EUROPEAN SURGICAL ASSOCIATION

Twenty-fifth Annual Meeting

11th- 12th May, 2018

Starhotels Savoia Excelsior Palace, Trieste - Italy

Programme

Final - WEB Edition

EUROPEAN SURGICAL ASSOCIATION

WELCOME

It is a pleasure to welcome ESA members, honorary members, and guests to the 25th Annual Meeting of the European Surgical Association.

Trieste is an unusual venue, since our meetings are usually held in national capitals. For this reason, I am particularly honoured by the Association's unconventional choice. The history of my city, its blend of Mitteleuropean, Italian, and Mediterranean cultures, makes it a crossroads well worth discovering. The city's architecture clearly illustrates its Roman, medieval, and neoclassical roots, which come together in its easily visited city centre.

The venue for the Meeting and the hotel accommodations are located in the heart of the city along the seafront, with a unique view of the only Italian city on the Adriatic where the sun sets over the sea.

The Welcome Party will take place just one hundred meters from the Meeting's venue, in a historic café located on the largest Italian seafront city square, so as to highlight Trieste's centuries-old bond with the sea.

The Gala Dinner will take place at the Meeting's venue, where guests will be able to socialize while sampling some of Trieste's typical dishes.

All of these places are located quite close to one another, allowing participants ample time to see each other and chat even outside of the conference itself.

There will be programmes for spouses and other guests of the participants, visiting the most characteristic attractions in the city and its surroundings.

For anyone who intends to stay on Sunday as well, there will be a wine and oil tasting event to conclude your visit to Trieste where our best olive oils and wines are produced.

The entire organizational staff will be at your disposal for the duration of the Meeting, and we wish you a pleasant and productive stay in Trieste for one of the year's key surgical events.

Professor Nicolò de Manzini
Local Organiser
&
Professor Mario Morino
ESA President

PERSONAL NOTES

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SCIENTIFIC PROGRAMME

THURSDAY, MAY 10th 2018

15:00 - 19:00 REGISTRATION

FRIDAY, MAY 11th 2018

07:00 REGISTRATION

08:00 - 08:20 PRESIDENT'S WELCOME
Presentation of new members confirmed.

08:20 - 10:20 SESSION I *Papers 1 > 6*
Moderators: M. Morino, J-M. Regimbeau

01] The influence of anti-reflux surgery on esophageal cancer risk - national population-based cohort study.

Sheraz Markar [1], Chanpreet Arhi [1], Astrid Leusink [1], Alberto Vidal-Diez [1], Alan Karthikesalingam [2], Jesper Lagergren [3], George Hanna [1]
(1) Imperial College London - London - United kingdom
(2) St George's University of London - London - United kingdom
(3) Karolinska Institutet - Stockholm - Sweden

02] Iniquity in the access of patients with pancreatic duct adenocarcinoma (PDAC) to resection surgery. A national evaluation in Western Europe.

Olivier Farges [1], Noelle Bendersky [1], Pascal Hammel [1]
(1) Hôpital Beaujon, APHP, University paris 7 - Clichy - France

03] The prevalence of burnout among surgical residents: a survey at an Italian university hospital.

Matteo Serenari [1], Antonio Daniele Pinna [1], Katia Mattarozzi [2], Guido Fallani [1], Valentina Colonnello [2], Alessandro Cucchetti [1], Matteo Cescon [1], Paolo Maria Russo [2], Gilberto Poggioli[3]
(1) Department of Medical and Surgical Sciences – DIMEC, S.Orsola – Malpighi Hospital, Alma Mater Studiorum, University of Bologna - Bologna - Italy
(2) Department of Experimental, Diagnostic and Specialty Medicine - DIMES, S.Orsola – Malpighi Hospital, Alma Mater Studiorum, University of Bologna - Bologna – Italy
(3) Chief of Surgical Residency Program, University of Bologna, S.Orsola Hospital - Italy

04] Laparoscopic versus open pancreatoduodenectomy: the PADULAP randomized controlled trial.

Ignasi Poves [1], Fernando Burdío [1], Olga Morató [1], Aleksandar Radosevic [2], Mar Iglesias [3], Lucas Ilzarbe [4], Laura Visa [5], Luís Grande [1]
(1) Department of Surgery, Hospital del Mar - Barcelona - Spain
(2) Department of Radiology, Hospital del Mar - Barcelona - Spain
(3) Department of Pathology, Hospital del Mar - Barcelona - Spain
(4) Department of Gastroenterology, Hospital del Mar - Barcelona - Spain
(5) Department of Oncology, Hospital del Mar - Barcelona - Spain

05] Perioperative hydrocortisone treatment reduces postoperative pancreatic fistula after distal pancreatectomy. A randomized controlled trial.

Johanna Laukkarinen [1], Anne Antila [1], Antti Siiki [1], Juhani Sand [1]
(1) Dept. of Gastroenterology and Alimentary Tract Surgery, Tampere University Hospital - Tampere - Finland

06] Open vs laparoscopic liver surgery for colorectal liver metastases (LapOpHuva): a prospective randomized controlled trial.

López-López Victor [1], Ricardo Robles [1], Asunción López-Conesa [1], Roberto Brusadin [1], Pedro Jose Gil [1], Alvaro Navarro [1], Pascual Parrilla [1]
(1) HosPital Clinico Universitario Virgen de la Arrixaca - Murcia - Spain

10:20 - 10:45 COFFEE BREAK

10:45 - 12:45 SESSION II *Papers 7 > 12*

Moderators: E. Barroso, H. Lang

07] The growing discrepancy between resident training in colon surgery and rising numbers of general surgery graduates.

Samuel Käser [1], **Matthias Turina** [1], Andreas Rickenbacher [1], Daniela Cabalzar-Wondberg [1], Marcel Schneider [1]
(1) Division of General Surgery, Department of Surgery and Transplantation, University Hospital - Zurich - Switzerland

08] Centralization of colorectal cancer care over the last decade did not improve outcomes in Germany, a nation-wide analysis of hospital data.

Daniel R. Perez [1], **Tarik Ghadban** [1], Maximillian Bockhorn [1], Matthias Reeh [1], Jameel T. Miro [1], Jakob R. Izbicki [1]
(1) Department of General, Visceral and Thoracic Surgery, University Medical Center Hamburg-Eppendorf - Hamburg - Germany

09] Liver transplantation and hepatic resection can achieve the cure for hepatocellular carcinoma.

Antonio Daniele Pinna [1], Tian Yang [2], Vincenzo Mazzaferro [3], Luciano De Carlis [4], Jian Zhou [5], Sasan Roayaie [6], Feng Shen [7], Carlo Sposito [3], Matteo Cescon [1], Stefano Di Sandro [4], He Yi-Feng [5], Philip Johnson [8], **Alessandro Cucchetti** [1]

(1) Department of Medical and Surgical Sciences – DIMEC; Alma Mater Studiorum – University of Bologna, Bologna, Italy - Bologna - Italy

(2) Eastern Hepatobiliary Surgery Hospital; Second Military Medical University - Shanghai - China

(3) General Surgery and Liver Transplantation Unit, University of Milano and Istituto Nazionale Tumori (National Cancer Institute), IRCCS Foundation - Milano - Italy

(4) General Surgery and Abdominal Transplantation Unit, University of Milano-Bicocca and Niguarda-Cà Granda Hospital - Milano - Italy

(5) Liver Surgery Department, Liver Cancer Institute, Zhongshan Hospital, Fudan University - Shanghai - China

(6) Liver Cancer Program; White Plains Hospital - Montefiore Health System, White Plains - New York - United states

(7) Eastern Hepatobiliary Surgery Hospital; Second Military Medical University - Shanghai - China

(8) Department of Molecular and Clinical Cancer Medicine, The Duncan Building, Daulby Street, University of Liverpool - Liverpool - United kingdom

10] Novel benefits of remote ischemic preconditioning: protection of mouse liver from resection-induced liver failure via Vascular endothelial growth factor VEGF-dependent promotion of regeneration.

Patryk Kambakamba [1], **Pierre-Alain Clavien** [1], Michael Linecker [1], Marcel Schneider [1], Philipp Kron [1], Perparim Limani [1], Christoph Tschuor [1], Udo Ungethüm [1], Bostjan Humar [1]

(1) Swiss HPB Center Zurich, Department of Surgery and Transplantation, University Hospital Zurich - Zurich - Switzerland

11] The restore randomized controlled trial - Impact of a multidisciplinary rehabilitative programme on cardiorespiratory fitness in esophagogastric cancer survivorship.

Linda O'neill [1], Emer Guinan [2], Suzanne L Doyle [3], Annemarie E Bennett [4], Conor Murphy [5], Jessie A Elliott [5], Jacintha O' Sullivan [6], Juliette Hussey [1], John V Reynolds [7]

(1) Discipline of Physiotherapy, Trinity College Dublin - Dublin - Ireland

(2) School of Medicine, Trinity College Dublin - Dublin - Ireland

(3) School of Biomedical Sciences, Dublin Institute of Technology - Dublin - Ireland

(4) Department of Clinical Medicine, Trinity College Dublin - Dublin - Ireland

(5) National Esophageal and Gastric Center, St James's Hospital and Trinity College Dublin - Dublin - Ireland

(6) Trinity Translational Medicine Institute, Department of Surgery, Trinity College Dublin and St James's Hospital - Dublin - Ireland

(7) National Center for Esophageal and Gastric Cancer, St James's Hospital - Dublin - Ireland

12] Circulating methylated Septin-9 (SEPT-9) is a marker for early prediction of response to neoadjuvant chemotherapy in patients with colorectal cancer liver metastasis.

Jagdeep Singh-Bhangu [1], Thomas Bachleitner-hofmann [1], Hossein Taghizadeh [1], Martina Mittlboeck [2], Klaus Kaczirek [1], Martin Bodingbauer [1], Michael Gnant [1], Monika Sachet [3], Gerald Prager [4], Patrick Starlinger [1], Thomas Gruenberger [5], Michael Bergmann [6], Melanie Martini [7], Christine Mannhalter [8], Rudolf Oehler [9]

(1) Department of Surgery, Medical University of Vienna - Vienna - Austria
(2) Center for Medical Statistics, Informatics and Intelligent Systems, Medical University of Vienna - Vienna - Austria
(3) Surgical Research Laboratories, Medical University of Vienna - Vienna - Austria
(4) Department of Internal Medicine I, Medical University of Vienna - Vienna - Austria
(5) Department of Surgery, Rudolfstiftung Hospital, Vienna - Vienna - Austria
(6) Department of Internal Medicine I, Medical University of Vienna - Vienna - Austria
(7) Epigenomics Inc. - Berlin - Germany
(8) Clinical Department of Medical and Chemical Laboratory Diagnostics, Medical University of Vienna - Vienna - Austria
(9) Surgical Research Laboratories, Medical University of Vienna - Vienna - Austria

12:45 - 14:00 LUNCH

14:00 - 14:30 PRESIDENTIAL ADDRESS *by Mario Morino*
Introduced by M. Krawczyk

The impact of technology on Surgery: the future is unwritten.

14:30 - 16:10 SESSION III *Papers 13 > 17*
Moderators: M. Krawczyk, I. Popescu

13] Randomized prospective study of laparoscopic trans-abdominal preperitoneal repair (TAPP) vs the open repair for bilateral inguinal hernia.

Benedetto Ielpo [1], Emilio Vicente [1], Yolanda Quijano [1], Hipolito Duran [1], Riccardo Caruso [1], Luis Malavé [1], Valentina Ferri [1], Eduardo Diaz [1], Isa Fabra [1], Ernesto Barzola [1]
(1) Sanchinarro University Hospital CEU San Pablo - Madrid - Spain

14] European experience after left liver adult-to-adult living donor liver transplantation – Donor and recipient selection is the key.

Santiago Sánchez-Cabús [1], **Daniel Cherqui** [2], Niki Rashidian [3], Gabriella Pittau [2], Laure Elkrief [4], Aude Vanlander [3], Christian Toso [4], Constantino Fondevila [5], Antonio Sa Cunha [2],

Thierry Berney [4], Denis Castaing [2], Xavier Rogiers [3], Josep Fuster [5], René Adam [2], Pietro Edoardo Majno [4], Juan Carlos García-Valdecasas [5], Roberto Troisi [3]
(1) Hospital Clínic de Barcelona - Barcelona - Spain
(2) Centre Hépato-Biliaire Paul Brousse - Villejuif - France
(3) Ghent University Hospital Medical School - Ghent - Belgium
(4) University Hospitals of Geneva - Geneva - Switzerland
(5) Hospital Clínic de Barcelona - Barcelona - Spain

15] Mutations of Ras/Raf-Proto-Oncogenes impair survival after cytoreductive surgery & HIPEC: tumor biology remains king.

Kuno Lehmann [1], **Philippe Gertsch** [1], Marcel André Schneider [1], Janina Eden [2], Basile Pache [3], Felix Laminger [4], Victor Lopez-Lopez [5], Thomas Steffen [2], Martin Hübner [3], Friedrich Kober [6], Sebastian Roka [6], Pedro Cascales Campos [7], Lilian Roth [1], Anurag Gupta [1], Alex Siebenhüner [8]
(1) Division of Oncologic Surgery & HIPEC, Department of Surgery and Transplantation, University Hospital Zurich - Zurich - Switzerland
(2) Department of Surgery, Cantonal Hospital of St. Gallen - St. Gallen - Switzerland
(3) Department of Surgery, Lausanne University Hospital (CHUV) - Lausanne - Switzerland
(4) Department of Surgery, Hanusch-Krankenhaus - Vienna - Austria
(5) Department of Surgery, Hospital Clínico Universitario Virgen de la Arrixaca - Murcia - Spain
(6) Department of Surgery, Hanusch-Krankenhaus - Vienna - Austria
(7) Department of Surgery, Hospital Clínico Universitario Virgen de la Arrixaca - Murcia - Spain
(8) Department of Medical Oncology, University Hospital of Zurich - Zurich - Switzerland

16] Mitochondrial oxidative injury triggers HMGB1 (High Mobility Group Box 1) release following hepatic ischemia/reperfusion.

Rowan Van Golen [1], Megan Reiniers [1], Gerben Marsman [2], Lindy Alles [1], Derrick Van Rooyen [3], Björn Petri [4], Vincent Van Der Mark [1], Adriaan Van Beek [5], Ben Meijer [5], Adrie Maas [1], Sacha Zeerleder [1], Joanne Verheij [1], Geoffrey Farrell [3], Brenda Luken [2], Narci Teoh [3], Thomas Van Gulik [1], Michael Murphy [6], Michal Heger [1]
(1) Academic MedIcal Center - Amsterdam - Netherlands
(2) Sanquin - Amsterdam - Netherlands
(3) Liver Research Unit, Canberra Hospital - Australia
(4) Snyder Insitute, Calgary - Canada
(5) Wageningen University - Netherlands
(6) MRC Mitochondrial Biology Unit - United kingdom

17] A fully blinded randomized, placebo-controlled trial of bone-marrow-derived molecular cell therapy for non-reconstructable peripheral artery disease does not confirm the success of the earlier landmark study.

Jaap Hamming [1], **Jan Lindeman** [1], Jaap Jan Zwaginga [1], Graziella Kallenberg [1], Abbey Schepers [1], Rob Van Wissen [1], Hajo Van Bockel [1], Wim Fibbe [1]
(1) Leiden University Medical Center - Leiden - Netherlands

16:10 - 16:40 COFFEE BREAK

16:40 - 17:40 SESSION IV *Papers 18 > 20*

Moderators: G. Torzilli, G. Sotiropoulos

18] The impact of duration of brain death on outcomes in abdominal organ transplantation: rush and retrieve or relax and repair?

Catherine Boffa [1], Elinor Curnow [2], Kate Martin [2], Rachel Johnson [2], James Gilbert [3], Edward Sharples [3], Rutger Ploeg [1]

(1) Nuffield Department of Surgical Sciences, University of Oxford - Oxford - United kingdom

(2) NHS Blood and Transplant - Bristol - United kingdom

(3) Oxford University Hospitals Trust - Oxford - United kingdom

19] The influence of hospital and surgeon volume on survival and local control in rectal cancer: long-term results of the CAO/ARO/AIO-94 trial

Michael Ghadimi [1], Thilo Sprenger [1]

(1) University Medical Center Goettingen - Goettingen - Germany

20] Hyperthermic Intraperitoneal Chemotherapy (HIPEC) can trigger a systemic inflammatory response by intestinal bacterial translocation. A prospective study in humans.

Kuno Lehmann [1], **Philippe Gertsch** [1], Dilmurodjon Eshmuminov [1], Lilian Roth [1], Marcel André Schneider [1], Theresia V. Reding Graf [1], Anurag Gupta [1]

(1) Division of Oncologic Surgery & HIPEC, Department of Surgery and Transplantation, University Hospital Zurich - Zurich - Switzerland

17:40 END OF SESSION

19:00 WELCOME RECEPTION

Dress Code: Business / informal

Caffè degli Specchi -piazza Unità d'Italia 7 Trieste

SATURDAY, MAY 12th 2018

07:00 REGISTRATION

08:00 - 10:00 SESSION V *Papers 21 > 26*

Moderators: C. Bruns, N. de Manzini

21] Efficiency of fibrin glue for sleeve gastrectomy complications: a two-centre prospective randomized study.

Lionel Rebibo [1], Jean Marc Regimbeau [1], Abdennaceur Dhahri [1], Rachid Chati [1], Cyril Cosse [1], Emmanuel Huet [1]

(1) Department of Digestive Surgery - Amiens - France

22] The Comprehensive Complication Index as a novel readily available cost assessment tool for surgical procedures.

Roxane D. Staiger [1], Matteo Cimino [2], Ammar Javed [3], Sebastiano Biondo [4], Constantino Fondevila [5], Julie, Périnel [6], Ana Carolina Aragão [7], Guido Torzilli [2], Mustapha Adham [6], Hugo Pinto-Marques [7], Christopher Wolfgang [3], Philipp Dutkowski [1], Milo A. Puhan [8], Pierre-Alain Clavien [1]

(1) Department of Surgery and Transplantation, University Hospital of Zurich - Zurich – Switzerland
(2) Department of Surgery & Division of Hepatobiliary and General Surgery, Humanitas Research Hospital - Milan - Italy
(3) Department of Surgery, Johns Hopkins School of Medicine - Baltimore - USA
(4)Department of General and Digestive Surgery, Bellvitge University Hospital, University of Barcelona and IDIBELL - Barcelona - Spain
(5) Department of Surgery, Hospital Clinic de Barcelona - Barcelona - Spain
(6) Department of General and Digestive Surgery, University Hospital of Lyon - Lyon - France
(7) Hepato-Biliary-Pancreatic and Transplantation Centre, Curry Cabral Hospital, CHLC - Lisbon -Portugal
(8) Epidemiology, Biostatistics and Prevention Institute, University of Zurich - Zurich - Switzerland

23] Preoperative biliary stenting and major morbidity after pancreatoduodenectomy - Does elapsed time matter? The FRAGERITA study group.

Marta Sandini [1], Gianotti Luca [1], Kim C Honselmann [2], David J. Birnbaum [3], Francesca Gavazzi [4], Mircea Chirica [5], Ulrich Wellner [2], Théophile Guilbaud [3], Louisa Bolm [2], Marco Angrisani [1], Vincent Moutardier [3], Marco Cereda [1], Édouard Girard [5], Marco Montorsi [6], Tobias Keck [2], Alessandro Zerbi [4]

(1) School of Medicine and Surgery, Milano Bicocca University, Department of Surgery, San Gerardo Hospital - Monza - Italy
(2) Department of Surgery, University Medical Center Schleswig-Holstein, Campus Luebeck - Luebeck - Germany
(3) Department of Digestive Surgery, Hôpital Nord, Aix-Marseille University - Marseille - France
(4) Pancreatic Surgery Unit, Department of Surgery, Humanitas Research Hospital - Milano - Italy
(5) Department of Digestive Surgery and Liver Transplantation, Hôpital Michalon - Grenoble - France
(6) Department of Surgery, Humanitas Research Hospital, Humanitas University - Milano – Italy

24] Use of activity tracking in major hepatobiliary and gastrointestinal surgery— Results of the enhanced perioperative mobilization trial.

Thilo Welsch [1], Steffen Wolk [1], Benjamin Müssle [1], Theresa Meissner [1], Ann Wierick [1], Andreas Bogner [1], Dorothee Sturm [1], Nuh Rahbari [1], Marius Distler [1], Juergen Weitz [1]
(1) TU Dresden - Dresden - Germany

25] Single incision laparoscopy versus multiport laparoscopy for colonic surgery: a multicenter double-blinded randomized controlled trial.

Léon Maggiori [1], Yves Panis [1], Jean-Jacques Tuech [2], Eddy Cotte [3], Bernard Lelong [4], Quentin Denost [5], Mehdi Karoui [6], Eric Vicaut [7]
(1) Beaujon Hospital - Clichy - France
(2) Rouen Hospital - Rouen - France
(3) Lyon Sud Hospital - Lyon - France
(4) IPC - Marseille - France
(5) Haut Lévêque Hospital - Bordeaux - France
(6) Pitié-Salpétrière Hospital - Paris - France
(7) Fernand Widal Hospital - Paris - France

26] Postoperative acute pancreatitis following pancreaticoduodenectomy: a determinant of fistula driven by the intraoperative fluid management.

Elisa Bannone [1], Stefano Andrianello [1], Giovanni Marchegiani [1], Gaia Masini [1], Giuseppe Malleo [1], Claudio Bassi [1], Roberto Salvia [1]
(1) University of Verona Hospital Trust - Unit of General and Pancreatic Surgery - Verona - Italy

10:00 - 10:45 COFFEE BREAK

10:45 - 11:25 SPECIAL LECTURE

Introduced by M. Morino

Towards a consensus on centralization in surgery.

René Vonlanthen [1], Olivier Farges [2], Peter Lodge [3], Henrik Kehlet [4], Jeffrey S. Barkun [5], Sebastiano Biondo [6], Philippe Nafteux [7], Peter Naredi [8], John Vincent Reynolds [9], Kjetil Soreide [10], Inne Borel-Rinkes [11], Hugo Marques [12], Guillaume Martel [13], Justin B. Dimick [14], Wolf Bechstein [15], Michael Gnant [16], Marek Krawczyk [17], Attila Olah [18], Antonio Daniele Pinna [19], Irinel Popescu [20], Pauli Antero Puolakkainen [21], Miroslav Ryska [22], Georgios Sotiropoulos [23], Erkki Juhani Tukiainen [24], Pierre - Alain. Clavien [1]
(1) Department of Surgery and Transplantation, University Hospital Zurich - Zurich - Switzerland
(2) Department of Surgery, Hôpital Beaujon, Université Paris Nord Val de Seine - Clichy -France
(3) HPB and Transplant Unit, St. James's University Hospital - Leeds - United Kingdom
(4) Section for Surgical Pathophysiology, The Juliane Marie Centre - Copenhagen - Denmark
(5) Department of Surgery, McGill University/Royal Victoria Hospital - Montreal – Canada

(6) Department of General and Digestive Surgery, Bellvitge University Hospital, University of Barcelona - Barcelona - Spain
(7) Department of Thoracic Surgery, University Hospital Leuven - Leuven - Belgium
(8) Department of Surgery, Sahlgrenska University Hospital - Gothenburg - Sweden
(9) Trinity Centre for Health Sciences, St. James's Hospital, Clinical Surgery - Dublin – Ireland
(10) Department of Clinical Medicine, University of Bergen - Stavanger - Norway
(11) Department of Surgery, University Medical Center Utrecht - Utrecht - Netherlands
(12) Deparment of HPB and Transplant Surgery, Hospital Curry Cabral - Lisboa – Portugal
(13) Surgical Oncology Program, Liver and Pancreas Unit, The Ottawa Hospital, University of Ottawa - Ottawa - Canada
(14) Division of Minimally Invasive Surgery, University of Michigan Health Systems - Ann Arbor - United States
(15) Department of General and Vascular Surgery, Frankfurt University Hospital and Clinics - Frankfurt am Main - Germany
(16) Department of Surgery, Medical University of Vienna - Vienna - Austria
(17) Department of General, Transplant and Liver Surgery, Medical University of Warsaw - Warsaw - Poland
(18) Surgical Department, Petz Aladár County Teaching Hospital - Györ - Hungary
(19) Department of Surgery and Transplantation, University Hospital Bologna - Bologna - Italy
(20) General Surgery and Liver Transplantation, Fundeni Clinical Institute - Bucharest - Romania
(21) Department of Surgery, Helsinki University - Helsinki - Finland
(22) Department of Surgery, 2nd Medical Faculty, Charles University and Central Military Hospital - Prague - Czech Republic
(23) Department of Surgery, Laiko General Hospital of Athens - Athens - Greece
(24) Reconstructive Surgery, Department of Plastic Surgery, Helsinki University Hospital - Helsinki - Finland

11:25 - 12:45 SESSION VI *Papers 27 > 30*

Moderators: M. Morino, R. Adam

27] Clinical validation of the comprehensive complication index as a measure of postoperative morbidity at a surgical department. Prospective study.

JoseM Ramia [1], **Roberto De La Plaza** [1], Juan M Bellon [1], Vladimir Arteaga [1], Cristina Garcia Amador [1], Aylhin Lopez Marcano [1], Anibal Medina Velasco [1], Begoña Gonzalez Sierra [1], Alba Manuel Vazquez [1]
(1) Dept. of Surgery. University Hospital of Guadalajara. Univ. of Alcala - Guadalajara - Spain

28] The impact of hospital volume and Charlson score on postoperative mortality of proctectomy for rectal cancer. A nationwide study of 45569 patients.

Mehdi El Amrani [1], Clement Guillaume [2], Xavier Lenne [2], Moshe Rogosnitzky [1], Didier Theis [2], François-René Pruvot [1], Philippe Zerbib [1]
(1) Department of Digestive Surgery and Transplantation, Lille University Hospital - Lille - France
(2) Medical Information Department, Lille University Hospital - Lille – France

29] Impact of a multi-modal personalised prehabilitation programme in patients undergoing treatment for oesophago-gastric cancer.

Moorthy Krishna [1], Laura Halliday [1], Alex King [1], hayley Osborn [1], Maria Halley [1], Claudia Rueb [1], George Hanna [1], **Venetia Wynter Blyth** [1]
(1) Imperial College London - London - United kingdom

30] Observational study of neoadjuvant therapy for localized pancreatic adenocarcinoma: a three-year experience on 769 patients.

Laura Maggino [1], Giuseppe Malleo [1], Giovanni Marchegiani [1], Elena Viviani [1], Chiara Nessi [1], Debora Ciprani [1], Alessandro Esposito [1], Luca Landoni [1], Luca Casetti [1], Massimiliano Tuveri [1], Salvatore Paiella [1], Alessandra Auriemma [2], Davide Melisi [2], **Claudio Bassi** [1], Roberto Salvia [1]
(1) University of Verona Hospital Trust - Unit of General and Pancreatic Surgery - Verona - Italy
(2) University of Verona Hospital Trust - Unit of Oncology - Verona - Italy

12:45 - 14:10 LUNCH

14:10 - 15:50 SESSION VII *Papers 31 > 35*

Moderators: X. Rogiers, H. Silva Pinto Marquez

31] Neoadjuvant chemotherapy in patients with upfront resectable colorectal liver metastases: a multicentric international study.

Marc-Antoine Allard [1], Rene Adam [1], Yujiro Nishioka [2], Katsunori Imai [3], Nassiba Beghdadi [1], Maximilliano Gelli [4], Suguru Yamashita [2], Yuki Kitano [3], Takashi Kokudo [2], Yo-ichi Yamashita [3], Antonio Sa Cunha [1], Eric Vibert [1], Dominique Elias [4], Daniel Cherqui [1], Diane Goere [4], René Adam [1], Hideo Baba [3], Kiyoshi Hasegawa [2]
(1) Centre Hepatobiliaire, Hôpital Paul Brousse, Univ Paris Sud Inserm U935 - Villejuif - France
(2) Department of Hepatobiliary surgery and Transplantation, University of Tokyo - Tokyo - Japan
(3) Department of Gastroenterological Surgery, Graduate School of Life Sciences, Kumamoto University - Kumamoto - Japan
(4) Department of Surgery, Gustave Roussy - Villejuif – France

32] Half of postoperative deaths after hepatectomy are preventable: results of the root-cause analysis of a prospective multicenter cohort.

Iman Khaoudy [1], **Jean Marc Regimbeau** [1], Emmanuel Boleslawski [2], Eric Vibert [3], Olivier Soubrane [4], Olivier Farges [4]
(1) University hospital of Amiens - Amiens - France
(2) University hospital of Lille - Lille - France
(3) University hospital of Paul Brousse - Paris - France
(4) University hospital of Beaujon - Paris - France

33] Quadratus lumborum block vs. perioperative intravenous lidocaine for postoperative pain control in patients undergoing laparoscopic colorectal surgery: A prospective, randomized, double-blind controlled clinical trial.

Geertrui Dewinter [1], Steve Coppens [1], Marc Vande Velde [1], Andre D'hoore [1], Albert Wolthuis [1], Eva Cuypers [1], Steffen Rex [1]
(1) University hospitals of Leuven - Leuven - Belgium

34] Short-term outcomes of transanal hemorrhoidal dearterialization with mucopexy (THD) vs. Ligasure Hemorrhoidectomy for grade III-IV hemorrhoids: a prospective randomized multicenter trial.

Loris Trenti [1], Sebastiano Biondo [1], Esther Kreisler [1], Jose Luis Sanchez [2], Eloy Espin-Basany [2], Aitor Landaluce [3], Fernando Jimez [3], Elena Bermejo [4], Adolfo Alonso-Casado [4], Maria Teresa Garcia-Martinez [5], David Alias [6], Belen Manso [6]
(1) Bellvitge University Hospital - Barcelona - Spain
(2) Vall d'Hebron University Hospital - Spain
(3) Galdakao Usansolo Hospital - Spain
(4) Hospital Universitario de La Princesa - Spain
(5) Hospital Comarcal de Valdeorras - Spain
(6) Hospital Universitario Rey Juan Carlos - Spain

35] Failure-to-rescue in patients undergoing pancreatectomy : is hospital volume a standard for quality improvement programs? A nationwide analysis of 12333 patients.

Mehdi El Amrani [1], Guillaume Clement [2], Xavier Lenne [2], Francois-Rene Pruvot [1] Didier Theis [2], Stephanie Truant [1]
(1) Department of Digestive Surgery and Transplantation, Lille University Hospital, Lille, France - Lille - France
(2) Medical Information Department, Lille University Hospital, Lille, France - Lille - France

15:50 - 16:20 COFFEE BREAK

16:20 - 17:40 SESSION VIII *Papers 36 > 39*

Moderators: R. Busuttil, A. Hölscher

36] Outcome of total pancreatectomy for intraductal papillary mucinous neoplasia – a multicentric study of the French Surgical Association (AFC).

Stephanie Truant [1], **Charles Poiraud** [1], Medhi El Amrani [1], Laurence Chiche [2], Jean-Yves Mabrut [3], Philippe Bachellier [4], Francois-René Pruvot [1], Christophe Mariette [5], Jean-Robert Delpero [6], Mustapha Adham [3], Alain Sauvanet [7], Jean-Jacques Tuech [8], Olivier Turrini [6]

(1) Department of Digestive Surgery and Transplantation - Lille - France
(2) CHU Bordeaux - Bordeaux – France
(3) CHU Lyon - Lyon - France
(4) CHU strasbourg - Strasbourg - France
(5) CHU Lille - Lille - France
(6) Institut Paoli-Calmettes - Marseille - France
(7) AP-HP Hopital Beaujon - Paris - France
(8) CHU Rouen - Rouen - France

37] Tacrolimus (TAC) and single intra-operative high-dose of r-ATG (Rabbit anti-thymocyte globulin) induction vs. tacrolimus monotherapy as immunosuppression (IS) in adult liver transplantation (LT): one-year results of an investigator-driven prospective randomized, controlled, trial (RCT).

Jan Lerut [2], **Samuele Iesari** [1], Kevin Ackenine [2], Maxime Foguenne [2], Mina Komuta [2], Olga Ciccarelli [2], Laurent Coubeau [2], Eliano Bonaccorsi-Riani [2], Quirino Lai [3], Chantal De Reyck [2], Pierre Gianello [2]

(1) University Aquila - L'Aquila - Italy
(2) Université catholique de Louvain - Louvain - Belgium
(3) University La Sapienza - Italy

38] Centralized management of postoperative complications reduces 90 day mortality rate after bariatric surgery.

Francois Pattou [1], Robert Caiazzo [1], Xavier Lenne [1], Arnaud Clement [1], Benoit Dervaux [1], Fanelly Torres [1], Julien Branche [1], Bernard Leroy [1], study group Osean [2]

(1) Lille University Hospital - Lille - France
(2) Nord-pas de Calais - Lille - France

39] Neoadjuvant chemoradiation for esophageal cancer impairs pulmonary physiology preoperatively, with impact on postoperative respiratory complications and quality of life.

Jessie A Elliott [1], Lisa O Byrne [1], Gemma Foley [2], Conor F Murphy [1], Sinead King [1], Emer M Guinan [2], Narayanasamy Ravi [1], **John V Reynolds** [1]

(1) Department of Surgery, Trinity Centre for Health Sciences, Trinity College Dublin, and St. James's Hospital - Dublin 8 - Ireland
(2) School of Medicine, Trinity College Dublin - Dublin 2 – Ireland

17:45 - 18:30	GENERAL ASSEMBLY
18:30	END OF CONGRESS
20:00	GALA DINNER

Dress Code: Black tie
Starhotel Savoia Excelsior Place - Riva del Mandracchio 4 – Trieste

SPECIAL LECTURE

Towards a consensus on centralization in surgery.

René Vonlanthen [1], Olivier Farges [2], Peter Lodge [3], Henrik Kehlet [4], Jeffrey S. Barkun [5], Sebastiano Biondo [6], Philippe Nafteux [7], Peter Naredi [8], John Vincent Reynolds [9], Kjetil Soreide [10], Inne Borel-Rinkes [11], Hugo Marques [12], Guillaume Martel [13], Justin B. Dimick [14], Wolf Bechstein [15], Michael Gnant [16], Marek Krawczyk [17], Attila Olah [18], Antonio Daniele Pinna [19], Irinel Popescu [20], Pauli Antero Puolakkainen [21], Miroslav Ryska [22], Georgios Sotiropoulos [23], Erkki Juhani Tukiainen [24], Pierre - Alain. Clavien [1]

(1) Department of Surgery and Transplantation, University Hospital Zurich - Zurich - Switzerland
(2) Department of Surgery, Hôpital Beaujon, Université Paris Nord Val de Seine - Clichy -France
(3) HPB and Transplant Unit, St. James's University Hospital - Leeds - United Kingdom
(4) Section for Surgical Pathophysiology, The Juliane Marie Centre - Copenhagen - Denmark
(5) Department of Surgery, McGill University/Royal Victoria Hospital - Montreal – Canada
(6) Department of General and Digestive Surgery, Bellvitge University Hospital, University of Barcelona - Barcelona - Spain
(7) Department of Thoracic Surgery, University Hospital Leuven - Leuven - Belgium
(8) Department of Surgery, Sahlgrenska University Hospital - Gothenburg - Sweden
(9) Trinity Centre for Health Sciences, St. James's Hospital, Clinical Surgery - Dublin – Ireland
(10) Department of Clinical Medicine, University of Bergen - Stavanger - Norway
(11) Department of Surgery, University Medical Center Utrecht - Utrecht - Netherlands
(12) Deparment of HPB and Transplant Surgery, Hospital Curry Cabral - Lisboa – Portugal
(13) Surgical Oncology Program, Liver and Pancreas Unit, The Ottawa Hospital, University of Ottawa - Ottawa - Canada
(14) Division of Minimally Invasive Surgery, University of Michigan Health Systems - Ann Arbor - United States
(15) Department of General and Vascular Surgery, Frankfurt University Hospital and Clinics - Frankfurt am Main - Germany
(16) Department of Surgery, Medical University of Vienna - Vienna - Austria
(17) Department of General, Transplant and Liver Surgery, Medical University of Warsaw - Warsaw - Poland
(18) Surgical Department, Petz Aladár County Teaching Hospital - Györ - Hungary
(19) Department of Surgery and Transplantation, University Hospital Bologna - Bologna - Italy
(20) General Surgery and Liver Transplantation, Fundeni Clinical Institute - Bucharest - Romania
(21) Department of Surgery, Helsinki University - Helsinki - Finland
(22) Department of Surgery, 2nd Medical Faculty, Charles University and Central Military Hospital - Prague - Czech Republic
(23) Department of Surgery, Laiko General Hospital of Athens - Athens - Greece
(24) Reconstructive Surgery, Department of Plastic Surgery, Helsinki University Hospital - Helsinki - Finland

OBJECTIVES:
To critically assess centralization policies for highly specialized surgeries in Europe and North America and propose recommendations.

BACKGROUND/METHODS:
Most countries are increasingly forced to maintain quality medicine at a reasonable cost. An all-inclusive perspective, including health-care providers, payers, society as a whole and patients, has ubiquitously failed, arguably for different reasons in different environments. This special article follows three aims: first, analyze the impact of centralization on health-care delivery in different countries, second, analyze how centralization strategies affect patient outcome and other aspects such as medical education and cost, and third, propose recommendations for centralization, which could apply across continents.

RESULTS:
Conflicting interests have led many countries to compromise for a healthcare system based on factors beyond best patient-oriented care. Centralization has been a common strategy, but modalities vary greatly among countries with no consensus on the minimal requirement for the number of procedures per center or per surgeon. Most national policies are either partially or not implemented. Data overwhelmingly indicate that concentration of complex care or procedures in specialized centers have positive impacts on quality of care and cost. Countries requiring lower threshold numbers for centralization, however, may cause inappropriate expansion of indications, as hospitals struggle to fulfill the criteria. Centralization requires adjustments in training and credentialing of general and specialized surgeons, and patient education.

CONCLUSION/RECOMMENDATIONS:
There is an obvious need in most areas for effective centralization. Unrestrained, purely “market driven” approaches are deleterious to patients and society. Centralization should not be based solely on minimal number of procedures, but rather on the multidisciplinary treatment of complex diseases including well-trained specialists available around the clock. Audited prospective database with monitoring of quality of care and cost are mandatory.

01] The influence of anti-reflux surgery on esophageal cancer risk - national population-based cohort study.

Sheraz Markar [1], Chanpreet Arhi [1], Astrid Leusink [1], Alberto Vidal-Diez [1], Alan Karthikesalingam [2], Jesper Lagergren [3], George Hanna [1]
(1) Imperial College London - London - United kingdom
(2) St George's University of London - London - United kingdom
(3) Karolinska Institutet - Stockholm - Sweden

BACKGROUND AND AIMS

Gastroesophageal reflux disease (GERD) is a major risk factor for esophageal adenocarcinoma, and the United Kingdom has the highest incidence of esophageal adenocarcinoma globally. The objective of this study was to evaluate how anti-reflux surgery influences the incidence of esophageal cancer in patients with GERD in England.

STUDY DESIGN

To study this issue we utilized two different datasets: (i) The Nationwide English Hospital Episode Statistics (HES) database achieves 100% coverage of all National Health Service (NHS) hospitals in England and minority of private institutions. This dataset was used to identify all patients aged over 50 years diagnosed with GERD with or without Barrett's esophagus from 2000 to 2012. Procedural codes were used to identify patients undergoing anti-reflux surgery, and follow-up patients to identify those that developed esophageal cancer. (ii) The Clinical Practice Research Datalink (CPRD) captures approximately 10% of the primary care practices in England. These practices enter various data, including the use of medications. This dataset was used to provide a sensitivity analysis comparing those patients with GERD using proton pump inhibitor (PPI) therapy, with those receiving anti-reflux surgery. Patients with GERD aged over 50 years during the study period from 2000 to 2012 were eligible for inclusion. For both datasets a subgroup analysis of the influence of anti-reflux surgery in esophageal cancer risk was conducted in patients with Barrett's esophagus.

STATISTICAL ANALYSIS

Anti-reflux surgery and conservatively managed GERD (usually PPI therapy) were compared for the incidence of esophageal cancer using Cox proportional hazards model with inverse probability weights based on the probability of having surgery to adjust for selection bias and confounding. The results were adjusted for patient age, sex, and comorbidity (Charlson comorbidity index score).

RESULTS

(i) From the HES database, among the 534,472 patients with GERD and 22,110 with Barrett's esophagus, 9,313 (1.7%) and 463 (2.1%) underwent anti-reflux surgery, respectively. Compared to non-operated GERD patients, those who underwent anti-reflux surgery were not at a decreased risk of esophageal cancer (adjusted HR=1.04; 95%CI 0.96-1.13) . In the corresponding analysis restricted to Barrett's esophagus patients, anti-reflux surgery appeared to increase the risk of esophageal cancer (adjusted HR=1.30; 95%CI 1.18-1.43). (ii) From the CPRD database, 17,168 GERD patients receiving PPI therapy were compared with 685 GERD patients receiving anti-reflux surgery. Anti-reflux surgery did not statistically significantly influence the risk of esophageal cancer (adjusted HR=0.39; 95%CI 0.06-2.83). Subset analysis of Barrett's esophagus patients, 842 receiving PPI therapy and 121 receiving anti-reflux surgery, showed anti-reflux surgery did not statistically significantly influence the incidence of esophageal cancer (adjusted HR=1.32; 95%CI 0.51-3.47).

