THE AMERICAN ASSOCIATION OF

ENDOCRINE SURGEONS

Thirty-Fifth Annual Meeting

APRIL 27-29, 2014

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THE AMERICAN ASSOCIATION OF

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THE OLIVER COPE MERITORIOUS ACHIEVEMENT AWARD RECIPIENTS

In April of 1984 at the American Association of Endocrine Surgeons Meeting in Kansas City, Drs. Edward Kaplan, Jack Monchik, Leonard Rosoff, Norm Thompson and Stuart Wilson proposed to the Council a new achievement award. The award honors a member of the AAES in recognition for contributions in the field of endocrine surgery as an investigator, teacher and clinical surgeon. It is not an annual award but is to be given to members of our Association who truly aspire to the spirit of this award.

On April 15, 1985 at the annual meeting of the AAES in Toronto, our President, Leonard Rosoff announced the first member to receive this award, Dr. Oliver Cope. In giving this award to Dr. Cope the decision of the Council was that from this day forward the award would be known as the Oliver Cope Meritorious Achievement Award for the American Association of Endocrine Surgeons.

Oliver Cope, MD

Professor of Surgery, Harvard University and the Massachusetts General Hospital

Awarded in Ontario in April 1985.

Stanley R. Friesen, MD, PhD

Professor of Surgery, University of Kansas

Awarded in Detroit, MI in April 1994.
Dr. Friesen served as the President of our Association in 1983.

Norman W. Thompson, MD

Henry King Ransom Professor of Surgery, University of Michigan

Awarded in Atlanta, GA in April 2001.
Dr. Thompson served as our inaugural President in 1980 and also in 1981.

THE OLIVER COPE MERITORIOUS ACHIEVEMENT AWARD RECIPIENTS CONT.

Jon A. van Heerden, MD

Professor of Surgery Mayo Clinic

Awarded in Charlottesville, NC in April 2004.
Dr. van Heerden served as our Recorder from 1987-1989, as our Vice-President in 1994, and as President in 1996.

Orlo H. Clark, MD

Professor of Surgery, UCSF Mount Zion Medical Center

Awarded in New York, NY in May 2006.
Dr. Clark served as our inaugural Vice President in 1980 and also in 1981, and as President in 1993.

Edwin L. Kaplan, MD

Professor of Surgery, University of Chicago

Awarded in Madison, WI in May 2009.
Dr. Kaplan served as our President in 1982.

George L. Irvin, III, MD

Professor Emeritus of Surgery, University of Miami

Awarded in Pittsburgh, PA in April 2010.
Dr. Irvin served as our Recorder from 1993-1996, as Vice President in 1996 and as President in 1998

HONORARY MEMBERS

Individuals who have made outstanding contributions to the discipline of Endocrine Surgical Disease

J. Aidan Carney, Pathologist

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RESIDENT/FELLOW RESEARCH AWARD WINNERS & POSTER COMPETITION WINNERS

The AAES Resident/Fellow Research Award was established in 1990 to encourage interest in endocrine surgery by those training as students and residents in general surgery. Presented work may be honored in either the Clinical or Basic Research categories.

The AAES Poster Competition was established in 2007.

1990

Michael J. Demeure – San Francisco, California
"Actin Architecture of Cultured Human Thyroid Cancer Cells: Predictor of Differentiation?"

Gerard M. Doherty – Bethesda, Maryland
"Time to Recovery of the Hypothalamic-Pituitary-Adrenal Axis After Curative Resection of Adrenal Tumors in Patients with Cushing's Syndrome"

1996

Jennifer Meko – St. Louis, Missouri
"Evaluation of Somatostatin Receptor Scintigraphy in Detecting Neuroendocrine Tumors"

Beth A. Ditkoff – New York, New York
"Detection of Circulating Thyroid Cells in Peripheral Blood"

1997

Herbert Chen – Baltimore, Maryland
"Implanted Programmable Insulin Pumps: 153 Patient Years of Surgical Experience"

K. Michael Barry – Rochester, Minnesota
"Is Familial Hyperparathyroidism a Unique Disease"

1998

Julie Ann Sosa – Baltimore, Maryland
"Cost Implications of the Different Management Strategies for Primary Hyperparathyroidism in the US"

David Litvak – Galveston, Texas
"A Novel Cytotoxic Agent for Human Carcinoid"

RESIDENT/FELLOW RESEARCH AWARD WINNERS & POSTER COMPETITION WINNERS CONTINUED

1999

Andrew Feldman – Bethesda, Maryland
"Results of Heterotrophic Parathyroid Autotransplantation: A 13 Year Experience"

Alan Dackiw – Houston, Texas
"Screening for MENI Mutations in Patients with Atypical Multiple Endocrine Neoplasia"

2000

Electron Kebebew – San Francisco, California
"ID1 Proteins Expressed in Medullary Thyroid Cancer"

2001

Nestor F. Esnaola – Houston, Texas
"Optimal Treatment Strategy in Patients with Papillary Thyroid Cancer: A Decision Analysis"

Katherine T. Morris – Portland, Oregon
"High Dehydroepiandrosterone-Sulfate Predicts Breast Cancer Progression During New Aromatase Inhibitor Therapy and Stimulates Breast Cancer Cell Growth in Tissue Culture: A Renewed Role for Adrenalectomy"

2002

Rasa Zarnegar – San Francisco, California
"Increasing the Effectiveness of Radioactive Iodine Therapy in the Treatment of Thyroid Cancer Using Trichostatin A (TSA), A Histone Deacetylast (HDAC)"

Denise M. Carneiro – Miami, Florida
"Rapid Insulin Assay for Intraoperative Confirmation of Complete Resection of Insulinomas"

2003

Petra Musholt – Hanover, Germany
"RET Rearrangements in Archival Oxyphilic Thyroid Tumors: New Insights in Tumorigenesis and Classification of Hürthle Cell Carcinoma"

Tina W.F. Yen – Houston, Texas
"Medullary Thyroid Carcinoma: Results of a Standardized Surgical Approach in a Contemporary Series of 79 Consecutive Patients from The University of Texas, M. D. Anderson Cancer Center in Houston"

RESIDENT/FELLOW RESEARCH AWARD WINNERS & POSTER COMPETITION WINNERS CONTINUED

2004

Rebecca S. Sippel – Madison, Wisconsin
"Does Propofol Anesthesia Affect Intra-Operative Parathyroid Hormone Levels During Parathyroidectomy?: A Randomized Prospective Trial"

David Finley – New York, New York
"Molecular Analysis of Hürthle Cell Neoplasms by Gene Profiling"

2005

Mark Cohen – St. Louis, Missouri
"Long-Term Functionality of Cryopreserved Parathyroid Autografts: A 13-Year Prospective Analysis"

Kepal N. Patel – New York, New York
"MUC1 Plays a Role in Tumor Maintenance in Aggressive Thyroid Carcinomas"

2006

Kyle Zanocco – Chicago, Illinois
"Cost-Effectiveness Analysis of Minimally Invasive Parathyroidectomy for Asymptomatic Primary Hyperparathyroidism"

Ashley Kappes Cayo – Madison, Wisconsin
"Lithium Ions: a Novel Agent for the Treatment of Pheochromocytomas and Paragangliomas"

2007

Tracy S. Wang – New Haven, Connecticut
"How Many Endocrine Surgeons Do We Need?"

David Yu Greenblatt – Madison, Wisconsin
"Valproic Acid Activates Notch1 Signaling and Inhibits Growth in Medullary Thyroid Cancer Cells"

RESIDENT/FELLOW RESEARCH AWARD WINNERS & POSTER COMPETITION WINNERS CONTINUED

2008

Elizabeth G. Grubbs – Houston, Texas
"Preoperative Vitamin D (VITD) Replacement Therapy in Primary Hyperparathyroidism (PHPT): Safe But Beneficial?"

Linwah Yip – Pittsburgh, Pennsylvania
"Loss of Heterozygosity of Selected Tumor Suppressor Genes in Parathyroid Carcinoma"

POSTER: Pierre Leyre – Poiters, France
"Does the Risk of Compressive Hematoma After Thyroidectomy Authorize One-Day Surgery?"

2009

Insoo Suh – San Francisco, California
"Candidate Germline Alterations Predisposing to Familial Nonmedullary Thyroid Cancer Map to Distinct Loci on Chromosomes 1 and 6"

Susan C. Pitt – Madison, Wisconsin
"Tertiary Hyperparathyroidism: Is Less Than a Subtotal Resection Ever Appropriate? A Study of Long-term Outcomes"

POSTER: Matthew Nehs – Boston, Massachusetts
"Inhibition of B-RAFV600 Oncoprotein Prevents Cell Cycle Progression and Invasion In Vitro and Reduces Tumor Growth and Metastasis in an In Vivo Orthotopic Model of Thyroid Cancer"

POSTER: Bian Wu – Los Angeles, California
"Utilization of Parathyroidectomy in the Elderly: A Population-Based Study"

2010

David T. Hughes – Ann Arbor, Michigan
"Routine Central Lymph Node Dissection For Papillary Thyroid Cancer"

Matthew A. Nehs – Boston, Massachusetts
"Thyroidectomy With Neoadjuvant Plx4720 Extends Survival And Decreases Tumor Burden In An Orthotopic Mouse Model Of Anaplastic Thyroid Cancer"

POSTER: Aarti Mathur – Bethesda, Maryland
"Adrenal Venous Sampling in Primary Hyperaldosteronism: Standardizing A Gold Standard"

RESIDENT/FELLOW RESEARCH AWARD WINNERS & POSTER COMPETITION WINNERS CONTINUED

2011

Paxton V. Dickson – Houston, Texas
"Achieving Eugastrinemia in MEN1 Patients: Both Duodenal Inspection and Formal Lymph Node Dissection are Important"

Matthew Nehs – Boston, Massachusetts
"Necroptosis is a Novel Mechanism of Radiation-Induced Cell Death in Anaplastic Thyroid Cancer and Adrenocortical Cancer"

POSTER: Luc G.T. Moris – New York, New York
"Rising Incidence of Second Primary Cancer in Low-Risk Patients Receiving Radioactive Iodine Therapy"

2012

Ashley K. Cayo – Milwaukee, Wisconsin
"Predicting the Need for Calcium and Calcitriol Supplementation After Total Thyroidectomy: Results of a Prospective, Randomized Study"

Thomas J. Quinn – Bronx, New York
"Pasireotide (Som230) Is Effective for the Treatment of Pancreatic Neuroendocrine Tumors in a Multiple Endocrine Neoplasia Type 1 Conditional Knockout Mouse Model"

POSTER: Kevin Shepet – Madison, Wisconsin
"Parathyroid Cryopreservation Following Parathyroidectomy: A Worthwhile Practice?"

2013

Kai-Pun Wong – Hong Kong
"A Prospective Evaluation of Surgeon-Performed Transcutaneous Laryngeal Ultrasonography in Assessing Vocal Cord Function Before and After Thyroidectomy"

Scott K. Sherman – Iowa City, Iowa
"Gastric Inhibitory Polypeptide Receptor: A Future Alternative to Somatostatin Type 2 Receptor Imaging and Treatment in Neuroendocrine Tumors?"

POSTER: Sara Murray – Madison, Wisconsin
"Timing of Symptom Improvement After Parathyroidectomy"

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Sze Ling Wong
Melbourne, Australia

2013-14 CONTRIBUTORS TO THE AAES FOUNDATION AND THE PAUL LOGERFO EDUCATIONAL RESEARCH FUND

Dr. Paul LoGerfo passed away September 16, 2003 during his tenure as President of the AAES. Dr. LoGerfo was very interested in education and clinical research, and in his honor the AAES established the Educational Research Fund to support educational and research activities of the Membership. As of press time, the following members and organizations contributed in 2013-14:

Shabir Husain S. Abadin
Christa Abraham
Göran Åkerström
Shaghayegh Aliabadi-Wahle
Menelaos A. Aliapoulios
John Allendorf
Peter Angelos
Shalini Arora
Todd Beyer
Thomas A. Broadie
L. Michael Brunt
Samuel P. Bugis
Blake Cady
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Bradford Carter
Sally E. Carty
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Steven A. De Jong
Michael Joseph Demeure
Shamly V. Dhiman
Gerard M. Doherty
Quan-Yang Duh
Douglas B. Evans
Thomas Joseph Fahey III
Rafael E. Fajardo-Cevallos
Youben Fan
David R. Farley
Josefina Farra
Gennaro Favia
Andrea Frilling
Paul G. Gauger
Randall D. Gaz
Melanie Goldfarb
Jessica Gosnell
Raymon Grogan
Clive S. Grant
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Philip Haigh
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John B. Hanks
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Richard James Harding
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Miguel F. Herrera
Richard A. Hodin
William M. Hopkins
Marybeth S. Hughes
Masatoshi Iihara
Masayuki Imamura
William B. Inabnet
George L. Irvin
Philip H. G. Ituarte
Richard L. Jamison
Philippe R. Kauffmann
Barbara K. Kinder
Vikran D. Krishnaumurthy
John S. Kukora
Leon Kushnir
Amanda Michelle Laird
James Lee
John I. Lew
Frank LoGerfo
Jonathan S. Lokey
Dougald Charles MacGillivray
Lloyd Mack
Christina Lynn Maser
Haggi Mazeh
Peter Joseph Mazzaglia
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Travis J. McKenzie
William Mendez
Stacey A. Milan
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Bradford K. Mitchell
Elliot J. Mitmaker
Akira Miyauchi
Jacob Moalem
Alberto Salgueiro Molinari
John M. Monchik
Vinod Narra
Patricia Numann
Jennifer B. Ogilvie
John A. Olson Jr
Randall P. Owen
Sareh Parangi
Janice L. Pasieka
Kepal N. Patel
Subhash Patel
Ivan R. Paunovic
Nancy D. Perrier
Roy Phitayakorn
Douglas E. Politz
John R. Porterfield
Jason David Prescott
Richard Allen Prinz
Chris Raeburn
Reza Rahbari
Gregory W. Randolph
Steven Rodgers
Kaye Roe
Sanziana A. Roman
Jonathan Romanowsky
Irving Bernard Rosen
Rashmi Roy
Nis Schmidt
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Melwyn John Sequeira
Ashok R Shaha
Alexander L. Shifrin
Mauricio Sierra Salazar
Dietmar Simon
Bhuvanesh Singh
Allan Siperstein
Rebecca S. Sippel
Philip Smith
Samuel Kevin Snyder
Carmen C. Solorzano
Julie Ann A. Sosa
Antonia E. Stephen
Cord Sturgeon
Sonia L. Sugg
James W. Suliburk
David J. Terris
Serdar T. Tezelman
Colin G. Thomas, Jr.
Geoffrey B. Thompson
Norman W. Thompson
Doug R. Trostle
Joel A. Turner
Robert Udelsman
Jon A. van Heerden
James J. Vopal
Kristin E. Wagner
Tracy S. Wang
Collin J. Weber
Kaare J. Weber
Ronald J. Weigel
Ronald D. Wenger
Scott Michael Wilhelm
Robert Jeremy Wilmoth
Stuart D. Wilson
David James Winchester
Michael W. Yeh
Tina Wei-Fang Yen
Linwah Yip
Rasa Zarnegar
Martha A. Zeiger

Donations may be made online at www.aaesfoundation.org

PAST MEETINGS

1980 **Ann Arbor, Michigan**
Local Arrangements Chair: Norman W. Thompson

1981 **Washington, DC**
Local Arrangements Chair: Glenn Geelhoed

1982 **Houston, Texas**
Local Arrangements Chair: Robert C. Hickey

1983 **San Francisco, California**
Local Arrangements Chair: Orlo Clark

1984 **Kansas City, Kansas**
Local Arrangements Chair: Stanley R. Friesen

1985 **Toronto, Ontario, Canada**
Local Arrangements Chair: Irving Rosen

1986 **Rochester, Minnesota**
Local Arrangements Chair: Jon A. van Heerden

1987 **Chicago, Illinois**
Local Arrangements Chair: Edwin L. Kaplan

1988 **Boston, Massachusetts**
Local Arrangements Chair: Blake Cady

1989 **Chapel Hill, North Carolina**
Local Arrangements Chair: Robert D. Croom

1990 **Cleveland, Ohio**
Local Arrangements Chair: Caldwell B. Esselstyn

1991 **San Jose, California**
Local Arrangements Chair: Maria Allo

1992 **Miami, Florida**
Local Arrangements Chair: George L. Irvin, III

1993 **Williamsburg, Virginia**
Local Arrangements Chair: H. Heber Newsome

1994 **Detroit, Michigan**
Local Arrangements Chair: Gary B. Talpos

1995 **Philadelphia, Pennsylvania**
Local Arrangements Chair: John Kukora

1996 **Napa, California**
Local Arrangements Chair: Quan-Yang Duh

PAST MEETINGS CONTINUED

1997 **Baltimore, Maryland**
Local Arrangements Chair: Robert Udelsman

1998 **Orlando, Florida**
Local Arrangements Chair: Peter J. Fabri

1999 **New Haven, Connecticut**
Local Arrangements Chair: Barbara Kinder

2000 **Joint Meeting: London, United Kingdom/Lille, France**
Local Arrangements Chair: Jack Monchik

2001 **Atlanta, Georgia**
Local Arrangements Chair: Collin Weber

2002 **Banff, Alberta, Canada**
Local Arrangements Chair: Janice L. Pasieka

2003 **San Diego, California**
Local Arrangements Chairs: Jay K. Harness & John Kukora

2004 **Charlottesville, Virginia**
Local Arrangements Chair: John B. Hanks

2005 **Cancun, Mexico**
Local Arrangements Chair: Miguel F. Herrera

2006 **New York, New York**
Local Arrangements Chair: Ashok R. Shaha

2007 **Tucson, Arizona**
Local Arrangements Chair: Michael J. Demeure

2008 **Monterey, California**
Local Arrangements Chair: Quan-Yang Duh

2009 **Madison, Wisconsin**
Local Arrangements Chair: Herbert Chen

2010 **Pittsburgh, Pennsylvania**
Local Arrangements Chair: Sally E. Carty

2011 **Houston, Texas**
Local Arrangements Chair: Nancy D. Perrier

2012 **Iowa City, Iowa**
Local Arrangements Chair: Ronald Weigel

2013 **Chicago, Illinois**
Local Arrangements Chair: Peter Angelos

SPECIAL SESSIONS

AAES PANEL SESSION: RAISING OUR VOICES

SUNDAY, APRIL 27, 2014 ■ 11:00 AM – 12:00 PM

Imperial Ballroom

MODERATOR: Richard A. Hodin, MD – *Massachusetts General Hospital*

PANELISTS
- Cord Sturgeon, MD – *Northwestern Memorial Hospital*
- Kai Pun Wong, MD – *University of Hong Kong*
- Steve Zeitels, MD – Massachusetts General Hospital

AAES PANEL SESSION: INTERNATIONAL THYROID ONCOLOGY GROUP (ITOG)

"What Surgeons Need to Know: An Update on the Latest Clinical Trials and Research."

SUNDAY, APRIL 27, 2014 ■ 2:00 PM – 3:00 PM

Imperial Ballroom

MODERATOR: Sareh Parangi, MD – *Massachusetts General Hospital*

PANELISTS
- Keith C. Bible, MD, PhD – *Mayo Clinic, Rochester*
- James Fagin, MD – *Memorial Sloan-Kettering Cancer Center*
- Steven Sherman, MD – *MD Anderson Cancer Center*

HISTORICAL LECTURER

Ode to an Indian Rhinoceros

Patricia J. Numann, MD
SUNY Upstate Medical University

SUNDAY, APRIL 27, 2014 ■ 3:20 PM – 4:00 PM

Imperial Ballroom

Dr. Patricia J. Numann is a native New Yorker who was educated at the University of Rochester and obtained her medical degree and completed her general surgery residency at the State University of New York, Health Science Center at Syracuse. She holds Board Certification from the National Board of Medical Examiners and the American Board of Surgery.

Dr. Numann is an active member of numerous professional societies such as the American College of Surgeons, the American Medical Association, the Association of Endocrine Surgeons, the International Society of Surgery, and the American Surgical Association. She has served as Vice-President of the American Association of Endocrine Surgeons and President of the Association for Surgical Education. She is the 92nd President of the American College of Surgeons. Dr. Numann is the past second Vice-President of the American College of Surgeons, and past Chair of the American Board of Surgery, the first woman in either position.

She was one of the founding members of the Association for Surgical Education and founded the Association for Women Surgeons. She was the first woman elected to the American Medical Association Council on Scientific Affairs. Dr. Numann has received numerous honors and awards at the local, state and national level. She has received the Post Standard Woman of Achievement Award, the Onondaga County Physician Service to the Community Award, the New York State Woman of Accomplishment Award, and the Nina Starr Braunwald Award of the Association of Women Surgeons. She is listed in Best Doctors in America. She has been named by the SUNY Board of Trustees, as a SUNY Distinguished Teaching Professor and a SUNY Distinguished Service Professor. She received the Upstate Medical University Distinguished Alumna Award and SUNY Alumna of Distinction Award. She served as Medical Director of University Hospital for 10 years. She was designated the Lloyd S. Rogers Professor of Surgery in 2000. She was inducted into the International Women Physicians' Hall of Fame and named "Local Legend" to The National Library of Medicine's "Changing Faces of Medicine" exhibit. In January of 2007, she retired from active clinical practice, and as Lloyd S. Rogers Professor of Surgery, but remains active in many teaching and organizational activities.

HISTORICAL LECTURERS AT RECENT MEETINGS

2009 **Edwin L. Kaplan, MD**
University of Chicago
Radiation Induced Thyroid Cancer – A Chicago Experience

2010 **Norman W. Thompson, MD**
University of Michigan
The Time Was Right

2011 **Jon A. van Heerden, MD**
Medical University of South Carolina
Pheochromocytoma Resection: Now and Then

2012 **Murray F. Brennan, MD**
Memorial Sloan-Kettering Cancer Center
Re-Operative Parathyroid Surgery Circa 1975

2013 **Orlo H. Clark, MD**
University of California, San Francisco
Recognition of Endocrine Glands and Abnormalities by Artists and Surgeons

Carlos Viesca, MD
Universidad Nacional Autonoma de Mexico
Thyroid Disease in XVI Century Mexico

Wen T. Shen, MD
University of California, San Francisco
Kindred Spirits to The Social Network

INVITED LECTURER

Progress in Genomic Markers for Thyroid Cancer: How Does if Affect Patient Management?

Yuri E. Nikiforov, MD, PhD
Division of Molecular Genomic Pathology
University of Pittsburgh School of Medicine

MONDAY, APRIL 28, 2014 ■ 7:45 AM – 8:25 PM

Imperial Ballroom

Dr. Nikiforov is Professor of Pathology and Vice Chair at the Department of Pathology, University of Pittsburgh where he also serves as Director of the Division of Molecular & Genomic Pathology. His research program is funded by the National Institute of Health and focused on molecular genetics of thyroid cancer, thyroid cancer diagnostics, and molecular mechanisms of chromosomal rearrangements induced by exposure to ionizing radiation. He has published more than 120 peer-reviewed articles and more than 15 book chapters, and is a senior editor of the book "Diagnostic Pathology and Molecular Genetics of the Thyroid". He is an elected member of the American Society for Clinical Investigation, and a recipient of the 2007 ATA Van Meter Award.

