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THE MOYNIHAN ACADEMY
PURSUIT OF SURGICAL EXCELLENCE

ASGBI
Association of Surgeons of Great Britain and Ireland

The Moynihan's Academy Autumn Newsletter 2025

Welcome to Autumn's 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

This Newsletter is hot off the heels of our sold-out flagship event: the Moynihan Academy Trauma and Emergency Surgery Masterclass, which was held at the Royal College of Surgeons of Edinburgh, Birmingham Hub on Thursday, 13th November 2025.

A huge thank you to all who attended, the presenters who shared their expertise, and to my MA colleagues (especially Ms Faiza Soomro, Education Lead) who organised this excellent event.

This unique meeting featured a fantastic agenda that showcased the latest developments and best practices in trauma and emergency surgery. Attendees benefited from expert-led sessions covering a broad range of topics, including upper and lower GI bleeding, vascular trauma, acute hernias, colorectal emergencies, upper GI perforations, acute pancreatitis, and endocrine emergencies. Attendees participated in engaging breakout rooms focused on FRCS VIVA practice and human factors, crisis resource management, and leadership for future consultants, ensuring the event fostered both clinical knowledge and leadership skills.

The standout presentation was the keynote lecture from Mr. Ammar Darwish on humanitarian surgery, which delivered profound insights into emergency care in challenging environments. The day concluded with announcing the winners of our “Academy Awards” for our Essay Prize and Video Prize Competitions (1st, 2nd and 3rd prizes for each competition).

Can’t wait till next year’s event?
Don’t fret! **There are many ways to engage with the Moynihan Academy:**

Webinars planned, hosted on ASGBI and the Royal College of Surgeons of Edinburgh, with more collaborations upcoming

Podcasts on ASGBI’s own Podbean, as well as with Behind the Knife!

Twitter/Instagram to help you prepare for your exams, including #MRCSMondays, #WellbeingWednesdays, #FRCSFridays, and the brand new #MedStudentWednesdays

Research, both led by and endorsed by the MA

Watch this space for more great content and collaborations.


Humanitarian Surgery and Training on the Frontline
Mr Ammar Darwish
David Nott Foundation
Manchester University NHS Foundation Trust Hospitals
X : @Ammar_Darwish1


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Papers of the Month

with Georgios Geropoulos, MA Research Lead

A frequent topic that comes up in EGS circles is nonoperative management of acute appendicitis. Whilst its popularity surged significantly during the COVID-19 pandemic, and following the publication of the CODA study (probably the most definitive on the topic, so far) around the same time, it is not a novel concept; the first trial comparing antibiotics to appendicectomy was published in 1956, only 15 years after

penicillin was first administered to a human patient. One of the reasons why this is an ongoing point of contention relates to an incomplete understanding of the pathophysiology of this common condition. There is substantial variation in the phenotype of disease - some patients present with a week of symptoms and you end up removing a “mildly injected” appendix, whereas others have four-quadrant peritonitis less than 24 hours after they develop pain. In this aspect, appendicitis is not too dissimilar to acute sigmoid diverticulitis, where we now have robust evidence that supports symptomatic management alone in select patients. This month’s paper asks whether the same non-antibiotic approach can be applied to those with appendicitis.

Antibiotics versus placebo in adults with CT-confirmed uncomplicated acute appendicitis (APPAC III): randomized double-blind superiority trial

Salminen P et al. British Journal of Surgery 2022;109(6): p503-509

https://doi.org/10.1093/bjs/znac086

Question

In CT-confirmed uncomplicated (non-perforated, no abscess no radiologically-identified appendicolith) appendicitis, are antibiotics (2 days IV ertapenem, followed by 5 days oral levofloxacin and metronidazole) superior to placebo, as defined by discharge from hospital and avoiding appendicectomy at 10 days?

Findings

35 patients were assigned to receive antibiotics, 31 to placebo. The 10-day treatment success rate was 97% in the antibiotic group and 87% in the placebo group. The study was not adequately powered for a 10% difference and therefore was not statistically significant (1-sided p = 0.142). The secondary outcomes (pain scores, complications, hospital stay, return to work) were similar in both groups.

