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THE MOYNIHAN ACADEMY
PURSUIT OF SURGICAL EXCELLENCE

ASGBI
Association of Surgeons of Great Britain and Ireland

The Moynihan's Academy Newsletter - March 2026

Welcome to the Spring edition of The Moynihan's Academy newsletter!

Follow us on Instagram @asgbi_ma, X @ASGBI_MA, LinkedIn @The Moynihan Academy and on WhatsApp for updates and registration links for our planned events.

Presidential Update

Jared Wohlgemut, The Moynihan Academy President

Dear Colleagues,

It has been a remarkable start to 2026 for The Moynihan Academy. We are delighted to continue with our podcast collaboration with Behind the Knife, delivering an episode on Surgical Quality, and we have delivered several joint webinars with the Royal College of Surgeons of Edinburgh. More recently, we have published an article in the Royal College of Surgeons of England Bulletin. These achievements reflect the energy, talent, and commitment within our community.

We are looking forward to an exciting few months ahead. On 6th March, we delivered the "ASiT x Moynihan Academy Basic Skills in EGS & Trauma Surgery" pre-conference course at ASiT in Manchester. It was an excellent opportunity to equip 18 trainees with practical, high-impact trauma skills. Ms Garima Govind led the course, along with Ms Stella Smith, Ms Rute S Castelhano, Mr George N Davis, and myself.

In May, we will, of course, be strongly represented at the ASGBI Congress in Brighton from 12–14 May, as we work hard to support podium sessions, poster sessions, the training village and breakfast academy, and best of all: the social events!

We are particularly excited to launch a BRAND-NEW initiative: a 1-day pre-conference course on 11th May 2026: the "Surgical Decision-Making in Trauma", designed by Ms Kate Hancorn (ASGBI Trauma Lead) and myself. The course will be taught by leading trauma clinicians, including Dr Anne Weaver, Mr Max Marsden, Mr John Taylor, and Mr Phill Pearce. This promises to be a dynamic and practical course focused on developing confident, effective decision-makers. The focus will be on highly interactive clinical scenarios, mixed with expert didactic teaching and live discussion. Mark your calendars! It can be booked when you book your registration for the ASGBI conference. More information on the advert here.

There are many ways to engage with The Moynihan Academy:

Monday MRCS

Weekly MRCS MCQs to help trainees build exam confidence and maintain steady revision habits.

Friday FRCS

Every Friday we post FRCS-style questions to support senior trainees preparing for the fellowship exam.

Wednesday Wellbeing & Medical Student Wednesdays

These run on an alternating schedule:

Wellbeing Wednesday – practical wellbeing advice, tips, and webinars to promote a healthier surgical life.

Medical Student Wednesday – guidance for medical students who wish to begin a surgical career, including study tips and early exposure opportunities.

What else do we share?

Alongside our weekly themes, we regularly post about:

Important national audits
Masterclasses and teaching events
Moynihan Academy and ASGBI updates
RCSEd webinar adverts
FRCS webinar series announcements
Highlights from partner surgical associations

We are active on Twitter, LinkedIn, and Instagram, and we welcome everyone interested in surgery, education, and wellbeing to join our growing community.

Have ideas or suggestions?

We would love to hear from you — please message us on any of our platforms. Your feedback helps us improve and continue delivering valuable content.

Watch this space for more great content and collaborations.

Papers of the Month

with Georgios Geropoulos, MA Research Lead

This month, two papers caught my attention for their practical relevance to Emergency General Surgery. The SUNRISE randomised trial in JAMA examined whether incisional negative pressure wound therapy after emergency laparotomy reduces surgical site infection—useful evidence when we're deciding which interventions genuinely add value beyond good fundamentals. In parallel, a large nationwide study in BJS Open compared early cholecystectomy outcomes in recurrent versus first-time acute cholecystitis, reinforcing why "first-admission definitive management" can matter for safety and operative risk.

