President’s Message Mr Graeme Poston

sub-specialty recognition of each specialism within General Surgery. Upper GI, Coloproctology and Breast received provisional approval to proceed to the next level, and we hope that Transplant and Endocrine will follow suit shortly.

There are several important points to make with regard to our sub-speciality:
• The CCT remains within General Surgery, and the accreditation is at sub-speciality level. This is especially important with regard to the general emergency take, that none of the five sub-speciality groups could automatically assume a default position abdicating responsibility for emergency surgery.
• This development at face value is lagging more than ten years behind the further specialization within upper GI into oesophago-gastric, hepato-pancreato-biliary, and bariatric surgery (as represented by the various societies now formed within AUGIS). However, to even get this far has been difficult and drawn out (with some members of the GMC side holding the view that sub-specialism within General Surgery couldn’t have happened already as they hadn’t approved it!).
• The position of those trainees currently in recognized training positions and whether they can opt to remain as they are (aiming to obtain a CCT in General Surgery) or to opt to achieve sub-specialist accreditation when they achieve their CCT and go on to the specialist register.

Clearly there is much work to be done. We have been tasked with providing the GMC with a draft Upper GI Syllabus and Curriculum by December 22nd and have been invited back to the GMC in the last week of January to present our proposals. I am very grateful to Bill Allum, John Primrose, our own sub-specialty chairs (Alberic Fiennes, Giles Toogood and Dave Hewin) and the Education and Training Committee for the work that their currently undertaking on behalf of upper GI surgery in this process. Going to be a busy Christmas for some!

We have now published our position paper on Surgeon Volumes and Outcomes in Upper GI cancer surgery and our paper has been approved by the DoH in England. We would hope that it would also be used to determine upper GI cancer surgery strategy in Ireland, Scotland, Wales and Northern Ireland as well. As I said in the last newsletter, I am extremely grateful to Richard Charnley and the Clinical Services Committee for all the work that went into what could have been an extremely contentious process.

Much has happened since we met in Oxford in September. Probably the most significant development for Upper GI surgery has been our preliminary discussions regarding sub-specialty recognition within General Surgery with the GMC. As you know, the GMC has now assumed responsibility from PMETB for final accreditation and signing off the CCT with appropriate specialty recognition at the end of training. Despite the clear developments of the last two decades into sub-specialisation within what was ‘General Surgery’, including the option to submit to sub-specialist sections in the final FRCS examination, these have not been mirrored by the legal recognition of a consultant’s specialist status on the medical register, which continues to be no more clearly defined than General Surgery.

At the outset I would like to thank the outgoing chair, Peter Lamont, and incoming chair, Bill Allum, (AUGIS President-elect) of the General Surgery SAC (with the support of JCST), for the tremendous work they have done in the previous months with Sallie Nicholas at the SAC in getting all the preparatory work done for this process. Without their efforts I’m not sure that the progress made so far would have been at all possible. The Presidents of the five remaining sub-specialty associations within General Surgery (Upper GI, Coloproctology, Breast, Transplantation, and Endocrine, following the departure of Vascular to be a stand-alone specialty outside General Surgery) supported by members of SAC and JCST met with the specialist sub-committee of the GMC in early October to put the case for
BOMSS continues to flourish, with ever an increasing membership. We have also forged closer and stronger links with AUGIS, with both societies now having representation on each other’s council.

All members of BOMSS are now automatically members of IFSO, our international umbrella organisation. After some early difficulties, our members are now able to access the journals “Obesity Surgery” and “SOARD” at the discounted IFSO rates. We are also looking into the possibility of BOMSS hosting the IFSO Annual Scientific Congress in the UK at some time in the next few years.

We are in the process of setting up a number of subcommittees to further the work of BOMSS and hopefully extend our influence in the UK surgical and bariatric communities. We are facing trying financial times, with significant changes in the commissioning of NHS bariatric surgery imminent. We hope to be able to influence these where possible so as to allow greater access to obesity surgery.

Earlier this year we gained eligibility to make ACCEA recommendations for our members and in September the first such citations were submitted. We now wait to hear whether or not these applications were successful.

After the success of our Inaugural Annual Scientific Meeting earlier this year, we are now looking forward to the Second BOMSS Annual Scientific Meeting to be held at the Cedar Court Hotel in Wakefield, West Yorkshire, on 20-21 January 2011. We have an exciting scientific and social programme planned, with several renowned national and international speakers having confirmed their attendance. I hope to see as many of you as possible at this meeting.

Finally it only remains for me to wish you all a very Happy Christmas and a prosperous New Year.

Best wishes,

Roger Ackroyd
BOMSS Honorary Secretary
Mr Nick Hayes

I am keeping this winter’s report brief as there have been few developments in the Association’s financial position recently. You might recall that AUGIS felt the need to increase its annual subscription fees for the first time in a number of years but that the increase agreed at the AGM in Oxford in September was modest and was confined to the ranks of the consultant membership. These will be effective from January 2011.

By the time this newsletter has been printed and distributed, AUGIS will have formally cemented its partnership amongst the group of specialist organisations making up the Digestive Disorders Federation. The number of associations choosing to become full partners in this federation at the present time is limited to four; namely BSG, AUGIS, BAPEN (British Association for Parenteral and Enteral Nutrition) and BASL (British Association for the Study of the Liver). Many more associations and societies have consistently expressed an interest in contributing to the meeting in 2012, but have not committed to an agreement which explicitly excludes members from holding their own scientific meeting that year. Preliminary programme development is underway and a venue has been chosen, the ACC in Liverpool. The meeting will begin with a training day, followed by a three day scientific programme.