DISCUSSION

Anti-reflux surgery has no consistent effect upon the development of esophageal cancer when compared to proton pump inhibitor treatment, in GERD patients or in patients with Barrett's esophagus.

CONCLUSION

Anti-reflux surgery does not seem to prevent esophageal cancer to any higher degree than anti-reflux medication, and patients should be counselled that it is primarily an operation for symptomatic relief from GERD and to improve quality of life, with no oncological long-term benefit.

02] Iniquity in the access of patients with pancreatic duct adenocarcinoma (PDAC) to resection surgery. A national evaluation in Western Europe.

Olivier Farges [1], Noelle Bendersky [1], Pascal Hammel [1]
(1) Hôpital Beaujon, APHP, University paris 7 - Clichy - France

BACKGROUND AND AIMS

Information on the incidence, management, and survival of patients with pancreatic duct adenocarcinoma (PDAC) is derived from population samples, regional data, or registries. Comprehensive national evaluation within a given country has not been performed so far.

STUDY DESIGN

French administrative databases were screened to identify patients with PDAC diagnosed between 2010-2013. Using their unique identifier, each patient was traced backwords in the 2007-2009 databases to exclude non-incident cases and forward in the 2010-2016 databases to record management and follow-up, whether at the index-hospital or anywhere else in the country. The incidence of PDAC, access to treatment (resection surgery, chemo- and/or radiotherapy) and survival were computed nationally and at the geographical scale of the 95 departments into which France is divided administratively. The influence on outcome of the characteristics of the hospital where patients were first managed (administrative type, annual caseload of incident PDAC) was assessed.

STATISTICAL ANALYSIS

Kaplan-Meier curves were used to illustrate overall survival, from the date of PDAC. Cox-proportional hazards model was used to determine independent potential confounders of survival. Cutoff of annual-case load were identified by Spline-modeling.

RESULTS

A total of 47,514 patients with incident PDAC were identified. The annual incidence increased linearly by 9.5% between 2010 and 2013 ($p<0.0001$). Mean age at diagnosis was 71.7 years and 45.6% were older than 75 years. At the national level, the median survival was 7.1 [6.9-7.2] months. Only 15.9% of patients had resection surgery (with or without neoadjuvant treatment), 39.2% had chemotherapy (with or without radiotherapy) and 44.8% had no treatment. Their median survival were 25.7 [24.6-26.7], 9.5 [9.3-9.7] and 1.6 [1.56-1.66] months, respectively. There were marked variations between administrative departments in the incidence (range 17.1-38.0 per 10⁵ adults), access to resection surgery (7.4-23.6%), and median survival (range 4.0-10.5, Figure 1). These patients were initially managed at 1210 distinct hospital facilities. The annual PDAC-caseload of the hospital where patients were first admitted was linearly correlated with access to resection and survival (Figure 2). The two cutoff of case-load that independently influenced

survival were 41 an 86 PDAC / year. Up to 65% of the patients were initially managed at one of the 1141 facilities with an annual case-load < 41 PDAC/year, compared to 11.3% at one of the 14 facilities with a case-load > 86 PDAC/year (HR of survival 0.56 [0.54-0.59] in the latter group). Among patients undergoing surgery, 6.6% had neoadjuvant chemo/radiotherapy; their survival was increased from the time of diagnosis but not from the time of surgery.

DISCUSSION

This first nationwide study highlights that the incidence of PDAC is increasing and that in a country with high healthcare expenditure and full insurance coverage, there are marked variations in the access to curative treatment and the survival of patients with PDAC, despite national-guidelines and framed recommendations by Health authorities. Half of PDAC patients are older than 75-years, whereas these patients are currently excluded from randomised-trials assessing new treatment options.

CONCLUSION

These findings should stimulate clinicians and politicians to improve management networks and to dedicate a specific research to the elderly population of PDAC patients.

03] The prevalence of burnout among surgical residents: a survey at an Italian university hospital.

Matteo Serenari [1], Antonio Daniele Pinna [1], Katia Mattarozzi [2], Guido Fallani [1], Valentina Colonnello [2], Alessandro Cucchetti [1], Matteo Cescon [1], Paolo Maria Russo [2], Gilberto Poggioli[3]
(1) Department of Medical and Surgical Sciences – DIMEC, S.Orsola – Malpighi Hospital, Alma Mater Studiorum, University of Bologna - Bologna - Italy
(2) Department of Experimental, Diagnostic and Specialty Medicine - DIMES, S.Orsola – Malpighi Hospital, Alma Mater Studiorum, University of Bologna - Bologna – Italy
(3) Chief of Surgical Residency Program, University of Bologna, S.Orsola Hospital - Italy

BACKGROUND AND AIMS
Surgical training is considered to be very stressful among residents and graduating medical students choose less often surgical specialties for their career. The present study aims to assess the prevalence of burnout in residents attending the surgical specialties compared to residents attending other medical specialties, considering the residency-related organizational and work characteristics.

STUDY DESIGN
Residents from the University of Bologna were asked, during the 2016/2017 academic year, to participate in an anonymous online survey. The residents completed a set of questions regarding their training schedule (i.e., worktime, frequency of night work, perceived control about work time schedule, intrinsic motivation, satisfaction with the relationship with colleagues and tutors) and three standardized questionnaires: 1) the Maslach Burnout Inventory that consists of 22 items assessing the 3 primary dimensions of burnout: emotional exhaustion (EE), depersonalization (DP), and personal accomplishment (PA). Burnout was defined as having a score in the highest tertile for EE (≥24) or DP (≥9) or lowest tertile for PA (≤29), based on normative data for Italian version; 2) the Zung's Self-Rating Depression scale, a 20-item self-report measure widely used to provide a brief quantification of depressive state; 3) The Psychosomatic Problems scale that measures psychosomatic health, with items referring to 8 different somatic problems (e.g., "suffered from headaches', "suffered from stomach aches', "had little appetite').

STATISTICAL ANALYSIS
For each scale, the total score was computed and differences between groups were analyzed using ANOVA, ANCOVA and correlation analyses.

RESULTS
Six hundred and seventy-nine total residents were contacted with requests to participate, and 190 completed responses to the survey (response rate 28%). There were 117 women (61.6%) and 73 men (38.4%). Surgical residents (SR) and non-surgical residents (NSR) accounted for the 33.7% and 66.3% of the respondents. Overall, the prevalence of burnout was 74.7%, 82.8% in the SR group and 70.6% in

the NSR group, respectively. More specifically, SR reported higher levels of EE and DP compared to NSR. No significant differences between SR and NSR emerged for PA, depression and somatic problems total score. Higher burnout levels were associated with heavier workload, higher number of night shifts per month, lower intrinsic motivation and lower respondents' satisfaction with their relationship with tutors.

DISCUSSION

The number of medical students applying to surgical training programs is declined over the past few years, and medical students' concern over the stress associated with the surgical training program is considered one of the causes of such decline. To elaborate burnout prevention programs, the assessment of the prevalence of burnout during the early career stage of the surgeons becomes central.

CONCLUSION

The present findings indicate that the burnout is highly prevalent among surgeons in the training stage of their career and more prevalent in SR than in NSR, especially in terms of emotional exhaustion and depersonalization. Future research is needed to assess surgical residents' awareness of the symptoms and consequences of stress associated with their career choice and the changes of coping strategies across the career stages.

04] Laparoscopic versus open pancreatoduodenectomy: the PADULAP randomized controlled trial.

Ignasi Poves [1], Fernando Burdío [1], Olga Morató [1], Aleksandar Radosevic [2], Mar Iglesias [3], Lucas Ilzarbe [4], Laura Visa [5], Luís Grande [1]
(1) Department of Surgery, Hospital del Mar - Barcelona - Spain
(2) Department of Radiology, Hospital del Mar - Barcelona - Spain
(3) Department of Pathology, Hospital del Mar - Barcelona - Spain
(4) Department of Gastroenterology, Hospital del Mar - Barcelona - Spain
(5) Department of Oncology, Hospital del Mar - Barcelona - Spain

BACKGROUND AND AIMS
Open pancreatoduodenectomy (OPD) is a well stablished procedure associated to severe morbidity and prolonged hospital stay. Laparoscopic pancreatoduodenectomy (LPD) is an evolving procedure, not yet standardized. Valuable results from selected retrospective series and from the only one randomized controlled clinical trial (RCT) comparing LPD vs OPD limited for periampullary tumors has been reported. To define the role of LPD as a standard technique, a RCT was designed (PADULAP trial, ISRCTN93168938).

STUDY DESIGN
A single-center, non-stratified, open-label, parallel-group, intention to treat RCT was conducted from February 2013 to September 2017 in a university center. The study protocol was approved by the Ethical Committee. Primary end-point of the study was the length of hospital stay (LOS). Secondary end-points were operative time, blood transfusion, 90-days morbimortality and quality of pathological resection. Recruitment and PD indication were established in a multidisciplinary committee basis. Patients were assigned to OPR or LPD groups immediately after indication throughout a randomization electronically table. Exclusion criteria were: locally advanced disease requiring major vascular resection; other concomitant neoplasia; severe associated chronic disease; clear hostile abdomen for laparoscopic approach; or declining to participate.

STATISTICAL ANALYSIS
Sample size calculation was based on the primary end-point. Based on a mean LOS of 19 days for OPD in our center, it was estimated a 50% reduction in LPD. To achieve a power of 80% to detect differences with a two-sided test having a type I error of 0.5, 33 patients were required in each group. For comparison of continuous variables parametric or nonparametric test were used as needed. Extreme values that skewed the data were omitted. P>0.05 was considered statistically significant.

RESULTS
Of 86 patients assessed for PD, 66 were randomized, 34 to LPD and 32 to OPD. In LPD group, 8 patients were converted to open (4 requiring major vascular resection, 2 for technical difficulties and 2 for bleeding), but were included in the LPD for final

analysis. The median LOS was significantly shorter in LPD than for OPD (13.5 vs 17 days; p=0.012), while operation time was longer (486 vs 365 minutes; p=0.000). No differences were found in blood transfusion and postoperative specific complications (pancreatic fistula, delayed gastric emptying, hemorrhage, biliary fistula). Severe complications (Clavien-Dindo III-V) were lower in the LPD than in the OPD (5 vs 11 patients; p=0.04). Comprehensive Complication Index was significantly lower in the LPD than OPD group (20.6 vs 29.6; p=0.038). No differences in number of lymph nodes retrieved and R0 rate were found. There were no deaths in the LPD group vs two in the OPD group.

DISCUSSION

LPD is a technically demanding procedure with an extended operative time and a conversion rate up to 25% when a minimally selection of the patient is done. However, LPD can be done with better postoperative outcomes.

CONCLUSION

In this RCT, LPD presented a shorter hospital stay and less severe postoperative complications than OPD.

05] Perioperative hydrocortisone treatment reduces postoperative pancreatic fistula after distal pancreatectomy. A randomized controlled trial.

Johanna Laukkarinen [1], Anne Antila [1], Antti Siiki [1], Juhani Sand [1]
(1) Dept. of Gastroenterology and Alimentary Tract Surgery, Tampere University Hospital - Tampere - Finland

BACKGROUND AND AIMS

Postoperative pancreatic fistula (POPF) is the major complication after distal pancreatectomy (DP) and the incidence remains high at 16-50%. Many strategies have been studied to decrease the fistula formation. In our recent RCT, we showed that perioperative hydrocortisone (HC) treatment reduces Clavien-Dindo 3-5 complications after pancreaticoduodenectomy (Laaninen et al, Annals of Surgery 2016). The aim of this study was to investigate whether perioperative hydrocortisone treatment reduces the risk for POPF after DP.

STUDY DESIGN

This prospective randomized placebo controlled study included 40 patients planned for DP. They were randomized to intravenous treatment with hydrocortisone 100mg or placebo. All received the first dose at the induction of anestehesia. 1 patient was excluded due to ongoing cortisone treatment, 5 had on inoperable disease and 3 patients went through a different procedure. The remaining 31 patients continued through the study protocol and received in total 8 doses of randomization-based hydrocortisone/placebo treatment every 8 hours. During the operation, the percentage of acini was calculated from pancreatic transection line frozen samples by a pathologist to clarify the high-risk patients. Primary endpoint was the development of clinically relevant POPF after DP and the secondary endpoint was major complications graded by Clavien-Dindo scoring (Clavien-Dindo grades 3-5 were considered as major complications).

STATISTICAL ANALYSIS

Incidence of clinical POPF is about 30% in the literature. For power calculation, we used the estimate that HC would decrease the incidence of POPF rate by 50%. With this, 15 patients in each group were needed to show statistically significant difference (alpha 0.05, 80% power). Thus, originally 30 patients were planned for randomization. The interim analyses showed dropouts due to a spread disease and extended resection, the number of randomized patients were increased to 40, in order to have at least 30 patients completing the study. Statistical analysis was performed using Fisher`s exact test, Mann-Whitney U-test and the analysis was performed using SPSS statistical software. The clinical trial number is NCT02113046.

RESULTS

Median age was 68 (39-92) years, 35% were men. The groups were similar for age, sex, ASA class distribution and comorbidities. 90 days mortality was zero. All

patients were determined as high-risk patients, having > 40 % acinar cells in the pancreatic transection line analyzed preoperatively. Pancreatic duct diameter, operative time and blood loss were similar between the groups. With HC treatment the rate of clinically significant POPF (grades B/C) were significantly reduced compared to placebo (5.9% vs 28.6%, p=0.016). The rate of overall Clavien -Dindo III-V complications were 5.9 and 21.4 % in the HC and placebo group, respectively (ns; p=0.058)

DISCUSSION

Perioperative HC treatment reduces the clinically relevant POPF after distal pancreatectomy. HC may have a favorable effect even on overall major complications.The frequency of POPF after HC treatment is comparable to the lowest frequencies seen with other means of POPF prevention studied earlier.

CONCLUSION

Perioperative HC treatment prevents clinically relevant POPF after distal pancreatectomy.

06] Open vs laparoscopic liver surgery for colorectal liver metastases (LapOpHuva): a prospective randomized controlled trial.

López-López Victor [1], Ricardo Robles [1], Asunción López-Conesa [1], Roberto Brusadin [1], Pedro Jose Gil [1], Alvaro Navarro [1], Pascual Parrilla [1]
(1) HosPital Clinico Universitario Virgen de la Arrixaca - Murcia - Spain

BACKGROUND AND AIMS
The role of laparoscopic surgery (LS) in colorectal liver metastases (CRLM) is still discussing. Only one randomized controlled trial (OSLO-COMET) comparing open liver surgery (OLS) versus LS has been published but without survival outcomes. The aim of this study was to compare postoperative and long-term survival outcomes of LS versus OLS in patients with CRLM.

STUDY DESIGN
A randomized, prospective and controlled trial was conducted between February 2005 and March 2017. Patients with CRLM, who met the inclusion criteria (resectable by laparoscopy, ≥18 years and informed consent), were randomly assigned to LS or OLS. Exclusion criteria were: multiples, hughe or bilobar metastases, close to major vessels, oncological contraindications, cirrhotics or two stage resections. Endpoint was to compare overall survival (OS) and disease free survival (DFS) at 1, 3, 5 and 7 years. Others secondary endpoints were analyzed.

STATISTICAL ANALYSIS
Randomization was done using a computer-generated sequence (EPIDAT 4.0). According to the literature at the time of the initiation of the study the sample size was calculated with an incidence of 35% postoperative complications for OLS. An estimated reduction of morbidity to 17 % in LS was considered clinically relevant. Utilizing a power of 0.80 and α of 0.05 in a two-tailed model and estimated losses of 10 %. Categorical variables were compared with $\chi 2$ test or Fisher's exact test. Normal and non-normal continuous variables were compared by Student t test and Mann-Whitney U test, respectively. OS and DFS were estimated using Kaplan-Meier's analysis. A 95 % confidence interval ($p<0.05$) was considered for statistical significant differences. The study was registered during the recluting in ClinicalTrials.gov (NCT00757133).

RESULTS
Two-hundred and four patients were randomized and 193 were included in the analysis: LS (n=96) and OLS (n=97). There were no differences in the patients' characteristics at baseline, number and size of lesions, mayor resections, posterior segments, blood loss, transfusions, surgical time and time between surgery and adjuvant chemotherapy. In LS, Pringle maneouver was more frequently used (15.5% vs 30.2%, P=0.025) and hospital stay was inferior (4 vs 6 days, P<0.001). LS group presented with lower morbidity (11.5% vs 23.7%, P=0.025) with no differences in

major complications. One patient in each group died. One, -3, -5 and -7 years overall survival for OLS was 94.7%, 81.1%, 62.9% and 35.5% vs 93.6%, 74%, 55.9% and 33.3% for LS group (long-rank=0.047, P=0.82). One, -3, -5, -7 years DFS for OLS group was 90%, 70%, 44% and 23.9% vs 89.6%, 71.5%, 46.6% and 22.7% for LS group (long-rank=1.427, P=0.23).

DISCUSSION

Retrospective comparative studies about LS in CRLM describe similar postoperative and survival outcomes versus OLS. As OSLO-COMET study, in the present study we concluded that LS is associated with less morbidity and hospital stay but this is the first randomized controlled trial where we describe similar long-term survival outcomes at 7 years between both groups.

CONCLUSION

In patients with CRLM, LS presents similar long-term survival outcomes than OLS with lower morbidity and hospital stay.

07] The growing discrepancy between resident training in colon surgery and rising numbers of general surgery graduates.

Samuel Käser [1], **Matthias Turina** [1], Andreas Rickenbacher [1], Daniela Cabalzar-Wondberg [1], Marcel Schneider [1]

(1) Division of General Surgery, Department of Surgery and Transplantation, University Hospital - Zurich - Switzerland

BACKGROUND AND AIMS

In times of working hour directives and increasing sub-specialization in general surgery, there is a growing debate on how to achieve adequate technical proficiency and operative experience during residency. In previous years, residents typically performed segmental colonic resections, which were considered training operations. The aim of our present study is to examine how the numbers of colonic resections used for resident training have evolved since the introduction of working hour directives, and how these results compare to the numbers of newly graduated general surgeons.

STUDY DESIGN

This study is based on an analysis of the nationwide surgical prospective quality assurance database. All segmental colon resections (i.e., ileocecal resections, right and left colectomies, transverse or sigmoid resections) performed at 86 participating centers from 2006 to 2015 were identified. Total colectomies and rectal resections were excluded. Numbers of newly graduated surgeons by year were made available from the National Medical Association. The numbers of segmental colectomies were grouped into two time periods (2006-2010 and 2011-2015), analyzed according to presence or absence of residents and brought into perspective with the numbers of graduates in surgery. Predictive factors for teaching operations were identified.

STATISTICAL ANALYSIS

Two-sided Fisher's exact test was used for univariate analysis while logistic regression was used for multivariate analysis. P-values of less then 0.05 were considered statistically significant.

RESULTS

From 2006 to 2015, 5368 segmental colonic resections were identified. The rate of colonic resections performed by residents decreased significantly between the two time periods studied (2006 - 2010: 7.5% vs. 2011 - 2015: 4%, p<0.001), even though the number of graduates increased by fifty percent from 197 (2006 to 2010) to 296 (2011 to 2015), p=0.0004 (<u>Figure</u>). Multivariate analysis identified the following predictors for teaching operations (odds ratios, OR, 95% confidence interval): emergency operation (OR 4.5, 3.3 - 6.3), tertiary referral center (OR 4.3, 3.2 - 5.7), general insurance (OR 3.6, 2.4 - 5.4), higher ASA class (OR 2.3, 1.8 - 2.8),

and diagnosis of colon cancer (OR 1.8, 1.2 - 2.5). Analysis from 2012 to 2015 revealed that residents performed a total of 3.2%, junior staff surgeons 29.6%, senior staff surgeons 55.3%, and private surgeons 11.9% of all segmental colonic resections. Of these, 2 % were effectively taught to residents under supervision, 16% were taught to junior staff surgeons, and 3% were taught to senior staff surgeons.

DISCUSSION

Despite segmental colonic resections being an integral part of general surgical training, only a surprisingly low percentage is being used for resident training. Furthermore, we found a growing discrepancy between the number of teaching colectomies and the number of newly graduated surgeons. Together, these data imply that technical proficiency in routine colonic resections of current graduates in general surgery has dramatically diminished during the past 10 years.

CONCLUSION

Care must be taken to utilize the available numbers of colonic resections for resident training to assure adequate competence in routine colonic surgery in times of working hour directives, and thereby secure the availability of competent surgeons in the future.

08] Centralization of colorectal cancer care over the last decade did not improve outcomes in Germany, a nation-wide analysis of hospital data.

Daniel R. Perez [1], **Tarik Ghadban** [1], Maximillian Bockhorn [1], Matthias Reeh [1], Jameel T. Miro [1], Jakob R. Izbicki [1]

(1) Department of General, Visceral and Thoracic Surgery, University Medical Center Hamburg-Eppendorf - Hamburg - Germany

BACKGROUND AND AIMS

Centralization of cancer care in high-volume centers was previously reported to improve outcomes in several disease entities and different national health care systems. In Germany, since 2006 the German Cancer Society has offered a curriculum for institutions to achieve colorectal cancer (CRC) center certification. The number of certified CRC centers has grown rapidly reaching a total of 261 centers in 2015. We aimed to assess the impact of centralizing CRC care in Germany over the last decade through a comprehensive and unbiased analysis.

STUDY DESIGN

We performed an analysis of the national diagnosis related groups (DRG) inpatient statistics from 2005 to 2015. The source was provided by the German research data centers of the federal statistical office. All patients operated for primary CRC in Germany during the study period were included.

STATISTICAL ANALYSIS

We analyzed the data descriptively. Linear regression models, including least square weighting by number of observations, were used to assess temporal trends. P values of less than 5% were considered as significant. The reference was the outcome in 2005 since no certified centers existed.

RESULTS

A total of 351.028 cases were analyzed. Of those, 61.6% cases were colonic and 38.4% were rectal resections. During the study period the use of minimal-invasive surgery (MIS) compared to open surgery increased continuously; while in 2005 only 5.9% of colonic resections were performed by MIS the rate increased to 20.3% in 2015 ($P<0.001$). In rectal resections the rate increased from 7.4% in 2005 to 38.4% in 2015 ($P<0.001$). The mortality rate of colonic resections did not decrease significantly during the study (4.9% in 2005; 4.5% in 2015; $P=0.57$). Reduced perioperative mortality after rectal surgery was observed only after 2012 compared to previous years (3.8% in 2005; 3.0% in 2015; $P<0.001$), with no further improvement after 2012. The rate of anastomotic leak, wound infections, hemorrhage, pneumonia, deep vein thrombosis and lung embolism did not improve neither for rectal nor for colonic surgery. Surprisingly, in both colon and rectal cancer cases the rate of anastomotic leak (2015 vs. 2005 $P<0.001$ each), wound

infection (2015 vs. 2005 P<0.001 each) and pneumonia (2015 vs 2005 P<0.001 and 0.008) increased during the observation period.

DISCUSSION

Despite a rapidly growing number of certified CRC centers, no effect on mortality rate after colon surgery and only marginal improvement after rectal resection were observed. The rate of MIS in CRC cancer management remains low compared to the international level. Thus, the certification program failed to reach its goals of improving surgical outcomes. The low number of cases needed for certification, the limited quality control of surgical outcomes and the plethora of CRC centers across the country might be some reasons for the disappointing long-term development observed.

CONCLUSION

The present study challenges current national health policies that aim to improve the outcome of cancer patients in Germany. New national certification strategies with greater focus on quality outcomes are needed. Reducing the number of CRC centers by increasing the number of cases necessary for certification and stringent quality assurance of surgical outcomes are promising measures for the future.

09] Liver transplantation and hepatic resection can achieve the cure for hepatocellular carcinoma.

Antonio Daniele Pinna [1], Tian Yang [2], Vincenzo Mazzaferro [3], Luciano De Carlis [4], Jian Zhou [5], Sasan Roayaie [6], Feng Shen [7], Carlo Sposito [3], Matteo Cescon [1], Stefano Di Sandro [4], He Yi-Feng [5], Philip Johnson [8], **Alessandro Cucchetti** [1]

(1) Department of Medical and Surgical Sciences – DIMEC; Alma Mater Studiorum – University of Bologna, Bologna, Italy - Bologna - Italy

(2) Eastern Hepatobiliary Surgery Hospital; Second Military Medical University - Shanghai - China

(3) General Surgery and Liver Transplantation Unit, University of Milano and Istituto Nazionale Tumori (National Cancer Institute), IRCCS Foundation - Milano - Italy

(4) General Surgery and Abdominal Transplantation Unit, University of Milano-Bicocca and Niguarda-Cà Granda Hospital - Milano - Italy

(5) Liver Surgery Department, Liver Cancer Institute, Zhongshan Hospital, Fudan University - Shanghai - China

(6) Liver Cancer Program; White Plains Hospital - Montefiore Health System, White Plains - New York - United states

(7) Eastern Hepatobiliary Surgery Hospital; Second Military Medical University - Shanghai - China

(8) Department of Molecular and Clinical Cancer Medicine, The Duncan Building, Daulby Street, University of Liverpool - Liverpool - United kingdom

BACKGROUND AND AIMS

Hepatic resection (HR) and liver transplantation (LT) are considered as potentially curative therapies for hepatocellular carcinoma (HCC). However, their impact on the life-term has never been investigated. Cure is said to occur when the mortality of a specific population returns to values of that of general population. The present study aims to provide such estimate after HR and LT in different clinical scenarios.

STUDY DESIGN

This observational retrospective study included 3286 HCC patients treated with LT (n=1218) or HR (n=2068) in 7 tertiary referral hospitals. The estimation of statistical cure was based on the disease-free survival (DFS) as primary survival measure, defined by the chance of being alive without tumor equivalent to that of the general population matched by age, sex, year and race. Overall survival (OS) was a secondary measure, defining the only chance of being alive, regardless of tumor recurrence, equivalent to that of the matched general population. Distinct models for the prediction of cure were built for LT and for HR and results within different morphologic criteria were compared. Variations of estimated cure fractions after LT were also adjusted for drop-out risk in waiting-list to provide an intention-to-treat analysis.

STATISTICAL ANALYSIS

Multivariable non-mixture (DFS) and mixture (OS) cure models were applied for LT and HR patients including hepatitis C status, Model for End-Stage Liver Disease score, alpha-fetoprotein and number and diameter of largest active tumor. Differences between estimated cure fractions were measured through effect size

calculation. Adjustment for drop-out risk was calculated by considering drop-out as a proportional reduction in probabilities of reach LT and, consequently, of being cured.

RESULTS

224 transplanted (18.4%) and 797 resected (38.5%) patients were beyond Milan criteria. Five and 10-year DFS rates were 73.3% and 66.0% after LT, and 33.6% and 19.2% after HR. On this ground, the whole cure fraction after LT was 74.1% and after HR was 24.1% (effect size >0.8). Considering DFS, LT outperformed HR in all transplant criteria considered (effect size>0.8), especially for multiple tumors (effect size>0.9) and even in presence of a drop-out risk up to 20% (effect size >0.5). Considering OS, 5 and 10-year rates were 77.1% and 67.4% after LT, and 57.3% and 33.9% after HR. On this ground, the cure fraction after LT marginally increased to 75.8% and that after HR increased to 40.5%. Using OS, the effect size of LT over HR in terms of cure decreased (effect size ~0.5), became small (effect size <0.2) when the drop-out risk increased toward ~20% or negligible for single tumors <5cm.

DISCUSSION

LT can provide higher chances of being cured from HCC than HR but efficacy of treatments for tumor recurrence after resection and waiting-list drop-out risk can result in similar survival expectations. In presence of high drop-out risks, HR can be considered as the first treatment option for single tumors <5cm.

CONCLUSION

As other malignancies, statistical cure can occur even for HCC, primarily with LT and secondarily with HR, depending on waiting-list capabilities and efficacy of treatments of tumor recurrence after HR.

10Novel benefits of remote ischemic preconditioning: protection of mouse liver from resection-induced liver failure via Vascular endothelial growth factor VEGF-dependent promotion of regeneration.

Patryk Kambakamba [1], **Pierre-Alain Clavien** [1], Michael Linecker [1], Marcel Schneider [1], Philipp Kron [1], Perparim Limani [1], Christoph Tschuor [1], Udo Ungethüm [1], Bostjan Humar [1]
(1) Swiss HPB Center Zurich, Department of Surgery and Transplantation, University Hospital Zurich - Zurich - Switzerland

BACKGROUND AND AIMS

Liver failure following extended hepatectomy remains the commonest cause of death. It has been established that resection-induced liver failure (known as small-for-size syndrome (SFSS) develops owing to deficient regeneration. Thus logically, strategies to promote the regenerative capacity of liver remnants are of highest clinical interest. Remote ischemic preconditioning (RIPC - the repetitive transient mechanical obstruction of vessels at a limb remote to the operative site) is a novel strategy to mitigate surgery-associated ischemia injury. Besides its ischemic benefits, RIPC confers systemic organ protection against various insults via increases in circulating vascular endothelial growth factor (VEGF). VEGF, however, is central to the initiation and progression of liver regeneration following tissue loss. We therefore aimed at exploring the potential of RIPC to promote liver regeneration and to protect from surgery-induced liver failure.

STUDY DESIGN

RIPC was applied to C57BL/6 mice through intermittent clamping (three cycle of 5 min ischemia followed by 5 min of reperfusion) of the femoral vessels prior to standard (70%) or extended (86%) resection and compared to sham surgery. Liver regeneration was assessed through weight gain, proliferative markers (KI67, pH3, mitoses), cell cycle-associated molecules, and survival. Downstream signaling of the VEGF-ID1-WNT2 axis was modulated through WIF1 (Wnt inhibitor 1) and recombinant WNT2 injected prior to surgery.

STATISTICAL ANALYSIS

The significance of differences between groups was assessed through two-tailed t-testing and one-way ANOVA testing if more than two groups were compared.

RESULTS

RIPC displayed marginal benefits in settings of standard hepatectomy. In contrast, when applied prior to extended hepatectomy, RIPC significantly improved liver weight gain along with the promotion of mitoses and the downregulation of Cdkn1a (P21), a key effector of liver failure. In line with these findings, survival after extended hepatectomy rose from 40% to 80% in RIPC-exposed animals (Figure). Mechanistically, RIPC promoted after resection early release of VEGF followed by the upregulation of the endothelial transcription factor Id1

and its target WNT2, a paracrine mitogen that activates β-catenin signaling in target cells. Accordingly, nuclear accumulation of β-catenin in hepatocytes was increased through RIPC. Injection of WIF1 prior to RIPC and extended hepatectomy markedly inhibited the pro-regenerative effects of RIPC, while recombinant WNT2 alone induced most of the benefits seen after RIPC.

DISCUSSION

Our findings provide clear evidence for a potent pro-regenerative effect of RIPC that protects mouse liver from SFSS. These benefits rely on the promotion of an endothelial VEGF-ID1-WNT2 axis, which induces mitogenic β-catenin signaling in hepatocytes. Unlike other preconditioning strategies, RIPC does not require manipulation of the target organ, but acts through humoral VEGF. VEGF-mediated protection is powerful and even shields aged liver from injury. If the pro-regenerative effects can be confirmed in humans, these facets render RIPC a unique and readily available approach for the reduction of postoperative complications.

CONCLUSION

In addition to the protection from ischemia, RIPC improves the regenerative capacity of marginal mouse liver remnants in a VEGF-dependent way, and may become the preconditioning strategy of choice in mitigating the SFSS.

11] The restore randomized controlled trial - Impact of a multidisciplinary rehabilitative programme on cardiorespiratory fitness in esophagogastric cancer survivorship.

Linda O'neill [1], Emer Guinan [2], Suzanne L Doyle [3], Annemarie E Bennett [4], Conor Murphy [5], Jessie A Elliott [5], Jacintha O' Sullivan [6], Juliette Hussey [1], John V Reynolds [7]
(1) Discipline of Physiotherapy, Trinity College Dublin - Dublin - Ireland
(2) School of Medicine, Trinity College Dublin - Dublin - Ireland
(3) School of Biomedical Sciences, Dublin Institute of Technology - Dublin - Ireland
(4) Department of Clinical Medicine, Trinity College Dublin - Dublin - Ireland
(5) National Esophageal and Gastric Center, St James's Hospital and Trinity College Dublin - Dublin - Ireland
(6) Trinity Translational Medicine Institute, Department of Surgery, Trinity College Dublin and St James's Hospital - Dublin - Ireland
(7) National Center for Esophageal and Gastric Cancer, St James's Hospital - Dublin - Ireland

BACKGROUND AND AIMS
Patients following treatment for esophageal or gastric cancer are at risk of physical deconditioning, nutritional compromise, and sarcopenia. There is accordingly a compelling rationale to target these in recovery and survivorship programs. The feasibility of a multidisciplinary rehabilitation programme has been established at this National Center, and this randomized controlled trial (RCT) evaluated the efficacy of the intervention on increasing cardiorespiratory fitness and quality of life (QOL).

STUDY DESIGN
The RESTORE (Rehabilitation Strategies in Esophagogastric cancer) RCT randomized 43 disease free patients at a median(range) of 30(6-62) months following treatment with curative intent, and without contraindications to exercise participation. Participants were randomized to receive either usual care, or a 12-week multidisciplinary rehabilitation consisting of tailored supervised and home-based aerobic and resistance exercise, individualized dietary counselling, and multidisciplinary education sessions. Aerobic exercise intensity was progressed from 30-60% of heart rate reserve over the 12 week intervention, and resistance training was prescribed at a low/moderate intensity (<75% 1-repetition max). The primary outcome was maximal cardiopulmonary exercise testing (VO₂max). Secondary outcomes included body composition (bio-impedance analysis), and QOL (EORTC-QLQ-C30). Outcomes were assessed at baseline (T0), post-intervention (T1), and at three-month follow-up (T2).

STATISTICAL ANALYSIS
In order to achieve a 3.5ml/min/kg increase in aerobic fitness, standard deviation 3.81 ml/min/kg with 5% significance and 80% power, a total sample size of 19 participants per arm was required. Statistical analysis was performed using SPSS 22 (SPSS Inc.; Chicago, IL, USA). Parametric data was analyzed using Analysis of Covariance (ANCOVA), and non-parametric data was analyzed with Quade's test. Baseline values were used as the covariate.

RESULTS

Twenty-two participants were randomized to the control group (mean(standard deviation) age 64.14(10.46) years, BMI 25.67(4.83) kg/m2, time post-surgery 33.68(19.56) months), and 21 to the intervention group (age 67.19(7.49) years, BMI 25.69(4.02) kg/m2, time post-surgery 23.52(15.23) months). Three participants withdrew due to disease recurrence and one control participant dropped-out. Mean adherence to the exercise sessions were 94(12)% (supervised) and 78(27)% (home-based). Compared to T0, the intervention arm experienced a mean improvement in VO₂max of 3.47(2.58)ml/min/kg at T1, and 2.99(3.37)ml/min/kg at T2. In significant contrast, the control group VO₂max declined by 0.86(2.50)ml/min/kg at T1, and by 1.64(2.73)ml/min/kg at T2. Correcting for baseline VO₂max, the intervention arm had significantly higher VO₂max at both T1, 22.20(4.35) vs 21.41(4.49)ml/min/kg, p<0.000, and T2, 21.75(4.27) vs 20.74(4.65)ml/min/kg, p=0.001, compared with the control group (Figure 1). Correcting for baseline values, no significant changes in body composition or QOL were observed, (control vs intervention (median(interquartile range)), BMI at T1, 24.90(5.90) and 24.90(5.25)kg/m2, p=0.67, and at T2, 24.50(5.30) and 24.80(5.80)kg/m2, p=0.43, FM at T1, 20.66(11.59) vs 21.47 (13.13)kg, p=0.61, and T2, 20.87(11.68) vs 21.54(11.42)kg, p=0.91, FFM at T1, 54.13(18.36) and 50.55 (16.16)kg, p=0.56, and at T2, 51.91(18.22) vs 50.84(15.28)kg, p=0.24, and global QOL, T1, 66.67(25.00) vs 83.33(20.83), p=0.43, and T2, 75.00(16.66) vs 79.17(29.16), p=0.89).

DISCUSSION

A 12 week multidisciplinary rehabilitation programme significantly improved cardiorespiratory fitness of disease-free patients after esophagogastric cancer surgery, without compromise in body composition.

CONCLUSION

This RCT provides proof of principle for rehabilitation programs in survivorship of upper gastrointestinal cancer.

12] Circulating methylated Septin-9 (SEPT-9) is a marker for early prediction of response to neoadjuvant chemotherapy in patients with colorectal cancer liver metastasis.

Jagdeep Singh-Bhangu [1], Thomas Bachleitner-hofmann [1], Hossein Taghizadeh [1], Martina Mittlboeck [2], Klaus Kaczirek [1], Martin Bodingbauer [1], Michael Gnant [1], Monika Sachet [3], Gerald Prager [4], Patrick Starlinger [1], Thomas Gruenberger [5], Michael Bergmann [6], Melanie Martini [7], Christine Mannhalter [8], Rudolf Oehler [9]

(1) Department of Surgery, Medical University of Vienna - Vienna - Austria

(2) Center for Medical Statistics, Informatics and Intelligent Systems, Medical University of Vienna - Vienna - Austria

(3) Surgical Research Laboratories, Medical University of Vienna - Vienna - Austria

(4) Department of Internal Medicine I, Medical University of Vienna - Vienna - Austria

(5) Department of Surgery, Rudolfstiftung Hospital, Vienna - Vienna - Austria

(6) Department of Internal Medicine I, Medical University of Vienna - Vienna - Austria

(7) Epigenomics Inc. - Berlin - Germany

(8) Clinical Department of Medical and Chemical Laboratory Diagnostics, Medical University of Vienna - Vienna - Austria

(9) Surgical Research Laboratories, Medical University of Vienna - Vienna – Austria

BACKGROUND AND AIMS

Neoadjuvant chemotherapy (neoCTx) followed by hepatic resection is the treatment of choice for patients with colorectal cancer liver metastasis (CLM). Importantly, only responders to neoCTx are suitable candidates for hepatic resection. About 70% of patients respond to neoCTx, while 30% do either stabilize or even progress under therapy. Treatment response is generally assessed using radiologic imaging after several cycles of chemotherapy. However, earlier assessment of response would be desirable since patients who are going to progress during neoCT could be switched early to an alternative, potentially more effective chemotherapy regimen. The circulating DNA coding for methylated Septin-9 (SEPT-9) is a valuable marker for early detection of colorectal cancer (CRC) in peripheral blood. Aim of the present study was to evaluate whether serial measurements of methylated SEPT-9 can help to detect patients with disease progression at a time-point earlier than with conventional radiologic imaging.

STUDY DESIGN

Thirty-four patients with colorectal cancer liver metastasis who received neoCTx prior to intended hepatic resection were included in this prospective non-randomized study. All patients received standard 5-FU-based and RAS-adapted neoCTx. Peripheral blood plasma for determination of methylated SEPT-9 using the validated SEPT-9 gene methylation assay (Epigenomics Inc., Berlin, Germany) was collected at baseline and before each cycle of neoCTx. Methylated SEPT-9 was measured using quantitative PCR. In addition, the tumor markers CEA and CA 19-9 were also determined.

STATISTICAL ANALYSIS

The ability of SEPT-9 to diagnose progression of disease was assessed at several time-points by an ROC analysis, where the area under the curve (AUC) is assessed and promising cutpoints are described with sensitivity to diagnose progression, specificity to diagnose operability and corresponding 95% confidence intervals (CI).

RESULTS

Importantly, all patients tested positive for methylated SEPT-9 while the tumor markers CEA and CA 19-9 could only be detected in 80% and 50% of patients, respectively. Twenty-two of 34 patients (68%) responded to neoCTx and finally underwent hepatic resection while 12 patients (35%) developed progressive disease and did not undergo surgery. Importantly, serial measurement of SEPT-9 during neoCTx was able to discriminate between patients with progressive disease and patients who finally underwent surgery. The best separation between the two groups was achieved after the first cycle of chemotherapy, with an AUC of 0.86 upon ROC analysis. Assuming a cycle of threshold (CT) cutoff level of ≥30 on quantitative PCR for methylated SEPT-9 we were able to discriminate patients that finally underwent surgery from patients with progressive disease with an 82% sensitivity (95% CI: 52-95%) and 100% specificity (95% CI: 85-100%) after the first cycle of neoCTx.

DISCUSSION

The present study provides first evidence that SEPT-9 may be a valuable marker for early response prediction in patients with CLM.

CONCLUSION

Our data suggest that serial measurements of methylated SEPT-9 seem to be a particularly valuable tool for early prediction of disease progression in patients receiving neoCTx for CLM. This stratey could allow for an earlier switch to an alternative chemotherapy regimen in non-responders to treatment than with the current practice of repeat conventional radiologic imaging.

13] Randomized prospective study of laparoscopic trans-abdominal preperitoneal repair (TAPP) vs the open repair for bilateral inguinal hernia.

Benedetto Ielpo [1], Emilio Vicente [1], Yolanda Quijano [1], Hipolito Duran [1], Riccardo Caruso [1], Luis Malavé [1], Valentina Ferri [1], Eduardo Diaz [1], Isa Fabra [1], Ernesto Barzola [1]
(1) Sanchinarro University Hospital CEU San Pablo - Madrid - Spain

BACKGROUND AND AIMS
In the last decade there has been an increased interest in the laparoscopic repair approach of inguinal hernia showing benefits. We expect that even more benefits may exist for bilitateral inguinal hernias However, in the scientific literature, benefits of laparoscopic versus open approach for bilateral inguinal hernia repair are still unknown. The aim of this study is to compare the open Lichtenstein repair (OLR) and laparoscopic trans-abdominal preperitoneal (TAPP) repair.

