

Get credit right away by taking all CME tests online

<http://jacscme.facs.org>

Article 1: Pediatric Surgery; Burn, Trauma, Critical Care

Operative vs nonoperative management of pediatric blunt pancreatic trauma: evaluation of the National Trauma Data Bank. Mora MC, Wong KE, Friderici J, et al. *J Am Coll Surg* 2016;222:977–982

Article 2: General Surgery

Patterns of failure of a standardized perioperative venous thromboembolism prophylaxis protocol. Cassidy MR, Macht RD, Rosenkranz P, et al. *J Am Coll Surg* 2016;222:1074–1080

Article 3: Plastic Surgery; Breast

Are prophylactic postoperative antibiotics necessary for immediate breast reconstruction? Results of a prospective randomized clinical trial. Phillips BT, Fourman MS, Bishawi M, et al. *J Am Coll Surg* 2016;222:1116–1124

Article 4: Burn, Trauma, Critical Care

Integrating geriatric consults into routine care of older trauma patients: one-year experience of a level I trauma center. Olufajo OA, Tulebaev S, Javedan H, et al. *J Am Coll Surg* 2016;222:1029–1035

Objectives: After reading the featured articles published in this issue of the *Journal of the American College of Surgeons* (JACS) participants in this journal-based CME activity should be able to demonstrate increased understanding of the material specific to the article featured and be able to apply relevant information to clinical practice.

A score of 75% is required to receive CME and Self-Assessment credit. The JACS Editor-in-Chief does not assign a manuscript for review to any person who discloses a conflict of interest with the content of the manuscript. Two articles are available each month in the print version, and usually **4 are available online for each monthly issue, going back 24 months.**

Accreditation: The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Designation: The American College of Surgeons designates this journal-based CME activity for a maximum of 1 *AMA PRA Category 1 Credit*[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.



AMERICAN COLLEGE OF SURGEONS
DIVISION OF EDUCATION
*Accredited with Commendation by the
Accreditation Council for Continuing Medical Education*

ARTICLE 1

(Please consider how the content of this article may be applied to your practice.)

Operative vs nonoperative management of pediatric blunt pancreatic trauma: evaluation of the National Trauma Data Bank

Mora MC, Wong KE, Friderici J, et al
J Am Coll Surg 2016;222:977–982

Learning Objectives: After review of this article, surgeons should have a more complete understanding of the current management practices for blunt pediatric pancreatic trauma at multiple trauma centers and the associated complications.

Question 1

Guidelines for blunt pediatric pancreatic trauma are currently lacking because:

- the only data published are case reports.
- pancreatic injuries are rare, leading to low sample size.
- randomized controlled trials are not justifiable in children.
- there are not enough pediatric level I trauma centers to conduct the study.
- current IRB guidelines make multi-institutional trials impossible.

Critique: Multiple studies have been published on pediatric pancreatic trauma. Multiple trauma centers, including those in the United States and Canada, have contributed to this topic. However, due to current limitations, level I data are lacking. Because pancreatic injuries are infrequent, sample size remains low for single institutions to gather data with appropriate power to measure patient outcomes. There are current set guidelines that allow multi-institutional studies to occur. The current agreement is set so that the institutions rely on the review of one IRB, allowing continued collaboration on diseases with limited exposure.

Question 2

Grade III pancreatic injury includes:

- minor contusion with duct injury.
- major contusion with duct injury.
- distal transection or parenchymal injury with duct injury.
- proximal transection or parenchymal injury without duct injury.
- distal transection or parenchymal injury without duct injury.

Critique: The American Association for the Surgery of Trauma has developed grading scores for organ injuries including the pancreas. It categorizes injuries based on a grading system. The more severe the injury is, the higher the assigned grade. Higher grades correspond to injuries involving the main pancreatic duct and injuries involving the proximal pancreas. This is used for both penetrating and blunt traumas. There is no separate category for adults and children. Grade I and II injuries do not have ductal injury. Grade III injury is based on distal transection or parenchymal injury with duct injury. Grade IV injury has proximal transection or parenchymal injury involving the ampulla. Grade V injury has massive disruption of the pancreatic head.

Question 3

Immortal time bias allowed:

- exclusion of all deaths in this study.
- exclusion of patients who survived past 24 hours.
- exclusion of deaths related to the treatment group.
- exclusion of deaths before the first 24 hours.
- had no influence on this study.

Critique: Immortal time bias affects observational studies (ie, retrospective reviews). It refers to the cohort

entry and the date of the first treatment exposure. During this time period, any outcome that influences analysis cannot be secondary to the treatment itself. This flaw can occur in any treatment study, and if not accounted for, can lead to the illusion of treatment effectiveness. To reduce the likelihood of immortal time bias, deaths within 24 hours of admission were excluded.

Question 4

Which common complication of blunt pancreatic trauma has been a reason to endorse operative intervention?

- Increased ICU length of stay
- Pseudocyst formation
- Pancreatic fistula
- Sepsis
- Increased risk of mortality

Critique: Integrity of the main pancreatic duct is critical in determining whether operative intervention is necessary; however, most studies are retrospective and duct injury is not always documented. The limited availability of ERCP in pediatric centers also decreases diagnostic accuracy. There is a lower risk of pancreatic pseudocyst formation when the pancreatic duct is intact. The current controversy continues in patients with main pancreatic duct injury. According to multiple studies, patients undergoing pancreatic resection have a 3% to 26% risk of developing a pancreatic fistula. Our data demonstrated that complication rates were similar between groups. However, as previously noted in other studies, pseudocyst formation was significantly higher in the nonoperative group. We did not observe any significant difference in mortality, sepsis, or length of stay between operative and nonoperative management, though length of stay was increased in the delayed operative group. Increased ICU stay was noted in the operative group.

ARTICLE 2

(Please consider how the content of this article may be applied to your practice.)

Patterns of failure of a standardized perioperative venous thromboembolism prophylaxis protocol

Cassidy MR, Macht RD, Rosenkranz P, et al
J Am Coll Surg 2016;222:1074–1080

Learning Objectives: After study of this article, surgeons should be able to recognize important risk

Download English Version:

<https://daneshyari.com/en/article/4290607>

Download Persian Version:

<https://daneshyari.com/article/4290607>

[Daneshyari.com](https://daneshyari.com)