Negative Pressure Dressings to Prevent Surgical Site Infection After Emergency Laparotomy: The SUNRRISE Randomised Clinical Trial

SUNRRISE Trial Study Group, JAMA (2025)

DOI: https://10.1001/jama.2024.24764

Question

In adults undergoing emergency laparotomy with primary skin closure, does incisional negative

pressure wound therapy (iNPWT) reduce 30-day surgical site infection (SSI) compared with the surgeon's choice of dressing?

Findings

A pragmatic, assessor-masked RCT across UK and Australian centres (n≈840) found no statistically significant difference in 30-day SSI rates: 28.4% with iNPWT vs 27.4% with surgeon's preference dressing.

Take Away Points

This is a helpful "de-implementation" paper for EGS: despite theoretical benefits and prior mixed evidence, routine iNPWT did not improve SSI outcomes after emergency laparotomy in this large pragmatic trial. It supports reserving iNPWT for clearly defined subgroups (if any) rather than default use, and re-emphasises fundamentals (source control, antibiotics, technique, normothermia, glycaemic control, dressing care).

Early cholecystectomy for recurrent versus first-time cholecystitis: nationwide population-based study

Edblom M et al., BJS Open (2026)

DOI: https://doi.org/10.1093/bjsopen/zraf166

Question

Is early laparoscopic cholecystectomy performed for recurrent acute cholecystitis associated with worse outcomes than early cholecystectomy at the first episode?

Findings

In a Swedish nationwide registry cohort (2006–2020; 34,925 patients), recurrent cholecystitis was associated with higher 30-day complications (20.2% vs 13.8%). Adjusted analyses showed increased odds of total complications (OR 1.38), and higher risks of bile duct injury (OR 2.44), intestinal perforation (OR 2.54), open surgery (OR 1.76) and prolonged operating time (OR 1.64).

Take Away Points

This paper strengthens the "do it on the first admission if feasible" message: delaying definitive surgery

may convert a straightforward first episode into a higher-risk recurrent operation with more complications and higher bile duct injury risk. Useful for counselling, pathway design, and for escalation discussions when early lists are pressured.

Trauma Update

with Ellie Smith, MA Trauma Lead

Enhanced Recovery after Trauma and Intensive Care (ERATIC)

The care of the severely injured trauma patients has traditionally focused on damage control surgery and resuscitation. This approach has led to improved survival, but with that improved survival has come prolonged (intensive care unit) ICU stays, high complication rates, delayed functional recovery and significant high long-term morbidities.

Over the past two decades, enhanced recovery pathways have transformed elective surgical care, reducing length of stay and improving outcomes. However, similar advances have been slower to emerge in emergency general surgery and trauma. This international collaborative work aimed to adapt Enhanced Recovery After Surgery (ERAS) principles for severely injured trauma patients and develop a standardised, evidence-based pathway covering care from admission through intensive care and recovery. The primary aims were to integrate early rehabilitation, reduce practice variability, and improve

both short- and long-term outcomes.

The authors employed a multi-step consensus methodology comprising a systematic literature review and the formation of a multidisciplinary expert panel, including trauma surgeons, intensivists, anaesthetists, rehabilitation specialists, nutritionists, and nursing staff. A Delphi-style process with multiple rounds of anonymous voting was used to achieve consensus. Recommendations were graded based on the strength of evidence, clinical feasibility, and risk–benefit balance.

The authors divided their work into three papers. The first focused on the initial management of the patient in the emergency department, intra-operative care, and the first days in intensive care; the second focused on longer-term ICU care, transition to the ward, and eventual recovery. The final paper covered ethical decision-making and trauma system requirements. While the papers contain numerous detailed recommendations for specific injury patterns, this review focuses on the principal general management principles from the first two papers.

During the first twenty-four hours following injury, the primary goal is to optimise physiological stability and prevent secondary injury. This is facilitated by rapid transfer to an appropriate level of care, with prehospital interventions limited to life-saving measures and haemorrhage control. In hospital, resuscitation should prioritise whole blood and early balanced component therapy guided by dynamic coagulation testing. Crystalloids should be reserved as a last resort.

In relation to anaesthesia and airway management, awareness of the risk of cardiovascular collapse during induction is essential and should be mitigated through appropriate pre-induction resuscitation. Intraoperative management should emphasise normothermia, restrictive fluid administration, and lung-protective ventilation. Multimodal anaesthesia incorporating non-opioid and non-benzodiazepine agents is recommended to reduce delirium, prolonged ventilation, and delayed mobilisation.