By the next newsletter, AUGIS will be busy not only preparing for our own Annual Meeting in Belfast 2011, but also be only 12 months away from the new venture of the UK’s inaugural DDF meeting and I hope to be able to tell you more at that time. Best wishes to all.

Nick Hayes
Honorary Treasurer
Council Reports

Report from the Education, Training and Research Committee

**Professor John Primrose**

Following the Annual Meeting at Oxford this committee has now changed its name to the Education, Training and Research Committee (ETRC) to reflect the evolution of the Society and its remit. The expansion of the Annual meeting over the last few years meant that much of the Chairs activity relates to organising, with other members of the Executive, the meeting and leaving a committee which had no major role or ongoing activity. Henceforth the Scientific Programme will be developed by the Executive and Chaired by the President Elect. The ETRC will develop further the organisation’s training agenda, the issue of the moment being the subspecialty recognition of upper GI surgery by PMETB. Crucially, as research is now embedded in the NHS and a key performance indicator for Trusts it is important that both developing and promoting recruitment to clinical trials becomes core business for AUGIS.

The Oxford meeting maintained the pattern of excellence in annual meetings of the Society. Additional features in 2011 were a parallel BOMSS session and parallel research updates describing current portfolio trials in Upper GI surgery. The outstanding overseas speakers for the meeting included Don Low from Seattle, Ugo Boggi from Pisa, Harry Frydenberg from Melbourne and Rene Adam from Paris.

The Belfast meeting in September 2011 is being run in collaboration with the Dutch Association of GI Surgeons and an exciting programme is currently being put together. We hope also to have delegates from the Scandinavian GI surgical associations. A highlight of the meeting will be the presence of Tekeishi Sano from Tokyo as the major overseas speaker. Professor Sano has unparalleled expertise in the surgery of gastric cancer.

In June 2012 the first UK combined gastrointestinal meeting, the Digestive Disease Foundation meeting will take place in Liverpool. This meeting will represent the annual meeting of AUGIS as well as the BSG, BASL and BAPEN. In addition a large number of other GI medical and surgical societies plan to contribute. The programme of the meeting is already well developed. On the Sunday there will be a combined training day for trainees in both surgery and gastroenterology which will deal with areas of treatment interface between surgery and gastroenterology. The programme on Monday to Wednesday includes a series of multidisciplinary symposia of interest to surgeons as well as gastroenterologists. There will also be joint affiliates sessions. All of the normal AUGIS events, such as the BJS Prize session will also take place during the meeting. If as suspected the meeting proves to be a major success the plan is to repeat event in 2015.

Most will know by now that I have had the honour to be elected to the Presidency of the Association of Surgeons of Great Britain and Ireland in 2013/14. This means that I am currently Vice President of ASGBI. Clearly the commitment to both societies is not possible so the Council will consider succession planning in the near future, after the plans for the 2011 and 2012 meetings are complete and the new committee is fully functional.

Prof JN Primrose  
Chair, Education and Training Committee.
Trainee Representative Report

Mr John S Hammond

AUGIS Trainees Winter Newsletter

2010 has seen the AUGIS trainee membership grow to over 200. To respond to this AUGIS has set out to engage more with its trainee members. It staged the first formal election for its trainee representative and has established a new trainee committee comprising representatives from around the UK and from across specialities.

The main focus of the AUGIS trainee calendar is the annual training day, run this year in Oxford. Mr Nick Maynard put together an excellent programme which provided an opportunity to learn from the experts, with small group teaching and viva sessions run by members of the AUGIS council, visiting experts and Past Presidents. This is the second year the training day has used this format and it continues to provide an invaluable training opportunity particularly for those approaching their exit examination.

The quality of gastrointestinal endoscopy training remains an important concern for upper GI trainees, and the preliminary results of the national survey carried out on behalf of the Joint Advisory Group on GI Endoscopy has highlighted some of the current deficiencies in training. The results of this survey will be published in the New Year together with further guidance for surgeons planning to train in endoscopy.

The AUGIS trainee website will be launching in January. It will be accessible from the AUGIS website and contain a range of useful content on training, fellowships and education. I am also pleased to announce the launch of the ASiT-AUGIS prize for the best upper GI abstract submitted to their meeting in Sheffield in April 2011. This should increase the profile of AUGIS among younger trainees and act as incentive to present their research at the ASiT conference. We are grateful to the AUGIS council for providing their support for this award. Details can be found at:

http://www.asit.org/events/conferences/index_conference_2011/prizes

After much deliberation we have decided to rebrand Barrett’s Club as AUGIS, the Association of upper GI Surgical Trainees. We feel that this better represents the varied speciality interests of its members. The annual dinner following the Training day will be called the AUGIS Barrett’s dinner.

Finally it remains for me to thank Natasha Henley for all her excellent work as trainee representative. The next 2 years will hopefully see AUGIS continue to grow and develop.

We look forward to seeing you at AUGIS 2011 in Belfast.

