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THE MOYNIHAN ACADEMY
PURSUIT OF SURGICAL EXCELLENCE

Welcome to our Summer Newsletter, and our first one with our fantastic new Council for 2024-2025. They have already been busy working behind the scenes planning webinars, podcasts, articles, research and developing our website and resources to better support you and improve surgical training. The MA is committed to reducing the financial and non-financial the cost of training by promoting free educational opportunities and building a surgical community where everyone is included and able to learn and grow.

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, 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. In the meantime make sure to let us know what you love about a career in surgery and why we're winning with the hashtag #SurgeryFTW

For those rotating to General Surgery in August, welcome to the team! Check out our med student corner and e-learning modules (2 free, and more available to members) for top tips and guidance to enable you to hit the ground running and make the most of your placements. For our CSTs and HSTs we'll also be releasing guidance in September on how to make the most of your ISCP and careers advice, and if you're revising for exams make sure you use your members discount for 40% off the teach me surgery question bank.
Thank you for being part of our community, and as always if there's anything else we can do to support you let us know. Hope you all have a wonderful summer!

Warmest Regards,

Kellie
The Moynihan Academy President

TeachMeSurgery.com

Find your TeachMeSurgery discount code on the members section of our website, here.

Papers of the Month

The trauma systems implemented across the UK in the past decade or so have allowed significant improvements to trauma patients outcomes. And many of us are lucky enough to work within some of the world's best trauma hospitals…
But there remains ongoing debate in how these trauma systems can best be structured and developed, both in the UK and globally. These two papers represent the ongoing research in trauma system design globally, with our European counterparts showing such examples.
Make sure you keep your eyes out for the Moynihan Academy's upcoming research project coming out later this year, which will be focusing on the topic on global trauma systems.

Barbieri G. et al. Trauma Center model application in the University Hospital of Pisa: a single-

center comparative study. Intern Emerg Med (2024).
DOI: 10.1007/s11739-024-03644-1

Question: How have patient outcomes changed since the implementation of a “Hub and Spoke” trauma system model in the Pisa and Tuscany region, Italy?

Findings: A pre- and post-implementation retrospective comparison of key performance indicators and patient outcomes at the Pisa Hub centre were reported. Overall clinical assessments and patient mortality improved, among other measured parameters.

Take home thoughts: For patients who made it to the “Hub” hospital, outcomes do seem to have improved. But it’s important to remember that this paper does not show the patients remaining at the “Spoke” hospitals – if a hospital just cherry-picks the patients its treats, how can we determine an overall regional outcome of benefit?

Doran J et al. Major trauma patients and their outcomes – A retrospective observational study of critical care trauma admissions to a trauma unit with special services. Injury (2024)
DOI: 10.1016/j.injury.2024.111622

Question: Ireland is in the process of developing its own trauma system, with the University Hospital Galway being designated a Trauma Unit with Specialist Services. How have trauma patients and injuries changed over the last decade at this unit?

Findings: From 2010 to 2021, annual admissions for trauma patients doubled, with falls and RTAs being the main mechanisms of injury. Patients >65years accounted for nearly half of trauma admissions and 40% of patients suffered polytrauma. Overall mortality rates reduced for trauma patients during the study period.

Take home thoughts: This paper emphasises the current trends seen globally of an increasing trauma burden, with growing complexity of injuries and advancing years of patients. Trauma system design must be designed with these important concepts in mind.

Mr Mike Bath, MA Research Lead

SAVE THE DATE

The Moynihan Academy EGS and Trauma Weekend

10th -11th January 2025, Austin Court, Birmingham

Trauma in Depth

with

Matt McKenna, MA Trauma Lead

The BMJ has recently published an article calling for greater use of tranexamic acid (TxA) in surgical practice, but what evidence do we have to support this?