The authors also highlight the increasing role of non-operative management, particularly for blunt solid organ injuries when appropriately imaged and closely monitored.

Several key recommendations are provided for ICU care. These include early extubation where feasible, protocolized ventilatory management, and early initiation of thromboprophylaxis.

In patients without traumatic brain injury, thromboprophylaxis is recommended within 24 hours, and within 48 hours in those with stable intracranial imaging.

Early enteral nutrition is advised, ideally on admission to the ICU or within eight hours postoperatively in patients with gastrointestinal continuity. Parenteral nutrition is recommended by days three to five when enteral feeding is not possible.

Ongoing sepsis surveillance and early mobilisation are also emphasised, with evidence suggesting reduced ventilator days and improved functional outcomes.

Overall, these papers provide a comprehensive synthesis of current evidence and offer practical guidance across all stages of trauma care. They represent an important step towards recovery-focused trauma management and are valuable reading for surgical trainees and clinicians involved in major trauma care.

Papers in this article:

https://pmc.ncbi.nlm.nih.gov/articles/PMC12338446/

https://pmc.ncbi.nlm.nih.gov/articles/PMC12338449/

https://pubmed.ncbi.nlm.nih.gov/40696567/

EGS Hot Topics

with Georgios Karagiannidis, MA EGS Lead

Laparoscopic vs Open Adhesiolysis for SBO: Do the Long-Term Outcomes Differ?

Räty P, et al. Long-Term Outcomes After Laparoscopic vs Open Adhesiolysis for Small Bowel Obstruction: The LASSO Randomized Clinical Trial. JAMA Surg, Feb 2026.

DOI: 10.1001/jamasurg.2025.6726

Question

Does laparoscopic adhesiolysis reduce long-term SBO recurrence, incisional hernia formation, or improve quality of life compared with open surgery?

Findings

This 5-year follow-up of the LASSO randomised clinical trial (100 patients across 8 centers in Finland and Italy) provides the highest-level evidence to date comparing long-term outcomes after laparoscopic vs open surgery for adhesive SBO.

- **SBO Recurrence (5 years):**
  - Open: 9.7%
  - Laparoscopic: 12.5%
  - No statistically significant difference
- **Incisional Hernia (5 years):**
  - Open: 9.7%
  - Laparoscopic: 12.5%
  - No statistically significant difference
- **Quality of Life (GIQLI and SF-36):**
  - No meaningful differences between groups at 5 years

Importantly, while laparoscopy showed short-term recovery benefits in the original LASSO trial, those advantages did not translate into superior long-term outcomes.
The study also highlights that recurrence rates overall were relatively low (~11% at 5 years), reinforcing that operative treatment itself reduces future SBO risk.

Take Away Points

This paper is particularly relevant for EGS teams navigating the open vs laparoscopic debate in adhesive SBO.

1. Open surgery remains a valid standard — long-term outcomes are not inferior.
2. Laparoscopy offers short-term benefits, but not long-term superiority.
3. Patient selection remains critical — the LASSO trial included carefully selected patients likely to have a single adhesive band.
4. This study challenges assumptions drawn from retrospective data suggesting laparoscopy reduces recurrence or hernia rates.

Latest in Surgical Education

with Faiza Soomro, MA Educational Lead

Moynihan Academy x ASiT: P4 ST3 General Surgery Mock Interview Course

This year, Moynihan Academy was invited by the Association of Surgeons in Training (ASiT) to run the General Surgery component of the national P4 ST3 Mock Interview programme. As Educational Lead, I was delighted to coordinate the course on behalf of the Academy, and we were grateful for the organisation and oversight of the MA Treasurer, Mr George Neelankavil Davis, who played a key part in the success of the day.

We had a full house of delegates, comprising 20 candidates and 17 faculty members, and kicked off the day with a welcome by Ms Shrusti Bhat, followed by a Recruitment and Interview Update for 2026, delivered by Amal Boulbadaoui and George Neelankavil Davis, which provided the candidates with a

grounding in the current national context and requirements.

