

RESIDENT RESEARCH SYMPOSIUM 2025

A blue liquid is being dispensed from a pipette into a series of test tubes. The liquid is captured mid-fall, creating a small droplet above the tubes. The background is a light, neutral color.

MONDAY, FEB. 3, 2025

12 - 5:30 PM

FAGAN THEATRE - 1M101

FACULTY OF MEDICINE

ABSTRACTS

AGENDA

Co-hosts: Dr. John Thoms, Assistant Dean, Clinical Research (RGS) and Dr. Sohaib Al-Asaad, Associate Dean, PGME		12:00
Welcome – Dr. Dolores McKeen, Dean of Medicine		12:05
KEYNOTE LECTURE - DR. VALERIE TAYLOR		12:10
LUNCH		
Dr. Colin Chan	Resident Speaker - Medicine	1:30 V
Dr. Steven Rowe	Resident Speaker - Medicine	1:45
Dr. Ibrahim Mohammad Dogar	Resident Speaker - General Surgery	2:00
Dr. Charity-Jean Drover	Resident Speaker - Psychiatry	2:15
Dr. Soleil Chahine	Resident Speaker - Anesthesiology	2:30 V
Dr. Fatimah Sorefan-Mangou	Resident Speaker - Lab Medicine	2:45
BREAK		
Dr. Justin Upshall	Resident Speaker - Orthopedics	3:15
Dr. Kris Hoover	Resident Speaker - Radiology	3:30 V
Dr. Marisa O'Brien	Resident Speaker - Emergency Medicine	3:45
Dr. Nadine McKay	Resident Speaker - Family Medicine	4:00
Dr. Lauren Winsor	Resident Speaker - Medicine	4:15
Dr. Mandy Litt	Resident Speaker - Obstetrics/Gynecology	4:30
Dr. Jessa Vokey	Resident Speaker - Pediatrics	4:45
Award Adjudication	Room 2M218	5:00
Award Announcement	Dr. John Thoms	5:15



KEYNOTE SPEAKER

BIOMARKERS AND BEYOND: THE ROLE OF THE GUT MICROBIOME IN MOOD DISORDERS

DR. VALERIE TAYLOR
MD, PHD, FRCPC, ICD.D

Dr. Taylor, is a Professor and the Head of the Department of Psychiatry at the University of Calgary and the Departmental Science Advisor for Health Canada.

Dr. Taylor completed a Bachelors of Medical Science and graduated from medical school at Memorial University of Newfoundland. She subsequently finished her residency training in Psychiatry, a PhD in Neuroscience and two post-doctoral fellowships at McMaster University in Hamilton, Ontario. She has also obtained an Improving and Driving Excellence across Sectors (IDEAS) Ontario certification in Quality Improvement, a certificate from the Mental Health Commission of Canada for their Promotion of Activated Research and Knowledge (SPARK) Training Program, a Rotman Advanced Health Leadership diploma and a certificate from the Haskayne School of Business as part of their inaugural "financial feminist" cohort. Most recently she completed the Institute of Corporate Directors Certificate and the Behavioral Economics program at Harvard School of Business. In 2020 she was named one of the top 100 most powerful women in STEM in Canada.

Her academic focus has been on the area of medical psychiatry, with a focus on biomarkers. For the last 10 years she has worked on the gut brain axis and the area of the gut microbiome. She is the only funded researcher examining the therapeutic effects of fecal transplant as a treatment for mental illness and she currently has 4 novel clinical trials looking at modifying the gut microbiome to treat mood disorders and runs the largest biological neuroscience microbiome repository in North America. She has over 200 peer reviewed publications and funding from a variety of national and international funding agencies.

Prior to coming to Calgary, Dr. Taylor was the chief of Psychiatry at Women's College Hospital and the chief of Adult Health Services at the Center for Addiction and Mental Health in Toronto. She was very involved in mental health systems reform there, looking at designing virtual care programs and designing tools to facilitate improvements in patient flow within the health system. She has a strong interest in board governance and recently completed the Rotman Institute for Corporate Directors training program. She currently sits on the board of Kids Help Phone, and the Canadian Network for Mood and Anxiety Treatments (CANMAT) and Brain Canada.

She is also CEO of a drug discovery start up, Taylored Biotherapeutics.

