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Message from the Advisory Council Chair Courageous Captains and Brave Quartermasters

The time for my second editorial has arrived: I feel like I wrote the previous one yesterday, but in fact a whole year has passed. And it was not a very easy one: I cannot avoid mentioning that 2020 was imprinted by one of the worst disasters the world has experienced since World War II: the SARS-CoV-2 pandemic. Currently, the pandemic does not seem to be over and the epidemiological situation is now forcing us to consider the scenario of a second wave of contagion¹.

Thus, I would like to share some reflections with you regarding the role of our residents in this event. I am sure you are asking yourself why I am so attracted to this topic....

As you surely know in the last few months, my region, Lombardy, Northern Italy, was heavily hit by the COVID-19 outbreak² and together with it by the incapacity of the health system to cope with the unexpected surge in medical needs³: many patients were left to die at home without assistance; hospitals were flooded by COVID-19 patients and unfortunately some patients died not because the disease but because of the lack of resources, despite the great effort done to increase the number of beds, ICU work-stations, ventilators⁴....

Eventually the most limiting factors, as always by the way in disasters⁵, was not the “stuff” but the “staff”, meaning, in this scenario, medical personnel specialized in the care of patients in severe respiratory distress, septic shock and coagulation derangement: Ospedale San Raffaele managed a 100% increase in the number of ICU beds in 2 weeks, but it takes years to train medical staff specialized to care for those severely ill patients⁶.

Due to the situation of a lack of specialized medical staff, ordinary activities, including surgeries, were placed on hold and all available personnel were shifted to COVID-19 units. Myself I learned how to use a Boussignac mask or how to calculate the P/F ratio⁷.

Because of the disproportion between the needs and the available resources, medical residents were also called in to give their contribution.

However, eventually on 1 May 2020, the Medical Director of an important Italian Hospital of Veneto Region publicly asserted that the presence of the residents in the hospitals constituted a major risk for the spreading of COVID-19 because young people have a habit to socialize evading the restrictive measures imposed for containment by the government⁸.

Early after this unfair press release and the strong judgment of the residents’ official representatives, as well as of the Italian Health Authorities, the Dean of the local University and the Governor of Veneto Region called for a public apology and confirmed the important role played by residents in the management of the emergency. Nevertheless, the “stigma” against the residents, guilty of being too social, does not seem to be completely gone, despite the fact that they have been working very hard, sometimes without the due supervision by the seniors, facing a situation for which they were not prepared and finally even becoming infected and sick.

Now that there are increasing reports in the literature regarding the impact of the COVID-19 pandemic on health workers⁹, essentially meaning the employees of the health sector, it becomes a moral imperative to ask ourselves about the non-employees, for instance



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our residents: is there anyone who takes care of them? How did we behave towards them? Have we fulfilled our duty to tutor them or have we sent them into trouble without any guidance? Were we careful enough to protect them or were we too concerned about protecting ourselves? Did we ask them how they felt in the middle of the storm? Have we been “Captains Courageous”¹⁰?

Faithful to the spirit of my previous editorial¹¹, we do not pretend to know how the last few months have been for our residents but give them voice: in this case to some of the residents of Vita & Salute San Raffaele University (the university associated with my hospital). I once again believe we need to listen to them more. And we need to ask them to talk more.

Dario

I am a resident in emergency medicine. Looking back at the years of my medical training, I can say I passed through challenging times (and more relaxed ones) and I have always had the impression of being surrounded by highly qualified professionals. Then COVID-19 came and my way of thinking has changed a lot. At the beginning of February 2020, I was attending the surgical side of the emergency department (ED), tutored by the surgeons on duty, to learn more about surgical emergency conditions, evaluation and maneuvers. At the same time, I was also called to enforce the medical side of the ED during the weekend. We were strictly following the WHO guidelines, trying to localize patients coming from East Asia who could be suspected to carry SARS-CoV-2. We were not actually looking at symptoms of COVID-19, but just at the geographical origin of people: I remember having visited a person coming from Korea (who for instance had flown through Shanghai) with high fever, cough and conjunctivitis, without testing for SARS-CoV-2 because he was not from Hubei province. Approximately 10 days later, everything started and it was too fast to keep up the pace. In order to cope with the lack of specialized emergency physicians (EP), although residents, we were asked to take the responsibility of the “low-risk COVID-19” area of the ED, with the tutorship of a surgeon. We were in charge of the diagnostic and therapeutic path of patients presenting for many different symptoms and recognized that they were affected by many different types of diseases: stroke, acute kidney failure, deep vein thrombosis and pulmonary thromboembolism, Guillain Barre syndrome, among others. We could not get the advice of a specialized EP or rely on somebody competent to oversee our decisions. I made mistakes. I am sure I have done many. I know it happens in every job, when you are at the beginning of your career and you are supposed to be supervised but eventually you are forced to take action without supervision. Nevertheless, I am very sorry about this. In addition, the amount of work was so huge that after each shift I felt exhausted. We were just five residents when the new rules started. In the month of March, I had been on night shift 7–8 times (12 hours per shift) and, of course, all the days I was not in the bed after a night shift—I was again on duty in the ED. Not one single day off in the whole month. In those days, I had the opportunity to meet many good people and doctors. Some of them taught me so many things I probably do not even realize. I have seen more patients dying in front of me than in the rest of my short career: every doctor knows death is part of the game of our job, but I really feel the game was unfair this time.

Taking a balance of this “COVID-19 era” (that is not finished yet) I can definitely say I am a better doctor today than I was before. And I am really proud of the people who have been working “hand in hand” with me: first of all my resident colleagues Federica, Giorgia, Gloria, Marta and Alessandra (I love them all); my supervisors, surgeons and nonsurgeons: I can now recognize they were overloaded as well, but were still making an effort to teach me something every day; all the nurses and the health workers: they were always very active and supportive. I think it is important to face the responsibilities that we had at that time and have right now in our job, our patients and ourselves. In a critical situations, as a group and as individuals we have shown our best and worst, and we need to confront both of them. It has been hard. Some people may say the “COVID-19 era” was somehow good because he/she could finally show the potentiality at work and enjoy the time at home alone. I admire those resilient people. I did not feel fine at all. I realize this only now, day by day. Every time I look back at those days, I can see I was not happy and I am not happy right now either. However, I can say at least I have finally started trying to do something to be happy again.



