President’s Message

Endoscopy in Canada

July is a great month in Canada. The weather finally gets better, it is our country’s birthday (and my birthday too) and many of us have vacation. Of course, for those in teaching centers, July also brings new residents. The teaching cycle starts anew. June sees senior residents being polished and shined for the exams with tensions running high. Clinically, the teaching is at it’s most sophisticated levels. In June, it is hard to exhale, we are waiting: Will they pass?? July brings a post exhalation focus on the new residents whose enthusiasm infuses us with inspiration to start at the beginning again. I would like to offer congratulations to all the new Surgeons who have graduated this year, and also welcome our new trainees.

Last Friday morning I had the pleasure of supervising two residents in my Endoscopy clinic. One, a PGY2 resident in General Surgery, is in his second week of a GI rotation; the other a senior resident in Gastroenterology, just starting his final year of training. We had a perfect list of cases for these two learners, a mix of screening and investigative procedures. The morning went well, in fact very well. As expected, I had little technical advice for the senior Gastroenterology resident; the discussions focused more on patient issues. Also, as expected, with the surgical resident, there was more teaching around the technical aspects of navigating the scope. At the end of the morning, I offered some positive feedback for both residents. I was honestly impressed with the abilities of the junior surgical resident, who at the end of two weeks was quite facile with the scope and now learning the subtler components. However, what really stood out for me that day, were the comments of the Gastroenterology resident who concurred that the Surgical resident was exceeding expectations. “Well, you’re a surgeon, you naturally have advanced hand-eye coordination. You are going to pick this up a lot faster than I did. It took me weeks just to figure out how to get out of the rectum”. Of course he was joking, but the point was there, some learners pick things up faster than other. Both of these residents will reach competence in Endoscopy, but the learning curve is different. This is exactly why CAGS has publically endorsed the American Board of Surgery statement on Endoscopy and why CAGS has issued a Statement on Endoscopy in Canada. Not only do we firmly believe surgeons are essential in the provision of Endoscopy services in Canada, we refuse to assign numbers of procedures as the sole marker of competence. There are transferable skills in surgery that allow surgeons to pick up new technical skills quickly and maintain those skills. However long, and after how many cases it takes to get there, at the end of the day, what is crucial, is the final skill set of all who are performing endoscopy and the maintenance of those skills. For practicing surgeons, to ensure we provide safe and effective services to Canadians, it is imperative that we embrace the concepts of practice audit and continual.

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President’s Message — Endoscopy in Canada continued

Continued from page 1

quality improvement. This year during CSF, the CAGS booth will feature a Practice Audit tool for colonoscopy developed by the Canadian Association of Gastroenterology. Surgeons participated in the trialing of the tool, and under the direction of Dr. Chris DeGara, the CAGS Clinical Practice Committee has long advocated for its use.

As the Voice of Canadian surgeons, CAGS will continue to advocate for access to Endoscopy resources, so surgeons can continue to be trained and participate in the provision of services that Canadians require. As Surgeons, it is time for each of us to demonstrate that our way works, and that the quality our patients deserve and expect is there. A practice audit tool is not punitive, it allows one to assess practice and adjust if necessary. CAGS will be working with CAG to determine the best methods of introducing this tool to surgeons. So here is my personal request: if you are approached to use the tool, please participate. If you are attending the CSF, please look for more information at the CAGS booth. If you are unable to attend this year, continue to look for updates on the website and in our newsletters.

I wish you all a safe and happy summer and look forward to seeing many of you in London in September at the CSF.

Dr. Susan Reid
CAGS President

Canadian Association of General Surgeons Statement on Endoscopy

The provision of diagnostic and therapeutic endoscopy and colonoscopy is essential to the health and well being of the Canadian Public. In continuing to address this healthcare need, the Canadian Association of General Surgeons (CAGS) supports and promotes access to endoscopic resources for General Surgeons as well as for the training of General Surgery Residents in Endoscopy and Colonoscopy. For the healthcare of Canadians, it is critical that access to endoscopic resources is securely available throughout training and into practice.