John S Hammond
Mr Richard Charnley  

ASSOCIATION OF UPPER GI SURGEONS  
CLINICAL SERVICES COMMITTEE

Since the June newsletter the Clinical Services Committee has been involved in several areas including the following:

Revalidation  
The GMC ran an extensive consultation process on revalidation. The points made by AUGIS in its response to the GMC revalidation draft document, that is minimising the time doctors will have to spend completing the revalidation process and the need for assistance in the collection and collation of supporting information, have been clearly noted in the GMC’s response. The GMC has indicated that, following this consultation, “the plans and proposals for revalidation will change although appraisal and robust clinical governance will remain the key foundations of the process” and…. “revalidation must add value for both patients and doctors, and must be workable in the pressured and busy environments in which most doctors work. Revalidation must give assurance to the public but not be bureaucratic or costly – it should be part of a range of measures to ensure high quality safe care”. AUGIS has initiated audit systems for OG and HPB and these will be appropriate for the purposes of revalidation. For subspecialists it will be difficult to proceed through revalidation without submitting data to the AUGIS audit process. To view the latest on revalidation from the GMC “Revalidation: a Statement of Intent” (October 2010) see: http://www.gmc-uk.org/doctors/7330.asp

Hospital and Surgeon Volumes Document  
The minimum volumes document is on the AUGIS website (News and Guidelines Section) and has also been sent out to ASGBI, BSG, BASO, ACP and ALS. Comments are awaited.

Endoscopy Training Document  
Recommendations for endoscopy training have been agreed (see AUGIS website). The key recommendations emphasise the equal access of GI endoscopy training for surgical and medical trainees. It is the view of AUGIS that surgeons should continue to be involved in the endoscopic assessment and treatment of OG and HPB patients and that our trainees should have the opportunity to undertake endoscopic training. If consultants or trainees encounter any difficulties regarding endoscopy training they should contact a member of the Clinical Services Committee or another member of Council.

Clinical Guidelines  
AUGIS representatives, amongst others, are participating in updating the UK guidelines for acute pancreatitis and pancreatic and periampullary tumours and the writing (first edition) of guidelines for chronic pancreatitis, pancreatic pseudocysts and pancreatic cystic tumours. Once the first draft of these have produced, they will be circulated to all interested parties and it is hoped that there will be comprehensive feedback.

AUGIS Provision of Services Document  
AUGIS has been asked by ASGBI to produce a ‘Provision of Services’ document which is likely to be useful in defining the work carried out by Upper GI Surgeons and subspecialists within the field. Members of Council and the subspecialty committees will produce a rough draft for the January Council Meeting which will then be completed by May, circulated to the membership and then presented to the AGM in September 2011 in Belfast.

If AUGIS members have any issues which they wish to discuss with the Clinical Services Committee please contact Richard Charnley, (Newcastle upon Tyne, Chairman), Alberic Fiennes, (London, BOMSS), Shaun Preston, (Guildford, OG) or Ian Tait, (Dundee, HPB).

Richard Charnley  
Chairman, Clinical Services Committee, December 2010
**Personalised therapy for mCRC**

ERBITUX® is recommended by NICE for first-line treatment of mCRC within the licensed indication in combination with FOLFOX® or FOLFIRI®, only in patients who meet all of the following criteria:

- Primary tumour has been resected or is potentially resectable.
- The metastatic disease is confined to the liver and is unresectable.
- Patient is fit enough to undergo resection of the primary tumour, and metastases if they become resectable after treatment with ERBITUX®.

FOLFOX®: 10% of ERBITUX® used is isolated by manufacturer on a per-patient basis.

Special note: Patients should receive treatment with ERBITUX® for no more than 72 h. The patient should then be assessed for resection of liver metastases.

**Metastatic Colorectal Cancer**

**Merck Serono Oncology | Combination is key**

ERBITUX® is indicated for the treatment of patients with epidermal growth factor receptor (EGFR)-expressing, KRAS wild-type mCRC—

as a single agent in patients who have failed oxaliplatin- and irinotecan-based therapy and who are intolerant to irinotecan.

**Prescribing information (UK and EU)****

**Summary of product characteristics**

**Indication**

ERBITUX® is indicated for the treatment of patients with epidermal growth factor receptor (EGFR)-expressing, KRAS wild-type mCRC as a single agent in patients who have failed oxaliplatin- and irinotecan-based therapy and who are intolerant to irinotecan.

**Contraindications**

- Hypersensitivity to humanized monoclonal antibody ERBITUX®.
- Pregnancy or breastfeeding. Do not administer ERBITUX® to nursing mothers.

**Warnings**

- Injection site reactions: Rash, pruritus, injection site inflammation and irritation.
- Hypersensitivity reactions: Anaphylactic reactions with urticaria, angioedema, fever, chills, hypotension, bronchospasm, angioedema, and death have been reported in patients treated with ERBITUX®. Discontinue ERBITUX® if symptoms of hypersensitivity occur.
- Infusion reactions: Elevate lower body and slow or stop infusion if infusion-related reactions occur. Do not restart infusion if symptoms are delayed.

**Precautions**

- Patients with a history of rash or a positive photopatch test should be evaluated for photosensitivity reactions.
- Patients with a history of rash or photosensitivity reactions should be evaluated for phototoxicity reactions.
- Patients with a history of rash or photosensitivity reactions should be evaluated for phototoxicity reactions.
- Patients with a history of rash or photosensitivity reactions should be evaluated for phototoxicity reactions.
- Patients with a history of rash or photosensitivity reactions should be evaluated for phototoxicity reactions.

**Adverse reactions**

- The most common adverse reactions observed in clinical studies were rash, pruritus, injection site inflammation, and injection site irritation.