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Omar

I am a senior resident in anesthesia and intensive care, working and learning in a large hospital in Milan. Before the SARS-CoV-2 pandemic, I spent little time in the general intensive care unit (ICU), so it was a little shocking to be thrown in a “COVID-19 ward” on my first day, with my first COVID patient ... in cardiac arrest! It was 1 March 2020 and I hardly knew what an FFP2 mask was. In a few weeks’ time, our ICU beds doubled and my senior colleagues were just too few. My fellow residents and I had to step up and share the burden in full and I felt, above all, proud and glad to be helpful. I learned to care for these patients together with my seniors. This shared experience was what really brought us together and gave us the strength to resist the hardships of the moment. In the first days secluded in a COVID ICU my biggest concern was to protect myself the best I could. My wife was pregnant at that time so I could not be more worried... but I managed to be thorough. This meant wearing a full protective suit, 2 pairs of gloves and 2 face masks (the surgical on top of the FFP2, to spare the latter) in a closed environment for 8 hours straight, performing frequent hand sanitization, until the skin on my hands nearly fell off! Hard, but worth every layer. Then I started worrying about the patients and their relatives too. I felt the confusion and uncertainty of experimental therapies and of our inability to find something effective beyond usual supportive care. Even more: traditional ARDS care was not enough; the evidence we studied was not enough. Everyone had his own theory on how to best treat these patients, so it was also hard to find the right advice. On top of that, I could not even comfort a patient or at least her relatives with a simple smile. As months passed, I have resumed the usual good spirit and began to see those smiles. Recovered patients came to visit us and this was by far the best reward. I also saw fellow physicians and nurses building a group from nothing, including forming an ICU staff to care for patients in a tennis air dome converted ad hoc into an ICU, which was very rewarding. At the end, I think this pandemic changed everything. And I expect no less: we have to learn something from this catastrophe. We have to learn to be responsible, what it means to be a good citizen, a good member of a community that is necessarily interconnected. I also hope we will learn something else from this virus: it knows no borders, ignores walls and does not care about differences among humans. Way ahead of us.

Roberto

The word ‘emergency’ derives from the Latin *emergens*, present participle of *emergere*, itself being the fusion of *e-* ‘out’ and *mergere-* ‘to drop’. Literally, “emergency” is what is dropping out from water. At the origin, the word did not necessarily have a negative meaning: whatever suddenly emerges from the smooth water surface could be either something beautiful and lucky or something dangerous and catastrophic. To the present day, however, the negative meaning overcomes any other. In fact, we usually refer to an emergency as something limited in time, instantaneous and sudden.

What could happen therefore if an emergency lasts longer, has an exponential growth searching a peak that does not arrive at all? What could happen if an emergency keeps going on for an undefined time?

Disaster medicine provides health care to disaster survivors and plans action protocols in those situations in which resources are insufficient compared with necessities. I discovered in this period the existence of Bernini Carri’s equation, which says that the intensity of damage is directly proportional to the number of people involved and to its duration and inversely proportional to the availability of resources and the ‘resilience factor’, where resilience means the ability of a population to deal with an emergency.

I live with my girlfriend (also a resident) near San Raffaele Hospital in Milan. During the COVID-19 lockdown, we were surprised to experience a new feeling hearing the ambulances continuously driving to the emergency department: discouragement. Every ambulance was carrying a patient destined for an uncertain prognosis, one more competitor for the limited resources. Ambulance sirens, a routine in our work, intimidated two medical doctors: how to find our ‘resilience factor’?

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Inside one of the new “COVID wards” in which I worked together with many volunteer residents, however, the discouragement gave way to the spirit of collaboration. The crisis was able to bring up a sense of responsibility in many doctors who ensured participation and diligence and forgot the fear of an unknown, new disease. Residents of various departments (surgery, radiology, ophthalmology, etc.), despite being inexperienced with the new disease, offered their availability and became familiar with P/F ratio, NIV, ultrasound, X-ray and CT findings of COVID-19-related pneumonia, along with the heat and the sweat of wearing full PPE. I am proud to say that ultimately the response to the common overwhelming needs, even if scientifically unsatisfactory, was adequate at least from the human viewpoint.

I hope that we will not need to wait for another emergency to again find this spirit of cooperation for a better healthcare. It would be nice to give back to the word ‘emergency’ its antique capacities, believing that something good could emerge even from a tragic period.

Valentina

My experience with SARS-CoV-2 started unfortunately with being quarantined at the very beginning of March 2020. At that time, as emergency medicine resident, I was attending an internal medicine ward, where patients coming from the emergency department were allowed to be admitted only after two negative COVID-19 throat swabs.

On a Saturday morning, one of my colleagues phoned me, informing I had to undergo a swab test, as one of our patients got quickly worse, developing severe acute respiratory distress and was tested again for COVID-19, ultimately testing positive. I spent the entire weekend thinking that it was impossible I could have been infected: I had always worn a surgical mask, latex gloves and a single use coat when I visited that patient as all the other patients... but I was wrong: on Monday morning, I was tested and the result was positive.

That was the beginning of the nightmare of quarantine for me and my parents. However, I was lucky because it lasted only two weeks. During my quarantine, I often felt a sense of guilt because I was at home and I could not do anything, while my colleagues were on the frontline, subjected to exhausting shifts. I was feeling fine with no symptoms. Then one day I woke up really asthenic, with muscular and joint pain and a terrible headache. I was so tired I could not stand up from my bed; but again very lucky, after a few days the asthenia and pain began to improve slowly.

At the end of those two weeks, I was called to repeat the swab in order to go back to work and the test result was fortunately negative.

My return to the hospital reminded me of my first day of residency: I was very anxious because I did not know what awaited me, despite my colleagues having already told me some things about their experience. Once I arrived in the ward, I had to wear two facemasks, protective glasses and a plastic suit: I could hardly breathe dressed like that. On top, before entering a room, I had to wear also two pair of latex gloves and a single use coat and to change them after every single examination. I was shocked at the severity of the clinical condition of most of the patients: some of them needed noninvasive ventilation (NIV); some were put in prone position to improve breathing. It often happened that patients admitted in relatively good conditions got worse quickly and needed further respiratory support with NIV, first, then orotracheal intubation and invasive ventilation in the intensive care unit (ICU). Every day was similar to the others: it began and ended with the hope that all efforts and attempts were enough to heal our patients and with the fear that someone could suddenly get worse or die. I was struck by the patients’ sense of loneliness: they could not receive visits from their relatives and friends. Every day my colleagues and I called our patients’ relatives to update them about their loved one’s clinical conditions. I often put myself in their shoes: how would they feel waiting for that daily update, with the fear and anxiety that their beloved relatives could get worse or die, without the possibility to do anything for them except waiting for a call?

This “health emergency” taught me a lot about the management of acute lung failure, ARDS and contagious infective disease and gave me the opportunity to reflect about the human and emotional aspects of what means being a good doctor. The focus is often the treatment of a disease and the physical healing of the patient, forgetting that we are in front of a suffering person, full of fears and worries. While facing up to their diseases and hospitalization, patients also need other types of attention: sometimes a smile or a word of encouragement can be enough to help them to feel less alone.



