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Moynihan's Academy Summer Newsletter 2025

A very warm welcome to our Summer Newsletter, the first one with our brilliant new Council for 2025-2026. The new team is ambitious and enthusiastic, and have been planning and preparing educational material, webinars, research, podcasts, and events to support your surgical education and training. We are a diverse team with a huge responsibility to provide high-quality resources for our over 650 members across the UK and Ireland. Our aim is "the Pursuit of Surgical Excellence" in general and trauma surgery.

Save the date : **Moynihan Academy Trauma & Emergency Surgery Masterclass Thursday, 13th November 2025, Birmingham**

It will be immediately following the Wednesday, 12th November ASGBI EGS Symposium in Birmingham. Back by very popular demand, the MA Trainee Day will be an excellent day of expert teaching, viva practice, surgical skills practice and networking. Most importantly, the event will be very low-cost and will cater to all stages of training, from medical school to senior registrar and SAS doctors. Join us for this immersive one-day masterclass, bringing together a faculty of leading experts in trauma and emergency surgery.

We encourage you to connect and engage with us via our WhatsApp (add yourself to the chat via this link) and our socials @asgbi_MA on X/Twitter, Instagram and LinkedIn. Many of you would have already seen and interacted with our #FRCSFriday #MRCSMonday and #WellbeingWednesday posts. We'll be taking a summer break in August, but don't worry, we'll be back in September with more clinical cases and educational resources.

For those rotating to General Surgery in August, welcome to the team! We have multiple resources to help you with your journey, from medical school to FY years, CT years, ST years, and SAS doctors on our website. If you're revising for exams make sure you use your members discount for 40% off the

TeachMeSurgery question bank and 25% discount for StatPearls question bank.
Thank you for being part of our community. If there's anything else we can do to support your surgical journey, let us know. Hope you all have a wonderful summer!

Jared Wohlgemut, The Moynihan Academy President

Papers of the Month

with Georgios Geropoulos, MA Research Lead

Earlier this year, The Lancet Gastroenterology & Hepatology Journal published a meta-analysis comparing antibiotics to surgery for uncomplicated appendicitis in adults. It's a great example of how high-quality, pooled patient data can inform clinical decision-making in emergency surgery.

If you're considering doing your own meta-analysis, it's worth keeping the Hozo et al. paper in mind— it provides practical methods for estimating means and standard deviations when only medians and ranges are reported. A valuable tool for anyone looking to include more studies in their evidence synthesis.

Antibiotic treatment versus appendicectomy for acute appendicitis in adults: an individual patient data meta-analysis. Scheijmans JC et al., The Lancet Gastroenterology & Hepatology (2025)

https://doi.org/10.1016/S2468-1253(24)00349-2

Question

Can antibiotic therapy serve as a safe and effective alternative to appendicectomy in adults with imaging-confirmed uncomplicated acute appendicitis?

Findings

An individual patient data meta-analysis of 2531 participants across five RCTs showed that 69% of patients treated with antibiotics avoided surgery at one year, though the treatment failure rate was higher compared to appendicectomy (27% vs 7%).

Take Away Points

Antibiotics can be a valid first-line treatment option for selected patients, but shared decision-making is crucial, as nearly one in three may ultimately require surgery. In patients with an appendicolith, antibiotic treatment significantly increased the risk of complications at 1 year compared with initial appendicectomy, and almost half had an appendicectomy within 1 year.

Estimating the mean and variance from the median, range, and the size of a sample. Hozo et al., BMC Medical Research Methodology (2005)

doi.org/10.1186/1471-2288-5-13

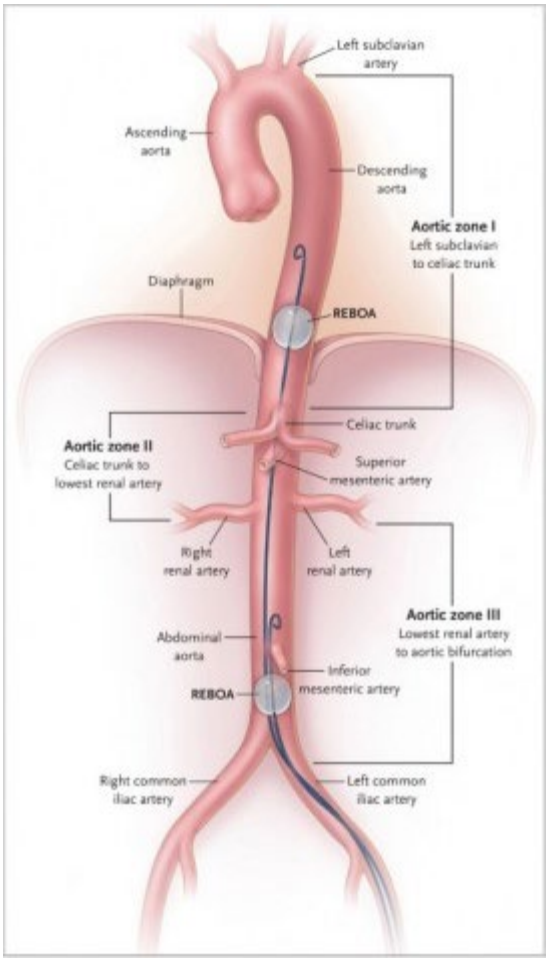
Are you considering doing a meta-analysis but finding that included studies only report medians and ranges instead of means and standard deviations? Take a look at this classic 2005 paper by Hozo et al., which offers simple, practical formulas to estimate the mean and variance from limited summary data. It's an essential tool that can help expand the number of studies you're able to include in your analysis!