NOSOCOMIAL TRANSMISSION OF COVID-19 IN NEWFOUNDLAND AND LABRADOR ACROSS THE PANDEMIC

Colin Chan, MD and Peter Daley, MD MSc FRCPC DTM+H
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Abstract:

Early in the COVID-19 pandemic, it was recognized that preventing health care related (nosocomial) transmission of COVID-19 would be essential to prevent outbreaks, morbidity and mortality in some of the most vulnerable populations. Many infection control methods including negative pressure rooms, visitor restrictions and masking policies were devised in order to prevent the spread of COVID within hospitals in Newfoundland and Labrador. While many studies have validated each method of transmission prevention in hospitals, there has been an absence of data investigating the ability for these benefits to persist throughout the duration of the entire pandemic. Additionally, the currently available data on COVID transmission, morbidity and mortality focus on the initial phase of the pandemic in 2020 with a lack of studies on transmission in 2021 and 2022. In this retrospective cohort study, we determine the number of COVID-19 cases in Newfoundland that can be attributed to in-hospital (nosocomial) transmission, analyze whether the rates of transmission changed across different waves of the pandemic as hospital protocols and understanding of COVID evolved. This study also determines the differences between the groups on the key factors including morbidity, mortality, ICU admissions and hospital location (rural vs urban). Our study showed that ICU admission and mortality were similar between nosocomial and community acquired cases. However, in the longitudinal data, we found that while community acquisition did have clear peaks and troughs, the nosocomial cases were minimal until a rise in February 2021 and remained at a consistently elevated level without returning back to pre-2021 levels. Overall, this study reinforces the importance of infection control and prevention as well as the sustainability of these strategies over long periods of time.

FERRITIN, CRP, AND SOLUBLE CD25 HELP DISTINGUISH BETWEEN HLH AND TAFRO

Steven Rowe¹, Mariam Goubran², Mateo Sarmiento Bustamante³, Saishravan Shyamsundar³, Kathleen McNicholas¹, Marley Blommers⁴, Andre Mattman², Janyan Shi², Lusia Sepiashvili⁵, Joshua Brandstadter⁴, David C. Fajgenbaum³, and Luke Y.C. Chen^{2,4}

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⁵Hospital for Sick Kids, University of Toronto

Background:

Hemophagocytic lymphohistiocytosis (HLH) and TAFRO are rare cytokine storm syndromes which are difficult to diagnose and often fatal without treatment. Ferritin, CRP, and soluble CD25 levels are elevated in these diseases, however no studies compare the extent of elevation between TAFRO and HLH.

Objective:

Determine the sensitivity and specificity of optimum cut-off values for ferritin, CRP, and soluble CD25 in distinguishing HLH and TAFRO.

Methods:

A retrospective cohort of patients with HLH and TAFRO were identified from Vancouver General Hospital and the ACCELERATE Castleman disease database. Ferritin, CRP, and soluble CD25 levels were compared using ROC curves to determine cut-off values for optimum sensitivity and specificity. Ethics was approved through the Vancouver General Hospital and University of Pennsylvania research ethics boards.

Results:

113 patients were identified with HLH (n=44) and TAFRO (n=69 total, n=24 for sCD25). The optimal cut-off for CRP is 128.6 with sensitivity 60.4% and specificity 90.9% (AUC 0.75). The optimal cutoff for ferritin is 1854 with a sensitivity 93.1% and specificity 97.7%, (AUC 0.94). The optimal cutoff for soluble CD25 is 3354 with sensitivity 95.8% and specificity 76.7%, (AUC 0.89). The combined optimal cutoffs are CRP >80, ferritin <4900, and soluble CD25 <3300 with a sensitivity 100% and specificity 68.4% for TAFRO over HLH.

Conclusions:

These findings suggest that HLH and TAFRO can be reliably differentiated based on ferritin, CRP, and soluble CD25. This aids in rapid and accurate diagnosis, facilitating earlier disease-directed treatment.

THE UTILITY OF PRE-EMPTIVE KETOROLAC FOR HERNIA REPAIR UNDER LOCAL ANESTHESIA

Kala Hickey¹, Erin Bonisteel¹, Jurgienne Umali¹, Ibrahim Dogar¹, Shianne Fairlie¹, Geoffrey Warden², Darrell Boone¹, Alexander Matheison¹, Michael Hogan¹, Bradley Evans¹, & David Pace¹

¹Discipline of Surgery, ²Discipline of Anesthesia, Memorial University

Abstract:

Local anesthesia (LA) has been shown to be a safe and effective alternative to general anesthesia (GA) in the setting of open hernia repair and avoids GA-related side effects. Our study aims to evaluate the effect of pre-emptive ketorolac in patients undergoing hernia repair under LA.

