient (2.3%) within one year of watchful waiting.

AAS scores remained similar throughout the study period (baseline, 24.2; after 12 months, 24.3). In addition, the patients’ physical functioning on the SF-36 decreased from 40.8 to 36.5, and mental functioning increased from 48.5 to 55 during the study period.

Pain scores on the Brief Pain Inventory and the 10-point visual analog scale decreased slightly over the year of observation.

“It appears that quality of life does not significantly change over 12 months, pain does not worsen and the risk of acute hernia accidents is low,” Dr. Bellows said. “This means that one can safely offer nonoperative treatment in patients with large, uncomplicated incisional hernias without the fear of incarceration or a significant decline in the patient’s quality of life due to the hernia disease.”

Dr. Bellows also commented that in the second year of follow-up, which was not reported at the AHS meeting, there have been no further incarcerations.
Both Drs. Bellows and Fitzgibbons were quick to point out that the pendulum should not swing completely toward observation. Any patient who definitely wishes to have a hernia fixed should have an operation offered to them, and certain hernias prone to later problems should continue to be repaired prophylactically.

“Watchful waiting is best for those patients who are deemed high-risk for surgery [and] who are minimally symptomatic or asymptomatic and who do not report any pain from their hernia that interferes with normal activities,” Dr. Bellows said. “Watchful waiting is most likely not right for those patients with severe debilitating pain from their hernia disease, and this approach should most likely not be used for small defects,” he added, characterizing hernias less than 3 x 3 cm as those too small to leave alone.

In addition to the small neck suggested by Dr. Bellows, Dr. Fitzgibbons included an incarcerated, irreducible hernia or one with a history of rapid enlargement as relative indications for surgery.

Dr. Bellows said an observational approach for incisional hernia needs a well-designed, multi-center, prospective randomized controlled trial to confirm that his results from a small group of VA patients hold true for the general population.

If confirmation does occur, Dr. Fitzgibbons said watchful waiting likely would be embraced by the surgical community at large.

“I think that surgeons would welcome it, just as they did for inguinal hernias,” Dr. Fitzgibbons said. “In general, I think surgeons would like to see in the literature confirmation of what they’re actually [already] doing, if for no other reason than medicolegal reasons.

Just like the potato chip, that you can’t have just one, Cambodia is a country you can’t visit just once. I discovered that almost four years ago, when my wife, Marlene, and I visited Cambodia and Laos under the auspices of People to People in a trip co-sponsored by the American College of Surgeons Operation Giveback program. We met the remarkably generous and loving Khmer people, and were staggered by their lack of resources and medical knowledge. One brief trip and I was hooked. I have returned several times each year since and have already planned for four educational missions this academic year.

The major focus of my project has been trauma care, and it takes just one moment on the massively crowded streets of Phnom Penh to understand Cambodia’s incredible mortality rate from motor vehicle accidents, said to be the highest in the world. The variety of vehicles is impressive, including automobiles, lorries piled high with goods and people, motorcycles each carrying as many as five passengers, bicycles, rickshaws (called cyclos), and tuk tuks (small four-passenger vehicles propelled by tiny lawn motor engines that go tuk tuk tuk tuk tuk). Traffic lanes and signals aren’t even suggestions; drivers ignore lanes completely and turn at will from anywhere in the road without signaling. The few drivers who stop for the occasional traffic signals don’t wait for the light to turn green before charging ahead.

Trauma care is not taught in the developing medical education system. There is no specialty of emergency medicine or trauma surgery; the emergency departments of the central and university hospitals are staffed by rotation by all staff members. Thus a patient with a serious injury is likely to be cared for the hospital gynecologist, pediatrician, dermatologist, etc.

Over the last four years I have trained hundreds of doctors, nurses and medical students on the care of injured patients. I have developed a two-day course focusing on protocol-driven assessment, resuscitation, and definitive care, leaving charts of the protocols in every ED. Operation Smile has adopted the project and provides significant educational support, including staff, translators, intubatable mannequins, etc...
Cambodia Program continued...