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Stefania

When almost one year ago I began my residency in emergency medicine, I could not imagine having to face a pandemic that had previously only been seen in movies. The COVID-19 outbreak represented for me the opportunity to contribute to a healthcare event which, at the very beginning, no one was able to manage. While living and experiencing a situation that will be part of history, I also had the chance to acquire knowledge and skills. The collaboration between healthcare workers of diverse departments and the sharing of knowledge and experience within several different professional figures was what enriched me most. The hardest things I experienced were coping with highly demanding working schedules and wearing very heavy protective equipment. Being completely covered with safety devices, the only way to communicate and being recognizable from my colleagues was through eye contact and the names written on the suits.

My reflection at the end of this experience starts from the dissociation of the necessity to wear a protective disguise, which in fact was compulsory, but in turn gave me the feeling of being isolated from reality. Behind the suit, I kept my fears, but experienced also the desire to be helpful. I found myself face to face with why I chose this profession, but without the possibility of escaping the question and making the answer superfluous and childish. Outside my suit, I was surrounded by many other microcosms like mine.

Alessio

February 20, 2020: the first case of COVID-19 in Italy was ascertained in Codogno Hospital (Lodi). March 8, 2020: all of Italy became a “restricted area”; the lockdown involved the whole country.

My colleagues and I, like everyone else, were astonished by the exponential increase of the epidemic, as in just over two weeks we had gone from normal everyday life to the obligation to stay at home, leaving only out of strict necessity. Our ophthalmology department had at the time only suffered indirect effects of the emergency: outpatient and surgical activities were reduced to a minimum, reserved only for urgent and nonpostponable cases. We ourselves spent hours phoning patients to persuade them to postpone visits, when not urgent.

March 11, 2020: all residents received an email from the Hospital Health Direction inviting us to serve in activities related to the COVID-19 emergency on a voluntary basis. The majority of ophthalmology residents, also thanks to the heartfelt invocation of our Head Professor Bandello, decided to join. Some of us were assigned to “COVID-19 wards”; the rest collaborated in an observational study on patients affected by the new SARS-CoV-2.

The decision to contribute to the management of the emergency was taken with determination because we felt we were joining a collective national effort in facing an unexpected and, in many respects, still unknown threat. However, this decision was accompanied by at least two types of fear: the first was obviously to actually become infected ourselves, while the second was exquisitely “medical”; we were afraid of not being able to provide adequate care to the COVID-19 patients. As ophthalmology residents, in fact, we learn to treat eye diseases and eye involvement in extraocular diseases, not to manage life-threatening conditions. Those of us who were assigned to the “COVID-19 wards” found themselves immersed in a clinical routine completely different from everyday ophthalmology. On one hand, it was a question of regaining confidence with medical acts for which however we had been thoroughly prepared during the university studies, such as physical examinations of the chest and abdomen for example; but nevertheless also to learn acts that, as students before and ophthalmologists after, we had never practiced, such as administration of oxygen, management of noninvasive ventilation and interpretation of blood gas analysis of patients with severe interstitial pneumonia.

Some of us were assigned to support the COVID-19 research activities, led by a team of immunologists. The objectives were the creation of a biobank on COVID-19 and the study of the clinical characteristics of the patients, during the entire course of the disease. The biobank was to be used to better characterize the virus and understand its interaction with human tissues, the comprehension of which existing drugs were effective and the development of new ones. With this in mind, some of us had the task of physically taking samples collected from patients in the emergency department, in the intensive care units and in the “COVID-19 wards” to store them in a freezer and at the same time acquiring consent for their use for research purposes. On the other hand, the observational study on patients could have highlighted

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positive and negative prognostic factors and helped to identify the most effective therapeutic strategies. For this reason, a portion of us had to acquire each patient's data from medical records on a daily basis and fill in appropriate case report forms.

This last work in particular has provided us with a sort of overview of the emergency, albeit restricted to a single hospital. We personally saw how even patients who were our age or a little older could be infected and develop serious complications. Obviously, these cases impressed us the most, identifying ourselves with them. As evidence of this, one of us, two weeks after the beginning the research activity, developed a febrile syndrome and subsequently tested positive for SARS-CoV-2. As in the majority of younger patients, however, he did not develop significant respiratory symptoms, having no sequelae.

With the advent of May, the daily number of infected people has drastically reduced, leading to the end of the lockdown. After the most difficult phase of the emergency, my colleagues and I were able to gradually return to our work as ophthalmologists.

It was an experience that will remain forever engraved in our memory because nowadays no doctor could have imagined being moved from her/his "profession" to adapt to another type of work with a one-day notice; and no one will be able to forget the speed and the context in which this transitory transformation took place. However, the kind of pleasure we all felt in returning to our professional activities could only confirm the correctness of our choice: we are happy to be ophthalmologists.

Grazioli Moretti Alessio

Di Biase Carlo

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Capone Luigi

Gorgoni Francesca

Grosso Domenico

Nadin Francesco

Pederzoli Matteo

Bandello Francesco

Andrea

I remember, in late September 2019, entering a bookstore to buy Albert Camus's *The Plague*. As a third-year resident in infectious diseases, reading this book was for me a mixture of feelings; I focused on "the plague" not as the real bacterial disease, but as the allegory of the difficulties, we go through in our lives. I was far from thinking that, less than a year later, I would read it again comparing the fictional story to my personal experience.

I remember the first time I took care of a COVID-19 patient. I was assigned to be part of the staff of a brand-new ward, exclusively built up for the COVID-19 epidemic. I remember donning all the protective equipment: googles, mask, double gown, double pair of gloves.... Those strange gestures that would have become morning routine in the months afterward.

The patient was an 83-year-old man, coming from a long-term care facility with severe pneumonia; former farmer, big hands marked by a 50-year history of hard work. While we had been through the pandemic for a couple of weeks at that time, he was the first confirmed case of SARS-CoV-2 infection we admitted. During the visit, I remember the anxiety of dealing with the unknown features of a new disease, but also the reassuring power of an established working methodology: collecting medical history, performing physical examination, draw a sample for arterial blood gases, ordering lab tests. As a mechanism of defence against all the doubts and fears, we kept ourselves busy by

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collecting data, discussing new therapies, reorganizing our everyday activities, and above all by providing true support for these new types of patients: alone, frightened, without being able to see any relative. We, the healthcare workers, were literally the only human contact these people had for weeks, while being in their darkest moment. I remember the words of one of our nurses, whose eyes have witnessed AIDS pandemic and much more: “I have never seen patients so depressed in my whole life”.

When the true epidemic began, our ward—which was originally conceived for 10 beds—exponentially increased as the cases did: 12, 15, 20, 24 beds, all occupied by severely ill patients. I remember the fear of not being able to provide each with adequate care: unusual concepts for an infectious diseases resident, like noninvasive ventilation (NIV), rise time/EPAP/IPAP, prone positioning, immunomodulation drugs, just became everyday matters of concern and discussion. The whole country was shut down, hoping for a miraculous drug to relieve us all from that nightmare; COVID-19 was just everywhere, in every thought, in every word.