Trauma Update

with Ellie Smith, MA Trauma Lead

Management of non-compressible trauma haemorrhage is the domain of the surgeon. However, what happens if a surgeon isn't available or the patient isn't sitting in the operative room exsanguinating?

Link to the article



Resuscitative endovascular balloon occlusion of the aorta (REBOA) was developed to use in resuscitation of patients with non-compressible thoraco-abdominal haemorrhage. The aim is to occlude the descending aorta and maintain perfusion to the thoraco-abdominal haemorrhage or junctional haemorrhage. This should therefore preserve coronary and cerebral perfusion, buying time until definitive treatment (ie surgery or interventional radiology) can be performed.

REBOA device works by placing a 7Fr sheath in the patient's femoral artery, through which the REBOA catheter is placed and advanced up from the femoral to common iliac artery, eventually into the aorta. The balloon at the end of this catheter can then be inflated at one of the three zones in order to occlude aorta and prevent downstream haemorrhage.

- **Zone I:** involves advancing REBOA between left subclavian artery and the celiac trunk.
- **Zone II:** between the celiac trunk and renal arteries.
- **Zone III:** above the iliac bifurcation.

It is important to note that these positions are approximate, and this procedure is designed to occur in the field or the emergency room and not under fluoroscopic guidance.
There have been two recent papers that assessed different uses of REBOA in the UK healthcare system.

Emergency Department Resuscitative Endovascular Balloon Occlusion of the Aorta in Trauma Patients with Exsanguinating Haemorrhage: The UK-REBOA Randomized Clinical Trial. Jan O. Jansen et al, JAMA Oct 2023

doi:10.1001/jama.2023.20850

This was a multi-centre randomized control trial across 16 Major Trauma Centres with a 1:1 randomization of standard care (as per local policy) or standard care PLUS an emergency room placed REBOA. Inclusion criteria was any patient, over the age of 16 who was suspected to have life-threatening torso haemorrhage.

Key Points

- 90 patients enrolled - 46 REBOA plus standard care (SC), 44 SC only;
- Primary outcome was 90 day mortality: 54% mortality in the REBOA +SC group compared to 42% SC alone;
- Odds ratio was 1.58 – with an 86.9% probability that REBOA was associated with an increase in mortality;
- This result led to the trial being stopped early. Initial trial recruitment was to be 120 patients; however, trial was stopped following interim review as the prespecified stopping rule for harm had been met.

Secondary outcome

- Early mortality was higher –24% vs 5%, with an ongoing elevated risk of death at both 6 hours and 24 hours;
- Time to definitive haemorrhagewas delayed 83min vs 64 min;
- Death due to bleeding was more common in REBOA, particularly early deaths.

Take Away Points

- This was the first randomized controlled clinical trial to examine the effectiveness of REBOA for the management of exsanguinating haemorrhage;
- REBOA in hospital does not reduce mortality and may lead to an increase in mortality for these critical ill patients.
- REBOA in hospital may lead to a delay in definitive haemorrhage management which does not lead to a benefit in longer term survival.

So what's next for REBOA? And what does all this mean for the surgeon?

The use of REBOA is going to continue to divide medical community for the time being. The results of these two papers highlight that the use of REBOA is about using it in the correct clinical situation, with an experienced medical provider and the correct patient choice. Especially in the UK, where the volume of these patients is much lower than other healthcare systems, the numbers of patients who could be recruited to trials such as these remains low. REBOA isn't going away but there is more work to be done evaluating its effectiveness and benefits and to determine its optimal uses. REBOA is something that the general surgical team should be aware of…especially if the air ambulance team brings you a patient with one in situ!