It is hard to imagine, but CPR is not taught in medical school or residency programs. The course is given in English (most Cambodians younger than 40 years of age learned English in school and are bilingual) but the syllabus, slides, and multiple choice examination (required to receive the certificate of completion from Operation Smile, which carries a lot of weight) are simultaneously translated into Khmer. I have taught this course in the two medical schools in Phnom Penh, one of which is in session only on weekends to allow students to work during the week. In addition to the university (public) hospitals in Phnom Penh, I have also trained the medical personnel in all the regional hospitals, in Siem Reap, Battambang, and Sihanookville. It has been incredibly rewarding to return to the teaching sites and watch trauma care provided in the effective, structured manner I have taught the staffs. Several months ago, in a direct response to the training program, Tulane has entered into an affiliation agreement with the University of the Health Sciences of the Royal University of Cambodia to allow for an exchange of residents and medical students, a program that has just gotten underway in the last few months.

With the apparent success of the educational program (Operation Smile’s assessment, not mine), I have been assured at least three more years of funding for staff (I pay the overwhelming majority of my own expenses), and we have entered into a period of expansion. For example, during my first 2010 mission, I trained more than 350 Vietnamese medical personnel in hospitals in Ho Chi Minh and Hanoi (including the Vietnam Military University and Hospital). We have made plans to bring this program to the regional medical centers throughout Vietnam over the next two or three years. I also taught the course this October to the staff of the Mittaphab Hospital, the major trauma facility in Vientiane, Laos, as well as a pediatric trauma variant to the National Women’s and Children’s Hospital in Vientiane. Via an intermediary foundation that operates in Myanmar, we have been invited to teach at the First Medical School in Yangon, Burma, this November.

Since the ambulance systems in these developing countries are primitive (they are for-profit and the drivers have no medical training), the majority of first responders are police officers. Accordingly, in my most recent trip, I taught injury care on the streets and safe transport to 206 policemen and women in the Police Academy of Cambodia, which serves the entire country.

Operation Smile is interested in supporting additional classes to assure continuity and to allow me to expand into additional areas in Asia and elsewhere. For example, Mali, Rwanda, and the Democratic Republic of the Congo are being discussed currently. Dr. Rodney Steiner, Chief of Pediatric Surgery, has already accompanied me to Cambodia last Fall, and others are scheduled to assist in upcoming training missions.

As a huge benefit to the Tulane surgical training program, funding has been offered by Operation Smile via the Regan Foundation for resident participation in these missions, all expenses paid. PGY 3’s will be accompanying me on a regular basis and act as faculty for the 2-3 week educational missions.

Dr. Marie Unruh was first and joined the October 2010 mission to Cambodia and Laos. Dr. Marquinn Duke will travel with me in November to Myanmar and Vietnam. The remainder of the PGY3’s will be involved in spring missions. This is an incredible opportunity for Tulane residents to see and participate in educational programs in the Third World and, needless to say, a striking recruiting advantage for Tulane’s residency program.

http://www.operationsmile.org/
While laparoscopy has revolutionized surgery by improving patient outcomes it requires that the surgeon master a new skill set. Contrary to open surgery, where surgeons have complete visual and tactile control of the operating field, during laparoscopic procedures both of these senses are altered. Tactile feedback from the operating field is limited due to the nature of the laparoscopic instruments and visual control is impacted by both the loss of depth perception and because the surgeon has to rely on an assistant to control the camera and the corresponding field of view.

Laparoscopic camera navigation (LCN) is perceived to be an easy task but in reality it requires a unique set of skills including centering the operative field, maintaining a correct horizontal axis, holding a steady image, and tracking instruments in motion. Significant dexterity is required to ensure the correct use of the additional degrees of freedom afforded by an angled laparoscope, particularly when sizing the field of vision appropriately. Inefficient camera navigation skills require that the surgeon divert their attention from the operation and may lengthen procedure times.