I remember the first 83-year-old patient going back home, healed. I remember the cheerful sensation of changing the valves of the Venturi mask, gradually taking the percentage of supplemental oxygen down to the final goal of 21%. I remember the gratitude of those who we have helped make it possible to go back to their relatives.

However, I also remember too many others, young ones and old ones, who were not so lucky. There were banners out of the windows in my street, while going to and from work during those months: “everything will be fine”. It sure was not, for too many families.

Months after that period and with the worrisome shadow of a possible second-wave on the horizon, I reassure myself by remembering the people I met during this period, friends and colleagues who lighted up the darkness of the pandemic’s days and that made me believe in Dr. Rieux’s words from *The Plague*: “there are more things to admire in men than to despise.”

Reflections:

- 1) Given the disproportion between need and availability of specialized resources to face a pandemic as well as any other disaster, we can count on our residents to give their contribution: in keeping with Omar, most of them will be “proud and glad to step up and share the burden”. To use Alessio’s words, they will be determined to join “a collective national effort in facing an unexpected and, in many respects, still unknown threat”. They will not miss “to ensure participation and diligence, forgetting personal fatigue and fears”, as Roberto says. Actually I believe it would have been a mistake to keep them out: they would have felt excluded from serving the community and from being what they actually are: doctors.
- 2) It will be a mistake even bigger in regard to our mandate to develop and train the next generation of physicians. In this sense, the SARS-CoV-2 pandemic represents a unique learning environment: residents have dramatically increased their knowledge, experience, skills and decision-making capacity. We can make them “better doctors than they were before” as it was for Dario. As it seems it has been for Valentina, who recognized that our “main focus is often the treatment of a disease and the physical healing of the patient, forgetting that we are in front of a suffering person, full of fears and worries. While facing up to their diseases and hospitalization, patients also need other types of attention: sometimes a smile or a word of encouragement can be enough to help them to feel less alone”. Being a good doctor is not just matter of being a good clinician, but also to reserve a “smile or a word of encouragement” to people caught “alone, frightened... in their darkest moment”, as Andrea says.
- 3) Nevertheless, we cannot leave our residents alone to face such “unfair” times. We have the responsibility to guide them through the fatigue of long shifts and sleep deprivation, excessive heat and dehydration due to personal protective equipment, uncertainty of diagnostics and treatment for an unknown disease, depersonalization of wearing a face mask, frustration for losing so many patients, for inhibiting them to be assisted and consoled by relatives and last but not least through the pressure represented by the fear to get the virus or to take it home to our loved ones. The example, the openness to discuss, the capacity to admit in front of them our own doubts and frailty will be the most important teaching and will turn this dramatic experience in an extraordinary learning experience.

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- 4) Actually we also have the challenge to convince them that we, as doctors, as healthcare providers, have the amazing power, to use Roberto's words, "to give back to the word 'emergency' its antique capacities, believing that something good could emerge even from a tragic period": we are capable to lighten up the dark days of patients and relatives, to make it possible for people who were apparently doomed to die to return home, to perform research to convert today's deaths into lives saved tomorrow.
- 5) History has proven that disasters are one of the forces behind evolution.¹² Natural and man-induced hazards play an active role in the morphology and evolution of past, present and future ecosystems, both natural and human.¹³ The constant battle between pathogens and their hosts has long been recognized as a key driver of evolution.¹⁴ Wars have been always a driver of human¹⁵ and in particular medical advances¹⁶. We have to consider ourselves to be at war against COVID-19. In addition, we have some very powerful allies: our residents. Second COVID-19 wave, be aware: if you do eventually arrive, you will find courageous captains and brave quartermasters.

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1. <https://www.euronews.com/2020/08/06/is-europe-having-a-covid-19-second-wave-country-by-country-breakdown>
2. Kurihara, H. & Bisagni, P. & Faccincani, R. et al. (2020). COVID-19 outbreak in Northern Italy: Viewpoint of the Milan area surgical community. *Journal of Trauma and Acute Care Surgery*. 88. 1. 10.1097/TA.0000000000002695
3. <https://www.nytimes.com/2020/03/12/world/europe/12italy-coronavirus-health-care.html>
4. <https://www.advisory.com/research/global-forum-for-health-care-innovators/the-forum/2020/03/italian-hospitals>
5. Zangrillo, A. & Beretta, L. & Silvani P, et al. Fast reshaping of intensive care unit facilities in a large metropolitan hospital in Milan, Italy: facing the COVID-19 pandemic emergency [published online ahead of print, 2020 Apr 1]. *Crit Care Resusc*. 2020;22(2):91-94
6. Faccincani, R. & Pascucci, F. & Lennquist, S. (2020). How to surge to face SARS-CoV-2 outbreak. Lessons learned from Lombardy, Italy. *Disaster Medicine and Public Health Preparedness*. 1-7. 10.1017/dmp.2020.64
7. Faccincani, R. Personal reflections of an emergency general surgeon on the COVID-19 pandemic. *Eur J Trauma Emerg Surg* **46**, 511–512 (2020). <https://doi.org/10.1007/s00068-020-01363-8>
8. https://www.ilgazzettino.it/nordest/padova/coronavirus_specializzandi_favoriscono_contagio_ospedale_polemica_scuse-5203860.html
9. https://en.wikipedia.org/wiki/Impact_of_the_COVID-19_pandemic_on_healthcare_workers
10. Kipling, R. (1897). *Captains Courageous*. New York. The Century Co. 1897
11. Faccincani, R. Message from the Advisory Council Chair. ESTES News 5. 2019
12. Toshikazu, E. & Shigenori, M. United theory of biological evolution: Disaster-forced evolution through Supernova, radioactive ash fall-outs, genome instability, and mass extinctions. *Geoscience Frontiers*, Volume 6, Issue 1, January 2015, Pages 103-119 <https://doi.org/10.1016/j.gsf.2014.04.009>
13. Laoupi, A. The socio-cultural profile of hazards. *Disaster Archaeology and the risk assessment of past catastrophic events*. Article assessed August 30th 2020 <http://www.drgeorgepc.com/DisasterArchSocCultLaoupi.html>
14. Enard, D. & Cai, L. & Gwennap, C. et al. Viruses are a dominant driver of protein adaptation in mammals. *eLife* 2016;5:e12469. DOI: 10.7554/eLife.12469
15. Strickland, J. Do wars drive technological advancement? <https://science.howstuffworks.com/war-drive-technological-advancement.htm> Article assessed August 30th 2020
16. Tobey, R. Advances in Medicine During Wars <https://www.fpri.org/article/2018/02/advances-in-medicine-during-wars/Article> assessed August 30th 2020

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Disaster & Military Surgery Section Meeting Minutes – June 29, 2020

17 people registered:

13 people attended: Frederic Rongieras, Mark Haverkort, Francois Pons, Piotr Koleda, Simon Herman, Stefan Leichtle, Miklosh Bala, Khalid Akhtar, Jonathan Tilsed, Manuela Walland, Itamar Ashkenazi Tankj Hofman, Amir Khorram-Manesh

Agenda:

1. Opening and welcome
2. Note taking
3. Approval of the agenda
4. Oslo ECTES 2021 update:
 - a. The Congress
 - b. The D&MS section program

The Oslo Congress 2021 will be very similar to that which was planned for 2020. As much as we are aware, there will be some space for new abstracts. We were asked, as the D&MS section, to take upon us the main burden and enable space within the sections' sessions for the COVID pandemic. This forced us to make some rearrangements, discarding some topics and arranging for one whole new session devoted to the COVID-19 epidemic. Since we are a surgical society, we have chosen surgically related topics.