INVITED LECTURERS AT RECENT MEETINGS

1991 **Gregory B. Bulkley, MD**
Johns Hopkins University, Baltimore, Maryland
Endothelial Xanthine Oxidase: a Radical Transducer of Signals and Injury

1992 **Donald Coffey, PhD**
Bethesda, Maryland
New Concepts Concerning Cancer

1993 **John L. Doppman, MD**
National Institutes of Health, Bethesda, Maryland
Recent Advances in Endocrinologic Imaging

1994 **Gordon J. Strewler, MD**
San Francisco, California
The Parathyroid Hormone Related Protein: Clinical and Basic Studies of a Polyfunctional Protein

1995 **Ivor M.D. Jackson, MD**
Providence, Rhode Island
Regulation of TSH Secretion: Implications for Disorders of the Thyroid Function

1996 **Victor E. Gould, MD**
Rush-Presbyterian-Medical Center, Chicago, Illinois
The Diffuse Neuroendocrine System: Evolution of the Concept and Impact on Surgery

1997 **Bertil Hamberger, MD, PhD**
Karolinska Institute, Stockholm, Sweden
The Nobel Prize

1998 **Susan Leeman, PhD**
Boston University, Boston, Massachusetts
The NeuroPeptides: Substance P and Neurotensin

1999 **James Hurley, MD**
Cornell University, New York, New York
Post-Operative Management of Differentiated Thyroid Cancer

INVITED LECTURERS AT RECENT MEETINGS CONTINUED

2000 **James Shapiro, MD**
University of Alberta, Edmonton, Alberta
Pancreatic Islet Cell Transplantation

2001 **Andrew F. Stewart, MD**
University of Pittsburgh, Pittsburgh, Pennsylvania
Parathyroid Hormone-Related Protein: From Hypercalcemia of Malignancy to Gene Therapy from Diabetes

2002 **William F. Young Jr., MD**
Mayo Clinic, Rochester, Minnesota
Adrenal-Dependent Hypertension: Diagnostic Testing Insights

2003 **Sissy M. Jhiang, MD**
The Ohio State University, Columbus, Ohio
Lessons From Thyroid Cancer: Genetics and Gene Therapy

2004 **Edward R. Laws Jr, MD**
University of Virginia, Charlottesville, Virginia
The Diagnosis and Management of Cushing's Disease

2005 **David Duick, MD**
Phoenix, Arizona
Thyroid Nodules and Mild Primary Hyperparathyroidism: Examples of Clinical Perplexities or Unresolvable Conundrums

2006 **Michael Bliss, PhD**
University of Toronto, Ontario, Canada
Harvey Cushing and Endo-Criminology

2007 **Virginia A. Livolsi, MD**
University of Pennsylvania, Philadelphia, Pennsylvania
Thyroid Nodule FNA and Frozen Section: Partners or Adversaries

2008 **F. John Service, MD, PhD**
Mayo Clinic, Rochester, Minnesota
Hypoglycemia in Adults – 80th Anniversary of Hyperinsulinism

INVITED LECTURERS AT RECENT MEETINGS CONTINUED

2009 **Jeffrey M. Trent, PhD**
Translation Genomics Research Institute, Phoenix, Arizona
Integrating Genetics, Genomics, and Biology Towards a More Personalized Medicine

2010 **Alexander J.B. McEwan, MB**
University of Alberta, Edmonton, Alberta, Canada
The State of the Art of Radionucleotide Imaging and Therapy in Patients with Neuroendocrine Tumors

2011 **Allan H. (Bud) Selig**
9th Commissioner of Major League Baseball
Major League Baseball – 2011 Economic and Health Related Issues

2012 **Atul A. Gawande, MD, MPH**
Brigham and Women's Hospital
Strategies for Improving Surgical Performance

2013 **Anders O.J. Bergenfelz, MD, PhD**
Lund University Hospital
Quality Control in Clinical Practice and Postgraduate Education in Endocrine Surgery

CONFERENCE INFORMATION

ACCREDITATION

LEARNING OBJECTIVES

This program is designed for all endocrine surgeons seeking the latest developments in endocrine surgical technique and its related research. The intent of the program is to improve the quality of patient care and improve overall patient safety. Audience participation and interaction will be encouraged. The content and format of the program have been determined based on evaluations and suggestions of attendees of previous programs.

At the end of this activity, attendees will:

1. Participate in discussions, and explain current developments in the science and clinical practice of endocrine surgery.
2. Be able to explain practical new approaches and solutions to relevant concepts and problems in endocrine surgical care.
3. Have additional working knowledge to assist them with their existing and growing endocrine practice.
4. Possess additional information and recent developments as they relate to recently established guidelines and procedures.
5. Obtain and utilize the latest information regarding new oncologic developments and clinical trials on medullary, differentiated and anaplastic thyroid cancers.
6. Understand the latest therapeutic approaches to patients with advanced thyroid cancer.
7. Understand the role of voice assessment and laryngeal functional assessment in the care of endocrine surgical patients.

ACCREDITATION STATEMENT

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the American College of Surgeons and the American Association of Endocrine Surgeons. The American College Surgeons is accredited by the ACCME to provide continuing medical education for physicians.

AMA PRA CATEGORY 1 CREDITS™

The American College of Surgeons designates this live activity for a maximum of **16.25 *AMA PRA Category 1 Credits***™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Division of Education, American College of Surgeons

DISCLOSURE INFORMATION

In compliance with ACCME Accreditation Criteria, the American College of Surgeons, as the accredited provider of this activity, must ensure that anyone in a position to control the content of the educational activity has disclosed all relevant financial relationships with any commercial interest. All reported conflicts are managed by a designated official to ensure a bias-free presentation. Please see the insert to this program for the complete disclosure list.

CME CERTIFICATES AND EVALUATION FORMS

You may complete your attendance verification, meeting evaluation and self-assessment online. Your final CME hours will be submitted to the ACS and you will be notified when your final credits are available.

The American Board of Surgery requirement for fulfillment of MOC Part 2 is the completion of a minimum of 90 hours of *Category 1 Credit*™ over a three year cycle. At least 60 of the 90 hours must include a self-assessment activity–a written Q&A exercise (paper or online) that assesses the surgeon's understanding of the material presented during the CME program. A score of 75% or higher must be attained on the self-assessment exercise. Multiple attempts are permitted.

SUNDAY, APRIL 27, 2014	**5.25 credits**
PANEL: Raising Our Voices	(1 credit)
HANDS ON STATIONS: Laryngeal Ultrasound and Larangoscopy	(1 credit)
ITOG: What Surgeons Need to Know: An Update On the Latest Clinical Trials and Research	(1 credit)
HISTORIC LECTURER: Ode to An Indian Rhinoceros	(0.75 credit)
Interesting Cases	(1.5 credits)
MONDAY, APRIL 28, 2014	**7 credits**
SCIENTIFIC SESSION #1	(1 credit)
SCIENTIFIC SESSION #2	(1.5 credits)
HANDS ON STATIONS: Laryngeal Ultrasound and Larangoscopy	(1 credit)
SCIENTIFIC SESSION #3	(1.25 credits)
SCIENTIFIC SESSION #4 & 5	(2.25 credits)
TUESDAY, APRIL 29, 2014	**4 credits**
SCIENTIFIC SESSION #6	(1.25 credits)
SCIENTIFIC SESSION #7	(1.25 credits)
SCIENTIFIC SESSION #8	(1.5 credits)

HOTEL INFORMATION

HOTEL INFORMATION

BOSTON PARK PLAZA HOTEL & TOWERS
50 Park Plaza, Boston, MA 02116

T: 617-426-2000
W: www.bostonparkplaza.com

WEATHER

Temperatures in mid-April are generally around 50 degrees. A more accurate weather forecast can be found closer to the date of the meeting at www.weather.com.

AIRPORT INFORMATION

The Boston Park Plaza is located just 4.3 miles away from Logan International Airport.

BOSTON AREA GROUND TRANSPORTATION

Taxi Services, **T-Line** (subway) and **Shuttle Services** are the three forms of transportation in Boston. A taxi from Logan Airport will run approximately $26 one way. The T-Line is complimentary but please be aware taking the subway from the airport will involve several transfers (Destination will be Arlington Station). For more information and schedules, contact the Massachusetts Bay Transit Authority at www.mbta.com/rider_tools/trip_planner or call 800-392-6100.

Town Car Service and **Limousines** can be arranged through the Boston Park Plaza in advance by calling 617-654-1912 (concierge's desk).

CONTACTS

RICHARD A. HODIN, MD
Local Arrangements Chair
E: rhodin@mgh.harvard.edu

AMERICAN ASSOCIATION OF ENDOCRINE SURGEONS
11300 W. Olympic Blvd., Suite 600, Los Angeles, CA 90064

T: 310-986-6452
F: 310-437-0585
E: meetings@endocrinesurgery.org
W: www.endocrinesurgery.org

AGENDA

AGENDA

FRIDAY, APRIL 25, 2014

1:00 pm – 5:00 pm *Terrace Room*
Endocrine Surgery University
For 1st Year Fellows Only

COURSE DIRECTOR
Martha A. Zeiger, MD, FACS, FACE – *Johns Hopkins University School of Medicine*

COURSE FACULTY/PANELISTS
- Sally E. Carty, MD, FACS – *University of Pittsburgh*
- Orlo H. Clark, MD – *University of California, San Francisco*
- William B. Inabnet, MD – *Mount Sinai Medical Center*
- Mira M. Milas, MD, FACS – *Oregon Health and Science University*
- Francis D. Moore, MD – *Brigham and Women's Hospital*
- Sareh Parangi, MD – *Massachusetts General Hospital*
- Nancy D. Perrier, MD, FACS – *UT MD Anderson Cancer Center*
- Allan E Siperstein, MD – *Cleveland Clinic*
- Rebecca S. Sippel, MD – *University of Wisconsin*

6:00 pm – 8:30 pm *Dr. Hodin's Residence*
ESU Dinner
Invitation Only

SATURDAY, APRIL 26, 2014

7:00 am – 3:00 pm *Terrace Room*
Endocrine Surgery University – CONTINUED

12:00 pm – 1:00 pm *Exeter Room*
Education and Research Committee Meeting

1:30 pm – 6:00 pm *Brae Burn Country Club*
AAES Annual Golf Tournament
Transportation arrangements on own

2:00 pm – 6:00 pm *Longwood Cricket Club*
AAES Annual Tennis Tournament
Transportation arrangements on own

3:00 pm – 7:00 pm *Berkely/Clarendon Room*
AAES Council Meeting

9:00 pm – 11:00 pm *McCormick & Schmick's*
Young Endocrine Surgeon Social
Inside Boston Park Plaza Hotel

SUNDAY, APRIL 27, 2014

6:00 am – 6:00 pm *Plaza & Imperial Foyer*
Registration Open

7:00 am – 8:30 am *Charles River*
AAES Annual Walk/Run
Meet in the lobby of the Boston Park Plaza at 6:30 am

7:30 am – 8:30 am *Exeter Room*
CESQIP Committee Meeting

8:30 am – 9:30 am *Exeter Room*
Information Technology Committee Meeting

9:30 am – 11:00 am *Plaza Ballroom*
Poster Walk Around

10:30 am – 12:00 pm *Whittier Room*
Nurse/Advanced Practice Nurse Session: The Endocrine Team in Action
SPEAKER: Douglas B. Evans, MD

11:00 am – 12:00 pm *Imperial Ballroom*
Panel: Raising Our Voices
MODERATOR: Richard A. Hodin, MD – *Massachusetts General Hospital*

PANELISTS
- Cord Sturgeon, MD – *Northwestern University*
- Kai Pun Wong, MD – *University of Hong Kong*
- Steve Zeitels, MD – *Massachusetts General Hospital*

12:00 pm – 1:00 pm *Imperial Ballroom*
Outcomes Committee Meeting

12:00 pm – 1:15 pm *On Your Own*
Lunch

12:00 pm – 1:15 pm *Georgian Room*

Laryngeal Ultrasound and Larangoscopy Hands On Stations

FACULTY
- Denise M. Carneiro, MD – *Medical University of South Carolina*
- Brian Lang, MD – *University of Hong Kong*
- Barbra S. Miller, MD – *University of Michigan*
- Sareh Parangi, MD – *Harvard Medical School*
- Gregory W. Randolph, MD – *Harvard Medical School*
- Cord Sturgeon, MD – *Northwestern University*
- Scott M. Wilhelm, MD – *University Hospitals*
- Kai Pun Wong, MD – *University of Hong Kong*
- Jung-Woo Woo, MD – *Seoul National University Hospital*

1:30 pm – 2:00 pm *Imperial Ballroom*

AAES Opening Session

- New Member Introductions
- Paul LoGerfo Education Research Presentation

2:00 pm – 3:00 pm *Imperial Ballroom*

INTERNATIONAL THYROID ONCOLOGY GROUP (ITOG)
What Surgeons Need to Know: An Update On the Latest Clinical Trials and Research

MODERATOR: Sareh Parangi, MD – *Massachusetts General Hospital*

PANELISTS
- Keith C. Bible, MD, PhD – *Mayo Clinic, Rochester*
- James Fagin, MD – *Memorial Sloan-Kettering Cancer Center*
- Steven Sherman, MD – *MD Anderson Cancer Center*

3:00 pm – 3:20 pm *Plaza Ballroom*

Afternoon Break, Exhibits and Poster Viewing

3:20 pm – 4:00 pm *Imperial Ballroom*

Historical Lecturer: Ode to an Indian Rhinoceros

SPEAKER: Patricia J. Numann, MD – *SUNY Upstate Medical University*

4:00 pm – 4:15 pm *Imperial Ballroom*

CESQIP Update

4:15 pm – 5:45 pm *Imperial Ballroom*

Interesting Cases

MODERATOR: Julie Ann Sosa, MD

6:30 pm – 8:30 pm *Boston Public Library*
700 Boylston Street

AAES Welcome Reception

Meet in lobby at 6:15 pm to walk together to the library.

MONDAY, APRIL 28, 2014

6:00 am – 7:30 pm *Plaza & Imperial Foyer*
Registration Open

6:45 am – 7:45 am *Plaza Ballroom*
General Breakfast

6:45 am – 7:45 am *The Paramount*
AAES Advanced Practice Nurse/Nurse Breakfast *44 Charles Street*

6:45 am – 7:45 am *Beacon Hill*
AAES New Members Breakfast

7:45 am – 8:25 am *Imperial Ballroom*
Presidents Invited Lecturer: Progress in Genomic Markers for Thyroid Cancer: How Does if Affect Patient Management?
SPEAKER: Yuri E. Nikiforov, MD, PhD – *Division of Molecular Genomic Pathology, University of Pittsburgh School of Medicine*

8:25 am – 9:40 am *Imperial Ballroom*
SCIENTIFIC SESSION I: Papers 1-5
MODERATORS: John A. Olson, MD and Wen Shen, MD

9:40 am – 10:00 am *Plaza Ballroom*
Morning Break, Exhibits and Poster Viewing

10:00 am – 11:00 am *Imperial Ballroom*
SCIENTIFIC SESSION II: Papers 6-9
MODERATORS: Sareh Parangi, MD and Dan Ruan, MD

11:00 am – 12:00 pm *Imperial Ballroom*
Presidential Introduction and Address: Evolution
Sally E. Carty, MD, University of Pittsburgh School of Medicine

12:00 pm – 1:15 pm *On Your Own*
Lunch

12:00 pm – 1:15 pm *Georgian Room*

Laryngeal Ultrasound and Larangoscopy Hands On Stations

FACULTY

- Denise M. Carneiro, MD – *Medical University of South Carolina*
- Brian Lang, MD – *University of Hong Kong*
- Barbra S. Miller, MD – *University of Michigan*
- Sareh Parangi, MD – *Harvard Medical School*
- Gregory W. Randolph, MD – *Harvard Medical School*
- Cord Sturgeon, MD – *Northwestern University*
- Scott M. Wilhelm, MD – *University Hospitals*
- Kai Pun Wong, MD – *University of Hong Kong*
- Jung-Woo Woo, MD – *Seoul National University Hospital*

12:15 pm – 1:15 pm *Exeter Room*

Accreditation Committee Meeting

1:15 pm – 2:30 pm *Imperial Ballroom*

SCIENTIFIC SESSION III: Papers 11-15

MODERATORS: Steven DeJong, MD and Barbra Miller, MD

2:30 pm – 2:50 pm *Plaza Ballroom*

Afternoon Break, Exhibits and Poster Viewing

2:50 pm – 4:05 pm *Imperial Ballroom*

SCIENTIFIC SESSION IV: Papers 16-20

MODERATORS: Cord Sturgeon, MD and Tracy Wang, MD

4:05 pm – 5:05 pm *Imperial Ballroom*

SCIENTIFIC SESSIONS V: Papers 21-24

MODERATORS: Ralph Tufano, MD and Scott Wilhelm, MD

5:05 pm – 6:05 pm *Imperial Ballroom*

AAES Business Meeting

Voting members only.

7:30 pm – 10:30 pm

AAES Gala Reception *Georgian Room*

AAES Gala Banquet *Imperial Ballroom*

TUESDAY, APRIL 29, 2014

7:00 am – 12:30 pm *Plaza & Imperial Foyer*
Registration Open

6:30 am – 7:30 am *Fairfield Room*
AAES Foundation Meeting

6:30 am – 7:30 am *Newbury Room*
CBS Committee Meeting

7:00 am – 8:00 am *Presidential Suite*
Fellowship Committee Meeting

7:00 am – 8:00 am *Plaza Ballroom*
General Breakfast

8:00 am – 9:15 am *Imperial Ballroom*
SCIENTIFIC SESSION VI: Papers 25-29
MODERATORS: Geeta Lal, MD and Amanda Laird, MD

9:15 am – 9:30 am *Plaza Ballroom*
Morning Break, Exhibits and Poster Viewing

9:30 am – 10:45 am *Imperial Ballroom*
SCIENTIFIC SESSION VII: Papers 30-34
MODERATORS: Bhuvanesh Singh, MD and Marybeth Hughes, MD

10:45 am – 11:00 am *Plaza Ballroom*
Morning Break, Exhibits and Poster Viewing

11:00 am – 12:30 pm *Imperial Ballroom*
SCIENTIFIC SESSION VIII: Papers 35-40
MODERATORS: Mira Milas, MD and Erin Felger, MD

12:30 pm
Meeting Adjourned

2:00 pm – 3:00 pm *Fairfield Room*
Wrap Up Meeting
New Officers and Local Arrangements Chairs

SCIENTIFIC PROGRAM

★ Denotes Resident/Fellow Research Award Competition Paper

NOTE: Author listed in **BOLD** is the presenting author

SCIENTIFIC PROGRAM

SUNDAY, APRIL 27, 2014

9:30 am – 11:00 am *Plaza Ballroom*

Poster Walk Around

10:30 am – 12:00 pm *White Hill Room*

Nurse/Advanced Practice Nurse Session: The Endocrine Team in Action

SPEAKER: Douglas B. Evans, MD

11:00 am – 12:00 pm *Imperial Ballroom*

Panel: Raising Our Voices

MODERATOR: Richard A. Hodin, MD – *Massachusetts General Hospital*

PANELISTS

- Cord Sturgeon, MD – *Massachusetts General Hospital*
- Kai Pun Wong, MD – *University of Hong Kong*
- Steve Zeitels, MD – *Massachusetts General Hospital*

12:00 pm – 1:15 pm *On Your Own*

Lunch

12:00 pm – 1:15 pm *Georgian Room*

Laryngeal Ultrasound and Larangoscopy Hands On Stations

FACULTY

- Denise M. Carneiro, MD – *Medical University of South Carolina*
- Brian Lang, MD – *University of Hong Kong*
- Barbra S. Miller, MD – *University of Michigan*
- Sareh Parangi, MD – *Harvard Medical School*
- Gregory W. Randolph, MD – *Harvard Medical School*
- Cord Sturgeon, MD – *Northwestern University*
- Scott M. Wilhelm, MD – *University Hospitals*
- Kai Pun Wong, MD – *University of Hong Kong*
- Jung-Woo Woo, MD – *Seoul National University Hospital*

1:30 pm – 2:00 pm *Imperial Ballroom*

AAES Opening Session

- New Member Introductions
- Paul LoGerfo Education Research Presentation

2:00 pm – 3:00 pm *Imperial Ballroom*
INTERNATIONAL THYROID ONCOLOGY GROUP (ITOG)
What Surgeons Need to Know: An Update On the Latest Clinical Trials and Research
MODERATOR: Sareh Parangi, MD – *Massachusetts General Hospital*

PANELISTS
- Keith C. Bible, MD, PhD – *Mayo Clinic, Rochester*
- James Fagin, MD – *Memorial Sloan-Kettering Cancer Center*
- Steven Sherman, MD – *MD Anderson Cancer Center*

3:00 pm – 3:20 pm *Plaza Ballroom*
Afternoon Break, Exhibits and Poster Viewing

3:20 pm – 4:00 pm *Imperial Ballroom*
Historical Lecturer: Ode to an Indian Rhinoceros
SPEAKER: Patricia J. Numann, MD - *SUNY Upstate Medical University*

4:00 pm – 4:15 pm *Imperial Ballroom*
CESQIP Update

4:15 pm – 5:45 pm *Imperial Ballroom*
Interesting Cases
MODERATOR: Julie Ann Sosa, MD

MONDAY, APRIL 28, 2014

7:45 am – 8:25 am *Imperial Ballroom*
Presidents Invited Lecturer: Progress in Genomic Markers for Thyroid Cancer: How Does if Affect Patient Management?
SPEAKER: Yuri E. Nikiforov, MD, PhD – *Division of Molecular Genomic Pathology, University of Pittsburgh School of Medicine*

8:25 am – 9:40 am *Imperial Ballroom*
SCIENTIFIC SESSION I: Papers 1-5
MODERATORS: John A. Olson, MD, PhD and Wen Shen, MD

8:25 am – 8:40 am
★ **01.** FOUR-DIMENSIONAL CT VS. 2-PHASE CT IN PATIENTS WITH PRIMARY HYPERPARATHYROIDISM: HOW MANY PHASES DO WE REALLY NEED?
Salem I. Noureldine, MD, Nafi Aygun, MD, Michael Walden, MD, Ralph P. Tufano, MD, MBA – *Johns Hopkins University School of Medicine*

8:40 am – 8:55 am
★ **02.** THE EFFECT OF CINACALCET (SENSIPAR®) ON INTRAOPERATIVE FINDINGS IN TERTIARY HYPERPARATHYROIDISM PATIENTS UNDERGOING PARATHYROIDECTOMY
Yash R. Somnay, BS, Eric Weinlander, BA, David F. Schneider, MD, MS, Rebecca S. Sippel, MD, FACS, Herbert Chen, MD, FACS – *University of Wisconsin*

8:55 am – 9:10 am
★ **03.** HYPERPARATHYROIDISM-JAW TUMOR SYNDROME: WHAT IS THE BEST APPROACH TO SURGICAL MANAGEMENT?
Amit Mehta, BA, Dhaval Patel, MD, Avi Rosenberg, MD, Myriem Boufraqech, PhD, Ryan J. Ellis, BS, Krisana Gesuwan, CRNP, Rachel Aufforth, MD, Naris Nilubol, MD, William F. Simonds, MD, Electron Kebebew, MD – *National Cancer Institute, NIH; Geisel School of Medicine at Dartmouth; Perelman School of Medicine at the University of Pennsylvania*

9:10 am – 9:25 am
04. A RANDOMIZED PROSPECTIVE TRIAL OF SURGICAL TREATMENTS FOR HYPERPARATHYROIDISM IN PATIENTS WITH MULTIPLE ENDOCRINE NEOPLASIA TYPE 1
Terry C. Lairmore, MD, Cara M. Govednik, MD, Courtney E. Quinn, MD, Benjamin R. Sigmond, MD, Cortney Y. Lee, MD, Daniel C. Jupiter, PhD – *Baylor Scott & White Health Care, Texas A&M University System Health Science Center*

9:25 am – 9:40 am
★ **05.** IS CENTRAL LYMPH NODE DISSECTION NECESSARY FOR PARATHYROID CARCINOMA?
Kun-Tai Hsu, MD, Rebecca S. Sippel, MD, FACS, Herbert Chen, MD, FACS, David F. Schneider, MD, MS – *University of Wisconsin*

9:40 am – 10:00 am *Plaza Ballroom*
Morning Break, Exhibits and Poster Viewing

10:00 am – 11:00 am *Imperial Ballroom*
SCIENTIFIC SESSION II: Papers 6-9
MODERATORS: Sareh Parangi, MD and Dan Ruan, MD

10:00 am – 10:15 am
06. DICER EXPRESSION AND MICRORNA DYSREGULATION ARE ASSOCIATED WITH AGGRESSIVE FEATURES IN THYROID CANCER
Michael J. Crowley, MSc, Piril Erler, MSc, Xavier M. Keutgen, MD, David A. Kleiman, MD, Toni Beninato, MD, Theresa Scognamiglio, MD, Olivier Elemento, PhD, Rasa Zarnegar, MD, Thomas J. Fahey III, MD – *New York Presbyterian Hospital- Weill Cornell Medical College*

10:15 am – 10:30 am
★ **07.** MUTATIONS REVEALED IN WHOLE-EXOME SEQUENCING IMPLY COMMON TUMORIGENICITY PATHWAYS IN MEN1 PATIENTS
Minerva A. Romero Arenas, MD, MPH, Richard G. Fowler, PhD, F. Anthony San Lucas, MS, Rachel S. Morris, MD, Thereasa A. Rich, MS, Ashley K. Cayo, MD, Paul H. Graham, MD, Elizabeth G. Grubbs, MD, Jeffrey E Lee, MD, Paul A. Scheet, PhD, Hua Zhao, PhD, Nancy D. Perrier, MD – *The University of Texas MD Anderson Cancer Center*

10:30 am – 10:45 am
★ **08.** A PRACTICAL METHOD TO DETERMINE THE SITE OF UNKNOWN PRIMARY IN METASTATIC NEUROENDOCRINE TUMORS
Jessica E. Maxwell, MD, MBA, Scott K. Sherman, MD, Kristen M. Stashek, MD, Thomas M. O'Dorisio, MD, Andrew M. Bellizzi, MD, James R. Howe, MD – *University of Iowa Carver College of Medicine*

10:45 am – 11:00 am
★ **09.** EXPANDED CRITERIA FOR CARCINOID LIVER DEBULKING: MAINTAINING SURVIVAL AND INCREASING THE NUMBER OF ELIGIBLE PATIENTS
Amanda N. Graff-Baker, MD, David A. Sauer, MD, SuEllen J. Pommier, MD, Rodney F. Pommier, MD – *Oregon Health and Science University*

11:00 am – 12:00 pm *Imperial Ballroom*
Presidential Introduction and Address: Evolution
Sally E. Carty, MD, University of Pittsburgh School of Medicine

12:00 pm – 1:15 pm *On Your Own*
Lunch

12:00 pm – 1:15 pm *Georgian Room*
Laryngeal Ultrasound and Larangoscopy Hands On Stations

FACULTY
- Denise M. Carneiro, MD – *Medical University of South Carolina*
- Brian Lang, MD – *University of Hong Kong*
- Barbra S. Miller, MD – *University of Michigan*
- Sareh Parangi, MD – *Harvard Medical School*
- Gregory W. Randolph, MD – *Harvard Medical School*
- Cord Sturgeon, MD – *Northwestern University*
- Scott M. Wilhelm, MD – *University Hospitals*
- Kai Pun Wong, MD – *University of Hong Kong*
- Jung-Woo Woo, MD – *Seoul National University Hospital*