**NATURAL HISTORY AND MECHANISM OF ACTION**

- ERBITUX® is a recombinant humanized monoclonal antibody that targets the EGFR. ERBITUX® binds to the EGFR, preventing it from interacting with its ligands and inhibiting its downstream signaling pathways. This results in the inhibition of proliferation and induction of apoptosis in cancer cells.

**References**

2. ERBITUX Summary of Product Characteristics, November 2010.
HPB cancer resection audit
http://www.hpbaudit.nhs.uk
The AUGIS HPB cancer resection database was launched at the AUGIS meeting in Nottingham in September 2009. To date over 950 cancer resections have been entered and an annual update was presented at the 2010 Annual meeting in Oxford. The presentation, given by Mr Iain Cameron, highlighted the excellent patient recruitment to date, confirmed the generous support of MerckSerono who have agreed to sponsor the database for the next 3 years and detailed future plans for the database.

Alongside the Cancer resection audit runs the Ablation audit supported by an educational grant from Acculis: http://mta.emdt.net:8080/emdt/login.jsp
Access to the AUGIS HPB cancer resection database and the Ablation database is obtained by logging in and using your password. If you do not have login details or a password then please contact Ardeo on lad@ardeo.com or telephone: 0870 909 4100. Alternatively contact me at david.berry@uhl-tr.nhs.uk.

A major reason cited for the failure of individuals or units to enter data into the AUGIS HPB cancer resection database has been the need for dual data entry where an in-house database exists. I can report that AUGIS and Ardeo are in the final stages of discussions regarding direct electronic transfer of data from existing databases. Establishing electronic links is expensive but funds should be available to facilitate this process with the added advantage of contributors being able to access their own data as required. Until the electronic links are established I would encourage you to continue to enter data personally or you may be fortunate enough to have a data entry person in your unit to whom you can delegate this responsibility. However you enter the data please use your specific login/ID so the patients/data can be traced back to you for your own analysis.

Data entry to National datasets is strongly supported by the Academy of the Royal Colleges and this form of central data collection will become a corner stone of revalidation/recertification and as such discussions continue with the Royal College of Surgeons to link the database to the RCS portfolio/logbook.

Finally, we are constantly exploring options to secure additional funding either from Industry partners or Government initiatives to facilitate National data collection. Additional funding will facilitate electronic national data collection and there is little doubt that if we, as a professional body, demonstrate our willingness and ability to collect data, it is much more likely that we will secure significant funding to facilitate the whole process.

Bariatric Audit Report
The National Bariatric Surgery Registry continues to accumulate data from UK bariatric surgical operations in both NHS and private hospitals. There have been over 10 000 operations uploaded onto the database in the first 24 months of the Registry. The first annual report will analyse data uploaded prior to March 31st 2010. The report is due for publication around the time of the BOMSS annual meeting in Wakefield in January 2011 and will provide the most comprehensive review of UK bariatric surgery to date. The excellent efforts of the many contributors are much appreciated.
National Oesophago-Gastric Cancer Audit

Background
The Audit published its Third Annual Report at the beginning of November 2010. It concentrated on the results of the main prospective study and contained data on over 17,000 patients. In total it included data on over 3,800 resections, 3,600 courses of curative oncological therapy, 4,330 courses of palliative oncological therapy, and approximately 3,250 endoscopic / radiological palliative treatments. Overall case ascertainment was 71% and for surgical resections it was over 85%. All but four cancer centres provided enough information for their outcomes to be compared to the national average, and hence for the safety of their practice to be publicly demonstrated.

Overall, the results were very encouraging. Operative mortality has fallen significantly since the last AUGIS audit in 2002, chemotherapy completion rates are approaching those seen in clinical trials and the stent deployment success rate is nearly 100%. The Audit also contained centre-level data for four surgical outcomes: 30-day mortality, 90-day mortality, anastomotic leak rate and reoperation rate. We are pleased to report that no centre was outside the 99.8% control limits, indicating that surgery was being performed safely in all of those centres that had provided sufficient data.

The results contained in the Audit Report can now be used for providing up-to-date information to patients and for comparing local results with the national benchmarks. Where the results differ, hospitals can investigate this and thereby use the results to identify areas of potential improvement, hence improving the quality of the service they deliver. This was the primary objective of the Audit – to provide national information and hence facilitate and drive local quality improvement. The high-levels of case ascertainment meant that this is possible so a big thank-you to everyone who worked so hard to collect and enter data.

A detailed analysis and presentation of the results of the Audit is planned for the March 2011 meeting of the BSG. This will include comment from invited experts, both national and international, so we would encourage you to attend.

The future
Healthcare Quality Improvement Partnership (HQIP) has allocated funding for a new national oesophago-gastric cancer audit that will begin in April 2011.

Further information will soon be sent to lead clinicians. The Audit will continue to be led clinically by Richard Hardwick (AUGIS) and Stuart Riley (BSG) and will be hosted by the RCS Clinical Effectiveness Unit.

If you have any further questions, please contact either Richard Hardwick (Richard.hardwick@addenbrookes.nhs.uk) or Tom Palser (tpalser@rcseng.ac.uk) and thank-you again for all of your hard work.

You will see from the above synopsis that the various National audits are progressing well and I would encourage all colleagues to enter data into their subspecialty audit.

Best wishes to all,
Dave Berry

Mr David P Berry
Chair of AUGIS Audit Committee
Dear Affiliate member

Just a short message this time, I’ve been relaxing since the AUGIS conference in September!