Main points discussed:

- a. People whose abstracts were accepted for the 2020 congress will be able to present in 2021 if they wish so. All those whose abstracts were accepted for 2020 were approached by the congress organizers and those interested to present in 2021 will need to approve their participation by August 31st. Soon after that it will be decided whether there is space for more new abstracts to be submitted, and how many.
- b. The current working mode is that this will be a frontal congress if this is indeed possible. However plans are being made to enable a hybrid congress or online congress if necessary.
5. Current status of the initiative to give autonomy to humanitarian agencies and military representatives to decide on the contents of sessions in future programs.

When Roberto Faccincani and I were elected as chair and vice chair of the section, we started negotiating with the executive board for the possibility of having more autonomy in deciding the program for the section's sessions. Briefly, the scientific program of ECTES has been decided for years by a scientific committee comprised of the local organizers and members of the board. The sections' representatives suggested topics and possible speakers and the scientific committee had their final say regarding what would be included and what not and how. For two years we negotiated to receive more autonomy on the program, not only for us as chairs, but for specific members of the section. Specifically: we asked the executive board to enable members of each of the military organizations and humanitarian agencies to conduct one session (out of 4–6 allotted to us each year), in which they would decide on the pertinent topics and also the speakers. In return, they would each fund one speaker. Our plan was to start this as a pilot study in the Ljubljana ECTES congress and enlarge this autonomy in the future if the plan proved successful. We approached the different organizations last year. Members of the German Army were the only ones to return with a definite approval of the plan. Representatives of other national armies initially provided a favorable response, but nothing has progressed since. As much as the humanitarian agencies are concerned, MSF declined and ICRC never answered.

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As someone who conceived this idea and worked hard for it, I decided to proclaim it a total failure. We cannot proceed with this idea as long as we do not have the commitment of the different military organizations and humanitarian agencies. I am therefore returning the mandate concerning the two sessions to the board. This does not mean that we are closing our doors for possible cooperation in the future. It just means that we cannot commit to an idea, when the potential partners in question are not willing to commit themselves to it as well.

Main points discussed:

- a. There was a general agreement that such an attempt demands commitment on behalf of the parties involved. There was a request not to close this option altogether but to keep it as a viable option if the commitment does arise in the future.
 - b. The tension between representatives of the humanitarian agencies and the representatives of the military organizations which we all witnessed in the last section meeting was brought up. Those attending this section meeting thought it is important to emphasize, that in the end, all the section members, whether humanitarian or military surgeons, all have the same objective which is the optimal treatment of their patients. The whole idea behind this section is that it allows us to learn from each other so we can all perform better in the difficult environment where we might be working whether we are military surgeons or humanitarian surgeons (or both, depending on the circumstances).
 - c. The issue of the name of the section was discussed. It had been proposed in Prague to consider changing the name of the section from Disaster & Military Surgery to Global Surgery. This theoretically could involve both the humanitarian surgeons and the military surgeons within the section without giving undue emphasis to the background of the different members. However, changing the name is not something we can do lightly or quickly. The current section's name which emphasizes not only the military but also the disaster, also encompasses two [of three] parties currently involved in the section.
 - d. An alternative to what had been done in this pilot study would have been to approach NATO rather than individual national militaries.
6. Expert committees and other ventures in the field of military surgery and humanitarian surgery

Roberto Faccincani organized a round table at the Oslo congress which was supposed to discuss cooperation between different organizations in performing a cooperative study in the field of disaster medicine. We invite anyone wishing to lead any other initiative within the field of disaster/military/humanitarian/global surgery to use the section as a platform. The section has some power that could help facilitate multiorganizational projects.

Main points discussed:

- a. none
7. ESTES webinars

Jonathan Tilsed approached us with a recent project already running within ESTES. The society is planning to run a series of ESTES webinars. An experienced 'backstage' team has been set up and there are some webinar suggestions that will be running over the coming weeks. It has been suggested that each of the sections should also contribute to this series. Experience has shown that the key to success is to make these as interactive as possible and we have adopted the following formula to facilitate this: (1) a relevant clinical case is presented; (2) at key points during the case, participants in the audience are asked to choose management options in real time and the results of these polls are revealed; (3) the case is followed by a panel discussion during which the audience are invited to submit questions via a 'Q&A' link; (4) an invited speaker gives a 15-minute presentation on the topic; (5) this is followed by a short discussion; (6) the session ends with an update on the relevant literature. This formula should be used as a guide, but reasonable variance will be permitted! What ESTES needs from the Disaster & Military Section: a topic; case for presentation (and presenter); 3–4 panelists; invited speaker; list of key references. The organizers wish to have these preferably by July 31st.

The support team will do the rest.



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Main points of discussion:

- a. ESTES has a good platform for webinars that relies on the experience accumulated by SICUT. The first webinar will be next Monday and the plan is to run a webinar every two weeks. Many more webinars are being organized, most of them on orthopedic topics. Some emergency surgery webinars are being planned as well. The members of the section are urged to offer a topic for such a webinar.
- b. The legal issues of presenting patient data were discussed. It was emphasized that these should follow the EU's General Data Protection Regulation (GDPR) and these are very strict. All participants will need to sign consent.
8. Other topics: no other topics were raised.

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ESTES Emergency Surgery Section Meeting Minutes – June 26, 2020

via Zoom web conference – 11:00 CET

Attendance: 16 participants

Participants: Hayato Kurihara (HK), Gary Bass (GB), Shahin Mosheni (SM), Isidro Martinez Casas (IM), Miklosh Bala (MB), Luca Fattori (LF), Andrei Mihailescu (AM), Cristina Rey (CR), Dimitrios Damaskos (DD), Henrique Alexandrino (HA), Khalid Akhtar (KA), Luca Fattori (LF), Olga Rutka (OR), Tjarda Tromp (TT), Jorge Pereira (JP) and Michael Sugrue (MS).