Creating proper visualization for the surgeon depends on the ability of the camera operator but the skill required to operate the camera is far from intuitive and camera operators may need to overcome a considerable learning curve before becoming proficient. Laparoscopic training of surgeons outside of the operating room has been shown to improve surgeon skill and efficiency but, historically, little time has been spent on training the camera operators in situations other than an active surgery. In order to counter this deficiency Dr. James Korndorffer, Professor of Clinical Surgery and Director of the Tulane Center for Advanced Medical Simulation, has developed a cost-effective LCN simulation system that has been shown to significantly improve the operating room performance of camera operators.

Dr. Korndorffer has received a patent for this device and has licensed it, free of royalties, to the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) where it will be used in the Fundamentals of Laparoscopic Surgery program, enhancing training nationally.

**Tulane Advanced Medical Simulation Center**

Website:  http://tulane.edu/som/sim/
Office:  (504) 988-9150
Fax:  (504) 988-9151
Alumni Information

On the Tulane Medical Alumni Association (TMAA) website you’ll find items like networking resources for potential employers and employees, notices about events and news about Tulane Medicine and alumni.

The mission of the Tulane Alumni Association is to promote the interest, welfare and advancement of the Tulane University School of Medicine, to advance the cause of medical education, and to maintain close and mutually beneficial relationships among the Tulane medical alumni, students and institutional leadership.

On the TMAA site you will find an online alumni community, locate a friend finder, continuing medical education information in addition to much more useful information. Remember to sign up for their mailing list at http://tmaa.tulane.edu so you’ll be updated on the latest TMAA events and news.

If you have any alumni related questions or need additional information please contact Cynthia Hayes, Executive Director, Tulane Medical Alumni Association.

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Dr. Juan Duchesne visited his son’s, Esteban Duchesne, Pre-K4 class at St. Clement of Rome School in Metairie, Louisiana. The class was studying the letter “D” during that week so they had Dr. Duchesne come in as a community helper that starts with this letter.
DR. CHARLES BELLOWS, III, General Surgery, Surgical Research, Laparoscopic Surgery

Publication

DR. ABIGAIL CHAFFIN, Plastic & Reconstructive Surgery

Publication

Presentation
CHAFFIN, A. E. (Presenter Only), Department of Surgery Grand Rounds, Tulane University School of Medicine, New Orleans, LA, "Abdominal Wall Reconstruction," Academic, Local. (March 24, 2010).

DR. ERNEST CHIU, Plastic & Reconstructive Surgery

Publications


Presentations


CHIU, E. S. (Presenter Only), Department of Surgery Grand Rounds, Tulane University School of Medicine, New Orleans, LA, "Current Options in Head and Neck Reconstruction," Academic, Local. (January 20, 2010)
**DR. JUAN DUCHESNE, Trauma Critical Care**

**Publications**


**Presentations**


DUCHESNE, J. C. (Presenter Only), Military Pre-Hospital Resuscitation Task Force, Dallas, TX, "Role of lyophilized fibrinogen in hemorrhagic shock.," Non-Academic, Invited. (January 2010).


**DR. PAUL FRIEDLANDER, Otolaryngology Oncology**

**Publications**


Dr. Friedlander continued


DR. BERNARD JAFFE, Professor Of Surgery Emeritus

Publication


DR. EMAD KANDIL, Endocrine Surgery

Publications


Presentations


KANDIL, E., Tulane Cancer & Transplant Symposium, Tulane University School of Medicine, New Orleans, LA, "Robotics in minimally invasive GI surgery," Academic. (April 10, 2010).