Patients undergoing inguinal, umbilical, ventral, or femoral hernia repair under LA were split into a control and experimental group. Patients with recurrent hernias, history of chronic pain, or use of intraoperative sedation were excluded. The experimental group received 30 mg Ketorolac IV preoperatively. Postoperatively, all patients were given a prescription for oral ketorolac; no patients were prescribed opioids. Telephone surveys were then conducted on postoperative day 0, 1, and 7. Pain was assessed using a 4-point Verbal Rating Scale (VRS) while recovery was assessed using a validated 9-item Quality of Recovery Score (QoR-9). Demographic data, self-reported data on analgesic adjuncts, and data on postoperative complications were also collected.

There was no significant difference between the control (48 patients) and ketorolac (50 patients) groups regarding age, sex, BMI, operative time, mesh utilization, or hernia type. Pain scores on POD0 were significantly lower for the ketorolac group (0.80) than the control group (1.35) ($p < 0.001$). Similarly, recovery scores for the ketorolac group (17.32) were significantly improved compared to the control group (16.21) ($p < 0.001$). Between groups, there were similar pain and recovery scores on POD1 and POD7, as well as similar rates of adjunctive analgesia use and discontinuation prior to POD7. Complication rate was 10% for both groups with no hernia recurrences or admission at 2-months.

Our study shows that, when compared with controls, patients receiving pre-emptive ketorolac for hernia repair under LA have a significant improvement in pain and quality of recovery in the early postoperative period without a rise in complication rate.

MANAGING AGITATION: ASSESSING MUN INTERNS' SELF-PERCEIVED COMPETENCY IN INPATIENT SETTINGS

Charity-Jean Drover, MD; Nicholas Fairbridge, PhD
Discipline of Psychiatry, Memorial University

Background:

Agitation management is a fundamental pillar of medicine. Scenarios in which interns have to manage agitation transcend all disciplines. Currently, there is limited teaching time in the MUN undergraduate curriculum for agitation management, and teaching to interns is inconsistent. As a result, interns rely on ad hoc 'survival guides' to teach them agitation management.

Objectives:

This study aimed to assess MUN interns' competence in managing agitation. It assessed interns' confidence in their medical school curriculum on agitation management versus any formal or informal training they received in internship. It aimed to compare the interns' perceived competence in agitation management across various scenarios, including verbal de-escalation and medication selection. The study also sought to gather data on the number of instances interns have had to manage agitation, providing a comprehensive understanding of the interns' experiences in this area.

Methods:

After Human Research Ethics Board (HREB) approval, all eighty-five MUN interns were invited to participate in an anonymous Qualtrics survey. They were provided ten statements about their competence in agitation management and asked to rate each on a five-point Likert scale from "Strongly Disagree" to "Strongly Agree". A descriptive methodology was employed, and descriptive statistics and range analysis were used to yield the results from the interns' Likert responses.

Results:

The study's findings revealed that interns felt somewhat competent in agitation management. However, they lacked confidence in their medical school training in this area. The study highlighted the varied experiences of interns in agitation management education during their internships, with some receiving adequate education and others receiving very little. This disparity underscores the interns' belief in standardized education in agitation management.

Conclusions:

Despite feeling competent in their agitation management skills, interns unanimously expressed a desire for further training. This strong consensus among interns supports the proposal to consider standardized academic half-day training in this area.

Disclosure Statement:

There are no actual or potential conflicts of interests to disclose.

MONITORING ENDOTRACHEAL TUBE CUFF PRESSURE UNDER GENERAL ANESTHESIA: A QUALITY IMPROVEMENT PROJECT

Soleil Chahine, MD^{1,2}; Kirkland Lockyer, MD^{1,2}; Geoff Warden, MD, PhD^{1,2}

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Endotracheal tube (ETT) cuff pressures outside the optimal range of 20-30 cm H₂O are associated with complications, such as aspiration and tracheal injury. The updated 2023 Canadian Anesthesiologists' Society guidelines recommend routine use of a manometer for quantitative monitoring of ETT cuff pressure under general anesthesia. Using the Plan-Do-Study-Act (PDSA) methodology, we implemented a quality improvement project addressing ETT cuff pressure management at our tertiary care center. The Standards for Quality Improvement Reporting Excellence (SQUIRE 2.0) guidelines were used to report the study's findings.