Take Away Points

This is a small study (as a comparison, CODA included 1552 patients) that didn’t reach its primary outcome of statistical superiority of antibiotics. Clearly, whatever its findings are, they need to be reinforced by a much larger non-inferiority RCT (APPAC-IV, currently ongoing). This belies the key point, however: **87% of patients with CT-confirmed appendicitis got better without any antibiotics or operation at all.** If these results are replicated, this is potentially practice-changing. Appropriately-selected patients may be able to undergo ambulatory supportive management for their appendicitis, similar to how mild uncomplicated diverticulitis is managed (often in the community). Perhaps with the support of AI decision-making aids, I suspect this is how personalised medicine will take form in non-

oncological surgery in the near future.

Trauma Update

with Ellie Smith, MA Trauma Lead

Whole Blood – Back to the Future for Trauma Resuscitation?

The optimal transfusion strategy for haemorrhaging trauma patients has been a long-debated topic among trauma surgeons around the world. Current UK guidelines recommend a rapid, balanced transfusion with goal-directed correction of coagulopathy if appropriate resources are available. Although the use of whole blood fell out of favour decades ago, recent studies have brought renewed interest and consideration of its use in early haemostatic resuscitation. It brings the option of a single product that is able to deliver physiological ratios of red cells, plasma and platelets, simplifying the concept of balanced transfusion to one bag.

The use of whole blood is not a new concept. When transfusions were first made possible following the discovery of ABO groups in 1901, it was whole blood that was transfused to patients. This was initially as direct donor-to-recipient transfusions and later, during advancements in medical care during World War I, via stored citrated anticoagulated whole blood. Throughout civilian care as well as military care through the end of World War II, whole blood remained the sole transfusion component (1).

In the 1950s, advancements in centrifuge and storage enabled separation into red cells, plasma and platelets. This allowed for more efficient use of donations via administration to target a specific deficiency. During conflicts such as the Korean and Vietnam wars, the longer shelf life of components offered advantages in these logistically challenging environments (1). In the following decades, civilian practice increasingly adopted this component therapy, with many blood donation centres ceasing to collect whole blood entirely (2). At the same time, there was also a shift to the use of crystalloid resuscitation (3). It is important to note that this shift to component transfusion from whole blood was never done on the basis of any significant research demonstrating improved outcomes.

In the early 2000s, recognition of trauma-induced coagulopathy prompted a move towards balanced transfusions, typically a 1:1:1 ratio of plasma, platelets and red blood cells.

Questions were then raised regarding appropriate transfusion ratios.

The PRoPPR trial (4), a randomised control study that compared a 1:1:1 ratio to 1:1:2, found no significant difference in either 24-hour or 30-day mortality. More recently, viscoelastic haemostatic assays (such as TEG or ROTEM) have enabled the move to targeted transfusions or goal-directed therapy. The ITACTIC study (5) was a randomised controlled study that compared the use of goal-directed therapy vs standard protocol across numerous trauma centres in Europe. This trial did not find an overall outcome benefit from goal-directed care, but secondary analysis noted that due to delays in delivery of specifically requested blood products in the goal-directed group, interventions often arrived late during resuscitation and therefore were only partially effective at correcting coagulopathy (6). This highlights key infrastructure issues with the implementation of goal-directed therapies.

So what does the data tell us about the efficacy of whole blood in trauma patients?

A small randomised control study of 100 patients saw that those who received whole blood (excluding those with severe brain injuries) required a significantly lower total transfusion volume compared to standard therapy (7). A larger observational study of approximately 1400 trauma patients from across the US showed improved survival in those who received whole blood earlier in their emergency department admission, though no comparison was made to alternative transfusion protocols. A meta-analysis published last year found that whole blood transfusion was associated with improved 24 hour and late survival compared to component therapy (8). The SWIFT randomised control trial (9), conducted by air ambulance services across the UK to assess for the superiority of whole blood vs component transfusion in pre hospital care will provide higher quality evidence comparing prehospital transfusion options and their implications on mortality and requirement of further transfusions when it reports in the coming months.