Preliminary investigation into endoscopic services provided by General Surgeons in Canada was recently undertaken by the ten provinces represented on the CAGS Provincial Affairs Committee. Due to the variety of data gathering methods in each province, the purest common measurable available was colonoscopy billing data by specialty. All Provincial Representatives requested colonoscopy billing totals from their respective provincial medical services branch. The data table is below:

Figure 1

Colonscopy procedures by Province and Specialist 2010

<table>
<thead>
<tr>
<th>Performed by</th>
<th>Province</th>
<th>General Surgeon</th>
<th>Gastroenterologist</th>
<th>Other Specialist*</th>
</tr>
</thead>
<tbody>
<tr>
<td>BC</td>
<td>63</td>
<td>32</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>AB</td>
<td>34</td>
<td>53</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>SK</td>
<td>72</td>
<td>28</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>MB</td>
<td>73</td>
<td>15</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>ON**</td>
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<td></td>
</tr>
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<td>QC**</td>
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<td>5</td>
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<td></td>
</tr>
<tr>
<td>NS</td>
<td>56</td>
<td>10</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>PEI</td>
<td>81</td>
<td>19</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>NL</td>
<td>48</td>
<td>52</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

* Other Specialists performing colonoscopies that have been recorded by some provinces and can include: Pediatric Gastroenterologists, General Internists and Family Physicians.
**Data is from 2009

Continued on page 3
Currently in Canada, General Surgeons are delivering fifty percent or more of all colonoscopies. The remainder is provided by both Gastroenterologists, and “other” health care providers (see figure 1). In addition, the table also demonstrates that General Surgeons perform the majority of endoscopic procedures in provinces that do not have large urban centres. This confirms that General Surgeons are the primary providers of endoscopy services for rural areas.

The Canadian population requiring endoscopy and colonoscopy is increasing with the advancing age of our population. In addition, due to the nature of the patient health issues that General Surgeons diagnose and treat, CAGS maintains that General Surgeons are an essential component of any health care strategy, local, provincial or national, to provide safe and timely endoscopic services. A practicing General Surgeon requires a minimum of one half to one full day of Endoscopy time per week. The variation takes into account those General Surgeons whose practice may have an increased focus on the GI tract, such as Colorectal Surgeons and Hepatobiliary Pancreatic surgeons requiring ERCP resources.

It is the opinion of the Canadian Association of General Surgeons that quality endoscopy training for all Canadian General Surgery Residents is in the best interest of the Canadian Public. The Royal College objectives of training for General Surgery include Endoscopy and Colonoscopy; General Surgery training programs and their faculty must have access to Endoscopy resources in all hospitals where Residents train.

General Surgeons in Canada have been and remain committed to providing safe and quality endoscopy services. CAGS members are encouraged to participate in quality assurance programs and continuing medical education to provide the best possible care for patients. The ongoing training of surgical residents in the skill of endoscopy is absolutely essential, as is the continued involvement of General Surgeons in the provision of endoscopic services. CAGS firmly believes that any attempts to exclude surgical residents from receiving training in endoscopy, or any attempts to hamper a trained surgeon’s provision of endoscopic services can only lead to inadequate care for the Canadian Public.

This Statement is endorsed by:

The Canadian Society of Colon and Rectal Surgeons

The Canadian Society of Internal Medicine

Society of American Gastroenterologists and Endoscopic Surgeons

Residents’ Corner

Dear Residents,

The Canadian Surgical Forum is fast-approaching and we’re looking forward to seeing you there! We’re hoping for great resident turn-out again this year. While many residents will be presenting, many come simply to attend the talks, poster presentations and take part in the fun!

There are plenty of activities for everyone and we strongly encourage you to come! It is great fun and a great opportunity for residents to meet their future surgical colleagues and make connections across the country.

It’s also a fun way to brush up on your surgical knowledge and skills.

While residents are invited to all the sessions, I wanted to highlight a few in particular which have you in mind. Thursday post-graduate courses are excellent full day academic sessions for residents to really brush up on a particular topic—see program for details. The CAGS Resident Committee will be putting on their annual symposium on Friday afternoon from 1430-1550; this year we will be hosting a lively debate on the role of competency-based training in surgical residency. In light of some controversial changes to resident work hours taking place, many wonder how we will be able to attain the Royal College requirements in a five-year program. This is a very relevant topic for both residents and surgeons alike, future changes will affect us directly. We’ll also get a sneak preview of the future of specialty resident education at the College. Don’t miss it!

Thursday don’t forget the exciting laparoscopic suturing competition, following the welcome reception. Friday evening will start off with the CAGS’ annual resident awards and Surgical Jeopardy. Following
The CAGS Bariatric Surgery Working Group has submitted a comprehensive and informative report which is now posted on the CAGS website. Space allows us to provide highlights of this excellent contribution, but members are invited to view its full content on the CAGS Home Page (www.cags-accc.ca).