1:15 pm – 2:30 pm *Imperial Ballroom*

SCIENTIFIC SESSION III: Papers 11-15

MODERATORS: Steven DeJong, MD and Barbara Miller, MD

1:15 pm – 1:30 pm

★ **11.** A NOVEL STAGING SYSTEM FOR ADRENAL CORTICAL CARCINOMA BETTER PREDICTS SURVIVAL IN PATIENTS WITH STAGE I/II DISEASE

Elliot A. Asare, MD, Tracy S. Wang, MD, MPH, Karl Y. Bilimoria, MD, MS, Katherine Mallin, PhD, Electron Kebebew, MD, Cord Sturgeon, MD, MS – *American College of Surgeons, Medical College of Wisconsin, Northwestern University, National Cancer Database, National Cancer Institute Endocrine Oncology Branch*

1:30 pm – 1:45 pm

★ **12.** ALDOSTERONOMA RESOLUTION SCORE PREDICTS LONG-TERM RESOLUTION OF HYPERTENSION

Anna Aronova, MD, Benjamin L. Gordon, BA, Brendan M. Finnerty, MD, Rasa Zarnegar, MD, Thomas J. Fahey, III, MD – *New York Presbyterian Hospital, Weill Cornell Medical College*

1:45 pm – 2:00 pm

★ **13.** LONG-TERM BLOOD PRESSURE CONTROL IN PATIENTS UNDERGOING ADRENALECTOMY FOR PRIMARY HYPERALDOSTERONISM

Heather Wachtel, MD, Isadora Cerullo, BA, Edmund K. Bartlett, MD, Rachel R. Kelz, MD, MSCE, Giorgos C. Karakousis, MD, Robert E. Roses, MD, Debbie L. Cohen, MD, Douglas L. Fraker, MD – *Hospital of the University of Pennsylvania*

2:00 pm – 2:15 pm

★ **14.** HYPOGLYCEMIA AFTER RESECTION OF PHEOCHROMOCYTOMA

Yufei Chen, MD, Richard A. Hodin, MD, Chiara Pandolfi, Daniel T. Ruan, MD, Travis J. McKenzie, MD – *Massachusetts General Hospital, Brigham and Women's Hospital*

2:15 pm – 2:30 pm

15. BOTH PREOPERATIVE ALPHA AND CALCIUM CHANNEL BLOCKADE IMPACT INTRAOPERATIVE HEMODYNAMIC STABILITY SIMILARLY IN THE MANAGEMENT OF PHEOCHROMOCYTOMA

L. Brunaud, M. Boutami, P.L. Nguyen, A. Germain, A. Ayav, T. Fahey, L. Bresler, E. Mirallie, R. Zarnegar – *University of Nantes-CHU Nantes, New York Presbyterian Hospital-Weill Cornell Medical College, University of Lorraine-CHU Nancy Brabois*

2:30 pm – 2:50 pm *Plaza Ballroom*

Afternoon Break, Exhibits and Poster Viewing

2:50 pm – 4:05 pm *Imperial Ballroom*

SCIENTIFIC SESSION IV: Papers 16-20

MODERATORS: Cord Sturgeon, MD and Tracy Wang, MD

2:50 pm – 3:05 pm

★ **16.** RISK FACTORS FOR 30-DAY HOSPITAL READMISSION FOLLOWING THYROIDECTOMY AND PARATHYROIDECTOMY IN THE UNITED STATES: AN ANALYSIS OF NATIONAL SURGICAL QUALITY IMPROVEMENT PROGRAM (NSQIP) OUTCOMES

Matthew G. Mullen, MD, Damien J. LaPar, MD, MSc, Florence E. Turrentine, PhD, RN, Philip W. Smith, MD, John B. Hanks, MD – *University of Virginia Health System*

3:05 pm – 3:20 pm

★ **17.** RISK SCORING CAN PREDICT READMISSION AFTER ENDOCRINE SURGERY

James C. Iannuzzi, MD, MPH, Fergal J. Fleming, MBBCh, Kristin N. Kelly, MD, Daniel T. Ruan, John R. Monson, MD, Jacob Moalem, MD – *University of Rochester Medical Center*

3:20 pm – 3:35 pm

18. DEVELOPING A WASTE REDUCTION STRATEGY TO STREAMLINE VARIABILITY IN HOSPITAL CHARGES FOR STANDARD, ROUTINE THYROIDECTOMY

Lilah F. Morris, MD, Minerva A. Romero Arenas, MD, MPH, Jeffrey Cerny, MD, Joel S. Berger, CRNA, Connie Borror, PhD, Meagan Ong, PAC, Ashley K. Cayo, MD, Paul H. Graham, MD, Elizabeth G. Grubbs, MD, Jeffrey E. Lee, MD, Nancy D. Perrier, MD – *The University of Texas MD Anderson Cancer Center*

3:35 pm – 3:50 pm

★ **19.** SURGEON VOLUME AND ADEQUACY OF THYROIDECTOMY FOR DIFFERENTIATED THYROID CANCER

Cameron D. Adkisson, MD, Gina M. Howell, MD, Kelly L. McCoy, MD, FACS, Michaele J. Armstrong, PhD, Meghan Kelley, BS, Michael T. Stang, MD, FACS, Judith M. Joyce, MD, Steven P. Hodak, MD, Sally E. Carty, MD, FACS, Linway Yip, MD, FACS – *University of Pittsburgh Medical Center*

3:50 pm – 4:05 pm

★ **20.** ENDOCRINE SURGERY IN MODERN DAY ACADEMIA

Jennifer H. Kuo, MD, Kevin M. Parrack, MD, John A. Chabot, MD, James A. Lee, MD – *Columbia University*

4:05 pm – 5:05 pm *Imperial Ballroom*

SCIENTIFIC SESSIONS V: Papers 21-24

MODERATORS: Ralph Tufano, MD and Scott Wilhelm, MD

4:05 pm – 4:20 pm

★ **21.** MALIGNANCY RISK AND REPRODUCIBILITY IN ATYPIA OF UNDETERMINED SIGNIFICANCE ON THYROID CYTOLOGY

Aarti Mathur, MD, Alireza Najafian, MD, Martha A. Zeiger, MD, FACS, Matthew T. Olson, MD – *The Johns Hopkins Hospital*

4:20 pm – 4:35 pm

★ **22.** PREOPERATIVE LARYNGOSCOPY IN THYROID SURGERY: DO PATIENTS' SUBJECTIVE VOICE COMPLAINTS MATTER?

Kristin L. Long, MD, Cortney Y. Lee, MD, FACS, Roberta Eldridge, David A. Sloan, MD, FACS – *University of Kentucky*

4:35 pm – 4:50 pm

★ **23.** COMPARABLE OUTCOMES OF PATIENTS WITH T1A AND T1B DIFFERENTIATED THYROID CANCER- IS THERE A NEED FOR CHANGE IN THE AJCC CLASSIFICATION SYSTEM?

Laura Y. Wang, MBBS, MS, Frank L. Palmer, BA, Iain J. Nixon, MBChB, Dorothy Thomas, BA, Robert M. Tuttle, MD, Ashok R. Shaha, MD, Jatin P. Shah, MD, Snehal G. Patel, MD, Ian Ganly, MD, PhD – *Memorial Sloan Kettering Cancer Center*

4:50 pm – 5:05 pm

★ **24.** THE UTILITY OF LYMPH NODE MAPPING SONOGRAM AND THYROGLOBULIN SURVEILLANCE IN POST-THROIDECTOMY PAPILLARY THYROID CANCER PATIENTS

Jessica A. Zaman, MD, Chowdhury F. Miah, MD, Mitchell Simon, MD, Tomer Davidov, MD, FACS, Gandhi Lanke, MD, Stanley Z. Trooskin, MD, FACS – *Rutgers University - Robert Wood Johnson Medical School*

5:05 pm – 6:05 pm *Imperial Ballroom*

AAES Business Meeting

All AAES Members welcome to attend. Only current Members may vote.

TUESDAY, APRIL 29, 2014

8:00 am – 9:15 am *Imperial Ballroom*

SCIENTIFIC SESSION VI: Papers 25-29

MODERATORS: Geeta Lal, MD and Amanda Laird, MD

8:00 am – 8:15 am

25. REAPPRAISAL OF LYMPHATIC MAPPING FOR MIDGUT NEUROENDOCRINE PATIENTS UNDERGOING CYTOREDUCTIVE SURGERY

Yi-Zarn Wang, DDS, MD, Jean P. Carrasquillo, MD, Elizabeth McCord, BS, J. Philip Boudreaux, MD, Eugene A. Woltering, MD – *Louisiana State University Health Sciences Center New Orleans*

8:15 am – 8:30 am

26. COMPARISON OF TUMOR MARKERS FOR PREDICTING NON-FUNCTIONING PANCREATIC NEUROENDOCRINE TUMOR OUTCOME

Jovenel Cherenfant, MD, Mark S. Talamonti, MD, Mistry K. Gage, MS, Susan J. Stocker, CCRP, Brittany Lapin, Edward Wang, PhD, Jonathan C. Silverstein, MD, Kathy Mangold, PhD, Tiffany A. Thurrow, MD, Melanie Odeleye, MD, Karen L. Kaul, MD, Curtis R. Hall, MD, Ihab Lamzabi, MD, Paolo Gattuso, MD, David J. Winchester, MD, Robert W. Marsh, MD, Kevin K. Roogin, MD, Marshall S. Baker, MD, David J. Bentrem, MD, Richard A. Prinz, MD – *NorthShore University HealthSystems, Jesse Brown Medical Center, University of Chicago, Rush University Medical Center*

8:30 am – 8:45 am

27. PERITONEAL CARCINOMATOSIS FROM SMALL INTESTINAL NEUROENDOCRINE TUMORS, CLINICAL COURSE AND GENETIC PROFILING.

Olov Norlén, MD, PhD, Katarina Edfeldt, MSc, Goran Akerstrom, MD, PhD, Gunnar Westin, PhD, Per Hellman, MD, PhD, Peyman Bjorklund, PhD, **Peter Stalberg, MD, PhD** – *Surgical Sciences, Uppsala, Sweden*

8:45 am – 9:00 am

28. PREDICTORS OF RECURRENCE IN ADRENAL PHEOCHROMOCYTOMA

Danielle M. Press, MD, Muhammet Akyuz, MD, Jamie Mitchell, MD, Amir Hamrahian, MD, Allan Siperstein, MD, Eren Berber, MD – *Cleveland Clinic*

9:00 am – 9:15 am

29. SURVIVAL IMPROVES WITH SURGERY IN ADRENAL CANCER, EVEN IN METASTATIC DISEASE

Masha Livhits, MD, Ning Li, PhD, Michael W. Yeh, MD, **Avital Harari, MD** – *UCLA*

9:15 am – 9:30 am *Plaza Ballroom*

Morning Break, Exhibits and Poster Viewing

9:30 am – 10:45 am *Imperial Ballroom*

SCIENTIFIC SESSION VII: Papers 30-34

MODERATORS: Bhuvanesh Singh, MD and Marybeth Hughes, MD

9:30 am – 9:45 am

30. SIN1, A CRITICAL COMPONENT OF THE MTOR- RICTOR COMPLEX, IS OVEREXPRESSED AND ASSOCIATED WITH AKT ACTIVATION IN MEDULLARY AND AGGRESSIVE PAPILLARY THYROID CARCINOMAS

Dimitrios Moraitis, MD, PhD, Chyssoula Liakou, MD, Maria Karanikou, BSc, Georgios Tzimas, MD, PhD, Sofia Tseleni-Balafouta, MD, PhD, George Z. Rassidakis, MD, PhD, Maria A. Kouvaraki, MD, PhD – *National and Kapodistrian University of Athens; Academy of Athens Biomedical Research Foundation*

9:45 am – 10:00 am

31. E-SELECTIN EXPRESSION AND BRAF STATUS IN PAPILLARY THYROID CARCINOMAS: CORRELATION WITH CLINICOPATHOLOGICAL FEATURES

Fulvio Basolo, MD, Liborio Torregrossa, MD, **Paolo Miccoli, MD** – *Università di Pisa*

10:00 am – 10:15 am

32. EXPRESSION OF THE EMBRYONIC MORPHOGEN NODAL IN THYROID CARCINOMAS: USING IMMUNOHISTOCHEMISTRY IN TISSUE MICROARRAY

Young Jun Chai, Su-jin Kim, June Young Choi, Do Hoon Koo, Kyu Eun Lee, Jung-Woo Woo, Se Hyun Paek, Hyungju Kwon, Soon Young Tae, Heeseung Lee, Kyuhyung Kim, Young A. Kim, Bo-Gun Jang, Young Joo Park, Yeo-Kyu Youn, Jun Woo Jung, Yong Jun Suh – *Seoul National University Hospital & College of Medicine*

10:15 am – 10:30 am

33. BRAF MUTATION IN PAPILLARY THYROID CANCER: A COST-UTILITY ANALYSIS OF PREOPERATIVE TESTING

Barnard J. Palmer, MD, MEd, Wayne Lee, MD, Arturo Garcia, MD, Vincent Chong, MD, Terrence H. Liu, MD, MPH – *UCSF-East Bay Department of Surgery*

10:30 am – 10:45 am

34. RISK-ADAPTED MANAGEMENT OF PAPILLARY THYROID CARCINOMA ACCORDING TO OUR OWN RISK-GROUP CLASSIFICATION SYSTEM: IS THYROID LOBECTOMY THE TREATMENT OF CHOICE FOR LOW-RISK PATIENTS?

Aya Ebina, MD, Iwao Sugitani, PhD, Yoshihide Fujimoto, PhD – *Division of Head and Neck, Cancer Institute Hospital, Japanese Foundation for Cancer Research and Division of Endocrine Surgery, Department of Surgery, Nippon Medical School, Tokyo, Japan*

10:45 am – 11:00 am *Plaza Ballroom*

Morning Break, Exhibits and Poster Viewing

11:00 am – 12:30 pm *Imperial Ballroom*

SCIENTIFIC SESSION VIII: Papers 35-40

MODERATORS: Mira Milas, MD and Erin Felger, MD

11:00 am – 11:15 am

35. STUDYING THE EFFECT OF SONOGRAPHIC LANDMARKS IMAGED ON TRANSCUTANEOUS LARYNGEAL ULTRASONOGRAPHY ON PERIOPERATIVE VOCAL CORD ASSESSMENT

Kai Pun Wong, **Jung-Woo Woo**, Se Hyun Paek, Felix Chi Lok Chow, Kyu Eun Lee, MD, Brian Hung Hin Lang, MS – *The University of Hong Kong, Seoul National University*

11:15 am – 11:30 am

36. FEASIBILITY OF SURGEON-PERFORMED TRANSCUTANEOUS VOCAL CORD ULTRASONOGRAPHY IN IDENTIFYING VOCAL CORD MOBILITY: A MULTI-INSTITUTIONAL EXPERIENCE

Denise Carneiro-Pla, MD, FACS, Barbra Miller, MD, FACS, Scott M. Wilhelm, MD, FACS, Cord Sturgeon, MD, FACS, Mira Milas, MD, FACS, Mark Cohen, MD, FACS, Paul Gauger, MD, FACS, David Hughes, MD, FACS, Carmen C Solorzano, MD, FACS – *Medical University of South Carolina, University of Michigan, University Hospitals/Case Medical Center, Northwestern University, Oregon Health Sciences University, Vanderbilt University Medical Center.*

11:30 am – 11:45 am

37. THE EFFECTS OF ACUPUNCTURE ON POST-OPERATIVE PAIN AFTER THYROID SURGERY. A PROSPECTIVE RANDOMIZED STUDY

M. Iacobone, MD, M. Citton, MD, S. Tropea, MD, G. Pagura, MD, G. Viel, MD, N. Sella, MS, D. Nitti, MD – *University of Padua, Italy*

11:45 am – 12:00 pm

38. FIBROMYALGIA SYMPTOMS AND MEDICATION REQUIREMENTS RESPOND TO PARATHYROIDECTOMY

Cameron D. Adkisson, MD, Linwah Yip, MD, FACS, Michaele J. Armstrong, PhD, Michael T. Stang, MD, FACS, Sally E. Carty, MD, FACS, Kelly L. McCoy, MD, FACS – *University of Pittsburgh Medical Center*

12:00 pm – 12:15 pm

39. PARATHYROID CARCINOMA IN MORE THAN 1000 PATIENTS: A POPULATION-LEVEL ANALYSIS

Claire Sadler, BS, Melanie Goldfarb, MD – *University of Southern California Keck School of Medicine*

12:15 pm – 12:30 pm

40. PREDICTORS OF TERTIARY HYPERPARATHYROIDISM: WHO WILL BENEFIT FROM PARATHYROIDECTOMY?

Lindel C. Dewberry, BS, Collin J. Weber, MD, Sudha Tata, MD, Sharon Graves, MD, Jyotirmay Sharma, MD – *Emory University*

ABSTRACTS

★ *Denotes Resident/Fellow Research Award Competition Paper*

NOTE: Author listed in **BOLD** *is the presenting author*

NOTES

★ 01. FOUR-DIMENSIONAL CT VS. 2-PHASE CT IN PATIENTS WITH PRIMARY HYPERPARATHYROIDISM: HOW MANY PHASES DO WE REALLY NEED?

Salem I. Noureldine, MD, Nafi Aygun, MD, Michael Walden, MD, Ralph P. Tufano, MD, MBA

Johns Hopkins University School of Medicine

BACKGROUND: Four-dimensional CT (4D-CT) is a multiphase, multidetector imaging modality that has been reported to accurately identify abnormal parathyroid glands when conventional imaging has failed in patients with primary hyperparathyroidism (PHPT). A reported concern with 4D-CT is the increased amount of radiation exposure to the patient with a conservative dose estimate of 27 mSv for a typical 4-phase exam. We hypothesized that 2-phase imaging (non-contrast and immediate arterial) would provide equivalent parathyroid localization as 4-phase imaging and reduce the overall radiation exposure.

METHODS: Informed consent was waived by our institutional review board for this retrospective study. Radiological images and surgical reports were reviewed for all consecutive patients with PHPT who underwent parathyroidectomy and whom 4D-CT was utilized. Scans were interpreted independently by one experienced head and neck radiologist blinded to the surgical pathology results and prior image readings; once using 4 phases and another using only two. Accuracy of 4-phase and 2-phase images were compared with intraoperative and surgical findings serving as standard of reference. Sensitivity and positive predictive value (PPV) were calculated, and PPV was used to determine accuracy.

RESULTS: In the 45 patients, fifty two abnormal parathyroid glands were found during surgery with a mean (±SD) weight of 384.2±296.7 mg. For the traditional 4-phase readings, sensitivity was 86% and PPV was 72.5%. For the 2-phase readings, sensitivity was 85.3% and PPV was 67.3%. Accuracy was 65.5% for 4-phases and 60.3% for 2-phases. The mean volume CT dose index for 4-phase and 2-phase CT were 63.6 mGy and 31.8 mGy, respectively. Forty four (97.8%) patients were rendered eucalcemic on six month follow-up.

CONCLUSION: The PPV and accuracy of 2-phase CT did not significantly differ from 4D-CT. The reduced radiation exposure to the patient with 2-phase CT may make this a more acceptable alternative to 4D-CT for localizing parathyroid glands in patients with PHPT. Future studies are required to determine the exact role of 2-phase CT in the management of patients with PHPT.

NOTES

★ 02. THE EFFECT OF CINACALCET (SENSIPAR®) ON INTRAOPERATIVE FINDINGS IN TERTIARY HYPERPARATHYROIDISM PATIENTS UNDERGOING PARATHYROIDECTOMY

Yash R. Somnay, BS, Eric Weinlander, BA, David F. Schneider, MD, MS, Rebecca S. Sippel, MD, FACS, Herbert Chen, MD, FACS

University of Wisconsin

INTRODUCTION: Tertiary hyperparathyroidism (3HPT) patients who undergo parathyroidectomy are often managed with calcium lowering medications like cinacalcet (Sensipar®) up until surgery. Cinacalcet activates calcium sensing receptors on the parathyroid thereby decreasing PTH and calcium levels. We assess how cinacalcet treatment influences intraoperative PTH (IOPTH) kinetics and overall outcomes, and its relationship with disease etiology.

METHODS: 116 retrospectively reviewed 3HPT patients who underwent parathyroidectomy between March 2001 and March 2013 at our institution were stratified into those on cinacalcet and on no calcimemetic at time of surgery. IOPTH levels were fitted to linear curves vs time. Cure was defined as calcium normalization at 6 months after surgery (8.5-10.2mg/dl). Student's T-test, Wilcoxin rank sum test, and Pearson's chi square test were used for comparison.

RESULTS: Of the 116 3HPT patients, 14 (12%) were taking cinacalcet perioperatively, while 102 (88%) were on no calcimimetic. Median treatment duration was 26 months (1.9 - 56 months). Combined cure rate was 97%, with a 2.5% recurrence rate. Cinacalcet did not significantly correlate with rates of cure (p=0.37) or recurrence (p=0.52). Patients on cinacalcet experienced a significantly steeper decline in IOPTH compared to those not on medication (p=0.008). However, cinacalcet did not affect the number of IOPTH readings required to be taken in order to attain the 50% drop to confirm surgical success. No significant difference was found in the likelihood of single adenomas, double adenomas or hyperplasia between cinacalcet and non-cinacalcet treated groups (p= 0.17). Although cinacalcet did not significantly alter postoperative PTH at 1 week (p=0.17), the weights of the heaviest glands (p=0.02), and preoperative PTH levels (p=0.004) were significantly higher among patients on cinacalcet, collectively indicative of the severity of their disease. Notably, cinacalcet treatment did not significantly affect postoperative calcium levels nor the rate of postoperative hypocalcemia (p=0.21).

CONCLUSION: Perioperative cinacalcet treatment in 3HPT patients alters IOPTH kinetics by causing a steeper IOPTH decline, but does not require modifying standard IOTPH protocol. Although cinacalcet does not adversely affect cure rates or postoperative hypocalcemia, it may be an indicator of more severe disease. Thus, cinacalcet does not need to be held prior to surgery.

NOTES

★ 03. HYPERPARATHYROIDISM-JAW TUMOR SYNDROME: WHAT IS THE BEST APPROACH TO SURGICAL MANAGEMENT?

Amit Mehta, BA, Dhaval Patel, MD, Avi Rosenberg, MD, Myriem Boufraqech, PhD, Ryan J. Ellis, BS, Krisana Gesuwan, CRNP, Rachel Aufforth, MD, Naris Nilubol, MD, William F. Simonds, MD, Electron Kebebew, MD

National Cancer Institute, NIH; Geisel School of Medicine at Dartmouth; Perelman School of Medicine at the University of Pennsylvania

BACKGROUND: There are limited data on the optimal surgical management of hyperparathyroidism-jaw tumor syndrome (HPT-JT), a rare autosomal dominant disease secondary to germ-line inactivating mutations of the tumor suppressor gene *HRPT2/CDC73*. The aim of the present study is to determine the optimal surgical approach in patients with HPT-JT based on an analysis of clinical, genetic, pathological and radiological features.

METHOD: Retrospective analysis of six families with 15 affected members (nine males, six females) diagnosed with HPT-JT. Demographic, clinical, disease outcomes and family pedigrees were assessed. Primary endpoints were persistent/recurrent disease, development of parathyroid carcinoma, and operative complications.

RESULTS: Six families with four distinct germline *HRPT2/CDC73* mutations were analyzed. Fifteen affected family members (median age of 29.9 years) were diagnosed with primary hyperparathyroidism. Thirteen of the 15 patients underwent preoperative localization studies (ultrasound and/or Sestamibi scan). Preoperative imaging correctly identified 10 patients with single gland disease and two patients with multiglandular disease, confirmed intraoperatively and by pathology. One patient had preoperative imaging identifying single gland disease, but was found to have multiglandular disease intraoperatively, which was confirmed by pathology. Fourteen of the 15 patients underwent uncomplicated bilateral neck exploration at initial operation and all were biochemically cured. Nine of the 15 patients had intraoperative PTH monitoring. All patients had a decrease of ≥75% of their baseline IOPTH after parathyroidectomy and these patients had a 100% cure rate. At initial operation and/or during follow-up, 40% of patients were diagnosed with parathyroid carcinoma, with two-thirds developing metastases (median survival 7.41 years). There was a trend toward higher preoperative average total calcium in patients with parathyroid carcinomas versus adenomas (p=0.088). Preoperative intact PTH levels (p=0.146), gland size (p=0.295), and age at diagnosis (p=0.279) were not significantly different. Long-term follow-up showed 20% of patients had recurrent hyperparathyroidism. Bilateral renal cysts were found in 20% of patients, uterine involvement in one third of women, and jaw tumors in only 13.3% of patients.

CONCLUSIONS: Given the high risk of malignancy, multiglandular involvement, and limitations of preoperative localization studies, we recommend bilateral exploration and en-bloc resection of parathyroid tumors suspicious for cancer and life-long postoperative follow-up.