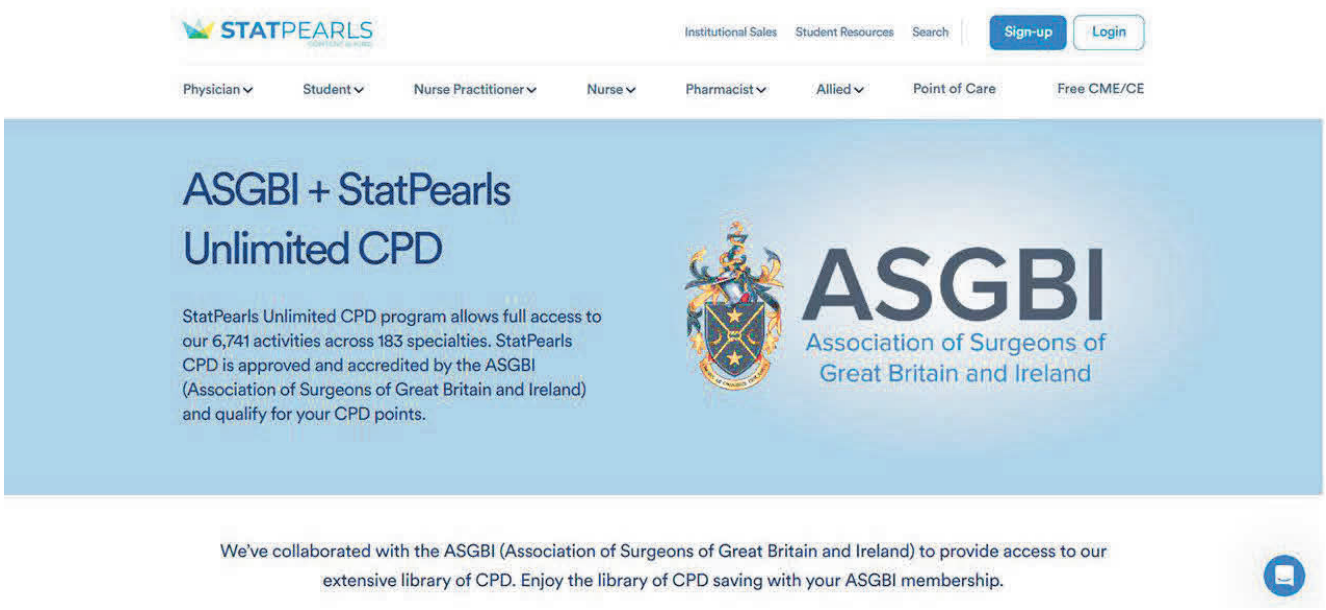
Given recent research, renewed interest in the use of whole blood to treat traumatic haemorrhage is logical. A single product delivering all major blood components is likely to enhance efficiency and haemostatic effectiveness. I recently attended the American Association of Trauma Surgeons Annual Meeting, and there were numerous discussions around the use of whole blood, with the consensus of the room that, as surgeons, whole blood is the preferred transfusion component, although many highlighted limits on its availability as an ongoing issue.

⌛ So why aren't we rushing to use whole blood on our patients?

Whole blood transfusion carries haemolytic risk, necessitating low-titre group O units, which are in short supply. There is also the issue of platelet and coagulation factor degradation, which leads to whole blood having a significantly shorter shelf life of up to 21 days (optimal use in 14), compared to the 42 days of RBCs and 1 year of FFP. Consequently, efficiency and wastage are significant considerations.

Availability, logistics, and governance continue to limit widespread adoption across the UK. Whole blood

may once again become the cornerstone of trauma resuscitation, but its future role will ultimately be defined by ongoing evidence from trials such as SWiFT and by the ability of healthcare systems to overcome logistical and supply constraints.



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EGS Hot Topics

with Georgios Karagiannidis, MA EGS Lead

Percutaneous Cholecystostomy in Acute Cholecystitis: Revisiting the Evidence for Optimal Use.

Sadaka AH, Tseng JF, Itani KMF. Indications for and Optimal Management of Percutaneous Cholecystostomy Drainage: A Systematic Review. JAMA Surgery. 2025.

https://doi.org/10.1001/jamasurg.2025.3748

Question

When is percutaneous cholecystostomy (PC) most appropriate in acute cholecystitis, and what is the best approach to managing the drain?

Findings

This systematic review synthesises findings from 38 studies across multiple healthcare systems to clarify when and how PC should be used. Key takeaways include:

Indications for PC:

- Primarily recommended for critically ill or inoperable patients with acute cholecystitis (AC), particularly Tokyo Grade III.
- Not routinely recommended for low-risk or operable patients (Grade I–II), reaffirming a selective-use approach.

Timing of Cholecystectomy Post-PC:

- Interval cholecystectomy (IC) is preferred, ideally within 6–8 weeks. Delays beyond this window may increase risk of complications or recurrence.
- Some evidence supports early cholecystectomy (<72h) even in patients post-PC, provided clinical improvement is seen.