Contributions to this report are provided by the Working Group’s Membership which has broad country-wide representation and consists of:

Dr. Dan Birch: Chair  
Dr. Jim Ellsmere  
Dr. Olivier Court  
Dr. Mehran Anvari  
Dr. Chris Andrew  
Dr. Shahzeer Karmali  
Dr. John Hagen  
Dr. Nam Nguyen

As the Chairman states, this group formed following an initial email from the president of CAGS which is excerpted below …

“During the last CAGS executive and board meetings, as well as teleconferences, there has been discussion surrounding the issues related to Bariatric Surgery and General Surgery. Initially a proposed position paper was discussed and not supported due to lack of clarity and necessity. In order to explore in more depth the concerns of Canadian General Surgeons, with respect to both Bariatric surgery and surgery for the obese patient, it was suggested that a Working group be formed to advise the executive and the board.”

A perusal of this report allows members to benefit from the Working Group’s work on each of the following four issues of its mandate for which it will be advising the board:

1. The relationship between the Canadian Association of Bariatric Physicians and Surgeons (CABPS) and CAGS

This part of the report details that CABPS and CAGS have many common goals and mandates which has facilitated a close working relationship between the two societies.

2. The current status of Provincial Programs including a catalogue of programs

Under this section, the Group took advantage of its geographic representation and all members submitted a statement on the status of obesity/bariatric surgery of their province/region of Canada. This included basic information such as number of sites, surgeons, procedures offered and extent of private clinics offering surgery. Statements were submitted for each of the provinces and territories, bringing to light both the progress and shortfalls in obesity/bariatric surgery care available to patients.

3. The educational needs of General Surgeons and General Surgery Trainees who are not practicing Bariatric Surgery but must meet the needs of morbidly obese patients requiring General Surgery procedures, and the needs of patients who have had Bariatric surgery procedures.

Under this point, the Group reported that obesity has an impact on both the General Surgeons performing general surgical operations as well as awareness of issues of patients undergoing bariatric surgery.

In particular, the following section taken from the report outlines the Obesity impact on General Surgical Care:

Etiologies: Obesity demonstrated association with surgical diseases
- Gallstone disease
- Colorectal carcinoma
- Hernias-incisional, umbilical, inguinal

Preoperative issues: Obesity related co-morbidities
- Sleep apnea
- Diabetes
- Hypertension

Intraoperative issues:
- Access/Entry to abdomen in morbidly obese patient
- Liver size
- Managing intra-abdominal adiposity
- Abdominal wall closure

Post-operative issues:
- Managing bariatric patient on ward-sleep apnea, mobility, diet
- Risks of post-surgical infection, dehiscence
- Incisional hernia risk

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Managing the bariatric patient:

Goals:
Understanding of the commonly performed bariatric operations in Canada and their effect on the digestive tract

Managing complications:
Gastric Bypass:
• Immediate: Leak, Bleed, Bowel obstruction
• Delayed: Internal hernia, Stricture, Marginal ulcer, Bowel obstruction, Nutritional deficiencies
Adjustable Gastric Banding
• Immediate: Dysphagia, Perforation
• Delayed: Band slip, Band erosion, Port site infection
Sleeve Gastrectomy:
• Immediate: Leak, Bleed
• Delayed: Leak, Abdominal abscess, Stricture, Ulcer, Nutritional deficiencies.

4. The practice resources and standards for optimal care of the bariatric patient.

The following introductory paragraph from the report provides an understanding of the points of interest raised by the Group under this last mandate.

“It is clear that when morbidly obese patients present for consideration of a surgery for control of their disease, they have exhausted all other options. The care of these patients exceeds simply immediate pre and postoperative considerations. The positive impact of surgery on long term morbidity and mortality as well as the demand on the health care system has been well-established. For the benefits to be of any impact, satisfactory long-term results (>5 years) is the goal. The general guidelines from the National Institutes of Health (NIH) consensus conference statement published over two decades ago are still highly relevant. Bariatric surgical procedures should be offered in carefully selected patients with acceptable operative risks after assessment by a multidisciplinary team with medical, surgical, psychiatric and nutritional expertise. The operation should be performed by a surgeon with substantial expertise with these procedures and who is working in a clinical setting with adequate support for all aspects of management and assessment. Appropriate lifelong medical surveillance after surgery is also necessary.

Each of these key points is addressed in further detail in the report and members are urged to go to the CAGS website to enjoy reading it in full.
competition to crown the “Canada’s National Champion” in laparoscopic suturing. The competition is designed to promote interest in technical skills training through simulation across Canada.

**Friday, September 16, 2011**

**1330-1420**
Ballroom 4/5, 2nd Level, London Convention Centre

**CAGS Presidential Address:**
Canadian general surgery – It is what it is, or is it? Can deconstruction theory instruct our future? (audio recorded) S. Reid, McMaster University, Hamilton

**Learning objectives:** The session is designed for members of the Association and guests. At the end of the session, participants will have gained insight into the complexities of General Surgery practice in Canada, the role and value of deconstruction theory in examining our profession and the potential for our future successes.