EGS Hot Topics

with Georgios Karagiannidis, MA EGS Lead

Percutaneous Cholecystostomy in Acute Cholecystitis: What the Experts Now Agree On

Ramia JM, et al. International Delphi consensus on the management of percutaneous cholecystostomy in acute cholecystitis. World J Emerg Surg. 2024;19:32.
https://doi.org/10.1186/s13017-024-00561-8

Question

What are the current international expert recommendations on the indications, technique, and follow-up of percutaneous cholecystostomy (PC) in acute cholecystitis?

Findings

This Delphi consensus, led by experts from the E-AHPBA, ANS, and WSES, gathered global insights on the controversial use of PC in managing acute cholecystitis. Among 27 clinical statements, only six reached consensus (>70% agreement), emphasizing how varied practice remains. These are the key endorsed points:

- Do not delay PC: When clearly indicated, PC should be performed without waiting 48 hours.
- Grade I cholecystitis? No PC needed: PC is not recommended in Tokyo Grade I cases.
- Surgery first for Grade II: Surgery remains first-line for Grade II AC in operable patients.
- Transhepatic is best: The preferred access for PC is the transhepatic route.
- Cholangiogram before removal: Always perform cholangiography before removing the PC tube.
- Laparoscopic approach preferred post-PC: LC is the ideal follow-up intervention—even after PC.
- Notably, there was no consensus on PC duration or withdrawal timing, reaffirming the need for local protocol standardisation.

Take Away Points

This expert-driven study highlights a narrowing scope for PC—focused firmly on high-risk, inoperable patients—and rejects its overuse in mild or moderate cases. For EGS teams, the key messages are: don't delay PC when it's needed, avoid unnecessary PC in mild AC, and prepare patients for a laparoscopic cholecystectomy as the ultimate goal. These findings bring welcome clarity and are likely to inform future updates to WSES and Tokyo guidelines.

Latest in Surgical Education

with Faiza Soomro, MA Educational Lead

Upcoming Events

- ASiT x RaDiST Robotics for Trainees Conference 2025: 21st- 22nd July 2025, RCS England

th

ASGBI EGS Symposium

Wednesday 12th November 2025, Birmingham

Register now! And don't forget to get your study leave well in advance

Register here

Moynihan Academy Trauma & EGS Masterclass

13th November, Birmingham

Join us for this immersive one-day masterclass, bringing together a faculty of leading experts in trauma and emergency surgery.

The programme is designed to deliver interactive, case-based learning across a wide range of critical topics, including:

· Managing upper and lower GI bleeds;
· Vascular abdominal emergencies;
· Controversies in small bowel obstruction;
· Trauma principles and resuscitation strategies;

· Decision-making in major abdominal trauma;
· Gastric and oesophageal perforations;
· Acute severe pancreatitis pathways;

Alongside the main sessions, delegates can tailor their experience with breakout workshops, including: FRCS-style viva practice with experienced faculty, Human factors, crisis resource management, and leadership development for the future consultants.
Whether you are a new to your surgical job, a senior registrar preparing for the FRCS or a consultant wishing to refresh and benchmark your practice against the latest standards, this day offers essential insights, practical strategies, and opportunities for networking.

The programme will also feature a keynote lectures on advances and the future of emergency general surgery.
Don’t miss this unique opportunity to enhance your expertise and stay at the forefront of trauma and emergency surgical care.

Register here

Wellbeing in Surgery

with Lily Mills, MA Wellbeing Lead

Hello everyone!

As the new Wellbeing Representative, I'd like to begin by saying thank you to Rute for her inspiring contributions and thoughtful wellbeing insights over the past few years. I'd also like to offer a warm welcome to all members of the ASGBI MA community—I hope this message finds you well.

It's been incredibly encouraging to see surgeon wellbeing gain traction as a serious topic in surgical research and literature. The key message is clear: wellbeing is not a luxury—it's a necessity. In the demanding, high-pressure environment of surgery, we sometimes forget that our most important instrument isn't a scalpel or a suture—it's ourselves. Our wellbeing directly influences clinical performance, decision-making, team cohesion, and ultimately, patient outcomes. Burnout, fatigue, and anxiety aren't signs of weakness—they're signs that something needs care and attention. Prioritising your mental and physical health isn't just an option—it's essential!

Looking Ahead: Wellbeing Month – October 2025

In recognition of World Mental Health Day, October will be dedicated to surgeon wellbeing, with a particular focus on how to access support when it's needed.

Did you know that surgeons are among the least likely medical professionals to seek support? That's why this initiative matters. Our goal is to raise awareness, reduce stigma, and promote access to practical resources.