STUDY DESIGN
This randomized prospective study was conducted at Sanchinarro University Hospital between March 2013 and May 2017. Patients who presented with a primary, reducible bilateral inguinal hernia were included as patients which reach a minimum of one year of follow up. Cases were randomized using a simple randomization with a computer program. Outcome parameters included hospital stay, operation time, postoperative complications, immediate postoperative and chronic pain, recurrence. Quality of life according to the standardized SF36 questionnaire was recorded preoperatively and at 2, 6 and 12 months after surgery. The primary end-point was to compare main clinical outcome between both groups.

STATISTICAL ANALYSIS
Data has been recorded in a SPSS Statistics Version 20.0 database. To compare the means of the quantitative variables when the variables followed a normal distribution, a variance analysis and a Student's t-test were used. For the rest of the variables, both Mann-Whitney and Kruskal-Wallis tests were performed. Statistical significance was defined as having a P value of <0.05.

RESULTS
A total of 148 patients were enrolled (70 of them underwent TAPP and 78 OLR). Drop out occurred in 5 cases (2 of TAPP and 3 of OLR group). Patient characteristics were statistically similar between the 2 groups. TAPP procedure had less early post-operative pain ($p=0.037$), a shorter length of stay ($p=0.031$) and less postoperative complications ($p=0.002$) when compared with the OLR approach. A slightly higher recurrence rate in the TAPP group was found. Additionally, there is a trend towards a higher postoperative quality of life and less chronic pain in the TAPP group.

DISCUSSION

This study for the first time provide data of clinical differences between laparoscopic and open approach for bilateral inguinal hernia showing a clear benefit for the TAPP.

CONCLUSION

TAPP procedure for bilateral inguinal hernia effectively reduces early postoperative pain, hospital stay and postoperative complications.

14] European experience after left liver adult-to-adult living donor liver transplantation – Donor and recipient selection is the key.

Santiago Sánchez-Cabús [1], **Daniel Cherqui** [2], Niki Rashidian [3], Gabriella Pittau [2], Laure Elkrief [4], Aude Vanlander [3], Christian Toso [4], Constantino Fondevila [5], Antonio Sa Cunha [2], Thierry Berney [4], Denis Castaing [2], Xavier Rogiers [3], Josep Fuster [5], René Adam [2], Pietro Edoardo Majno [4], Juan Carlos García-Valdecasas [5], Roberto Troisi [3]

(1) Hospital Clínic de Barcelona - Barcelona - Spain
(2) Centre Hépato-Biliaire Paul Brousse - Villejuif - France
(3) Ghent University Hospital Medical School - Ghent - Belgium
(4) University Hospitals of Geneva - Geneva - Switzerland
(5) Hospital Clínic de Barcelona - Barcelona - Spain

BACKGROUND AND AIMS

Adult-to-adult living donor liver transplantation using the left liver as a graft (LL-aaLDLT) decreases donor risk but provides a smaller graft that increases recipient risk as compared to right liver (RL-aaLDLT). However, since this is a procedure that has mainly been used in Asia, there is little knowledge of results obtained after LL-aaLDLT in Europe.

STUDY DESIGN

This is a European multicenter observational retrospective study. The aim was to analyze outcomes of both donors and recipients associated with LL-aaLDLT, with emphasis on donor and recipient postoperative complications, as well as recipient and graft survival.

STATISTICAL ANALYSIS

Categorical variables were analyzed with the Chi-square test or Fisher's exact test, and continuous variables were analyzed with Student's t-test. Survival was calculated with a Kaplan-Meier analysis. Two-tailed p values <0.05 were considered statistically significant.

RESULTS

46 consecutive LL-aaLDLT procedures performed from July 2007 to May 2017 were analyzed. 76% of the grafts were harvested by minimally invasive approach. Mean postoperative donor hospital stay was 7.5 ± 3.5 days. Donor liver function at 3rd and 5th postoperative day in terms of total bilirubin (1.5±1.1 mg/dL and 1.1±1.0, respectively) and INR (1.22±0.21 and 1.07±0.26, respectively) was preserved. 35 donors (76%) did not experience any complication, 9 (19.6%) minor and 2 (4.3%) major complications, which is similar to recent benchmark studies. Recipient survival was 90.9%, 82.7% and 82.7% at 1, 3 and 5 years, respectively. However, 25 recipients (54.3%) presented major complications, with a 50% reoperation rate, a 19.6% vascular complications rate and a 37% rate of biliary complications (21.7% biliary leak, 26.1% biliary stenosis). Small-for-size syndrome (SFSS) was observed in 12 patients (26.1%), and absence of portal blood flow modulation was associated

with SFSS development (p=0.038). Urgent liver retransplantation was needed in 12 patients (26.1%), mainly due to SFSS (5) and hepatic artery thrombosis (5) which led to a graft survival of 59.4%, 56.9% and 56.9% at 1, 3 and 5 years respectively. Risk factor analysis for urgent retransplantation, SFSS and hepatic artery thrombosis revealed an association with a graft to body weight ratio (GBWR) <0.6% (p=0.017) and recipient MELD ≥14 (p=0.041). In addition, a combination of donor age <45 years, MELD <14 and GBWR >0.6% was associated with a significant inferior urgent retransplantation rate (0% vs. 33.3%, p=0.044).

DISCUSSION

In western countries, where other sources for LT are readily available, LL-aaLDLT must be justified by excellent donor outcomes and non-inferior results in the recipients. Our analysis showed low donor morbidity and preserved liver function, consistent with previously published results. Recipient outcomes, however, are hampered by a high rate of postoperative morbidity and urgent liver retransplantation. Analysis of risk factors revealed that a strict selection of both donor and recipients is the key to minimize graft loss.

CONCLUSION

The present experience of LL-aaLDLT confirms reduced donor risk but its value is limited by a high retransplantation rates mainly due to SFSS and HAT. Donor/recipient selection i.e. donor age<45, recipient MELD <14 and GRWR >0.6% is the key to success.

15] Mutations of Ras/Raf-Proto-Oncogenes impair survival after cytoreductive surgery & HIPEC: tumor biology remains king.

Kuno Lehmann [1], **Philippe Gertsch** [1], Marcel André Schneider [1], Janina Eden [2], Basile Pache [3], Felix Laminger [4], Victor Lopez-Lopez [5], Thomas Steffen [2], Martin Hübner [3], Friedrich Kober [6], Sebastian Roka [6], Pedro Cascales Campos [7], Lilian Roth [1], Anurag Gupta [1], Alex Siebenhüner [8]
(1) Division of Oncologic Surgery & HIPEC, Department of Surgery and Transplantation, University Hospital Zurich - Zurich - Switzerland
(2) Department of Surgery, Cantonal Hospital of St. Gallen - St. Gallen - Switzerland
(3) Department of Surgery, Lausanne University Hospital (CHUV) - Lausanne - Switzerland
(4) Department of Surgery, Hanusch-Krankenhaus - Vienna - Austria
(5) Department of Surgery, Hospital Clínico Universitario Virgen de la Arrixaca - Murcia - Spain
(6) Department of Surgery, Hanusch-Krankenhaus - Vienna - Austria
(7) Department of Surgery, Hospital Clínico Universitario Virgen de la Arrixaca - Murcia - Spain
(8) Department of Medical Oncology, University Hospital of Zurich - Zurich - Switzerland

BACKGROUND AND AIMS

Cytoreductive surgery (CRS) and hyperthermic intraperitoneal chemotherapy (HIPEC) can improve cancer specific survival (CSS) in patients with peritoneal metastasis of colorectal origin. However, prognostic factors and preoperative selection criteria are only poorly defined. We therefore aimed to assess the unknown influence of Ras/Raf-mutations on cancer specific outcomes after CRS/HIPEC.

STUDY DESIGN

The present study is a multicentric retrospective cohort analysis from 5 European tertiary center hospitals. Patients received standard perioperative chemotherapy. HIPEC was indicated after radical cytoreduction (CC-score 0, no visible tumor) and conducted at 42°C for 90 minutes with mitomycin C/doxorubicin (≥15 mg/m²) or 43°C for 30 minutes with oxaliplatin (300-400 mg/m²). Follow-up included clinical exams, tumor markers and CT scan every six months. The study was approved by the responsible ethics committee (Nr. 2017-01656).

STATISTICAL ANALYSIS

Statistical analyses were performed with R-Studio using R version 3.4.1. T-test, Wilcoxon-test or Fisher's exact test were used to test for differences between groups. Kaplan Meier curves and Mantel-Cox Log Rank test were used to test for differences on CSS and DFS. Uni- and multivariate analyses were performed with Cox Regression analysis.

RESULTS

Overall, 137 patients (median age 58 (IQR: 47-66) years, 54% female) with peritoneal metastasis from colorectal cancer with a median peritoneal cancer index of 7 (IQR: 4-12) were included, and a complete resection (CC-0) was possible in 116 (84.7%) patients. Median CSS was 51 months (95%CI: 39-not reached). The overall

complication rate was 45.3%, major complications (Clavien-Dindo classification ≥ IIIB) occurred in 12 (10.95%) patients, and one patient died in the postoperative course. Uni- and multivariate analyses of potential factors predicting CSS yielded mutations of Ras/Raf proto-oncogenes (HR: 3.19, 95% CI: 1.28-7.87, =0.012, <u>Figure 1</u>) and major complications (HR: 2.40, 95% CI: 1.13-5.09, =0.022) as significant factors predicting CSS. Further analyses in regard to disease-free survival bore Ras/Raf mutations (HR: 2.41, 95% CI: 1.43-4.06, <0.001) and N2-stage (HR: 3.40, 95% CI: 1.74-6.62, <0.001) as significant parameters influencing the duration until disease relapse. A subgroup analysis was performed for patients with wildtype Ras/Raf who received chemotherapy without anti-EGFR treatment and patients with wildtype Ras/Raf treated with anti-EGFR treatment. Overall, patients with wildtype Ras/Raf tumors showed a survival benefit regardless of treatment with (median CSS not reached) or without (median CSS: 52 months) targeted anti-EGFR-therapy compared to patients with mutated Ras/Raf (median CSS: 35 months, =0.06), demonstrating the distinct role of individual tumor biology on outcomes after CRS/HIPEC (<u>Figure 2</u>).

DISCUSSION

Mutations of Ras/Raf proto-oncogenes significantly impair long-term oncological outcomes in patients with peritoneal carcinomatosis.

CONCLUSION

This role of Ras/Raf mutations is novel, and can help to improve patient selection for CRS/HIPEC.

16] Mitochondrial oxidative injury triggers HMGB1 (High Mobility Group Box 1) release following hepatic ischemia/reperfusion.

Rowan Van Golen [1], Megan Reiniers [1], Gerben Marsman [2], Lindy Alles [1], Derrick Van Rooyen [3], Björn Petri [4], Vincent Van Der Mark [1], Adriaan Van Beek [5], Ben Meijer [5], Adrie Maas [1], Sacha Zeerleder [1], Joanne Verheij [1], Geoffrey Farrell [3], Brenda Luken [2], Narci Teoh [3], Thomas Van Gulik [1], Michael Murphy [6], Michal Heger [1]
(1) Academic Medlcal Center - Amsterdam - Netherlands
(2) Sanquin - Amsterdam - Netherlands
(3) Liver Research Unit, Canberra Hospital - Australia
(4) Snyder Insitute, Calgary - Canada
(5) Wageningen University - Netherlands
(6) MRC Mitochondrial Biology Unit - United kingdom

BACKGROUND AND AIMS
Activation of sterile inflammation after hepatic ischemia/reperfusion (I/R) culminates in liver injury. The route to liver damage starts with mitochondrial oxidative stress and cell death during early reperfusion. The link between mitochondrial oxidative stress, damage-associated-molecular pattern (DAMP) release, and sterile immune signaling is incompletely understood and lacks clinical validation. The aim of this study was to determine the connection between mitochondrial oxidative stress and the release of immunogenic DAMPs after hepatic ischemia/reperfusion (I/R) in mouse and man.

STUDY DESIGN
In an observational study (NCT01700660), plasma levels of the DAMPs high-mobility group box 1 (HMGB1), mitochondrial DNA, and nucleosomes were measured in 39 patients who underwent a major liver resection (≥3 Couinaud segments) with (N=29, I/R) or without (N=13, control) intraoperative vascular inflow occlusion. Samples were obtained at baseline and at 1 h and 6 h after reperfusion (I/R group) or completion of parenchymal transection (control group). Systemic cytokine and neutrophil activation markers were also determined. In mice, the antioxidant MitoQ was intravenously infused in an attempt to limit DAMP release, reduce sterile inflammation, and suppress I/R injury. The latter was measured by transaminase release, liver histology, intravital microscopy/spectroscopy, cytokine arrays, and DAMP reconstitution experiments.

STATISTICAL ANALYSIS
n/a, see above (study design)

RESULTS
In the I/R group, patients were exposed to median (IQR) 48 (31-68) minutes of vascular inflow occlusion. HMGB1 was elevated following liver resection with I/R compared to liver resection without I/R. The increase in HMGB1 was noted at 1 h of reperfusion. HMGB1 correlated positively with ischemia duration and peak post-

operative transaminase (ALT) levels. There were no differences in mitochondrial DNA, nucleosome, or cytokine release. In mice, the mitochondria-targeted antioxidant MitoQ neutralized hepatic oxidative stress and decreased HMGB1 release by ~50%. MitoQ suppressed transaminase release, hepatocellular necrosis, and cytokine production. Reconstituting disulfide HMGB1 at the start of reperfusion reversed the protective effects of MitoQ.

DISCUSSION

Supportive care still remains the only treatment option for hepatic I/R injury. This is the first report that demonstrates DAMP release in a clinical hepatic I/R cohort. Moreover, HMGB1 was identified as a relevant DAMP in clinical liver I/R, and could be targeted in pharmacological interventions following liver surgery. Reducing oxidative injury with mitochondria-targeted antioxidants is a feasible strategy to reduce HMGB1 release and treat hepatic I/R injury.

CONCLUSION

HMGB1 is responsible for clinical hepatic I/R injury. Neutralizing mitochondrial oxidative stress may limit HMGB1/DAMP release after hepatic I/R.

17] A fully blinded randomized, placebo-controlled trial of bone-marrow-derived molecular cell therapy for non-reconstructable peripheral artery disease does not confirm the success of the earlier landmark study.

Jaap Hamming [1], **Jan Lindeman** [1], Jaap Jan Zwaginga [1], Graziella Kallenberg [1], Abbey Schepers [1], Rob Van Wissen [1], Hajo Van Bockel [1], Wim Fibbe [1]
(1) Leiden University Medical Center - Leiden - Netherlands

BACKGROUND AND AIMS

Prospects for no-option, end-stage peripheral artery disease (PAD) patients are poor, and the disease can only be managed by symptomatic therapy and ultimate amputation. Ensuring preclinical successes, and promising results from the semi-blinded Therapeutic Angiogenesis by Cell Transplantation (TACT) study (Lancet. 2002; 360: 427-35) fueled hope for cell-based strategies as a novel strategy for no-option PAD patients. The study was followed by a series of alternative protocols. Unfortunately, so far, none of the placebo-controlled studies confirmed the successful findings from the TACT study. Although this failure may reflect critical differences in the study protocols used, it cannot be excluded that the promising conclusions of the TACTstudy reflect a type-II statistical error, and that cell based therapies fail in no-option PAD patients. As such, we considered confirmation of the conclusions of the TACT study relevant.

STUDY DESIGN

This randomized controlled trial was approved by the national and local competent authorities, and registered (NCT00539266). Inclusion criteria included stable or progressive Fontaine II-B PAD, no imminent need for amputation, no accepted options for revascularization. Diabetic disease was an exclusion criterion. Bone marrow (500-700 ml) was harvested for multiple locations of the cristae (regional or full anesthesia). The bone marrow-derived mononuclear cells were concentrated at a certified stem cell facility to an injectable volume of 40 ml, and the concentrated cells or placebo (diluted autologous peripheral blood, hct. 2%)) intramuscularly injected at 40 locations of the calf muscle. Blinding was performed at the stem cell facility. Patients and clinical staff remained unaware of the group allocation until reaching the end point of the study.

STATISTICAL ANALYSIS

Power calculation was based on our earlier open study (J. Cardiovasc. Surg. (Torino) 2008; 49: 51-8) which showed clinical improvement (doubling of walking distance, improved ABI) in 14/25 cases. According to this data group sizes of 27 patients per group allows a discriminating power of 90% for a 35% difference in efficacy between BM-MNC and placebo treatment. Differences between the two groups were estimated by Fischer's exact test or unpaired t-tests.

RESULTS

Fifty-four patients (mean (sd) age 58.2 (14.2) yrs, 58% males) were randomized. 28 patients received BM-MNCs, 26 placebo. In one patient in the placebo group bone marrow harvest failed (dry taps). Baseline criteria were similar in the two groups. Conclusions summarized in the table show full equivalence for BM-MNCs and placebo treatments.

DISCUSSION

This fully-blinded replication trial does not confirm earlier successful findings of the semi blinded TACT study, and extends the negative conclusions from the other placebo controlled cell-based trials in PAD. Apparent improvements in functional and experienced restrictions over time observed for both groups underscore the importance of controlled trial design in evaluating interventions in PAD.

CONCLUSION

Results from this fully blinded trial fail to confirm promising results from the semi-blinded Therapeutic Angiogenesis by Cell Transplantation (TACT) landmark study. The present non-confirmative conclusions extend results from the other placebo-controlled studies and seem to conclude the discussion: Cell-based therapy is not an evidence based clinical option for non-reconstructable PAD.

18] The impact of duration of brain death on outcomes in abdominal organ transplantation: rush and retrieve or relax and repair?

Catherine Boffa [1], Elinor Curnow [2], Kate Martin [2], Rachel Johnson [2], James Gilbert [3], Edward Sharples [3], Rutger Ploeg [1]
(1) Nuffield Department of Surgical Sciences, University of Oxford - Oxford - United kingdom
(2) NHS Blood and Transplant - Bristol - United kingdom
(3) Oxford University Hospitals Trust - Oxford - United kingdom

BACKGROUND AND AIMS

Brain death (BD) induces a hostile inflammatory response affecting donor organs. Longer BD duration increases injury in donor organs, but up-regulation of defence mechanisms also occurs, possibly initiating repair. This poses the question whether we have to retrieve organs as-soon-as-possible or can wait and optimise or even target in-situ repair?

STUDY DESIGN

A retrospective analysis of the UK Transplant Registry evaluated donation after brain death in 1794 DBD donors between 1st January 2008 and 31st December 2012 with subsequent liver (1493), pancreas (519) and/or kidney (2655) transplantation. The relationship between BD duration and post-transplant survival (1 and 3 yrs) and function (1 yr) was analysed.

STATISTICAL ANALYSIS

The distribution of BD duration across donors was described using histogram, median and inter-quartile range. Donor characteristics were also summarised for the kidney cohort for four categories (quartiles) of BD duration (0-27.6, 27.6 - 35.7, 35.7 - 48.7 and >48.7 hrs). Kaplan-Meier estimates of transplant survival were compared for each type of abdominal organ for four categories of BD duration (categories as before) using the log-rank test. Regression models were used to investigate the relationship between BD duration and long-term kidney, liver and pancreas transplant outcome (Cox regression), initial kidney function (logistic regression) and long-term kidney function (eGFR as a categorical variable) (multinomial regression).

RESULTS

The median duration of brain death increased from 33 hours in 2008 to 36 hours in 2012 ($p=0.03$). Longer BD duration did not have a detrimental association with liver transplant survival ($p=0.89$, 1yr survival), whilst prolonged BD duration was associated with increased transplant survival following first kidney-only transplantation ($p=0.02$, 1yr survival) for prolonged cold ischaemic time (18 - 24 hrs) and following pancreas transplantation ($p<0.0001$, 1yr survival) in recent years. Delayed graft function was more common in kidney transplants as duration of BD increased ($p<0.0001$), but there was no association with primary non-function

(p=0.62). Longer BD duration had no detrimental association with graft function at 1 yr when the donor was 30 yrs or older and was associated with increased graft function for donors aged 30 to 40 yrs (p=0.01).

DISCUSSION

This study demonstrates that prolonged BD is not detrimental to outcomes in abdominal organ transplantation. This finding supports that time for donor management may be effectively used to optimise donor organs and justifies further clinical trials to immunomodulate or reduce injury, especially in marginal or higher risk donors.

CONCLUSION

This analysis renounces the need for a "Rush and Retrieve' policy and suggests using the time prior to retrieval for optimisation of donor organs.

19] The influence of hospital and surgeon volume on survival and local control in rectal cancer: long-term results of the CAO/ARO/AIO-94 trial

Michael Ghadimi [1], Thilo Sprenger [1]
(1) University Medical Center Goettingen - Goettingen - Germany

BACKGROUND AND AIMS
The association of hospital and surgeon volume with the oncological outcome of rectal cancer patients is under debate. In this study the long-term influence of the hospital as well as the surgeon volume on overall survival (OS) and local recurrence (LR) were investigated.

STUDY DESIGN
In a post-hoc analysis of the randomized phase III CAO/ARO/AIO-94 trial after a follow-up of more than 10 years, 799 patients with locally advanced rectal cancers were evaluated. OS and LR-rates were stratified by the hospital recruitment volume (≤20 vs. 21-90 vs. >90 patients) and by the surgeon volume (≤10 vs. 11-50 vs. >50 procedures).

STATISTICAL ANALYSIS
Patient survival was displayed in Kaplan-Meier analysis and significance was assessed using the Cox proportional Hazards model and the results of the log-rank test. Correlation of categorical clinical variables was assessed using the Fisher's Exact Test, correlation of continuous and categorical variables was assessed using the Wilcoxon Test.

RESULTS
Patients treated in "high-volume" hospitals had a longer OS than those treated in hospitals with medium or low treatment volume (p=0.03). The surgeon volume was significantly associated with decreased LR (p=0.01) but had no influence on overall survival. The positive effect of neoadjuvant chemoradiation on local control as compared with adjuvant chemoradiation was the strongest in patients being operated by medium-volume surgeons, less in patients being operated by high-volume surgeons and missing in those being operated by low-volume surgeons.

DISCUSSION
While the hospital recruitment volume has significant influence on OS but not on LR, the surgeon volume - vice versa - has significant influence on LR but not on OS. High-volume hospitals might provide enhanced oncologic infrastructure (tumor boards, multidisciplinary decisions and treatment, stringent follow-up) resulting in better long-term OS. However, the occurrence of LR was correlated with the individual surgeon`s routine and might be based on the quality of total mesorectal excisision. Furthermore, the positive effect of neoadjuvant chemoradiation on local

control demonstrated by the CAO/ARO/AIO-94 trial seems to be distinctly different dependent on the surgeon volume.

CONCLUSION

Patients with locally advanced rectal cancers might benefit from treatment in in specialized high-volume hospitals. In particular, the surgeon volume had significant influence on local control.

20] Hyperthermic Intraperitoneal Chemotherapy (HIPEC) can trigger a systemic inflammatory response by intestinal bacterial translocation. A prospective study in humans.

Kuno Lehmann [1], **Philippe Gertsch** [1], Dilmurodjon Eshmuminov [1], Lilian Roth [1], Marcel André Schneider [1], Theresia V. Reding Graf [1], Anurag Gupta [1]

(1) Division of Oncologic Surgery & HIPEC, Department of Surgery and Transplantation, University Hospital Zurich - Zurich - Switzerland

BACKGROUND AND AIMS

CRS/HIPEC has become a treatment of choice for many patients with peritoneal metastasis originating from appendix or colorectal tumors, leading to improved survival rates. However, the pathophysiology behind HIPEC is only rarely understood, and there is an ongoing discussion which protocol to use for HIPEC: a mitomycin C based protocol currently preferred by many surgeons in the US, or the oxaliplatin based protocol developed by FRENCH groups. For the first time, we describe dramatic changes in the postoperative systemic inflammatory reaction, highly different among treatment protocols.

STUDY DESIGN

151 patients after CRS/HIPEC were included in a prospective database. HIPEC was performed according the US protocol for 90min at 42° with mitomycin C/doxorubicin (30mg/15mg per m²BSA) or the FRENCH protocol for 30min at 43°C with oxaliplatin (300mg per m²BSA). White blood cells (WBC), C-reactive protein (CRP), body temperature, thrombocytes were serially analyzed. In (n=50) patients, serial blood samples were assessed for procalcitonin (PCT), Interleukin-6 (IL-6), pancreatic stone protein (PSP), and bacterial components (16s rDNA). Computed tomography, blood and urine cultures, were routinely performed in any suspicion of infection. The study was approved by the ethics committee (KEK Nr. 2015-0529).

STATISTICAL ANALYSIS

Statistical analysis was performed with SPSS (version 23) and Graph Pad Prism (version 7.0). Non-parametric variables were compared with the Mann-Whitney U test, considering a significance level of $p<0.05$. 16s rDNA levels were compared with the student`s t-test.

RESULTS

In patients after 90min HIPEC with mitomycin C/doxorubicin, a significant secondary CRP increase ($p=0.039$) was observed in the second postoperative week, even after uncomplicated CRS/HIPEC, highlighting an ongoing inflammatory process (<u>Figure 1</u>). This increase did not correlate with infectious complications, and hence, postoperative CRP levels did not contribute to clinical decision making. WBC was not contributing since consistently in a normal range in patients with or without infection, indicating an immunosuppressed status. Finally, after CRS/HIPEC, only

persistent elevation of PCT was indicative of infection since it otherwise normalized within one week in all patients without complications. To test our hypothesis of intestinal translocation after HIPEC with mitomycin C/doxorubicin, patients with an uncomplicated course were further explored, and compared to patients after HIPEC with oxaliplatin. Both groups were similar with regard to PCI (7 vs. 5, p=0.954) and OR time (315min vs. 404min, p= 0.289). After HIPEC with mitomycin C/doxorubicin, but not after oxaliplatin based HIPEC, a massive increase of PSP (p=0.014) (<u>Figure 2</u>), and increasing IL-6 levels (<u>Figure 3</u>) were observed, indicating a triggering source from the portal blood flow. Finally, elevated 16s rDNA levels (p=0.022) in the serum (<u>Figure 4</u>), identified a bacterial origin, mostly due to intestinal translocation after HIPEC with mitomycin C/doxorubicin.

DISCUSSION

HIPEC for ninety minutes with mitomycinC/doxorubicin induces a systemic inflammatory response, not observed after HIPEC with oxaliplatin for 30 minutes. Our findings indicate a source from the portal blood flow, and bacterial components as a responsible trigger. These novel finding are important for the understanding of molecular mechanisms for the further developments of HIPEC.

CONCLUSION

HIPEC for ninety minutes with mitomycinC/doxorubicin induces a systemic inflammatory response secondary to intestinal bacterial translocation.

21] Efficiency of fibrin glue for sleeve gastrectomy complications: a two-centre prospective randomized study.

Lionel Rebibo [1], Jean Marc Regimbeau [1], Abdennaceur Dhahri [1], Rachid Chati [1], Cyril Cosse [1], Emmanuel Huet [1]
(1) Department of Digestive Surgery - Amiens - France

BACKGROUND AND AIMS
The main complications following sleeve gastrectomy (SG) are gastric leak (GL), postoperative bleeding (hemorrhage, hematoma) and stenosis. At present, the available data shows contradictory findings on the possibility of prevention used to reduce these complications due to underpowered studies. The objective of this study was to evaluate the effectiveness of the use of fibrin sealant (FS) on the development of staple line complications after SG.

STUDY DESIGN
This was a prospective, randomized, two center study of a group of patients undergoing primary SG (ClinicalTrials.gov identifier: NCT01613664) between March 2014 and June 2017 (600 patients). Randomization was stratified by center, age, sex gender, and body mass index with two groups of equal size as 301 in the fibrin sealant group (FS group) and 299 in the no fibrin sealant group (control group). Exclusion criteria were previous history of bariatric or gastric surgery, other surgical procedure than primary SG, BMI ≥ 60kg/m2, allergy to TISSEEL. SG technique was standardized and application of FS was performed on the gastric staple line at the end of procedure. Post-operative complications were evaluated on the first 30 post-operative days and were considered as gastric leak (GL), post-operative bleeding or hematoma next to the staple line, and intra-abdominal collection. Lost to follow-up were considered as post-operative complications. The study's efficacy endpoint was the incidence of post-operative complication related to gastric staple line. Secondary endpoints were the overall and specific mortality rate, overall morbidity rate, specific morbidity rate.

STATISTICAL ANALYSIS
To validate the hypothesis that the use FS during SG could reduce from 7 to 2% the rate of complications with a significance level of 5% and a power level of 20%, the population required by group must be of 290 patients totaling 580 patients. In this population, it must take account of patients excluded from the study (lost to follow-up) representing about 3.5% of the total population (20 patients). The total workforce in the study must be of 600 patients. Categorical variables were compared in a chi-squared test. The results are quoted the mean ± SD (range) or the number (percentage). All tests were two-tailed and the threshold for statistically significance was set to $p<0.05$.

RESULTS

There were no demographic differences between arms. There was 4 lost to follow-up (two in each groups). The overall complication was 2.31% in the FS group and 2.66% in the control group (p=0.784). The overall complication rate (after excluding lost to follow-up) related to gastric staple line was 1.66% in the FS group and 2.01% in the control group (p=0.752). The mortality rate was 0.3% in the FS group (one related to gastric leak) and 0% in the control group (p=1). The rate of GL was 0.33% in the FS group and 1.33% in the control group (p=0.685). The rate of post-operative bleeding/hematoma was 1.32% in the FS group and 0.67% in the control group (p=0.686).

CONCLUSION

This series confirm the low rate of post-operative complications following SG. This randomized trial shown no significant differences regarding postoperative staple-line complications.

22] The Comprehensive Complication Index as a novel readily available cost assessment tool for surgical procedures.

Roxane D. Staiger [1], Matteo Cimino [2], Ammar Javed [3], Sebastiano Biondo [4], Constantino Fondevila [5], Julie, Périnel [6], Ana Carolina Aragão [7], Guido Torzilli [2], Mustapha Adham [6], Hugo Pinto-Marques [7], Christopher Wolfgang [3], Philipp Dutkowski [1], Milo A. Puhan [8], Pierre-Alain Clavien [1]

(1) Department of Surgery and Transplantation, University Hospital of Zurich - Zurich – Switzerland
(2) Department of Surgery & Division of Hepatobiliary and General Surgery, Humanitas Research Hospital - Milan - Italy
(3) Department of Surgery, Johns Hopkins School of Medicine - Baltimore - USA
(4)Department of General and Digestive Surgery, Bellvitge University Hospital, University of Barcelona and IDIBELL - Barcelona - Spain
(5) Department of Surgery, Hospital Clinic de Barcelona - Barcelona - Spain
(6) Department of General and Digestive Surgery, University Hospital of Lyon - Lyon - France
(7) Hepato-Biliary-Pancreatic and Transplantation Centre, Curry Cabral Hospital, CHLC - Lisbon -Portugal
(8) Epidemiology, Biostatistics and Prevention Institute, University of Zurich - Zurich - Switzerland

BACKGROUND AND AIMS

There is strong economic pressure worldwide to slow down the rising of healthcare costs. Reducing postoperative complications, the most influential driver of costs in surgical patients, has the potential to significantly lower health care spending and improve patients' quality of life. However, costs are often difficult to ascertain, making comparisons over time and across centers difficult. We hypothesized that the cumulative burden of postoperative complications together with some readily available information like age and type of surgery may provide a good approximation of resulting costs, and thus have the potential to become a valuable surrogate for cost ascertainment. Therefore, our aim was to assess how accurately postoperative morbidity, age and type of surgery predict total inpatient costs.

STUDY DESIGN

Data on postoperative complications and total costs from a single tertiary center were retrospectively collected from a prospective database (2014-2016). Five procedures were analyzed: Cholecystectomies, colon, rectum, liver and pancreas resections. The Comprehensive Complication Index (CCI®), based on the Clavien-Dindo ranking of complications, was the metric for overall postoperative morbidity. In case of combined surgeries, the more severe operation defined case allocation.

STATISTICAL ANALYSIS

The complication/cost correlation at discharge was calculated by Pearson Correlation Coefficient (PCC). To assess how well the CCI®, age and surgery type predicted total inpatient costs a multiple linear regression model was fitted with total cost (its logarithmic transformation due to skewed data) as outcome and validated the findings internationally.

RESULTS

832 cases were included. A strong correlation between CCI® and costs was found (PCC 0.90). In the multiple regression model CCI®, age and type of surgery explained much of the variation in cost (R-squared 0.80, all associations with p<0.001). For each 10-point increase of the CCI® cost increased by 20%. Cost significantly increased by age, e.g. costs were 15% higher for patients 51-70-year-old compared to younger ones, and 24% higher for ≥70-year-old. Compared with cholecystectomy, with similar CCI® values colon surgery was associated with 65% higher cost, rectum surgery with 86%, liver surgery with 89% and pancreas surgery with 116% higher cost. An international validation confirmed these observations.

DISCUSSION

Overall postoperative morbidity correlates strongly with cost. Less expected was the substantial cost increase of 20% per 10 CCI® points. These new insights are highly relevant since they enable a reliable prediction of inpatient costs by the overall postoperative burden, age and type of surgery. Valid, easy to use cost comparison enables benchmarking of expenses and permits medical cost reduction by comparing with the best possible outcome. Ideal cases, used to establish the benchmark, are patients expected to have the least postoperative complications. Comparison of the own ideal cases with the benchmark may help discover economizing potentials.

CONCLUSION

The CCI® together with age and type of surgery is a novel reliable predictor of cost. This approach overcomes the burdensome ascertainment of cost data and avoids inconsistencies in their calculations and reimbursement across health care systems. Thereby, global comparison of cost through surgical outcome using the CCI® may greatly facilitated transparent cost assessment and comparisons.

23] Preoperative biliary stenting and major morbidity after pancreatoduodenectomy - Does elapsed time matter? The FRAGERITA study group.

Marta Sandini [1], **Gianotti Luca** [1], Kim C Honselmann [2], David J. Birnbaum [3], Francesca Gavazzi [4], Mircea Chirica [5], Ulrich Wellner [2], Théophile Guilbaud [3], Louisa Bolm [2], Marco Angrisani [1], Vincent Moutardier [3], Marco Cereda [1], Édouard Girard [5], Marco Montorsi [6], Tobias Keck [2], Alessandro Zerbi [4]

(1) School of Medicine and Surgery, Milano Bicocca University, Department of Surgery, San Gerardo Hospital - Monza - Italy

(2) Department of Surgery, University Medical Center Schleswig-Holstein, Campus Luebeck - Luebeck - Germany

(3) Department of Digestive Surgery, Hôpital Nord, Aix-Marseille University - Marseille - France

(4) Pancreatic Surgery Unit, Department of Surgery, Humanitas Research Hospital - Milano - Italy

(5) Department of Digestive Surgery and Liver Transplantation, Hôpital Michalon - Grenoble - France

(6) Department of Surgery, Humanitas Research Hospital, Humanitas University - Milano – Italy

BACKGROUND AND AIMS

Biliary stenting for periampullary tumor-induced jaundice may improve liver function recovery but increases the risk of postoperative complication when compared to upfront pancreatoduodenectomy (PD). However, biliary stenting is often inevitable and the effect of stent duration on postoperative outcomes has not been investigated. The goal of this study was to analyze whether elapsed time from biliary stenting to surgery is associated with the occurrence and severity of major postoperative complications.

STUDY DESIGN

From 2013 to 2016, patients who underwent PD after biliary drainage at 5 European Academic Centers were analyzed. Demographic and clinical data were retrieved from prospectively maintained databases. The primary end-point was to assess the association between the duration of preoperative biliary stent placement and major postoperative morbidity rate. Patient were stratified into three groups according to the elapse time from biliary stenting to surgery: short (< 4 weeks), intermediate (4-8 weeks) and long (> 8 weeks). Postoperative morbidity was defined as all complications within 30 days after surgery and graded according to the Clavien-Dindo classification (CDC). Major morbidity was defined as CDC ≥3. Preoperative liver function was estimated through the ALBI score.

STATISTICAL ANALYSIS

The Fisher Exact $\chi 2$ test and the Student t test with Bonferroni correction for multiple comparisons were used. The rough and adjusted risk of CDC≥3 were calculated as Odds Ratios (ORs) through a logistic regression model.

RESULTS

812 patients underwent PD during the study period. 312 (38.4%) out of these had a preoperative biliary stent placed and constituted our study cohort. The mean age at surgery was 68±10 years, the median time from stenting to surgery was 37 days (2-559 days) and most operations were performed for pancreatic cancer (68%). Morbidity and mortality rates were 56.0% and 1.2%, respectively. We observed no differences among groups for baseline characteristics, however patients in the short group (n=106) experienced shorter operation time [436±90 min. vs. 481±88 vs. 497±93, in intermediate (n=115) and long (n=91) respectively, p<0.001], but higher rate of major morbidity (43.4% vs. 20.0% vs. 24.2%; p<0.001), biliary fistulae (13.2% vs. 4.3% vs. 5.5%; p=0.031) and longer in-hospital stay (21±16 days vs. 15±13 vs. 16±15; p=0.027). Type of stent (plastic vs. metallic), antibiotic resistance pattern at intraoperative bile culture, or occurrence of pancreatic fistulae were not significantly different among groups. Liver function progressively improved with time (beta=-0.309, p<0.001 at regression), although all groups had a normal ALBI score at operation. A multivariate adjusted model identified the short stent duration as an independent risk factor of severe postoperative morbidity, with an OR of 2.44 (p=0.019).

DISCUSSION

The results of this large multicenter study suggest that the risk of major morbidity increases when surgery is performed within 4 weeks after biliary stent placement. This effect does not seem to be related to a detectable impairment of liver function, or to aggressive resistance patterns of bile contamination.

CONCLUSION

When treatment of jaundice cannot be avoided, major morbidity, procedure-related complications, and length of in-hospital stay may be reduced by delaying surgery up to one month after biliary stenting.

24] Use of activity tracking in major hepatobiliary and gastrointestinal surgery— Results of the enhanced perioperative mobilization trial.

Thilo Welsch [1], Steffen Wolk [1], Benjamin Müssle [1], Theresa Meissner [1], Ann Wierick [1], Andreas Bogner [1], Dorothee Sturm [1], Nuh Rahbari [1], Marius Distler [1], Juergen Weitz [1]
(1) TU Dresden - Dresden - Germany

BACKGROUND AND AIMS
Enhanced recovery after surgery (ERAS) programs aim to minimize postoperative stress and accelerate postoperative recovery by implementing multiple perioperative items. "Early mobilization" is one such item, but the quality of assessment and monitoring has been poor. Activity trackers allow precise monitoring and auto feedback to the patients to enhance the motivation for early mobilization. The aim of the study was to monitor and increase the postoperative mobilization of patients after major abdominal surgery by providing continuous auto-feedback of the step count using activity tracking wristbands.

STUDY DESIGN
The study was designed as a randomized controlled single center trial (NCT02834338). Patients (18-75 years) undergoing elective open and laparoscopic surgery of colon, rectum, stomach, pancreas and liver for any indication were included. Patients were allocated to two subgroups, laparoscopic and open surgery, and were randomized 1:1 for automatic feedback of their step-count using an activity-tracker wristband (Polar Loop, Polar Electro GmbH, Germany). The control group had no auto feedback. The sample size (n = 30 patients in each of the four groups, overall: n=120) was calculated on an assumed difference in step count of 250 steps daily (intervention group versus control group). The primary study endpoint was the mean step count during the first five postoperative days. Secondary endpoints were: the percentage of patients who mastered the predefined step-count targets, calorie consumption, length of hospital and intensive care unit stay, 30-day mortality and morbidity.

STATISTICAL ANALYSIS
The sample size estimation was based on our results from a pilot study with 30 participants to collect data about standard mobilization at the first five postoperative days. Based on those data, an increase in the daily step count by 250 steps/day was estimated. To achieve an 80% power with a 2-sided P value of less than 0.05, and a dropout rate of 10%, the total sample size calculated with a 2-tailed unpaired t-test was 120 patients with 30 in each of the four groups. Statistical analysis was based on an intention-to-treat analysis.

RESULTS
A total of 132 patients were randomized. After laparoscopic operations the average step count during the first five days was significantly influenced by the feedback

compared with the control group (2044 versus 1245 steps, p = 0.035); the total step count and activity time were also significantly increased. These results could not be confirmed in the open surgery arm. Most likely, the reasons were a higher age and significantly more comorbidities in the open intervention group. Patients who mastered the predefined mobilization targets had a significant shorter length of hospital stay (laparoscopic arm: 7.8 versus 12.5 days, p = 0.031; open arm: 12.4 versus 16.7 days, p = 0.017). Additionally, these patients also had lower perioperative morbidity. The average step count also correlated with the length of hospital stay (R = -0.341, p < 0.001).

DISCUSSION

This study is the first randomized controlled trial investigating the use and feasibility of activity tracking to monitor and enhance postoperative mobilization in abdominal surgery.

CONCLUSION

Our results demonstrate that activity tracking can enhance perioperative mobilization.

25] Single incision laparoscopy versus multiport laparoscopy for colonic surgery: a multicenter double-blinded randomized controlled trial.