The review, titled 'Wider use of tranexamic acid to reduce surgical bleeding could benefit patients and health systems,' highlights the crucial benefits of tranexamic acid in reducing surgical bleeding and improving patient outcomes. Each year, major surgical bleeding is a significant cause of mortality, with over 300 million surgeries worldwide resulting in approximately four million deaths within 30 days. In the UK, there are eight million surgeries annually, with 85,000 deaths.

Tranexamic acid, an affordable and effective drug, has strong evidence supporting its ability to reduce surgical bleeding and the need for transfusions. Despite its benefits, a 2023 NHS audit revealed that one-third of eligible patients in England do not receive it, missing out on significant advantages. Full adherence to NICE guidelines could prevent 15,000 major bleeds, save 45,000 hospital days, and millions of pounds annually.

An implementation group formed in 2022, including various Royal Colleges, is advocating for increased awareness and use of tranexamic acid. Evidence from large trials like Poise-3 and Atacas confirms that tranexamic acid significantly reduces bleeding without increasing thrombotic risk, resulting in fewer transfusions and faster recoveries.

Globally, wider use of tranexamic acid is essential, especially in regions with limited blood supplies and higher transfusion risks. Inclusion in WHO guidelines and national surgical checklists could enhance patient safety and surgical outcomes worldwide. The NHS's CQUIN framework and recommendations from the Infected Blood Inquiry also support increased use of tranexamic acid in surgery.

In summary, tranexamic acid presents a clear opportunity to improve patient care, reduce healthcare costs, and enhance global surgical outcomes. Surgeons, anaesthetists, and health systems should prioritise its implementation.

For more information, we recommend you read the article: [https://doi.org/10.1136/bmj-2024-079444] (https://doi.org/10.1136/bmj-2024-079444). Furthermore, familiarising yourself with the Poise-3 trial is highly recommended for anyone approaching surgical exit exams: [https://doi.org/10.1186/s13063-021-

05992-1](https://doi.org/10.1186/s13063-021-05992-1).

Latest in Surgical Education

presented by

Garima Govind, MA Education Lead

Other upcoming events

RCSEd and ASGBI Surgical Oncology Webinar,
Wednesday 11th September 7pm - save the date
RCSEd Laparoscopic Skills in Emergency Surgery,
Thursday 24th October 2024, Edinburgh - details here

Trauma Care UK Meeting,
6-7th September 2024, Belfast, abstracts welcomed - details here

Upcoming Abstract Deadlines

SRS, Abstracts until 30th September 20224
ESTES, Abstracts available from September 2024
Western Trauma Association, Abstracts until 3rd September 2024

Educational resources

MA Useful Guidelines and Resources
Landmark Papers in Trauma and Acute Care Surgery
Free Headspace app for NHS workers

EGS Hot Topic

with

Faiza Hashim Soomro, MA EGS Lead

Goodbye Hartmann Trial

Perrone, G., Giuffrida, M., Abu-Zidan, F. et al. Goodbye Hartmann trial: a prospective, international, multicenter, observational study on the current use of a surgical procedure developed a century ago. World J Emerg Surg 19, 14 (2024). doi.org/10.1186/s13017-024-00543-w

Question: What are the surgical options globally used to treat patients with acute left-sided colonic emergencies, and what factors lead to the choice between Hartmann's Procedure (HP) and Resection & Primary Anastomosis (RPA)?

Findings: This is a prospective, international, multicenter, observational study of total 1215 patients with left-sided colonic emergencies who required surgery with a 1-year follow-up. 564 patients (43.1%) were females. HP was performed in 697 (57.3%) patients and RPA in 384 (31.6%) cases. Complicated acute diverticulitis was the most common cause of left-sided colonic emergencies (40.2%), followed by colorectal malignancy (36.6%). Severe complications (Clavien-Dindo ≥ 3b) were higher in the HP group ($P < 0.001$). 30-day mortality was higher in HP patients (13.7%), especially in case of bowel perforation and diffused peritonitis. 1-year follow-up showed no differences on ostomy reversal rate between HP and RPA. ($P = 0.127$). RPA was preferred in younger patients, having low ASA score (≤ 3). This study concluded that RPA should be considered as the gold standard for surgery, with HP being an exception.