KANDIL, E., Dept of Medicine Grand Rounds, Tulane University School of Medicine, New Orleans, LA, "Thyroid cancer: Current guidelines," Academic, Local. (April 7, 2010).
Dr. Kandil continued

KANDIL, E., Dept of Otolaryngology Grand Rounds, Tulane University School of Medicine, New Orleans, LA, "Endocrine head and neck surgery," Academic, Local. (March 18, 2010).

KANDIL, E., 2nd Annual Symposium on Thyroid and Parathyroid Diseases, Tulane University School of Medicine, New Orleans, LA, "Current surgical management of primary hyperparathyroidism." (March 6, 2010).

KANDIL, E., 2nd Annual Symposium on Thyroid and Parathyroid Diseases, Tulane University School of Medicine, New Orleans, LA, "Technical Advice on Transaxillary Robotic Thyroid Surgery." (March 6, 2010).

KANDIL, E., 2nd Annual Symposium on Thyroid and Parathyroid Diseases, Tulane University School of Medicine, New Orleans, LA, "Ultrasound of Neck." (March 6, 2010).

KANDIL, E., Pan American Oncology Symposium, M.D. Anderson Hospital, Houston, TX, "Nerve Monitoring during Transaxillary Robotic Thyroid Surgery." (February 25, 2010).

KANDIL, E., Oncology Grand Rounds, Tulane University School of Medicine, New Orleans, LA, "Current management of thyroid cancer." (February 12, 2010).


KANDIL, E., LACS/SAL Joint Annual Meeting, Louisiana Chapter of American College of Surgeons/Surgical Association of Louisiana, New Orleans, LA, "Does a preoperative PTH level predict the likelihood of multiglandular disease in primary hyperparathyroidism?," State. (January 17, 2010).

KANDIL, E., LACS/SAL Joint Annual Meeting, Louisiana Chapter of American College of Surgeons/Surgical Association of Louisiana, New Orleans, LA, "Is the intraoperative parathyroid hormone assay in patients with primary hyperparathyroidism and double adenoma important?," State. (January 17, 2010).

KANDIL, E., Surgery Grand Rounds, Tulane University School of Medicine, New Orleans, LA, "Thyroid and Parathyroid Surgery: Who moved my cheese?" (January 13, 2010).

**DR. MARY KILLACKEY**, Abdominal Transplant Surgery

Publication


**DR. JENNIFER MCGEE**, Abdominal Transplant Surgery

Publications


Dr. McGee continued

Presentations

MCSWAIN, N. E. (Presenter Only), Surgery Grand Rounds, Tulane University School of Medicine, New Orleans, LA, "Surgical Diagnosis and Management of Abdominal Trauma.,” Academic, Local, Invited. (April 14, 2010).


MCSWAIN, N. E. (Presenter Only), Surgery Grand Rounds, Tulane University School of Medicine, New Orleans, LA, "Kinematics.," Academic, Local, Invited. (February 24, 2010).


MCSWAIN, N. E. (Presenter Only), Surgery Grand Rounds, Tulane University School of Medicine, New Orleans, LA, "Kinematics.," Academic, Local, Invited. (February 24, 2010).


DR. PETER MEADE, Trauma Critical Care & General Surgery

Publication


DR. ANIL PARAMESH, Abdominal Transplant Surgery

Publication


DR. DOUGLAS P. SLAKEY, Abdominal Transplant Surgery

Publications


Presentations


**RONALD STEIN, Nurse Practitioner, Abdominal Transplant Surgery**

**Presentation**

STEIN, R. A., National League for Nursing Education Summit, Baltimore, Maryland, "Cultural Sensitization of Nursing Students to Inner City Client's Economic Constraints."

**DR. THOMAS YEH, Pediatric Cardiothoracic Surgery**

**Publications**


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If your call is regarding plastic surgery call 504-988-4167.

**The Cutting Edge**

To learn more about the Tulane Department of Surgery, please visit [http://tulane.edu/som/departments/surgery/](http://tulane.edu/som/departments/surgery/)

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