From 10:00 onwards, structured one-hour interviews were conducted to closely mimic the national selection process. Each candidate was assessed in a clinical station, management scenario, and portfolio discussion, with dedicated time for feedback. The interviews were structured to ensure realism. In some interviews, two faculty members interviewed one candidate (a 2:1 ratio), reflecting the realism of national interviews. In other interviews, single and paired interviewers were used to reflect real-world variation.

Feedback received from the delegates was outstanding. Candidates consistently reported that the interviews were authentic, challenging, and constructive. We are extremely grateful to our faculty for their time, professionalism, and dedication to providing quality and development-focused feedback.

ASiT x MA Basic Skills in EGS and Trauma Surgery Course

with Garima Govind, MA Training Lead

Our long awaited *ASiT x MA Basic Skills in EGS and Trauma Surgery* was held on 6th March and was attended by 20 delegates spanning the width of the UK (and abroad!). We had an expert faculty made up of senior MA committee members and Miss Stella Smith, Consultant Colorectal and Trauma Surgeon based in Manchester.

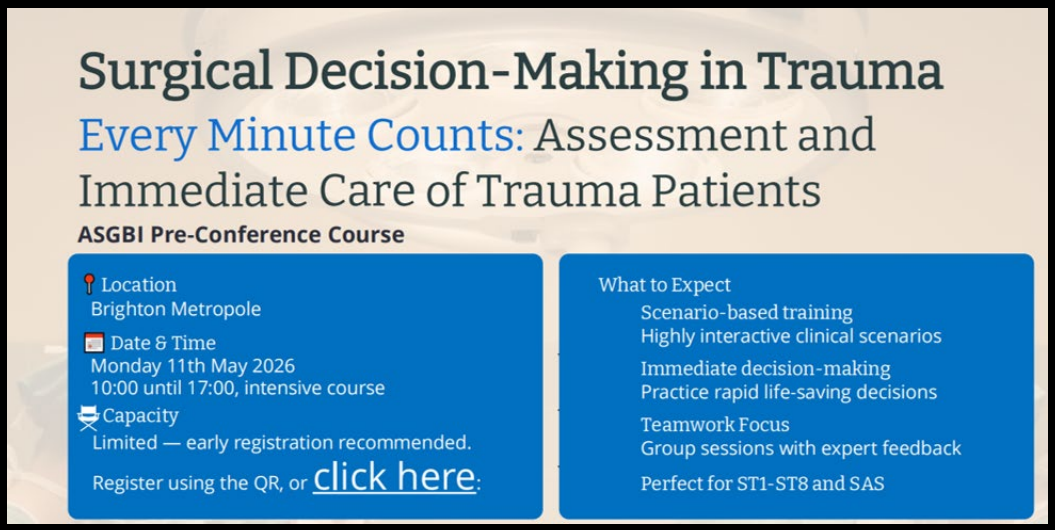
We were able to run high quality stations to allow delegates to practice trauma skills, including resuscitative thoracotomy, trauma laparotomy and ATLS skills. It was a fast paced day with a lot of information covered and we hope to continue this course next year!

Upcoming Moynihan Academy Events

18th March 2026: MA & RCSEd Webinar on “Paediatric Emergencies for the General Surgeon”
Register Here

18th March 2026: MA Women’s Month Webinar on “Endometriosis”

25th March 2026: MA Women’s Month Webinar on “Performance of female surgeons”



Further Upcoming Events

22nd - 23rd April 2026: Advanced Coloproctology Course (ACC)

Details Here

12th - 14th May 2026: EAES Advanced Laparoscopic Lower GI Surgery Course

Details Here

16th - 17th May 2026: Advanced Upper Gastrointestinal Robotic Surgery Course

Details Here

27th - 28th Nov 2026: European Hernia Society (EHS) Advanced Open Cadaveric Hernia Course

Details Here

Research Opportunities

Excited to take your research to the next level and need some funding? Apply for E-AHPBA Scientific & Research Grants.