My Takehomes: The "Goodbye Hartmann Trial" significantly impacts surgical practice by demonstrating the benefits of Resection and Primary Anastomosis (RPA) over Hartmann's Procedure (HP) for left-sided colonic emergencies. The study shows RPA reduces postoperative complications and eliminates the need for a second surgery, improving patient outcomes. Despite its observational nature and potential biases, the study's extensive, diverse dataset lends robustness to its findings. The paper concluded that RPA should be the gold standard surgical procedure for the left sided colonic emergencies while HP should be an exception, however there have been numerous factors where significant percentage of patints underwent HP and the factors involved were low volume hospitals, inexperienced surgeons, night time surgery, older patients, bowel perforation, colonic ischaemia and patient's high ASA score.The main concern and the rationale of not performing a RPA was anastamotic leak. While that is an understandable surgical option, but there is plenty of literature available that suggest in last decade with evidence suggesting no difference in major post-operative complications between HP and RPA. This study confirms the pre-existing data of HP associated with higher complication rate, nonetheless the practices of HP in event of emergency stays the same. It calls for more randomized controlled trials to further validate these results and highlights the need for standardized surgical protocols, emphasizing a patient-specific approach to enhance care quality in emergency surgeries.

Wellbeing in Surgery with Rute

Dear Moynihan Academy Community,
I am honoured to serve as your Wellbeing Lead. During my tenure, I am eager to foster a culture of wellness within the Moynihan Academy community and contribute to the collective betterment of the surgical field. We have plenty of exciting initiatives planned for the upcoming months and we've highlighted a few below.

Upcoming Webinar: Non-Technical Skills in Conflict Resolution in Surgery

We are thrilled to announce a forthcoming webinar that focuses on the critical topic of Non-Technical Skills in Conflict Resolution in Surgery.
This webinar will provide practical strategies and insights to manage and resolve conflicts constructively and maintaining a harmonious and effective workplace.
Stay tuned for more details and registration information in the coming weeks.

Join the Conversation: #WellbeingWednesday

We are excited to continue our social media campaign, #WellbeingWednesday.
Each Wednesday, we share insightful posts, tips, and resources aimed at promoting mental and physical wellbeing within the surgical community.

Together, we can prioritise our wellbeing and create a healthier, happier professional community.

MED STUDENT CORNER
Top Tips for Surgical Electives

With elective season upon us, we thought we would get some helpful insights from some of the committee who have been on elective most recently. Please enjoy these useful and practical tips from our Foundation Reps, Michal Kawka and Sai Kotecha.

1. Set goals
Think about whether you want to use this opportunity to build contacts in a future place of work, get work experience with the best in the world, or experience the challenges of delivering care in a resource-poor environment.

2. Get inspiration
Ask older students in where they've been, speak to surgical trainees on placement, and check out sites like The Student Room (ask for the contact details of the elective coordinator at the hospital they went to!) or the Elective Network.

3. Start planning early
It's never too early to think about organising your elective – some centres in South Africa, the USA, or Canada require applications 12-18 months in advance.
If you want to do a popular elective like this, get organised to avoid being disappointed.

4. Land your dream elective
Large teaching hospitals may have formalised application processes requiring references and registration fees, but you can secure an elective at some smaller hospitals just by emailing the relevant person (this can sometimes be tricky to find – it might be a doctor or clinical supervisor or a member of the admin team).

5. Think about finances
Flights, fees, visas and accommodation all add up. The good news is that there are loads of elective prizes available through the Royal Colleges, and speciality associations (think about applying for these early though).

6. Get the most out of the experience
Once on your elective, ensure you keep a logbook of surgeries you have observed, or assisted in, as well as ensuring you get a letter of recommendation or certificate. These will prove valuable when you think of applying to speciality training.

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