Léon Maggiori [1], **Yves Panis** [1], Jean-Jacques Tuech [2], Eddy Cotte [3], Bernard Lelong [4], Quentin Denost [5], Mehdi Karoui [6], Eric Vicaut [7]
(1) Beaujon Hospital - Clichy - France
(2) Rouen Hospital - Rouen - France
(3) Lyon Sud Hospital - Lyon - France
(4) IPC - Marseille - France
(5) Haut Lévêque Hospital - Bordeaux - France
(6) Pitié-Salpétrière Hospital - Paris - France
(7) Fernand Widal Hospital - Paris - France

BACKGROUND AND AIMS
The potential benefits of single port laparoscopy (SPL) over multiport laparoscopy (MPL) is yet to be demonstrated in large randomized trials. This trial aimed to compare outcome of SPL and MPL for colonic surgery.

STUDY DESIGN
This was a prospective randomized, multi-institutional, two-arm, double-blinded, superiority trial. Patients with scheduled laparoscopic colonic resection for diverticulitis, Crohn's disease, benign neoplasia or colon cancer were randomly assigned to SPL or MPL. Patients with history of laparotomy, obesity, planned stoma construction during surgery, scheduled transverse, total, or subtotal colectomy, synchronous metastasis, associated resection of another organ, and pregnancy were excluded. To participate, each surgeon had to be a senior consulting surgeon, and to had performed at least 50 MPL and 10 SPL colonic resections. The patient and the ward physician in charge of the patient were not informed of the randomization result. At the end of the procedure, 5 dressings were placed at the exact theoretical position of the 5 MPL ports in all patients, including SPL patients. Primary outcome was length of hospital stay (LHS). Secondary outcomes were procedure duration, intra-operative blood-loss, intra-operative complication, conversion to open approach, total length of skin incision, postoperative 30-day overall morbidity, postoperative pain, postoperative time to first bowel movement, quality of life at six months, and aesthetic outcome at 6 months.

STATISTICAL ANALYSIS
Statistical analysis: A sample size of 64 patients per group was calculated to ensure a power of at least 80% to detect a difference regarding LHS of 1 day using a Student's T test with a significance level set at 5%. This study was registered as NCT01959087.

RESULTS
Results: 128 patients were randomized and 125 analyzed: 62 in SPL group and 63 in MPL group, including 91 right (SPL: n=44, 71%; MPL: n=47, 75%) and 34 left (SPL:

n=18, 29%; MPL: n=16, 25%) colectomies, performed for Crohn's disease (n=53, 42%), cancer (n=36, 29%), diverticulitis (n=21, 17%), or benign neoplasia (n=15, 12%). Additional port insertion was required in 5 (8%) SPL patients and conversion to laparotomy occurred in 7 patients (SPL: n=3, 5%; MPL: n=4, 7%; p=1.000). Total length of skin incision was significantly shorter in the SPL group (SPL: 56 ± 41 (30-300) mm; MPL: 87 ± 40 (50-250) mm; p<0.001). Procedure duration, intra-operative blood-loss, intra-operative complication rate, conversion to open approach, postoperative 30-day morbidity, postoperative pain, and time to first bowel movement showed no difference between groups, leading to similar mean LHS (SPL: 6 ± 3 days; MPL: 6 ± 2 days, p=0.298). At six months, quality of life was similar between groups but significantly more patients from the SPL group were satisfied or very satisfied with their scar (SPL: 65%; MPL: 46%; p=0.003).

DISCUSSION

These results highlight that SPL can be safely proposed for colonic resection, especially in young and active patients, with high aesthetics expectations.

CONCLUSION

SPL for laparoscopic colectomy does not confer any additional benefit other than aesthetic result, as compared to MPL.

26] Postoperative acute pancreatitis following pancreaticoduodenectomy: a determinant of fistula driven by the intraoperative fluid management.

Elisa Bannone [1], Stefano Andrianello [1], Giovanni Marchegiani [1], Gaia Masini [1], Giuseppe Malleo [1], Claudio Bassi [1], Roberto Salvia [1]
(1) University of Verona Hospital Trust - Unit of General and Pancreatic Surgery - Verona - Italy

BACKGROUND AND AIMS
Post-operative acute pancreatitis (POAP) after pancreaticoduodenectomy (PD) is related to postoperative pancreatic fistula (POPF). Despite the lack of specific studies, a standardized definition has been recently proposed. Aim of the study was to verify the association between POAP and POPF, and to assess possible predictors of both.

STUDY DESIGN
Data from 292 consecutive PD at Verona Hospital were retrospectively analyzed. POAP was defined as an elevation of serum amylase levels above the upper limit of normal (52 U/l) on post-operative days (POD) 0 or 1. The primary end point was to define the rate of POAP after PD. Secondary endpoints were to identify possible predictors of POAP and the association with POPF.

STATISTICAL ANALYSIS
A receiver operating characteristic (ROC) curve was used to assess the association between serum amylase on POD 0/1 and POPF occurrence. Chi-square or Fisher's exact tests were used to evaluate categorical variables. Continuous variables were analyzed with Student's t-test or Mann-Whitney test. Stepwise logistic regression analysis was carried out to identify predictors of POAP and POPF.

RESULTS
POAP rate after PD was 54.5%, whereas POPF rate was 22.3%. ROC curve analysis revealed that the area under the curve (AUC) for POPF prediction through serum amylase value on POD 0 was 0.79. Using the proposed cut-off, POAP showed 92% sensitivity, 54% specificity, 94% negative predictive value and 46% positive predictive value for POPF (Figure 1). POAP resulted an independent predictor of POPF (OR 3.8, CI95% 1.2-11.9, p= 0.02). POAP protective factors were pre-operative exocrine insufficiency (OR 0.39; CI 95% 0.13-0.87; p=0.02), neoadjuvant therapy (OR 0.29; CI95% 0.1-0.8; p=0.01) additional resection of the pancreatic stump margin (OR 0.25; CI95% 0.05-0.9; p=0.05). Soft pancreatic texture (OR 4.38; CI95% 1.9-10; p<0.01) and a main pancreatic duct (MPD) diameter3 mm (OR 0.67; CI95% 1-5.3; p<0.01) were associated with an increased rate of POAP. Once patients at high risk for POAP have

been identified, they were dichotomized according to intraoperative fluid volume administration. An intraoperative near-zero fluid management (3mL/Kg/h) was associated with an increased incidence of POAP (24.6 vs. 0%, p= 0.04) and POPF (27.6 vs. 11.4%, p= 0.05) when compared to a liberal fluid balance (> 3 ml/kg/h).

DISCUSSION

This study represents the first clinical validation of POAP as a specific pancreatic surgery complication. POAP appears to be a relevant factor related to POPF development, probably as the direct expression of pancreatic stump ischemia eventually leading to anastomotic failure. Most studies regarding POPF evaluated different surgical techniques or pharmacologic pancreatic secretion inhibition, whereas others only described not modifiable factors. Our results demonstrated that intraoperative fluids management could impact on POAP occurrence and consequently on POPF in specific clusters of patients.

CONCLUSION

POAP is a predictor of pancreatic anastomosis leakage and could potentially be avoided through an intraoperative fluid regimen managed according to patient's and pancreas' specific risk factors. The present series represents the basis for further prospective studies aimed to systematically assess the implications on intraoperative fluid management and postoperative complications.

27] Clinical validation of the comprehensive complication index as a measure of postoperative morbidity at a surgical department. Prospective study.

JoseM Ramia [1], **Roberto De La Plaza** [1], Juan M Bellon [1], Vladimir Arteaga [1], Cristina Garcia Amador [1], Aylhin Lopez Marcano [1], Anibal Medina Velasco [1], Begoña Gonzalez Sierra [1], Alba Manuel Vazquez [1]

(1) Dept. of Surgery. University Hospital of Guadalajara. Univ. of Alcala - Guadalajara - Spain

BACKGROUND AND AIMS

The Clavien-Dindo classification (CDC) is the most frequently used system worldwide to assess postoperative morbidity. The new Comprehensive Complication Index (CCI) summarizes numerically all the complications classified according to CDC. The present study aims to clinically validate the CCI in all patients operated upon at a surgery department. Its validation would allow its universal application for comparing postoperative complications at different departments either locally or internationally.

STUDY DESIGN

Prospective observational study. Primary end-point: to determine the clinical validity of CCI as a measure of postoperative morbidity in all patients operated upon at a Surgery Department. Secondary end point: to determine frequency and severity of all complications according to the CDC and CCI. Recruitment. All patients (reference area: 254609 inhabitants) who underwent surgery during the one-year study period were included. Analytical methods to demonstrate the hypothesis. All the complications associated with initial admission, or until discharge if patient was readmitted within 90 days of surgery, were prospectively included. Surgical procedures were classified according to the Operative Severity Score (OSS, Copeland et al. 1991) as minor, moderate, major and major+. Surgeons were instructed to record all the complications according to the CDC and CCI. Any doubts were resolved in a clinical session. The researchers reviewed all the complications recorded by the surgeons and nurses. The clinical validation of the CCI was made according to its correlation with: hospital stay, prolongation of the stay, re-admission and disability.

STATISTICAL ANALYSIS

The univariate models were estimated to identify possible factors associated with events. Associated variables were included in the initial model and a final model was obtained using backward stepwise selection. Linear regression models were performed with the quantitative dependent variables and logistic regression models with the qualitative dependent variables. The multivariate model reflects the estimation of the indices, adjusted for other confounding factors. Once the models were estimated, they were validated by their discriminative capacity (area under the ROC curve, AUC-ROC) and their calibration (Hosmer-Lemeshow goodness of fit test).

RESULTS
A total of 1850 patients were included. The distribution according to the OSS was 777 minor, 625 moderate, 392 major and 56 major+. Four hundred and sixty-two patients presented complications (24.9%) and 101 (5.46%) were readmitted. In the multivariate analysis, the CCI and CDC were associated with hospital stay (coefficient 95% CI, p <0.001) and with prolongation of stay, re-admission and disability in all OSS groups (Odds Ratio 95% CI, p <0.001,). The AUC-ROC was above 90% in all the models except for the prolongation of stay after minor OSS (CDC and CCI) and after moderate OSS (CCI). The adjusted R-squared ranged from 33.90 to 69.40% in the hospital stay model for all four OSS groups.

DISCUSSION
The CDC and CCI were strongly associated with the clinical parameters considered. However, their predictive capacity was lower in the hospital stay model.

CONCLUSION
Determination of the CDC and CCI provides accurate information on the overall morbidity in a surgery service, and the CCI allows the consideration of all the complications. These instruments can be used at any surgery service to determine postoperative morbidity.

28] The impact of hospital volume and Charlson score on postoperative mortality of proctectomy for rectal cancer. A nationwide study of 45569 patients.

Mehdi El Amrani [1], Clement Guillaume [2], Xavier Lenne [2], Moshe Rogosnitzky [1], Didier Theis [2], François-René Pruvot [1], Philippe Zerbib [1]

(1) Department of Digestive Surgery and Transplantation, Lille University Hospital - Lille - France

(2) Medical Information Department, Lille University Hospital - Lille – France

BACKGROUND AND AIMS

A volume-outcome relationship has been observed in complex surgical procedures, and hospital volume (HV) is suggested as a strong predictor of patient outcome. In addition, centralization of care in centers of excellence has led to improved outcomes in oncologic surgery. However, little is known regarding the impact of HV on postoperative mortality (POM). We conducted a large nationwide study to identify the association between rectal cancer POM and HV. We also examined the influence of comorbidities according to Charlson Comorbidity Index (CCI) on the relationship between POM and HV.

STUDY DESIGN

Data were extracted from the French national administrative database for hospital care (Programme de Médicalisation des Systèmes d'Information (PMSI)). All patients nationwide who underwent proctectomy for rectal cancer between 2012 to 2016 were included. Patient condition was assessed on the basis of the validated Charlson Comorbidity Index (CCl) and patients were stratified into 3 groups according to the CCI score (0-2, 3, and ≥4). Chi-square Automatic Interaction Detector (CHAID) was used to identify the cut-off values of the annual proctectomy caseload affecting the 90-day POM. The 90-day POM was analyzed according to HV (low:< 10, intermediate: 10-40 and high volume ≥ 41 cases/year) and CCI.

STATISTICAL ANALYSIS

Quantitative variables were expressed as median and qualitative variables as percentages. The chi-square or Fisher tests were used to compare categorical data. Predictors of 90-day POM were identified using a multivariate logistic regression. To determine the calibration and discrimination of the model, the Hosmer-Lemeshow Chi-square test was performed. All p values presented were for a two-sided test and the threshold of significance was set at $P < 0.05$.

RESULTS

Results. The overall rate of laparoscopic proctectomy among 45569 rectal cancer resections was 60%, with a higher rate in high volume than in intermediate or low volume centers (respectively, 67% vs 60 vs 50%; p<0.001). The overall 90-day POM was 3.5% and correlated with the CCI (CCI 0-2: 1.9%, CCI 3: 4.9%, CCI≥4: 5.8%, p<0.001). There was a linear decrease in POM with increasing HV (low volume: 5.6%,

intermediate volume: 3.5%, high volume: 1.9%; p<0.001). For low risk patients (CCI 0-2), 90-day POM was significantly higher in low and intermediate HV compared to high HV centers (respectively, 3.2%, 1.8% vs 1.1, p<0.001). A significant decrease in postoperative hemorrhage rate was observed with increasing center volume (low: 13.3%, intermediate: 11.9% and high volume: 9.4%; p<0.001). After multivariate analysis, proctectomy in low (OR=2.1, IC95[1.71-2.58], p<0.001) and intermediate (OR=1.45, IC95[1.2-1.75], p<0.001) HV centers was independently associated with higher risk of mortality.

DISCUSSION

Our findings suggest that centralization of rectal cancer surgery in high volume centers improves postoperative outcomes independent of patients' comorbidities. The benefit of referral of complex rectal surgery to high HV centers is confirmed, and has strong implications for health care policy in France (i.e., high volume centers saturation or important population movement).

CONCLUSION

POM following proctectomy for rectal cancer is strongly associated with hospital volume regardless of patients' comorbidities. To improve postoperative outcomes, rectal surgery should be centralized in specialized high-volume units.

29] Impact of a multi-modal personalised prehabilitation programme in patients undergoing treatment for oesophago-gastric cancer.

Moorthy Krishna [1], Laura Halliday [1], Alex King [1], hayley Osborn [1], Maria Halley [1], Claudia Rueb [1], George Hanna [1], **Venetia Wynter Blyth** [1]
(1) Imperial College London - London - United kingdom

BACKGROUND AND AIMS
Patients with oesophago-gastric (OG) cancer are elderly, frail and require major surgery. Their functional capacity is further compromised by neo-adjuvant chemo/ radio therapy (NAC). OG surgery is associated with a high complication rate, prolonged hospital stay and delayed recovery. Prehabilitation aims to provide a physiological and psychological reserve to help overcome the stress of surgery. The aim of this study is to evaluate the effectiveness of a home based personalised, multi-modal prehabilitation programme on functional, psychological and post-operative outcomes for patients undergoing surgery for OG cancer.

STUDY DESIGN
This is a prospective study. All Patients undergoing OG cancer surgery after Jan 2015 were offered the PREPARE For Surgery prehabilitation programme. Following screening for baseline physical activity, distress, self- confidence and nutritional status, a personalised programme is agreed with the patient. This consists of a plan for structured exercise, nutrition and psychological well being with personalised goals. Weekly phone calls are used to monitor progress to the programme. Study measurements are taken at four time points during PREPARE: diagnosis (P1), completion of NAC (P2), immediate before surgery (P3) and six weeks post-surgery (P4). Measures include- functional capacity expressed as metabolic equivalent of task score (METS), self-efficacy (SE) using Lorig's 6-item scale and health-related quality of life (HRQoL) using EORTC clc-30. Median hospital stay, overall complication rate and pneumonia rate following implementation of PREPARE (2015-16) were compared with 2013-14.

STATISTICAL ANALYSIS
Non-parametric tests were used. Friedman's test was used for analysis of METS and SE across P1-P3. Wilcoxon test was used for paired data with Bonferroni correction for post-hoc analysis. Post-operative outcomes were assessed used Mann-Whitney U and chi-squared tests.

RESULTS
90 patients started but only 74 completed the programme mainly due to disease progression. 2 declined participation. 54 received NAC. A significant increase in METS was seen in patients who received NAC (METS P1 5.0, P2 4.0, P3 6.0; p=0.001) and those who did not receive NAC (P1 4.5, P3 6.0; p=0.007). There was a parallel increase in self-efficacy (NAC-P1 8.7, P2 8.8 and P3 9.0; p=0.017) (No NAC- P1 8.5,

P3 9.3, p=0.012). There was no significant difference in METS (5 and 5, p=0.57) or overall HRQOL (70.8 and 66.7; p=0.16) between P1 and P4. However, there was a significant fall in the physical function domain (93.3 and 80, p=0.001). There was a decrease in both the overall post-operative complication (68% and 43%, p=0.007) and pneumonia rates (55% and 30%, p=0.006). The median length of stay in 2013-4 was 13 days (10-17) and 11 days (9-17) in 2015-16 (p=0.08).

DISCUSSION

It is feasible to deliver home-based prehabilitation with remote clinical support. Our programme led to an improvement in functional capacity in the pre-operative period. This led to two important post-operative effects. Firstly, the fall in HRQoL domains at 6 weeks after surgery is much less than seen in previous research indicating a quicker recovery. Secondly, an improvement in post-operative outcomes and hospital stay.

CONCLUSION

Prehabilitation provides a functional reserve to patients and protects against the stress of surgery. This leads to improved post-operative outcomes.

30] Observational study of neoadjuvant therapy for localized pancreatic adenocarcinoma: a three-year experience on 769 patients.

Laura Maggino [1], Giuseppe Malleo [1], Giovanni Marchegiani [1], Elena Viviani [1], Chiara Nessi [1], Debora Ciprani [1], Alessandro Esposito [1], Luca Landoni [1], Luca Casetti [1], Massimiliano Tuveri [1], Salvatore Paiella [1], Alessandra Auriemma [2], Davide Melisi [2], Claudio Bassi [1], Roberto Salvia [1]
(1) University of Verona Hospital Trust - Unit of General and Pancreatic Surgery - Verona - Italy
(2) University of Verona Hospital Trust - Unit of Oncology - Verona - Italy

BACKGROUND AND AIMS

The use of neoadjuvant therapy (NAT) is gaining momentum in the treatment of localized pancreatic adenocarcinoma (L-PDAC) based on results reported in surgical series. However, there is little information on patients who received NAT with intent for later resection, but did not ultimately proceed to surgery. The aim of this observational cohort study was to thoroughly evaluate the clinical applicability and results of NAT in a real-life scenario.

STUDY DESIGN

Patients with L-PDAC submitted to NAT between 2013 and 2015 were included in the study and followed-up over time. Metastatic patients and patients who received upfront resection were excluded. The resectability status was classified according to the National Comprehensive Cancer Network (NCCN) guidelines. Initiation, type and completion of NAT were recorded, as well as the rate of surgical exploration and resection. Follow-up information was recorded up to September 2017. The primary endpoint was the disease-specific survival (DSS) following NAT, either in patients who were resected and in those who were not. Furthermore, the results were stratified by NCCN classes at the time of diagnosis.

STATISTICAL ANALYSIS

The DSS was calculated from the date of diagnosis to the date of last follow-up or death from disease using the method of Kaplan-Meier. Differences between groups were assessed using the log-rank test.

RESULTS

769 patients were included in the study, of whom 11.7% were resectable (R), 35.1% borderline resectable (BR) and 53.1% locally advanced (LA). 7.9% of patients were never started on NAT, due to ineligibility or rapid clinical deterioration. When NAT was initiated, the completion rate of the treatment schedule was 72.1%. Remarkably, 33% of patients received a second-line therapy. The most common NAT protocols were FOLFIRINOX (50%), Gemcitabine/Nab-Paclitaxel (31%), Gemcitabine (31%) and Gemcitabine-Oxaliplatin (15%). 22.4% of patients received additional radiation therapy. Overall, 23.7% of patients underwent surgical exploration after NAT, with significant differences according to the NCCN class at the time of diagnosis (27.0% vs 30.7% vs 17% for R, BR and LA patients, $p<0.001$).

Only 15.3% of patients were ultimately resected (20.2% vs 23.9% vs 8.4% for R, BR and LA patients, p<0.001). The R0 resection rate was 62%. The median DSS of the entire cohort was 13.2 months (95% CI 12.2-14.2). There was no difference between R and BR PDAC, whereas the DSS was shorter in LA patients (14.2 vs 14.3 vs 12.3 months, p=0.006). When limiting the analysis to resected patients, the median DSS was 35 months, with no significant differences based on resectability status prior to NAT.

DISCUSSION

The results of NAT appear less encouraging than previously reported by surgical series. A substantial amount of patients does not complete the treatment schedule, and will never qualify for surgical exploration, with a disappointing overall resection rate of 15.3%. Significant differences in survival are identifiable based on resectability status at diagnosis; however these disappear when resection is successfully undertaken.

CONCLUSION

This is the first intention-to-treat analysis of L-PDAC, providing a comprehensive representation of the clinical impact of NAT in a real-life scenario, and a strong pallet for future investigations on optimal treatment strategies for PDAC.

31] Neoadjuvant chemotherapy in patients with upfront resectable colorectal liver metastases: a multicentric international study.

Marc-Antoine Allard [1], Rene Adam [1], Yujiro Nishioka [2], Katsunori Imai [3], Nassiba Beghdadi [1], Maximilliano Gelli [4], Suguru Yamashita [2], Yuki Kitano [3], Takashi Kokudo [2], Yo-ichi Yamashita [3], Antonio Sa Cunha [1], Eric Vibert [1], Dominique Elias [4], Daniel Cherqui [1], Diane Goere [4], René Adam [1], Hideo Baba [3], Kiyoshi Hasegawa [2]

(1) Centre Hepatobiliaire, Hôpital Paul Brousse, Univ Paris Sud Inserm U935 - Villejuif - France

(2) Department of Hepatobiliary surgery and Transplantation, University of Tokyo - Tokyo - Japan

(3) Department of Gastroenterological Surgery, Graduate School of Life Sciences, Kumamoto University - Kumamoto - Japan

(4) Department of Surgery, Gustave Roussy - Villejuif – France

BACKGROUND AND AIMS

All randomized studies comparing perioperative chemotherapy versus adjuvant chemotherapy in patients with upfront resectable colorectal liver metastases (CLM) have been abandoned because of recruitment issues. Whether perioperative chemotherapy yields improved disease-free survival (DFS) compared to adjuvant chemotherapy alone, remains unknown. Evaluating the effect of neoadjuvant therapy might provide an indirect argument in favor of one or the other strategy. The aim of the study was to estimate the impact of neoadjuvant chemotherapy on the DFS of patients, operated on for upfront resectable CLM by comparing two managements: perioperative chemotherapy versus adjuvant chemotherapy alone.

STUDY DESIGN

We included all consecutive patients who underwent a first hepatectomy for upfront resectable CLM in 2 Japanese and 2 French centers, from 2008 to 2016. Of them, we excluded patients with more than 5 tumors at diagnosis or with extrahepatic disease, those treated by local ablation, hepatic arterial infusion or with R2 resection. Two institutions favored perioperative chemotherapy whereas the two others systematically preferred upfront surgery followed by adjuvant chemotherapy. We then formed two groups: the perioperative group, including all patients who received neoadjuvant chemotherapy (a minimum of 4 cycles of FOLFOX and/or FOLFIRI) and the adjuvant chemotherapy group, including all patients who underwent upfront surgery. Patients who received other neoadjuvant protocols or 3 or fewer cycles were not included.

STATISTICAL ANALYSIS

The effect of neoadjuvant therapy was estimated by comparing the perioperative group to the adjuvant therapy group after adjusting for prognostic factors according to inverse probability of treatment weighting (IPTW). The variables included for calculating the propensity score were: number of tumors, maximal tumor size, carcinoembryonic antigen at diagnosis, disease history, positive lymph nodes of the primary, type of adjuvant chemotherapy. The first analysis was made by using the whole cohort, mimicking an intent-to-treat analysis. A second analysis was done

with the subgroup of patients who effectively received intravenous adjuvant chemotherapy.

RESULTS

A total of 301 patients were included (Perioperative Group N = 151 and Adjuvant chemotherapy group N = 150). In the perioperative group, the number of tumors was higher and the maximal size was larger. The disease was also more often synchronous. Before adjusting, the 3-year DFS was 31% in the perioperative group versus 41% in the adjuvant chemotherapy group (P=0.35). After adjusting for confounders with IPTW method, neoadjuvant chemotherapy had no significant influence on DFS (HR: 0.83; 95%CI [0.58-1.18]; P=0.31). When considering the subgroup of patients (N=177) who received intravenous adjuvant chemotherapy, the adjusted effect of neoadjuvant remained not significant (HR: 0.85 [0.43-1.66]; P=0.63).

DISCUSSION

The strategy "upfront surgery plus adjuvant chemotherapy" seems to be valid only if adjuvant chemotherapy is administered. This means that upfront surgery should not be indicated in patients at high risk of not receiving adjuvant therapy, like those planed for complex procedures.

CONCLUSION

Neoadjuvant therapy yields no improvement of DFS in patients with upfront resectable 5 or less CLM, treated with complete resection and adjuvant chemotherapy. This suggests that upfront surgery plus adjuvant chemotherapy might be an acceptable strategy when the disease is limited and resection is at low risk.

32] Half of postoperative deaths after hepatectomy are preventable: results of the root-cause analysis of a prospective multicenter cohort.

Iman Khaoudy [1], Jean Marc Regimbeau [1], Emmanuel Boleslawski [2], Eric Vibert [3], Olivier Soubrane [4], Olivier Farges [4]
(1) University hospital of Amiens - Amiens - France
(2) University hospital of Lille - Lille - France
(3) University hospital of Paul Brousse - Paris - France
(4) University hospital of Beaujon - Paris - France

BACKGROUND AND AIMS

The risk associated with liver resection, notably the 90-day mortality, has not decreased over the past decade, whether assessed at specialized HPB-centers (4.7%) or nationally (5.8%). One reason is that surgeons inaccurately predict the postoperative outcome. Sensitizing HPB-centers to their outcome and providing them evidence to improve outcome also fails to improve the postoperative course. To address these discrepancies, a root-cause analysis of postoperative mortality was performed. Root-cause analysis is a method commonly employed outside medicine to retrospectively explore and overcome the causes of adverse events. In the field of surgery, a root-cause of mortality following pancreatectomy revealed that it was related to intra operative events (12%), technical errors (21%), poor patient selections (15%) and that the cause of 25% of deaths remained unknown.

STUDY DESIGN

The study population was a prospective cohort of hepatectomies performed at 13 HPB-centers between 10/2012 and 12/2014. Of the 1906 patients enrolled, 90 patients died within 90-days of surgery (4.7%). The perioperative data of these 90 patients were retrieved from their original medical files where they had been collected prospectively. The root-cause analysis was performed independently by a senior HPB-surgeon and an HPB-fellow and disagreements were resolved by consensus. The aims were to assess if: (1) the cause of death had been identified by the attending surgeons; (2) the patient had been managed according to International guidelines; (3) the intra and post-operative management had been inappropriate (defined as a surgical procedure more important than anticipated, a macroscopically incomplete tumor resection, or a delay in management of adverse events); 4) the death was preventable (i.e., inappropriate management or non-compliance with guidelines); (5) a typical root-cause of postoperative death could be identified

STATISTICAL ANALYSIS

The analysis was performed using the fishbone cause-and-effect diagram as shown in Figure 1.

RESULTS

The cause of death was identified by the index surgeon and by the root-cause in 84% and 88% of the patients, respectively (liver failure, 34.9%; pulmonary complications, 18.6%; biliary fistula, 12.8%; hemorrhage, 7%; cardiac complications, 4.7%; intestinal fistula, 3.5%; early tumor recurrence, 3.5%; other, 4.7%). The root-cause was intra-operative in 33% (technical error, 24%; inappropriate judgement, 22%) or related to delayed postoperative management (23%). Guidelines were not followed in 57% (insufficient remnant liver volume, 28%; CHILD-Pugh ≥B9, 12%; portal hypertension, 7%; lack of updated preoperative imaging, 9%). Overall, 47% of the deaths were preventable: There was only 10% discordance between the senior surgeon and the fellow assessment of the root-cause. The typical cause of death was a patient operated for a malignancy, with insufficient evaluation of tumor stage or progression, in whom a larger than expected procedure was performed. This was not surgeon or center specific.

DISCUSSION

The root-cause of death following hepatectomy is almost equally identified by the index surgeon, and a third party senior or junior HPB-surgeons. Almost 50% of postoperative deaths are preventable, being related to poor patient evaluation or inadequate intraoperative decisions. The typical root-cause is pursing surgery despite unplanned adverse intraoperative findings.

CONCLUSION

Compliance with guidelines and team communication if an unplanned operative finding occurs should be strictly implemented.

33] Quadratus lumborum block vs. perioperative intravenous lidocaine for postoperative pain control in patients undergoing laparoscopic colorectal surgery: A prospective, randomized, double-blind controlled clinical trial.

Geertrui Dewinter [1], Steve Coppens [1], Marc Vande Velde [1], Andre D'hoore [1], Albert Wolthuis [1], Eva Cuypers [1], Steffen Rex [1]
(1) University hospitals of Leuven - Leuven - Belgium

BACKGROUND AND AIMS
Background: While epidural analgesia is the gold standard to control pain in patients undergoing open colorectal surgery, optimal analgesic management in laparoscopic surgery is less well-defined. There is need for effective and efficient alternatives to epidural analgesia for pain management in patients undergoing laparoscopic colorectal surgery. Quadratus lumborum (QL)-block and intravenous lidocaine both have been used in this setting.

STUDY DESIGN
Study Design: 125 patients undergoing laparoscopic colorectal surgery were included in this randomized, double-blind controlled clinical trial. Patients randomly received an intravenous infusion with placebo plus a quadratus QL-block with placebo, a QL-block with ropivacaine 0.25% plus intravenous placebo, or intravenous lidocaine plus a QL-block with placebo. Postoperatively, all patients received patient-controlled intravenous anesthesia (PCIA) with morphine. Primary outcome parameter was the cumulative opioid consumption during the first 24 postoperative hours. Secondary endpoints included severity of postoperative pain, time to return of intestinal function, incidence of PONV and length of hospital stay.

STATISTICAL ANALYSIS
The study was powered to detect the differences in postoperative morphine consumption between the QL-group and the Lidocaine-group, and between the QL-group and the Placebo-group. A coefficient of variation (CV) equal to 0.5 was assumed in the power calculation. A two-sided test for a ratio of means (with alpha=5%) was used and a power of 80% was to be achieved. A two-sided t-test for the ratio of means was used to compare the 24h cumulative morphine intake between the QL-group and the lidocaine group and between the QL-group and the Placebo-group. A Mann-Whitney U-test was used to test the conclusion. To enable confirmatory claims about both comparisons without inflating the type-I error, a hierarchical closed test procedure was used, i.e., both comparisons were tested on a 5% level, with however the comparison of QL versus control only being tested in case that the comparison of QL versus lidocaine was significant. Secondary outcomes were compared using Fisher's exact test and Mann-Whitney U-tests. Kaplan-Meier estimates were used to obtain the cumulative distribution curves for the event times, and the treatment groups were compared using the log-rank test.

A linear model for longitudinal measurements was used for variables measured over time.

RESULTS

Results: The QL-block was not superior to systemic lidocaine for the reduction of morphine requirements in the first 24 postoperative hours: QL-group: 37.5(28.4)mg [mean(SD)] vs. lidocaine-group: 40.2(25)mg, p=0.15. The majority of secondary outcome parameters did not differ between the groups. Notably, total morphine consumption in the PACU, the total number of PCIA-boli demanded, and the number of PCIA-boli delivered by the PCIA-pump during the first 24 postoperative hours were significantly lowest in the Placebo-group.

DISCUSSION

Discussion: The efficacy of abdominal wall blocks and systemic lidocaine are controversial. The obtained results are in line with the findings of a recently published trial that compared the effect of systemic lidocaine and TAP-block on pain after open prostate surgery and failed to report a significant difference in postoperative opioid consumption for systemic lidocaine and TAP-block.

CONCLUSION

Conclusion: The QL-block did not provide superior postoperative analgesia when compared to systemic lidocaine in laparoscopic colorectal surgery.

34] Short-term outcomes of transanal hemorrhoidal dearterialization with mucopexy (THD) vs. Ligasure Hemorrhoidectomy for grade III-IV hemorrhoids: a prospective randomized multicenter trial.

Loris Trenti [1], **Sebastiano Biondo** [1], Esther Kreisler [1], Jose Luis Sanchez [2], Eloy Espin-Basany [2], Aitor Landaluce [3], Fernando Jimez [3], Elena Bermejo [4], Adolfo Alonso-Casado [4], Maria Teresa Garcia-Martinez [5], David Alias [6], Belen Manso [6]

(1) Bellvitge University Hospital - Barcelona - Spain
(2) Vall d'Hebron University Hospital - Spain
(3) Galdakao Usansolo Hospital - Spain
(4) Hospital Universitario de La Princesa - Spain
(5) Hospital Comarcal de Valdeorras - Spain
(6) Hospital Universitario Rey Juan Carlos - Spain

BACKGROUND AND AIMS

Hemorrhoidal transanal dearterialization with mucopexy (THD) and Ligasure ™hemorrhoidectomy (LIGA) seems to reduce post-operative pain compared to classic excisional hemorrhoidectomy. The aim of this trial was to analyze the differences between THD vs. LIGA for grade III/IV hemorrhoids in terms of short-term outcomes.

STUDY DESIGN

This is a randomized multicenter trial carried out at 6 centers to test the hypothesis that THD is associated with a shorter period of analgesic treatment compared to LIGA. Patients aged ≥ 18 years with grade III/IV hemorrhoids were included. Exclusion criteria were fecal incontinence, sphincter lesions and recurrent hemorrhoids. Patients were randomized into two groups (THD and LIGA) according to a single-masked design and stratified by center (with blocks of 4 and 6 patients). Primary outcome was considered the mean postoperative number of days in which patients needed NSAID. Secondary outcomes were pain, measured daily during the first 15 post-operative days by a simple verbal numerical scale (0-10), 30 days post-operative morbidity, patients' satisfaction, Vaizey incontinence score and quality of life (SF-12).

STATISTICAL ANALYSIS

A difference of 5 days less (SD 7.5) was expected for THD group. Using an alpha error of 0.05 and a beta error of 0.2 in a two-tailed test resulted in a number of 40 patients per arm (loss to follow-up rate: 10%).

RESULTS

Eighty patients were randomized. Thirty-nine patients underwent THD and 41 LIGA. No differences were observed for gender (P=0.725), age (P=0.426), ASA (P=0.311) and hemorrhoid grade (P=0.166). Mean operative time was higher for THD (48 min, SD 11.6 vs. 28 min, SD 15.5; P<0.001). 85% of the patients were discharged home the same day of surgery without difference between the groups (P=0.301). The

mean pain was similar during both the first (THD: 3.82, SD 2.22 vs. LIGA: 3.70, SD 2.26; P=0.662) and second postoperative weeks (THD: 1.52 SD 1.95 vs. LIGA: 2.14 SD 2.01; P=0.111). More patients were still taking NSAID in the LIGA group during the second postoperative week compared to THD group (82.9% vs. 53.8%; P=0.010). For the THD group, consumption of NSAID continued until day 10.1 (mean; SD 7.28) whereas in the LIGA group until day 14.9 (mean; SD 9.02) (P=0.011). Post-operative complication rate was similar between the two groups (THD: 25.6% vs. LIGA: 17.1%; P=0.507). No differences on patients' satisfaction (P= 0.228), Vaizey incontinence score (P= 0.319), Mental (P= 0.254) and Physical (P= 0.715) Health SF-12 Quality of Life score were observed at one month of surgery.

DISCUSSION

Although the postoperative pain between THD and LIGA was similar, in the second post-operative week there is a tendency to a lower pain for THD jointly with a higher use of pain medication in the LIGA group.

CONCLUSION

LIGA is associated with a longer need of postoperative analgesia compared with THD. Long-term results evaluating recurrence are expected

35] Failure-to-rescue in patients undergoing pancreatectomy : is hospital volume a standard for quality improvement programs? A nationwide analysis of 12333 patients.

Mehdi El Amrani [1], Guillaume Clement [2], Xavier Lenne [2], Francois-Rene Pruvot [1] Didier Theis [2], Stephanie Truant [1]
(1) Department of Digestive Surgery and Transplantation, Lille University Hospital, Lille, France - Lille - France
(2) Medical Information Department, Lille University Hospital, Lille, France - Lille - France

BACKGROUND AND AIMS
Pancreatic surgery is a complex procedure that involves considerable postoperative morbidity and mortality related to hospital volume. Early diagnosis and effective management of complications may directly reduce POM. But there is growing concerns that failure-to-rescue (FTR), could be an important quality measure for perioperative care after pancreatectomy. The aim of this study is to evaluate the rate and factors associated with a significant increase of FTR in patients who underwent pancreatectomy.

STUDY DESIGN
Data were extracted from the French national administrative database for hospital care (Programme de Médicalisation des Systèmes d'Information (PMSI)). All patients nationwide who underwent pancreatectomy between 2012 to 2015 were included. Patient condition was assessed on the basis of the validated Charlson Comorbidity Index (CCl) and patients were stratified into 3 groups according to the CCI score (0-2, 3, and ≥4). FTR was defined as the 90-day POM after failure to manage patients with specific medical or surgical complications.

STATISTICAL ANALYSIS
Spline model analysis was used to identify the cut-off values of the annual pancreatectomy caseload affecting the 90-day POM. Seemingly unrelated multivariable logistic regression models identified factors independently associated with failure to rescue.

RESULTS
Overall, 12333 patients who underwent pancreatectomy were identified. Among patients with complications (8165, 66.2%), over half (73.1%) underwent pancreaticoduodenectomy. The rate of postoperative complications was significantly higher in high volume centers (50.9% vs 19.2% vs 29.9%; p=0.002), in male (55.4% vs 44.6%; p<0.001) and for age>60 years (72.3%; p<0.001). The overall 90-day POM was 6.9%. The rate of FTR was 9.3% and varied significantly with hospital volume (11.9% in low hospital volume vs 7.2% in high hospital volume, p<0.001), sex (11.1% for male and 7.2% for female, p<0.001), age (p<0.001) and ChCl (CCl0-2: 6.5%, ChCl3: 9.5%, CCl ≥4:13.1%; p<0.001). FTR increased significantly

after pancreaticoduodenectomy (10.6%) and total pancreatectomy (17.9%) in comparison to distal pancreatectomy (4.3%) ($p<0.001$). Failure to rescue for renal failure was the highest of all complications (43.8%), followed by postoperative shock (33.7%), cardiac complications (24.7%), reoperation (22.1%) and hemorrhage (17.6%). In multivariate analysis, pancreatic surgery in intermediate (OR=1.51, IC95[1.23-1.84], $p<0.001$) and low volume centers (OR=1.71, IC95[1.43-2.04], $p<0.001$), CCl3 and CCl>4 and age> 60 were independently associated with increased FTR rates. In intermediate volume centers, the risk of POM increased significantly with an incremental impact as complications occurred (ΔOR=0.775, p=0.047). However, in low volume centers, the risk of mortality was independent of the occurrence of complications (ΔOR=0.077, p=0.852).

DISCUSSION

FTR for pancreatic surgery is high and directly correlated to hospital volume. Our findings suggest that patients are more likely to survive their complications following both early and appropriate interventions in high-volume units with greater experience and resources.

CONCLUSION

While complication rates were higher in high-volume hospitals following pancreatectomy, mortality rates were substantially lower. This appears to be due to the ability of high-volume hospitals to rescue patients from major perioperative complications. Measurement of failure to rescue rate should become a standard for quality improvement programs.

36] Outcome of total pancreatectomy for intraductal papillary mucinous neoplasia – a multicentric study of the French Surgical Association (AFC).

Stephanie Truant [1], **Charles Poiraud** [1], Medhi El Amrani [1], Laurence Chiche [2], Jean-Yves Mabrut [3], Philippe Bachellier [4], Francois-René Pruvot [1], Christophe Mariette [5], Jean-Robert Delpero [6], Mustapha Adham [3], Alain Sauvanet [7], Jean-Jacques Tuech [8], Olivier Turrini [6]

(1) Department of Digestive Surgery and Transplantation - Lille - France
(2) CHU Bordeaux - Bordeaux – France
(3) CHU Lyon - Lyon - France
(4) CHU strasbourg - Strasbourg - France
(5) CHU Lille - Lille - France
(6) Institut Paoli-Calmettes - Marseille - France
(7) AP-HP Hopital Beaujon - Paris - France
(8) CHU Rouen - Rouen - France

BACKGROUND AND AIMS

Indications for elective total pancreatectomy (TP) changed significantly in the last decades. This procedure is increasingly performed for IPMN. The decision to perform TP can be decided pre-operatively based on imaging, or intra-operatively in patients with positive margins on frozen section. Only few data are available about morbidity and mortality of TP in this specific setting. The aim of the study was to assess the perioperative and long-term outcomes of TP based on the largest series of TP for IPMN to date

STUDY DESIGN

Data of 888 patients undergoing pancreatic resection for IPMN between 2004 and 2013 were retrospectively collected in the multicentric database of the French Surgical Association (AFC). Among them all patient with an elective TP were included. Exclusion criteria were emergent TP or non-IPMN indication. Patient demographics, indications, intra-operative data, 3-month morbi-mortality graded according to Clavien classification and long-term outcome were analyzed.