Thanks to all of you who helped and supported me throughout the conference and making it such an informative and enjoyable event.

For those of you, who didn’t attend the conference, please visit the affiliate webpage on the AUGIS website to view all the presentations and the winner of the best affiliate poster and my blogs!

I’m now making preparations for next year’s conference in Belfast and invite you to contact me if you are interested in presenting at the affiliate sessions.

Although 2 years away, I will shortly be preparing for DDF 2012. I have been invited to attend a RCN meeting in January 2011 to meet with the programme organisers to ensure the interests of AUGIS affiliates are represented in the nursing programme. It will also be an opportunity to forge ongoing links with the RCN Gastrointestinal Forum.

Once more, I encourage you to make use of the affiliate webpage to share your practice and local events.

Wishing you all a very happy Christmas and prosperous New Year.

Jane
Miss Jane Tallett
Affiliate Representative
Following the success of the Inaugural BOMSS Scientific meeting in Croydon earlier this year work is well underway for the 2011 meeting, which will be held at the Cedar Court Hotel, Wakefield on January 20th and 21st 2011.

Registration for the meeting includes a year’s membership and I look forward to seeing as many AHP members as possible. The society is committed to a multi-professional approach, team working both clinically and academically underpins the society’s aims.

A most exciting development this year has been the validation by Leeds Metropolitan University of the Advanced Professional Diploma and Professional Diploma in Bariatrics and Metabolic Management, which can potentially be topped up to a Masters degree.

The programmes have been jointly developed by the British Obesity and Metabolic Surgery Society [BOMSS] and Leeds Metropolitan University.

The aims of the programmes are to facilitate the critical application of theory to practice to enable professionals to co-ordinate, deliver, manage and evaluate the care of individuals requiring bariatric and / or metabolic in either a surgical or community setting.

These courses are suitable for professionals working in a broad range of services, in meeting the needs of people requiring bariatric and / or metabolic management support. Significantly, in health, the course will be available to registered practitioners from multi-professional groups including nurses, dieticians, physiotherapists, occupational therapists and medical staff. Additionally, modules within the course may be accessed by staff working in health related fields including police service, fire service and social work.

For further information please contact either
Dr Deborah J Fox, Course Leader, Leeds Metropolitan University, Leeds
Tel: 0113 812 4480
Email: d.fox@leedsmet.ac.uk

Or
Andi Fox-Hiley, Training and Education Development Manager, Medical Education Leeds, St James University Hospital, Leeds.
Tel: 0113 206 6152
Email: Andrea.Fox-Hiley@leedsth.nhs.uk
THE PROGRAMME
This programme has been jointly developed by the British Obesity and Metabolic Surgery Society (BOMSS) and Leeds Metropolitan University. The aim of the programme is to facilitate the critical application of theory to practice to enable professionals to co-ordinate, deliver, manage and evaluate the care of individuals requiring bariatric and/or metabolic in either a surgical or community setting.

SUITABLE FOR
Professionals working in a broad range of services, in meeting the needs of people requiring bariatric and/or metabolic management support. Significantly, in health, the course will be available to registered practitioners from multi-professional groups including nurses, dieticians, physiotherapists, occupational therapists and medical staff. Additionally, modules within the course may be accessed by staff working in health related fields including police service, fire service and social work.

LEARNING OUTCOMES
Upon successful completion of the course students will be able to:

- Demonstrate a critical understanding of the pathophysiology and psychosocial aspects of metabolic disorders and obesity
- Demonstrate the ability to critically appraise and review appropriate evidence related to bariatric and metabolic management strategies
- Demonstrate a critical understanding of different bariatric surgical interventions / complications and provide expert knowledge and skills to support other professionals in hospital or community settings
- Promote and drive effective collaboration and communication across multi-disciplinary and multi-agency services in managing bariatric and/or metabolic care in the community or surgical environment
- Critically appraise and utilise education and information strategies to promote / maximise successful public health

LEARNING STRATEGIES / METHODS
The course will be delivered in 1 x 3 day and 2 x 2 days blocks of teaching per module. The methods used will include lectures, student led seminars and group work in order to provide opportunities for debate and shared learning.

ENTRY REQUIREMENTS
Currently Registered Practitioner with
- A degree from a UK University, or equivalent
- A Higher National Diploma Award or equivalent together with relevant work experience

Or
- Appropriate APL including current professional experience

FEES
£2800 per course.

WHERE DELIVERED
Leeds Teaching Hospitals NHS Trust & Leeds Metropolitan University

ENQUIRIES
Andi Fox-Hiley, Manager LIMIT, St James University Hospital, Leeds.
Tel: 0113 206 6026
Email: Andrea.Fox-Hiley@leeds-hosp.nhs.uk

Dr Deborah J Fox, Course Leader, Leeds Metropolitan University, Leeds
Tel: 0113 812 4480
Email: d.fox@leedspriv.ac.uk
THE PROGRAMME
This programme has been jointly developed by the British Obesity and Metabolic Surgery Society (BOMSS) and Leeds Metropolitan University. The aim of the programme is to facilitate the critical application of theory to practice to enable professionals to co-ordinate, deliver, manage and evaluate the care of individuals requiring bariatric and/or metabolic in a surgical and community setting.