Throughout October, we'll be hosting a series of weekly talks by experts in surgeon wellbeing. These sessions will feature the latest research, real-life stories from colleagues, and interactive Q&As. Whether you're looking for insight, support, or simply a space to reflect, we hope you'll join us.

Keep an eye on our social channels for further updates—we're excited to share more soon.

And just to leave you with my favourite Wellbeing Tips for the days in theatre

1. Micro-breaks matter: take 60-90 seconds between cases to stretch, hydrate, or simply breathe. These brief resets improve focus and reduce cumulative stress.

2. Debrief emotionally, not just clinically: Case debriefs often focus on technical outcomes—but psychological processing is equally important. Create space to share feelings after tough cases with trusted colleagues or a peer support group.

3. Set boundaries, respectfully: Say yes to what aligns with your goals—and no without guilt when needed. Guard your time off and take leave seriously.

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

5 Resources to Read & Listen to for Pride Disability Month

1. **Disability & Neurodivergence in Medicine — BMA Survey**

The BMA 2020 survey gives you an idea of how common both learning and physical difficulties/ disability are! Awareness of this in communication and actions towards colleagues is paramount! How do you approach this as an AES? Or as the rota maker?

https://www.bma.org.uk/advice-and-support/equality-and-diversity-guidance/disability-equality-in-medicine/disability-and-neurodivergence-in-the-medical-profession

2. **Disability in Surgery — A Call to Action**

Chugh PV, Jones BA, Twomey KE. *JAMA Surg.* 2025;160(6):611–612.
A powerful editorial urging the surgical community to recognize and support surgeons with disabilities.

3. **Ergonomic Challenges for Female Surgeons**

Would the theatre set up work for you if you injured your neck? Does it take women longer to train on endoscopy because their hands literally can't fit on the scope wheel? Our language, way of work and standards seem to centre the able bodied, tall man.

https://www.templehealth.org/about/news/study-led-by-temples-dr-christina-jacovides-finds-female-surgeons-face-unique-ergonomic-challenges-in-the-operating-room

4. **Surgical Ergonomics Recommendations**

Surgical ergonomics recommendations. ACS division of education, committee of ergonomics.

5. **Podcast: Surgeons Navigating Acquired Disability**

Our podcast with Rhiannon Richards and Mo Belal. Two surgeons facing acquired disability and navigating life as a surgeon.

https://www.podbean.com/ew/pb-m7hf8-176c51f

Medical Student Corner

with Parwaaz Upadhyay, MA Medical Student Rep

Theatre Etiquette and Scrubbing In

We all know how scary it is stepping into the operating theatre for the first time, but with the right approach, you can contribute meaningfully and make a positive impression. Here are essential tips to help you scrub in confidently and navigate the Operating Theatre for your next surgical placement:

1. Know Before You Go

- Read the notes: Familiarise yourself with the patient's history and the planned procedure. Look at YouTube videos or PubMed articles for basic steps of the procedure.
- Check theatre lists and times: Be punctual and clarify expectations with the team. Different trusts have varied starting times for surgery so find out beforehand to show your organisation.
- Ask to scrub in: Surgeons like when you show passion and interest in their specialty. Don’t be afraid to ask to scrub in for a closer look.

2. Master the Scrub Technique

- Bare below the elbows: Remove jewellery, roll up sleeves, and ensure short nails.
- Follow the five moments for hand hygiene: As per NHS Infection Prevention and Control (IPC) guidelines.
- Scrubbing up: Use a standard chlorhexidine-based scrub, and follow a systematic technique (nails, hands, forearms for at least 2–5 minutes).

3. Gowning & Gloving

- Sterility is key: Avoid touching anything non-sterile once you’ve scrubbed in.

- Let theatre staff assist: A scrub nurse will help show you how to put your gloves on. Don't be scared by them!

4. Theatre Etiquette

- Stand where you can observe without obstructing: Ask where you should position yourself.
- Speak minimally and respectfully: Never break sterility by reaching over the field.
- Always introduce yourself: Let the team know your role as a student.
- Keep your hands close: When scrubbed in, hold your hands together and don't brush them against anything.

5. Stay Curious, But Safe

- Ask questions—but not during critical moments of the procedure.
- Watch how the team communicates during WHO Surgical Safety Checklist briefings.

It can be overwhelming to be in theatre for the first time. But with experience, your skills will improve over time and your theatre sessions will continue to be more rewarding. I hope this section helps in that!

THE MOYNIHAN ACADEMY
PURSUIT OF SURGICAL EXCELLENCE