STATISTICAL ANALYSIS

Continuous data were expressed as median [ranges]. Categorical variables (%) were compared using the Fischer's exact test. Survival rates were calculated according to the Kaplan-Meier method.

RESULTS

Overall 79 (8.9%) out of 888 patients operated for IPMN had TP. Most patients (83.5%) were symptomatic, with a dilated main pancreatic duct >10mm in 76% diffuse in 8.9%, or mural nodule in 24.1%. Total pancreatectomy was decided preoperatively (60.8%), intra-operatively (35.4%) or was an elective pancreatectomy completion (3.8%). Median operative time was 300 minutes [165-600] with blood losses of 325cc [100-2800] and hospitalization duration of 17.5 days [1-53]. Postoperative complications occurred in 54.4%, which were severe

(Clavien>2) in 12.7%. Three patients died. There were higher morbi-mortality and lower R0 resection rates (36%) in case of unplanned TP. On histopathological examination, 12 patients (15%) had in situ carcinoma and 46 (58%) invasive carcinoma, mostly pT3 (67.4%), N+ (58.7%) and R0 (76%). A pancreatic mass on CT was associated with in situ or invasive carcinoma in 23/24 patients. After a median follow-up of 24.6 months [0-97.4], there was no lethal hypoglycemia; recurrences occurred in 21/46 patients (46%) with invasive carcinoma, 15 of those died. In cases of R0 resection with N0 status, the recurrence rate was as high as 29%. Overall 3- and 5-year survival rates were 69.8% and 60.9%, respectively. Non-invasive IPMN was associated with significantly-better survival rates (92.8% and 77.8% versus 50.4% and 39.2% for invasive IPMN; $p<0.001$).

DISCUSSION

In this study, more than half of patients with IPMN were operated at an invasive carcinoma stage. Intra-operative findings, including frozen section results represented a significant part of the overall indication for TP. Overall morbidity and mortality rates were acceptable, although outcome was impaired in cases of intra-operatively-decided TP. Strikingly, nearly 50% of the patients with invasive carcinoma developed recurrences within 2 years despite the total removal of the pancreas.

CONCLUSION

In the largest series of TP for IPMN so far, morbidity and mortality rates were acceptable as comparable to those of other pancreatic resection procedures. In case of invasive IPMN, long-term outcome of TP was disappointing with high recurrence rate.

37] Tacrolimus (TAC) and single intra-operative high-dose of r-ATG (Rabbit anti-thymocyte globulin) induction vs. tacrolimus monotherapy as immunosuppression (IS) in adult liver transplantation (LT): one-year results of an investigator-driven prospective randomized, controlled, trial (RCT).

Jan Lerut [2], **Samuele Iesari** [1], Kevin Ackenine [2], Maxime Foguenne [2], Mina Komuta [2], Olga Ciccarelli [2], Laurent Coubeau [2], Eliano Bonaccorsi-Riani [2], Quirino Lai [3], Chantal De Reyck [2], Pierre Gianello [2]

(1) University Aquila - L'Aquila - Italy

(2) Université catholique de Louvain - Louvain - Belgium

(3) University La Sapienza - Italy

BACKGROUND AND AIMS

The role of induction therapy using anti-lymphocytic serum isn't well established in LT nor is its role in tolerance induction. We aimed to assess efficacy of one high-dose of rabbit anti-lymphocytic serum (r-ATG, Grafalon®, Neovii - Fresenius) administered intra-operatively in combination with TAC (Prograft®, Astellas) in primary adult LT. The primary endpoint was minimization of IS to TAC monotherapy within 12 months. Co-primary (safety) endpoints were patient (PS)and graft survival (GS). The secondary endpoint was one-year biopsy-proven acute cellular rejection (ACR).

STUDY DESIGN

Investigator-driven, single-centre, open-label, prospective RCT stratifying pats into intra-operatively one dose of 9 mg/kg r-ATG followed by TAC monotherapy maintenance IS (TAC-ATG group; n=97) and TAC monotherapy IS (TAC group, n=109). All patients had similar clinical, biochemical and histological follow-up (FU) including 7 days, 6 and 12 months biopsies. ACR treatment was based on concordance of Banff score > 5 and biochemical score >2 (including evolution of bilirubin, platelet and eosinophilia count and absolute eosinophilia >600 103/µl). Steroid-resistant rejection (SRR) was defined as absence of response to 3- 5 pulses of 200 mg methylprednisolone. Mean FU for TAC-ATG and TAC groups were 87 and 95 months.

STATISTICAL ANALYSIS

200 patients were enrolled to provide a power of 80% to detect a difference of 9% in the probability of obtaining TAC monotherapy within 12 mo, accepting 5% level of α error. Medians were compared with t-test and proportions with Pearson's $\chi 2$ test. Time to clinical rejection, PS and GS were analysed with the Kaplan-Meier method. Group differences were assessed by the log-rank test. (EudraCT 2006-004830-34)

RESULTS

78/80 (97.5%) TAC-ATG pats and 100/101 (99.0%) TAC pats were steroid free (p=0.429). A second immunosuppressant (steroids, mycophenolate, azathioprine or mTOR inhibitor) was administered in 29/80 (36.3%) TAC-ATG pts. and 35/101 (34.7%) TAC pats (p=0.823). One-year mean TAC trough level was 5.19 (±3.06) mg, in TAC-ATG pts. and 5.04 (±2.80) mg in TAC pts. (p=0.738). No significant differences in one-year PS (83% TAC-ATG pts. vs. 92% TAC pts., p=0.260) and GS (76% - TAC-ATG pts. vs. 90% - TAC pts., p=0.054) were observed although there was a trend towards worse results in TAC-ATG pats. A Banff score of 6 to 9 (= moderate-to-severe rejection) was seen in 27/107 (25.2%) TAC and 14/83 (16.9%) TAC-ATG pats (p=0.164). No difference was observed in relation to the number of treated rejection (15% TAC-ATG pats vs. 18% TAC pats developed steroid-sensitive rejection (SSR) (p=0.449) ;2% TAC-ATG pats and 3% TAC pats (p=0.628) developed SRR. Chronic rejection was diagnosed in 1% in TAC-ATG pats vs. 4% in TAC pats (p=0.307).

DISCUSSION

Discussion: This first ever-done RCT comparing TAC and single intra-operative high-dose of r-ATG induction vs. TAC monotherapy as IS in adult LT did not show any benefit in relation to IS minimization nor survival. Rejection treatment based on concordance between histology and biochemistry was similar in both groups.

CONCLUSION

The studied induction IS protocol didn't offer short-term clinical benefit. Long-term results have to be awaited in order to analyse its' influence on tolerance induction.

38] Centralized management of postoperative complications reduces 90 day mortality rate after bariatric surgery.

Francois Pattou [1], Robert Caiazzo [1], Xavier Lenne [1], Arnaud Clement [1], Benoit Dervaux [1], Fanelly Torres [1], Julien Branche [1], Bernard Leroy [1], study group Osean [2]
(1) Lille University Hospital - Lille - France
(2) Nord-pas de Calais - Lille - France

BACKGROUND AND AIMS

Early postoperative complications after bariatric surgery are decreasing but remain associated with a significant risk of mortality. Their optimal management requires rapid and coordinated multidisciplinary management. Our aim was to increase the overall safety of bariatric surgery by an organization of care favoring the early referral of postoperative complications in tertiary referal center.

STUDY DESIGN

A regional organization centralizing care for postoperative complication after bariatric surgery was initiated in 2013 under the auspices of health authority in the Nord-Pas de Calais (NPC) region (4M inhabitants) and enrolled all institutions performing bariatric surgery. This organization was coordinated by one tertiary referal center and based on four principles: 1) 24/7 on call avaibility for surgeon to surgeon discussion in case of postoperative complication; 2) rapid transfer of the patient to the referal center; 3) referal to the primary center after complication management; 4) regional morbi-mortality metings, gathering all participants together twice a year. The primary outcome was the 90-day mortality of bariatric surgery in the NPC region vs rest of France since the implementation of the organization. Data were extracted from the French prospective database providing information on all hospital stays, irrespective of hospital affiliation, including public hospitals and private clinics.

STATISTICAL ANALYSIS

Descriptive statistics. Ajusted multivariate logistic regression

RESULTS

Between 2013 and 2016, 15,082 bariatric procedures (Sleeve / Gastric bypass / Band) have been performed in NPC vs 185,452 in the rest of France (Fig.1). Patients in NPC had slighlty more comorbidities than in the rest of France (diabetes 11.8% vs 11.2% p=0.03); sleep apnea 24.8% vs 21.5%, P<0.001). During the study period, mortality rate in NPC vs the rest of France was 0.01% (N=2) vs 0.06% (N=99) at 30 days (p=0.02), and 0.03% (N=4) vs 0.08% (N=137) at 90 days (P=0.03), respectively (Fig.2). The 90-day mortality was lower in NPC after all 3 procedures (gastric bypass 0,05% vs 0,12%; sleeve 0.01 vs 0.06%; gastric band 0.00% vs 0.01%). In the mean time, 44 patients (0.29%) were admitted in ICU in NPC vs 2,670 (1.57%) in rest of France (P<0.01). Mortality was associated with age (OR:1.072;P<0.001), male

gender (OR 2.116, P<0.001), diabetes (OR:1.634;P<0.001), and lower with band (OR:0.713;P=0.40) and higher with gastric bypass (OR:0.203;P<0.0001). When compared with the rest of France during the previous period (2009-2012) and ajusted to patient characteristics and procedures, 90-day mortality rate was similar in NPC in the previous period (OR:0.713;P=0.40), but lower than for rest of France in the study period (OR:0.202 vs 0.565;P=0.49).

DISCUSSION

Bariatric surgery appeared significantly safer in NPC than in the rest of France in the study period , with lower 90-day mortality (-67%) and ICU admissions (-40%). A comparison with the previous period confirmed the association of this difference with the implementation of the centralized management of postoperative complications. If applied nationwide with similar results, this organization may have saved 1068 ICU admissions and 92 lives in 4 years.

CONCLUSION

Centralized care for early postoperative complications after bariaric surgery increased overall safety of bariatric surgery by reducing overall mortality and admissions in intensive care units.

39] Neoadjuvant chemoradiation for esophageal cancer impairs pulmonary physiology preoperatively, with impact on postoperative respiratory complications and quality of life.

Jessie A Elliott [1], Lisa O Byrne [1], Gemma Foley [2], Conor F Murphy [1], Sinead King [1], Emer M Guinan [2], Narayanasamy Ravi [1], John V Reynolds [1]

(1) Department of Surgery, Trinity Centre for Health Sciences, Trinity College Dublin, and St. James's Hospital - Dublin 8 - Ireland

(2) School of Medicine, Trinity College Dublin - Dublin 2 – Ireland

BACKGROUND AND AIMS

Neoadjuvant chemoradiation (nCRT) results in lung exposure to radiation, but whether modern quality-assured nCRT results in major pulmonary complications during treatment, postoperatively, or in the longer term, is unclear. Moreover, whether subclinical impairment of pulmonary physiology occurs has not been studied. The objective of this prospective observational study was to systematically examine pulmonary physiology and related outcomes through the continuum of treatment, postoperatively, and in survivorship. The objective of this study was to assess the impact on pulmonary physiology and related clinical outcomes of neoadjuvant therapy for esophageal cancer.

STUDY DESIGN

Consecutive patients with locally advanced esophageal cancer treated with curative intent between 2010 and 2016 were studied. A dose-volume histogram of V20 <25% was set for nCRT, with total radiation between 40-44Gy. Chemotherapy was as per the MAGIC regimen. Pulmonary physiology, including diffusion capacity for carbon monoxide (DLCO), forced expiratory volume (FEV1) and forced vital capacity (FVC), was assessed at baseline and at one month post completion of neoadjuvant therapy. Radiation-induced lung injury (RILI, EORTC grade ≥2) was monitored, as well as postoperative comprehensive complications index (CCI), Clavien-Dindo (CDC), and pulmonary complications as per the ECCG criteria. Heath-related quality of life (HR-QL) was assessed by EORTC QLQ-C30, OES18 and OG25.

STATISTICAL ANALYSIS

Linear, logistic and Cox proportional hazards regression models were utilized to identify independent predictors of RILI, operative morbidity and oncologic outcome.

RESULTS

384 patients were studied (nCRT, n=228; neoadjuvant chemotherapy [nCT], n=156) Neoadjuvant therapy significantly decreased FEV1 (P=0.0002), FVC (P=0.003) and DLCO (P<0.0001). Compared with nCT, nCRT was associated with significantly greater reduction in DLCO (14±14% vs 7±15%; P=0.002), but not FEV1 (1±14% vs 3±13%, P=0.72) or FVC (1±12% vs 3±12%, P=0.83). After nCRT, 5 (2.2%) patients developed RILI precluding surgical resection, and this was significantly (P=0.03)

associated with baseline DLCO. Smoking at diagnosis, pack-years and age independently (P<0.05) predicted decline of pulmonary function. Comparing nCRT and nCT, major PPCs (CDC ≥IIIb) occurred in 14.3% and 6.6% of patients (P=0.037), pneumonia in 30.9% and 24.8% (P=0.30), and in-hospital mortality in 1.1% and 0.8% (P=0.81), respectively. FEV1 (P=0.004, P=0.017, P=0.03), FVC (P=0.004, P=0.006, P=0.04) and DLCO (P=0.001, P=0.04, P=0.04) post neoadjuvant therapy, but not at baseline, were associated with CCI, inpatient length of stay, and pneumonia, respectively. Post-treatment DLCO predicted prolonged intubation (P=0.03). No pulmonary physiological parameter or respiratory complication impacted on overall survival. In survivorship, at one year postoperatively, global HR-QL was similar in both cohorts (P=0.66). However post-nCRT DLCO (P=0.03) and a history of respiratory disease (P=0.001) were independently predictive of poorer physical function scores among disease-free patients.

DISCUSSION

Modern neoadjuvant chemoradiation rarely results in RILI precluding surgery, or postoperative mortality, however these data highlight for the first time a significant impact on pulmonary diffusion capacity, and this impaired physiology is associated with postoperative major respiratory complications and compromised physical function in survivorship.

CONCLUSION

Monitoring of pulmonary function, particularly DLCO, may be of value in the risk assessment and management of patients undergoing modern combination approaches to locally advanced esophageal cancer.

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PAST MEETINGS

1st	Paris: April 22nd - 23rd, 1994	Host:	Henri Bismuth
2nd	Paris: April 28th - 29th, 1995	Host:	Henri Bismuth
3rd	Paris: May, 3rd - 4th, 1996	Host:	Henri Bismuth
4th	Brussels: April 25th - 26th, 1997	Host:	Paul Kinnaert / Toni Lerut
5th	Milan: April 24th - 25th, 1998	Host:	Alberto Peracchia
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7th	Amsterdam: April 14th - 15th, 2000	Host:	Hans Jeekel / Hugo Obertop
8th	Berlin: April 20th - 21th, 2001	Host:	Albrecht Encke / Peter Neuhaus
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10th	Paris: April 11th - 12th, 2003	Host:	Henri Bismuth
11th	Barcelona: April 2nd - 4th, 2004	Host:	Laureano Fernández-Cruz
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17th	Budapest: May 6th - 7th, 2010	Host:	János Kiss

18th	Helsinki: May 20th - 21st, 2011	Host:	Krister Hoeckerstedt
19th	Hamburg: May 4th - 5th, 2012	Host:	Jakob Izbicki
20th	Beaune: April 12th - 13th, 2013	Host:	Henri Bismuth
21th	Athens: April 24th - 26th, 2014	Host:	Christos Dervenis
22nd	Warsaw: May 8th - 9th, 2015	Host:	Marek Krawczyk
23rd	Edinburgh: April 8th - 9th, 2016	Host:	James Garden
24th	Bucharest: May 4th - 6th, 2017	Host:	Irinel Popescu

PRESENT MEETING

25th	**Trieste: May 11th - 12th, 2018**	**Host:**	**Nicolò de Manzini**

FORTHCOMING MEETING

26th	Madrid: May 17th - 18th, 2019*	Host:	Pascual Parrilla / Ricardo Robles

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ESA OFFICERS

	Secretary	Treasurer	Councillors
1994	J. Jeekel	T. Lerut	L. Fernández-Cruz, S. Stipa, P. Morris, M. Trede
1995	J. Jeekel	T. Lerut	L. Fernández-Cruz, I. Ihse, R. Shields, A. Peracchia
1996	J. Jeekel	T. Lerut	F. Harder, I. Ihse, R. Shields, A. Peracchia, A. Encke
1997	H. Obertop	K. Höckerstedt	R. Shields, I. Ihse, A. Encke, A. Peracchia, F. Harder
1998	H. Obertop	K. Höckerstedt	A. Fingerhut, A. Johnson, A. Encke, A. Peracchia, F. Harder
1999	H. Obertop	K. Höckerstedt	A. Fingerhut, A. Johnson, P. Neuhaus
2000	P. Neuhaus	P. Bell	A. Fingerhut, A. Johnson, G. Nuzzo
2001	P. Neuhaus	P. Bell	M. Büchler, C. Russell, G. Nuzzo
2002	P. Neuhaus	M. Büchler	M. Büchler, C. Russell, G. Nuzzo
2003	P. Neuhaus	M. Büchler	A. Eggermont, C. Russell, V. Di Carlo, P.-A. Clavien
2004	P.-A. Clavien	M. Büchler	A. Eggermont, O.J. Garden, V. Di Carlo, J. Kiss, M. Rothmund
2005	P.-A. Clavien	L. Bonavina	A. Eggermont, V. Di Carlo, J. Kiss, M. Rothmund
2006	P.-A. Clavien	L. Bonavina	A. Frilling, U. Haglund, J. Kiss, M. Rothmund

	Secretary	Treasurer	Councillors
2007	P.-A. Clavien	L. Bonavina	A. Frilling, U. Haglund, M. Rothmund
2008	P.-A. Clavien	L. Bonavina	R. Adam, A. Frilling, U. Haglund, N. Mortensen,M. Morino
2009	P.-A. Clavien	L. Bonavina	R. Adam, A. Frilling, U. Haglund, N. Mortensen, M. Morino
2010	P.-A. Clavien	L. Bonavina	R. Adam, J. Izbicki, M. Krawczyk, N. Mortensen, M. Morino
2011	R. Adam	J. van Lanschot	J. Izbicki, M. Krawczyk, N. Mortensen, M. Morino, B. Walther
2012	R. Adam	J. van Lanschot	J. Figueras, A. Hölscher, J. Izbicki, M. Krawczyk, B. Walther
2013	R. Adam	J. van Lanschot	J. Figueras, A. Hölscher, M. Krawczyk, P. Lodge, B. Walther
2014	J. van Lanschot	R. Adam	P. Lodge, B. Walther, C. Bruns, A. Hölscher, J-C. Garcia-Valdecasas Salgado
2015	J. van Lanschot	R. Adam	P. Lodge, A. Pinna, C. Bruns, A. Hölscher, J. C. Garcia-Valdecasas Salgado
2016	O. Farges	R. Adam	P. Lodge, C. Bruns, R. Robles Campos, I. Popescu, H. Silca Carvalho
2017	O. Farges	C.Bruns	E. Tukiainen, I. Popescu, H. S. Pinto Marques, X. Rogiers, R. Robles

ESA COUNCIL 2017 - 2018

PRESIDENT
Mario Morino (Italy)

PRESIDENT-ELECT
Irinel Popescu (Roumania)

PAST PRESIDENT
Marek Krawczyk (Poland)

HONORARY FOUNDING PRESIDENT
Henri Bismuth (France)

SECRETARY
Olivier Farges (France)

TREASURER
Christiane Bruns (Germany)

COUNCILLORS
Irinel Popescu (Roumania)
Ricardo Robles Campos (Spain)
Xavier Rogiers (Belgium)
Hugo Silva Carvalho Pinto Marques (Portugal)
Erkki Tukiainen (Finland)

CHAIR ADVISORY MEMBERSHIP COMMITTEE
Jan Lerut (Belgium)

CHAIR PROGRAMME COMMITTEE
Antonio Pinna (United Arab Emirates)

CHAIR EDITORIAL BOARD COMMITTEE
Pierre-Alain Clavien (Switzerland)

CHAIR NOMINATING COMMITTEE
Marek Krawczyk (Poland)

ESA COMMITTEES 2017 - 2018

ADVISORY MEMBERSHIP COMMITTEE

Chair - Jan Lerut

Members

Cornelis Dejong, Michael Griffin, Attila Olah, Stefan Post, Thomas Walsh.

Member (ex officio)

Olivier Farges (Secretary)

PROGRAMME COMMITTEE

Chair - Antonio Pinna

Members

Derek Alderson, Sebastiano Biondo, John Reynolds, Kjetil Soreide.

Members (ex officio)

Mario Morino (President)
Olivier Farges (Secretary)
Pierre-Alain Clavien (Chair Editorial Board Committee)

EDITORIAL BOARD COMMITTEE

Chair - Pierre-Alain Clavien

Asscociates Editors: Christiane Bruns, Peter Lodge, Giovanni Zaninotto.

Members (ex officio)

Mario Morino (President)
Antonio Pinna (Chair Programme Committee)
Olivier Farges (Secretary)

NOMINATING COMMITTEE

Chair - Marek Krawczyk

Members

Andrea Frilling, Jakob Izbiki, Eduardo Barroso Garcia Da Silva, Pierre Alain Clavien.

By-laws accepted at the special general assembly in Zurich on 8 April, 2006

Article I: LEGAL FORM

The Association is governed by the French law of July 1, 1901, by the laws in effect which have amended or completed such law and by these By-laws.

Article II: NAME

This Association shall be called The European Surgical Association.

Article III: OBJECT

The Object of this Association shall be the cultivation and improvement of the science and art of surgery, the elevation of the standards of the medical profession in Europe and such other matters as may come legitimately within its sphere.

Article IV: REGISTERED OFFICE

The Association's registered office shall be located at Centre Hépato-Biliaire - Hôpital Paul Brousse - 14 Avenue Paul Vaillant Couturier - 94800 VILLEJUIF (France). This registered office may be transferred to any other location whatsoever under a decision by the Council, subject to the ratification of such decision by the next following General Meeting of Members.

Article V: MEMBERSHIP

Section 1

This Association shall consist of Active, Senior and Honorary Members.

Section 2

To be eligible for Active Membership, a candidate must have established a reputation as a surgeon from contributions as a practitioner, author, teacher, and/or original investigator, and have been recommended by the Council.
Candidates for Active Membership must be active in clinical, scientific and academic surgical practice. They should have a position of a senior staff or consultant surgeon. Candidates must express a clear intention to contribute actively to the society and its goals.

Section 3

The Active Membership shall not exceed three hundred (300) members.

Section 4

Active members who reach the age of sixty five (65) years will be automatically placed on the list of senior members at the end of the calendar year following their sixty fifth birthday.

Active Members can apply for Senior Membership by giving satisfactory reasons (e.g.: early retirement from surgical or academic practice) in a written request to the Council. Active Members can also apply for prolongation of the Active Membership (e.g.: continuation of a surgical or academic practice) until the age of seventy (70) years in a written request to the Council.

Senior Members are exempt from the annual fees, and are not subjected to the condition applied to each Active Member to participate at the annual meeting. They may not be elected into the Council. Furthermore, Senior Members have the right to vote at the General Assembly, and may submit and sponsor abstracts/papers for the annual meeting. Senior Members can propose and support candidates for Active Membership.

Section 5

Honorary Members shall be distinguished surgeons whose contributions to surgery have been unusually noteworthy, of lasting value and worthy of the highest international recognition.

Honorary Members are exempt from annual fees, and are not subjected to the condition applied to each Active Member to participate at the annual meeting. They shall not be elected to Council. Furthermore, Honorary Members have the right to vote at the General Assembly, and can propose and support candidates for Active Membership from Europe, and may submit and sponsor abstracts for the annual meeting. However, accepted papers outside of Europe for presentation shall be limited to a reasonable number for presentation at the annual meeting.

The Honorary Membership shall not exceed fifty (50) members.

Section 6

Proposals for Active Membership shall be made by members, on forms which shall be furnished by the Secretary of the Association. The application for membership shall be signed by three (3) members who shall vouch for the candidate's character and professional standing. The sponsors of a candidate shall send the application to the chair of the Membership Committee along with two confidential letters.

Active Membership applications will be reviewed by the Advisory Membership Committee and submitted for approval to the Council. Membership shall be approved by the Active Members through the General Assembly or through an electronic vote. If three fourths of the votes are favourable, the candidate shall be declared elected. Active Membership shall be granted on the occasion of their first (1st) attendance at the annual meeting. The new membership is terminated if the elected member cannot attend the annual meeting within three years after election.

Section 7
If a candidate is not recommended by the Council for three (3) successive years, the application shall be withdrawn from consideration, and the sponsors shall be notified. Such a candidate may be proposed again without imposed delay. If a candidate is recommended by the Council, but fails to be elected by the Active Members, the individual cannot be proposed again within two (2) years.

Section 8
Candidates for Honorary Membership may be proposed to the council by any member of the Association. The council will vote, and the elected new Honorary Member will be invited to join the next Annual meeting to receive the Honorary Membership.

Section 9
Active Membership shall be terminated in the event that an Active Member is absent from three (3) consecutive meetings without submitting adequate excuse to the Secretary, in writing. The member shall then be notified of the proposed termination of membership and shall thereafter be given an adequate opportunity to respond, and, in the absence of a satisfactory response, termination shall become final upon written notice from the Secretary and may only be reinstated by a two thirds vote of the Council, on presentation of reasons considered to be valid. Similarly Active Membership shall be automatically terminated in the event an Active Member fails to pay the annual fee for three (3) consecutive years despite proper notifications.

Article VI: FEES
Section 1
There shall be an annual subscription for all Active Members.

Section 2
The amount of the annual subscription shall be fixed by the Council.

Section 3
Senior and Honorary Members shall not be required to pay the subscription.

Section 4
Subscriptions and all financial arrangements are managed by the Treasurer. The annual budget must be reviewed by a qualified agent, and be presented to the Council and at the General Assembly during the annual meeting of the Association.

Article VII: OFFICERS
Section 1
The Council of the Association is constituted by the officers and chairs and vice chairs of committees. The Officers of the Association shall consist of the President,

the Vice-President, the Past-President, Secretary, Treasurer, and a maximum of five (5) Councillors. The Chairman of the Advisory Membership Committee, the Chairman of the Programme Committee and Chair of the Editorial Board Committee, as well as the two Vice-chairmen of the Editorial Board Committee are included in the council. The council shall not exceed fourteen (14) members.

Section 2
The Officers and Chairmen of all Committees shall be nominated by the Nominating Committee.

Section 3
The election of Officers shall take place at the General Assembly of the Annual Meeting. A majority of the votes shall constitute election.

Section 4
The term of service of the President, Vice-President and immediate Past-President shall be one (1) year, without the possibility for re-election. The terms of service of the Secretary, Treasurer and Chair of each committee shall be three (3) years with the possibility for one re-election, for a maximum of three years. The terms of service of the five Councillors shall be two (2) years with the possibility for one re-election, for a maximum of two years. New Members of the Council shall be elected at the General Assembly of the Association to take the place of the retiring Members.

Section 5
The President of the Association shall be the Chairman and the Secretary of the Association shall be the Secretary of the Council.

Section 6 Vice-President
The Vice-President of the Association shall be the proxy of the President.

Section 7 Past-President
To maintain continuity, it is customary to elect the retiring President as Past-President to the Council. The immediate Past-President will serve as Chairman of the Nominating Committee.

Section 8 Secretary
The Secretary of the Association shall be the Secretary of the Council. He is responsible for all administrative work of the Society, with adherence to the by-laws and acts as liaison officer between the committees. The term of service shall last three (3) years, with the possibility for one re-election, for a maximum of three (3) years.

Section 9 Treasurer

The Treasurer shall be responsible for the finances of the Society, including the collection of the annual subscription. The term of service shall last three (3) years, with the possibility of re-election, for a maximum of three (3) years.

Section 10 Councillors

Five active members are elected as Councillors for two (2) years, with the possibility of one re-election, for a maximum of two (2) years. They shall serve as executive members of the Council.

Article VIII: COUNCIL

Section 1

The President of the Association shall be the Chairman and the Secretary of the Association shall be the Secretary of the Council.

Section 2

The Council shall be the executive body of the Association and accurate minutes of its proceedings shall be kept by the Secretary.

Section 3

Meetings of Council shall be held at the call of the President. Ordinarily this will include one meeting held between two annual meetings in addition to the meeting held in conjunction with the annual meeting. Special meetings of the Council may be held on call of the President or at the request of three (3) members of the Council, in the interval between the annual meetings of the Association.

Section 4

All proposals for membership shall be submitted to the Council for action in accordance with Article V and only the names of those candidates who have received favourable recommendation shall attend the annual meeting and be granted Active Membership.

Section 5

The Council shall act as a Board of Censors for alleged offences against the by-laws or unprofessional conduct by any member of the association, and it alone shall have the power of presenting a motion to the members for suspension or expulsion of members. Due process must be granted to members accused of such offences.

Section 6

For the transaction of business a majority of the members of the Council shall constitute a quorum and a majority of those present shall prevail, subject to the provisions of Article V, Section 9.

Article IX: COMMITTEES

Section 1

The Council shall appoint the following standing committees:

- Advisory Membership Committee
- Programme Committee
- Editorial Board Committee
- Nominating Committee

In addition, the Council may appoint ad hoc committees as the need arises, their continuance to be subject to subsequent approval by the Association.

Section 2

The Council shall appoint the following ad hoc committee: Committee on Local Arrangements.

Section 3

The Advisory Membership Committee shall consist of eight (8) Members who shall be appointed by the Council, each member shall serve for four (4) years. The Secretary will serve as a member (ex officio). The Chairman shall be designated by the Nominating Committee.

It shall be the duty of members of this Committee to review all candidates proposed for Active Membership in the Association, to seek out desirable candidates for proposal to the Association and to consult with members in their areas of interest about proposed candidates. This Committee shall advise the Council concerning the eligibility of those candidates under consideration for Membership each year.

The Committee shall hold at least one meeting annually prior to the meeting of the Association in order to evaluate the candidates for Active Membership.

The establishment of the Committee shall in no way infringe upon Article V, Section 6 of the by-laws, which provides the proposal of candidates for Membership through three (3) members of the Association.

Section 4

The Programme Committee shall consist of four (4) Members, and the President, the Secretary, and the Chair of the Editorial Board ex officio with vote. The chair shall be appointed by the Nominating Committee. The other members shall be proposed by the Chair of the Programme Committee and elected by the Council. They are appointed for a maximum of three (3) years. The Chair can be re-elected for one more term of three years. The chairman shall provide a report to be reviewed at the mid-winter council meeting and at the General Assembly.

The duties of this Committee shall consist of arranging for the scientific papers, symposia and discussions at the annual meeting. The Programme Committee shall

recommend which papers shall be accepted, and their order of presentation. The Committee may recommend that individuals who are not Members of the Association be invited to present a paper or discussion. Acceptance of papers

outside of Europe shall be restricted to a reasonable proportion by the Chair of the Programme Committee.

The President of the Association is authorised to appoint substitute Members to the Committee for any member unable to attend.

Section 5

The Editorial Board Committee shall consist in a maximum of nine (9) members, and the President, the Secretary, and the Chair of the Programme Committee ex officio with vote. The chair shall be appointed by the Nominating Committee and the two associate editors, and the other members shall be proposed by the Chair of the Editorial Board Committee and elected by the Council. They are appointed for a maximum of three (3) years. The chair and the two Vice-Chairs of the Editorial Board Committee can be re-elected for one more term of three years. The chairman shall provide a report to be reviewed at the mid-winter council meeting and at the General Assembly.

Section 6

A Chairman on the Committee on Local Arrangements shall be appointed by the Council from members residing at or near the place of the next meeting. Additional members may be appointed. The duties of the Committee shall be to make general arrangements for the Annual Meeting of the Association.

Section 7

The Nominating Committee shall consist of the five (5) most recent living Past-Presidents, the most recent President

(Past-President) to serve as Chairman. The Committee shall nominate officers and elected members of the Council.

Article X: MEETINGS

Section 1

The Members of the Association shall meet at General Meetings. The General Meeting of Members shall consist of all the Members of the Association. Such General Meeting of Members shall be chaired by the President or by another person authorised for such purpose by the Council. The decisions by the General Meeting of Members shall be recorded in minutes.

Section 2
The call notices shall be sent by the Council by all means to the Members, no less than fifteen (15) days prior to the date scheduled for the General Meeting of Members, and they must indicate the agenda defined by the Council.

Section 3
Each Member of the Association shall have one (1) vote.

Section 4 Annual general meeting of members
The Members of the Association shall meet each year, for an Annual General Meeting of Members, upon the notice of call issued by the Council, which must indicate therein the date and time for such meeting.

The Annual General Meeting of Members shall examine the annual report from the Council, on the management and on the "moral" and financial position of the Association. It shall:

- approve the accounts for the fiscal year closed;
- Elect the Officers of the Association; and conduct deliberations on all the issues of general interest and all those referred to it by the Council.

The Annual General Meeting of Members shall only take decisions validly where at least twenty percent of the Members of the Association are present at the meeting. If such quorum is not reached, the General Meeting of Members shall be adjourned and reconvened pursuant to the procedure and within the time limits specified above in section 2.

Upon the second holding of this General Meeting of Members, it shall take decisions validly whatever the number of Members present at the meeting, but only with regard to those items indicated on the agenda for the previous General Meeting of Members.

Decisions shall be adopted at a simple majority of the votes of those Members present at the meeting.

Any Member may invite one physician or other scientist to an Annual Meeting of the Association, and such a guest, at the Member’s request to the President or Secretary, may receive the privilege of the floor.

Section 5 Extraordinary general meeting of members
The Extraordinary General Meeting of Members shall have the authority to amend any and all provisions of the By-Laws, to adopt and to amend the Internal Rules and Regulations, and it shall have the authority to resolve the Association's early dissolution or its merger with other associations.

The Extraordinary General Meeting of Members shall only take decisions validly where at least twenty percent of the Members of the Association are present at the meeting. If such condition is not satisfied, the General Meeting of Members shall be reconvened pursuant to the procedure and within the time limits specified above in section 2.

Upon the second holding of this General Meeting of Members, it shall take decisions validly whatever the number of Members present at the meeting, but only with regard to those items indicated on the agenda for the previous General Meeting of Members.

Decisions shall be adopted at a simple majority of the votes of those members present at the meeting.

Article XI: INTERNAL RULES

The Council can establish internal rules. These rules will complete the by-laws. They must be approved by the General Assembly.

Article XII: LIABILITY

The association only assumes liability with the association's fortune. There is no individual liability of the members.

ESA Internal Rules

Internal Rules accepted at the General Assembly in Beaune on 13 April 2013

1. ABSTRACTS AND PAPERS

1.1. Submission of Abstracts

Abstracts submitted after the deadline set by the chair of the Programme Committee will not be accepted.

1.2. Submission of Papers

Each ESA member can submit an unlimited number of abstracts. However, only two abstracts per group will eventually be accepted for presentation at the Annual Meeting. A group is defined as the senior author of a particular study. There may, however, be more than one group per centre.

Rule 1.2 shall not apply to multicenter trials (defined by 3 or more centres), however no Centre can present more than 2 abstracts to the Annual Meeting.

1.3. Sponsorship of non-European Abstracts

It is the role of Honorary Members to sponsor abstracts from their countries or continent.

Non-European abstracts sponsored by a European ESA member will be rejected unless this member qualifies for authorship.

1.4. Presentation of Papers

Papers can only be presented at the Annual Meeting if a manuscript has been submitted to the Editorial Board on time.

1.5. Publication in the Annals of Surgery

The submission of a manuscript implies that if accepted by the editorial board it may only be published in the pages reserved for ESA in the December issue of the Annals of Surgery.

2. ANNUAL MEETINGS

2.1. Venue

The Council will decide on the venue for the annual meetings. The choice should be made two years in advance at the winter council meeting. The local organiser must present to the Council a detailed budget 18 months before the planned meeting.

2.2. Sponsoring

The local organiser of the Annual Meetings may seek sponsorship, but must inform the sponsors that the only acknowledgement will be their logo on the back of the program booklet. Commercial exhibits are not permitted.

2.3. Fees

The fee should be reasonable.
The ESA will neither share profit nor loss with the local organiser. The local organiser needs to transfer € 30.00 per paying participant to the treasurer of the ESA.

2.4. Assistant of Local Organiser of Future Meetings

The local organiser of a future meeting can invite a member of his organising committee to the annual meeting preceding his meeting. The local organiser of the future meeting has to take care of all the costs involved.

2.5. Social Events

2.5.1. Gala Dinner

Dress Code: black tie. This information should be made available on the website and in the programme.
Speakers are invited to the gala dinner. According to internal rules (2.4.3) only honorary members will be invited free of charge.

2.5.2. President Dinner

On behalf of the President, the Secretary will invite the guests chosen by the President. The Dinner will be organised by the local organising committee on behalf of the President. The costs of the dinner will be covered by the President. Sponsoring is permitted. Under special circumstances presidents can ask for some support as deficit warranty. The council will decide on the level of support. Requests for support need to be submitted no later than the preceding Winter Council Meeting.

2.5.3. Honorary Members

The Registration Fee and the fee for the gala dinner shall be waved for honorary members. These costs shall be covered by the local organiser. The hotel costs for newly elected honorary members and their accompanying person will also be covered by the local organiser.

3. CONTRACTS

All contracts between a third party and ESA need to be signed by the Council Member responsible for the contract and the Secretary. The President must be informed prior to the signing of any contract.

The secretary's office shall always keep one copy of each contract.

4. FINANCIAL ISSUES

4.1. Financial Support of Officers

The office of the Treasurer, Chairman of the Scientific Committee, Chairman of the Advisory Membership Committee, Editor-in-chief and Secretary General receive some financial support. Hotel and travel expenses of the secretary's staff assistant to be present at the annual meeting will be covered by the Association. The local

activities for the staff (e.g. lunches, gala dinner, welcome reception, etc.) will be covered by the local organiser.

4.2. Annals of Surgery and British Journal of Surgery

The financial contribution by the Annals of Surgery and British Journal of Surgery must be transferred to the Treasurer, and used to support the activities of the Association.

5. MEMBERSHIP

5.1. Duration of Membership

Members who are neither traceable nor answer mail will be removed from the member list.

5.2. Membership of Active Members out of Europe

Active members who have been out of Europe for several years can remain active members. However, while they need to pay the fees, they are exempt of the requirement to attend the annual meetings. They can only submit abstracts if all dues are paid.

5.3. Exclusion from Association

Below rule shall supplement Art. V: Membership, section 9 of the bylaws.
Members who have been absent from the annual meeting for three consecutive meetings will be invited twice. Should they not attend one of the following two meetings, they will automatically be excluded from the association.

5.4. Payment of Fees

Senior Members do not have to pay fees but shall be encouraged to do so.
These Internal Rules will become active with their acceptance by the general assembly. Concessions made by previous versions of the internal rules are not applicable with the acceptance of these Internal Rules.

These Internal Rules were accepted at the General Assembly in Beaune on 13 April, 2013 and replace those accepted in Helsinki on 21 May, 2011.
Based on art. XI of the by-laws these Internal Rules shall complete the by-laws of 8 April, 2006.