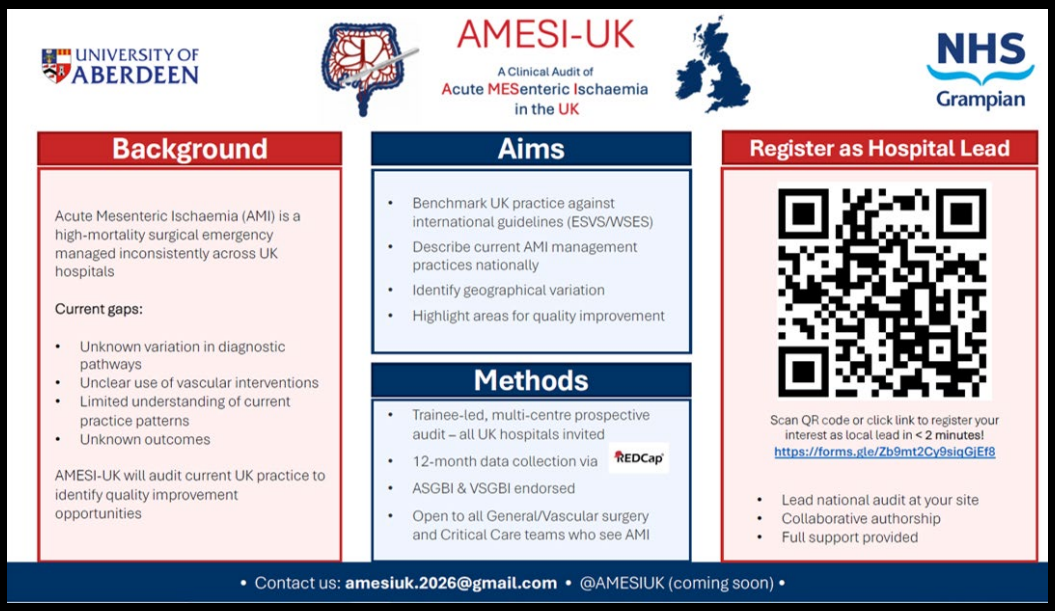
Details Here

Enthusiastic to promote surgical careers and training? Apply for RCSEd Affiliate Fellowship Programme 2026.