NOTES

04. A RANDOMIZED PROSPECTIVE TRIAL OF SURGICAL TREATMENTS FOR HYPERPARATHYROIDISM IN PATIENTS WITH MULTIPLE ENDOCRINE NEOPLASIA TYPE 1

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BACKGROUND: Patients with MEN 1 develop hyperparathyroidism (HPT) due to multiglandular parathyroid disease. Accepted surgical treatment includes either subtotal 3 and ½ gland parathyroidectomy (SP), or total parathyroidectomy with heterotopic autotransplantation (TP/AT). Previous retrospective studies have not clearly established that improved outcomes are associated with one of these surgical approaches. Direct comparison in a prospective study has not been performed. A randomized, prospective trial of these two treatments was conducted.

METHODS: Informed consent was obtained under an IRB approved protocol. Patients were randomly assigned to SP or TP/AT. Demographic data, pre- and post-operative biochemical data, and intraoperative PTH levels were prospectively collected. Outcomes compared included persistent HPT, recurrent HPT, and postoperative hypoparathyroidism.

RESULTS: From September 1996 to September 2012, 32 patients were randomized prior to surgery to receive either SP or TP/AT. The study included five different endocrine surgeons, and spanned treatments at two academic medical centers. The mean follow-up was 7.6+5.8 years. Two patients died during the study period, and there was minimal follow-up obtainable on three additional patients. For the entire study group, the rate of recurrent HPT over the follow-up period was 4/25(16%). Recurrent HPT occurred in 2/13(15.4%) of patients undergoing SP, and 2/12(16.7%) of patients treated with TP/AT (p=1.0). Permanent postoperative hypoparathyroidism occurred in 5/28(15.6%) of the study patients overall. The rate of permanent hypoparathyroidism was 3/15(20%) in the SP group and 2/13(15.4%) in the TP/AT group (p=1.0). A second surgical procedure was performed in 4/17(23.5%) of patients initially treated with SP as compared with 1/15(6.7%) of patients undergoing TP/AT (p=0.338).

CONCLUSION: This is the first randomized, prospective trial comparing the outcomes of SP and TP/AT in patients with MEN 1. The study included randomization of 32 patients with long-term follow-up results, but does have limitations in power and lack of follow-up data on all patients. No significant differences in outcome of major endpoints were demonstrated when comparing results of SP versus TP/AT. Although both procedures are associated with acceptable results, SP may have advantages in involving only one surgical incision and avoiding an obligate period of transient postoperative hypoparathyroidism.

NOTES

★ 05. IS CENTRAL LYMPH NODE DISSECTION NECESSARY FOR PARATHYROID CARCINOMA?

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BACKGROUND: Parathyroid carcinoma has a five-year mortality rate of 9% to 31%. Unlike other more common malignancies, the significance of lymph node (LN) status remains controversial in parathyroid carcinoma. Current surgical guidelines recommend en-bloc resection of the parathyroid tumor, the ipsilateral thyroid lobe, and ipsilateral central compartment LN dissection. The purpose of this study was to determine the relative importance of LN metastases in disease-specific survival (DSS).

METHODS: This was a retrospective review using the Surveillance, Epidemiology, and End Result (SEER) database of parathyroid carcinoma cases diagnosed between 1988 and 2010. Kaplan-Meier survival estimation and Cox proportional hazards models were used to evaluate factors affecting DSS. Logistic regression was used to identify predictors of LN metastases.

RESULTS: 405 parathyroid carcinoma patients were identified from the SEER registry. The median age at diagnosis was 56 years (range 20-89), and 212 patients (52.3%) were male. Among 114 patients whose LNs were examined at surgery, only 12 (10.5%) had positive LNs. We performed sensitivity analysis and found a tumor size threshold of 3 cm best divided the cohort by DSS. Tumor size ≥3cm (HR 3.67; p=0.03), positive LN (HR 5.63; p=0.02) and distant metastasis (HR 69.55; p<0.001) were significant adverse predictors of DSS on univariate analysis. Only tumor ≥3cm (HR 4.40; p=0.01) and distant metastasis (HR 2.89; p=0.004) remained significant on multivariate analysis. Notably, LN metastases did not independently predict DSS (HR 0.82; p=0.53). Furthermore, there was no significant relationship between local invasion and positive LNs (p=0.40). When examining factors associated with LN status, only tumor ≥3cm predicted LN metastasis (OR 40.03; p=0.02). LN metastases were 7.5 times more likely in patients with tumors ≥3cm than those with tumors <3cm (21% vs. 2.8%; p= 0.02).

CONCLUSIONS: Positive LN status was not associated with DSS for parathyroid carcinoma. Therefore, central compartment LN dissection may be unnecessary in the treatment of parathyroid carcinoma except for patients with large tumors (≥3 cm).

NOTES

06. DICER EXPRESSION AND MICRORNA DYSREGULATION ARE ASSOCIATED WITH AGGRESSIVE FEATURES IN THYROID CANCER

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Alteration in global miRNA expression has been identified in several solid tumors and is regulated in part by Dicer, a class III endonuclease. Dicer is a key component of the RISC complex, which mediates miRNA processing and whose expression has been shown to be downregulated in a variety of cancers. In this study, we investigated the expression of Dicer and the global miRNA environment in correlation with malignant features of thyroid tumors.

MATERIALS AND METHODS: mRNA was extracted from 22 normal thyroids, 16 follicular adenomas, 28 classic papillary thyroid carcinomas (PTC), 10 tall cell variant PTC, 11 follicular variant PTC, as well as the BCPAP, TPC1, TAD2 and KTC1 thyroid cell lines. Dicer gene expression was assessed in all samples via qPCR. Sanger sequencing for BRAF V600E mutations was completed on gDNA from 31 tumors. miRNA from a subset of 10 matched PTC and normal samples was isolated and submitted for Next-Generation sequencing on the Illumina Hi-Seq 2000. Differentially expressed miRNAs were confirmed by qPCR. Protein levels in these same 10 samples and cell lines were assessed via western blotting and immunohistochemistry.

RESULTS: Dicer mRNA was downregulated in malignant thyroid samples and cell lines compared to normal tissues, benign neoplasms, and TAD2. Decreased Dicer gene expression in malignant tissues was significantly correlated with aggressive features including: extrathyroidal extension, angiolymphatic invasion, multifocality, lymph node metastasis, distant metastasis, recurrence and BRAF V600E mutations. Conversely, western blotting and immunohistochemistry revealed elevated Dicer protein levels in malignant tissues and cell lines. miRNA sequencing yielded 19 differentially expressed miRNAs, 8 of which were validated via qPCR. miRNA expression profiles trended toward a global downregulation in malignant tissues.

CONCLUSION: Dicer protein upregulation leads to a downregulation of Dicer mRNA probably due to a negative feedback loop and altered expression of specific miRNAs associated with aggressive features in thyroid cancers. These findings suggest that a disruption in normal miRNA processing involving Dicer may play a role in thyroid cancer progression.

NOTES

★ 07. MUTATIONS REVEALED IN WHOLE-EXOME SEQUENCING IMPLY COMMON TUMORIGENICITY PATHWAYS IN MEN1 PATIENTS

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BACKGROUND: The genetic mechanisms of tumorigenesis in multiple endocrine neoplasia type 1 (MEN1) are poorly understood. Whole-exome sequencing (WES) in MEN1 or sporadic hyperparathyroidism (HPT) has not revealed clear mutation patterns. Because of the known germline mutation in MEN1 patients, we hypothesized that mutations involved in functional pathways of parathyroid tissue could also elucidate tumorigenic networks.

METHODS: We identified patients with HPT who underwent parathyroidectomy at our institution and consented to enrollment in a prospective research database and parathyroid tissue bank. MEN1 and sporadic HPT patients were matched for age at HPT diagnosis. WES was performed on parathyroid tissue; sequenced reads were aligned to the human genome reference hg19 to improve mapping quality. Somatic mutations were identified using Mutect and annotated with ANNOVAR, Cancer Gene Census, and Cosmic tools. Driver status was predicted using CHIASM. Genes with functional mutations were also analyzed using the interactive pathway analysis of complex 'omics data (IPA; Ingenuity Systems) to characterize aberrant biological functions and pathways.

RESULTS: Specimens were available for 14 patients with HPT (4 MEN1, 10 sporadic). Eighteen somatic mutations (stop-gain) were identified in 3 MEN1 patients; one MEN1 patient had no somatic mutations. Based on IPA analysis, these mutations are involved in networks of cellular function and maintenance, tumor morphology, and cardiovascular disease (IPA score 49). A driver mutation on the p53 gene, causing a K to E change at codon 81 (p=0.002), was identified in a MEN1 patient. In the sporadic group, 41 somatic mutations were identified (stop-gain and –loss) but no functional pathways were associated on IPA analysis.

CONCLUSIONS: WES of parathyroid tissue from HPT patients revealed mutation patterns among MEN1 patients that are distinct from patients with sporadic disease. We identified a p53 mutation and somatic mutations leading to aberrant functional pathways that may be important in development of MEN1-related HPT. Next, we will use a cDNA array to evaluate whether these mutations lead to altered gene expression. Further research using a larger cohort, and other tissues – such as neuroendocrine pancreas – could determine the significance of aberrant pathways in development of MEN1-related neoplasms.

NOTES

★ 08. A PRACTICAL METHOD TO DETERMINE THE SITE OF UNKNOWN PRIMARY IN METASTATIC NEUROENDOCRINE TUMORS

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INTRODUCTION: The primary tumor site is unknown prior to surgery in approximately 20% of small bowel (SBNET) and pancreatic (PNET) neuroendocrine tumors despite optimal workup. Biopsies of PNET and SBNET metastases are histologically similar, yet knowing the primary site has important therapeutic and prognostic implications. We sought to compare the utility of a three-marker immunohistochemistry (IHC) panel and our previously defined gene expression classifier (GEC) to determine the primary site of NET metastases.

METHODS: RNA was extracted from 109 SBNET and PNET liver and lymph node metastases, and gene expression determined using qPCR. The GEC employs a logistic regression model using expression of Bombesin receptor, BRS3, and Opioid receptor, OPRK1, in metastases to determine their site of origin. The IHC algorithm was evaluated in 86 primary SBNETs and PNETs and 37 metastases. Tumors with diffuse, strong CDX2-positivity were called SBNETs, while those with any PAX6 and/or ISLET1-positivity were called PNETs. Site of origin was considered indeterminate in tumors negative for all three markers. IHC was assessed by a pathologist blinded to the primary site, and results compared to those with the GEC.

RESULTS: The GEC correctly identified the primary site in 76/78(97%) SBNET and 27/31(87%) PNET metastases. IHC correctly classified 83/86(97%) primary SBNETs and PNETs. In metastases, IHC called 33/37(89%) correctly, with 4 indeterminate. In the 23 metastases tested by both methods, GEC correctly classified 22/23(96%) metastases. IHC correctly classified 19/23(83%) samples, while the remaining 4 were negative for all three markers. One SBNET metastasis misclassified as pancreatic by GEC was correctly classified by IHC. All 4 IHC-indeterminate samples were correctly classified by GEC.

CONCLUSION: Three-marker IHC is a simple and accurate initial test to determine the primary tumor site from NET metastases. Although it made no incorrect classifications, 15% of metastases were indeterminate, necessitating a supplemental test. Our GEC demonstrates excellent independent accuracy (94% overall), and identified the primary tumor site in all cases where IHC failed. These results suggest that by performing IHC, followed by GEC for indeterminate cases, the primary site of SBNET and PNET metastases can be identified in virtually all patients.

NOTES

★ 09. EXPANDED CRITERIA FOR CARCINOID LIVER DEBULKING: MAINTAINING SURVIVAL AND INCREASING THE NUMBER OF ELIGIBLE PATIENTS

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BACKGROUND: Cytoreduction of carcinoid liver metastases currently aims for ≥90% debulking in patients without extrahepatic disease, achieving 5-year survival rates of 61-74%. Data on the impact of less restrictive resection criteria and other clinical and tumor-specific factors on outcomes are limited. This study will determine which factors impact liver progression-free (PFS) and disease-specific (DSS) survival in patients selected for liver debulking based upon expanded eligibility criteria.

METHODS: Records of carcinoid patients undergoing liver debulking from 2007-2011 were reviewed. The debulking threshold was 70%; extrahepatic disease did not preclude cytoreduction. Intraoperatively, positive margins via enucleation were allowed. Tumors were retrospectively reviewed for size and grade by one pathologist. Kaplan-Meier PFS and DSS were calculated and compared by log-rank analysis. Correlations between PFS or DSS and clinical or tumor-specific factors were determined by Chi-squared analysis.

RESULTS: Fifty patients were identified (mean age=58, range 29-77). Fifteen had anatomic resections and 49 had wedges/enucleations. Mean number of liver tumors resected was 23 (range 1-131), the largest was 16.0cm. Ten had complete resection; 40 had incomplete (>70%) resection. Fourteen had residual extra-hepatic disease. All primaries reviewed were low grade, but 37% of patients had at least one intermediate grade metastasis. Fifteen patients (30%) had liver progression; five underwent a second liver debulking. Median PFS was 60 months. Five-year DSS was 89% with all deaths from liver failure. Neither PFS nor DSS correlated with size, number, location, grade, or margins of resected metastases, extent/type of resection, amount of residual hepatic disease, or extrahepatic disease. Only age was a significant adverse prognostic factor. Median PFS for patients <50 years was 29 months and was not yet reached in older patients (p=0.001). Five-year DSS for patients <50 years was 67%, compared to 97% in older patients (p=0.016).

CONCLUSIONS: Our data support expanding eligibility criteria for liver resection. Lowering the debulking threshold to 70% and allowing positive margins and extrahepatic disease resulted in 89% 5-year DSS. Number, size, intermediate grade, or distribution of metastases need not be exclusionary. Although younger age portends a poorer prognosis, the favorable PFS and DSS justify also utilizing expanded criteria in this subgroup.

NOTES

★ 11. A NOVEL STAGING SYSTEM FOR ADRENAL CORTICAL CARCINOMA BETTER PREDICTS SURVIVAL IN PATIENTS WITH STAGE I/II DISEASE

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BACKGROUND: In 2009, the European Network for the Study of Adrenal Tumors (ENSAT) proposed a modification to Union for International Cancer Control (UICC) staging for adrenocortical carcinomas (ACC) by limiting stage IV to distant metastases. However, ENSAT criteria failed to show a statistically significant difference in survival between stages I/II. The objectives of this study were: (1) to evaluate ENSAT staging for survival prediction using a larger cohort of patients, and (2) to assess whether incorporating age into ACC staging improves predictions of survival.

METHODS: Patients with a histologic diagnosis of ACC were identified in the National Cancer Data Base from 1985-2006. The Surveillance, Epidemiology and End Results summary stage was used to derive TNM stage using ENSAT criteria. An alternative staging system was developed: stage I (T1/T2N0M0, age =55); stage II (T1/T2N0M0, age >55); stage III (any T with local invasion or N1, M0, any age); stage IV (any T, any N, M1, any age). Differences in overall survival (OS) by stage were compared between ENSAT and the alternative staging system using a Cox proportional hazards model.

RESULTS: TNM stage could be derived for 1597/ 3262 patients. Median age was 55 years (IQR: 18-90). Average tumor size was 12cm. Based on ENSAT, 5-year OS rates were: 68% (stage I; n=105), 61% (stage II; n=585), 37% (stage III; n=384), and 9.7% (stage IV; n=523). Significant differences in 5-year OS existed only between stages II and III ($p<0.0001$) and stages III and IV ($p<0.0001$). Using the alternative system, 5-year OS rates were: 70% (stage I; n=373), 53% (stage II; n=317), 37% (stage III; n=384), and 9.7% (stage IV; n=523). The difference in 5-year OS between all stages was significant (I and II [$p<0.0001$], II and III [$p=0.0004$], III and IV [$p<0.0001$]).

CONCLUSIONS: A staging system that incorporates patient age and UICC/AJCC tumor definitions performs better than ENSAT for predicting 5-year OS among patients with stages I/II ACC. A revised staging system for ACC would better inform caregivers about treatment and prognosis. Consideration should be given to including age in staging for ACC in the next AJCC staging manual.

NOTES

★ 12. ALDOSTERONOMA RESOLUTION SCORE PREDICTS LONG-TERM RESOLUTION OF HYPERTENSION

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BACKGROUND: The Aldosteronoma Resolution Score (ARS) takes into consideration four readily available pre-operative clinical parameters in predicting the likelihood of resolution of hypertension in patients six months after undergoing unilateral adrenalectomy for aldosterone-producing adenoma (APA). The model scores BMI≤25 (1 point), female sex (1 point), duration of hypertension ≤6 years (1 point), and pre-operative antihypertensive medications ≤2 (2 points), with ARS ≥4 predicting a high likelihood of resolution. We sought to determine the durability of this predictive model after one year.

METHODS: A retrospective chart review was undertaken of 60 patients who underwent unilateral adrenalectomy for APA at a single institution between 2004 and 2013. Clinical and laboratory data were collected for patients at their pre-operative and post-operative visits. Patients were classified based on complete resolution of hypertension at greater than one year follow-up, defined by normotension and no antihypertensive medication requirement.

RESULTS: Forty-seven patients had data available for analysis. Median follow-up was 1135 days (371-3202) with 76.5% having more than two-year follow-up. Forty-five percent of patients had complete resolution, 45% had marked improvement, and 10% had no improvement in hypertension. Applying the ARS, there was complete resolution of hypertension in 73% of patients with ARS 4-5, 53% of patients with ARS 2-3, and 24% of patients with ARS 0-1 in comparison to 75% (p=0.9), 46% (p=0.66), 28% (p=0.76), respectively, in the original cohort used to create the ARS. Compared to the original cohort, our population was similar except for younger age (p=0.0001). On multivariate analysis, number of pre-operative antihypertensive medications was a significant predictor of resolution (OR 2.45, 95%CI 1.1-5.47; p=0.03) as was duration of hypertension (OR 5.6, 95%CI 1.1-27.8; p=0.04), but female sex (OR 2.9, 95%CI 0.58-15; p=0.19) and BMI (OR 0.25, 95%CI 0.38-1.65; p=0.15) were not significant predictors. The area under the ROC curve was 0.84.

CONCLUSION: The majority of patients (90%) have long-term improvement or complete resolution of hypertension after unilateral adrenalectomy for APA. The ARS continues to accurately predict patients at low or high likelihood for complete resolution of hypertension beyond one year.

NOTES

★ 13. LONG-TERM BLOOD PRESSURE CONTROL IN PATIENTS UNDERGOING ADRENALECTOMY FOR PRIMARY HYPERALDOSTERONISM

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INTRODUCTION: Primary hyperaldosteronism (PHA) is one of the few curable causes of hypertension. Adrenalectomy is the standard of care for PHA due to aldosteronoma or unilateral hyperplasia, but data on long-term blood pressure (BP) control after surgery is limited. In this study, we evaluate long-term outcomes in our large series of patients undergoing adrenalectomy for PHA.

METHODS: We performed a retrospective cohort study using our prospectively maintained endocrine surgery database. Patients undergoing adrenalectomy for PHA between 1997-2012 were identified for inclusion. Patient variables included demographics, medical comorbidities, biochemical testing, anti-hypertensive medications (AHM), and BP values. Standard BP criteria were used, with hypertension defined as ≥140/90. Long-term follow up (LTFU) was defined as ≥12 months after surgery. Patients without LTFU in the medical record were contacted by telephone to obtain current BP measurements, and AHM. Primary outcome at LTFU was cure, defined as normotension off AHM. Univariate analysis utilized Student's t-test, chi-square test, or Wilcoxon rank sum test, as appropriate.

RESULTS: Of 164 patients identified for inclusion, LTFU data was obtained for 85 patients (51.8%), who were included in the final analysis. With a median of 36 months of LTFU, 15.3% (n=13) were cured; 54.1% (n=46) were normotensive while remaining on AHM, and 30.6% (n=26) were persistently hypertensive. On univariate analysis, age (p=0.011), female gender (p<0.001), lower BMI (p=0.018), shorter duration of hypertension (p=0.002), lower serum creatinine (p=0.001), and smaller number of preoperative AHM (p<0.001) were associated with cure. Female gender (OR=32.5, 95% CI= 3.8-280.8), BMI≤25 (OR=9.3, 95% CI=1.8-47.2), hypertension <5 years (OR=4.5, 95% CI=1.1-18.1), creatinine ≤0.8 (OR=7.6, 95% CI=1.7-32.9,) and <2 preoperative AHM (OR=10.4, 95% CI=2.3-46.7) were incorporated into a scoring system. A score of 0-1 (n=61) was associated with a 5% cure rate; a score of 2-3 (n=21) had double the baseline cure rate (33%), and patients with a score of 4-5 (n=3) had a 100% cure rate.

CONCLUSIONS: Prior studies have focused on short term outcomes after surgery for PHA. In this study, we identify factors associated with durable long-term blood pressure control after adrenalectomy. These data provide a potential tool to guide preoperative patient counseling and expectations.

NOTES

★ 14. HYPOGLYCEMIA AFTER RESECTION OF PHEOCHROMOCYTOMA

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BACKGROUND: Hypoglycemia following resection of pheochromocytoma is a rare and poorly understood complication and is thought to be secondary to a rebound hyperinsulinemia and increased peripheral glucose uptake. Hypoglycemia usually occurs in the early post-operative period and if undetected, can have severe neurological consequences. We examined the incidence of this complication in a large surgical series of patients after resection of pheochromocytoma and aimed to identify predisposing risk factors.

METHOD: Patients who underwent a pheochromocytoma resection between 1993 and 2013 at two large academic medical centers were identified retrospectively from a research patient data registry. The primary endpoint was the occurrence of post-operative hypoglycemia defined as blood glucose <55mg/dL.

RESULTS: 213 patients underwent resection of pheochromocytoma for a total of 215 operations. The average age was 50 years with a male preponderance (62.8%). Nine patients (4.2%) experienced post-operative hypoglycemia with 8 (88.9%) occurring in the first 24 hours and 5 (55.6%) within the first 4 hours. Patients who developed hypoglycemia were more likely to have higher pre-operative 24-hour urinary epinephrine (468 vs 85 mcg/24hours, p=0.06) and metanephrine (4726 vs 2461 mcg/24hours, p=0.05). These patients also experienced longer operative times (270 vs 142 minutes, p<0.01) and had larger neoplasm size (7.6 vs 4.6cm, p=0.02). Post-operatively, patients with hypoglycemia more frequently required intensive care level monitoring (88.9% vs 34.5%, p<0.01), but there was no statistical difference in length of hospital stay (5 vs 3 days, p=0.10).

CONCLUSION: Our data demonstrate that hypoglycemia is a rare complication after resection of pheochromocytoma. Patients with larger neoplasms and epinephrine-predominant neoplasms may be predisposed to complicated post-operative hypoglycemia requiring admission to the intensive care unit. We suggest hourly glucose monitoring after pheochromocytoma resection in the early post-operative period with routine administration of dextrose-containing intravenous fluids.

NOTES

15. BOTH PREOPERATIVE ALPHA AND CALCIUM CHANNEL BLOCKADE IMPACT INTRAOPERATIVE HEMODYNAMIC STABILITY SIMILARLY IN THE MANAGEMENT OF PHEOCHROMOCYTOMA

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BACKGROUND: Alpha-blockade is commonly regarded as the standard management preoperatively to prevent intraoperative hemodynamic instability (IHD) during resection of a pheochromocytoma. However, alpha-blocking agents are expensive and difficult to access. Calcium channel blockers (CCB) have been employed to lower the risk of IHD by some groups with good results. However, it is controversial if one regimen is superior. We aimed to determine the difference between preoperative alpha-blockade and CCB regimens in minimizing IHD during adrenalectomy for pheochromocytoma.

METHOD: Retrospective analysis from a tri-institutional database. Inclusion criteria were unilateral total adrenalectomy using a transabdominal approach from 2002 to 2012. Converted patients were excluded. IHD episodes were defined as the presence of at least one intraoperative systolic blood pressure (SBP) > 160 mmHg and at least one intraoperative mean arterial pressure (MAP) < 60 mmHg episode.

RESULTS: One-hundred fifty-five consecutive patients were analyzed including 110 CCB and 41 alpha-blocakde patients. Preinduction blood pressure was normal (<130/85mmHg) in 27% of CCB patients versus 80% of alpha-blockade patients (p<0.0001). Intraoperatively, mean maximal SBP was lower after alpha blockade (169 vs 198 mmHg; p<0.0001) as well as incidence and duration of SBP > 200mmHg episodes (12 vs 49% and 1 vs 6 min, respectively, p<0.01). However, severe hypotensive episodes (MAP < 60mmHg) were more frequent (85% vs 42%; p<0.001) and longer (14 vs 4 min; p<0.0001) in alpha-blockade patients. Consequently, intraoperative vasoactive drugs were administered more frequently in these patients (98 vs 85%; p=0.03) and mean volume of intraoperative infusions per patient was larger (3800 vs 2600 mL; p<0.001). IHD episodes were observed in 54 patients (35%). IHD was not associated to type of preoperative medication used, or preinduction blood pressure normalization after preoperative medical therapy (< 130/85 mmHg). On multivariate analysis, familial disease was the only predictor of IHD (OR 0.15; 0.03-0.79; p=0.02).