**1000-1050**
Ballroom 4/5, 2nd Level, London Convention Centre

**CAGS Langer Lecture:** New genetic markers – New horizons in combating colorectal cancer – M.G. Dunlop, University of Edinburgh, Edinburgh, UK

**Learning objectives:** The session is designed for all practising surgeons. The session will explore the possibilities of utilizing genetic risk profiling as a public health measure to refine surveillance and prevention strategies. At the end of the session, participants will have a better understanding of our current knowledge of the genetic architecture of colorectal cancer, the notion of heritability, and the contribution of common genetic variation to colorectal cancer incidence.

**1600-1650**
Ballroom 4/5, 2nd Level, London Convention Centre

**CAGS H. Thomas G. Williams Lecture:** A decade in review – Evidence for surgical critical care – D.J. Cook, McMaster University, Hamilton

**Learning objectives:** The session is designed for surgeons, residents and medical students. At the end of the session, participants will be able to highlight recent literature relevant to caring for critically ill surgical patients; review key issues in study design to help with critical appraisal of the surgical ICU literature; underscore advances in practice and research for surgical critically ill patients.

**17:00 – 18:00**
Salon E, Main Level, London Convention Centre

**CAGS Information Session**
Get to know CAGS better! Attend this session and learn more about CAGS and how to get involved. Members of the CAGS Executive will be on hand to discuss strategic direction and ways of participating in CAGS.

**Saturday, September 17, 2011**

**0800-0930**
Salon E, Main Level, London Convention Centre

**CAGS: Highlights of CSRF Awards**

**Learning objectives:** The session is designed for all general surgeons and residents. At the end of the session participants will have a better understanding of the latest advances in clinical and translational surgical research from CSRF Research Award recipients.

**REGISTRATION**
Pre-registration closes August 26th. (Visit [http://www.cags-accg.ca/index.php?page=57 to register online])

After that, you can register on-site. Save time by downloading the Registration Form (PDF) from the Web site ([www.cags-accg.ca](http://www.cags-accg.ca)), completing it and bringing it with you to the Forum. On-site registration will open at the London Convention Centre, beginning at 1600 hours on Wednesday, September 14.
Notice of Annual Meeting of Members
(For CAGS Members only)

Pursuant to Articles XII of the CAGS Bylaws, notice is hereby given that the Annual Meeting of Members of CAGS will be held in London, Ontario, on Saturday, September 17th, 2011 from 4:30 to 5:30 p.m. in Ballroom 4/5, 2nd Level, of the London Convention Centre.

Please try to attend this important meeting – your presence is valued and appreciated.

The Agenda and other materials will be available at the meeting.

Congratulations to the winners of the Stevens Norvell Award 2011

First prize recipients (including ties) receive $500 each
Second Place recipients (including ties) receive $300 each.

R1:
1st:  (Tie) Amir Yousef Taheri, University of Alberta
      Stephen Gowing, McGill University

2nd:  (Tie) Steven Smith, Dalhousie University
      Joanna Antonescu, McGill University

R2:
1st: Peter Graham, University of Saskatchewan

2nd:  (Tie) Nathan Zilbert, University of Toronto
      Ramin Kholdebarin, University of Manitoba

R3:
1st:      Aniedi Dear, Dalhousie University

2nd:      Bonnie Tsang, University of Alberta

R4:
1st:  (Tie) Anton Cherney, Queen’s University
      Sarah Lai, University of Alberta

2nd:      Michael Gora, Queen’s University

R5/6:
1st:  (3Tied) Mantaj Brar, University of Calgary
      Luc Dubois, University of Western Ontario
      Jane Watson, Dalhousie University

2nd:      Christian Zalai, McGill University

Residents’ Corner continued

this, residents are invited to start their night off at Moxie’s Bar and Grill where we will have some complimentary drinks and hors d’oeuvres; this is always a lot of fun and a great way to meet fellow residents (who else understands what you’re going through?)! London is a small city and we’re bound to end up meeting the other CAGS members (ie. your staff) either at Moxie’s or another venue. Saturday, residents are also invited to join in at the CAGS Presidential Gala, which should be a very exciting trip back to the 1920s!

The Canadian Surgical Forum is one conference you really shouldn’t miss! Something for everyone and certainly for residents! The only tricky business is selecting among the excellent talks and activities! See you there!

Your CAGS Residents Committee

The Canadian Association of General Surgeons gratefully acknowledges the support of this newsletter’s production by Pfizer Inc.