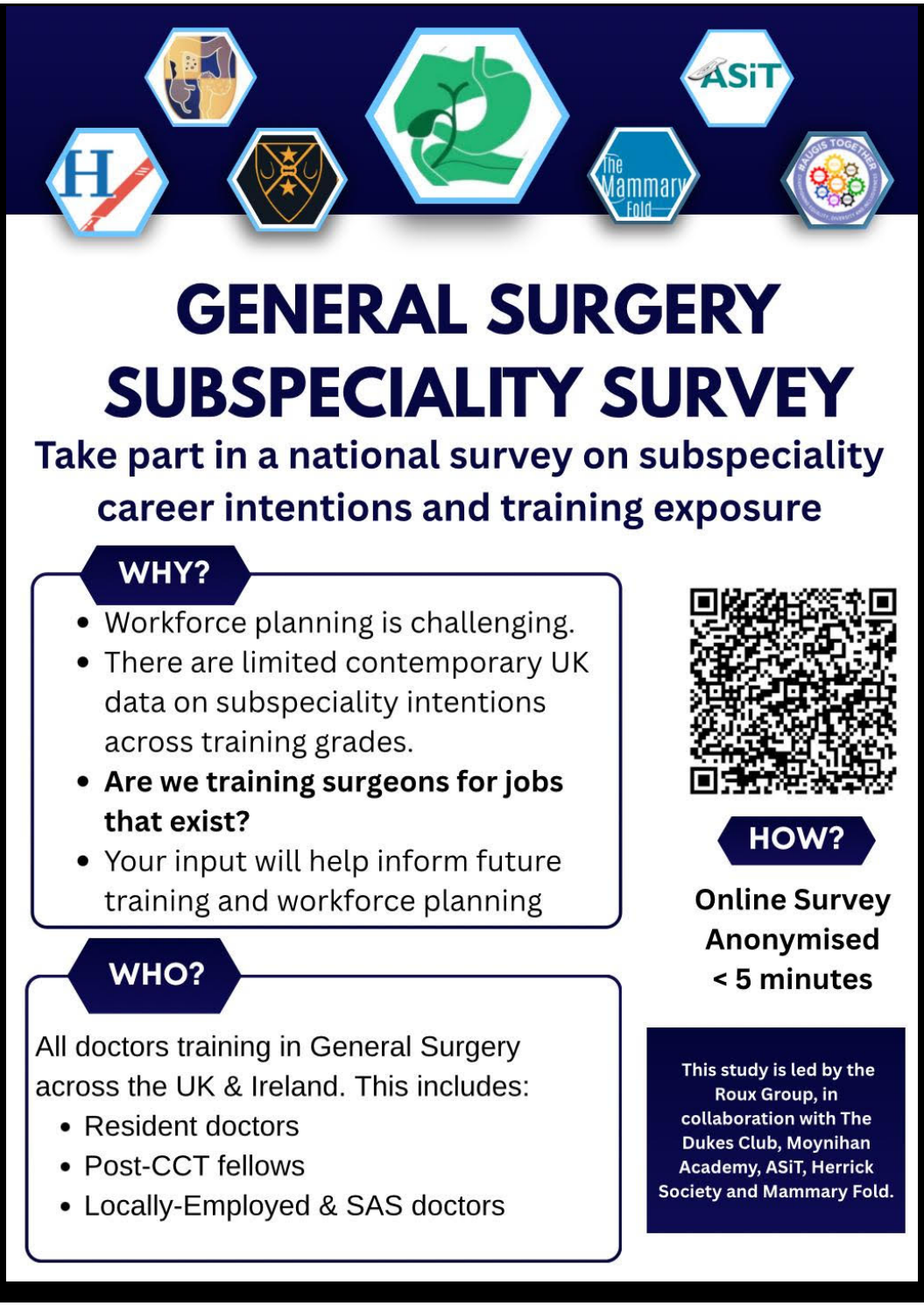
Details Here

BASO/ROSETREES Research Grants in Cancer Surgery

Details Here



AMESI-UK, a trainee-led national clinical audit of acute mesenteric ischaemia, endorsed by ASGBI and VSGBI. We are currently recruiting Local Hospital Leads across the UK to coordinate data collection at their sites. Expression of interest takes less than 2 minutes - see the flyer above and scan the QR code.



Wellbeing in Surgery

with Lily Mills, MA Wellbeing Lead

♀ Surgical Wellbeing and International Women's Day: A Moment to Reflect ♀

International Women's Day offers an opportunity to pause and reflect on what wellbeing means within surgery. As the number of women pursuing surgical careers continues to grow, an important question

remains: how can we ensure that surgical training environments support everyone to thrive?

Wellbeing in surgery is closely linked to culture, mentorship, and representation. For many students and junior doctors considering surgery, seeing female surgeons in leadership roles can be both motivating and reassuring. Visible role models help challenge traditional perceptions of the profession and demonstrate that diverse career pathways in surgery are possible. Mentorship also plays a crucial role. Having someone to turn to for guidance, whether about clinical development, career progression, or managing challenges during training.

International Women's Day also provides an opportunity to highlight women's health within surgical education. Conditions such as endometriosis remain under-recognised despite affecting a large proportion of patients, while acute presentations such as breast emergencies are important areas where trainees benefit from greater clinical confidence and awareness.

The Moynihan Academy aims to tackle these topics this month (March 2026), in a series of webinars. Sessions exploring breast emergencies, the performance and progression of female surgeons, and endometriosis aim not only to provide education, but also to encourage conversation.