CONCLUSION: Alpha blockade is associated with less hypertensive but more hypotensive intraoperative episodes than calcium channel blockade. IHD was independent of either type of preoperative medical management but was dependent on familial disease. These findings broaden the options for clinicians in the preoperative management of patients with pheochromocytoma.

NOTES

★ 16. RISK FACTORS FOR 30-DAY HOSPITAL READMISSION FOLLOWING THYROIDECTOMY AND PARATHYROIDECTOMY IN THE UNITED STATES: AN ANALYSIS OF NATIONAL SURGICAL QUALITY IMPROVEMENT PROGRAM (NSQIP) OUTCOMES

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BACKGROUND: 30-day hospital readmission has become a metric for quality and penalty under the Affordable Care Act. However, an understanding of factors influencing readmission after thyroid and parathyroid surgery remains ill-defined. Outpatient surgery (postoperative length of stay <24 hours) has become popular as a cost reduction measure, but resultant readmission rate is largely unknown. The purpose of this study was to evaluate the contribution of patient- and operation-related risk factors and the influence of outpatient surgery on hospital readmission following thyroidectomy and parathyroidectomy.

METHODS: Patient records from the ACS NSQIP Participant Use File (2011) for elective thyroid (n=3,711) and parathyroid (n=3,358) resections were analyzed. The relative contribution of patient- and operation-related factors to the likelihood for readmission was assessed by univariate and multivariate analyses.

RESULTS: A total of 7,069 patients were studied. Overall 30-day hospital readmission rate was 4.0% (n=280), including 4.1% (n=153) following thyroidectomy and 3.8% (n=127) following parathyroidectomy. Length of stay <24 hours occurred among 37.0% (n=2,613). Patients undergoing 30-day readmissions presented with increased operative risk with higher median estimated probability of morbidity (1.6% vs. 1.4%, P<0.001), and experienced more frequent unplanned reoperations (23.0% vs. 0.7%, P<0.001). Importantly, upon multivariable risk adjustment, factors demonstrating significant associations with likelihood for 30-day hospital readmission included: patient age (OR 0.9, P=0.01), declining functional status (OR 7.3 - 10.2, P=0.04), preoperative hemodialysis (OR 2.4, P<0.001), malnutrition (OR 3.3, P=0.02), advancing American Society of Anesthesiologists (ASA) Class (OR 2.1 - 4.3, P<0.001), unplanned reoperation (OR 60.0, P<0.001), and outpatient surgery (OR=0.63, P=0.001). Furthermore, hospital readmission status was associated with longer total and postoperative hospital lengths of stay after the index operation and occurrence of major postoperative complications, including renal insufficiency (all P<0.01).

CONCLUSIONS: Thirty-day hospital readmission following performance of cervical endocrine resections occurs in approximately 4% of patients nationwide. Outpatient surgery does not adversely affect the likelihood of readmission, while risk-factors for readmission are multifactorial and appear largely driven by potentially modifiable preoperative patient condition. Identifying best practice patterns to reduce index hospital stays and incidence of major postoperative complications may reduce hospital readmission rates and improve hospital quality.

NOTES

★ 17. RISK SCORING CAN PREDICT READMISSION AFTER ENDOCRINE SURGERY

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BACKGROUND: While hospitals and surgeons are increasingly pressured to reduce length of stay, there is increasing scrutiny on hospital readmissions. We hypothesized that readmissions following endocrine surgery could be predicted using a risk-score.

METHODS: The NSQIP database was queried for cervical endocrine operations identified by CPT code for the years 2010-2012. Inpatient deaths (n=47), and cases with length of stay (LOS) >30-days (n=76) were excluded. The primary end point was unplanned readmission within 30-days. Two-thirds of the data were used for development, and one-third for validation of a scoring system. Bivariate analysis was performed and significant factors were included in a stepwise logistic regression. Points were assigned based on the beta-coefficient within the development model and applied to the validation dataset. Predictive ability was assessed using a C-statistic of an ROC curve.

RESULTS: We captured 34,046 cases with a readmission rate of 2.8% (n=947). Time to readmission averaged 11.1 days (SD 8.6, mode=2 days). Readmission rates ranged from 2.5% following total or subtotal thyroidectomy(n=19,540), 2.9% following parathyroidectomy(n=7,795) and 4.3% following cervical lymphadenectomy(n=1,689), although procedure type was not retained in the final model. In 299 cases(2012 data only) the reason for readmission was specified: most common were hypocalcemia(32.4%, n=97), surgical site infection(8.4%, n=25), and hematoma(8.0%, n=24).

Significant predictive factors for readmission included pre-discharge incisional complication(8-points, OR=4.71, CI:1.52-14.64, P=0.007); steroid(OR=1.96, CI 1.35-2.84, P<0.001) use or neurologic comorbidity(OR=2.11, CI:1.40-3.18, P<0.001) (4-points); renal insufficiency(OR=1.68 CI:1.16-2.44, P<0.002), bleeding disorder(OR=1.68 (1.16-2.44, P=0.029), LOS>2 days(OR=1.83 CI:1.48-2.26, P<0.001), ASA≥3(OR=1.69 , CI:1.40-2.03, P<0.001) or elevated preoperative alkaline-phosphase(OR=1.76 CI:1.24-2.50, P=0.002) (3-points); cancer(OR=1.54 CI:1.28-1.86, P<0.001), cardiac comorbidity(OR=1.49 CI:1.01-2.18, P0.042), preoperative hematocrit <36(OR=1.56, CI:1.26-1.94, P<0.001), or inpatient case(OR=1.37, CI:1.14-1.66, P=0.001) (2-points); and obesity(OR=1.20, CI:1.01-1.42, P=0.038) or smoking(OR=1.27, CI:1.02-1.58, P=0.034) (1-point). The c-statistic in the development group was 0.702, and 0.659 in the validation group.

Overall readmission rate by risk class was 1.6 % for low-risk(0-4 points, n=29,073, 56%,), 3.2% for moderate-risk(5-11 points, n=11,934, 35.1%) and 8.5% for high-risk patients(>11 points, n=3,040, 8.9%).

CONCLUSION: Readmissions following cervical endocrine operations can be predicted using. This risk score could be used to direct resource utilization for preoperative, inpatient, and outpatient care delivery to reduce readmissions.

NOTES

18. DEVELOPING A WASTE REDUCTION STRATEGY TO STREAMLINE VARIABILITY IN HOSPITAL CHARGES FOR STANDARD, ROUTINE THYROIDECTOMY

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BACKGROUND: Momentum is growing in the United States healthcare system to encourage improved resource utilization and quality of care. As part of a formal clinical safety and effectiveness proposal, we assessed the efficiency, consistency, and appropriateness of perioperative processes for standard (total) thyroidectomy. We devised a valuable strategy to reduce variability and waste.

METHODS: Our multidisciplinary team evaluated outpatient (<23 hours observation) standard thyroidectomy performed by three surgical endocrinologists at our institution in 2011. Cases with lobectomy or lateral neck dissection were excluded. We used the nominal group technique, process flowcharts, and root cause analysis to evaluate 6 perioperative processes: preoperative clinic, preoperative holding area, operating room (OR), post-anesthesia care unit, overnight observation, and postoperative clinic. Anticipated reductions in costs, charges, and resources from improvements were calculated.

RESULTS: The median total charge for standard thyroidectomy was $27,363 (n=80, $48,727 variation). Preoperative coordination between surgery and anesthesia clinics would eliminate unnecessary and duplicative labs and visits (potential charge reduction of $1,505). Non-operating room time was significantly shorter in the outpatient OR (43 vs. 52 min, p<0.001). Appropriately scheduling standard thyroidectomy cases in the outpatient OR would decrease charges by $502 per case. Analysis of OR instrumentation revealed 20% of non-disposable instruments on the thyroidectomy surgical tray were unused. Elimination of 17 instruments would decrease sterile processing costs by $11.90/case. Over 75% of disposable supplies in standard packs opened for every case went unused (31/40 items). Opening only needed items would reduce the number of wasted disposable supplies by 2,480 for the next 80 cases. Modification of outdated postoperative order sets and standardization of postoperative labs would decrease charges for all patients by $643 and $117 per patient, respectively. Overall, this comprehensive review of 6 perioperative processes identified an anticipated charge reduction of over $200,000 for the next 80 cases.

CONCLUSIONS: Perioperative process analyses revealed a wide variability for a single procedure within one academic surgical group. The systematic assessment helped identify opportunities to improve efficiency, reduce waste, and focus on patient-centered quality of care. This multidisciplinary strategy could substantially reduce costs and charges for common operative procedures.

NOTES

★ 19. SURGEON VOLUME AND ADEQUACY OF THYROIDECTOMY FOR DIFFERENTIATED THYROID CANCER

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INTRODUCTION: Conservative use of radioiodine (RAI) to ablate remnant tissue after thyroidectomy (Tx) for patients with differentiated thyroid cancer (DTC) is dependent on completeness of resection. The aim of this study is to determine the influence of surgeon volume on 1) the frequency of appropriate initial surgery for DTC and 2) the adequacy of initial surgery.

METHODS: With QI/QA-IRB approval, we reviewed inpatient and outpatient initial Tx (lobectomy and total) performed in a regional health system during 2011. Surgeons were grouped by number of Tx, selecting a threshold based on preliminary analysis and existing literature. For patients with histologic DTC ≥1 cm, comparative analysis was used to correlate surgeon volume to initial extent of surgery. Available markers of complete resection were examined, including percentage uptake on initial TSH-stimulated RAI pre-treatment scan, pre-ablation stimulated thyroglobulin (Tg) levels when Tg-antibody levels were undetectable, and RAI dose administered.

RESULTS: 1249 patients had Tx by 42 surgeons at 10 regional hospitals, and 570 (46%) patients had DTC ≥1 cm without distant metastasis. Surgeons performing ≥30 Tx/year were considered high volume (HVS) and accounted for 80% of Tx and 78% of DTC cases. For histologic DTC ≥1 cm, HVS were more likely to perform initial total Tx (73% vs 54%, $p<0.001$) and central compartment lymph node dissection (38% vs 17%, $p<0.001$). Although TNM stage III/IV disease was more often treated by HVS (19% vs 11%, $p<0.05$), initial surgery by HVS was associated with less uptake on TSH-stimulated pre-treatment RAI scan (mean 2.3% vs 4.4%, $p<0.05$), lower mean stimulated Tg levels (3.8 vs 8.4 ng/mL, $p<0.01$), and lower mean RAI dose (90.1 vs 107 mCi, $p<0.05$). In subset analysis of <25 Tx/year, no differences were observed identified in stimulated RAI uptake or Tg levels or RAI uptake, although dose of RAI after total Tx remained lower among HVS (90 vs 110 mCi, $p<0.05$).

CONCLUSIONS: Surgeons who perform ≥30 thyroidectomies a year are more likely to achieve the appropriate initial operation for clinically significant DTC and are also more likely to achieve complete resection. Surgeon volume is an essential consideration in optimizing outcomes for thyroid cancer patients.

NOTES

★ 20. ENDOCRINE SURGERY IN MODERN DAY ACADEMIA

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BACKGROUND: Endocrine Surgery is a new surgical specialty that is evolving. The pattern and scope of an Endocrine Surgeon's practice is relatively unknown. In this study, we sought to delineate the pattern and scope of practice of the modern academic endocrine surgeon.

METHODS: A retrospective review of the Faculty Practice Solutions Center database was conducted from January to June 2013. Practice patterns were determined by ICD-9 and CPT codes. Endocrine Surgeons were identified using the American Association of Endocrine Surgeons (AAES) membership roster. Non-AAES surgeons who incorporate endocrine surgeries in ≥40% of their practice were identified for comparison.

RESULTS: 45 academic medical centers across the nation were identified to have practicing AAES Endocrine Surgeons–18 in the Northeast, 9 in the Midwest, 13 in the south, and 7 in the West. A total of 104 Endocrine Surgeons were included in the study, 52% in General Surgery, 46% in Surgical Oncology, and 6% in a different surgical specialty. Disorders of the parathyroid gland (ICD 252.01), nontoxic nodular goiter (241.1), and malignant neoplasm of thyroid gland (ICD 193) comprise 31-53% of billed diagnoses. Malignant neoplasm of the pancreas (ICD 157) totals 1-6% of practices. Malignant neoplasm of female breast encompasses 5-8% of billed diagnoses in the Midwest, South, and West. Endocrine surgeons in the Northeast and Midwest perform more surgeries and a greater number of thyroid lobectomies and central neck dissections are performed in the Northeast.

Of the other surgical specialties that include a significant portion of endocrine surgeries in their practice, 53% are general surgeons, 26% are otolaryngologists, and 21% are surgical oncologists. On average, non-AAES surgeons are treating more parathyroid disease (25% vs 19%) and less thyroid disease (34% vs 41%), but are performing a higher percentage of endocrine surgeries overall (54% vs 36%).

CONCLUSION: Although the majority of the modern academic Endocrine Surgeon's practice encompasses disorders of the parathyroid and thyroid glands, breast surgery is also a significant component of practices. In addition, the majority of endocrine surgeries are performed by non-AAES Endocrine Surgeons, suggesting that the presence of Endocrine Surgery in academic centers can be further expanded.

NOTES

★ 21. MALIGNANCY RISK AND REPRODUCIBILITY IN ATYPIA OF UNDETERMINED SIGNIFICANCE ON THYROID CYTOLOGY

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BACKGROUND: The Bethesda System for Reporting Thyroid Cytopathology (TBSRTC) describes subcategories within Atypia of Undetermined Significance (AUS). These include: 1. Presence of focal nuclear atypia (AUS-N); 2. Focal microfollicular proliferation (AUS-F); 3. Focal hürthle cell proliferation (AUS-H); and 4. Other (AUS-O). Several publications suggest that 5-15% underestimates the malignancy risk for AUS, that the underestimation is due to the similarity between AUS-N and suspicious for malignancy (SFM), and that subjectivity exists in this morphologic distinction. Thus, we investigated the AUS subcategories during morphological re-review and their associated malignancy risk.

METHODS: Of 5247 FNA specimens that were sent between January 2009 and August 2013 to a tertiary care institution for morphological re-review, 846 were categorized as AUS. Comparison of AUS subcategory diagnoses were made between outside and re-review results. The malignancy risk was also determined for 255 nodules with available surgical pathology.

RESULT: The outside diagnoses of the 846 cases read as AUS on second review were as follows: 463 (55%) AUS, 149 (16%) benign, 124 (15%) suspicious for a Hürthle cell or follicular neoplasm (SFN/SHN), 56 (7%) SFM, 9 (1%) malignant, and 40 (5%) non-TBSRTC diagnoses. Of the 463 cases in which both the outside and re-review diagnosis was AUS, the distribution of the subcategories was 257 (56%) AUS-N, 79 (17%) AUS-F, 53(11%) AUS-H, and 74 (16%) AUS-O. Of the 255 resected nodules 39% (99/255) were malignant. Subcategory malignancy rates were: AUS-N, 54% (57/105); AUS-F, 39% (19/49); AUS-HC 19% (9/47), and AUS-O 26% (14/54). Cases in which both the referring institution and re-review agreed about the AUS-N subcategory had an even higher risk of malignancy, 68% (17/25).

CONCLUSION: Disagreement about diagnosis of AUS between institutions is frequent (up to 45%). The malignancy risk for AUS is higher than originally proposed by TBSRTC and attributable to the high risk of AUS-N. Furthermore, agreement on AUS-N after re-review portends a malignancy risk that borders on that of SFM. This suggests that AUS-N may have discrete features that can provide specific morphological predictors and enable the consolidation of AUS-N into SFM.

NOTES

★ 22. PREOPERATIVE LARYNGOSCOPY IN THYROID SURGERY: DO PATIENTS' SUBJECTIVE VOICE COMPLAINTS MATTER?

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BACKGROUND: One of the most dreaded complications of thyroid surgery is injury to the recurrent laryngeal nerve causing a temporary or permanent change in voice. In the past, standard practice included routine preoperative laryngoscopy on all patients undergoing thyroid surgery to document cord function. Recent literature recommends performing laryngoscopy only in a select subset of patients (subjective voice changes, prior neck surgery, advanced cancer, etc). We hypothesize that a patient's opinion of preoperative voice abnormalities does not correlate to abnormalities in laryngeal evaluation.

METHOD: Using an IRB-approved protocol, a retrospective chart review from a single-surgeon experience was performed. Records of patients undergoing thyroid surgery from January 2011 through August 2013 were reviewed for evidence of subjective patient voice complaints, prior neck surgery, surgeon-evaluated voice quality and results of laryngeal evaluation by indirect or flexible nasolaryngoscopy.

RESULTS: 467 patients were included in the study with an age range of 12-83 years (average 48.45 years) and 82% were female. 444 patients (95.1%) underwent attempted preoperative evaluation of the larynx and vocal cords by either indirect laryngoscopy or flexible nasolaryngoscopy. 93.4% of those evaluated were found to have normal anatomy and function. Of the various abnormalities on laryngoscopy, only 7 (1.8%) cord palsies were noted. 36.6% of patients had subjective voice complaints preoperatively, mostly commonly hoarseness, but only 8.2% had a corresponding abnormality on laryngoscopy (including 6 vocal cord paralyses). However, only 15 (3.6%) patients were noted to have an abnormal voice by the surgeon preoperatively and 10 (66.7%) of these patients had corresponding abnormal laryngoscopy findings, including 6 vocal cord paralyses. Of the 393 patients with a normal voice per the surgeon, only 1 patient (0.3%) had a cord paralysis on laryngoscopy.

CONCLUSION: The patient's subjective voice complaints do not correlate well with abnormalities on preoperative laryngoscopy. However, surgeon opinion of voice quality is much more specific and would result in far fewer unnecessary laryngoscopies without missing cord paralyses. We recommend using surgeon-documented voice abnormalities as a criteria for preoperative laryngoscopy while avoiding the use of subjective patient complaints.

NOTES

★ 23. COMPARABLE OUTCOMES OF PATIENTS WITH T1A AND T1B DIFFERENTIATED THYROID CANCER- IS THERE A NEED FOR CHANGE IN THE AJCC CLASSIFICATION SYSTEM?

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BACKGROUND: The current AJCC TNM classification system for differentiated thyroid cancer (DTC) separates T1 stage into T1a and T1b based on a 1cm cut off for maximal tumor dimension. American Thyroid Association (ATA) management guidelines recommends total thyroidectomy for tumors ≥1cm in contrast to the possibility of lobectomy for tumors < 1cm. Our aim was to investigate the prognostic significance of a 1cm tumor cut off.

METHOD: From an institutional database of 3548 patients with DTC treated between 1986 and 2010, 1461 patients with T1 tumors without neck disease or distant metastases (pT1N0M0) were identified. There were 855 T1a and 606 T1b patients. Clinical, tumor and treatment characteristics were compared by the Chi square test. Disease Specific Survival (DSS) and Recurrence Free Survival (RFS) were calculated for each group using the Kaplan Meier method.

RESULTS: The median age of the cohort was 48 years (4- 91) with a median follow up of 45 months (1-320). Patients who were T1a were more likely to be over 45yrs of age (62.6% vs. 52.8%, p<0.001), more likely to have papillary pathology (99.3% vs. 93.1%, p<0.001) and less likely to receive RAI (5.8% vs. 23.9%, P<0.001). Lobectomy and total thyroidectomy rates were similar between T1a and T1b patients (26.7% vs. 29.4%, 70.4% vs. 69.8% respectively). There were no disease specific deaths in T1a or T1b groups. 5 year RFS was 99.7% and 99.1% for T1a and T1b respectively (p=0.084). Two T1a patients developed tumor recurrence, both with nodal disease. Seven T1b patients developed tumor recurrence; 2 local recurrences (both treated with total thyroidectomy), 3 nodal recurrences and 2 distant recurrences. No factors were predictive of recurrence on univariate analysis.

CONCLUSION: Our data suggests that patients with T1a and T1b tumors have similar prognosis both in terms of DSS and RFS. Although we have limited follow up, it would appear a distinction between tumors of less than and great than 1 cm is of no prognostic benefit.

NOTES

★ 24. THE UTILITY OF LYMPH NODE MAPPING SONOGRAM AND THYROGLOBULIN SURVEILLANCE IN POST-THROIDECTOMY PAPILLARY THYROID CANCER PATIENTS.

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BACKGROUND: ATA guidelines recommend lymph node mapping sonogram (LNM) at 6 and 12 months after surgery for patients with papillary thyroid carcinoma (PTC) and then periodically based on risk for recurrence. The precise yield of LNM over thyroglobulin (TG) screening alone is not well defined. We sought to investigate the diagnostic yield of LNM and TG surveillance in patients with PTC.

METHODS: We identified 163 patients post total thyroidectomy for PTC undergoing follow-up surveillance LNM at 6 months and 6 years postoperatively. LNM was considered positive if one or more of the following four criteria were met: loss of fatty hilum, microcalcifications, hypervascularity, or architectural distortion. Surveillance serum TG levels (suppressed) were compared to LNM and fine needle aspiration (FNA) cytology. Results were stratified according to specific ultrasound features.

RESULTS: Of 163 patients, 75 had suspicious LNM (46%), 17 of which had PTC on FNA (22%). Of the patients with LNM, there were 150 total suspicious lymph nodes: 60.7% had loss of fatty hilum as the sole abnormality, 12.7% had microcalcifications, 8.7% had hypervascularity, and 25.3% had architectural distortion. Only 1/59 nodes with loss of fatty hilum had positive cytology on FNA, while 13/18 nodes with microcalcifications, 11/13 nodes with hypervascularity and 17/28 nodes with architectural distortion had PTC identified on FNA.

A total of 153 patients had surveillance TG data and 14 had elevated TG levels (9%). Seven patients with elevated TG were not biopsied, 1 had disease attributable to recurrence in the thyroid fossa, and 6 were found to have recurrence on FNA cytology. For TG < 2 pg/ml (anti-TG antibody negative), LNM identified cervical lymph node metastasis in 5 patients.

CONCLUSION: Loss of fatty hilum was poor at detecting metastasis to cervical lymph nodes and the overall specificity of LNM can be improved if this feature is disregarded. This study also demonstrates that LNM sonogram is a useful adjunct to TG surveillance. Of the patients with TG data, 5 additional patients were identified by LNM that would have been missed with TG surveillance alone.

NOTES

25. REAPPRAISAL OF LYMPHATIC MAPPING FOR MIDGUT NEUROENDOCRINE PATIENTS UNDERGOING CYTOREDUCTIVE SURGERY

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BACKGROUND: Well differentiated midgut neuroendocrine tumors (NETs) are rare malignancies with an indolent course. Advanced stages of disease are commonly discovered on their initial presentation. The only reliable and durable treatment for these tumors is surgical cytoreduction. We previously reported that midgut NETs often develop alternative lymphatic drainage pathways due to lymphatic obstruction from extensive mesenteric lymphadenopathy. This makes intraoperative lymphatic mapping essential and mandatory. We hypothesized that lymphatic mapping needed a longer term validation to prove that traditional "eye ball" resection margins are grossly inadequate. Inadequate margins increase the likelihood of local recurrence. More importantly, lymphatic mapping may safely preserve the ileocecal valve in selected patients.

METHODS: We reviewed the operative findings, pathology reports and long-term surgical outcomes of 605 NETs patients in our database. Three hundred and three (303) patients underwent cytoreduction from November 2006 to October 2011. Of these patients, 98 had midgut NET primaries and 112 lymphatic mappings were performed. Seventy-seven (77) of the lymphatic mappings were performed during the initial cytoreduction and 35 patients were mapped during re-exploration. The goal of our review was to determine the safety and efficacy of mapping.

RESULTS: No adverse events were observed during the 112 lymphatic mapping procedures. Lymphatic mapping changed traditional resection margins in 92% of patients. Of the 35 patients who underwent re-exploration without mapping during their first operation, 19 (54%) showed a recurrence at or near the anastomic sites. In contrast, none of the112 mapped patients had signs of recurrence in a 1-6 year follow-up at the end of the study. Additionally, 20/45 (44.4%) ileocecal valves were spared in patients whose tumors were so close to the ileocecal valve that a right hemicolectomy would, traditionally, be mandated.

CONCLUSIONS: Lymphatic mapping has proven to be a safe and effective way to determine adequate bowel resection margins in midgut NETs. We advocate using lymphatic mapping for patients with midgut NETs to determine the adequacy of resection margins and when proven feasible, to preserve the ileocecal valve.

NOTES

26. COMPARISON OF TUMOR MARKERS FOR PREDICTING NON-FUNCTIONING PANCREATIC NEUROENDOCRINE TUMOR OUTCOME

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BACKGROUND: The outcome of non-functioning pancreatic neuroendocrine tumors (PNETs) following resection remains incompletely defined by clinicopathologic parameters. We sought to identify tumor markers that predict distant metastasis and mortality in PNETs.

METHODS: A retrospective review of 128 patients who had pancreatectomy for non-functioning PNETs at 4 institutions between 1998 and 2011 was performed. Cytoplasmic and nuclear survivin, cytokeratin 19 (CK19), KIT, and Ki67 in PNETs have been proposed as useful tumor markers for malignant behavior. Expression of these 5 markers in all tumors in this current cohort was tested and scored by immunohistochemistry. Univariate, multivariate regression, and ROC curve analyses were done to evaluate the effect of these markers on distant metastasis and mortality.