During the initial phase of the project, a baseline assessment of cuff pressures revealed a mean pressure of 56.5 cm H₂O, with only 18% of measurements within the optimal range. Identified contributing factors included limited access to manometers and reliance on inaccurate techniques. Interventions included providing manometers in all operating rooms and conducting educational sessions for anesthesia providers and perioperative nurses. Three months after implementing these changes, a follow-up audit demonstrated significant improvements: mean cuff pressure decreased to 37.8 cm H₂O, and 44% of measurements were within the optimal range. The next cycle of the project includes an annual audit of cuff pressures and implementation of additional systems-based interventions, such as electronic charting alerts.

Limitations of this project include its single-center design, small sample size, non-randomized data collection, and bias from staff awareness of sampling. Despite these limitations, the project highlights the effectiveness of the PDSA cycle in improving patient safety through guideline adherence. Future work involves expansion of the audit to include clinically relevant outcomes, such as sore throat or ventilator-associated pneumonia.

SURGICAL SPECIMEN HANDLING AND COLD ISCHEMIC TIME: PART 1 OF A QUALITY ASSESSMENT PROJECT

Fatimah Sorefan-Mangou, MD; Simon Kirby, MD

Discipline of Laboratory Medicine, Memorial University

Background:

Precise diagnosis and biomarker evaluation are increasingly important as cancer treatments become more individualized. Accurate analysis of surgical specimens starts with the pre-analytical phase, which includes the cold ischemic time (CIT). Studies show that prolonged CITs have an overall negative effect on histology and biomarker analysis. This has influenced tissue handling guidelines for breast specimens, but there is no consensus on the optimal CIT for other tissue types and biomarkers. There are generalized recommendations from various societies which range from CITs being “as short as possible” to “less than 12 hours”.

Objectives:

To determine the average cold ischemic time for specimens received in our department and identify causes of specimen handling delays.

Methods:

Between June 25 and October 16, 2024, seven residents in the Department of Anatomical and Molecular Pathology at Memorial University of Newfoundland recorded the following data for pages received after hours: time of page, summary of the call, specimen time out, time in formalin, and time of opening.

Results:

A total of 112 pages were received from the Health Science Center and St. Clare’s Mercy Hospital. 89 pages (79.5%) were for specimen openings, 11 (9.8%) of which were missing data. CITs ranged from 27 to 1780 minutes, with an average of 236 minutes. Overall 72 of the 78 specimens that required opening were done so within 12 hours. Six specimens had CITs longer than 12 hours. The specimens with the longest CITs were mainly due to late pages (n=3) or overnight bowel specimens (n= 2). One delayed page was due to technical issues with the electronic health record.

Conclusions:

While the majority of specimen openings received after hours were completed within 12 hours, there were common barriers that precluded shorter CITs. This includes specimens forgotten in the operating room, knowledge gaps regarding which specimens require immediate handling, overnight bowel specimens opened the next morning, and longer surgeries with multiple specimens removed at different times during the procedure. These issues should be addressed in order to improve the CITs within our department and ensure accurate specimen analysis.

THE EFFECT OF PREOPERATIVE OPIOID USE ON POSTOPERATIVE PATIENT REPORTED OUTCOME MEASURES IN TOTAL KNEE ARTHROPLASTY

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Discipline of Surgery, Memorial University

Despite current recommendations, opioids are still being used for pain control in osteoarthritis patients. The effect of preoperative opioid use on total knee arthroplasty outcomes has not been thoroughly studied, and the current literature demonstrates inconsistent methodology and results. Furthermore, the measurement of opioid use in the arthroplasty population is not standardized, and opioid prescribing is often used as a proxy for opioid consumption. The purpose of this study is to examine the effect of preoperative opioid use on post-operative patient reported outcome measures (PROMs) in total knee arthroplasty, and to examine the reliability of current opioid use measurement procedures. We hypothesize that preoperative opioid use results in lower PROMs, and that there is a significant discrepancy between prescribing data and patient reported opioid consumption.