Drain Management:

- Routine cholangiography before drain removal is not universally required.
- Average drain duration ranges from 7 to 14 days in most series.
- High variability in clinical practice suggests the need for local standardisation.

Take Away Points

This systematic review reinforces that PC should remain a targeted rescue intervention, not a default approach. For EGS teams, the emphasis is on early identification of patients who truly benefit from PC—typically frail, septic, or unstable individuals—and ensuring structured plans for definitive surgery or drain management.
The review also highlights persistent variability in PC protocols, signalling an opportunity for us to develop or refine local guidelines to standardise care and avoid prolonged or inappropriate drain use.

Latest in Surgical Education

with Faiza Soomro, MA Educational Lead

Upcoming Events

REGISTER HERE

General Surgery FRCS Series

THE MOYNIHAN ACADEMY
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The ROYAL COLLEGE of SURGEONS of EDINBURGH

2nd Dec 2025: MA & RCSEd Webinar on Bariatric Emergencies for the General Surgeon
Register Here

19th Jan 2026: MA & RCSEd Webinar on Ischaemic Bowel - When to resect, when to palliate
Register Here

REGISTER HERE

REGISTER HERE

Further Upcoming Events

22nd November 2025: InciSioN UK Virtual Annual Conference 2025

Register Here

8th - 9th Jan 2026: Surgical Research Society (SRS) Annual Meeting 2026

Register 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

Register Here

Upcoming Abstracts Deadline ⏰

23rd Nov 2025: ASiT Foundation Essay Prize Submission Deadline

Submit Here

30th Nov 2025: ASiT Conference Abstract Submission Deadline

Submit Here

22nd Dec 2025: ASGBI BJS Prize Deadline

Submit Here

26th Jan 2026: ASGBI Congress Abstract Submission Deadline

Submit Here

Wellbeing in Surgery

with Lily Mills, MA Wellbeing Lead

Hello everyone,

Happy MA Wellbeing Month!

I wanted to start by defining surgical wellbeing. Well-being in the surgical context encompasses more than the absence of burnout or pathology. It includes:

- Psychological health
- Emotional and cognitive functioning
- Work-life balance and job satisfaction.

One study (Lebares et al., 2022) of general surgery trainees found that the concept of flourishing (emotional, psychological, and social well-being) is a valid measure of global well-being among surgeons. And why does this topic matter?

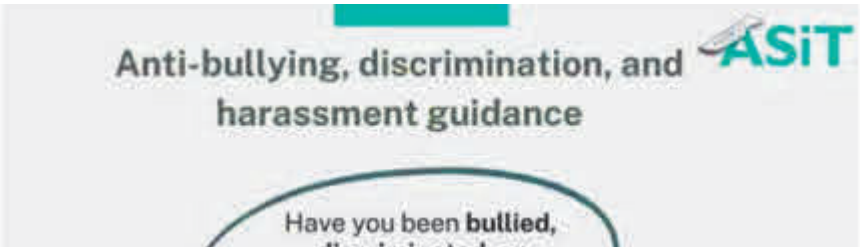
- A recent systematic review (Otukoya et al., 2025) concluded that surgeon well-being is “a critical determinant of surgical excellence and patient safety.”
- In a UK cross-sectional study of surgeons (Miller et al.), 100 % felt that surgical performance anxiety (SPA) affected surgeons, and 96% felt it negatively impacted their well-being.
- Surgical well-being affects the individual surgeon’s health, their performance, team functioning, and ultimately patient care.

What can the MA do for you?

There have been two fantastic virtual talks on wellbeing.

- Week 1: Ms Robyn Brown’s empowering talk educated us about what we should be expecting from our seniors and what we can do if we are not receiving the appropriate support. Mr Brown also kindly shared some wellbeing resources she has created on several topics, including: family planning, pregnancy, bullying, EDI, complaints, stress and burnout, injury and disability, carer roles and finance. These will be uploaded to the MA website in due course.

- Week 2: Mr Michael Boghdady spoke to us about harassment and bullying in the workplace. He shared some research he conducted with ASiT, providing an excellent infographic on how to escalate your concerns if you are experiencing bullying, discrimination, or harassment (Figure 1).