RESULTS: 116 (91%) of the tumors were positive for cytoplasmic survivin, 95 (74%) for nuclear survivin, 85 (66.4%) for CK19, 3 (2.3%) for KIT, and 41 (32%) for Ki67 >3%. No marker was positive in 12 (9%) tumors. Nine (7%) tumors had only one positive marker, 40 (31%) had 2, 41 (32%) had 3, 25 (20%) had 4, and 1 (0.7%) had all 5 markers. Using multivariate regression Cox analyses, cytoplasmic and nuclear survivin, CK19, and KIT positivity had no significant effect on distant metastasis or mortality. Age > 55, grade 3 histology, and Ki67 >3% were associated with mortality ($p<0.05$). A cut-off of Ki67 > 3% was the best overall predictor (82.8%) of mortality with an area under the curve of 0.85. In addition, Ki67 >3% predicted the occurrence of distant metastases with an Odds ratio (OR) of 9.22 and 95 % Confidence interval (CI) 1.55-54.55 ($p<0.015$).

CONCLUSION: Of the 5 markers studied, only ki67 >3% was significantly associated with distant metastasis and death. Although non-functioning PNETs do express other tumor markers, they have no detectable effects on outcome. Age > 55, grade 3 histology, distant metastasis and Ki67 >3% were independent predictors of mortality.

NOTES

27. PERITONEAL CARCINOMATOSIS FROM SMALL INTESTINAL NEUROENDOCRINE TUMORS, CLINICAL COURSE AND GENETIC PROFILING.

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BACKGROUND: The clinical incidence of small-intestinal neuroendocrine tumors (SI-NETs) is on the rise, the last decade ranging from 0.3-1.33/100 000. A third of all patients with SI-NETs present with distant metastases to the liver, and second most common is peritoneal carcinomatosis (PC). Since PC is an indicator of more advanced or more aggressive disease, it may be important to identify such patients at an early stage for aggressive therapy and close follow up. We hypothesized that genetic profiles of tumors in patients with PC may differ from the tumors in patients without PC, and that this may affect clinical decision making in the future.

METHODS: We included SI-NET patients (cases with PC, n=73, and controls without PC, n=468) that underwent surgery between 1985 and 2012. We used the GPS system and Lyon prognostic index as proposed by ENETS to score and correlate the amount of PC to survival. DNA samples from patients with (n=8) and without (n=7) PC were analyzed with a SNP-array (HumanOmni2.5beadchip, Illumina) to investigate genetic disparities between groups.

RESULTS: Patients with PC had poorer survival (median 5.1 years) than controls (11.1 years). An advanced post-operative Lyon prognostic index was a negative prognostic marker for survival by multivariable analysis (p=0.042). Emergency re-operation due to bowel obstruction was performed in more than 20% of patients with PC during follow-up. Patients with and without PC clustered differently based on loss-of-heterozygosity (LOH) and copy number variation (CNV) data from SNP-array of the primary tumors (p=0.042).At the chromosomal level, the main finding was that patients with PC generally displayed more loss at chromosome 18 in primary tumors compared to patients without PC.

CONCLUSION: SI-NET patients with PC have poor survival, which diminishes with increasing PC load after surgery. Bowel obstruction caused by PC is common in SI-NET patients presenting with PC, and causes significant morbidity. Clustering based on CNV and LOH data suggest different genotypes in primary tumors comparing patients with and without PC. These data suggest that more aggressive treatment is warranted in SI-NET with PC and that it may be possible to predict clinical behavior based on genetic profiling.

NOTES

28. PREDICTORS OF RECURRENCE IN ADRENAL PHEOCHROMOCYTOMA

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BACKGROUND: Recurrence of pheochromocytoma after adrenalectomy, a challenging dilemma to manage, is seen in 6.5% to16.5% of the patients. Data in the literature about factors that affect recurrence are scant, and lack consensus on the optimal method of postoperative surveillance. The aims of this study are to identify predictors of recurrence, and assess the utility of biochemical testing and imaging for detecting recurrence of pheochromocytoma.

METHODS: This is a retrospective analysis of all patients who underwent adrenalectomy for pheochromocytoma over a 14-year period at a single institution. Demographic, clinical, biochemical and pathologic parameters were evaluated using univariate and multivariate logistic regression analysis.

RESULTS: There were a total of 145 patients who had surgical resection for pheochromocytoma. With a median follow up of 85 months (range 8 to 172 months), 8 patients (5.5%) developed recurrent disease, involving the adrenal bed in 4 patients (50%), bone in 2 patients (25%), contralateral adrenal gland in 1 patient (12.5%), liver in 1 patient (12.5%), and lung in 1 patient (12.5%). The median time from initial operation to diagnosis of recurrence was 35 months (range 7 to 106 months). On multivariate analysis, tumor size > 5 cm and nuclear pleomorphism were independent predictors of recurrence. One patient with recurrence (12.5%) died, 4 (50%) had stable disease, 1 (12.5%) had progression of disease, 1 (12.5%) was cured, and 1 (12.5%) was lost to follow up. The 5-year survival of patients with recurrence was 83% with a median survival of 7.6 years. Recurrence was diagnosed by elevated plasma or urine metanephrines and positive cross sectional imaging in 6 patients (75%), and by positive imaging and normal biochemical levels in 2 patients (25%). Fourteen patients (10%) had elevated plasma or urine metanephrines in the absence of recurrence on imaging.

CONCLUSION: Patients with large tumors (> 5 cm) and nuclear pleomorphism should be followed vigilantly for recurrence of pheochromocytoma after adrenalectomy. Because 25% of patients with recurrence had positive imaging with normal biochemical levels, we recommend routine annual cross-sectional imaging in addition to serial testing of plasma metanephrines for prompt diagnosis of pheochromocytoma recurrence after adrenalectomy.

NOTES

29. SURVIVAL IMPROVES WITH SURGERY IN ADRENAL CANCER, EVEN IN METASTATIC DISEASE

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INTRODUCTION: Adrenal cortical carcinoma (ACC) is a rare tumor which carries a poor prognosis. Known predictors of prolonged survival are presentation with stage I/ II disease and complete surgical resection. We assessed the effect of different treatment strategies and demographic variables on stage-specific survival in ACC.

METHODS: Newly diagnosed ACC cases were abstracted from the prospectively collected California Cancer Registry and the Office of Statewide Health Planning and Development databases for the years 1999-2008. The following predictor variables were examined: stage, treatment type, hospital type, socioeconomic status (SES), race, age, sex, tumor size, and patient comorbidities. Stage was defined as local, regional, or metastatic. Treatments were defined as none, surgery alone, nonsurgical treatment alone (chemotherapy and/or radiotherapy, CRT), and surgery combined with nonsurgical treatment (S+CRT).

RESULTS: We studied 367 patients with a mean age at diagnosis of 53 years. At presentation, 37% (136) of patients had local disease, 17% (64) had regional disease, and 46% (167) had metastatic disease. Median tumor size was 10 cm (range 2-20 cm). Overall median survival was 1.7 years (7.4 years local, 2.6 years regional, and 0.3 years metastatic, $p<0.0001$). One and five year survival rates by stage were: 92%/62% (local); 73%/39% (regional); 24%/7% (remote). Patients with low SES had worse survival in both local and regional disease ($p<0.05$). Increased age (HR 1.16, $p<0.01$) and the presence of comorbidities (HR 1.41, $p=0.04$) also worsened survival. In multivariable regression analyses, in those patients with regional disease, both surgery (HR 0.21, $p<0.001$) and S+CRT (HR 0.52, $p<0.02$) improved survival over no treatment. In metastatic disease, both surgery (HR 0.52, $p<0.02$) and S+CRT (HR 0.33, $p<0.001$) also improved survival over no treatment or CRT alone.

CONCLUSION: In ACC, surgery improves survival for regional and metastatic disease. These findings suggest that surgery should be considered for these patients, even in cases where complete resection cannot be achieved.

NOTES

30. SIN1, A CRITICAL COMPONENT OF THE MTOR- RICTOR COMPLEX, IS OVEREXPRESSED AND ASSOCIATED WITH AKT ACTIVATION IN MEDULLARY AND AGGRESSIVE PAPILLARY THYROID CARCINOMAS

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BACKGROUND: Mammalian target of rapamycin (mTOR) forms two active complexes in the cell: the rapamycin–sensitive mTOR-Raptor and the rapamycin-insensitive mTOR-Rictor. The latter is known to activate AKT kinase, which promotes tumor cell survival and proliferation by multiple downstream targets. SIN1, an essential mTOR-Rictor subunit, has been shown to maintain mTOR-Rictor complex integrity and regulate Akt activation and substrate specificity. We have previously shown the significance of mTOR-Raptor signaling in thyroid cancer (Surgery, 2011;150(6):1258), however, the potential role of mTOR-Rictor complex activation in thyroid carcinogenesis remains unknown. Therefore, we investigated the expression patterns of SIN1 in thyroid carcinoma cell lines and tumors and their association with AKT activation, histologic type and tumor aggressiveness.

METHODS: Three cell lines were used including medullary (TT), anaplastic (ARO) and a novel cell line of aggressive papillary thyroid carcinoma (PTC-A) recently established in our laboratory. Total protein extracts from cells and paired (normal/tumor) patient samples were analyzed by Western blot for SIN1 expression and AKT phosphorylation. In addition, specimens obtained from 42 patients with thyroid cancer including follicular (5), papillary (18), medullary (16) and poorly differentiated (3) carcinomas were analyzed using immunohistochemistry. Eight of the 18 papillary carcinomas were considered aggressive histologic variants. Antibodies used were specific for SIN1 and Ser473-p-AKT. Moreover, using an ex-vivo (NOD-SCID) mouse model for PTC-A cells, SIN1 and p-AKT expression was analyzed in xenografts.

RESULTS: Using Western blot analysis, SIN1 and p-AKT were detected at a higher level in TT, ARO and PTC-A cells as well as in tumor samples of medullary and aggressive papillary thyroid carcinomas as compared to other tumor histologies and benign nodules. Similarly, using immunohistochemistry, SIN1 was overexpressed in medullary thyroid carcinomas and aggressive variants of papillary thyroid carcinomas as compared with conventional papillary and follicular carcinomas ($p<0.0001$). Furthermore, SIN1 expression correlated AKT activation in the entire study group ($p<0.05$). PTC-A xenografts also overexpressed SIN1 and showed high levels of AKT activation.

CONCLUSIONS: SIN1, a critical factor of mTOR-Rictor complex and AKT activation, is overexpressed in clinically aggressive thyroid cancer types and represents a promising target for investigational therapeutic approaches in these patient groups.

NOTES

31. E-SELECTIN EXPRESSION AND BRAF STATUS IN PAPILLARY THYROID CARCINOMAS: CORRELATION WITH CLINICOPATHOLOGICAL FEATURES

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BACKGROUND: Cell adhesion molecules such as selectins play a critical role in the mechanism of tumor progression and metastasis. Several studies have revealed a positive correlation between over-expression of these molecules in tumor cells and a more aggressive behavior. The aim is to verify if the over-expression of E-selectin is linked to a more aggressive behavior of the papillary thyroid carcinoma, regardless of histological variant and tumor size.

METHODS: 88 patients with papillary thyroid carcinomas showing similar pathological features (conventional variant and size about 20 mm) were studied. Mean age was 41.0±14 yr (range 12-78 yr). They were divided in two groups according to the grade of neoplastic infiltration: totally encapsulated tumors (42 out of 88) versus non-encapsulated tumors with extrathyroidal extension (46 out of 88). E-selectin expression was evaluated by immunohistochemical staining and semiquantitative Real Time RT-PCR. The E-selectin expression of each papillary thyroid carcinoma sample was normalized by calculating the z score; a positive z score indicates a value above the population mean and a negative score indicates a value below the mean.

RESULTS: Only 2 out of 42 (4.7%) totally encapsulated tumors showed lymph node metastasis, while 19 out of 46 (41.3%) tumors with extrathyroidal extension revealed a metastatic disease. BRAF V600E mutation was present in 22 totally encapsulated tumors (52.4%) and in 30 tumors with extrathyroidal extension (65.2%). The median E-selectin z score was -0.65 for totally encapsulated tumors and 0.17 for tumors with extrathyroidal extension. A significant correlation was observed between E-selectin expression and the degree of neoplastic infiltration (p value 0.04), the presence of lymph node metastasis (p value 0.04) and the mutation status of the BRAF gene (p value 0.02) based on the Kruskall–Wallis non-parametric test. Multiple regression analysis confirmed a strong association between E-selectin expression and BRAF mutation (p value 0.01).

CONCLUSIONS: These data suggest that the E-selectin over-expression in association to BRAF mutation status could promote a more aggressive phenotype in papillary thyroid carcinoma, in absence of other prognostic determinants, such as the histological variant and the tumor size.

NOTES

32. EXPRESSION OF THE EMBRYONIC MORPHOGEN NODAL IN THYROID CARCINOMAS: USING IMMUNOHISTOCHEMISTRY IN TISSUE MICROARRAY

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BACKGROUND: Nodal is a member of the transforming growth factor (TGF)-β superfamily, and plays a role in tumorigenicity of melanoma, breast cancer, and prostate cancer. TGF-βis associated with BRAF mutation and poor prognostic factors in human papillary thyroid carcinoma (PTC). However, as a member of TGF-βsuperfamily, the role of Nodal role has not been studied in thyroid carcinoma. The aim of this study was to evaluate Nodal expression in thyroid tumors using immunohistochemistry in tissue microarray (TMA).

METHODS: TMA was constructed with paraffin embedded thyroid tissues collected from January 1993 to December 2003, and it was composed of 147 PTCs, 58 follicular thyroid carcinomas (FTCs), 17 anaplastic thyroid carcinomas (ATCs), 57 adenomatous goiters (AGs), 57 follicular adenomas (FAs), and 5 normal thyroid tissues. Nodal immunostaining was scored on a scale of 0–3 (0, no staining; +1, weak stain; +2, moderate stain; +3, strong stain) by two experienced pathologist in a consensus method. Intensity score of 0 and +1 were categorized into low expression group while +2 and +3 into high expression group.

RESULTS: Nodal staining score of PTC, FTC, ATC, AG, and FA was 2.26, 1.74, 1.18, 1.13, and 1.26, respectively. Nodal was not expressed in normal thyroid tissue. PTC had significantly higher Nodal staining score than FTC ($p < 0.01$). Staining score of FTC was significantly higher than ATC ($p = 0.022$), AG ($p = 0.002$), and FA ($p = 0.003$). High Nodal expression group in PTC was associated with older age, higher TNM stage, and the presence of BRAF mutation. In multivariable analysis, the presence of BRAF mutation was an independent associated factor with high Nodal expression (OR 4.644, 95 % CI 1.643–13.128). High Nodal expression was associated with older age in FTC and distant metastasis in ATC.

CONCLUSIONS: PTC and FTC had higher Nodal expression than benign thyroid tumors, and high Nodal expression was associated with poor prognostic factors in PTC. Nodal might have a potential role as a diagnostic or prognostic marker as well as a treatment target of thyroid carcinoma.

NOTES

33. BRAF MUTATION IN PAPILLARY THYROID CANCER: A COST-UTILITY ANALYSIS OF PREOPERATIVE TESTING

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BACKGROUND: Papillary thyroid carcinoma (PTC) in patients with BRAF V600E mutation is associated with increased recurrence and mortality. Prophylactic central neck dissection (CND) is potentially beneficial in reducing local recurrence but has not been shown to be cost-effective in patients with low risk PTC. However, the cost-benefits of prophylactic CND in patients with more aggressive cancers remain unclear. We constructed this study to examine whether the strategy of preoperative BRAF testing followed by TT+CND in patients with proven BRAF mutation would be more cost-effective than TT alone.

METHOD: Our cost-utility analysis is based on a hypothetical cohort of 40 year-old women with low-risk papillary cancer (2cm, confined to the thyroid, negative nodes). The analysis compared preoperative BRAF testing by FNA to select patients for TT+CND if BRAF-mutated versus TT alone if BRAF-wild type. Utilities and outcome probabilities were derived from published data. Costs were measured in U.S. 2010 dollars and outcomes were measured in quality-adjusted life years (QALYs) both of which were calculated at a 3% annual discounted rate. The analysis was based on a societal perspective and calculations included medical costs and opportunity losses. Key variables were subjected to sensitivity analysis.

RESULTS: No preoperative BRAF testing was more cost-effective than testing, resulting in cost-savings of $801.51/patient with comparable QALYs. Preoperative BRAF testing carried the added expense of $33.96/QALY. Sensitivity analysis was performed to assess costs with different rates of BRAF mutation and recurrence. If the rate of BRAF positivity decreases to 31% or if the overall recurrence rate rises above 11.87%, preoperative BRAF testing becomes a more cost-effective strategy.

CONCLUSION: We believe that this is the first report of cost-utility analysis addressing preoperative BRAF testing in patients with PTC. Our analysis shows similar outcomes with or without preoperative BRAF testing with a slight cost-effectiveness advantage in favor of not testing. This is likely due to low surgical complication rates and the inability of prophylactic CND to decrease recurrence rates. We conclude that although preoperative BRAF testing may identify patients with increased recurrence, implementing a more aggressive initial operation does not offer a cost benefit.

NOTES

34. RISK-ADAPTED MANAGEMENT OF PAPILLARY THYROID CARCINOMA ACCORDING TO OUR OWN RISK-GROUP CLASSIFICATION SYSTEM: IS THYROID LOBECTOMY THE TREATMENT OF CHOICE FOR LOW-RISK PATIENTS?

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BACKGROUND: Current guidelines recommend risk-adapted management for patients with papillary thyroid carcinoma (PTC). Total thyroidectomy (TT) is well accepted as the initial surgery for all but the lowest-risk PTCs in Western countries. However, to maintain quality of life for a wide range of low-risk patients, the policy in Japan has favored less-than-total thyroidectomy (LTT). In 2004, we published a novel risk-group classification system for predicting cause-specific death. All patients with distant metastasis and older patients (>=50 years) with either massive extrathyroidal invasion (EX) or large (>=3 cm) lymph node metastasis (N) are classified as high-risk, while all others are classified as low-risk. Since 2005, in cases in which low-risk PTC is diagnosed as unilateral by preoperative ultrasonography, the extent of thyroidectomy has been determined based on the patient's autonomy. The objectives of this study were to verify the validity of our risk group definitions and to evaluate treatment outcomes for low-risk patients.

METHODS: We analyzed 1187 patients who underwent initial surgery for PTC (tumor size [T] >1 cm) between 1993 and 2010 (mean duration of follow-up, 8.3 years). Among these, 967 (82%) were classified as low-risk.

RESULTS: Ten-year cause-specific survival (CSS) rates for high- and low-risk patients were 74% and 99%, respectively (p<0.0001). Among low-risk patients, 791 (82%) underwent LTT (88% before 2005, 76% after 2005). Ten-year CSS and disease-free survival (DFS) rates for low-risk PTC did not differ significantly between patients who underwent TT and LTT (CSS, 99% vs. 99%, p=0.61; DFS, 91% vs. 87%, p=0.90). Among patients treated by LTT, 4 (0.5%) developed recurrence in the remnant thyroid, while 84% avoided overt hypothyroidism. According to multivariate analysis, age >=60 years (risk ratio [RR], 3.1), T >=3 cm (RR, 2.7), EX (RR, 2.4) and N >=2 cm (RR, 3.8) represented significant risk factors for recurrence in the low-risk group.

CONCLUSION: Our classification system appears useful for risk-adapted management in patients with PTC. The favorable overall survival of low-risk patients, regardless of the extent of thyroidectomy, enables patient autonomy in treatment-related decision-making. However, low-risk patients possessing risk factors for recurrence would receive an advantage from TT followed by radioactive iodine.

NOTES

35. STUDYING THE EFFECT OF SONOGRAPHIC LANDMARKS IMAGED ON TRANSCUTANEOUS LARYNGEAL ULTRASONOGRAPHY ON PERIOPERATIVE VOCAL CORD ASSESSMENT

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INTRODUCTION: Transcutaneous laryngeal ultrasound (TLUSG) is a non-invasive way of assessing vocal cord (VC) function. During examination, the assessor often looks at 3 sonographic landmarks (namely, false VC (FC), true VC (TC) and arytenoids (AR)) to ascertain VC movement. However, it is unclear among these landmarks, which one provides the most reliable VC assessment as not all patients would have all three landmarks identified on the same examination. We postulated that perhaps finding all three sonographic landmarks may further improve diagnostic accuracy. To address these questions, we prospectively evaluated consecutive patients over two institutions.

METHODS: One assessor from each institution performed all TLUSG examinations within the institution. To standardize interpretation, a workshop was organized between two institutions before the study. During each examination, each assessor was required to identify all three landmarks if possible and their findings were later validated by direct laryngoscopy (DL). VC palsy (VCP) was defined as decreased or no movement in ≥1 VC on DL or TLUSG. Rate of VC visualization was compared between two institutions and accuracy between the three landmarks was compared.

RESULTS: One-hundred and nineteen patients from Institution 1 and 127 patients from Institution 2 were analyzed. One patient from Institution 1 had preoperative VCP while 10 (8.4%) and 9 (7.1%) had postoperative VCP from institutions 1 and 2, respectively. Both institutions had comparable rate of VC visualization (91.6% and 92.1%,p=ns) and had 100% sensitivity and negative predictive value on postoperative TLUSG. The rate of FC, TC and AR visualization were 92.3%, 34.9% and 88.6%, respectively. The sensitivity, specificity and diagnostic accuracy between the three sonographic landmarks were comparable and the proportion of true-positives, false-positives and true-negatives were comparable between identifying 1 or 2 landmarks and all 3 landmarks (p>0.05).

CONCLUSION: Given the high (>90%) but comparable VC visualization rate between the two institutions, our study confirmed the technique of TLUSG is readily reproducible as a non-invasive perioperative VC assessment. Regardless of which of the 3 landmarks, each landmark appeared to have similar diagnostic accuracy. Finding all 3 landmarks does not necessarily improve the diagnostic accuracy and identifying any one landmark is sufficient.

NOTES

36. FEASIBILITY OF SURGEON-PERFORMED TRANSCUTANEOUS VOCAL CORD ULTRASONOGRAPHY IN IDENTIFYING VOCAL CORD MOBILITY: A MULTI-INSTITUTIONAL EXPERIENCE

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BACKGROUND: Transcutaneous vocal cord ultrasonography (TVCUS) is a non-invasive study used to identify true vocal cord (VC) mobility. The sensitivity of this method in predicting VC paralysis when compared to direct laryngoscopy (DL) ranges from 62-100%. Although routine screening with DL before neck exploration is considered necessary by some surgeons, the likelihood of finding clinically significant VC paralysis is low. Furthermore DL is invasive, costly and not universally available. We hypothesized that TVCUS could be used as a routine method to evaluate VC function in patients scheduled for cervical operations. The goal of this study was to evaluate the feasibility of surgeon-performed TVCUS in assessing VC mobility in the outpatient setting.

METHODS: 352 consecutive patients underwent 649 TVCUS performed by 10 endocrine surgeons at 6 institutions during initial surgical evaluation. DL was obtained in selected patients when indicated. A second TVCUS was performed during the first postoperative visit and DL was again obtained only when judged necessary. Clinical parameters evaluated were age, BMI, gender, presence of thyroid cartilage calcification, presence of hoarseness, distance from skin to thyroid cartilage, presence of reflux, and bilateral VC mobility visualized by TVCUS and DL.

RESULTS: 649 TVCUS were performed and visualization of true VC was possible in 495/649 (76%) TVCUS. VC function was evaluated by DL in 61(9%) patients and among those, TVCUS predicted VC paralysis in 100% of cases. True VC were visualized more often in females (82%) than in males (15%) ($p < 0.0005$). Likewise, patients without thyroid cartilage calcification had their VC visualized more frequently (79%) when compared to patients with calcification (48%) ($p < 0.0005$). Other clinical parameters did not influence VC visualization on TVCUS.

CONCLUSION: TVCUS performed by experienced endocrine surgeons in a clinical setting is a feasible, non-invasive, and highly sensitive method in predicting VC paralysis. True VC visualization by US was possible in the majority of the patients. This study suggests that transcutaneous VC ultrasonography can be used to screen patients for VC immobility, while directing the selective use of DL in patients with a higher probability of vocal cord paralysis.

NOTES

37. THE EFFECTS OF ACUPUNCTURE ON POST-OPERATIVE PAIN AFTER THYROID SURGERY. A PROSPECTIVE RANDOMIZED STUDY

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BACKGROUND: Acupuncture is a safe and well tolerated treatment for pain relief. Clinical randomized trials supported its efficacy in postoperative pain after surgery; several techniques have been reported, including electroacupuncture. The aim of this prospective randomized study was to evaluate the efficacy of traditional acupuncture and electroacupuncture in reducing postoperative pain after thyroid surgery.

METHODS: One hundred twenty one patients undergoing thyroid surgery were randomized in 3 groups: in the Control Group only postoperative usual analgesic drug treatment (acetaminophen) was administered; electroacupuncture and acetaminophen was administered in the Group A while traditional acupuncture and acetaminophen in the Group B. Postoperative pain was measured from 1st to 3rd postoperative day according to analgesic drug requirement (acetaminophen daily intake), Numeric Rating Scale (NRS, range 0-10) and Mc Gill Pain Questionnaire (range 0-20).