This ongoing prospective cohort study is recruiting primary total knee arthroplasty patients from an institutional preoperative arthroplasty clinic. Patients complete a proprietary medication use survey along with the Oxford Knee Score and EuroQol EQ-5D-5L PROMs prior to surgery. These measurements will be repeated by mail six months postoperatively. Electronic medical records will be used to collect data on opioid prescribing, comorbidities, complications, and length of stay. Opioid use data from both sources will be converted to morphine milligram equivalents and analyzed with the change scores of the two PROMs in continuous and dichotomous fashion. Patient reported opioid use will be compared to prescription data. Secondary outcomes will look at the effect of preoperative opioid use on complication rates, length of stay, and post-operative opioid use.

Preliminary data has been collected with further recruitment ongoing. Outcomes of this study will add much needed prospective data to the current body of literature and address shortcomings in previous methodologies. This evidence will help identify issues with current opioid prescribing practices and may help guide both primary care providers and specialists in the management of arthritic pain in the preoperative population.

DOES THE ADDITION OF MRI HELP IN BREAST CANCER DETECTION IN WOMEN WITH LOW BREAST TISSUE DENSITY IN TWO CANADIAN POPULATION-BASED HIGH-RISK BREAST SCREENING PROGRAMS?

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Objective:

The NLHS High-Risk Breast Screening Program and the Ontario High-Risk Breast Screening Program screen women who are confirmed to be at high risk of developing breast cancer with annual mammography and breast MRI. Mammographic breast tissue density (BTD) is an independent risk factor for breast cancer, and the sensitivity of mammography is diminished in women with dense versus fatty breasts. We aimed to compare incremental cancer detection rate (ICDR) according to BTD and determine if breast MRI in high-risk patients with fatty BTD is necessary given the improved sensitivity of mammography.

Materials and Methods:

IRB-approved retrospective review of a total of 10233 screening breast MRIs performed at our institutions between 2012 and 2022 was conducted. For each study, BI-RADS® BTD was recorded, and charts were reviewed to identify patients diagnosed with breast cancer during the screening period. Nearest mammograms were reviewed to determine if the cancer was also seen on mammography.

Results:

10233MRIs were reviewed. 91 cancers were detected in total (CDR=8.90/1000); 7(7.69%) detected in category A, 34(37.36%) in B, 40(43.96%) in C, and 10(10.99%) in D. 872(8.5%) of MRIs were performed in women with category A BTD, who had 6 cancers (85.7%) detected on MRI alone and 1 cancer on both mammography and MRI. There was no difference in ICDR by BTD (categories A=6.9/1000, B=5.9/1000, C=8.3/1000, and D=7.5/1000, $p>0.5$).

Conclusion:

Screening breast MRI in our high-risk patient population was equivalently beneficial for women with category A density breasts, despite the increased sensitivity of mammography in this patient population. Implications for patient care: High-risk screening programs with yearly mammography and breast MRI are essential for early detection of breast cancer, regardless of breast density.

FAMILY MEDICINE RESIDENCY PROGRAM SIMULATION SURVEY

Marisa O'Brien¹, Peter Rogers¹, and Sheila Smith²

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Introduction: Simulation-based education is a rapidly growing field within medical training and has been shown to be superior to traditional didactic and clinical training in achieving and retaining medical skills. It allows learners the opportunity to develop their clinical decision-making skills in a realistic environment while focusing on learning rather than the busy demands of a service.

Objective: This study explores simulation-based medical education utilization within Canadian family medicine residency training programs. In addition, determine perceived barriers to implementation of simulation, and learn from best practices of currently well-established curriculums.

Design: We developed two cross-sectional surveys, for site leads and residents, using a previously developed and validated survey created by Dr. Andrew Koch at Queen's University to assess simulation-based education in emergency medicine training programs. We adapted the survey questions to be applicable to family medicine with the permission of the author. Ethics was approved by Newfoundland and Labrador Health Research Ethics Board.

Setting: The surveys were anonymous and distributed using Qualtrics. The surveys were conducted from September 2022 to February 2023.

Participants: Participants included current site leads and residents in both years of family medicine residency programs in Canada. Responses to the surveys included 35 site leads and 108 residents.