HONORARY MEMBERS

**Honorary Founding Member*

Prof. John **BIRKMEYER** (2012)
2800 Plymouth Rd, Bldg. 520, Room 3145, Ann Arbor, MI 48109, USA
Speciality: General Surgery, Gastrointestinal Surgery
Fields of Interest: Health Services Research, Performance Measurement, Understanding Variation in Hospital Efficiency, Value-based Purchasing
Tel: +1 734 998 74 70
e-mail: jbirkmey@umich.edu

*Prof. Henri **BISMUTH** (1992)
Hepatobiliary Surgery, Hôpital Paul Brousse, 12 Paul Vaillant Couturier, 94800 Villejuif, FRANCE
Specialty: HPB Surgery
Fields of Interest: Transplantation, Liver, Biliary Tract, Adult Liver transplantation, Research in HPB.
Tel.: +33 1 4559 3835 Fax: +33 1 4588 2165
e-mail: henri.bismuth-ext@aphp.fr

Prof. Hans G. **BORST** (1999)
Widenmayerstr. 7, 80538 München, GERMANY
Specialty: Thoracic Surgery
Fields of Interest: Cardiac Surgery
Tel.: +49 89 2916 1191 Fax: +49 89 2916 1191
e-mail: hgborst@gmx.net

Sir Prof. Murray F. **BRENNAN** (2005)
Memorial Sloan-Kettering Cancer Center, Dept of Surgery, Vice President International Center 1275 York Ave., New York, NY 10065, USA
Speciality: Gastrointestinal Surgery, HPB Surgery
Fields of Interest: Pancreas, Nutrition, Teaching, Soft TIssue Sarcomas
Tel.: +1 212 639 8691 Fax: +1 212 794 5845
e-mail: brennanm@mskcc.org

Prof. Ronald W. **BUSUTTIL** (2007)
Dept. of Surgery, David Geffen School of Medicine at UCLA, 10833 Le Conte Avenue, 72-125 CHS, Los Angeles, CA 90095-1749, USA
Specialty: Speciality: Transplantation
Fields of Interest: Adult Liver Transplantation, Pediatric Liver Transplantation, Research in Transplantation
Tel.: +1 310 825 7017 Fax: +1 310 206 5235
e-mail: Rbusuttil@mednet.ucla.edu

Prof. John L. **CAMERON** (2005)
Dept. of Surgery, The Johns Hopkins Hospital, 600 N, Wolfe Str. 212874688, BALTIMORE MD, USA
Specialty: Gastrointestinal Surgery
Fields of Interest: Pancreas
Tel.: +1 410 955 5166 Fax: +1 410 502 6978
e-mail: jcamero1@jhmi.edu

Prof. Joel D. **COOPER** (1999)
Thoracic Surgery, University of Pennsylvania Health System, 3400 Spruce Street,
6 Silverstein, 19104 Philadelphia, PA, USA
Specialty: Thoracic Surgery
Fields of Interest: Oesophagus and Stomach, Oncological Surgery
Tel.: +1 215 662 2022 Fax: +1 215 614 1861
e-mail: joel.cooper@uphs.upenn.edu

Prof. Eduardo **DE SANTIBAÑES** (2011)
Liver Transplant Unit, General Surgical Service, Hospital Italiano, Buenos Aires, ARGENTINA
Specialty: HPB Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas, Teaching, Laparoscopy, Adult Liver, Transplantation, Teaching
Tel.: +11 54 4959 0812 or +11 54 4981 4501 Fax: +11 54 4981 4041
e-mail: eduardo.desantibanes@hospitalitaliano.org.ar

Prof. Tom R. **DEMEESTER** (1999)
Dept. of Surgery, University of Southern California, GI + Thoracic Surgery, 1510 San Pablo, Suite 514, 90033 Los Angeles, CA USA
Specialty: Gastrointestinal Surgery, Thoracic Surgery
Fields of Interest: Teaching
Tel.: +1 323 442 5925 Fax: +1 323 442 5872
e-mail: Tom.Demeester@med.usc.edu

Prof. Jiahong **DONG** (2015)
Foreign Member of the French Academy of Surgery, Professor & Head, Hospital & Institute of Hepatobiliary Surgery, Chinese PLA General Hospital, Fuxing road 28, Haidian District, Beijing 100853, CHINA
Tel.: + 86-10-68241383 Fax: +86-10-68241383
e-mail: dongjh301@163.com

Prof. Angelita **HABR-GAMA** (2006)
Rua Manoel da Nobrega 1564, Sao Paulo 04001-005, BRAZIL
Specialty: Colorectal Surgery
Fields of Interest: Colorectal, Teaching, Cancer
Tel.: +5511 3887 1757 Fax: +5511 3884 8845
e-mail: gamange@uol.com.br

Prof. Juan **HEPP** (2010)
Clinica Alemana Santiago, Medical School Clinica Alemana, Univ. del Desarrollo, Vitacura 5951, Santiago, CHILE
Specialty: General Surgery
Tel.: +56 2210 1302 Fax: +56 2210 1400
e-mail: jhepp@alemana.cl

Prof. John G. **HUNTER** (2010)
Dept. of Surgery, Oregon Health & Science University, 3181 SW Sam Jackson Park Road - L223, Portland, OR 97239-3098, USA
Specialty: Gastrointestinal Surgery
Fields of Interest: Oesophagus and Stomach, Laparoscopy, Research in GI Disease
Tel.: +1 503 4947 758 Fax: +1 503 4945 615
e-mail: hunterj@ohsu.edu

Prof. Bernard **LANGER** (2006)
180 Gordon Rd, Toronto, ON M5P 1E8, CANADA
Specialty: Gastrointestinal Surgery
Tel.: +1 416 445 5368
e-mail: drblanger@aol.com

Prof. Keith **LILLEMOE** (2008)
Chief, Department. of Surgery, Massachusetts General Hospital, 55 Fruit St, 02114 – 2696 BOSTON MA, USA
Specialty: General Surgery
Tel.: +1 617 643 1010 Fax: +1 617 726 7593
e-mail: klillemoe@partners.org

Prof. Chung-Mau **LO** (2013)
Dept. of Surgery, The University of Hong Kong, Queen Mary Hospital, Pokfulam, Hong Kong, PR CHINA
Specialty: HPB surgery, Transplantation
Tel.: +852 225 547 61 Fax: +852 281 627 65
e-mail: chungmlo@hkucc.hku.hk

Prof. Masatoshi **MAKUUCHI** (2002)
4-1-22 Hiroo, Shibuya-Ku, 150-8935 Tokyo, JAPAN
Specialty: HPB Surgery
Fields of Interest: Liver, Cancer, Adult Liver Transplantation
Tel.: +81 3 5800 8841 Fax: +81 3 5800 8843
e-mail: masatoshi.makuuchi@gmail.com

Prof. Keiichi **MARUYAMA** (1999)
Dept. of Surgical Oncology, University of Health and Welfare Sanno Hospital 8-10-16 Akasaka, Minato-Ku. Tokyo 107-0052, JAPAN
Specialty: Gastrointestinal Surgery
Fields of Interest: Oesophagus and Stomach
Tel.: +81 3 3469 5222 Fax: +81 3 3469 5236
e-mail: keiichi-maruyama@r01.itscom.net

Prof. Miguel Ángel **MERCADO DÍAZ** (2015)
Instituto Nacional de Ciencias Médicas y Nutricion Salvador Zubiran, Vasco de Quiroga No. 15 Col. Seccion XVI 140 80, MEXICO, D.F.
Fields of Interest: Liver, Pancreas, Transplantation
e-mail: Miguel.mercado@incmnsz.mx

Prof. Masaru **MIYAZAKI** (2014)
Department of General Surgery, Chiba University, 1-8-1-Inoha na Chuoh-Ku, 260-0856 Chiba, JAPAN
Fields of Interest: Liver, Biliary Tract
Tel.: +81 43 222 7 171 Fax: +81 43 224 3830
e-mail: masaru@faculty.chiba-u.jp

Prof. Elmi **MULLER** (2016)
University of Cape Town, Groote Schuur Hospital,Main Road, Observatory, Cape Town 7925, South Africa
Specialty: Transplant surgeon
Fields of Interest: Transplantation, HIV
e-mail: elmi.muller@uct.ac.za

Prof. Akimasa **NAKAO** (2011)
Dept. of Gastroenterological Surgery (Surgery II) Nagoya University Graduate School of Medicine, 65 Tsurumai-cho, Showa-ku, Nagoya 466-8550, JAPAN
Specialty: HPB Surgery
Fields of Interest: Pancreas, Liver, Cancer, Research in HPB
Tel.: +81 52 744 2232 Fax: +81 52 744 2255
e-mail: nakaoaki@med.nagoya-u.ac.jp

Prof. Yuji **NIMURA** (2008)
Nagoya University, Aichi Cancer Center, 1-1 Kanokoden, Chikusa-ku, Nagoya 464-8681, JAPAN
Specialty: HPB Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas
Tel.: +81 52 764 2900 Fax: +81 52 751 6948
e-mail: ynimura@aichi-cc.jp

Prof. Robert. **PADBURY** (2013)
Surgical & Specialty Services, Level 5, Flinders Medical Centre, Flinders Drive, Bedford Park, SA, AUSTRALIA
Specialty:
Fields of Interest:
Tel.: +61 8 8204 3948 Fax: +61 8 8204 3148
e-mail: rob.padbury@flinders.edu.au

Prof. Carlos A. **PELLEGRINI** (1999)
BB 4878 Health Science Center, Dept. of Surgery,, 1959 N.E. Pacific Street, Box 356410, Seattle, WA 98195-6410, USA
Specialty: Gastrointestinal Surgery
Fields of Interest: Liver, Biliary Tract, Upper Gastrointestinal
Tel.: +1 206 543 3106 Fax: +1 206 685 6912
e-mail: pellegri@u.washington.edu

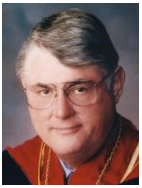
Prof. Shu You **PENG** (2009)
Dept. of Surgery, Zhejiang University, School of Medicine Second Affiliated Hospital, #88 Jiefang Road, Hangzhou 3100009, PR China
Specialty: General Surgery,
Tel.: +86 571 87783766 Fax: +86 571 87022776
e-mail: zrwkpsy@sina.com

Prof. Hiram C. **POLK, JR.** (2010)
Dept. of Surgery, School of Medicine, University of Louisville, Louisville, KY 40292, USA
Specialty: General Surgery
Fields of Interest: Cancer, Infection, Teaching
Tel.: +1 502 852 1897 Fax: +1 502 852 8915
e-mail: hcpolk01@louisville.edu

Prof. Layton F. **RIKKERS** (2005)
Dept. of Surgery, University of Wisconsin, H4/710 CSC, 600 Highland Avenue, Madison, WI 53792, USA
Specialty: HPB Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas
Tel.: +1 608 265 8854 Fax: +1 608 265 5963
e-mail: rikkers@surgery.wisc.edu

Prof. Takeshi **SANO** (2012)
Japanese Foundation for Cancer Research, Cancer Institute Hospital, Division Director, Upper GI, 3-10-6 Ariake, Koto-ku, Tokyo 135-8550, JAPAN
Tel.: +81 3 3520 0111 Fax: +81 3 3570 0343
e-mail: takeshi.sano@jfcr.or.jp

Prof. Michael G. **SARR** (2011)
Dept. of Surgery, Mayo Clinic, 200 First St. SW, Rochester, MN 55905, USA
Specialty: Gastrointestinal Surgery
Fields of Interest: Biliary Tract, Bariatric Surgery, Geriatric, Abdominal Wall
Tel.: +1 507 284 2683 Fax: +1 507 284 5196
e-mail: sarr.michael@mayo.edu



Prof. George F. **SHELDON** (1999)
Dept. of Surgery, The University of North Carolina at Chapel Hill, General Surgery, 180 Wing D, CB# 7228, 275997228, Chapel Hill NC, USA
Specialty: General Surgery
Fields of Interest: Teaching, Nutrition
Tel.: +1 919 966 4052 Fax: +1 919 966 6009
e-mail: gsheldon@med.unc.edu

Prof. Hans **SOLLINGER** (2009)
Dept. of Surgery, University of Wisconsin Medical School, H5/701 Clinical Science Center, 600 Highland Avenue, Madison, WI 53792-7375, USA
Specialty: Kidney and Pancreas Transplant Surgery
Fields of Interest: Pre-/clinical Test New Immuno-suppressive Agents, Gene therapy for cell transplantation
Tel.: +1 608 263 1406 Fax: +1 608 262 6280
e-mail: HANS@surgery.wisc.edu

Prof. Steven M. **STRASBERG** (2007)
HPB/GI Surgery, Washington University School of Medicine, Campus Box 8109, 660 S. Euclid, St. Louis, MO 63110, USA
Specialty: Gastrointestinal Surgery
Tel.: +1 314 362 7147 Fax: +1 314 367 1943
e-mail: strasberg@wudosis.wustl.edu

Prof. Andéas **TZAKIS** (2013)
Cleveland Clinic, Weston Family Health Center, 1825 North Corporate Lakes Blvd, Weston, FL 33326, USA
Specialty: Transplantation
Tel.: +1 305 355 5011 Fax: +1 305 355 5012
e-mail: tzakisa@ccf.org

Prof. Joseph **VACANTI** (2011)
Massachusetts General Hospital, Warren Building (WRN) 1151, 55 Fruit Street, Boston, MA 02114-2696, USA
Specialty: Transplantation, Pediatric Surgery
Fields of Interest: Liver, Pediatric Liver Transplantation, Research in Transplantation, Regenerative Medicine
Tel.: +1 617 724 1725 Fax: +1 617 726 02167
e-mail: jvacanti@partners.org

Prof. Jean Nicolas **VAUTHEY** (2017)
The University of Texas M. D. Anderson Cancer, 1515 Holcombe Boulevard, Unit 444, Houston, Texas 77030, USA
Specialty: Hepatobiliary tumours
Fields of Interest:
e-mail: jvauthey@mdanderson.org

Prof. Frank J. **VEITH** (2008)
4455 Douglas Avenue, Suite 11E, Riverdale, NY 10471, USA
Specialty: Vascular Surgery
Fields of Interest: Endovascular, Carotid and AAAs, Statin Treatment
Tel.: +1 718 549 3140 Fax: +1 718 549 3142
e-mail: FJVMD@msn.com

Prof. Umberto **VERONESI** (1999)
Instituto Europeo di Oncologia, Via Ripamonti 435, 20141 Milano, ITALY
Specialty: Breast Surgery
Fields of Interest: Cancer
Tel.: +39 02 5748 9221 Fax: +39 02 5748 9210
e-mail: umberto.veronesi@ieo.it

Prof. Samuel A. **WELLS** (1999)
Washington University School of Medicine, Campus Box 8109, 660 South Euclid Avenue, St. Louis, MO 63110, USA
Specialty: General Surgery
Fields of Interest: Endocrinology, Oncology
Tel.: +1 919 201 0310 Fax: +1 919 644 1664
e-mail: wellss@mail.nih.gov

Prof. Steven **WEXNER** (2015)
Cleveland Clinic Florida, 2950 Cleveland Clinic Blvd, Weston, FL 33331. USA
e-mail: wexners@ccf.org

Prof. John **WONG** (1996)
Esophageal and Hepatobiliary Surgery, Dept. of Surgery, University of Hong Kong Medical Centre, Queen Mary Hospital, Hong Kong, PR CHINA
Specialty: Gastrointestinal surgery
Fields of Interest: Oesophagus and Stomach, Teaching
Tel.: +852 2855 4610 Fax: +852 2816 2094
e-mail: jwong306@gmail.com

Prof. Han-Kwang **YANG** (2016)
Seoul National University Hospital, 101 Daehak-ro, Jongno-gu, Seoul 110-744, Korea
Specialty: Gastric cancer surgery
Fields of Interest: lymph node metastasis, minimal invasive surgery, robotic surgery, GIST translational research interests are gastric carcinogenesis, DDS, familial gastric cancer, biomarkers and developing PDX model for gastric cancer
e-mail: hkyang@snu.ac.kr

NEW MEMBERS 2018

New members to be presented this year

1	Pierre **CATTAN** (2018) Hôpital St-Louis, Head Dept. General, Digestive and Endocrine Surgery, Paris, FRANCE
2	Giovanni **DE MANZONI** (2018) Verona University, Head Division General and Upper GI Surgery, Verona, ITALY
3	Stefan **FICHTNER-FEIGL** (2018) University Medical Center, Dept.General and Visceral Surgery, Freiburg, GERMANY
4	Constantino **FONDEVILA CAMPO** (2018) Hospital Clinic, Dept. General and Digestive Surgery, Barcelona, SPAIN
6	Rosa **JORBA MARTÍN** (2018) Hospital Universitari Joan XXIII, Dept.General Surgery, Tarragona, SPAIN
7	Jörg C. **KALFF** (2018) University of Bonn Medical Center, Dept. Surgery, Bonn, GERMANY
8	Oskar **KORNASIEWICZ** (2018) Warsaw Medical University, Dept.General, Liver and Transplant Surgery, Warsaw, POLAND
9	Fabien **KOSKAS** (2018) Hôpital Pitié Salpêtrière, Dept Vascular Surgery, Paris, FRANCE
10	Laurent **LANTIERI** (2018) Hôpital Européen Georges Pompidou, Paris Descartes University, Plastic and Reconstructive Surgery, Paris, FRANCE
11	Kristoffer **LASSEN** (2018) Rikshospitalet, HPB section, Oslo University Hospital, Oslo, NORWAY

12	Massimo **MALAGO** (2018) Royal Free Hospital, Division of Surgery and Interventional Science, UCL, London, UNITED KINGDOM
13	Vincenzo **MAZZAFERRO** (2018) National Cancer Institute, Dept.Surgery, Milano, ITALY
14	Beat **MÜLLER** (2018) Heidelberg University, Dept.General Surgery, Heidelberg , GERMANY
15	Elisabeth **NIEVEEN VAN DIJKUM** (2018) Academic Medical Center, University of Amsterdam, Dept Endocrine Surgery Gastrointestinal Oncology and Endocrinology, Amsterdam, THE NETHERLANDS
16	Steven **OLDE DAMINK** (2018) University Medical Centre, Dept General Surgeryt, Clinical Lead Nutrition Team, Maastricht, THE NETHERLANDS
17	Andreas **PASCHER** (2018) Charité Universitaetsmedizin, Dept Transplantation, and neuroendocrine tumor surgery, Berlin, GERMANY
18	Christophe **PENNA** (2018) Hôpital Bicètre – Hopitaux Universitaires Paris-Sud, Service de chirurgie Générale et Digestive, Paris, FRANCE
19	Manuel Pedro **PEREIRA DIAS DE MAGALHÃES** (2018) Red Cross Hospital, Dept Cardiac Surgery and Pediatric Cardiology, Lisboa, PORTUGAL
20	Pablo RAMIREZ **ROMERO** (2018) University Hospital Virgen Arrixaca, Dept.surgery, Murcia, SPAIN
21	Frederic **RIS** (2018) University Hospitals, Dept Visceral and transplantation surgery, Geneva, SWITZERLAND
22	Oleg **RUMMO** (2018) 9th city clinical hospital, center of Organ and tissue transplantation, Minsk, BELARUSSIA

23	Francisco **SANCHEZ BUENO** (2018) University of Murcia, General Surgery, Murcia, SPAIN
24	Peter **SCHEMMER** (2018) Medical University Graz, Division of Transplant Surgery, Dept. of Surgery, Graz, AUSTRIA
25	Attila **SZIJARTO** (2018) Semmelweis University, Dept. Surgery, Budapest, HUNGARY
26	Matthias **TURINA** (2018) University Hospital, Dept.Visceral and transplantation Surgery, Zurich, SWITZERLAND
27	Olivier **TURRINI** (2018) Institut Paoli-Calmette, Dept. Surgical Oncology, Marseille, FRANCE

New Members 2017 waiting to be presented

1	Marc **BESSELINK** (2017) Academic Medical Center, University of Amsterdam, THE NETHERLANDS
2	Alessandro **GRONCHI** (2017) Fondazione IRCCS Istituto Nazionale dei Tumori, Milano - ITALY
3	Robert **GRUTZMANN** (2017) University Hospital, Erlangen, GERMANY
4	Fernando **PEREIRA** (2017) Autonoma University of Madrid, Madrid, SPAIN
5	Hubert **SCHELZIG** (2017) Clinic for Vascular and Endovascular Surgery, Heinrich-Heine University, Dusseldorf, GERMANY

New members 2016 to be presented this year

1	Hugues **DUFFAU** (2016) Gui de Chauliac Hospital, Department of Neurosurgery, Montpellier University Medical Center, Montpellier, FRANCE
2	Zoran **KRIVOKAPIC** (2016) First Surgical Clinic Clinical Center of Serbia, Department of Colorectal Surgery, Belgrade, SERBIA

MEMBERS

**Senior Member*

Prof. René A. **ADAM** (1999)
Centre Hepato-Biliaire, Hôpital Paul Brousse, Hepatobiliary Surgery, 14 Paul Vaillant Couturier, 94800 Villejuif, FRANCE
Specialty: HPB Surgery, Transplantation
Fields of Interest: Liver, Research in HPB, Biliary Tract, Cancer, Adult Liver Transplantation.
Tel.: +33 1 4559 30 49 Fax: +33 1 4559 38 57
e-mail: rene.adam@pbr.aphp.fr

Prof. Mustapha **ADHAM** (2012)
Edouard Herriot Hospital, Department of Digestive Surgery, HBP Unit, Pavillon D, 5 Place d'Arsonval, 69437 Lyon, Cedex 03, FRANCE
Specialty: HPB Surgery
Fields of Interest: Pancreas
Tel.: +33 4 7211 62 61 Fax: +33 4 7211 62 59
e-mail: mustapha.adham@chu-lyon.fr

*Prof. Göran **AKERSTRÖM** (2002)
Dept. of Surgery, University Hospital, 75185 Uppsala, SWEDEN
Specialty: HPB Surgery
Fields of Interest: Pancreas
Tel.: +46 18 611 0000 Fax: +46 18 504 414
e-mail: goran.akerstrom@kirurgi.uu.se

Prof. Derek **ALDERSON** (2003)
Academic Dept. of Surgery, Room 29, 4th Floor, Queen Elizabeth Hospital, Edgbaston, Birmingham B15 2TH, UNITED KINGDOM
Specialty: Gastrointestinal Surgery
Fields of Interest: Oesophagus and Stomach, Cancer, Research in GI Disease
Tel.: +44 121 627 2276 Fax: +44 121 472 1230
e-mail: d.alderson@bham.ac.uk

Prof. Donato **ALTOMARE** (2011)
Dept. of Emergency and Organ Transplantation, University of Aldo Moro of Bari, Policlinico, Piazza G. Cesare 11, 70124 Bari, ITALY
Specialty: Colorectal Surgery
Fields of Interest: Colorectal, Cancer, Research in GI Disease
Tel.: +39 080 547 8764 Fax: +39 080 547 8735
e-mail: altomare@clichiru.uniba.it

*Prof. Ermanno **ANCONA** (1993)
Clinica Chirurgica IV, Ospedale Giustinianeo, Dept. of Medical and Surgical Sciences, Esophageal Surgery Kidney Transplant, Via Giustiniani 2, 35128 Padova, ITALY
Specialty: General Surgery
Fields of Interest: Oesophagus and Stomach, Cancer, Laparoscopy
Tel.: +39 049 821 1240 Fax: +39 049 821 3151
e-mail: anconaermanno@libero.it

Prof. Roland **ANDERSSON** (2003)
Dept. of Surgery, Lund University, 22185 Lund, SWEDEN
Specialty: HPB Surgery
Fields of Interest: Liver, Pancreas, Research in HPB
Tel.: +46 4617 2359 Fax: +46 4614 7298
e-mail: Roland.Andersson@med.lu.se

Prof. Martin K . **ANGELE** (2014)
Professor-Huber-Platz 2, Viszeral, Transplantations 80539 München, GERMANY
Specialty: Oncological Surgery
Fields of Interest: Oesophagus and Stomach, Stomac Liver
Tel.: +49 89 218 02326
e-mail: martin.angele@med.uni-muenchen.de

*Prof. Nicos **ANGELIDES** (2003)
6 Evangelistrias Street, 2057 Strovolos, Nicosia, CYPRUS
Specialty: Vascular Surgery
Fields of Interest: Cancer, Laparoscopy, Liver
Tel.: +357 22 355 230 Fax: +357 22 357 270
e-mail: n_angelides@hotmail.com

*Prof. Licinio **ANGELINI** (1995)
IV Dept. of Surgery, University Hospital, Policlinico Umberto I, Viale del Policlinico, 1612 Roma, ITALY
Tel.: +357 22 355 230 Fax: +357 22 357 270
e-mail: licinio.angelini@gmail.com

*Prof. Antonio M. **ARAÚJO TEXEIRA** (1993)
GI Surgery, Rue Eugénio Castro 426 H 21, 4200-225 Porto, PORTUGAL
Tel.: +31 226 099 750 Fax: +35 522 200 9966
e-mail: antonioaraujoteixeira@gmail.com

*Prof. Jean-Pierre **ARNAUD** (2003)
31 rue de Thann, 67100 Strasbourg, FRANCE
Specialty: Oncological Surgery
Fields of Interest: Pancreas, Liver, Biliary Tract, Cancer
Tel.: +33 241 353 618 Fax: +33 241 354 742
e-mail: jparnaud67@yahoo.fr

Prof. Philippe **BACHELLIER** (2015)
Hôpitaux Universitaires de Strasbourg, Centre de chirurgie viscérale et de transplantation, Hôpital de Hautepierre - 1, Av Molière - BP 49 - 67200 Strasbourg, FRANCE
Specialty: HPB surgery
Fields of Interest: Pancreas, Liver, Adult liver Transplantation
Tel: + 33 3 88 12 72 58 Fax: + 33 3 88 12 72 86
e-mail: philippe.bachellier@chru-strasbourg.fr

Prof. Marcin **BARCZYNSKI** (2012)
Third Department of General Surgery, Jagiellonian University Medical College, 37 Prądnicka Street, 31-202 Krakow, POLAND
Specialty: General Surgery, Oncological Surgery, Endocrine Surgery
Fields of Interest:
Tel.: +48 12 633 19 95
e-mail: marbar@mp.pl

*Prof. Eduardo Manuel **BARROSO GARCIA DA SILVA** (2007)
Hospital Curry Cabral, Rua Beneficencia n° 8, 1069-166 Lisbon, PORTUGAL
Specialty: General Surgery
Fields of Interest: HPB Surgery, Transplantation
Tel.: +351 21 792 4251
e-mail: ebarroso@hccabral.min-saude.pt

Prof. Detlef Klaus **BARTSCH** (2007)
Klinik für Viszeral-, Thorax- und Gefässchirurgie, Universitätsklinikum Giessen und Marburg GmbH, Baldingerstrasse, 35043 Marburg, GERMANY
Specialty: Endocrine Surgery
Fields of Interest: Pancreas, Endocrine, Research in GI Disease
Tel.: +49 6421 58 66441
e-mail: bartsch@med.uni-marburg.de

Prof. Claudio **BASSI** (2002)
Hospital "G.B. Rossi", University of Verona, Dipartimento di "Scienze Chirurgiche, Odontostomatologiche e Materno Infantili" - Sez. "Chirurgia Generale e del Pancreas",37134 Verona, ITALY
Specialty: HPB Surgery
Fields of Interest: ,Biliary Tract, Pancreas, Cancer, Research in HPB
Tel.: +39 34 78 02 24 11
e-mail: claudio.bassi@univr.it

*Prof. Jacques **BAULIEUX** (1994)
Head of Dept. of Surgery, Hôpital de la Croix Rousse, Esoph, Liver Surg Transplantation, Digestive Surgery, 103 Grande Rue de la Croix Rousse, 69317 Lyon Cedex, FRANCE
Tel.: +33 472 071 627 Fax: +33 472 071 897
e-mail: jbaulieux@aol.com

Prof. Wolf **BECHSTEIN** (2007)
Dept. of General and Vascular Surgery, Goethe-University, Theodor-Stern-Kai 7, 60590 Frankfurt am Main, GERMANY
Specialty: HPB Surgery
Fields of Interest: Liver, Colorectal, Adult Liver Transplantation, Kidney Transpnatation.
Tel.: +49 69 6301 5251 Fax: +49 69 6301 7452
e-mail: wolf.bechstein@kgu.de

*Prof. Hans G. **BEGER** (1993)
General and Visceral Surgery, Silcherstrasse 36, 89231 Neu-Ulm, GERMANY
Tel.: +49 731 5002 6775
e-mail: hans@beger-ulm.de

*Prof. Jacques B. **BELGHITI** (1999)
Dept. of Surgery, Hôpital Beaujon, 100 Boulevard du Général Leclerc, 92110 Clichy, FRANCE
Specialty: HPB Surgery, Transplantation
Fields of Interest: Liver, Adult Liver Transplantation, Cancer, Biliary Tract, Pancreas
Tel.: +33 1 4087 5895 Fax: +33 1 4087 1724
e-mail: jacques.belghiti@aphp.fr

*Prof. Peter R.F. **BELL** (1997)
Dept. of Surgery, University of Leicester, Robert Kilpatrick Building, Leicester Royal Infirmary, Leicester LE2 7LX, UNITED KINGDOM
Tel.: +44 116 252 3142 Fax: +44 116 252 3179
Specialty: Vascular surgery
e-mail: peterrfbell@ntlworld.com

Prof. Wilhelmus A. **BEMELMAN** (2009)
Dept. of Surgery, Academic Medical Center, University of Amsterdam, Meibergdreef 9, 1105 AZ Amsterdam, THE NETHERLANDS
Specialty: Gastrointestinal surgery
Fields of Interest: Colorectal surgery, laroscopic surgery
Tel.: +31 20 566 6818 Fax: +31 20 691 4858
e-mail: w.a.bemelman@amc.uva.nl

Prof. Anders **BERGENFELZ** (2006)
Dept. of Surgery, Lund University Hospital, Barngatan 4, 22185 Lund, SWEDEN
Specialty: General Surgery
Fields of Interest: Pancreas, Endocrine, Cancer, Teaching, Sarcoma,
Tel.: +46 703 772 086
e-mail: anders.bergenfelz@med.lu.se

Prof. Thierry **BERNEY** (2009)
Service de Chirurgie viscérale Hôpitaux Universitaires Genève, 24 rue Micheli-du-Crest, 1211 Genève 14, SWITZERLAND
Specialty: Transplantation
Fields of Interest: Pancreas, Liver, Adult Liver Transplantation, Research in Transplantation
Tel.: +41 22 372 3404 Fax: +41 22 372 7707
e-mail: thierry.berney@hcuge.ch

*Prof. Henrique M. **BICHA CASTELO** (2008)
Faculty of Medicine of Lisbon, University Hospital of Santamaria, av. Prof. Egas Moniz, 169-028 Lisbon, PORTUGAL
Tel.: +351 21 780 5279 Fax: +351 21 780 5657
e-mail: h.bichacastelo@gmail.com

Prof. Sebastiano **BIONDO** (2013)
Bellvitge University Hospital, Department of General and Digestive Surgery - University of Barcelona, 08907 Barcelona, SPAIN
Specialty: General Surgery
Fields of Interest: Colorectal, Cancer, Diverticular Disease
Tel.: +34 932 607 688 Fax: +34 932 607 523
e-mail: sbn.biondo@gmail.com

Prof. Maximilian **BOCKHORN** (2014)
Department of General, Visceral and Thoracic-Surgery, Universitätsklinikum Hamburg-Eppendorf, Martinistr. 52, 20246 Hamburg, GERMANY
Specialty: General Surgery, Gastrointestinal Surgery
Fields of Interest: HPB Surgery, Oncological Surgery
Tel.: +49 15 2228 15142 Fax: +49 40 7410 46756
e-mail: m.bockhorn@uke.uni-hamburg.de

Prof. Luigi **BONAVINA** (2003)
University of Milan Medical School, Director, Division of General Surgery, IRCCS Policlinico San Donato, Via Morandi 30, 20097 San Donato Milanese, Milano, ITALY
Specialty: Gastrointestinal Surgery
Fields of Interest: Oesophagus and Stomach, Cancer, Laparoscopy
Tel.: +39 02 5277 4840 Fax: +39 02 5277 4395
e-mail: luigi.bonavina@unimi.it

Prof. Sylvie **BONVALOT** (2015)
Institut Curie, 26 rue d'ULM, 75005 Paris, FRANCE
Specialty: Oncological Surgery
Fields of Interest: Teaching, Sarcoma
Tel: + 33 1 5624 5769
e-mail: bonvalot@igr.fr

Prof. Inne **BOREL-RINKES** (2003)
Dept. of Surgery, University Medical Center Utrecht, Room No. G 04.228, P.O. Box 85500, 3508 GA Utrecht, THE NETHERLANDS
Specialty: Endocrine Surgery
Fields of Interest: Liver, Endocrine, Teaching
Tel.: +31 30 250 6901 Fax: +31 30 254 1944
e-mail: I.H.M.BorelRinkes@umcutrecht.nl

Prof. Karim **BOUDJEMA** (2011)
Service de chirurgie hépato-biliare et digestive, Hôpital Pontchaillou, 35033 Rennes, FRANCE
Specialty: HPB Surgery
Fields of Interest: Liver, Biliary Tract, Adult Liver Transplantation, Research in Transplantation
Tel.: +33 299 28 4129 Fax: +33 299 28 9008
e-mail: karim.boudjema@chu-rennes.fr

Prof. Marco **BRAGA** (2006)
Dept. of Surgery, San Raffaele Hospital, Via Olgettina 60, 20132 Milan, ITALY
Specialty: Gastrointestinal Surgery
Fields of Interest: Pancreas, Colorectal, Nutrition
Tel.: +39 02 2643 2146 Fax: +39 02 2643 3012
e-mail: braga.marco@hsr.it

*Prof. Inge **BREKKE** (2002)
Grasteinv. 22, 1157 Oslo, Norway
Tel.: +47 2274 67 61
e-mail: inge.brekke@rikshospital.no

*Prof. Christoph E. **BROELSCH** (1993)
Sybel Str. 26, 40239, Düsseldorf, GERMANY
Specialty: HPB Surgery
Fields of Interest: Liver, Adult Liver Transplantation, Pediatric Liver Transplantation, Kidney Transplant, Research in Transplantation, Research in HPB
Tel.: + 49 211 641 6575 Fax: + 49 211 641 6576
e-mail: broelsch@gmx.de

Prof. Christiane Josephine **BRUNS** (2008)
Direktorin der Klinik und Poliklinik für
Allgemein-, Viszeral- und Tumorchirurgie, Kerpener Str. 62, 50937 Köln, GERMANY
Specialty: Oncological Surgery
Fields of Interest: Liver, Pancreas, Cancer, Research in HPB
Tel.: +49 172 863 2493
e-mail: christiane.bruns@uk-koeln.de

Prof. Markus W. **BÜCHLER** (1996)
Pancreatic, Hepatic, GI Surgery, Dept. of Surgery, University of Heidelberg, Im Neuenheimer Feld 110, 69120, Heidelberg GERMANY
Specialty: General Surgery, Gastrointestinal Surgery, HPB Surgery, Colorectal Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas, Oesophagus and Stomac, Bariatric Surgery, Colorectal, Endocrine, Cancer Adult Liver Transplantation, Kidney Transplant.
Tel.: +49 6221 56 6200 Fax: +49 6221 56 5450
e-mail: markus.buechler@med.uni-heidelberg.de

Prof. Leo Hans **BÜHLER** (2006)
Unité d'Investigations chirurigicales Département de chirurgie, Hôpital Cantonal Universitaire, 1211 Genève 14, SWITZERLAND
Specialty: General Surgery, Gastrointestinal Surgery
Fields of Interest: Transplantation, Research, Immunology
Tel.: +41 22 372 7698 Fax: +41 22 372 7689
e-mail: leo.buhler@hcuge.ch

Prof. Olivier R.C. **BUSCH** (2014)
Academic Medical Center, Dept. of Surgery, Meibergdreef 9, Amsterdam 1105 AZ. THE NETHERLANDS
Specialty: Gastrointestinal Surgery
Fields of Interest: Pancreas, Laparoscopy, Teaching, Cancer.
Tel.: +31 655 345 564
e-mail: o.r.busch@amc.uva.nl

Prof. Gordon L. **CARLSON** (2003)
Dept. of Surgery, Hope Hospital, Eccles Old Road, Salford, M6 8HD, UNITED KINGDOM
Specialty: Colorectal Surgery
Fields of Interest: Nutrition, Infection, Colorectal, Research in GI Disease
Tel.: +44 161 206 5655
e-mail: gordoncarlson@yahoo.co.uk

*Prof. Alain **CARPENTIER** (1993)
Hôpital Européen Georges Pompidou, 20 Rue Leblanc, 75015 Paris, FRANCE
Tel.: +33 1 5609 3601 Fax: +33 1 5609 3604
e-mail: alain.carpentier@hop.egp.ap-hop-paris.fr

*Sir David **CARTER** (1993)
19, Buckingham Terrace, Edinburgh EH4 3AD, UNITED KINGDOM
e-mail: davidc.carter@virgin.net

*Prof. Daniel **CASANOVA RITUERTO** (2015)
Universidad de Cantabria, Avda. de los Castros, s/n, 39005 Santander, SPAIN
Specialty: HPB surgery
Fields of Interest: Transplantation, Liver, Pancreas, Kidney Transplant, HPB Surgery, Endocrine Surgery
Tel: + 34 677 244 673
e-mail: daniel.casanova@unican.es

Prof. Wim **CEELEN** (2017)
Ghent University HospitaL, Department of Gastrointestinal Surgery, UZ Gent, route 1275, De Pintelaan 185, Corneel Heymanslaan 10, 9000 Ghent, BELGIUM
Specialty:
Fields of Interest:
Tel.: +32 47 46 21 810
e-mail: wim.ceelen@ugent.be

Prof. Daniel **CHERQUI** (1999)
Hôpital Paul Brousse, Unité d'Hospitalisation Chirurgie Hépatique, Biliaire et Pancréatique, 12-14 avenue Paul-Vaillant Couturier 94800 Villejuif, FRANCE
Specialty: General Surgery, Gastrointestinal Surgery
Fields of Interest: HPB, Laroscopic Surgery, Transplantation
Tel.: + 33 1 4559 3036 Fax:
e-mail: daniel.cherqui@aphp.fr

Prof. Laurence **CHICHE** (2007)
Service de Chirurgie, CHU Bordeaux, 1 Avenue Magellan, 33600 Pessac, FRANCE
Specialty: Gastrointestinal Surgery
Fields of Interest: HPB Surgery, Transplantation, Oncology
Tel.: +33 2 3106 5020 Fax: +33 2 3106 4468
e-mail: laurence.chiche@chu-bordeaux.fr

Prof. Pierre-Alain **CLAVIEN** (2002)
Dept. of Visceral and Transplantation Surgery, University Hospital Zurich, Raemistrasse 100, 8091 Zurich, SWITZERLAND
Specialty: HPB Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas, Research in HPB
Tel.: +41 44 255 3300 Fax: +41 44 255 4449
e-mail: clavien@access.uzh.ch

Prof. Kevin C.P. **CONLON** (2005)
AMNCH Tallaght Hospital - Trinity College Dublin, Department of Surgery, A96 C7R0 Co Dublin- IRELAND
Specialty: Oncological Surgery, General Surgery, Gastrointestinal Surgery, HPB Surgery, Endocrine Surgery
Fields of Interest: Biliary Tract, Oesophagus and Stomach, Pancreas, Endocrine, Cancer, Lapoaroscopy, Teaching, Research in HPB, Research in GI Disease, Pancreatitis.
Tel.: +353 1 221 5031
e-mail: profsurg@tcd.ie

Prof. Francesco **CORCIONE** (2014)
Azienda Ospedaliera Monaldi, Divisione di Chirurgia Generale, via E. Ruggieri, 80100, Napoli, ITALY
Specialty: General Surgery,
Fields of Interest: Oesophagus and Stomach, Colorectal, Abdominal Wall, Laparoscopy.
Tel.: +39 081 706 5145 Fax: +39 081 706 2285
e-mail: francesco.corcione@ospedalemonaldi.it

*Sir Alfred **CUSCHIERI** (1993)
Dept. of Surgery and Molecular Oncology, Ninewells Hospital and Medical School, University of Dundee, Dundee, UNITED KINGDOM
Specialty: Gastrointestinal Surgery
Fields of Interest: Biliary Tract, Pancreas, Oesophagus and Stomach
Tel.: +44 1382 632 174 Fax: +44 1382 641 795
e-mail: a.cuschieri@dundee.ac.uk

*Prof. Davide F. **D'AMICO** (1993)
Dept. of Surgery, Policlinico, Via Giustiniani 2, 35128 Padova, ITALY
Tel.: +39 49 821 2210 Fax: +39 49 65 6145
e-mail: davide.damico@unipd.i

Prof. André J.L. **D'HOORE** (2013)
Department of abdominal surgery, University Hospitals Leuven, Herestraat 49, 3000 Leuven,BELGIUM
Specialty:
Fields of Interest:
Tel.: +32 163 442 65 Fax: +32 163 448 32
e-mail: andre.dhoore@uzleuven.be

---

*Prof. Bernard D.H. **DE HEMPTINNE** (1993)
Dept. of Surgery, University Hospital, De Pintelaan 185, 9000 Gent, BELGIUM
Tel.: +32 9 240 3233 Fax: +32 9 240 3891
e-mail: bernard.dehemptinne@ugent.be

Prof. Nicolo **de MANZINI** (2014)
Ospedale di Cattinara, Chirurgia Generale, Strada di Fiume 447, 34149, Trieste, ITALY
Specialty: General Surgery
Fields of Interest: Colorectal, Laparoscopy, Bariatric Surgery
Tel.: +40 399 4121 Fax: +40 399 4152
e-mail: demanzini@units.it

Prof. George **DECKER** (2015)
Thoracic and Visceral Surgery, Hopitaux Robert Schuman Luxembourg, Zithaklinik Luxembourg & Consultant Thoracic Surgery, UZ-Leuven BELGIUM
Specialty: Thoracic surgery
Fields of Interest: Oesophagus and stomach, Cancer
Tel: + 352 48920 6400 Fax: +352 489290 5923
e-mail: gdcker@gmail.com

Prof. Cornelis H.C. **DEJONG** (2013)
Maastricht University Medical Center, Surgery, 6202 AZ Maastricht, THE NETHERLANDS
Specialty: Gastrointestinal Surgery, HPB Surgery, Oncological Surgery
Fields of Interest: Metabolism, Basic Science, Liver Failure and Regeneration
Tel.: +31 6 26882750
e-mail: chc.dejong@mumc.nl

*Prof. Jean Roberto R. **DELPERO** (2003)
Service de Chirurgie Générale, Institut J. Paoli et I. Calmettes, 13273 Marseille Cedex 9, FRANCE
Specialty: HPB Surgery
Fields of Interest: Liver, Pancreas, Cancer
Tel.: +33 491 22 3660 Fax: +33 491 22 3550
e-mail: CHIRURGIE1@ipc.unicancer.fr

Prof. Nicolas **DEMARTINES** (2005)
Dept. of Visceral Surgery , University Hospital of Lausanne CHUV, Oncologic surgery, transplantation, 1011 Lausanne, SWITZERLAND
Specialty: Gastrointestinal Surgery
Fields of Interest: Colorectal, Liver, Pancreas, Oesophagus and Stomach
Tel.: +41 79 556 0548
e-mail: demartines@chuv.ch