Secretary: Manuela Walland (MW)

Chair: Jorge Pereira (JP), Portugal

Vice Chair: Michael Sugrue (MS), Ireland

Agenda:

1. Opening: JP welcomed the participants and thanked them for their availability.
2. Presentation of the actual committee member situation:

Active Members May 2019: 521; July 2020: 196 (updated)

Chair and vice chair maintain their positions for another year, as they were elected in 2019. Regarding the Committee's composition, Gary Bass, Beat Schnuriger, Shahin Mosheni and Marianne Vinbaer end their 3-year term. According to the bylaws, another 3-year mandate is possible if they are willing to proceed. To this end, JP previously questioned them by e-mail about their availability to continue. Gary, Shahin and Beat answered affirmatively. There was no response from MV. The remaining elements of the Committee maintain their positions since they were elected less than 3 years ago.

Committee 2019/2020

Chair Jorge Pereira (PT) 2019

Vice Chair Michael Sugrue (IR) 2019

Committee members Gary Bass (IR) 2017

Shahin Mosheni (SWE) 2017

Beat Schnuriger (SUI) 2017

Marianne Vinbaer (DEN) 2017

Luca Fattori (IT) 2018

Stefan Schulz-Drost (GER) 2018

Andrei Mihailescu (UK) 2019

Rifat Latifi (USA) 2019

3. Summary of activities developed:

a. Seven proposals were made for the Oslo ECTES, five accepted and two postponed. After cancellation of ECTES 2020 due to the COVID pandemic and the subsequent decision to postpone the Congress to the following year, the proposals and sessions remained in the new program:



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-
- i. Acute Cholecystitis—time to review our practice – 2020 – 2021
 - ii. Complicated Acute Appendicitis—get real – 2020 – 2021
 - iii. Bundles of Care in Emergency Surgery – 2020 – 2021
 - iv. Diverticular Disease—controversies in emergency surgery – 2020 – 2021
 - v. Improving Laparotomy Outcomes – 2020 – 2021
 - vi. Small Bowel Adhesions in the 21st Century – rejected/postponed
 - vii. Tertiary Peritonitis – rejected/postponed
- b. Simultaneously, according to the plan to prepare the scientific program of the congress one year in advance, talks began for the ECTES program in Ljubljana that would have taken place in 2021, now postponed to 2022. Seven proposals were made but have not yet been discussed in the organizing committee:
- i. Emergency Surgery Quiz
 - ii. Battle session: Acute Appendicitis: What is the best practice?
 - iii. Stomas in Emergency Surgery – The right way to do it
 - iv. Things That We Don't Learn in Medical School—NOTSS
 - v. Nightmare Fistulas
 - vi. Small Bowel Adhesions in the 21st Century
 - vii. Patient Optimization for Emergency Surgery
- c. The activities presented were developed using web tools provided by ESTES and through a WhatsApp group created to keep the committee members in contact more frequently.
- d. Development of a protocol to perform Snapshot on Acute Appendicitis, coordinated by committee member SM. Data collection will start in November. At this point, JP questioned SM about the pandemic's influence on the design of the protocol. SM replied that the protocol would keep the original idea since currently there are no recommendations for conservative treatment of appendicitis exclusively because of COVID-19.
- e. A group was created to develop guidelines for guidelines that have not yet progressed beyond the bibliography research phase.
- f. Noteworthy are the scientific productions and documents, made and published during 2019 and early 2020, associated with the Section:
- i. ESTES Educational Committee and Emergency Surgery Section Recommendations for emergency surgery during COVID-19 pandemic
 - ii. Self-reported and actual adherence to the Tokyo guidelines in the European snapshot audit of complicated calculous biliary disease. DOI: 10.1002/bjs5.50294
 - iii. Surgeon-performed point-of-care ultrasound for acute cholecystitis: indications and limitations: a European Society for Trauma and Emergency Surgery (ESTES) consensus statement. <https://doi.org/10.1007/s00068-019-01197-z>
 - iv. Congratulations to Matteo Marconi for his paper published in the *Italian Annals of Surgery* entitled: Not only FAST; The MUSEC® experience in training surgeons. PMID: 31815729. This work is not directly from the Section but represents scientific production based on activities that the Section helps to promote (MUSEC).
 - v. On this subject, MS talked about the snapshot paper and congratulated GB on the initiative and stressed its importance for the Section and ESTES.

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g. Although not organized by the Section, it is worth mentioning the several MUSEC courses that were held in 2019 and the ESC in Milan in February 2019, for the first time in Europe. Congratulations to HK for this achievement. HK replied that ESC was prepared to take place in Oslo, with 32 confirmed registrations but was, unfortunately, postponed. However, the team is ready to move forward to next year's ECTES.

h. Regarding the site, HK suggested that small presentations with about 2 minutes could be added to the site, in video or comments like short podcasts. These formats could be published on the ESTES YouTube channel and link them to the ESTES website and the Section's subpage.

4. EGS Registry at LUH:

MS introduced this project of a registration tool in emergency surgery, whose draft had been previously sent to the members of the Committee. He proposed sharing it with ESTES and have the approval to spread it among members of different countries so that they could use it. JP proposed to share the document with the members of the Section, the Advisory Council and the Executive board so that all could comment about its usefulness. The project may represent an added value in the study of the different types of care around Europe regarding Emergency Surgery and Trauma, at a more comprehensive level. JP referred to the need of a server to store the data collected. MS via chat (his internet connection was very poor) stated that the server will be provided by Donegal Clinical and Research Academy, and the possible publications resulting from that data analysis will be ESTES based. Moreover, the proposal is not intended for profit but only for sharing material and data for research. It is still a project in the making, a draft, but can be evaluated and eventually accepted as the registration recommended by ESTES.

5. Survey proposal involving ESTES:

MS previously sent two documents containing the survey proposals for evaluation by the Committee. At this time, MS was not connected, and JP proposed to share the two documents with the Committee to assess their feasibility. Later on, after reconnection, MS gave some clarifications on the subject. The surveys are part of the master's degree of 2 of MS's students. The intent to expand the scope and number of participants in the surveys is the main reason for ESTES' involvement, which MS stated, is relevant and necessary. MS said that both candidates would apply for membership of ESTES. The authorship of the resulting papers will include the Committee members and will be ESTES based. JP will forward the documents for the Committee's approval.

i. Survey of ESTES membership regarding the prevention of parastomal hernias, should include the use of a mesh in both elective and emergency surgery.

ii. Survey of ESTES membership regarding current practice in emergency surgery midline laparotomy closure

6. Election of the new Committee members:

a. First, anonymous voting was carried out to keep the three members of the Committee elected in 2017 who showed their willingness to remain one more term. IM proposed that Committee members who are not active and do not participate in the activities of the Section, should not have their term renewed and be warned of that. JP concurred.

b. The mandates of GB, SM and BS were renewed by a majority of votes, and MV term was ended.

c. The audience was asked to present a candidate to run for the free seat. HA proposed himself to replace the non-renewed member. Anonymous voting was then carried out, and HA was accepted for a 3-year term on the ESS Committee by the majority. HA took the opportunity to divulge a current ESTES Motivation Survey, organized by himself and Itamar, motivated by the recent decrease in the number of ESTES members. The survey aims to identify the causes of the members' growing disinterest in ESTES and try to point out a solution.