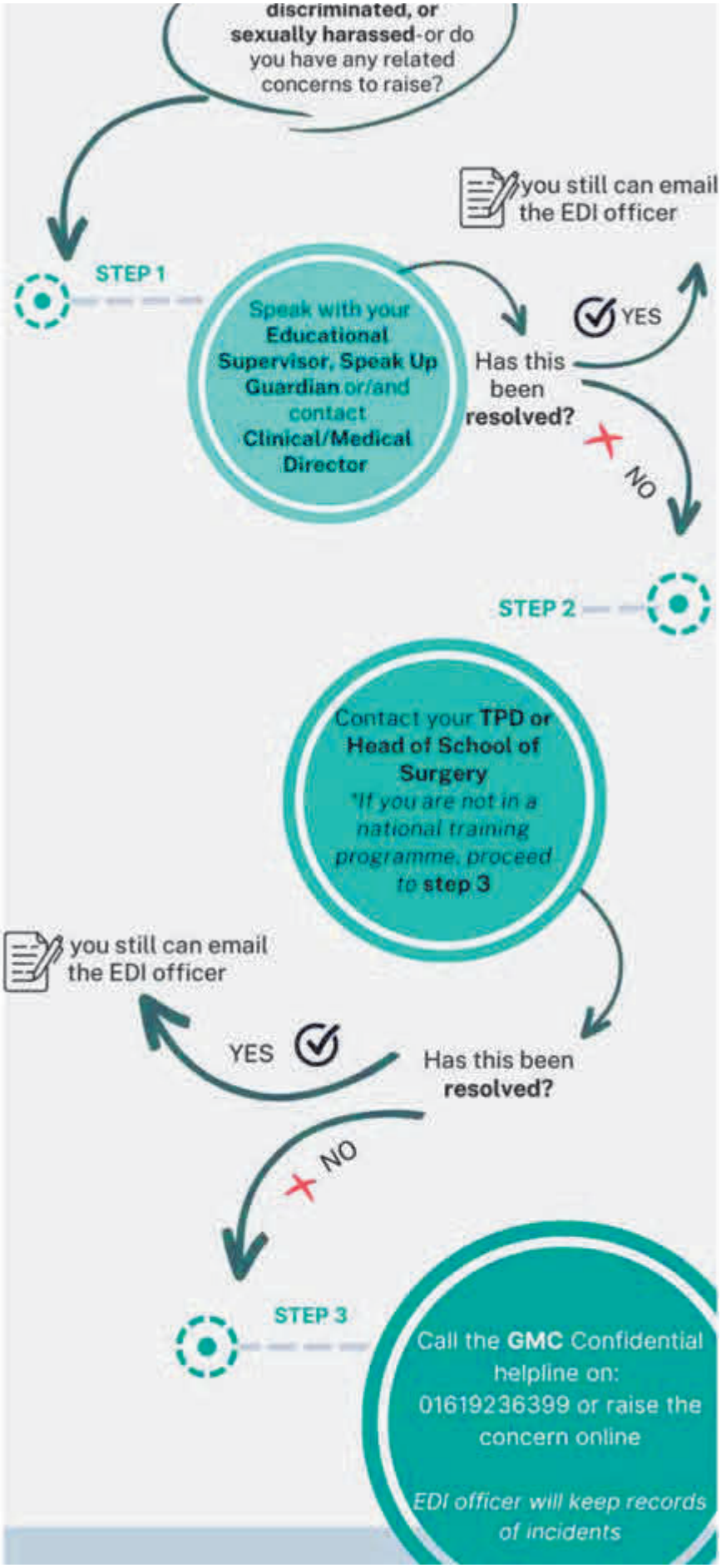


Figure 1: The ASiT anti-bullying, discrimination and harassment (M El Boghdady 2024).

These talks will be uploaded to the MA website for all to watch.

For more tips, or to join the discussion, please follow us on X to stay up to date with #wellbeingwednesday

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

Equality, Diversity and Inclusion

with Marwa Jama, MA EDI Lead

“You can’t be what you can’t see”

That’s why the MA is launching a new project, Blade bios.
In this series, we will interview Trauma surgeons on a wide array of topics. From work-life balance to training, curriculum and how to become one! We hope that accessible profiles on social media will inspire a new generation they can/should become Trauma surgeons too! Follow our social media pages to stay up to date!