Prof. Christos **DERVENIS** (2008)
1st Dept. of Surgery, Agia Olga Hospital, 3-5 Agias Olga Street, 14233 Athens, GREECE
Specialty: General Surgery
Fields of Interest: Liver, Pancreas, Cancer
Tel.: +30 210 277 5467 Fax: +30 210 685 9749
e-mail: chrisder@otenet.gr

*Prof. Valerio **DI CARLO** (1999)
Cattedra di Chirurgia Generale, Universitá Vita-Salute San Raffaele, Hepatobilio-Pancreatic Surgery Pancreas Transplantation, Via Olgettina 60, 20132 Milano, ITALY
Tel.: +39 02 2643 2661 Fax: +39 02 2643 2871
e-mail: valeriodicarlo@hotmail.it

*Prof. Renzo **DIONIGI** (1993)
Dept. of Surgery, University of Pavia, Ospedale Multizonale di Varese, 21100 Varese, ITALY
Specialty: General Surgery
Fields of Interest:
Tel.: +39 033 227 8450 Fax: +39 033 226 0260
e-mail: renzo.dionigi@uninsubria.it

*Prof. Lorenzo **DOMINIONI** (2014)
Ospedale di Circolo, General and Thoracic Surgery, Viale Borri, 57. 21100, Varese, ITALY
Specialty: Thoracic Surgery
Fields of Interest: Cancer, Infection, Nutrition
Tel.: +39 332 278 868 Fax: +39 332 264 169
e-mail: lorenzo.dominioni@uninsubria.it

Prof. Frank **DOR** (2017)
West London Renal and Transplant Centre, Hammersmith Hospital, Imperial College, London, UNITED KINGDOM
Specialty: Transplantation
Fields of Interest: Kidney Transplant, Laparoscopy, Research in Transplantation, Liver Kidney Donation, Education
Tel.: +44 750 142 4418
e-mail: frank@dorgroot.com

Prof. Philipp **DUTKOWSKI** (2012)
Department of Surgery and Transplantation, University Hospital Zurich, Rämistr. 100, 8091 Zürich, SWITZERLAND
Specialty: Transplantation, Oncological Surgery, Gastrointestinal Surgery
Fields of Interest: Adult Liver Transplantation, Clinical Research, Teaching
Tel.: +41 44 255 4236
e-mail: philipp.dutkowski@usz.ch

Prof. Adam **DZIKI** (2016)
Medical University Lodz, Department of General and Colorectal Surgery, 90-157 Lodz, POLAND
Specialty: Cancer, Colorectal, Laparoscopy
Fields of Interest: Colorectal Surgery
Tel.: +48 42 639 3070
e-mail: adziki@wp.pl

*Prof. Albrecht **ENCKE** (1993)
Visceral Surgery GI and Hepatobiliary Surgery, Univ. Klinikum, Theodor-Stern-Kai 7, 60590 Frankfurt/Main, GERMANY
Tel.: +49 69 6301 5251 Fax: +49 69 6301 7452
e-mail: a.encke@em.uni-frankfurt.de

Prof. Olivier **FARGES** (2003)
Hôpital Beaujon, 100 Boulevard du Général Leclerc, 92118 Clichy, FRANCE
Specialty: Hepato-biliary, Pancratic Transplantation Surgery
Tel.: + 33 1 40 87 52 22 Fax: + 33 1 40 87 45 74
e-mail: olivier.farges@bjn.ap-hop-paris.fr

*Prof. Eduard H. **FARTHMANN** (1992)
GI and Oncol. Surgery, Traumatology, Immunology, Gumpensteige 21, 79104 Freiburg, GERMANY
e-mail: Eduard.farthman@t-online.de

*Prof. Laureano **FERNÁNDEZ-CRUZ** (1993)
Biliopancreatic Surgery, Hospital Clínic, c/Villarroel 170, 08036 Barcelona, SPAIN
Specialty: HPB Surgery
Fields of Interest: Pancreas, Endocrine, Laparoscopy, Transplantation
Tel.: +34 93 227 5559 Fax: +34 93 227 5769
e-mail: lfcruz@clinic.ub.es

Prof. Arnt **FIANE** (2016)
Oslo University Hospital, Department of Cardiothoracic Surgery, P.O.Box 4950 Nydalen, 0424, Oslo, NORWAY
Specialty: Cardiac surgery
Fields of Interest: Research in Transplantation, Immunology, Teaching, Heartb failure
Tel.: +47 23 07 0875
e-mail: afiane@ous-hf.no

*Prof. Joan **FIGUERAS** (2006)
HPB Surgical Oncology Division, Josep Trueta Hospital, Crta de Franca s/n, 17007 Girona, SPAIN
Specialty: HPB Surgery
Fields of Interest: Liver, Cancer, Pancreas, Biliary Tract
Tel.: +34 97 294 0256 Fax: +34 97 294 0270
e-mail: jfigueras.net@icloud.com

*Prof. Abe L. **FINGERHUT** (1993)
G.I. Surgery, Section for Surgical Research (Prof Uranues) Department of Surgery Medical University of Graz, 8036, Graz, AUTRALIA
Specialty: General Surgery
e-mail: abefingerhut@aol.com

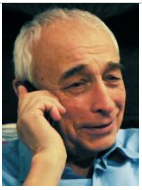
Prof. Peter J. **FRIEND** (2002)
Churchill Hospital, Oxford Transplant Centre, Headington, OX3 7LJ, Oxford, UNITED KINGDOM
Specialty: General Surgery
Fields of Interest: Liver, Kidney Transplant, Research in Transplantation,
Tel.: + 44 1865 223 872
e-mail: peter.friend@nds.ox.ac.uk

Prof. Helmut **FRIESS** (2003)
Klinik und Poliklinik für Chirurgie - Klinikum rechts der Isar der Technischen Universität München, Direktor Chirurgische Klinik und Poliklinik, 81675 Munich, GERMANY
Specialty: Oncological Surgery
Fields of Interest: Liver, Pancreas, Oesophagus and Stomach, Cancer
Tel.: +49 89 4140 2120
e-mail: helmut.friess@tum.de

Prof. Andrea **FRILLING** (2003)
Dept. of Biosurgery and Surgical Technology, Imperial College London, Hammersmith Hospital, Du Cane Road, London W12 0HS, UNITED KINGDOM
Specialty: Endocrine Surgery, Oncological Surgery, HPB surgery,
Fields of Interest: Cancer, Research in HPB, Liver, Biliary Tract, Pancreas, Endocrine
Tel.: +44 20 3313 3210 Fax: +41 20 3313 3963
e-mail: a.frilling@imperial.ac.uk

Prof. Josep **FUSTER OBRÉGON** (2009)
Dept. of Surgery, HPB Surgery, Liver Transplant Unit, Hospital Clinic, University of Barcelona, Villarroel 170, 08036 Barcelona, SPAIN
Specialty: General Surgery
Fields of Interest: HPB urgery, Transplantation, Oncology
Tel.: +34 93 227 5718 Fax: +34 93 227 5589
e-mail: jfuster@clinic.ub.es

Prof. Michael **GHADIMI** (2017)
University Medical Center, Dept of General, Visceral and Pediatric Surgery, Robert-Koch stasse 40, 37075 Gottingen – GERMANY
Specialty: Gastrointestinal Surgery
Fields of Interest: Pancreas, Oesophagus and Stomach, Colorectal
Tel.: +49 551 39 8730
e-mail: michael.ghadimi@chirurgie-goettingen.de



*Prof. Edward I. **GALPERIN** (1994)
Dept. of Liver Surgery, Moscow Sechenov Medical Academy Hospital 7, Kolomensky Pr. 4, Moscow 115446, RUSSIA
Specialty: HPB Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas, Cancer
Tel.: +7 095 118 8238 Fax: +7 095 118 8238
e-mail: dlsurgery@mtu-net.ru

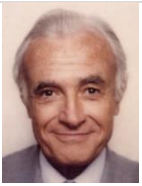
Prof. Juan Carlos **GARCIA-VALDECASAS SALGADO** (2008)
Hospital Clínic de Barcelona, Villarroel 170, 08036 Barcelona, SPAIN
Specialty: Gastrointestinal Surgery
Fields of Interest: HPB surgery, Laroscopic Surgery, Transplantation
Tel.: +34 93 227 5718 Fax: +34 93 227 5589
e-mail: jcvalde@clinic.ub.es

Prof. James O. **GARDEN** (1994)
Clincal Surgery, University of Edinburg, Royal Infirmary, 51 Little France Crescent, EH16 4SA, Edinburgh, UNITED KINGDOM
Specialty: HPB Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas, Research in HPB, Teaching
Tel.: + 44 754 077 8453
e-mail: ojgarden@ed.ac.uk

*Prof. Philippe **GERTSCH** (2006)
Visceral and Transplantation Surgery, University Hospital, Rämistrasse 100, 8091 Zurich, SWITZERLAND
Specialty: Generaly Surgery, Gastrointestinal Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas, Oesophagus and Stomach, Cancer, Pertoneal carcinomatosis
Tel.: +41 793 104 333
e-mail: philippegertsch@yahoo.it

*Prof. Karl-Erik **GIERCKSKY** (2002)
Dept. of Surgery, Rikshospitalet HF, 0027 Oslo, NORWAY
Specialty: Oncological Surgery
Fields of Interest: Colorectal, Cancer, Infection
Tel.: +47 2293 5739 Fax: +47 2293 5944
e-mail: karl-erik.giercksky@rikshospitalet.no

Prof. Jean-Francois **GIGOT** (1999)
Saint-Luc University Hospital, Hippocrate Avenue 10, 1200 Brussels, BELGIUM
Specialty: HPB Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas, Endocrine, Laparoscopy
Tel.: +32 2 764 1465 Fax: +32 2 764 8918
e-mail: jean-francois.gigot@uclouvain.be



*Prof. Robert **GIULI**, (2000)
3 Avenue FD Roosevelt, 75008 Paris, FRANCE
Specialty:
Fields of Interest: Oesogastric, Laparoscopic Surgery
Tel.: +33 1 5537 9015 Fax: +33 1 5537 9040
e-mail: robert.giuli@oeso.org

Prof. Olivier **GLEHEN** (2015)
CH Lyon Sud, Chirurgie Générale, Oncologique et Endocrinienne, 69495 Pierre Benite, FRANCE
Specialty: Oncological surgery
Fields of Interest: Peritoneal carcinomatosis, Oesophagus and stomach, Colorectal, Cancer, Research in GI diseas
Tel: + 33 6 32 95 76 71
e-mail: olivier.glehen@chu-lyon.fr

Prof. Michael **GNANT** (2014)
Medical University of Vienna, Department of Surgery, A-1090 Vienna, AUSTRIA
Specialty: General Surgery, Gastrointestinal Surgery, Breast Surgery
Fields of Interest: Clinical Research, HPB Surgery, Oncological Surgery
Tel.: +43 699 1006 52 80
e-mail: michael.gnant@meduniwien.ac.at

---

*Prof. Joao M. **GODINHO DE QUEIROZ** (1995)
Director Dept. of Cardiac Surgery, Hospital de Santa Cruz, Carnaxide 2795 Linda-a-Velha, Lisbon, PORTUGAL
Tel.: +351 214 163 466 Fax: +351214 163 3479
e-mail: jqmelo@hsc.min-saude.pt

*Prof. Finn **GOTTRUP** (2008)
Dept. of Dermatology, D42, Copenhagen Wound Healing Center, Bispebjerg Hospital, 2400 Copenhagen, DENMARK
Specialty: General Surgery, Gastrointestinal Surgery
Fields of Interest: Wound Healing
Tel.: +45 3531 2245 Fax: +45 3531 3724
e-mail: fgottrup@post4.tele.dk

*Prof. Dirk J. **GOUMA** (1994)
Dept. of Surgery, Academic Medical Center, Room G4-116, Meibergdreef 9, 1105 AZ Amsterdam, THE NETHERLANDS
Specialty: HPB Surgery
Fields of Interest: Biliary Tract, Pancreas, Laparoscopy, Research in HPB
Tel.: +31 20 566 3067 Fax: +31 20 691 4858
e-mail: d.j.gouma@amc.uva.nl

Prof. Luis **GRANDE** (2010)
Surgery Division, Hospital del Mar, Passeig Marítim 25-29, 08003 Barcelona, SPAIN
Specialty: Oncological Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas, Oesophagus and Stomach
Tel.: +34 93 248 3450 Fax: +34 93 248 3433
e-mail: lgrande@hospitaldelmar.org

*Prof. Roger M. **GREENHALGH** (1998)
Dept. of Surgery, Charing Cross Hospital, Fullham Palace Road, London W6 8RF, UNITED KINGDOM
Specialty: Vascular Surgery
Tel.: +44 181 846 7316 Fax: +44 181 846 7330
e-mail: r.greenhalgh@ic.ac.uk

Prof. Michael **GRIFFIN** (2003)
Royal Victoria Infirmary, Northern Oesophago-Gastric Unit, NE1 4LP, Newcastle Upon Tyne, UNITED KINGDOM
Specialty: Gastrointestinal Surgery
Fields of Interest: Oesophagus and Stomach, Therapeutic Endoscopy
Tel.: +44 777 615 1631
e-mail: michael.griffin@nuth.nhs.uk

Prof. Jean **GUGENHEIM** (2003)
Chirurgie Digestive, Centre de Transplantation Hépatique, Hôpital de l'Archet II, 151, route Saint-Antoine de Ginestière, BP 3079, 06202 Nice Cedex 3, FRANCE
Specialty: HPB Surgery
Fields of Interest: Liver, Bariatric Surgery, Biliary Tract, Cancer
Tel.: +33 4 9203 6476 Fax: +33 4 9203 6562
e-mail: gugenheim.j@chu-nice.fr

Prof. Alfredo **GUGLIELMI** (2013)
University School of Medicine, Ospedale Policlinico Borgo Roma, Piazzale Stefani 10, 37134 Verona, ITALY
Specialty: HPB Surgery
Fields of Interest: Research in HPB, Colorectal Cancer, Biliary Tract, Liver
Tel.: +39 045 812 44 64 Fax: +39 045 802 74 64
e-mail: alfredo.guglielmi@univr.it

Christian **GUTSCHOW** (2016)
University Hospital Zurich, Department Surgery and Transplantation, 8091 Zürich, SWITZERLAND
Specialty: Gastrointestinal Surgery
Fields of Interest: Oesophagus and Stomach, Laparoscopic Surgery, Bariatric Surgery, Research in GI Disease
Tel.:
e-mail: christian.gutschow@usz.ch

*Prof. Norbert P. **HAAS** (1999)
Trauma and Reconstructive Surgery, Klinik für Unfall- und Wiederherstellungschirurgie, Charité, Univ. Campus Virchow Klinikum, 13353, Berlin, GERMANY
Specialty: Trauma surgery, Orthopedic Surgery
Fields of Interest: Geriatric, Teaching
Tel.: +49 30 45055 2012 Fax: +49 30 45055 2901
e-mail: norbert.haas@charite.de

Prof. Nagy **HABIB** (2011)
Division of Surgery, Imperial College London, Hammersmith Campus, Du Cane Road, London W12 0NN, UNITED KINGDOM
Specialty: Gastrointestinal Surgery
Fields of Interest: Pancreas, Colorectal, Laparoscopy Reflux Research, Laparoscopic Surgery, Teaching
Tel.: +44 203 313 8574 Fax: +44 203 313 3212
e-mail: nagy.habib@imperial.ac.uk

Prof. Caj **HAGLUND** (2010)
Dept. of Surgery, Helsinki University Central Hospital, P.O. Box 340, 00029 HUS Helsinki, FINLAND
Specialty: Gastrointestinal Surgery
Fields of Interest: Research, Teaching, Laparoscopic Surgery
Tel.: +358 9 4717 2427 Fax: +358 9 4717 1403
e-mail: caj.haglund@hus.fi

*Prof. Ulf **HAGLUND** (1994)
Dept. of Surgery, University Hospital, 751 85 Uppsala, SWEDEN
Specialty: General Surgery
Fields of Interest: Liver, Biliary Tract, Oesophagus and Stomach, Pancreas, Adult Liver Transplantation, Research in GI Disease
Tel.: +46 18 611 4602 Fax: +46 18 556 808
e-mail: ulf.haglund@akademiska.se

Prof. Dieter **HAHNLOSER** (2014)
University Hospital, Department of Visceral Surgery, 46 rue du Bugnon, 1011, Lausanne, SWITZERLAND
Specialty: Colorectal Surgery
Fields of Interest: Colorectal, Laparoscopy, Cancer
Tel.: +41 21 314 2406
e-mail: dieter.hahnloser@chuv.ch

*Prof. Bertil **HAMBERGER** (1994)
Dept. of Surgery, Karolinska Hospital, 17176 Stockholm, SWEDEN
Specialty: Endocrine Surgery
Fields of Interest: Endocrine
Tel.: + 46 707 458 966 Fax: +
e-mail: bertil.hamberger@ki.se

Prof. Jacob Frans **HAMMING** (2008)
Leiden University Medical Center, Surgery, 2333ZA Leiden, THE NETHERLANDS
Specialty: Vascular Surgery
Fields of Interest: Research, teaching, Laparoscopic Surgery
Tel.: +31 652 894 402
e-mail: j.f.hamming@lumc.nl

Prof. George **HANNA** (2013)
Academic Surgery Unit, 10th Floor, QEQM Building, St Mary's Hospital, Praed Street, London, UNITED KINGDOM
Specialty: General Surgery
Fields of Interest: Upper Gastrointestinal
Tel.: +44 203 312 21 24 Fax: +44 203 312 63 09
e-mail: g.hanna@imperial.ac.uk

*Prof. Felix **HARDER** (1993)
General Surgery, Gastrointestinal and Breast Surgery, Rittergasse 27, 4051 Basel, SWITZERLAND
Specialty: General Surgery, Colorectal Surgery, Breast Surgery,
Fields of Interest: Colorectal Surgery
Tel.: +41 61 271 4640
e-mail: harder.felix@vtxmail.ch

*Mr. Peter R. **HAWLEY** (1994)
Regents Park, 35 Chester Close North, London NW1 4JE, UNITED KINGDOM
Specialty: Colorectal Surgery
Tel.: + 41 020 793 567 988
email: prhawley1@aol.com

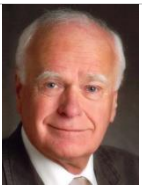
Prof. Doris **HENNE-BRUNS** (2003)
University Hospital Ulm, Dept. of General and Visceral Surgery, 89075 Ulm, GERMANY
Specialty: Gastrointestinal Surgery, HPB Surgery, Oncological Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas, Colorectal, Cancer
Tel.: +49 172 881 6033
e-mail: doris.henne-bruns@uniklinik-ulm.de

*Prof. Krister A.V. **HÖCKERSTEDT** (1993)
Transplantation and Liver Surgery Unit, Helsinki University Hospital, Kasarmikatu 11, 00130 Helsinki, FINLAND
Specialty: Transplantation
Fields of Interest: Liver, Adult Liver Transplantation, Research in Transplantation, Research in HPB
Tel.: +358 9 4718 8271 Fax: +358 9 174 975
e-mail: krister.hockerstedt@hus.fi

*Prof. Arnulf **HÖLSCHER** (2003)
Klinik und Poliklinik für Allgemein, Viszeral und Tumorchirurgie, Kerpener Strasse 62, 50937 Cologne, GERMANY
Specialty: Gastrointestinal Surgery, General Surgery, HPB Surgery, Colorectal Surgery, Oncological Surgery
Fields of Interest: Oesophagus and Stomach, Research in GI Disease, Laparoscopy
Tel.: +49 221 478 4801 Fax: +49 221 478 4843
e-mail: arnulf.hoelscher@uk-koeln.de

*Prof. Örs Péter **HORVÁTH** (2008)
Dept. of Surgery, Medical University of Pécs, 7624 Pécs, HUNGARY
Specialty: Gastrointestinal Surgery
Fields of Interest: Oesophagus and Stomach, Cancer, Laparoscopy
Tel.: +36 72 536 126 Fax: +36 72 536 127
e-mail: OPHorvath@clinics.pote.hu

*Prof. Claude **HUGUET** (1993)
Digestive Surgery, Barzalondeya, 64250 Cambo Les Bains, FRANCE
Specialty: HPB Surgery, Colorectal surgery
Fields of Interest: Liver , Pancreas, Colorectal
email: huguetcla@wanadoo.fr



*Prof. Ingemar **IHSE** (1993)
Practicum, Lund University Hospital, 22185 Lund, SWEDEN
Specialty: General Surgery, HPB surgery
Fields of Interest:Liver, Biliary Tract, Pancreas, Teaching
Tel.: +46 46 132349 Fax: + 46 70 6940545
email: Ingemar.Ihse@skane.se

*Prof. Helena **ISONIEMI** (2011)
Dept. of Transplantation and Liver Surgery Clinic, Helsinki University Hospital, Haartmaninkatu 4, 00029 Huch Helsinki, FINLAND
Specialty: General Surgery
Fields of Interest: Liver, Adult Liver Transplantation, Research in HPB, Research in Transplantation
Tel.: +358 50 427 0246 Fax: +358 9 174 975
e-mail: helena.isoniemi@hus.fi

Prof. Jakob R. **IZBICKI** (2000)
University Hospital Hamburg Eppendorf, General Surgery, 20246 Hamburg, GERMANY
Specialty: Gastrointestinal Surgery, Thoracic Surgery, General Surgery
Fields of Interest: Pancreas, Oesophagus and Stomach, Cancer, Bariatric Surgery
Tel.: +49 15 2228 15538
e-mail: izbicki@uke.de

*Prof. Daniel M. **JAECK** (1994)
Hepatic and Pancreatic Surgery, Liver TP 1,rue de Zurich, 67000 Strasbourg, FRANCE
Specialty: HPB Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas, Cancer
Tel.: +33 3 8835 09 73
e-mail: daniel.jaeck@noos.fr

*Prof. Johannes J. **JEEKEL** (1993)
Erasmus MC Rotterdam, P.O. Box 2040, 3000 CA Rotterdam, THE NETHERLANDS
Specialty:
Fields of Interest: Colorectal, Abdominal Wall
Tel.: + 31 654 736 337
e-mail: j.jeekel@erasmusmc.nl

*Prof. Bengt W. **JEPPSSON** (1996)
Dept. of Surgery, Malmö University Hospital, 20502 Malmö, SWEDEN
Specialty: Gastrointestinal Surgery
Fields of Interest: Liver, Colorectal, Infection, Nutrition, Research in GI Disease
Tel.: +46 40 333 760 Fax: +46 40 927 877
e-mail: Bengt.Jeppsson@med.lu.se

Prof. Sven **JONAS** (2010)
Dept. of Hepato-Pancreato-Biliary Surgery, Dept. of Visceral Surgery, 90411 Nuremberg, GERMANY
Specialty: HPB Surgery
Fields of Interest: Laparoscopy, Biliary Tract, Oesophagus and Stomach, Colorectal
Tel.: +49 172 449 4455
e-mail: svnjns@gmail.com

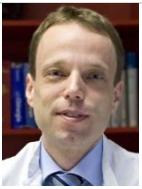
Prof. Aleksandar **KARAMARKOVIC** (2017)
Clinic for Emergency Surgery, University Clinical Center, HPB Service, Pasteur 2 Str, Belgrade , SERBIA
Specialty: General Surgery, Surgery
Fields of Interest: Liver, Pancreas, Biliary Tract
Tel.: +381 66 83 00040 Fax: +381 11 30 65 604
e-mail: alekara@sbb.rs

Prof. Alex H.E. **KARTHEUSER** (2013)
Cliniques Universitaires St-Luc, Colorectal Surgery Unit, 10, Avenue Hippocrate,1200 Brussels, BELGIUM
Specialty: Colorectal Surgery
Fields of Interes: Laparoscopy, Inflammatory Bowel Disease, Pelvic Floor Disorders, SILS, Fast-Track, Colorectal Cancer
Tel.: +32 475 85 95 03
e-mail: alex.kartheuser@uclouvain.be

*Prof. Henrik **KEHLET** (2003)
Section for Surgical Pathophysiology 4074 The Juliane Marie Centre, Rigshospitalet, Blegdamsvej 9, 2100 Copenhagen, DENMARK
Specialty: General Surgery
Fields of Interest: Colorectal, Abdominal Wall, Nutrition, Pathophysiology, Outcome
Tel.: +45 3545 40 74 Fax: +45 3545 65 43
e-mail: henrik.kehlet@rh.regionh.dk

Prof. Michael **KERIN** (2012)
National University of Ireland, Galway, Surgery, H91 TK33 Galway, IRELAND
Specialty: General Surgery, Breast Surgery, Endocrine *Surgery:*
Fields of Interest:
Tel.: +353 87 2344735
e-mail: michael.kerin@nuigalway.ie

*Prof. Paul C.A. **KINNAERT** (1993)
Transplantation, Endocrine Surgery, Route du Rôteu 14, 4960 Mont-Malmedy, BELGIUM
Tel.: + 32 277 1232



Prof. Jörg **KLEEFF** (2009)
Martin-Luther-University Halle-Wittenberg, Departement of Surgery, 6120 Halle (Saale), UNITED KINGDOM
Specialty: Gastrointestinal Surgery
Fields of Interest: Pancreas, Cancer, Research in HPB
Tel.: +49 34 5557 2314
e-mail: joerg.kleeff@uk-halle.de

*Prof. Marek **KRAWCZYK** (2007)
Dept. of General, Transplant and Liver Surgery, Medical University of Warsaw, 1A Banacha Str., 02-097 Warsaw, POLAND
Specialty: HPB Surgery, Oncological Surgery
Fields of Interest: Liver, Biliary Tract, Adult Liver Transplantation, Pancreas
Tel.: +48 22 599 2546 Fax: +48 22 599 1545
e-mail: marek.krawczyk@wum.edu.pl

Prof. Mario **LACHAT** (2011)
Clinic for Heart and Vascular Surgery, University Hospital Zurich, Rämistrasse 100, 8091 Zurich, SWITZERLAND
Specialty: Vascular Surgery
Fields of Interest: Teaching, Geriatric, Abdominal Wall, Adult Liver Transplantation
Tel.: +41 79 524 3980
e-mail: mario.lachat@usz.ch

Prof. Hauke **LANG** (2017)
Department of General, Visceral and Transplant Surgery, University Hospital Johannes Gutenberg University, University of Mainz, Langenbeckstrass 1, 55131 Mainz, GERMANY
Specialty: HPB Surgery
Fields of Interest: Liver, Pancreas, Biliary Tract, Cancer, Adult Liver Transplantation, Research in HPB
Fax: +381 11 30 65 604
e-mail: hauke.lang@unimedizin-mainz.de

Prof. Johanna **LAUKKARINEN** (2016)
Dept. of Gastroenterology and Alimentary Tract Surgery, Tampere University Hospital, Tampere, FINLAND
Speciality: Pancreatic surgery
Fields of interest: Pancretic tumors, pancreatitis, pancreatic surgery.
Tel.: +35 850 358 6556
e-mail: johanna.laukkarinen@fimnet.fi

***Prof. Franck J. **LAZORTHES** (1993)
Hôpital Purpan, Place du Docteur Baylac, 31509 Toulouse, FRANCE
Tel.: +33 561 772 530 Fax: +33 561 777 615
e-mail: lazorthes.f@gmail.com

Prof. Mickaël **LESURTEL** (2017)
Department of Visceral Surgery and Liver Transplantation, Croix Rousse University Hospital, Hospices Civils de Lyon, FRANCE
Tel.: +33 4 72 07 11 00
e-mail: mickael.lesurtel@chu-lyon.fr

***Prof. Yves Patrice. **LE TREUT** (2008)
Chirurgie Générale et Transplantation hépatique.Hôpital de la Timone11ème étage, 264 rue Saint Pierre, 13005 Marseille, FRANCE
Specialty: General Surgery, Transplantation
Fields of Interest: Liver, Pancreas, Biliary Tract, Adult Liver Transplantation, Endocrine
Tel.: +33 4 9138 3658 Fax: +33 4 9138 1655
e-mail: ypLeTreut@ap-hm.fr

Prof. Dink A. **LEGEMATE** (2011)
Dept. of Surgery, Academic Medical Center, University of Amsterdam, Meibergdreef 9, 1005 AZ Amsterdam, THE NETHERLANDS
Specialty: Vascular Surgery
Fields of Interest: Clinical Epidemiology, Governance, Vascular Disease
Tel.: +31 20 566 7832 Fax: +31 20 566 9432
e-mail: d.a.legemate@amc.uva.nl

*Prof. Paul **LEHUR** (2012)
University Hospital, Institut des maladies de l'appareil digestif (Imad), Hôtel-Dieu, 1 place Alexis Ricordeau, 44035 Nantes cedex, FRANCE
Specialty: Gastrointestinal Surgery
Fields of Interest: Colorectal, Teaching
Tel.: +33 2 4008 3022 Fax: +33 2 4008 3036
e-mail: paulantoine.lehur@chu-nantes.fr

Prof. Benoît **LENGELÉ** (2008)
University Hospitals St. Luc, Dept. of Plastic and Reconstractive Surgery, Avenue Hippocrates 10, 1200 Brussels, BELGIUM
Specialty: Plastic Surgery
Fields of Interest: Cancer, Reconstructive Surgery, Composite Tissue, Allotransplantation
Tel.: +32 472 52 35 36
e-mail: benoit.lengele@uclouvain.be

*Prof. Mauri **LEPÄNTALO** (2006)
Dept. of Vascular Surgery, Helsinki University Hospital, 00029 Hus Helsinki, FINLAND
Specialty: Vascular Surgery
Fields of Interest: Abdominal Wall
Tel.: +358 9 4717 4451
e-mail: mauri.lepantalo@hus.fi

Prof. Ari Kalevi **LEPPÄNIEMI** (2007)
Dept. of Surgery, University of Helsinki, Meilahti Hospital, Abdominal Center, Division of Emergency Surgery, 00029HUS Hus Helsinki, FINLAND
Specialty: General Surgery, Gastrointestinal Surgery
Fields of Interest: Abdominal Wall, Pancreas, Teaching, Trauma Surgery, Emergency Surgery
Tel.: +358 50 427 1281
e-mail: ari.leppaniemi@hus.fi

*Prof. Jan I. M. **LERUT** (1999)
Department of abdominal and transplantation surgery, University Hospitals Saint Luc, Av. Hippocrates 10, 1200 Brussels, BELGIUM
Specialty: Transplantation
Fields of Interest: Liver, Transplantation, Abdominal Wall, Research in Transplantation
Tel.: +32 2 764 1412 or 764 1401 Fax: +32 2 764 9039
e-mail: jan.lerut@uclouvain.be

*Prof. Toni M.E. **LERUT** (1993)
Dept. of Thoracic Surgery, University Hospital Gasthuisberg, Herestraat 49, 3000 Leuven, BELGIUM
Specialty: Thoracic Surgery
Fields of Interest: Oesophagus and Stomach, Cancer, Geriatric, Lung, Lung Transplantation
Tel.: +32 16 346 820 Fax: +32 16 346 821
e-mail: Toni.Lerut@med.kuleuven.be

*Prof. Emmanuele **LEZOCHE** (2002)
Dept. of Surgery "Paride Stefanini", University of Rome "La Sapienza", Policlinico Umberto I, University Hospital of Ancona, Viale del Policlinico 155, 00161 Rome, ITALY
e-mail: emanuele.lezoche@gmail.com

Prof. Pal-Dag **LINE** (2011)
Dept. of Organ Transplantation, Oslo University Hospital, Department of Transplantation Medicine, 424 Oslo, NORWAY
Specialty: General Surgery
Fields of Interest: Liver, Adult Liver Transplantation, Cancer, Abdominal Vascular Surgery
Tel.: +47 9303 0073
e-mail: p.d.line@medisin.uio.no

Prof. J. Peter A. **LODGE** (2012)
HPB and Transplant Unit, Bexley Wing Level 3, St James's University Hospital, Leeds LS9 7TF, UNITED KINGDOM
Specialty: General Surgery, Gastrointestinal Surgery, HPB Surgery
Fields of Interest: Liver resection, Biliary Tract, Liver Transplantation, Bariatric Surgery
Tel.: + 44 113 206 48 90 Fax: + 44 113 244 81 82
e-mail: peter.lodge@nhs.net

*Prof. Ricardo **LOZANO** (2002)
Hospital Clinico Universitario, Avda San Juan Bosco 15, 50009 Zaragoza, SPAIN
Specialty:
Fields of Interest:
Tel.: +34 976 556400 / 976 768884 Fax: +43 976 227936
e-mail: rilozma@posta.unizar.es

Prof. Pietro Edoardo **MAJNO** - **HURST** (2015)
Servizio di Chrurgia, Ospedale Regionale di Lugano, 6900 Lugano, SWITZERLAND
Specialty: HPB surgery
Fields of Interest: Liver, Biliary tract, Adult liver, Pediatric liver transplantation, Research in HPB, Research in transplantation
Tel: + 41-792204330
e-mail: pietro.majno-hurst@eoc.ch

*Prof. Michel **MALAFOSSE** (1993)
6 rue de l'Abbé Gillet, 75016 Paris, FRANCE
Tel.: +33 1 4647 6782
e-mail: mmalaf@club-internet.fr

*Prof. Raimund **MARGREITER** (1993)
Dept. of Visceral-, Transplant- and Thoracic Surgery, Anichstrasse 35, 6020 Innsbruck, AUSTRIA
Specialty: General Surgery
Fields of Interest: Kidney Transplant, Adult Liver Transplantation, Pediatric Liver Transplantation, Liver, Biliary Tract, Pancreas
Tel.: +43 512 5042 2600 Fax: +43 512 5042 2602
e-mail: Raimund.MARGREITER@tirol-kliniken.at

*Sir. Paul **McMASTER** (1993)
Hepatobiliary Surgery and Transplantation, Lilac Cottage, Ombersley Road, High Park, Droitwich WR9 0AG, UNITED KINGDOM
Tel.: +44 1905 776 961
e-mail: p.mcmaster@virgin.net

*Prof. Jonathan Larmonth **MEAKINS** (2005)
Apt. 21, 1509 Sherbrooke St. W., Montreal, Queb H3G 1M1, CANADA
Specialty: General Surgery, Infectious Desease
Tel.: +1 514 750 02 80 Fax: +1 450 826 44 67
e-mail: jonathan.meakins@videotron.ca

Prof. Jukka **MECKLIN** (2011)
Dept. of Surgery, Jyväskylä Central Hospital, Keskussairaalantie 19, 40620 Jyväskylä, FINLAND
Specialty: Gastrointestinal Surgery, Colorectal Surgery
Fields of Interest: Colorectal, Cancer, Research in GI Disease, Hereditary Cancer, Surgical Skills, Training
Tel.: +358 50 361 5920 Fax: +358 14 269 3626
e-mail: jukka-pekka.mecklin@ksshp.fi

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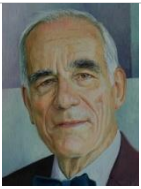
*Prof. Christian **MEYER** (1996)
Centre de Chirurgie Viscerale et de Transplantation, Hôpital Universitaire de Hautepierre, Avenue Molière, 67098 Strasbourg Cedex, FRANCE
Tel.: +33 3 8812 7239 Fax: +33 3 8812 7238
e-mail: Christian.Meyer@chru-strasbourg.fr

*Prof. Bertrand L.M. **MILLAT** (1998)
Dig. Surgery Unit, Hôpital St. Eloi, 34295 Montpellier, Cedex 5, FRANCE
Specialty:
Fields of Interest: Laparoscopy, Surgery Digestive
Tel.: +33 467 337106 or 05 Fax: +33 467 337424
e-mail: b-millat@chu-montpellier.fr

Prof. Pawel **MROCZKOWSKI** (2016)
University of Magdeburg, Leipziger Str. 44, 39120 Magdeburg, GERMANY
Specialty:
Fields of Interest:
Tel.:
e-mail: p.mroczkowski@vinzenz-verbund.de



*Prof. emeritus dr Jan C. **MOLENAAR** (1993)
Kastanjeplein 105, 3053 CB Rotterdam, THE NETHERLANDS
Specialty: General Surgery
Fields of Interest: Pediatric Surgery
Tel.: +31 10 422 4777
e-mail: j.molenaar@erasmusmc.nl

Prof. John R.T. **MONSON** (2002)
Center for Colon and Rectal Surgery, Center for Colon and Rectal Surgery, 32803 Orlando, USA
Specialty: Colorectal Surgery
Fields of Interest: Colorectal, Cancer, Laparoscopy, Teaching
Tel.: +1 585-754-4056
e-mail: john.monson.md@flhosp.org

Prof. Marco **MONTORSI** (2005)
Humanitas University, Department of Surgery
Humanitas Research Hospital, Via Manzoni 113, 20089 Rozzano MI, ITALY
Specialty: General Surgery
Fields of Interest: Pancreas, Colorectal, Laparoscopy
Tel.: +39 02 8224 4071 Fax: +39 02 8224 4509
e-mail: marco.montorsi@humanitas.it

Prof. Philippe **MOREL** (2002)
Clinique et Policlinique de Chirurgie viscérale, HUG - Hôpital Cantonal, 1211 Genève 14, SWITZERLAND
Specialty: Surgery, Transplantation
Fields of Interest: Abdominal Organs
Tel.: +41 22 372 7702 Fax: +41 22 372 7755
e-mail: philippe.morel@hcuge.ch

*Prof. Enrique **MORENO GONZALEZ** (1993)
Servicio de Cirurgia, Ap. Digestivo II Hospital 12 de Octobre, Carretera de Andalucia, Km 5.5, 28041 Madrid, SPAIN
Tel.: +34 91 390 8329 Fax: +34 91 390 8523
e-mail: emorenog.hdoc@salud.madrid.org

Prof. Mario **MORINO** (1999)
Digestive Surgery - minimal invasive surgery Chirurgia I, Ospedale San Giovanni Battista, Universitá di Torino, Corso Dogliotti 14, 100133 Torino, ITALY
Specialty: Gastrointestinal Surgery, Colorectal surgery
Fields of Interest: Laparoscopy, Colorectal, Bariatric Surgery
Tel.: +39 011 631 3149 Fax: +39 011 631 2548
e-mail: mario.morino@unito.it

*Sir Peter J. **MORRIS** (1993)
General Surgery Vascular Surgery Transplantation, The Royal College of Surgeons of England, 35-43 Lincolns Inn Fields, London, WC2A 3PE, UNITED KINGDOM
Specialty: Transplantation
Fields of Interest: Kidney Transplant, Pancreas, Evaluation of Evidence, Infection
Tel.: +44 207 869 6000 Fax: +44 207 869 6005

Prof. Dion **MORTON** (2011)
Academic Dept. of Surgery, College of Medical and Dental Sciences, School of Cancer Sciences, University of Birmingham and University Hospital Birmingham NHS Foundation Trust, Room 32, Birmingham B15 2HT, UNITED KINGDOM
Specialty: Colorectal Surgery
Fields of Interest: Colorectal, Cancer
Tel.: +44 121 627 2276 Fax: +44 121 472 1230
e-mail: dion.morton@uhb.nhs.uk

Prof. Pawel **MROCZKOWSKI** (2016)
Elisabeth-Krankenhaus, Weinbergstr. 7, 34117 Kassel, GERMANY
Specialty: Colorectal surgery
Fields of Interest: Cancer, Pancreas, Colorectal
Tel.: +49 561 7201143
e-mail: p.mroczkowski@vinzenz-verbund.de

Prof. Paolo **MUIESAN** (2017)
Liver Unit, Nuffield House, Queen Elizabeth Hospital, Edgbaston-, Birmingham, Liver Unit, 3rd floor, Nuffield House, B16 2TH Birmingham, UNITED KINGDOM
Specialty: Transplantation
Fields of Interest: Adult Liver Transplantation, Pediatric Liver Transplantation, Liver
Tel.: +44 (0) 7852 191002
e-mail: paolo.muiesan@uhb.nhs.uk

Prof. Philippe **NAFTEUX** (2017)
UZ Leuven, Department of Thoracic Surgery, Herestraat 49, 3000 Leuven, BELGIUM
Specialty: Thoracic Surgery
Fields of Interest: Oesophagus and Stomach, Cancer, Teaching, Lung
Tel.: 0032496741309
e-mail: philippe.nafteux@uzleuven.be

Prof. Peter **NAREDI** (2009)
Sahlgrenska University Hospital, Department of Surgery, 41345 Gothenburg, SWEDEN
Specialty: General Surgery
Fields of Interest: Liver, Pancreas, Cancer
Tel.: +46 70 68 14 981
e-mail: peter.naredi@gu.se

Prof. Slawomir **NAZAREWSKI** (2015)
Medical University of Warsaw, Department of General, Vascular and Transplant Surgery, Banacha 1a, 02-097 Warszawa, POLAND
Specialty: Vascular surgery, Transplant surgery
Fields of Interest: Open and endovascular aortic aneurysm repair, Kidney transplantation Pancreas transplantation, , surgical site infections, teaching,Research in transplantation
Tel: + 48 22 599 2467 Fax: + 48 22 599 1468
e-mail: slawomir.nazarewski@wum.edu.pl