SUITABLE FOR
Professionals working in a broad range of services, in meeting the needs of people requiring bariatric and/or metabolic management support. Significantly, in health, the course will be available to registered practitioners from multi-professional groups including nurses, dieticians, physiotherapists, occupational therapists and medical staff. Additionally, modules within the course may be accessed by staff working in health related fields including police service, fire service and social work.

LEARNING OUTCOMES
Upon successful completion of the course students will be able to:

• Demonstrate an advanced understanding of the pathophysiology and psychosocial aspects of metabolic disorders and obesity
• Demonstrate the ability to appraise and review appropriate evidence related to bariatric and metabolic management strategies
• Demonstrate an enhanced understanding of different bariatric surgical interventions / complications and provide expert knowledge and skills to support other professionals in hospital and community settings
• Promote and drive effective collaboration and communication across multidisciplinary and multi-agency services in managing bariatric and/or metabolic care in the community and surgical environment
• Appraise and utilise education and information strategies to promote and maximise successful public health

LEARNING STRATEGIES / METHODS
The course will be delivered in 1 x 3 day and 2 x 2 days blocks of teaching per module. The methods used will include lectures, student led seminars and group work in order to provide opportunities for debate and shared learning.

ENTRY REQUIREMENTS
Currently Registered Practitioner with

• A degree from a UK University, or equivalent
• A Higher National Diploma Award or equivalent together with relevant work experience

Or

• Appropriate APL including current professional experience

FEES
£2800 per course.

WHERE DELIVERED
Leeds Teaching Hospitals NHS Trust & Leeds Metropolitan University

ENQUIRIES
Andi Fox-Hiley, Manager LIMIT, St James University Hospital, Leeds.
Tel: 0113 206 6926
Email: Andrea.Fox-Hiley@leedsth.nhs.uk

Dr Deborah J Fox, Course Leader, Leeds Metropolitan University, Leeds
Tel: 0113 812 4480
Email: d.fox@leedsmet.ac.uk
<table>
<thead>
<tr>
<th><strong>COVIDIEN LAPAROSCOPIC SOLUTIONS</strong></th>
</tr>
</thead>
</table>

- **SILS™ Hand Instruments**
- **Endo GIA™ Reloads with Tri-Staple Technology**
- **LigaSure™ V Instrument**
- **V-loc™ 90 and 180 Wound Closure Device**
- **SILS™ Port 15mm with NEW Smoke Evacuation System**
- **LigaSure Advance™ Pistol Grip Instrument**
- **Versaport™ Bladeless Low Profile Trocars**

- **Parietex™ Parastomal Mesh**

*Ongoing research on surgical techniques and advancements.*
A Trip of Contrasting Experiences

Leaving seasonal UK temperatures of 7-8 °C in late March, I arrived in Coimbatore with daytime temperatures in excess of 35 °C. I was very grateful then, to be in the air conditioned theatre suite of GEM Hospital early the following morning. GEM Hospital (figure 1) was founded in 1991 by Dr C Palanivelu and is a 200-bedded private hospital managing a range of surgical and medical gastro-intestinal conditions.

Dr Palanivelu, the Chief, heads 3 surgical teams, with each team individually led by a senior surgeon (which would probably compare most accurately to the old senior registrar grade in the UK). The teams “rotate” through clinic, operating and ward work days so that a patient with for example, symptomatic gallstones, seen in the clinic is frequently operated on the following day by the same team and discharged from the ward the day after that. The referral pattern of patients to the clinic is in many ways similar to that in the UK. Patients may be referred by family physicians or they may receive referrals from other clinics but crucially and in a very different manner to the UK system, patients may also present themselves to the hospital, with the reputation of the Institution largely responsible for these self-referrals. With the influence of cultural differences, the fee-paying nature of the patients and the importance of reputation, it is not unusual for a patient presenting with suspicious upper or lower gastro-intestinal symptoms to undergo diagnostic tests, cross-sectional imaging and any medical consultations required before definitive operative intervention all within the space of 4-5 days.

Operations are carried out 6 days a week, with the case mix and the operating surgeon decided by the Chief depending on ability, experience and training needs. The vast majority of cases are approached laparoscopically, in both elective and emergency situations. There are 6 dedicated theatres (figure 2); all with high definition imaging systems and the harmonic scalpel is used in all cases requiring tissue dissection. They perform approximately 50 oesophageal resections a year and have adopted a minimally invasive approach. The procedure begins with thorascopic mobilisation of the oesophagus with the patient in the prone position. The patient is then turned supine, allowing laparoscopic gastric mobilisation, lymphadenectomy, pyloroplasty and formation of the gastric conduit, with a cervical anastomosis. Dr Palanivelu has also performed laparoscopic transhiatal resections.

The range of surgical procedures performed during my visit was extensive considering the usual practices of a single surgeon in the UK. Including upper gastro-intestinal resections for malignancy, other procedures included pancreatic resections, extended cholecystectomy, bariatric procedures (sleeve gastrectomy and duodenal switch), a range of colorectal operations and even some gynaecological procedures.

In stark contrast to the working practices at GEM hospital in Coimbatore, I spent four weeks observing the work of Dr J Luketich, at the University of Pittsburgh Medical Centre (UPMC). Dr Luketich is the Director of the Heart, Lung and Esophageal Surgery Institute (HLESI) and Chief of Thoracic
Surgery at UPMC. Although UPMC itself is comprised of a number of sites in and around Pittsburgh, the majority of the oesophago-gastric surgery is carried out at Presbyterian hospital (figure 3) close to the University and the Medical School.