Results: Urban training sites had more formal simulation curriculums with 62% having simulation while only 36% of rural sites have simulation. Barriers included limited access to equipment and limited protected faculty time. Although many felt the addition of allied health professionals is beneficial in simulation, only eight sites participate in multidisciplinary simulation. Although all sites agreed simulation is very beneficial to residents training, most programs only have a few sessions a year.

Conclusion: Our aim is to encourage programs to incorporate simulation into their training program and adapt their curriculum to meet the learning needs of family medicine residents.

HOW MUCH DOES A DIABETIC FOOT COST? THE ECONOMIC IMPACT FROM A MULTIDISCIPLINARY APPROACH TO CARE

Nadine McKay, MD, BSc(Hons), Discipline of Family Medicine

Dawn Curran, MD, MPH, Division of Orthopedic Surgery

Nicholas Smith, MD, FRCSC, Division of Orthopedic Surgery

Purpose:

Diabetes Mellitus (DM) is a worldwide public health concern. Nationally, DM is estimated to consume 6.6% of the healthcare budget. The prevalence of DM in Newfoundland and Labrador (NL) is the highest in Canada at 19%. Diabetic foot ulcer (DFU) is a costly complication of DM. The objective is to determine the total direct cost of DFU within the Eastern Health regional health authority (EH). It is hypothesized that the cost of DFU is underestimated.

Methods:

Patients with a medical care plan (MCP) seen at an EH facility between 2017 and 2019 for DFU were selected for a retrospective chart review-based study. NL Centre for Health Information dataset captured all inpatient admissions and operative procedures using International Classification of Diseases codes. Data related to DFU was collected from the electronic medical record (EMR) and cost estimates were provided from the Financial Services department and MCP billing schedule. Total direct costs were calculated.

Results:

Of 1265 charts reviewed, 200 were randomly selected for analysis. The majority (75%) of patients were assessed in the ER for DFU at least once, with an average of 9.37 (SD = 14.562) visits. Admissions accounted for 75% of total direct costs, averaging \$32,000 per person. The annual cost of ER, admissions, and operative interventions was \$1,758,608, \$13,489,353, and \$1,224,446 respectively. The cumulative regional cost was nearly \$54 million, with a per person cost of over \$42.6 thousand.

Conclusions:

Direct, per incident cost of DFU in EH is double of what has been estimated by previous national level analysis. DFU in EH is using more than 27% of the provincial budget for DM, as predicted by Diabetes Canada. DFU is currently underfinanced, necessitating a review of national and provincial budgets.

PREVALENCE OF PRIMARY HYPERPARATHYROIDISM AND ITS COMPLICATIONS IN AN MEN1 KINDRED IN NL

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¹Discipline of Medicine (Resident), Memorial University

²Discipline of Genetics, Memorial University

³Discipline of Endocrinology (Resident), Dalhousie University

⁴Discipline of Endocrinology, Memorial University

Background:

MEN1 is an autosomal dominant condition characterized by presence of primary hyperparathyroidism, pancreatic NETs, and pituitary adenomas. In NL, there is an MEN1 kindred associated with mutation of the R460X gene. Institutional protocols implemented in 2008 currently guide management of primary hyperparathyroidism in this kindred.

Objectives:

1. Assess prevalence of primary hyperparathyroidism in this MEN1 kindred
2. Assess current interventions for primary hyperparathyroidism in this kindred, and the rates of disease recurrence post-operatively
3. Assess prevalence hyperparathyroidism complications in this kindred

Method:

A retrospective chart review was conducted on consented patients with genetically-confirmed MEN1 in NL (R460X mutation). Included participants were those who had complete medical records and who were alive for the duration of the 2008-2023 study period. This study is included under ethics approval for a larger study on the natural history of MEN1 in this NL kindred.

Results:

Of 64 consented patients, 41 met inclusion criteria – 40 of whom had a diagnosis of primary hyperparathyroidism (98.5%). Mean age at diagnosis was 31 years, with a range of 13-54. Of these patients, 65% underwent parathyroidectomy, with 81% having recurrence post-operatively. Secondary parathyroidectomy was completed in 38% of patients with recurrence. Average age at initial surgery was 36.8 years. Average time between surgeries was 18.1 years.

Of the patients with primary hyperparathyroidism, 35% had nephrolithiasis, 32.5% had fractures – with 12.5% being fragility fractures, and 37.5% had low bone mass or osteoporosis on BMD.