Medical Student Corner

with Parwaaz Upadhyay, MA Medical Student Rep

Balancing Surgical Placement with Exams

Surgical placements are some of the most exciting and demanding parts of medical school. Between early ward rounds, long operating lists, and unpredictable finish times ⏱️, it can feel almost impossible to find time to revise. But with the right mindset and a few smart habits, it's possible to thrive both in theatre and in exams.

1. Integrate learning into your day

Use every patient encounter as a revision opportunity. When you see a case of appendicitis or bowel obstruction, quickly review the anatomy, physiology, and key surgical principles behind it. Learning from real patients sticks far better than reading in isolation.

2.⏳ Be strategic with your time

Identify small study windows — post-ward round, between cases, or during lunch breaks. Ten focused minutes on past questions can add up over a few weeks. Use flashcards or question banks that fit into short bursts of study.

3. Prioritise quality over quantity

You don't need to memorise every step of a Whipple procedure — focus on what's examinable and relevant to your level. Core surgical topics like wound healing, fluids, and perioperative care are high-yield for exams.

4. Look after yourself

Fatigue kills productivity. Protect your sleep and take real breaks when you can. A clear mind learns and retains far more than a tired one.

Remember, surgical placements are not a distraction from learning — they *are* learning. You're seeing medicine come alive, and that context will help your exam preparation more than you think.

SAS Update

Ralph Obure, MA SAS Lead

High-yield tips to get your portfolio pathway application on track

I was fortunate to catch up with Mr Gaurav Kulkarni, a newly appointed Consultant Abdominal Wall and Colorectal Surgeon based in York, for a brief chat about his key takeaways on entering the Specialist Register via the portfolio pathway.

Mr Kulkarni's meticulous approach is clearly not limited to developing abdominal wall planes in theatre but is a way of life — demonstrated by his extensive academic work and diligent portfolio submission, earning CESR within 8 months of submission and without needing a review. His achievements have been impossible to overlook, and he has been invited to speak at various important meetings including the ASGBI Annual Congress in Edinburgh. Despite his impressive journey, he maintains an easy-going and approachable demeanour and is always happy to share from his experiences. We had a great chat, and I have distilled his high-yield tips below.

1. Expect the unexpected — adapt early and adjust your plans.

The CESR pathway was revised to the current portfolio pathway three months before I had planned to submit. My target was February 2024; however, in November 2023 the pathway changed. This meant going back to the specialty-specific guidance (which I had to read three times). Some key differences forced me to delay my submission to March 2024.

2. Have reliable tools to permanently redact patient information.

I realised late that the redactions I was making were not permanent. You need either a paid PDF-editing

tool or a MacBook to ensure irreversible redaction. I subsequently had to redo all the redactions, and despite this, two of the 300 were still not permanent! The GMC advisor spotted them, and I had to complete a GDPR/confidentiality course and provide a reflection.

3. Support and mentorship are the cheat code.

I've been extremely fortunate to work with supportive trainers who went above and beyond for my application. I sat the FRCS while at Kettering General Hospital, and I owe much of this success to the support from the clinical director and clinical lead. During my fellowship at Broomfield Hospital, consultants who had never supported CESR applications before still made the effort to help me.

Without support, completing a strong application is incredibly difficult. Many components — MSFs, CEXCs, PBAs, CBDs — all require timely colleague input within four weeks.

4. Harness the power of incremental gains.

The portfolio pathway is compartmentalised and can be broken down into manageable goals. The philosophy of small, consistent daily progress works. Each day, ask yourself:
"What can I do today — even something small — that moves me closer to CESR?"
These small steps keep you motivated and "in the game".

5. A prospective online portfolio is worth more than gold.

Keeping WBAs, MCRs, and evidence on ISCP or another platform provides timestamped, credible, prospective documentation. Paper applications are risky and far less persuasive. Discuss your plans with consultants early so they can support the MCR process.

If I had to give one tip: embrace incremental gains and remain grounded — you are one of many working toward this, not a superstar simply because of years of experience.

6. A burden shared is a burden halved.

Although I didn't personally benefit from this, having a CESR buddy can be invaluable for motivation and accountability. Attending meetings like ASGBI Congress or Moynihan Academy EGS days is a great way to network and meet others at a similar stage.

Mr Kulkarni has also kindly shared a checklist he created for anyone working on the portfolio pathway in general surgery with an interest in colorectal surgery (see QR code below).

An online recording of his full presentation is available on the:

NHS England National Online Training Programme (NOTP) website:

https://pgvle.co.uk/course/view.php?id=485

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