UPMC has an excellent reputation for training with stiff competition for the residency program. There are also a number of fellows who come from all over the world to work with Dr Luketich, usually for a period of 1 year. Dr Luketich was routinely present in the operating room on Mondays, Wednesdays and Fridays and this is when all major oesophago-gastric cases are carried out. There were usually three rooms working concurrently, with Dr Luketich moving from room to room carrying out the more complicated steps of individual procedures. Up until 2005, he utilised a 3-stage approach to resection, but now prefers a two-stage procedure with a stapled, intra-thoracic anastomosis. The procedure begins with laparoscopic gastric mobilisation and formation of the conduit. Thoracoscopic mobilisation of the oesophagus, lymph node dissection, resection and restoration of continuity is carried out with the patient on their left side. The procedure is performed without epidural analgesia, but local anaesthetic is infiltrated into the intercostal spaces under direct vision prior to the end of the procedure. The majority of patients are extubated in the operating room and spend a single night in the surgical ICU. As long as there are no post-operative complications, the aim is to discharge patients home on the 5th or 6th post-operative day.

Using this approach Dr Luketich and his team have reduced the anastomotic leak rate requiring surgical intervention to 2%.

The management of simple and complex situations attributable to gastro-oesophageal reflux disease also forms a significant component of the work undertaken in the unit. The initial procedure of choice is a Nissen-type fundoplication, with the liberal use of the Collis gastroplasty for the shortened oesophagus. An aggressive surgical policy is adopted for those with on-going or recurrent symptoms and re-do fundoplication, oesophago-jejunostomy or even oesophago-gastrectomy are all utilised depending on the situation. I was able to observe all of these situations during my visit and was fortunate to attend a course designed specifically to address and discuss the role of surgery in the management of complex benign oesophageal disorders.

The increasing use of minimally invasive techniques in the surgical management of oesophago-gastric malignancy in the UK has led to UK trainees and Consultants seeking practical and observational experience in various parts of the world. A significant number of those have been supported financially by the AUGIS fellowship awards. I am very grateful to count myself in this group and I am indebted to AUGIS and Drs Palanivelu and Luketich for enabling me to complete this trip.
AUGIS Travelling Fellowship for Diploma course at ‘Centre Hepatobiliaire’ Paul Brousse Hospital Paris
Mr Vivek Upasani, St. James’s University Hospital, Leeds

The Hepatobiliary Centre at Paul Brousse Hospital, Paris is a leading European centre for liver transplantation and one of the biggest centres for liver cancer, biliary tract and pancreas surgery. It was established by Professor Henri Bismuth in 1970’s. It has 71 beds, 15 ICU beds and 5 operating theatres dedicated to HPB and transplant and performs around 200 liver resections and 130 liver transplants each year.

The institute conducts the ‘European University Diploma: HPB cancers’ course in partnership with University of Barcelona, Brussels, Torino and Stockholm along with University of Paris. It aims to promote the multidisciplinary approach to HPB cancer management and includes the latest advances in this field. The sessions include presentations on the latest scientific data and discussions on the evidence in literature. It is organised by Prof Rene Adam and his team, and is aimed at senior HPB trainees and junior consultants. It is well attended by HPB trainees and consultants across the European continent. Although the course is held in Paris, the sessions are in English!

The course consists of a series of 3 sessions of one week each followed by an exam at the end. We had a great opportunity to meet and discuss with expert faculty like Prof H Bismuth, R Adam, G Poston, L Capussotti, D Cherqui, J Figueras, PA Clavien, JF Gigot, J R Delpero, D Elias, D Azoulay, M Ducreux and others during the interactive scientific sessions.

The first session covered generalities on HPB cancers and included wide range of topics from prevention to latest treatment modalities like gene therapy and liver transplantation. The highlights included the increasing use of contrast enhanced ultrasound for liver metastases, portal vein embolisation, role of laparoscopic surgery, video presentations on laparoscopic liver resections, Surgery for Klatskin tumours and debate on the controversial role of liver transplantation in biliary tract cancers.

The second session included topics like liver metastases from colorectal cancer and new oncosurgical strategies, role of chemotherapy and surgery, timing of treatment, results of ‘rescue’ surgery, resectability of liver metastases (The Oncosurge model), two stage liver resection and ‘extreme’ liver surgery. The latest data on LiverMetSurvey was also presented.

The key topics of the third session were liver metastases from non-colorectal cancer, rationale for surgery, cancer of the pancreas, prognostic factors of pancreatic resection, neoadjuvant and adjuvant treatments. This final session concluded with the examination which I successfully passed.

I had a great opportunity to meet and exchange views with HPB community from different parts of Europe, learn about different health systems and training programmes. It was a good chance for cultural exchange and making new friends.

Besides all the academics, evenings in Paris were a real joy! Eiffel at night, Seine cruise and shopping at the capital of fashion were the exciting highlights. Daily commute from the hotel to the Paul Brousse Hospital by metro and tram gave me a true flavour of Parisian life.

I thank Prof Rene Adam and his team for their excellent organisation. I am extremely grateful to Mr G Poston for supporting me for this fellowship. I would like to thank AUGIS and my consultants at University Hospital Aintree for their support.

This diploma course has given me a new insight into the management of HPB cancers and has helped me to update my knowledge in this field. I thoroughly enjoyed this inspiring course.