Conclusions:

Primary hyperparathyroidism has a high penetrance rate in this MEN1 kindred and contributes to significant morbidity in affected patients. Further comparison studies should be undertaken to assess the optimal strategies for surgical intervention and monitoring in MEN1 patients, and to inform needed changes in current institutional management practices for MEN1 patients.

FEASIBILITY OF SAME-DAY DISCHARGE IN PATIENTS UNDERGOING LAPAROSCOPIC GYNECOLOGIC ONCOLOGY SURGERY

Mandy Litt, MD, Jack Thorburn, MSc, Joannie Neveu, FRCSC
Obstetrics & Gynecology, Memorial University of Newfoundland

Study Objective:

To evaluate the safety and feasibility of same-day discharge (SDD) of patients undergoing complex laparoscopic gynecologic oncology surgery in the context of the often more morbid oncology patient.

Design:

Retrospective review.

Setting:

Tertiary-care academic hospital.

Patients:

Patients from October 2019 to July 2023 undergoing surgical staging for endometrial, tubal, or cervical cancer, treatment for endometrial hyperplasia, or pelvic masses. All surgeries included a total laparoscopic hysterectomy.

Interventions:

Patients accomplishing same-day discharge were compared to those who required admission. Data collected included clinical and demographical characteristics, perioperative and postoperative variables up to 6 weeks after surgery. Univariate and multivariate analyses were used to determine factors associated with same day discharge.

Measurements & Main Results:

152 patients were included in the analysis. On multivariate analysis, variables that significantly predicted admission were an age ³ 61 (odds ratio [OR], .256; 95% confidence interval [CI], .102-.642; P = .004), BMI ³ 30-34.9 (OR, .291; 95% CI, .094-.905), BMI ³ 35 (OR, .207; 95% CI, .075-.569; P = .002), operative time ³181 minutes (OR, .143; 95% CI, .057-.361; P < .001), and an operative start time after 2:00 PM or later (OR, .135; 95% CI .036-.503; P =.003). A patient's location < 1 hr. away from the center significantly increased odds of same day discharge (OR, 2.50; 95% CI, 1.068-5.863; P =.035). Out of 51 patients who accomplished SDD, there was a <4% failure rate, with those who were discharged requiring admission >96 hours postoperatively. Of all those admitted, the average length of stay was 1.09 days.

Conclusion:

SDD for patients is safe and feasible for many patients. There are low complications, re-admissions, or unscheduled patient contact postoperatively.

DENTAL CONCERNS IN THE JANEWAY CHILDREN'S HOSPITAL EMERGENCY ROOM

Dr. Jessa Vokey, MD

Dr. Archana Shah MD FRCPC, Dr. Roger Chafe PhD, Sharon Smith RN MN

Janeway Children's Health and Rehabilitation Centre

Background: Dental care in childhood and adolescence is crucial to maintaining physical, social, and psychological health. However, dental care is not subject to the statutes of the Canada Health Act. When primary preventative care is inaccessible, patients and families must turn to their local emergency departments.

Objectives: How many emergency room visits occurred in the determined time range with dental or oral health concerns as their chief complaint? Of these presenting complaints, what primary diagnoses were most represented? Of these emergency room visits, what were the presenting demographics of the patients? What were the primary outcomes of these emergency room visits?

Methods: Retrospective chart review spanning a three-year period, from January 1, 2017 to December 31, 2019. This chart review analyzed demographics including date of visits, age, sex, geography, chief complaint, discharge diagnosis, referrals, prescriptions, and follow-up.

Results: A total of 470 charts were analyzed. Mean age of visit was 7.8 years. Most common diagnoses on discharge included dental injury or trauma (31% of all visits) and dental infection or caries (45% of all visits). Most cases of caries/infection were under the age of 12 (77%). Analysis of our emergency room visits reveals our rates of outpatient antibiotic prescribing (27% of all visits), inpatient IV antibiotic prescribing (5% of all visits) and referrals to the Janeway dentistry program for further care (34% of all visits).

Conclusions: Unlike many childhood illnesses where antibiotics are required, dental caries and infections are largely preventable. Despite all children in Newfoundland and Labrador having financial coverage for routine dental care up to age 12, 77% of visits for infection or dental caries were by children under the age of 12.