Committee 2020/2021

Chair Jorge Pereira (PT) 2019

Vice Chair Michael Sugrue (IR) 2019

Committee members Gary Bass (IR) 2017

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Shahin Mohseni (SWE) 2017

Beat Schnuriger (SUI) 2017

Henrique Alexandrino (PT) 2020

Luca Fattori (IT) 2018

Stefan Schulz-Drost (GER) 2018

Andrei Mihailescu (UK) 2019

Rifat Latifi (USA) 2019

7. Information:

ESTES webinars: JP presented a new format for science dissemination and teaching that ESTES is developing. JP learned of the project through Jonathan Tilsed (JT), who also requested the participation of ESTES ESS (unfortunately, he could not be present at this meeting for professional reasons). The format includes the interactive presentation of a case, followed by a discussion with a panel of experts in the field. After the presentation of the case, a guest speaker presents a 15-minute lecture on the topic. The webinar ends with an update on the relevant literature. ESS is invited to participate, having to perform the following tasks:

- i. Choose a topic
- ii. Choose the case for presentation
- iii. Choose and invite 3 to 4 panelists
- iv. Choose and invite the speaker
- v. Provide a list of relevant literature

The organizing team is ready to cover the remaining issues, namely the computer and technology needs. During the conversation with JT, JP put forward some possible topics, namely:

- Postoperative abdominal sepsis
- Soft-tissue infections
- Acute severe pancreatitis—when is surgical treatment definitely needed
- Cholecystostomy for severe acute cholecystitis in high-risk patients—is it worth it?
- Update on ultrasound for emergency surgeons—where do we stand?

JT said that they are ready to begin in July and he asked the Section to prepare one for the beginning of August. The intention is to hold one webinar every two weeks. JP asked for suggestions of topics and participants in order to organize this and other webinars. HK made an update, starting by saying that the first webinar had already been held on the 18th of June, in cooperation with the Italian Society of Trauma and Emergency Surgery. Tina Gaarder presented a trauma case. Mauro Zago, Diego Mariani and Alan Biloslavo are part of the webinar organizing team. HK recommended national delegates advertise the events among their national societies. HK plans to hold a webinar on peritoneal resuscitation in collaboration with MS. MS tried to give more information about this webinar. However, the connection was still weak, and it was impossible to understand what MS was saying. Another suggestion came from LF: to hold a webinar about abdominal closure after laparostomy. JP raised the question of the usefulness of webinars in August when there are many people on their annual leave. HK said it is an interesting question and replied that low live participation was not a concern because the idea was to record all the webinars for deferred broadcasting on another platform. The summer break can be harmful and lower the expected audience but it is necessary to move forward and keep a regular presentation to encourage people to watch. IM asked if there was any form of feedback from the audience,

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something like a survey, to assess the quality of the event and the most interesting topics. HK said there was a survey right after the webinar, answered by about 150 participants, just focusing on what they thought of the webinar and if they had any suggestions. DD mentioned on the chat to consider not overwhelming people with too many webinars as there seems to be a “zoom fatigue” because of the pandemic. HK said that it was expected that the number of participants may decline over time and that was why each webinar should be short but believes that it can be a tool to attract new generations of surgeons to the Society. JP stated that it is important to have a way to be able to watch or re-watch the webinars on-demand—a place where the webinars are deposited and accessible at any time. HK replied that ESTES’ YouTube account had been closed due to problems related to privacy and data protection, but that this problem would be solved shortly and the webinars will be accessible on that account.

b. Section members: IM pointed out the need to update the list of section members and requested that the WhatsApp group be available to members of the Section other than the Committee, to spread information on ongoing activities. HK agreed with this suggestion and suggested the use of Telegram application for that purpose. He added that the list of members of the Committee should be published on the ESTES website, possibly with each e-mail. He believes that doing so will improve communication between the members of the Section and the members of the Committee. MW stated that currently, the number of members was expected to be very close to 100. However, the numbers were inaccurate because of the transition from ESTES Belgium to ESTES Austria, and she would provide the correct number later (which she did and the number was added to point 2 of this report).

c. HK pointed out that MB is at the meeting and said that Israel has a very active surgical community committed in scientific dissemination in the area of trauma and emergency surgery. MB replied by stating that it was the first time he had participated in this type of meeting. He stated that in Israel, scientific societies have been conducting regular webinars for some time and are willing to maintain and strengthen cooperation with ESTES, offering their experience and know-how to improve the dissemination of knowledge.

d. HK made a final comment regarding the involvement of nurses in these activities and asked us to inform them and persuade them to participate.

8. Closing: JP thanked the participants, wishing all a lovely summer holidays. JP also thanked Manuela Walland for her work and monitoring of the meeting, allowing everything to go as planned. Her work and attention were essential for the success of the meeting.



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Skeletal Trauma and Sports Medicine Section Meeting – June 30, 2020

per video-conference

Report on ECTES 2021:

The sessions regarding our section were transferred to the next year's congress as planned in 2020:

1. State of the art in fracture care—the daily bread
2. Multiple rib fractures
3. Fractures in frail patients
4. Complex sports injuries
5. Limb reconstruction—the pendulum swings.

Currently, all speakers have confirmed their attendance for 2021.

Other sessions or guest symposia dealing with skeletal trauma are:

Polytrauma section:	Post trauma bone and soft tissue infection
EDUC:	How I do it: paediatric session
Polytrauma section:	New definition of major fracture?
AO trauma:	Multidisciplinary approach in open fractures and infections after ORIF
IOTA:	Pelvic injuries require a multidisciplinary approach
DGU:	Tibial head fractures
Gerhard Küntscher Society:	Failed nailing

Section activities:

Recommendations on proximal humeral fractures are in print.

Recommendations on cervical spine fractures, on thoracolumbar spine fractures, and on ankle sprains are work in progress. The responsible coordinators should present / report at the next section meeting.

As the Skeletal trauma and sports medicine section represents the major portion of ESTES members we are challenged to contribute appropriately to our society.

Upcoming general assemblies (GA):

All section members are asked to attend the GAs (held per video-conference) on July 11, 2020. The General Assemblies are crucial to secure the legal basis of ESTES in the future.

Intentions to change the bylaws:

During the past lock-down period according to COVID-19 there have been discussions (Advisory board, emergency surgery section, military & disaster section....) to change the bylaws in order to improve the attraction of ESTES.

The position of our section is that changing of bylaws is not a primary necessity at the very moment. Possible changes / improvements are to be discussed on a broad basis without pressure of time.