Mr Vivek Upasani
As we approach 2011 the AUGIS members in Belfast are gearing up to welcome you all to this rapidly changing city for the annual conference (Sept 14-16). Conference will be held at Belfast’s world renowned Waterfront Convention Centre.

We are honoured that the Surgical Societies from Holland, the Scandinavian countries and the British Hernia Society have all committed to joining AUGIS next September. This of course pushes the local contingent to ever greater efforts in order to ensure a meeting both scientifically and socially of the highest quality. My local organising committee in particular the Belfast contingent of Tom Diamond, Barry Clements, Andrew Kennedy, Lloyd McKie, Mark Taylor, Gareth Kirk and Gary Spence all look forward to welcoming our colleagues and friends for what promises to be an exciting meeting.

The programme under the direction of President elect Bill Allum and Chairman John Primrose, ably assisted by the President Graeme Poston is taking shape. A commitment from Dr Sano will allow us to build a first class symposium on Gastric Cancer with a session also proposed on Neuroendocrine Tumours. Other items include an important discussion on Quality and Outcomes for Upper GI Surgery and perhaps a look at Acute Pancreatitis. Programme items relating to metabolic surgery and an affiliate programme are in advanced planning. The usual poster and plenary prize sessions are also planned.

We look forward to the Wednesday training day where we will attempt to emulate the exceptionally high standards set in Nottingham and Oxford. The plan is to have live operating orientated towards everyday practice which will include laparoscopic management of bile duct stones and a session on ventral hernia management with our colleagues in the British Hernia Society. Also included will be the now traditional sessions for the trainees “Meet the Professors”. This is a major opportunity for AUGIS members from both the UK and the Republic of Ireland to engage at both senior and junior levels.

Preparation for the social programme is well underway. The AUGIS Council held a site visit last summer and plans for both council dinner and conference banquet to be held at unusual venues with a surprise mode of transport are well underway.

There are many and varied attractions in Belfast and my co-hosts in the Belfast Visitor and Convention Bureau would encourage members to stay beyond the meeting to enjoy local hospitality.

Can I encourage all past presidents, members, past members, associates and affiliates to fix this date in diaries and we will leave no stone unturned in our céad mile failte to Béal Feiriste.

Declan Carey
Echelon compression now with natural articulation

For more information or to arrange an evaluation please email: Stapling@its.jnj.com

Ethicon Endo-Surgery
part of the Johnson & Johnson family of companies

echelonflex ENDOPATH STAPLER
ALPS 2011

Alpine Liver & Pancreatic Surgery Meeting

Wednesday 26th - Sunday 30th January 2011
Hotel Carlo Magno, Madonna di Campiglio, Italy

INTERNATIONAL GUEST SPEAKERS
Vincenzo Mazzaferro MD, Milan
William Traverso MD, Idaho

PROPOSED FACULTY INCLUDE:
Prof Brian Davidson, London
Dr Mike Grocott, Southampton
Prof Olivier Busch, Amsterdam
Dr Hjalmar van Santvoort, Utrecht
Mr Rowan Parks, Edinburgh
Dr Marc Bemelmans, Maastricht
Prof David Tuveson, Cambridge

Prof Duncan Jodrell, Cambridge
Prof Steve Wigmore, Edinburgh
Dr Bill McCulloch, Raleigh NC
Dr Ronald van Dam, Maastricht
Mr David Lloyd, Leicester
Mr Mohammad Abu Hilal, Southampton
Prof Claudio Bassi, Verona

TOPICS TO INCLUDE:
- Pancreatic cancer
- Biomarkers in colorectal liver metastases
- Neuroendocrine tumours
- What trials need doing in HPB surgery?

In addition:
DVD Sessions (How I do it)

REGISTRATION FEES
- Consultant: £200
- Trainee & Accompanying Person: £100

ORGANISING COMMITTEE
John Primrose
Colin Johnson
Moh'd Abu Hilal
Merv Rees
James Garden
Mark I. Van Berge Henegouwen
Marc Bemelmans
Elise Patey

Please see website for more information, or email
Elise Patey (alps@soton.ac.uk)
www.alpshpbmeeting.soton.ac.uk
Dear Member

To ensure that we maintain an accurate database and are able to keep you informed of Association news, please fill out the form below, including all relevant contact details, together with TELEPHONE NUMBERS and E-MAIL ADDRESSES.

In order for members to access the professionals area of the website we will need up to date information and an e-mail address.

Please return form to:
Harriet Innes / Sarvjit Madhar
Specialty Managers
AUGIS
The Royal College of Surgeons
35-43 Lincoln's Inn Fields
London WC2A 3PE
or Fax 020 430 9235

PLEASE COMPLETE ALL SECTIONS USING BLOCK CAPITALS

<table>
<thead>
<tr>
<th>Title</th>
<th>First Name</th>
<th>Surname</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Membership No. (if known)</th>
<th>Date of Birth / /</th>
</tr>
</thead>
</table>

PLEASE INDICATE PREFERRED ADDRESS FOR CORRESPONDENCE

HOME ADDRESS

<table>
<thead>
<tr>
<th>Post Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Tel:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Fax:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Email:</th>
</tr>
</thead>
</table>

HOSPITAL ADDRESS

<table>
<thead>
<tr>
<th>Post Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Tel:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Fax:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Email:</th>
</tr>
</thead>
</table>
AUGIS
The Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland
at
The Royal College of Surgeons of England
35-43 Lincoln’s Inn Fields
London WC2A 3PE