Food for thought:

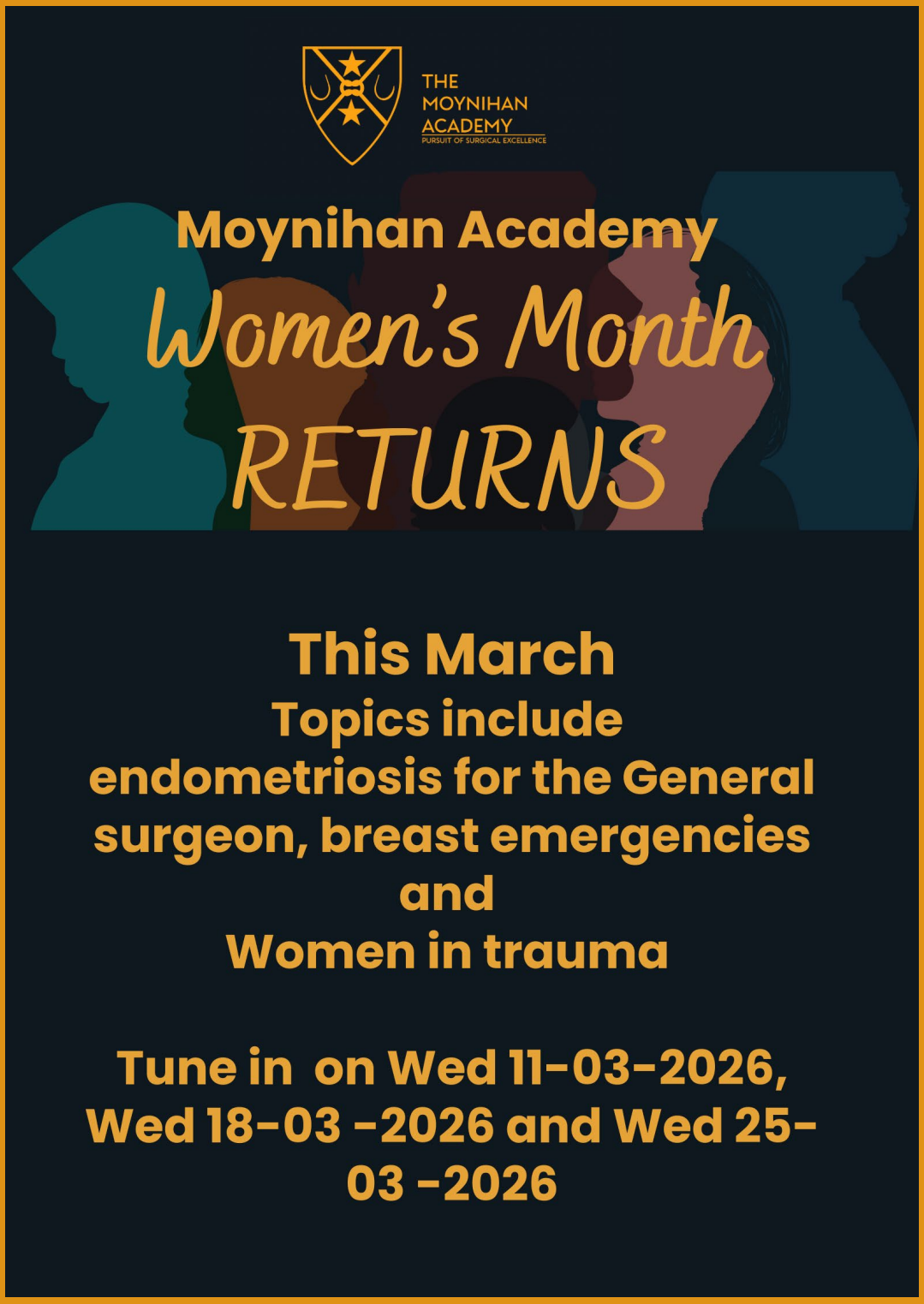
- Have you had any female surgical role models? What did you find inspiring?
- Who has influenced your journey so far?
- How can we foster environments where ALL trainees feel supported?
- What changes would make surgical careers more sustainable for ALL future generations?

I want to thank all of the female surgeon role models out there, inspiring the next generation!

As always, stay informed, stay engaged, stay well!
Lily

Equality, Diversity and Inclusion

with Marwa Jama, MA EDI Lead



Medical Student Corner

Stomas summarised:

Main elements summarised:

1. The basics

-
-
-

2. How to examine a stoma

-
-
-
-

3. Recognising common complications

-
-
-
-

4. Basic post-op understanding

-
-

When you see a stoma, think

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