Richard Kdolsky

Chair,

Skeletal Trauma and Sports Medicine Section—ECTES

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Visceral Trauma Section Meeting – June 17, 2020

Zoom meeting from 8–10 pm, Wednesday June 17

1. *Welcome by the Chair of the VTS (Tina Gaarder)*

Short information about the history of the current VTS section, with Tina Gaarder elected as chair in 2017, and with all other section members having served more than their 2+2 years. Therefore, 8 new members were elected in 2018 after volunteering during the section meeting. Since only 8 offered to join, all were approved (3-year term), and Ruben Peralta was elected vice chair (2-year term).

The current VTS members are therefore:

- Tina Gaarder (Chair), Norway
- Ruben Peralta (Vice Chair), Qatar
- Luke Leenen, The Netherlands
- Falco Hietbrink, The Netherlands
- Paal Aksel Naess, Norway
- Alan Biloslavo, Italy
- Diego Mariani, Italy
- Shahin Mohseni, Sweden
- Henrique Alexandrino, Portugal

The plan was 3 webex section meetings in connection with EAC meetings. The first 2 were organized but no meeting has taken place during the Pandemic before the annual meeting.

2. *Approval of the minutes from the VTS section meeting 2019*

3. *Attendance*

A total of 34 attendees connected to Zoom.

4. *Approval of the Agenda*

The agenda had been sent to the members in advance with an email describing activities and aims for the section. No additional items for the agenda were added.

5. *Name of the section*

The question about the appropriateness of the name VTS has come up. There was broad agreement that there is a need for a section focusing on visceral, torso, non-orthopedic trauma. A short discussion concluded that visceral trauma includes torso trauma. Maybe there is a case for adding resuscitation or critical care to the name. This should be on the agenda for the Annual meeting in Oslo 2021.

6. *Membership status*

The VTS membership had increased from 428 to 435 in 2019, with 10 countries counting more than 10 members. The current number of active members with paid dues (2020) after transfer of ESTES to Austria is 158. The members will be reminded to pay their dues and confirm transfer of membership. Will get a more realistic picture in Oslo 2021.

7. *Activities last year*

- Program ECTES 2020: The visceral trauma section did develop great sessions for ECTES 2020 in Oslo, but the congress was cancelled due to the pandemic. Fortunately, the ESTES Board has decided to postpone ECTES Oslo to 2021, and all the VTS speakers have confirmed their attendance in 2021.



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Website: the VTS had—in 2019—created content published on the VTS homepage of the ESTES website.

- The VTS section with member information
- The mission and why a VTS section is justified and needed
- *Guidelines – the VTS section has published links to existing relevant guidelines. The guidelines should be regularly assessed for relevance. Gaps should be identified.*
- *Courses – the VTS section has published names and owners of relevant courses*

Plans for ECTES 2021: All activities pre-, peri- and postcongress have been reactivated.

However, the website is not active. The pandemic has urged most members to use social media more actively. There is a need for boosting trauma interest, recruiting interested younger surgeons.

- Diego has taken the lead in the VTS on this together with Gary Bass and Carlos (?)
- The plan is to create short blogs and use Twitter etc. to promote
- In addition, ESTES is about to start a series of webinars that will be run every 2 weeks (Mondays at 6 pm) and cover topics with a case and a state-of-the-art lecture
- VTS will provide topics for some webinars
- One will be held week 43 in cooperation with the Annual Surgical Week in Norway to promote ECTES 2021 and ESTES in Norway. VTS will be involved
 - Research/papers
 - The three statement papers about the trauma patients needs are being developed
 - The retrospective review of patients to put the failed spleen RCT in perspective will potentially include other centres from the VTS section.
 - Surveys: one current survey of the ESTES membership includes members of the VTS.
 - Other research projects – members of the VTS should have in mind that it is possible to recruit participating centers through the VTS.

8. *Plans for the upcoming year*

- *How do we produce output from the VTS?*
- *Social media – blogs and webinars*
- *Guidelines – To evaluate existing guidelines for relevance*
- *Research – submit statement papers*
- *Education – practical courses have been cancelled during the pandemic forcing alternative solutions. There is a need for a master class (one day) in trauma organization, case-based decision-making and CRM. Tina will circulate a proposal for framework for input. Goal – run the course precongress in Oslo 2021.*

We also need to discuss how visceral trauma competence is being secured in Europe, maybe also how we could contribute outside Europe and in cooperation with other societies.

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9. Elections VTS committee

Tina Gaarder has served as section chair for 3 years and her term ends 2021. All other committee members have been serving 2 years (3-year terms) including Ruben Peralta as Vice Chair (2-year term). Shahin Mohseni proposed himself as Vice Chair and Ruben Peralta volunteer to step down. Shahin Mohseni was then elected as the only candidate. Ruben Peralta volunteered to stay on the committee as ordinary member (3-year term). All other committee members have served 3 years in 2021. In order to secure continuity, Luke Leenen and Paal Naess volunteered to be replaced in 2021. According to the bylaws all sections should consist of 8 members in addition to the Chair and Vice Chair. Gary Bass was proposed and elected. Due to poor female representation, the 2 new members next year should be recruited among the female members of VTS.

10. Next business meeting and communication between ECTES conferences

- Fewer topics to address every time
- Invite all VTS members for a didactic lecture or journal club or case discussion for 45 minutes before 45 minutes section meeting
- When possible coordinate with relevant ESTES webinars (Mondays 7–8 or 8–9 pm)? Example Monday week 43 after webinar ending 8 pm
- Responsibility for didactic content will be rotated between the section members.

There might be a need for a meeting longer than the one hour annual meeting (mini-workshop) in Oslo during ECTES 2021. This will be discussed during the next TC. In the meantime, the VTS section plans to continue organizing Webex or Zoom updates but increase the frequency to every 2 months.

Tina Gaarder

Chair, VTS

June 17, 2020



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Announcements

Upcoming related congresses & courses

Emergency Surgery Course – ESC

October 1–2, 2020
Graz, Austria

56. Jahrestagung der ÖGU “Wirbelsäule”

October 1–3, 2020
Salzburg, Austria

11th World Congress for NeuroRehabilitation

October 7–10, 2020
Virtual Meeting

ESTES Webinar “The good, the bad and the ugly – challenges in visceral trauma management”

October 12, 2020
Virtual Meeting

ESTES Webinar “Management of stab wounds to the chest”

October 26, 2020
Virtual Meeting

ESTES Webinar “Unusual causes of small bowel obstruction”

November 9, 2020
Virtual Meeting

15. Jahrestagung der Deutschen Gesellschaft für Interdisziplinäre Notfall- und Akutmedizin (DGINA) e.V.

November 11–13, 2020
Wolfsburg, Germany

The International Conference Trauma 2020: Multidisciplinary Approach

November 13–14, 2020
Moscow, Russia

EVTM Workshop Australasia

December 1–2, 2020
Melbourne, Australia

1st Triennial Meeting IOTA 2020

December 2–4, 2020
Amsterdam, Netherlands

More congresses and courses to be found in the **ESTES events calendar** at
www.estesonline.org

European Society for Trauma and Emergency Surgery

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