

Surgical Oncology Resident Handbook 2009 - 2010

Division of Surgical Oncology
The Cancer Institute of New Jersey
UMDNJ-Robert Wood Johnson Medical School

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Overview

Cancer therapy has evolved over the last few decades such that most cancers require multi-modality therapy for appropriate treatment. Surgery of the breast, skin, soft tissues, endocrine system, liver, pancreas and gastro-intestinal tract for cancer as well as the field of surgical oncology are all primary components of the field of surgery. The modern surgeon must understand the basic principles of cancer risk assessment, screening and diagnosis. The surgeon must be adept at the primary surgical treatment of cancer and be familiar with cancer staging, adjuvant treatment and patient follow-up. The surgeon performing cancer related surgery must know when to operate and when to defer to other treatment modalities. End of life issues must also be dealt with in an appropriate and sensitive manner. The surgical resident rotation on the Surgical Oncology Service is designed to allow the resident to become familiar with the above concepts. Clinical conferences, attending rounds and formal lectures along with supervised patient care encounters in the clinic and OR are used to achieve this goal. The RWJUH Library will have three copies of the MD Anderson Surgical Oncology Handbook (4th edition) reserved for use by residents and students on the service. The information contained here is also available at <http://www.cinj.org/education/SurgOncEducation.html>.

New for 2009

Residents must wear professional attire to conferences, rounds and office hours. Scrubs covered by a white coat are not acceptable.

Attendance at office hours and conferences is mandatory. Residents are only excused for issues related to work hour restrictions.

Residents will attend GI Rounds, Breast Conference and Melanoma Conference.

Clinical Patient Care and Consults

Basic pager contact information for the attending surgeons in the Surgical Oncology Division is listed on the quarterly call schedule. Please do not hesitate to contact the surgeons for patient care concerns. It is better to call too often than to not call. The primary number for the Division is 732-235-7701 and for CINJ 732-235-6777.

Each attending surgeon covers his or her own patients and rounds daily during the week. The resident team must discuss the care of each patient every day with the responsible attending surgeon. On weekends and holidays, the on-call attending will usually round for the division and review the patient care plan with the team. Some surgeons will ask the team to contact them on weekends even if that attending is not on-call.

Consults to specific attending surgeons should be discussed with that attending. The attending has the option of accepting the consult or asking the on-call attending to accept the consult. Consults to the service in general should be directed to the on-call attending. A written attending on-call schedule is available at numerous sites throughout the hospital as well as in the Office of Surgical Education and the CINJ Intranet (which can be reached via the RWJUH Intranet) and at <http://www.cinj.org/education/SurgOncEducation.html>.

Conferences

Attendance at conference is mandatory. At the Tuesday 7:00 AM pre-operative conference, cases for the upcoming week are reviewed along with tumor stage and the rationale for surgery. Complications and interesting cases from the previous week are reviewed. The chief resident will discuss all complications and interesting cases in advance with Dr. August by the previous Friday. The chief will then assign one resident each week to review and distribute an article related to that complication or interesting case. This article in electronic format must be provided to Carol Brodzinski (brodzica@umdnj.edu) (732-235-8524) by 3:00 PM of the previous Friday.

An attending will also select an article in their area of interest for discussion. Both the attending article and the resident article will be available on the web site by Friday evening before the conference. The residents should read both articles and be prepared to discuss them. You must provide Carol with your UMDNJ e-mail address on the first day of the rotation. This will allow you to be contacted if there is a last minute change. The residents are responsible for checking their e-mail as well as maintaining the appropriate software to read the articles (usually Adobe Acrobat Reader) on the website.

Attending Rounds and Didactic Lectures

Following the pre-operative conference, the residents will attend tumor specific rounds or conferences to allow for discussion of specific surgical oncology issues using current cases as a basis for the discussion. A schedule of these conferences is posted on the website. Residents will make formal, evidence-based patient presentations at some of these conferences.

Didactic topics specific to Surgical Oncology will be covered in a three-year cycle during the Wednesday Resident Lecture Series. A schedule is available from the Office of Surgical Education.

Office Hours

Clinic attendance is mandatory and takes precedence over scheduled OR cases. This policy has been confirmed with the Program Director, Dr. Trooskin. This implies that some cases will go uncovered and an RNFA will be scheduled as assistants by the attending surgeon when appropriate. The clinic experience is designed to maximize the opportunity to evaluate new patients who will subsequently be seen again in the OR. Continuity of care is emphasized.

Each resident except the chief is expected to attend two half day clinics each week. A separate schedule of assignments is posted on the web page and would represent the usual or expected assignments. These may be modified from time to time by the chief resident to comply with work hour regulations.

Operating Room

The Chief Resident can use the pre-operative conference to plan weekly assignments to the OR. Please contact Dr. Eisenstat and Drs. Zinkin and Patankar directly for the Colorectal OR schedule. The Surgery Residency Review Committee requires that the resident see and examine the patient pre-operatively and document this event in the medical record. Almost all patients are admitted on the day of surgery. You must briefly examine the patient and review the indications for surgery. Then write a brief pre-operative note in the chart. Two to three sentences summarizing the situation and the plan are sufficient. Almost all Surgical Oncology Division patients will have a typed H and P available for your review. Please read it.

The development of DVT with subsequent pulmonary embolism (PE) is a dramatic cause of post-operative morbidity and mortality. RWJUH has undertaken a significant performance improvement effort to ensure that adequate prophylaxis is required. Many patients on the Surgical Oncology service have risk factors for DVT including:

- 1) age greater than 40
- 2) malignancy
- 3) abdominal and pelvic surgery
- 4) surgery greater than two hours duration

Patients with even a single risk factor (essentially all surgical oncology patients except young women undergoing breast biopsy) require prophylaxis with sequential compression boots. The resident is responsible for ensuring that these are applied and working before the induction of anesthesia.

Patients with multiple risk factors require double coverage with sequential compression boots and pre-operative anticoagulation for at least 7 to 10 days. Please check with the attending surgeon to see if a longer duration is required. Acceptable choices include:

Heparin (Unfractionated)	5000 units SQ TID
Dalteparin (Fragmin®)	5000 units SQ daily
Enoxaparin (Lovenox®)	40 mg SQ daily

The resident should confirm that pre-operative anticoagulation has been given and is ordered post-operatively. In certain circumstances (epidural catheter anesthesia), please check with the attending surgeons and anesthesiologist since a special protocol is followed.

RWJUH has focused on infection control as part of the performance improvement effort. All OR's have posted guidelines for pre-operative antibiotics. Please confirm that the antibiotic has been given prior to the incision. Prophylactic antibiotics should be discontinued by 24 hours after surgery.