*Prof. Peter **NEUHAUS** (1993)
Klinik für Allgemein, Viszeral und Transplantationschirurgie, Charité, Campus Virchow-Klinikum, Augustenburger Platz 1, 13353 Berlin, GERMANY
Specialty: Transplantation, Oncological Surgery
Fields of Interest: Liver, Biliary Tract, Adult Liver Transplantation
Tel.: +49 30 450 552 001 Fax: +49 30 450 552 900
e-mail: peter.neuhaus@charite.de

Prof. Isto **NORDBACK** (2009)
Pirkanmaa Hospital District (Tampere University Hospital), P.O. Box 2000, 33521 Tampere, FINLAND
Specialty: Gastrointestinal Surgery
Fields of Interest: Pancreas
Tel.: +358 3 3116 4608 Fax: +358 3 3116 5548
e-mail: isto.nordback@pshp.fi

*Prof. Bernard **NORDLINGER** (2003)
Service de Chirurgie Générale, Digestive et Oncologique, Hôpital Ambroise Pare, 9 Avenue Charles de Gaulle, 92100 Boulogne, FRANCE
Tel.: +33 1 4909 5586 Fax: +33 1 4909 5869
e-mail: bernard.nordlinger@apr.ap-hop-paris.fr

*Prof. Lars **NORGREN** (2003)
Dept. of Surgery, Örebro University Hospital, 70185 Örebro, SWEDEN
Specialty: Vascular Surgery
Fields of Interest: Vascular
Tel.: +46 19 602 6530 Fax: +46 19 125 439
e-mail: lars.norgren@orebroll.se

*Prof. Wojciech **NOWAK** (2009)
Chairman and Head of III Dept.of Surg., Jagiellonian University, 35-37 Pradnicka St., 31-202 Krakow, POLAND
Tel.: +48 12 424 8007 Fax: +48 12 424 8007
e-mail: msnowakw@cyf-kr.edu.pl

*Prof. Gennaro **NUZZO** (1996)
Chairman Dept. of Surgery, Catholic University Sacro Cuore, Largo Agostino Gemelli 8, 00168 Rome, ITALY
Tel.: + 39 06 3015 4967 or 3015 5187 Fax: +39 06 305 8586
e-mail: chirucsc@rm.unicatt.it

Prof. Ronan P. **O'CONNELL** (2003)
University College Dublin, St. Vincent's University Hospital, Surgical Professorial UNit, D04 T6F4 Dublin, IRELAND
Specialty: Gastrointestinal Surgery, Colorectal Surgery
Fields of Interest: Colorectal, Cancer, Laparoscopy, Research in GI Disease, Pelvic floor physiology, inflammatory bowel disease
Tel.: +353 872 535 949
e-mail: ronan.oconnell@ucd.ie

Prof. Patrick J. **O'DWYER** (2012)
29 Westbourne Gardens, Glasgow, G12 9PF, UNITED KINGDOM
Specialty: Gastrointestinal Surgery
Fields of Interest: Hernia, Retroperitoneal Surgery, Colon Cancer
Tel.: +44 77 6038 73 88 Fax: +44 141 357 47 25
e-mail: pjod2j@clinmed.gla.ac.uk

*Prof. Huug **OBERTOP** (1993)
Tesselschadestraat 7, 1054 ET Amsterdam, THE NETHERLANDS
Specialty: Gastrointestinal Surgery
Fields of Interest: Biliary Tract, Pancreas, Oesophagus and Stomach
Tel.: +31 20 685 5109 Fax: +31 65 134 0010
e-mail: h.obertop@gr.nl

Prof. Attila **OLAH** (2008)
Surgical Dept., Petz Aladár County Teaching Hospital, 9024 Györ, HUNGARY
Specialty: HPB Surgery
Fields of Interest: Pancreas, Liver
Tel.: +36 96 503 320 Fax: +36 507 936
e-mail: drolaha@gmail.com

Prof. Michael **OLAUSSON** (2006)
Dept. of Surgery, Sahlgren's University Hospital, 41345 Gothenburg, SWEDEN
Specialty: General Surgery
Fields of Interest: Liver, Adult Liver Transplantation, Research in Transplantation, Pediatric Liver Transplantation, Kidney Transplant
Tel.: +46 31 342 1000
e-mail: michael.olausson@surgery.gu.se

Prof. Yves **PANIS** (2010)
Colorectal Dept., Beaujon Hospital, 100, bd du Gal Leclerc, 92118 Clichy Cedex, FRANCE
Specialty: Colorectal Surgery
Fields of Interest: Colorectal, Cancer, Laparoscopy, Inflammatory Bowel Disease
Tel.: +33 6 10 78 62 40
e-mail: yves.panis@aphp.fr

*Prof. Rolland **PARC** (1995)
Dept. of Digestive Surgery, Hospital St. Antoine, 184 Rue du fg Saint Antoine, 75571 Paris, FRANCE
Tel.: +33 1 4928 2546 Fax: +33 1 4928 2548
e-mail: rolland.parc@sat.aphp.fr

Prof. Yann **PARC** (2014)
Hôpital Saint-Antoine, Service de Chirurgie Générale et Digestive, 184 Rue du Faubourg Saint-Antoine, 75012 Paris. FRANCE
Specialty: Colorectal Surgery
Fields of Interest: Colorectal, Cancer, Laparoscopy.
Tel.: +33 1 71 97 02 41 Fax: +33 1 49 28 25 48
e-mail: yann.parc@sat.aphp.fr

Prof. Fernando **PARDO** (2015)
Clínica Universidad de Navarra, Av. Pío XII, 36 · 31008 Pamplona, SPAIN
Specialty: HPB Surgery, Liver Transplantation
Fields of Interest: Oncological Surgery, Transplantation
Tel.: +34 948255400
e-mail: fpardo@unav.es

Prof. Rowan **PARKS** (2003)
Dept. of Clinical and Surgical Sciences, The Universtiy of Edinburgh, Royal Infirmary, 51 Little France Crescent, Edinburgh EH16 4SA, UNITED KINGDOM
Specialty: HPB Surgery
Fields of Interest: Pancreas, Biliary Tract, Liver
Tel.: +44 131 242 3611 Fax: +44 131 242 3617
e-mail: r.w.parks@ed.ac.uk

*Prof. Pascual **PARRILLA PARICIO** (1995)
Dept. of Surgery, University Hospital, Virgen de la Arrixaca, 30120 El Palmar- Murcia, SPAIN
Specialty: Gastrointestinal Surgery
Fields of Interest: Oesophagus and Stomach, Adult Liver Transplantation
Tel.: +34 96 836 9677 Fax: +34 96 836 9716
e-mail: pascual.parrilla2@carm.es

*Prof. Christian P. **PARTENSKY** (1994)
Section ICE 150, International Agency for Research on Cancer, Cours Albert Thomas, 69372 Lyon Cedex 08, FRANCE
Specialty: HPB Surgery
Fields of Interest: Pancreas, Epigenetics
Tel.: +33 4 7273 8449 Fax: +33 4 7273 8345
e-mail: partenskyc@visitors.iarc.fr

Prof. François **PATTOU** (2013)
Head, Department of Endocrine and Metabolic Surgery, Lille University Hospital, Lille, FRANCE
Specialty: Kidney and Pancreas Transplant Surgery, Transplantation, Endocrine Surgery
Fields of Interest: Bariatric Surgery, Diabetes
Tel.: +33 320 44 42 73 Fax: +33 673 69 22 72
e-mail: fpattou@univ-lille2.fr

*Prof. Sergio **PEDRAZZOLI** (2002)
Dipartimento di Scienze Mediche e Chirurgiche, Sezione di Clinica Chirurgica IV, Ospedale Giustinianeo, Via Giustiniani, 2, 35128 Padova, ITALY
Tel.: +39 049 821 8827/28 Fax: +39 049 876 4671
e-mail: sergio.pedrazzoli@unipd.it

Prof. Manuel **PERA** (2009)
Gastroenterology, Hospital Universitari del Mar, section of gastrointestinal surgery. department of surgery, 08003 Barcelona, SPAIN
Specialty: Gastrointestinal Surgery
Fields of Interest: Oesophagus and Stomach, Research in GI Disease, Cancer
Tel.: +34 607516685
e-mail: Pera@parcdesalutmar.cat

Prof. Miguel **PERA** (2013)
Colorectal Surgery Unit, Department of Surgery, Hospital del Mar, Passeig Marítim 25-29, 08003 Barcelona, SPAIN
Specialty: Colorectal Surgery
Fields of Interest: Colon Cancer, Inflammatory Bowel Disease, Peritoneal carcinomatosis
Tel.: +34 932 483 207 Fax: +34 932 483 433
e-mail: mpera@hospitaldelmar.cat

*Prof. Alberto P. **PERACCHIA** (1993)
Instituto di Chirurgia Generale e Oncologia Chirurgica, Unità Operativa di Chirurgia/Istituto Clinico Humanitas, Via Manzoni 56, 20089 Rozzano, ITALY
Specialty: Gastrointestinal Surgery
Fields of Interest: Oesophagus and Stomach, Endocrine
Tel.: +39 02 8224 4506 Fax: +39 02 8224 4590

*Prof. Jacques **PERISSAT** (2014)
Université Victor Segalen, Bordeaux 2, D.E.T.E.R.C.A, 146 Rue Léo Saignat, B.P. 47, 332076, Bordeaux, FRANCE
Specialty: General Surgery
Fields of Interest: Liver, Biliary tract, Pancreas, Oesophagus and Stomach
Tel.: + 33 5 5757 1719 Fax: + 33 5 5696 2614
e-mail: Jacques.Perissat@u-bordeaux2.fr

Prof. Patrick **PESSAUX** (2016)
Nouvel Hôpital Civil, Service de chirurgie digestive et endocrinienne, 67000 Strasbourg, France
Tel.: +33 6 63 04 50 38
e-mail: patrick.pessaux@chru-strasbourg.fr

Prof. Henrik **PETROWSKY** (2014)
UniversitätsSpital Zürich, Department of Visceral and Transplant Surgery, Rämistrasse 100, 8091 Zürich, SWITZERLAND
Specialty: HPB Surgery
Fields of Interest: Liver, Biliary tract, Pancreas, Adult liver transplantation, Transplantation.
Tel.: +41 44 255 30 41 Fax: +41 44 255 11 11
e-mail: henrik.petrowsky@usz.ch

Prof. Andrea **PIETRABISSA** (2013)
University of Pavia, Dep. of Surgery, 27100 Pavia, ITALY
Specialty: Oncological Surgery, General Surgery
Fields of Interest: Laparoscopy
Tel.: +39 3 356 164 891
e-mail: andrea.pietrabissa@gmail.com

Prof. Antonio **PINNA** (2011)
Viale Carducci 50, 40125 Bologna, ITALY
Specialty: Transplantation
Fields of Interest: Adult Liver Transplantation, Liver, Kidney Transplant, Small Bowel Transplantation
Tel.: +39 051 636 4762 Fax: +39 051 220 427
e-mail: antoniodaniele.pinna@aosp.bo.it

Prof. Hugo **PINTO MARQUES** (2015)
Curry Cabral Hospital, Department of Surgery, 1050-099 Lisbon, PORTUGAL
Specialty: HPB surgery
Fields of Interest: Liver, Biliary tract, Adult liver transplantation, Cancer
e-mail: hugoscpm@gmail.com

Prof. Jacques **PIRENNE** (2008)
Dept. Abdominal Transplantation, University Hospital Leuven, Gasthuisberg, Herestraat 49, 3000 Leuven, BELGIUM
Specialty: Transplantation
Fields of Interest: Adult Liver Transplantation, Pediatric Liver Transplantation, Kidney Transplant, Research in Transplantation
Tel.: +32 475 30 63 13
e-mail: jacques.pirenne@uzleuven.be

Prof. Rutger J. **PLOEG** (2002)
Nuffield Department of Surgical Science, John Radcliffe and Churchill Hospitals, Oxford Transplant Centre, Oxford OX3 7LJ, UNITED KINGDOM
Specialty:
Fields of Interest:
Tel.: +31 50 3612283 Fax: +31 50 3614873
e-mail: rutger.ploeg@nds.ox.ac.uk

Prof. Gilberto **POGGIOLI** (2013)
S.Orsola-Malpighi hospital - Alma Mater Studiorum - University of Bologna -, DIMEC - Chirurgia generale-poggioli, 40138 Bologna, ITALY
Specialty: Gastrointestinal Surgery, General Surgery
Fields of Interest: Colorectal, Inflammatory Bowel Disease
Tel.: +39 33 58 36 36 01
e-mail: gilberto.poggioli@unibo.it

Prof. Wojciech Piotr **POLKOWSKI** (2013)
Department of Surgical Oncology, Medical University of Lublin, SPSK 1, Staszica 11, 20-081 Lublin, POLAND
Specialty: Breast Surgery, Colorectal Surgery, HPB Surgery, Gastrointestinal Surgery, Oncological Surgery
Fields of Interest: Hyperthermic IntraPEritoneal Chemotherapy (HIPEC), IntraOperative RadioTherapy (IORT)
Tel.: +48 81 534 43 13 Fax: +48 81 532 23 95
e-mail: wojciech.polkowski@am.lublin.pl

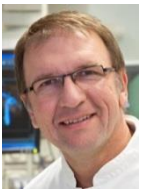
Prof. Irinel **POPESCU** (2007)
General Surgery and Liver Transplantation, Fundeni Clinical Institute, Sos. Fundeni, 258 Bucharest, ROMANIA
Specialty: General Surgery
Fields of Interest: Cancer, Adult Liver Transplantation, Teaching
Tel.: +40 72 403 3343
e-mail: irinel.popescu220@gmail.com

Prof. Robert **PORTE** (2006)
Dept. of Surgery, University Medical Center, Section Hepatobiliary Surgery and Liver Transplantation, P.O. Box 30.001, 9700 RE Groningen, THE NETHERLANDS
Specialty: HPB Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas, Adult Liver Transplantation, Pediatric Liver Transplantation
Tel.: +31 50 361 2896 Fax: +31 50 361 4873
e-mail: r.j.porte@chir.umcg.nl

Prof. Stefan **POST** (2006)
Chirurgische Klinik, Universitätsklinikum Mannheim, 68135 Mannheim, GERMANY
Specialty: General Surgery, Gastrointestinal Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas, Abdominal Wall, Laparoscopy, Teaching
TeachingTel.: +49 621 383 2225 Fax: +49 621 383 3809
e-mail: stefan.post@umm.de

Prof. Graeme John **POSTON** (2008)
Aintree University Hospital, Surgery, L23 6TJ Liverpool, UNITED KINGDOM
Specialty: HPB Surgery
Fields of Interest: Liver, Biliary Tract, Cancer
Tel.: +44 7930 336665
e-mail: graemeposton@blueyonder.co.uk

Prof. Stojan **POTRC** (2017)
Maribor University Medical Centre, Department of Surgery, Ljubljanska Street 5, 2000 Maribor, SLOVENIA
Specialty: General Surgery
Fields of Interest: Oesophagus and Stomach, Liver, Research in GI Disease
e-mail: potrc13@gmail.com



Prof. Johann **PRATSCHKE** (2010)
Visceral, Thoracic and Transplantation Surgery, University Innsbruck, Anichstrasse 35, 6020 Innsbruck, AUSTRIA
Specialty: HPB Surgery
Fields of Interest: Liver, Pancreas, Pediatric Liver Transplantation, Research in Transplantation
Tel.: +43 50 5042 2601 Fax: +43 50 5042 2602
e-mail: johann.pratschke@charite.de

Prof. François **PRUVOT** (2011)
University Hospital, Hôpital Huriez-CHU, 59037 Lille, FRANCE
Specialty: HPB Surgery
Fields of Interest: Liver, Biliary Tract, Adult Liver Transplantation, Cancer
Tel.: +33 3 2044 4260 Fax: +33 3 2044 6364
e-mail: francois-rene.pruvot@chru-lille.fr

Prof. Pauli Antero **PUOLAKKAINEN** (2013)
Department of Surgery, Helsinki University Hospital, 29 Helsinki, FINLAND
Specialty: General Surgery, Gastrointestinal Surgery
Fields of Interest: Oncological Surgery, HPB Surgery, Colorectal Surgery
Tel.: +358 505 829 785
e-mail: pauli.puolakkainen@hus.fi

Prof. José M. **RAMIA ANGEL** (2015)
Hospital Universitario de Guadalajara, HPB Surgical division, Donantes de Sangre, s/n, Calle Donante de Sangre, s/n, 19002 Guadalajara, SPAIN
Specialty: HPB surgery
Fields of Interest: Liver, Biliary tract, Pancreas
Tel. : +34 616 292 056
e-mail: jose_ramia@hotmail.com

Prof. Jari **RASANEN** (2016)
Helsinki University Hospital, Haartmanninkatu 4, Haartmaninkatu 4, P.O.B. 340 Helsinki, 29, FINLAND
Specialty: Thoracic Surgery
Fields of Interest: Oesophagus and Stomach, Research in GI Disease, Lung surgery
e-mail: jari.rasanen@hus.fi

Prof. Paul **REDMOND** (2007)
Dept. of Surgery, Cork University Hospital, Wilton, Cork, IRELAND
Specialty: General Surgery, Oncological Surgery, Breast Surgery
Fields of Interest: Endocrine, Cancer, Teaching
Tel.: +35 321 492 2371
e-mail: redmondhp@shb.ie

Prof. Jean-Marc **REGIMBEAU** (2015)
CHU Amiens Picardie - Site Sud, Chirurgie digestive et métabolique, Place Victor Pauchet, 80054 Amiens, FRANCE
Specialty:HPB surgery
Fields of Interest: Liver, Biliary tract, Pancreas, Research in HPB, Colorectal, Bariatric surgery
Tel: + 33 6 80 14 56 92
e-mail: regimbeau.jean-marc@chu-amiens.fr

Prof. John Vincent **REYNOLDS** (2006)
St. James's Hospital, Clinical Surgery, Department of Surgery, D08-W9RT Dublin, IRELAND
Tel.: +353 87 242 9998
e-mail: reynoljv@tcd.ie

Prof. Vicente **RIAMBAU** (2012)
Hospital Clínic, Villarroel 170, 08036 Barcelona, SPAIN
Specialty: Vascular Surgery
Fields of Interest: Aortic Surgery, Limb Revascularization, Endovascular, Carotid Surgery, Vascular malformations, Venous disorders
Tel.: +34 9 3227 55 15 Fax: +34 9 3227 57 49
e-mail: riambau@meditex.es

Prof. Piotr **RICHTER** (2013)
III Department of General Surgery, Jagiellonian University, 24 Golebia Str., 31-007 Krakow, POLAND
Specialty: General Surgery, Oncological Surgery
Fields of Interest:
Tel.: +48 604 076 286 Fax: +48 12 633 31 05
e-mail: piotr.richter@uj.edu.pl

Prof. Paolo **RIGOTTI** (2008)
UOC Trapianti Rene e Pancreas, Ospedale Giustinianeo aneo, Via Giustiniani 2, 35128 Padua, ITALY
Specialty: Transplantation
Fields of Interest: Kidney Transplant, Research in Transplantation
Tel.: +39 049 821 3173 Fax: +39 049 821 3152
e-mail: paolo.rigotti@unipd.it

Prof. Ricardo **ROBLES CAMPOS** (2016)
Virgen de la Arrixaca Clinic and University Hospital, Surgery, Liver Surgery, HPB Surgery, Liver Transplantation, Pancreas Transplantation, 30120 Murcia, SPAIN
Specialty: HPB Surgery, Transplantation
Fields of Interest: Liver, Biliary Tract, Adult Liver Transplantation, Laparoscopy, Pancreas
Tel.: +34 606 404 241
e-mail: rirocam@um.es

Prof. Xavier **ROGIERS** (2003)
Dept. of General Surgery, HPB Surgery and Organ Transplantation, Gent University Hospital and Medical School UZG, De Pintelaan 185 - 2K12 1 C, 9000 Gent, BELGIUM
Specialty: Transplantation, HPB Surgery
Fields of Interest: Liver, Adult Liver Transplantation, Biliary Tract, Pancreas, Pediatric Liver Transplantation, Education
Tel.: +32 9 240 3233 Fax: +32 9 240 6276
e-mail: xavier.rogiers@uzgent.be

Prof. Riccardo **ROSATI** (2003)
San Raffaele Hospital, Head Gastrointestinal Surgery, Via Olgettina, 60, 20122 Milan, ITALY
Specialty: General Surgery
Fields of Interest: Oesophagus and Stomach, Colorectal, Laparoscopy, Research in GI Disease
Tel.: +39 02 26 43 22 70 Fax: +39 02 26 43 55 92
e-mail: rosati.riccardo@hsr.it

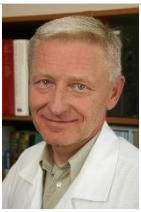
*Prof. Matthias **ROTHMUND** (1999)
Dekanat Fachbereich Medizin, Baldingerstrasse, 35033 Marburg, GERMANY
Tel.: +49 6421 586601
e-mail: rothmund.dekan@staff.uni-marburg.de

*Prof. Giancarlo **ROVIARO** (2003)
Istituto Auxologico Italiano Presidio Capitanio Via Mercalli 30 Milano, Milano, ITALY
Specialty: General Surgery, Oncological Surgery, Thoracic Surgery
Tel.: + 39 02 58313202
e-mail: gian.roviaro@unimi.it

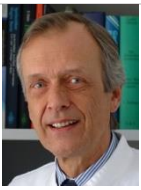
Prof. Eric **RULLIER** (2013)
Department of Surgery, University of Bordeaux, Saint Andre Hospital, 1 rue Jean Burguet, 33075 Bordeaux, FRANCE
Specialty:
Fields of Interest:
Tel.: +33 556 795 810 Fax: +33 556 795 861
e-mail: eric.rullier@chu-bordeaux.fr

Prof. Alberto **RUOL** (2012)
Clinica Chirurgica 1, Azienda Ospedaliera, Universita' di Padova, Via Giustiniani, 2, 35128 Padova, ITALY
Specialty: General Surgery
Fields of Interest: Upper Gastrointestinal, Malignancies of the Esophagus and Stomach
Tel.: +39 049 821 31 58 Fax: +39 049 821 31 51
e-mail: alberto.ruol@unipd.it

***Mr. Chris R.G. **RUSSELL** (1999)
Pancreatobiliary Surgery, Grey Roofs, 34 West Common, Gerrards Cross, SL9 7QY, Buks, UNITED KINGDOM
Specialty: HPB Surgery
Tel.: +44 207 380 9202 Fax: +44 207 380 9162
e-mail: r.russell3@btinternet.com



Prof. Miroslav **RYSKA** (2011)
Dept. of Surgery, 2nd Medical Faculty, Charles University and Central Military Hospital, Prague U vojenske nemocnice 1200, 150 00 Prague 6, CZECH REPUBLIC
Specialty: General Surgery
Fields of Interest: experimental, Oncological Surgery, Pancreas, Colorectal, Liver
Tel.: +420 973 202 901 Fax: +420 973 202 898
e-mail: miroslavriska@centrum.cz



***Prof. Dr. Hans-Detlev **SAEGER** (2002)
Direktor der Klinik und Poliklinik für Viszeral-, Thorax- und Gefässchirurgie, Universitätsklinikum Carl Gustav Carus, Fetscherstr. 24, 01307 Dresden, GERMANY
Tel.: +49 351 458 2742 Fax: +49 351 458 4895
e-mail: Hans-Detlev.Saeger@uniklinikum-dresden.de

Prof. Alain **SAUVANET** (2016)
Service de Chirurgie Hépatobiliaire et Pancréatique - Department of HBP Surgery, Chef du Pôle des Maladies de l'Appareil Digestif (PMAD), Hôpital BEAUJON, Université Paris VII,92118 CLICHY Cedex, France
Specialty: HPB Surgery
Fields of Interest: Pancreas, Cancer, Liver
Tel.:
e-mail: alain.sauvanet@aphp.fr

*Prof. Jarmo A. **SALO** (2012)
Division of General Thoracic- and Esophageal Surgery, Helsinki University Central Hospital (Meilahti), Haartmaninkatu 4, PL 340, 00290 Helsinki, FINLAND
Specialty: Gastrointestinal Surgery, General Surgery, Vascular Surgery, Cardiac Surgery, Thoracic Surgery
Fields of Interest: Esophageal and General Thoracic (lung) surgery
Tel.: +358 947 11 Fax: +358 947 174 479
e-mail: jarmo.salo@hus.fi

Prof. Markus **SCHÄFER** (2007)
Lausanne University Hopital, Department of Visceral Surgery, 1011 Lausanne, SWITZERLAND
Specialty: General Surgery
Fields of Interest:
Tel.: +41 79 556 16 99
e-mail: markus.schafer@chuv.ch

*Prof. Friedrich-Wilhelm **SCHILDBERG** (1994)
Ehem. Direktor der Chirurgischen Klinik und Poliklinik der Ludwig-Maximilians-Universität, München, Klinikum Grosshadern, Marchioninistraße 15, 81377 München, GERMANY
Specialty: General Surgery, Gastrointestinal Surgery, HPB Surgery, Colorectal Surgery, Vascular Surgery, Thoracic Surgery
Fields of Interest: Liver, Biliary Tract, Colorectal, Cancer, Infection,
Tel.: +49 89 859 7071 Fax: +49 89 8566 1932
e-mail: fw@schildberg.de

Prof. Stefan **SCHNEEBERGER** (2016)
Medical University Innsbruck, Department for Visceral Transplantation and Thoracic Surgery, nichstrasse 35, 6020 Innsbruck, AUSTRIA
Specialty: Transplantation
Fields of Interest: Liver, Biliary Tract, Adult Liver Transplantation, Pancreas, Pediatric Liver Malignancies, Kidney Transplant
Tel.:
e-mail: stefan.schneeberger@i-med.ac.at

Prof. Paul M. **SCHNEIDER** (2009)
Hirslanden Medical Center, Visceral, Thoracic and specialized Tumor Surgery, 8032 Zurich, SWITZERLAND
Specialty: Gastrointestinal Surgery
Fields of Interest: Oesophagus and Stomach, Cancer, Research in GI Disease
Tel.: +41 78 6488003
e-mail: paul@professor-schneider.ch

Prof. Norbert **SENNINGER** (2003)
Klinik und Poliklinik für Allgemeine Chirurgie, Department of General and Visceral Surgery, 48129 Muenster, GERMANY
Specialty: General Surgery, Gastrointestinal Surgery, HPB Surgery, Colorectal Surgery, Endocrine Surgery, Transplantation, Oncological Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas, Oesophagus and Stomach, Colorectal, Endocrine, Cancer, Adult Liver Transplantation
Tel.: +49 171 261 5525
e-mail: senning@uni-muenster.de

Prof. Utz **SETTMACHER** (2011)
Dept. of General, Visceral and Vascular Surgery, University Hospital of Jena, Erlanger Allee 101, 07740 Jena, GERMANY
Specialty: HPB Surgery, Transplantation, Oncological Surgery
Fields of Interest: Liver, Adult Liver Transplantation, Research in Transplantation
Tel.: +49 3641 932 2601 Fax: +49 3641 932 2602
e-mail: utz.settmacher@med.uni-jena.de

*Prof. Jörg R. **SIEWERT** (1992)
Leitender Ärztlicher Direktor und Vorstandsvorsitzender, Universitätsklinikum Freiburg, Hugstetter Strasse 49, 79095 Freiburg, GERMANY
Specialty: Gastrointestinal Surgery
Fields of Interest: Oesophagus and Stomach, Cancer, Research in GI Disease
Tel.: +49 761 270 180 60 Fax: +49 761 270 180 70
e-mail: jr.siewert@uniklinik-freiburg.de

*Prof. Maarten J.H. **SLOOFF** (2003)
Hepatobiliar Surgery and Liver Transplantation, University Hospital Groningen, P.O. Box 30.001, 9700 RB Groningen, THE NETHERLANDS
Specialty: HPB Surgery
Tel.: +31 50 361 2896 Fax: +31 50 361 4873
e-mail: mslooff@hotmail.com

Prof. Kjetil **SOREIDE** (2017)
Department of Clinical Medicine, Gastrointestinal Surgery, HPB unit, N-4068 Stavanger, NORWAY
Specialty: /
Fields of Interest: /
Tel.: +47 9228 1557
e-mail: ksoreide@mac.com

Prof. Georgios **SOTIROPOULOS** (2015)
University Hospital Laiko, 2nd Department of Propedeutic Surgery, 11527 Athina, GREECE
Specialty: HPB surgery
Fields of Interest: Liver, Adult liver transplantation, Research in HPB, Teaching
Tel: + 30 210 7709948
e-mail: geosotirop@med.uoa.gr

Prof. Olivier **SOUBRANE** (2015)
Beaujon Hospital, Dpt of HPB Surgery and Liver Transplant, 92110 Clichy, FRANCE
Specialty: HPB surgery
Fields of Interest: Liver, Biliary tract, Laparoscopy, Adult liver transplantation
Tel.: +33 6 72 74 37 58
e-mail: olivier.soubrane@aphp.fr

Prof. Dirk **STIPPEL** (2017)
University of Cologne, Department of General, Visceral and Cancer Surgery, Kerpener Straße 62, 50933 Cologne, GERMANY
Specialty: Transplantation
Fields of Interest: Liver, Kidney Transplant, Research in Transplantation, Research in HPB
Tel.: +49 178 7997 110
e-mail: dirk.stippel@uni-koeln.de

Prof. Ulrich **STÖCKLE** (2011)
Dept. of Trauma Surgery, BG Klinik Tübingen, Schnarrenbergstrasse 95, 72076 Tübingen, GERMANY
Specialty: Orthopedic Surgery
Fields of Interest: Trauma, Infection, Geriatric
Tel.: +49 7071 606 1001 Fax: +49 7071 606 1003
e-mail: ustoeckle@bgu-tuebingen.de

Prof. Malin **SUND** (2015)
Umeå University, Umeå University, Department of Surgical and Perioperative Sciences, 90185 Umeå, SWEDEN
Specialty:Breast surgery
Fields of Interest: Research in HPB, Biomarkers, Matrix
Tel: + 46-703758322
e-mail: malin.sund@surgery.umu.se

Prof. Eduardo **TARGARONA** (2009)
Service of Surgery, Gastrointestinal and Hematological Surgery, Hospital Sant Pau, Padre Claret 167, 08025 Barcelona, SPAIN
Specialty: General Surgery
Fields of Interest: Laparoscopy, Bariatric Surgery, Research in GI Disease
Tel.: +34 61 930 9277 Fax: +34 93 454 3647
e-mail: etargarona@santpau.cat

*Prof. Onno T. **TERPSTRA** (1993)
Dept. of Surgery, Leiden University Medical Centre, P.O. Box 9600, 2300 RC Leiden, THE NETHERLANDS
Tel.: +31 71 526 4005 Fax: +31 71 526 6746
e-mail: o.t.terpstra@lumc.nl

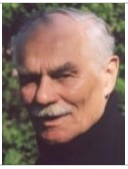
*Prof. Emmanuel **TIRET** (2007)
Centre de Chirurgie Digestive, Hospital Saint-Antoine, 184, rue de Faubourg Saint Antoine, 75012 Paris, FRANCE
Specialty: Colorectal Surgery
Fields of Interest: Colorectal, Cancer, Inflammatory Bowel Disease
Tel.: +33 1 4928 2563 Fax: +33 1 4928 2548
e-mail: emmanuel.tiret@aphp.fr

Prof. Antonio J **TORRES GARCIA** (2015)
Universidad Complutense de Madrid, Pza. Ramón y Cajal, s/n Ciudad Universitaria, 28040, Madrid, SPAIN
Specialty: Gastrointestinl surgery
Fields of Interest: bariatric surgery, Oesophagus and stomach, Laparoscopy
e-mail: ajtorresgarcia@gmail.com

Prof Guido **TORZILLI** (2008)
Faculty of Medicine, University of Milan, Istituto Clinico Humanitas IRCCS, Mia Manzoni 56, 20089 Rozzano, ITALY
Specialty: HPB Surgery
Fields of Interest: Liver, Biliary Tract, Research in HPB, Pancreas, Laparoscopy
Tel.: +39 02 8224 4502/3 Fax: +39 02 8224 4590
e-mail: guido.torzilli@unimi.it

Prof. Christian **TOSO** (2017)
Geneva University Hospitals, Rue Gabrielle-Perret-Gentil 4, 1211 Geneva, SWITZERLAND
Specialty: HPB Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas, Research in HPB
Tel.: +41796150843
e-mail: christian.toso@hcuge.ch

*Prof. Karl-Göran **TRANBERG** (2003)
Dept. of Surgery, Lund Unviersity, 22185 Lund, SWEDEN
Specialty: HPB Surgery
Fields of Interest: Liver, Pancreas, Cancer, Tumour Immunology
Tel.: +46 46 17 2767 Fax: +46 46 17 2335
e-mail: tranbergkg@gmail.com



*Prof. Michael **TREDE** (1993)
Nadlerstrasse 1A, 682597 Mannheim, GERMANY
Tel.: +49 621 796 301
e-mail: michael.trede@chir.ma.uni-heidelberg.de

Prof. Roberto **TROISI** (2008)
Hepato-Biliary Service UZG, Ghent University Hospital and Medical School, De Pintelaan 185, 9000 Gent, BELGIUM
Specialty: HPB Surgery
Fields of Interest: Liver, Laparoscopy, Adult Liver Transplantation, Research in HPB
Tel.: +32 474621811
e-mail: roberto.troisi@ugent.be

Prof. Jean-Jacques **TUECH** (2017)
Rouen University Hospital, Digestive surgery, 1 rue Germont, 76031 Rouen, FRANCE
Specialty:
Fields of Interest:
e-mail: jean-jacques.tuech@chu-rouen.fr

Prof. Erkki Juhani **TUKIAINEN** (2005)
Reconstructive Surgery, Dept. of Plastic Surgery, Helsinki University Hospital, Box 266, 00029 HUS Helsinki, FINLAND
Specialty: Plastic Surgery, Orthopedic Surgery, General Surgery
Fields of Interest: Cancer, Traumatology, Oncological Surgery, Chest and Abdomen Wall Defects, Reconstructive Microsurgery
Fax: +358 9 4718 7570
e-mail: erkki.tukiainen@hus.fi

Prof. Thomas **VAN GULIK** (2006)
University of Amsterdam, Dept.of Surgery, Academic Medical Center, 9 Meibergdreef, 1105 AZ Amsterdam, THE NETHERLANDS
Specialty: HPB Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas, Research in HPB
Tel.: +31 20 566 5570 Fax: +31 20 697 6621
e-mail: t.m.vangulik@amc.nl

Prof. Richard **VAN HILLEGERSBERG** (2014)
University Medical Center Utrecht, UMC Utrecht Surgery, Heidelberglaan 100 G04.228, Utrecht 3584CX, THE NETHERLANDS
Specialty: Gastrointestinal Surgery
Fields of Interest: Laparoscopy surgery, Oesogastric Surgery, Oncological Surgery, Research.
Tel.: +31 624524889
e-mail: r.vanhillegersberg@umcutrecht.nl

Prof. Kees **VAN LAARHOVEN** (2016)
Radboud UMC, PO Box 9101, internal code 618, Nijmegen, Gelderland, 6500 HB, THE NETHERLANDS
e-mail: kees.vanlaarhoven@radboudumc.nl

Prof. Jan **VAN LANSCHOT** (2003)
Dept. of Surgery, Erasmus Medical Center Rotterdam, P.O. Box 2040, 3000 CA Rotterdam, THE NETHERLANDS
Specialty: Gastrointestinal Surgery, Oncological Surgery
Fields of Interest: Oesophagus and Stomach
Tel.: +31 6-10649519
e-mail: j.vanlanschot@erasmusmc.nl

Prof. Dirk **VAN RAEMDONCK** (2008)
Dept. of Thoracic Surgery, UZ Gasthuisberg, Herestraat 49, Herestraat 59, 3000 Leuven, BELGIUM
Specialty: Thoracic Surgery, Transplantation
Fields of Interest: Lung Mediastinum
Tel.: +32 484443418
e-mail: dirk.vanraemdonck@uzleuven.be

Prof. Giulia **VERONESI** (2015)
Thoracic Surgeon, Director Lung Cancer Early Detection Unit, European Institute of Oncology, Via Ripamonti 435, 20141 Milano, ITALY
Specialty: Thoracic surgery
Fields of Interest: Teaching, Cancer
Tel: +39 02 57489666 Fax: +39 02 94379218
e-mail: giulia.veronesi@ieo.it

Prof. Emilio **VICENTE** (2016)
Sanchinarro University Hospital, General Surgery Service, 28050 Madrid, SPAIN
Specialty: Oncological Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas, Outcome
Tel.: +34 610254197
e-mail: emilvic@bitmailer.net

Prof. Thomas N. **WALSH** (2010)
Academic Dept. of Surgery, Royal College of Surgeons in Ireland, Academic Center, Connolly Hospital, Blanchardstown, Dublin 15, IRELAND
Tel.: +353 1822 8954 Fax: +353 1820 2284
e-mail: tnwalsh@indigo.ie

*Prof. Bruno **WALTHER** (2002)
Dept. of Surgery, Lund University, 22185 Lund, SWEDEN
Specialty: Gastrointestinal Surgery
Fields of Interest: Oesophagus and Stomach, Cancer, Research in GI Disease, Pediatric Oesophageal Surgery
Tel.: +46 46 172413 Fax: +46 46 172335
e-mail: Bruno.Walther@med.lu.se

Prof. Anders **WANHAINEN** (2017)
Uppsala University Hospital, Uppsala, SWEDEN
Specialty: Vascular Surgery
Fields of Interest: Vascular
Tel.: + 46 733 993 906
e-mail: anders.wanhainen@surgsci.uu.se

Prof. Markus **WEBER** (2005)
Birmensdorferstrasse 497, Klinik für Viszeral-, Thorax und Gefässchirurgie, Stadtspital Triemli, 8063 Zürich, SWITZERLAND
Specialty: Gastrointestinal Surgery, HPB Surgery, Colorectal Surgery, Endocrine Surgery, Oncological Surgery
Fields of Interest: Liver, Biliary Tract, Pancreas, Bariatric Surgery, Colorectal, Endocrine, Cancer
Tel.: +41 44 466 2202 Fax: +41 44 466 2601
e-mail: markus.weber@triemli.zuerich.ch

Prof. Jürgen **WEITZ** (2012)
Dept. of Surgery, University of Heidelberg, INF 110, 69120 Heidelberg, GERMANY
Specialty: Gastrointestinal Surgery, HPB Surgery, Colorectal Surgery, Transplantation, Oncological Surgery, Kidney and Pancreas Transplant Surgery
Tel.: +49 351 458 2742 Fax: +49 351 458 4395
e-mail: juergen.weitz@uniklinikum-dresden.de

Prof. Bas **WIJNHOVEN** (2016)
Erasmus University Medical Center Rotterdam, Erasmus Medical Center, 3015 CE Rotterdam, THE NETHERLANDS
Specialty: Gastrointestinal Surgery
Fields of Interest: Oesophagus and Stomach, Cancer, Laparoscopy, Research in GI Disease
Tel.: +31 630763623
e-mail: b.wijnhoven@erasmusmc.nl

Prof. Desmond **WINTER** (2009)
Dept. of Surgery, St. Vincent's University Hospital, Institute for Clinical Outcomes Research and Education (iCORE), Elm Park, Dublin 4, IRELAND
Specialty: Gastrointestinal Surgery
Fields of Interest: Laparoscopy, Colorectal, Cancer, Research in GI Disease
Tel.: +353 1 261 4010 Fax: +353 1 269 7949
e-mail: des.winter@gmail.com

Prof. Tadeusz **WRÓBLEWSKI** (2013)
Al. KEN 15/58, 02-797 Warszawa, POLAND
Specialty: General Surgery
Tel.: +48 601 678 844 Fax: +48 22 432 44 44
e-mail: wroblewskitad@o2.pl

Mr. Michael G. **WYATT** (2013)
Consultant Surgeon, Northern Vascular Centre, Freeman Hospital, High Heaton, Newcastle upon Tyne, NE7 7DN, UNITED KINGDOM
Specialty: General Surgery, Vascular Surgery
Fields of Interest: Aortic Aneurysm, EVAR, Thoracic aorta, Endovascular
Tel.: +44 191 213 79 41 Fax: +44 191 223 12 25
e-mail: mike.wyatt@nuth.nhs.uk

Prof. Emre F. **YEKEBAS** (2008)
Klinik f. Allgemein-, Viszeral- und Thoraxchirurgie, Klinikum Darmstadt, Grafenstrasse 9, 64283 Darmstadt, GERMANY
Specialty: Oncological Surgery
Fields of Interest: Pancreas, Oesophagus and Stomach, Cancer
Tel.: +49 6151 107 6001 Fax: +49 6151 107 6099
e-mail: yekebas@klinikum-darmstadt.de

***Prof. Giovanni **ZANINOTTO** (2006)
Department of Surgery and Cancer, St Mary's Hospital, Imperial College, W2 1NY, London, UNITED KINGDOM
Specialty: Gastrointestinal Surgery
Fields of Interest: Laparoscopy
Tel.: +39 041 529 4276 Fax: +39 041 529 4694
e-mail: g.zaninotto@imperial.ac.uk

Prof. Kaspar **Z'GRAGGEN** (2005)
Chirurgie, Klinik Beau-Site, Schänzlihalde 11, 3000 Bern 25, SWITZERLAND
Tel.: +41 31 335 3939 Fax: +41 31 335 3938
e-mail: kaspar.zgraggen@hirslanden.ch

PERSONAL NOTES

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