RESULTS: No significant differences were found between the 3 groups according to demographics, thyroid pathology, extent of surgery and operative time. Patients from the Group A had a lower postoperative acetaminophen requirement than Controls at the 2nd postoperative day (mean value 250 vs 800 mg/day, respectively, p=0.005) and at 3rd postoperative day (85 vs 550 mg/day, p=0.009). In the Group A, NRS evaluation was significantly lower than Controls at the 2nd postoperative day (0.8 vs 2.1, p=0.05); a trend towards statistically significance was found at the 1st (2.6 vs 3.7, p=0.09) and 3rd postoperative day (0.2 vs 1, p=0.07). Similarly, a trend towards a lower Mc Gill score was found in the Group A compared to the Control Group at the 1st, 2nd and 3rd postoperative day (p= 0.08, 0.06 and 0.06, respectively). NRS and Mc Gill score at 2nd and 3rd postoperative day were significantly lower in the Group A than Group B (p<0.05). No significant differences were found between the Group B and Controls concerning each examined outcome.

CONCLUSION: Electroacupuncture may be effective in reducing postoperative pain and analgesic requirement after thyroid surgery; it is more useful than traditional acupuncture, which achieves no significant effects.

NOTES

38. FIBROMYALGIA SYMPTOMS AND MEDICATION REQUIREMENTS RESPOND TO PARATHYROIDECTOMY

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INTRODUCTION: The prevalence of fibromyalgia ranges from 0.7-6% depending on region and diagnostic criteria. Fibromyalgia is characterized by musculoskeletal pain, headache, depression, cognitive decline and fatigue. These symptoms are also prevalent in primary hyperparathyroidism (PHP). The incidence of concurrent PHP and fibromyalgia is unknown, as is the response to parathyroid surgery of patients diagnosed with both conditions.

METHODS: We reviewed prospectively collected data of all patients with sporadic PHP who had PTx from 1995-2013 and identified those with a preexisting fibromyalgia diagnosis. We then compared pre- and postoperative (at 6 months) medication types, medication usage, and symptoms. PHP operative cure was defined by normal serum calcium at >6 months postoperatively.

RESULTS: A diagnosis of fibromyalgia was identified in 90/3375 (3%) patients at presentation for surgery for PHP. Among the 74/90 fibromyalgia patients with evaluable long-term data for analysis (mean 11 months, range 6-57 months), preoperative symptoms included musculoskeletal pain (100%), fatigue (92%), cognitive decline/memory loss (62%), depression (55%), and headache (19%). Operative cure of PHP after parathyroidectomy was achieved in 98.7%. Postoperative improvement in at least 1 symptom attributed to fibromyalgia was reported by 89% of patients, with reduced fatigue being the most common (71%). Improvement in ≥2, ≥3, and ≥4 symptoms attributed to fibromyalgia was appreciated by 71%, 43%, and 25% of operated patients respectively. Patients presenting for PHP surgery were taking antidepressants, anticonvulsants, narcotic and anti-inflammatory pain medications, calcium-channel modulators, and muscle relaxants; among these, narcotic and anti-inflammatory medications were decreased or discontinued in 77% and 74% of patients, respectively. Antidepressants, calcium-channel modulators, anticonvulsants, and/or muscle relaxants were decreased or discontinued in 31%. Altogether 21% of fibromyalgia patients discontinued all medication usage after parathyroid surgery.

CONCLUSIONS: A preexisting diagnosis of fibromyalgia is common in patients operated on for sporadic PHP. In 89% of patients with both conditions, symptoms attributed to fibromyalgia responded favorably to parathyroidectomy. In many patients diagnosed with both conditions, the use of medications prescribed for fibromyalgia was reduced or eliminated entirely after parathyroid surgery. These findings suggest that before diagnosis and treatment of presumed fibromyalgia, patients should be screened for PHP which is surgically correctable.

NOTES

39. PARATHYROID CARCINOMA IN MORE THAN 1000 PATIENTS: A POPULATION-LEVEL ANALYSIS

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BACKGROUND: Parathyroid carcinoma (PC) is a rare malignancy with a moderate prognosis. Since few large cohorts have been available for analysis, risk factors, appropriate surgical management, and a staging system are still under debate. This large cohort explores prognostic factors for PC.

METHODS: All cases of PC in the 1998-2011 National Cancer Database were extracted for analysis. Patients that were diagnosed at autopsy, had carcinoma in-situ, or did not undergo surgery were excluded. Demographic, tumor, and treatment variables were examined for predictors of decreased overall survival (OS) and relative risk (RR) of death at five years. Evaluation was also made using Schulte's high/low-risk staging system.

RESULTS: Of 1022 patients that underwent surgery for PC, most were non-Hispanic (96.5%), white (77.4%), and insured (94.3%) with an equal gender distribution. Median age was 57 years and for 12.5% of patients, PC was a subsequent neoplasm (SMN). 5-year OS was 81.1% in 528 patients with ≥60 months of follow-up. Mean OS was lower in Blacks (107.52m, p=0.014), older patients (<40yrs: 161.15m, 50-69yrs: 138.98m, 70-80yrs: 98.33m, ≥80yrs: 60.30m, p<.001), patients with a SMN (109.81m, p=0.015), at least 2 comorbidities (68.86m, p<0.001), in whom definitive surgery occurred more than one week from diagnosis (104.84, p=0.04), with positive surgical margins (116.87m, p=0.043), positive lymph nodes (66.16m, p<.001), or distant metastases (21.68m, p=0.008) and for Schulte's high-risk patients (65.75m, p<.001). Neither the surgical approach nor any adjunctive treatment significantly impacted survival. RR of death at five years was higher for patients ≥60 (60-69yrs RR: 4.34, CI:1.23-15.30; 70-79yrs RR: 10.11, CI:2.92-34.94, p<.001; ≥80years RR 24.0, CI:6.02-95.65), Blacks (RR: 1.72, CI:1.13-2.62), with a SMN (RR: 1.85 CI:1.13-3.02), at least 2 comorbidities (68.86m, RR: 4.67 CI:2.407-9.047, p<0.001), positive surgical margins (RR: 1.570 CI:1.028-2.40) or positive lymph nodes (RR: 5.37 CI:2.21-13.02). Schulte high-risk patients had a 4.67 (CI:2.41-9.05, p<.001) risk of death at five years compared to low-risk patients.

CONCLUSION: PC is a rare malignancy with an 81.1% 5-year OS. In addition to more aggressive tumor characteristics, Black race and increasing age predict lower OS. Moreover, this cohort serves as a large validation of Schulte's high/low-risk staging for PC.

NOTES

40. PREDICTORS OF TERTIARY HYPERPARATHYROIDISM: WHO WILL BENEFIT FROM PARATHYROIDECTOMY?

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BACKGROUND: Tertiary hyperparathyroidism (3°HPT) is defined as persistent hyperparathyroidism with hypercalcemia after renal transplantation. Near total parathyroidectomy (NTPTX), where a vascularized parathyroid remnant is left in situ, is the current standard for surgical intervention. The purpose of this study was to determine which patients develop persistent 3°HPTand would benefit from NTPTX.

METHOD: Retrospective review was conducted of patients undergoing renal transplantation (RTX) between 1994-2013. 105 patients undergoing NTPTX were identified and compared to 147 non-operated control patients. There were no significant differences between groups in terms of age, sex, race, and cause of renal failure. Dialysis vintage, calcium, PTH, and GFR were compared between groups. In the PTX group, surgery occurred at a mean of 4.7 years post RTX.

RESULTS: Post RTX median PTH and calcium values differed significantly between groups with PTH of 122 (IQR: 70-180.5) and calcium of 9.3 (IQR: 9-9.7) in the non-PTX group vs. PTH of 351 (IQR: 199-497) and calcium of 10.2 (IQR: 9.6-11.1) in the PTX group at 1 month post RTX ($p<0.02$), PTH of 114 (IQR: 73.8-189.3) and calcium of 9.4 (IQR: 9.2-9.7) in the non–PTX group vs. PTH of 339 (IQR: 231-480) and calcium of 10.5 (IQR: 9.9-11.1) in the PTX group at 3 months post RTX ($p<0.001$), PTH of 106.5 (IQR: 70.8-165.8) and calcium of 9.5 (IQR: 9.2-9.8) in the non-PTX group vs. PTH of 316 (IQR: 182-506.5) and calcium of 10.6 (IQR: 10-11.2) in the PTX group at 6 months post RTX ($p<0.001$), and PTH of 101 (IQR: 61-146) and calcium of 9.5 (IQR: 9.2-9.7) in the non-PTX group vs. PTH of 239 (IQR:190-480.5) and calcium of 10.6 (10-11.1) in the PTX group at 1 year post RTX ($p<0.001$). Dialysis vintage significantly differed ($p<0.001$) between groups: 2 years (IQR: 1-4.38) in the non-PTX group vs. 5 years (IQR: 2.5-9) in the PTX group. Post RTX GFRs did not differ significantly between groups.

CONCLUSIONS: PTH levels, calcium levels, and dialysis vintage serve as predictors of 3°HPT. Patients PTH>200 after RTX, calcium>10 after RTX, or dialysis vintage> 4 years will most likely develop persistent 3°HPT and would benefit from PTX.

POSTER DISPLAYS

★ *Denotes Resident/Fellow Research Award Competition Paper*

NOTE: Author listed in **BOLD** *is the presenting author*

POSTER DISPLAYS

POSTER GROUP 1: ADRENAL

★ 01. INCREASED BODY MASS INDEX IS ASSOCIATED WITH DECREASED SUCCESS OF ADRENALECTOMY FOR THE TREATMENT OF PRIMARY ALDOSTERONISM

Nicholas R. Kunio, MD, Isaac Siegfried, BS, Brian S. Diggs, PhD, Brett C. Sheppard, MD, Erin W. Gilbert, MD
Oregon Health & Science University

★ 02. CLINICOPATHOLOGIC CHARACTERISTICS OF INCIDENTALLY IDENTIFIED PHEOCHROMOCYTOMA

Heather Wachtel, MD, Isadora Cerullo, BA, Andrew Rhodes, DO, Edmund K. Bartlett, MD, Rachel R. Kelz, MD, MSCE, Giorgos C. Karakousis, MD, Robert E. Roses, MD, Debbie L. Cohen, MD, Douglas L. Fraker, MD
Hospital of the University of Pennsylvania

★ 03. TREATMENT PATTERNS AND OUTCOMES FOR PATIENTS WITH ADRENOCORTICAL CARCINOMA ASSOCIATED WITH FACILITY CASE VOLUME IN THE UNITED STATES.

Lauren Gratian, MD, John Pura, MPH, Mohamed A. Adam, MD, Michaela Dinan, PhD, Shelby Reed, PhD, Sanziana Roman, MD, Julie A. Sosa, MD, MA
Duke University Medical Center

04. NOVEL PREDICTIVE SCORE FOR THE RESOLUTION OF HYPERTENSION AFTER ADRENALECTOMY IN PATIENTS WITH HYPERALDOSTERONISM

Jasmine Kouz, MD, FRCP, Aaron Leong, MD, MSc, FRCP, Stavroula Christopoulos, MD, FRCP, Juan Rivera, MD, FRCP, Liane Feldman, MD, FRCSC, FACS, Roger J. Tabah, MD, FRCSC, FACS, Sapna Nagar, MD, Raymon H. Grogan, MD, FACS, **Elliot Mitmaker, MD, MSc, FRCSC**
McGill University, University of Chicago

★ 05. METASTATIC ADRENOCORTICAL CARCINOMA AT PRESENTATION: IS THERE A ROLE FOR SURGERY?

Benzon M. Dy, MD, Veljko Strajina, MD, Ashley K. Cayo, MD, Douglas B. Evans, MD, Melanie L. Richards, MD, Clive S. Grant, MD, David R. Farley, MD, William S. Harmsen, MS, Elizabeth G. Grubbs, MD, Keith C. Bible, MD, William F. Young, MD, Philip G. Rowse, MD, David M. Nagorney, MD, Florencia G. Que, MD, Nancy D. Perrier, MD, Brian K. Berdnarski, MD, Jeffrey E. Lee, MD, Geoffrey B. Thompson, MD
Mayo Clinic, MD Anderson

06. COST-EFFECTIVENESS OF SCREENING RESISTANT HYPERTENSIVE PATIENTS FOR PRIMARY ALDOSTERONISM: INTEGRATING LIFETIME CARDIOVASCULAR RISK & OUTCOMES

Carrie C. Lubitz, MD, MPH, Stephen Sy, Konstantinos P. Economopoulus, MD, PhD, G. S. Gazelle, MD, MPH, PhD, Pamela M. McMahon, PhD, Milton C. Weinstein, PhD, Thomas A. Gaziano, MD
Massachusettes General Hospital, Harvard School of Public Health, Brigham and Women's Hospital

07. HORMONAL EVALUATION OF ADRENAL INCIDENTALOMAS: UNFORTUNATELY THE EXCEPTION NOT THE RULE

Kun-Tai Hsu, MD, Matthew Lee, MD, Herbert Chen, MD, FACS, David H. Kim, MD, Perry J. Pickhardt, MD, Rebecca S. Sippel, MD, FACS
University of Wisconsin

POSTER GROUP 2: PANCREAS/CARCINOID/ NEUROENDOCRINE

08. MULTIFUNCTIONAL GOLD NANORODS FOR TARGETED IN VIVO DRUG DELIVERY TO GASTROINTESTINAL NEUROENDOCRINE CANCERS

Ajitha Dammalapati, MS, Yuling Xiao, PHD, Renata Jaskula-Sztul, PHD, Alireza Javadi, PHD, Wenjin Xu, PHD, Jacob Eide, BS, Shaoqin Gong, PHD, Herbert Chen, MD, FACS
University of Wisconsin

09. SCREENING OF A NEW COLLECTION OF HDAC INHIBITORS REVEALS PROMISING NOVEL THERAPEUTIC OPTIONS FOR GASTROINTESTINAL NEUROENDOCRINE CANCERS

April D. Harrison, BS, Ajitha Dammalapati, MS, Casi M. Schienebeck, BS, Renu Nair, Weiping Tang, PhD, Renata Jaskula-Sztul, PhD, Herbert Chen, MD, FACS
University of Wisconsin

10. SMALL NON FUNCTIONING PANCREATIC NEUROENDOCRINE TUMORS; RESECT OR OBSERVE?

A. Frilling, PhD, P. Burdelski, MD, A. Speller, PhD, **P. Drymousis, PhD**, D. Spalding, MD, J. R. Izbicki, MD, Y. Vashist, MD
Imperial College London, University Hospital Hamburg

11. ROLE OF THE TUMOR SIZE IN THE MANAGEMENT OF SPORADIC NON-FUNCTIONING PANCREATIC NEUROENDOCRINE TUMOR LESS THAN 2 CM

G. Boulanger, MD, N. Carrere, MD, PhD, E. Mirallie, MD, L. De Calan, MD, J.L. Kraimps MD, M. Mathonnet, MD, PhD, P. Pessaux, MD, PhD, A. Hamy, MD, N. Regenet, MD
CHU de Nantes

POSTER GROUP 3: PARATHYROID

★ 12. AGE-RELATED VARIABILITY IN PREOPERATIVE LOCALIZATION AND IPM CONSISTENCY IN TARGETED PARATHYROIDECTOMY FOR PATIENTS WITH SPORADIC PRIMARY HYPERPARATHYROIDISM

Brian E. Bishop, BS, Bryan Perez, BS, Punam Parikh, BS, John I. Lew, MD, FACS
University of Miami Leonard M. Miller School of Medicine

★ 13. FIVE MINUTE INTRAOPERATIVE PARATHYROID HORMONE LEVELS CAN IDENTIFY MULTIGLAND DISEASE

Amal Alhefdhi, MD, Kamal Ahmad, MD, Rebecca S. Sippel, MD, FACS, Herbert Chen, MD, FACS, David F. Schneider, MD, MS
University of Wisconsin

★ 14. HYPERCALCEMIA AND HYPERPARATHYROIDISM: UNDER-RECOGNIZED AND NEGLECTED CARDIOVASCULAR RISK FACTORS?

Myrick C. Shinall, MD, Carmen C. Solorzano, MD
Vanderbilt University Medical Center

★ 15. NO NEED TO ABANDON FOCUSED UNILATERAL EXPLORATION FOR PRIMARY HYPERPARATHYROIDISM WITH INTRAOPERATIVE MONITORING OF INTACT PARATHYROID HORMONE: A TEN YEAR FOLLOW-UP

K. M. Day, MD, J. Yu, BS, B. K. Avanessian, MD, G. L. Baird, MS, J. M. Monchik, MD, FACS
Brown University, Warren Alpert Medical School, Rhode Island Hospital

★ 16. A NOVEL ULTRA-RAPID PTH ASSAY TO DISTINGUISH PARATHYROID FROM NON-PARATHYROID TISSUE

Benjamin C. James, MD, Sapna Nagar, MD, Miles Tracy, BS, Edwin L. Kaplan, MD, Peter Angelos, MD, PhD, Neal H. Scherberg, PhD, Raymon H. Grogan, MD
University of Chicago Pritzker School of Medicine

17. THE BIOCHEMICAL SEVERITY OF PRIMARY HYPERPARATHYROIDISM DIRECTLY CORRELATES WITH THE LOCALIZATION ACCURACY OF ULTRASOUND AND SESTAMIBI

David T. Hughes, MD, Meredith J. Sorensen, MD, Mark S. Cohen, MD, Barbra S. Miller, MD, Paul G. Gauger, MD
University of Michigan Health System

★ 18. JUSTIFIED FOLLOW-UP: A FINAL IOPTH LEVEL OVER 40 PG/ML IS ASSOCIATED WITH INCREASED RISK OF PERSISTENCE AND RECURRENCE IN PRIMARY HYPERPARATHYROIDISM

Mohammad H. Rajaei, MD, David F. Schneider, MD, MS, Rebecca S. Sippel, MD, FACS, Herbert Chen, MD, FACS, **Sarah C. Oltmann, MD**
University of Wisconsin

★ 19. CAPTHUS SCORING MODEL IN PRIMARY HYPERPARATHYROIDISM: CAN IT ELIMINATE THE NEED FOR IOPTH?

Dawn M. Elfenbein, MD, MPH, Sara Weber, David F. Schneider, MD, MS, Rebecca S. Sippel, MD, FACS, Herbert Chen, MD, FACS
University of Wisconsin

POSTER GROUP 4: THYROID

★ 20. CLINICAL AND SOCIOECONOMIC FACTORS INFLUENCE TREATMENT DECISIONS IN GRAVES' DISEASE

Dawn M. Elfenbein, MD, MPH, Herbert Chen, MD, FACS, David F. Schneider, MD, MS, Jeffrey Havlena, MS, Rebecca S. Sippel, MD, FACS
University of Wisconsin

★ 21. PREVENTING POST-OPERATIVE HYPOCALCEMIA IN GRAVES' PATIENTS: A PROSPECTIVE STUDY

Sarah C. Oltmann, MD, Andrew V. Brekke, David F. Schneider, MD, MS, Sarah C. Schaefer, NP, Herbert Chen, MD, FACS, Rebecca S. Sippel, MD, FACS
University of Wisconsin

22. CALCITONIN MEASUREMENT IN FINE-NEEDLE ASPIRATE WASHOUTS VS CYTOLOGIC EXAMINATION FOR THE DIAGNOSIS OF PRIMARY OR METASTATIC MEDULLARY THYROID CARCINOMA

Carmela De Crea, MD, Marco Raffaelli, MD, Daria Maccora, MD, Cinzia Carrozza, MD, Giulia Canu, MD, Guido Fadda, MD, Rocco Bellantone, MD, Celestino P. Lombardi, MD
U.O. Chirurgia Endocrina e Metabolica, U.O. Analisi Ormonali and U.O. Anatomia Patologica e Istologia – Policlinico A. Gemelli – Università Cattolica del Sacro Cuore – Rome, Italy

23. IMPLICATIONS OF LYMPH NODE YIELD AND METASTATIC LYMPH NODE RATIO ON THE PROGNOSIS OF MEDULLARY THYROID CANCER PATIENTS IN THE NATIONAL CANCER DATA BASE

Tricia Moo-Young, MD, Chihsiung E. Wang, PhD, David J. Winchester, MD, Richard A. Prinz, MD
NorthShore University HealthSystems

★ 24. LEVEL 7 DISEASE DOES NOT CONFER WORSE OUTCOME THAN LEVEL 6 DISEASE IN DIFFERENTIATED THYROID CANCER

Laura Y. Wang, MBBS, MS, Frank L. Palmer, BA, Dorothy Thomas, BA, Iain J. Nixon, MBChB, Robert M. Tuttle, MD, Ashok R. Shaha, MD, Jatin P. Shah, MD, Snehal G. Patel, MD, Ian Ganly, MD, PhD
Memorial Sloan Kettering Cancer Center

★ 25. RECURRENCE RATES WITH AND WITHOUT PROPHYLACTIC NECK DISSECTION IN PAPILLARY THYROID CANCER: A MULTI-INSTITUTION ANALYSIS

Abbey L. Fingeret, MD, Abdullah Alghamdi, MD, John Allendorf, MD, Erin Hassett, NP, Jessica Henry, NP, James A. Lee, MD, Rasa Zarnegar, MD, Thomas Fahey III, MD
New York-Presbyterian Hospital of Columbia University Medical Center, New York Hospital of Weill Cornell Medical College

★ 26. SHOULD TUMOR SIZE MATTER IN CHOOSING EXTENT OF SURGERY FOR PAPILLARY THYROID CANCER PATIENTS UNDER THE AGE OF 45 YEARS?

Mohamed Abdelgadir Adam, MD, Lin Gu, MS, Lauren Gratian, MD, Michaela A. Dinan, PhD, Shelby D. Reed, PhD, Sanziana A. Roman, MD, Julie A Sosa, MD, MA
Duke University Medical Center & Duke Clinical Research Institute

★ 27. LYMPH NODE METASTASES ARE ASSOCIATED WITH DECREASED SURVIVAL IN PATIENTS UNDER THE AGE OF 45 WITH PAPILLARY THYROID CANCER: AN ANALYSIS OF 48,308 PATIENTS

Mohamed Abdelgadir Adam, MD, Lin Gu, MS, Lauren Gratian, MD, Michaela A. Dinan, PhD, Shelby D. Reed, PhD, Sanziana A. Roman, MD, Julie A. Sosa, MD, MA
Duke University Medical Center & Duke Clinical Research Institute

★ 28. BRAF V600E ANAPLASTIC THYROID CANCER IS DEPENDENT ON TWIST1 FOR MIGRATION

Jonathan Zagzag, MD, Laura Taylor, PhD, Jennifer B. Ogilvie, MD, Keith S. Heller, MD, Dafna Bar-Sagi, PhD, Kepal N. Patel, MD
NYU Langone Medical Center

29. MULTIFOCALITY RATE COULD CONTRAINDICATE THYROID LOBECTOMY IN PATIENTS WITH PAPILLARY THYROID CARCINOMA LARGER THAN 5 MM

Marco Raffaelli, MD, **Carmela De Crea, MD**, Luca Sessa, MD, Luigi Oragano, MD, Chiara Bellantone, MD, Celestino P. Lombardi, MD
U.O. Chirurgia Endocrina e Metabolica – Policlinico A. Gemelli – Università Cattolica del Sacro Cuore – Rome, Italy

30. NOTCH1 PATHWAY ACTIVATION INHIBITS TUMOR GROWTH AND METASTASES IN WELL-DIFFERENTIATED THYROID CARCINOMA

Xiao-Min Yu, MD, PhD, Yera Han, BS, Rebecca S. Sippel, MD, FACS, Herbert Chen, MD, FACS
University of Wisconsin

31. SUPPORT NEEDS AND SURVIVORSHIP CONCERNS OF NEWLY DIAGNOSED THYROID CANCER PATIENTS

Roxana Moayer, BS, Melanie Goldfarb, MD, Laurel Barosh, MPH
University of Southern California Keck School of Medicine

32. LYMPH NODE METASTASES DO NOT IMPACT SURVIVAL IN FOLLICULAR VARIANT PAPILLARY THYROID CANCER

David F. Schneider, MD, MS, Dawn Elfenbein, MD, MPH, Herbert Chen, MD, FACS, Rebecca S. Sippel, MD, FACS
University of Wisconsin

★ 33. PREDICTORS OF INSUFFICIENT ASPIRATION BIOPSY RESULTS IN LARGE THYROID NODULES

Brenessa M. Lindeman, MD, Matthew T. Olson, MD, Eric Schneider, PhD, Jason D. Prescott, MD, PhD
Johns Hopkins Hospital

★ 34. INCIDENCE AND FOLLOW-UP OF THYROID NODULES DISCOVERED ON CAROTID DUPLEX

Priya H. Iyer, MD, Anas Abdel Azim, MD, Eyas Alkhalili, MD, Allan Siperstein, MD
The Cleveland Clinic Foundation

★ 35. RISK OF PERIOPERATIVE BLEEDING FOLLOWING THYROIDECTOMY OR PARATHYROIDECTOMY IN PATIENTS MAINTAINED ON ORAL ANTICOAGULATION THERAPY

Justin Yozawitz, MD, Sharon Stanley, MD, Richard Tyrell, MD, Sanford Dubner, MD
North Shore - Long Island Jewish Health System

36. THYROID INCIDENTALOMAS IN PATIENTS WITH MULTIPLE ENDOCRINE NEOPLASIA TYPE 1 (MEN1).

L. Lodewijk, MD, P.J. Bongers, MD, J.W. Kist, MD, E.B. Conemans, MD, J.M. de Laat, MD, C.R.C. Pieterman, MD, G.D. Valk, MD, I.H.M. Borel Rinkes, MD, M.R. Vriens, MD
University Medical Center Utrecht

37. INCREASED AND SAFER DETECTION OF NON RECURRENT INFERIOR LARYNGEAL NERVE IN NECK SURGERY AFTER PREOPERATIVE ULTRASONOGRAPHIC IDENTIFICATION

M. Iacobone, M. Citton, S. Tropea, G. Pagura, G. Viel, N. Sella, D. Nitti
University of Padua, Italy

38. A COST-EFFECTIVENESS ANALYSIS OF ROUTINE LARYNGEAL EXAMINATION AFTER THYROIDECTOMY

Brian H. Lang, MS, Carlos Wong, PhD, Kai Pun Wong, MBBS, Raymond K. Tsang, MBBS
The University of Hong Kong

39. A PROSPECTIVE ANALYSIS OF POTENTIAL PATIENT-RELATED FACTORS AFFECTING THE VALIDITY OF ULTRASONOGRAPHIC ASSESSMENT OF VOCAL CORDS AFTER THYROID AND PARATHYROID OPERATIONS.

Kai Pun Wong, MBBS, Brian H. Lang, MS
The University of Hong Kong

BYLAWS

BYLAWS

BYLAWS OF THE AMERICAN ASSOCIATION OF ENDOCRINE SURGEONS

I. CORPORATION

1.1 **NAME.** The name of the corporation is The American Association of Endocrine Surgeons.

1.2 **PURPOSES.** The purposes for which the corporation is organized are as follows: The corporation is organized exclusively for the purposes set forth in Sections 501(c)(3) of the Internal Revenue Code of 1986 (or the corresponding provision of any future United States Internal Revenue law) (the "Code"), including, for such purposes, making of distributions to organizations that qualify as exempt organizations under Section 501(c)(3) of the Code. The objects of the corporation shall include: (1) advancement of the science and art of endocrine surgery and (2) maintenance of high standards in the practice and art of endocrine surgery; and doing anything reasonably in furtherance of, or incidental to, the foregoing purposes as the Council may determine to be appropriate and as are not forbidden by Section 501(c) (3) of the Code, with all the power conferred on nonprofit corporations under the laws of the State of Illinois.

1.3 **NONPROFIT OPERATION.** The corporation shall be operated exclusively for scientific, literary and educational purposes within the meaning of Section 501(c) (3) of the Code as a nonprofit corporation. No Councilor or member of the corporation shall have any title to or interest in the corporate property or earnings in his or her individual or private capacity and no part of the net earnings of the corporation shall inure to the benefit of any Councilor, member, officer or any individual. No substantial part of the activities of the corporation shall consist of carrying on propaganda or otherwise attempting to influence legislation, nor shall the corporation participate in or intervene in any political campaign on behalf of (or in opposition to) any candidate for public office.

II. MEMBERSHIP

2.1 **MEMBERSHIP.**

A. Membership in this Association shall be limited to physicians or scientists of good professional standing, who have a major interest and devote significant portions of their practice or research to endocrine surgery, and who are certified by the appropriate specialty boards as noted in Section B below.

B. Types of Members. There shall be seven types of members: Active, Senior, Allied Specialist, Honorary, Corresponding, Candidate, and Resident/Fellow.

1. **Active members** shall consist of original charter members and all members subsequently elected until they become eligible for senior membership. The number of active members shall not be limited.

1a. The candidates for Active membership would have attended at least two annual meetings (hereinafter "assembly") of the American Association of Endocrine Surgeons prior to their application;

1b. The candidates for Active membership should be able to provide evidence of special interest in endocrine surgery;

1c. The candidates for Active membership must be certified by the American Board of Surgery or its equivalent in Canada (FRCSC), Central America, Mexico, and South America. In addition, membership shall be limited to Fellows of the American College of Surgeons or its international equivalent. The candidates who are applying for Active membership, who have completed their Endocrine Surgical Fellowship, should be in practice at least for two years with special emphasis in endocrine operative surgery.

2. **Senior members** shall consist of Active members who have reached the age of 65 years or who have retired from active practice. Senior members shall have all the responsibilities and privileges of active members, excepting those regarding attendance at assemblies. Senior members are not required to pay dues.

3. **Honorary members** shall consist of individuals who have made outstanding contributions to the discipline of endocrine surgery. They shall have no voting privileges, are not eligible for election as officers, and are not subject to assessment for dues.

4. **Corresponding members** shall consist of individuals who meet all the same qualifications in their respective countries as active members. They shall have no voting privileges, are not eligible for election as officers, shall attend one annual meeting and may be subject to dues at a reduced amount.

5. **Allied Specialist members** shall consist of specialists with American Board certification in their respective field or its equivalent in Canada, Central America, Mexico and South America. In addition, Allied Specialist membership shall be limited to Fellows of the American College of Surgeons, FACE, FACR, FACP, ACP etc. or their international equivalent. Allied Specialist members shall have demonstrated a significant commitment to and documented excellence in clinical practice, education, and/or research in their area(s) of practice within endocrine surgery. Allied Specialist members shall have been in practice within their specialty for a minimum of five years beyond training. Non-physician scientists (PhD) with a demonstrated interest in, and who have made significant contributions to, the field of endocrine surgery, are also eligible for membership under the Allied Specialist category. Allied Specialist members must have attended at least two assemblies of the AAES prior to their application for membership. Allied Specialist members shall pay dues as levied by the Council and approved by the membership, shall have voting privileges, are subject to attendance requirements, shall attend the annual meeting, can serve on committees, and are not eligible for election to office or Council.

6. **Candidate members** shall consist of individuals who have completed their surgical training and who are awaiting qualification as Active members. Candidate members are required to pay dues at a reduced rate, do not have voting rights, and may register for the annual meeting at a reduced rate. Candidate membership will be limited to a period of time no more than three years following completion of all continuous training to include residency and fellowship(s). A letter of sponsorship from an Active, Corresponding, Allied, or Senior AAES member will be sufficient to be considered as a Candidate member. Candidate members are strongly urged to attend the annual meeting but need not have attended a prior meeting. Candidate members shall not have the right to attend the annual business meeting, cannot serve on committees, and are not eligible for election to office or Council and cannot act as sponsors for membership or submissions to the annual meeting.

7. **Resident/Fellow members** shall consist of individuals who are currently training, either as surgical residents or fellows. Resident/Fellow members are required to pay dues at a reduced rate, do not have voting rights, and may register for the annual meeting at a reduced rate. Resident/Fellow membership is limited to the time that an individual is in a residency, research, or clinical fellowship training program. A letter of sponsorship from an Active, Corresponding, Allied, or Senior AAES member will be sufficient to be considered as a Resident/Fellow member. Attendance at a prior meeting of the AAES is not required. Resident/Fellow members will become Candidate members upon completion of their training and upon request. Resident/Fellow

members shall not have the right to attend the annual business meeting, cannot serve on committees, and are not eligible for election to office or Council and cannot act as sponsors for membership or submissions to the annual meeting.

C. Election of New Members

1. Physicians fulfilling the requirements for Active or Allied Specialist membership stated in paragraphs 2.1A and 2.1B of these Bylaws who reside in the United States, Canada, Central America, Mexico or South America may be eligible for Active membership or Allied Specialist membership.

2. Application forms for Active, Corresponding, or Allied Specialist membership shall be provided by the Secretary-Treasurer on line. Completed application forms signed by the proposed member, one sponsor, and two endorsees shall be delivered to the Secretary-Treasurer at least four months before the annual assembly. Completed applications shall be reviewed by Council, which has the right to accept or reject any application for membership in the Association. Names of prospective members recommended for election by the Council shall be submitted to the membership at the annual assembly. Election shall be made by secret ballot, by a three-fourths affirmative vote of the members present. A prospective member who fails to be elected at one assembly may be considered at the next two annual assemblies of the Association. If election fails a third time, the prospective member's application may be resubmitted after a two year interval.

3. Prospective members for Honorary membership shall be proposed in writing to the Council through the Secretary-Treasurer. Prospective members approved by the Council will be elected by three-fourths affirmative vote of the Council and officers present.

4. Active members in good standing who subsequently take up practice in geographic areas outside of the United States, Canada, Central America, Mexico, or South America shall be changed to corresponding members of the Association upon request.

5. Sponsors and endorsers shall be Active, Allied, Corresponding, or Senior members.

D. Dues

Dues and assessments shall be levied by the Council and approved by the membership at the annual assembly.

E. Resignations / Expulsions

1. Resignations of members otherwise in good standing shall be accepted by majority vote of the Council.

2. Charges of unprofessional or unethical conduct against any member of the Association must be submitted in writing to Council. The Council's concurrence or disallowance of the charges shall be presented to the membership at the annual assembly executive session. A three-fourths affirmative vote of the members present shall be required for expulsion.

3. Any Active or Allied Specialist member who is absent from three consecutive annual assemblies without adequate explanation of this absence made in writing to the Secretary-Treasurer shall be dropped from membership in the Association by vote of the Council. Membership may be reinstated by vote of the Council.

4. Any member whose dues remain unpaid for a period of one (1) year shall be dropped from membership, provided that notification of such a lapse beginning at least three (3) months prior to its effective date. The member may be reinstated following payment of the dues in arrears on approval of the Council.

2.2 **PLACE OF ASSEMBLIES.** Annual and special assemblies of the members shall be held at such time and place as shall be determined by the Council.

2.3 **ANNUAL ASSEMBLY.** The annual assembly of the members of the corporation for election of Officers and Councilors and for such other business as may come before the assembly shall be held on such date and hour as shall have been determined by the members (or if the members have not acted, by the Council or the Chairperson), and stated in the notice of the assembly. If for any reason the annual assembly is not held on the determined date of any year, any business which could have been conducted at an annual assembly may be conducted at any subsequent special or annual assembly or by consent resolution.

A. During the annual assembly, there shall be an AAES Business Meeting of the membership. The business of the association shall be conducted at this time. The report of the nominating committee shall be presented to the membership during the AAES Business Meeting. Nominations may be made from the floor. Officers of the Association and Council members shall be elected by majority vote of the Active, Allied Specialist, and Senior members during the AAES Business Meeting.

B. Any member of the Association may invite one or more guests to attend the annual assembly.

C. Abstracts for consideration for presentation must be authored or sponsored by a member of the following categories: Active, Corresponding, Senior, Honorary, or Allied Specialist.

2.4 SPECIAL ASSEMBLIES. Special assemblies of the members of the corporation may be called by the Council or the President and shall be called by the President or the Secretary-Treasurer at the written request of any 30 members of the corporation. No business may be transacted at a special assembly except the business specified in the notice of the assembly.

2.5 NOTICE OF ASSEMBLIES OF MEMBERS. Except as otherwise provided by statute, written notice of the place, day, and hour of the assembly and in the case of a special assembly, the purpose or purposes for which the assembly of the members of the corporation is called, shall be given not less than five (5) nor more than sixty (60) days before the date of the assembly to each member, either personally or by mailing such notice to each member at the address designated by the member for such purpose or, if none is designated, at the member's last known address.

2.6 WAIVER OF NOTICE. Whenever any notice whatever is required to be given under the provisions of the Illinois Not for Profit Corporation Act of 1986 ("the Act") or under the provisions of the articles of incorporation or bylaws of this corporation, a waiver thereof in writing signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice. Attendance at any meeting shall constitute waiver of notice thereof unless the person at the meeting objects to the holding of the meeting because proper notice was not given.

2.7 QUORUM OF MEMBERS ENTITLED TO VOTE. A minimum of thirty (30) members eligible to vote shall constitute a quorum at the annual assembly to effect changes in the bylaws of the Association, to make assessments, to authorize appropriations or expenditures of money other than those required in the routine business of the Association, to elect officers, Council members and members, and to expel members. For the transaction of other business, the members entitled to vote present at any annual assembly shall constitute a quorum.

III. COUNCIL

3.1 **COUNCIL.** The business and affairs of the corporation shall be managed by or under the direction of a Council which is the governing body of the corporation. The Council shall meet as often as necessary to conduct the business of the corporation.

3.2 **NUMBER AND SELECTION OF COUNCIL.** The Council shall consist of the officers of the Association, the three immediate past Presidents, and six other Council members, as the membership shall from time to time determine. The Council shall be elected by majority vote of the Active, Allied, and Senior membership during the AAES Business Meeting at its annual assembly and vacancies shall be filled in the manner specified in Section 3.4 below. Councilors (other than those elected to fill vacancies) shall serve for three (3) year terms, with two (2) Councilors being elected annually so as to provide overlapping terms.

3.3 **REMOVAL.** Any Councilor may be removed from office with cause at any annual or special assembly of the members. No Councilor may be removed except as follows: (1) A Councilor may be removed by the affirmative vote of two-thirds of the votes present and voted, either in person or by proxy (2) No Councilor shall be removed at a meeting of members entitled to vote unless the written notice of such meeting is delivered to all members entitled to vote on removal of Councilors. Such notice shall state that a purpose or the meeting is to vote upon the removal of one or more Councilors named in the notice. Only the named Councilor or Councilors may be removed at such meeting. If the vote of Councilors is to take place at a special assembly of Councilors, written notice of the proposed removal shall be delivered to all Councilors no less than twenty (20) days prior to such assembly. Written notice for removal must include the purpose of the assembly (i.e., removal) and the particular Councilor to be removed.

3.4 **VACANCIES.** Vacancies occurring in the Council by reason of death, resignation, removal or other inability to serve shall be filled by the affirmative vote of a majority of the remaining Councilors although less than a quorum of the Council. A Councilor elected by the Council to fill a vacancy shall serve until the next annual assembly of the membership. At such annual assembly, the members shall elect a person to the Council who shall serve for the remaining portion of the term.

3.5 ANNUAL ASSEMBLY. The annual assembly of the Council shall be held at such place, date and hour as the Council may determine from time to time. At the annual assembly, the Council shall consider such business as may properly be brought before the assembly. If less than a quorum of the Councilors appear for such an annual assembly of the Council, the holding of such annual assembly shall not be required and matters which might have been taken up at the annual assembly may be taken up at any later regular, special or annual assembly or by consent resolution.

3.6 REGULAR AND SPECIAL ASSEMBLIES. Regular assemblies of the Council may be held at such times and places as the Councilors may from time to time determine at a prior assembly or as shall be directed or approved by the vote or written consent of all the Councilors. Special assemblies of the Council may be called by the President or the Secretary-Treasurer, and shall be called by the President or the Secretary-Treasurer upon the written request of any two (2) Councilors.

3.7 NOTICE OF ASSEMBLIES OF THE COUNCIL. Written notice of the time and place of all assemblies of the Council shall be given to each Councilor at least 10 days before the day of the assembly, either personally or by mailing such notice to each Councilor at the address designated by the Councilor for such purposes, or if none is designated, at the Councilor's last known address. Notices of special assemblies shall state the purpose or purposes of the assembly, and no business may be conducted at a special assembly except the business specified in the notice of the assembly. Notice of any assembly of the Council may be waived in writing before or after the assembly.

3.8 ACTION WITHOUT AN ASSEMBLY. Any action required or permitted at any assembly of the Council or a committee thereof may be taken without an assembly, without prior notice and without a vote, if a consent in writing, setting forth the action so taken, shall be signed by all of the Councilors and all of any non-Councilor committee members entitled to vote with respect to the subject matter thereof, or by all the members of such committee, as the case may be. The consent shall be evidenced by one or more written approvals, each of which sets forth the action taken and bears the signature of one or more Councilors or committee members. All the approvals evidencing the consent shall be delivered to the Secretary-Treasurer to be filed in the corporate records. The action taken shall be effective when all the Councilors or the committee members, as the case may be, have approved the consent unless the consent specifies a different effective date. Any such consent signed by all Councilors or all the committee members, as the case may be, shall have the same effect as a unanimous vote and may be stated as such in any document filed with the Secretary of State under the Illinois General Not for Profit Corporation Act.

3.9 QUORUM AND VOTING REQUIREMENTS. A majority of the Councilors then in office and a majority of any committee appointed by the Council constitutes a quorum for the transaction of business. The vote of a majority of the Councilors or committee members present at any assembly at which there is a quorum shall be the acts of the Council or the committee, except as a larger vote may be required by the laws of the State of Illinois, these bylaws or the Articles of Incorporation. A member of the Council or of a committee may participate in an assembly by conference telephone or similar communications equipment by means of which all persons participating in the assembly can hear one another and communicate with each other. Participation in an assembly in this manner constitutes presence in person at the assembly. No Councilor may act by proxy on any matter.

3.10 POWERS OF THE COUNCILORS. The Councilors shall have charge, control and management of the business, property, personnel, affairs and funds of the corporation and shall have the power and authority to do and perform all acts and functions permitted for an organization described in Section 501(c) (3) of the Code not inconsistent with these bylaws, the Articles of Incorporation or the laws of the State of Illinois. In addition to and not in limitation of all powers, express or implied, now or hereafter conferred upon Boards of Directors of nonprofit corporations, and in addition to the powers mentioned in and implied from Section 1.3, the Councilors shall have the power to borrow or raise money for corporate purposes, to issue bonds, notes or debentures, to secure such obligations by mortgage or other lien upon any and all of the property of the corporation, whether at the time owned or thereafter acquired, and to guarantee the debt of any affiliated or subsidiary corporation or other entity, whenever the same shall be in the best interests of the corporation and in furtherance of its purposes.

3.11 COMPENSATION. Councilors shall receive no compensation for their services on the Council. The preceding shall not, however, prevent the corporation from purchasing insurance as provided in Section 5.1 nor shall it prevent the Council from providing reasonable compensation to a Councilor for services which are beyond the scope of his or her duties as Councilor or from reimbursing any Councilor for expenses actually and necessarily incurred in the performance of his or her duties as a Councilor.

IV. OFFICERS

4.1 OFFICERS. The officers shall be a President, a President-Elect, a Vice President, a Secretary-Treasurer, and a Recorder.

4.2 ELECTION AND TERM OF OFFICE. The President, President-Elect, and Vice President of the Association shall be elected for terms of one year each. The Secretary-Treasurer and Recorder shall be elected for three year terms. Officers of the Association shall be elected by majority vote of the Active, Allied Specialist, and Senior members during the AAES Business Meeting.

4.3 REMOVAL. Any officer or agent may be removed with or without cause by the Council or other persons authorized to elect or appoint such officer or agent but such removal shall be without prejudice to the contract rights, if any, of the person so removed. Election or appointment of an officer or agent shall not of itself create any contract rights.

4.4 PRESIDENT. The President shall preside at Council assemblies and the annual members' assembly. The President shall appoint members to all standing and ad hoc committees and shall serve as an ex-officio member of each. Successors to vacated offices of the Association shall be appointed by the President until the position is filled at the next annual assembly. The President shall prepare an address to the annual assembly of the Association.

4.5 PRESIDENT-ELECT. The President-Elect, in the absence or incapacity of the President, shall perform the duties of the President's office.

4.6 VICE PRESIDENT. In the absence or incapacity of both the President and the President-Elect, the Chair shall be assumed by the Vice President

4.7 SECRETARY-TREASURER. The Secretary-Treasurer shall keep minutes of the Association and the Council, receive and care for all records belonging to the Association, and conduct the correspondence of the Association. This office will issue to all members a written report of the preceding year's transactions to be read to the Council and membership at the annual assembly. The Secretary-Treasurer will prepare an annual report for audit. The Secretary-Treasurer shall have the authority to certify the bylaws, resolutions of the members and Council and committees thereof, and other documents of the corporation as true and correct copies thereof.

4.8 RECORDER. The Recorder shall receive the manuscripts and edition of the discussions. The Recorder shall be custodian for the transactions of the Association.

V. INDEMNIFICATION

5.1 **INDEMNIFICATION.** Each person who is or was a Councilor, member, officer or member of a committee of the corporation and each person who serves or has served at the request of the corporation, as a Councilor, officer, partner, employee or agent of any other corporation, partnership, joint venture, trust or other enterprise may be indemnified by the corporation to the fullest extent permitted by the corporation laws of the State of Illinois as they may be in effect from time to time. The corporation may purchase and maintain insurance on behalf of any such person against any liability asserted against and incurred by such person in any such capacity or arising out of his status as such, whether or not the corporation would have power to indemnify such person against such liability under the preceding sentence. The corporation may, to the extent authorized from time to time by the Council, grant rights to indemnification to any employee or agent of the corporation to the fullest extent provided under the laws of the State of Illinois as they may be in effect from time to time.

VI. COMMITTEES

6.1 **COMMITTEES.** A majority of the Council may establish such committees from time to time as it shall deem appropriate and shall define the powers and responsibilities of such committees. The Council may establish one or more executive committees and determine the powers and duties of such executive committee or committees within the limits prescribed by law.

A. Standing committees of the Association shall consist of the Membership Committee (composed of the Council), Publication and Program Committee, Education and Research Committee, Information and Technology Committee, and Fellowship Committee.

B. The Nominating Committee shall consist of the President and three immediate past Presidents. The most senior past President is chairman of the committee.

C. All committees shall be chaired by members appointed by the President with the advice of the Council.

6.2 **COMMITTEES OF COUNCILORS.** Unless the appointment by the Council requires a greater number, a majority of any committee shall constitute a quorum, and a majority of committee members present and voting at a meeting at which a quorum is present is necessary for committee action. A committee may act by unanimous consent in writing without a meeting and, subject to the provisions of the bylaws for action by the Council, the committee by majority vote of its members shall determine the time and place of meetings and the notice required thereof. To the extent specified by the Council or in the articles of incorporation or bylaws, each committee may exercise the authority of the Council under Section 108.05 of the Act; provided, however, a committee may not:

A. Adopt a plan for the distribution of the assets of the corporation, or for dissolution;

B. Approve or recommend to members any act the Act requires to be approved by members, except that committees appointed by the Council or otherwise authorized by the bylaws relating to the election, nomination, qualification, or credentials of Councilors or other committees involved in the process of electing Councilors may make recommendations to the members relating to electing Councilors;

C. Fill vacancies on the Council or on any of its committees;

D. Elect, appoint, or remove any officer or Councilor or member of any committee, or fix the compensation of any member of a committee;

E. Adopt, amend, or repeal the bylaws or the articles of incorporation;

F. Adopt a plan of merger or adopt a plan of consolidation with another corporation, or authorize the sale, lease, exchange or mortgage of all or substantially all of the property or assets of the corporation; or

G. Amend, alter, repeal, or take action inconsistent with any resolution or action of the Council when the resolution or action of the Council provides by its terms that it shall not be amended, altered, or repealed by action of a committee.

VII. AMENDMENTS

7.1 **AMENDMENTS.** These bylaws may be amended at the annual assembly of the membership provided a notice setting forth the amendment or a summary of the changes to be effected thereby is given to each member entitled to vote thereon in the manner and within the time provided in these bylaws for notice of the assembly. These bylaws may be amended at the annual assembly by a two-thirds affirmative vote of the members present. No amendment inconsistent with the Articles of Incorporation shall be effective prior to amendment of the Articles of Incorporation.

VIII. BOOKS AND RECORDS

8.1 **BOOKS AND RECORDS.** The corporation shall keep correct and complete books and records of account and shall also keep minutes of the proceedings of its members, Council and committees having any of the authority of the Council, and shall keep at the registered or principal office a record giving the names and addresses of the Council and members entitled to vote. All books and records of the corporation may be inspected by any Councilor or member entitled to vote, or his or her agent or attorney for any proper purpose at any reasonable time.

IX. PARLIAMENTARY AUTHORITY

9.1 **PARLIAMENTARY AUTHORITY.** The rules of parliamentary procedure in "Robert's Rules of Order, Revised", shall govern the proceedings of the assemblies of this corporation, subject to all other rules contained in the Articles of Incorporation and Bylaws and except that proxy voting shall be allowed in accordance with the Illinois General Not for Profit Corporation Act of 1986

X. SEVERABILITY

10.1 **SEVERABILITY.** Each of the sections, subsections and provisions hereof shall be deemed and considered separate and severable so that if any section, subsection or provision is deemed or declared to be invalid or unenforceable, this shall have no effect on the validity or enforceability of any of the other sections, subsections or provisions.

MEMBERSHIP DIRECTORY

2013 - 2014

"J" indicates the addition of a journal subscription for corresponding and senior members

KEY

AAES Membership Types

Active
Allied Specialist
Candidate
Corresponding
Honorary
Resident/Fellow
Senior

MEMBERSHIP DIRECTORY 2014

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Per-Ola "PeO" Granberg, MD
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Professor Per-Ola Granberg (PeO) was an outstanding figure and a pioneer in developing endocrine surgery in Sweden. He was instrumental in forming the first endocrine surgical association within the Nordic Surgical Society in 1972 and one of the founders of IAES in 1979, and president of IAES 1983-85. One of his most important contributions was to introduce fine-needle aspiration and cytology of thyroid nodules internationally. This method is now used routinely in the initial evaluation of thyroid nodules.

PeO had a unique and wonderful ability to maintain a collegial atmosphere. Many colleagues all over the world will always remember the pleasure of working and meeting with this inspiring surgeon, teacher, and friend, Per-Ola Granberg.

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