Oncologic and Endocrine Surgery
Medical Student/Resident Handbook

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Goals
- Exposed residents and students to the multidisciplinary care of surgical oncology patients as well as management of breast and endocrine diseases.
Please refer to the goals provided by the residency program for each specific rotation (GI surgical oncology, breast/endocrine rotation)
## Division of Surgical Oncology Attendings

### Breast Disease / Cancer Surgery

<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Affiliation</th>
<th>Administrative Assistant</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Megan Baker Ruppel, MD, FACS</td>
<td>Associate Professor of Surgery Medical Director Comprehensive Breast Care Hollings Cancer Center</td>
<td>Katie Gracar</td>
<td>876-0179</td>
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<tr>
<td>David J. Cole, MD, FACS</td>
<td>Professor of Surgery McKoy Rose Professor and Chairman of Surgery</td>
<td>Dawn Hartsell</td>
<td>792-6194</td>
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<tr>
<td>Nancy De More, MD, FACS</td>
<td>Administrative Assistant: Katie Gracar</td>
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<tr>
<td>Rochelle Ringer, MD, FACS</td>
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<tr>
<td>Mark A. Lockett, MD, FACS</td>
<td>Associate Professor Vice Chair of Veteran Affairs</td>
<td>Beth Welch</td>
<td>876-0781</td>
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### Endocrine Surgery

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<th>Name</th>
<th>Title and Affiliation</th>
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<tr>
<td>Denise Cameiro-Pla, MD, FACS</td>
<td>Associate Professor of Surgery</td>
<td>Beth Welch</td>
<td>876-0181</td>
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### Melanoma / Sarcoma / Gastrointestinal / Hepatopancreatobiliary / Colorectal Surgery

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<tbody>
<tr>
<td>E. Ramsay Camp, MD, FACS</td>
<td>Assistant Professor of Surgery</td>
<td>Stacy Miers</td>
<td>876-4420</td>
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<tr>
<td>Name</td>
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<td>David J. Cole, MD, FACS</td>
<td>Professor of Surgery McKoy Rose Professor and Chairman of Surgery Administrative assistant: Dawn Hartsell 792-6194</td>
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<td>Associate Professor of Surgery Administrative Assistant: Stacy Miers 876-0179</td>
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<tr>
<td>Kevin Staveley-O’Carroll, MD, PhD, FACS</td>
<td>Alice Ruth Reeves Folk Endowed Chair of Clinical Oncology Professor and Chief, Oncologic &amp; Endocrine Surgery Medical Director of the Hollings Cancer Center Administrative Assistant: Stacy Miers 876-4420</td>
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**Division of Surgical Oncology Midlevel Support**

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<tr>
<th>Name</th>
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<tr>
<td>Denise Bradshaw, MSN, FNP-C</td>
<td>Clinical Instructor Dr. Carneiro-Pla</td>
</tr>
<tr>
<td>Laurrie Rumpp, RN, MSN/FNP</td>
<td>Clinical Instructor Dr. Camp, Dr. Kimchi, Dr. Staveley-O'Carroll</td>
</tr>
<tr>
<td>Brenda Toohey, MSN, APRN-BC, CBCN</td>
<td>Clinical Instructor Dr. Baker, Dr. Lockett, Dr. DeMore, Dr. Ringer</td>
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<tr>
<td>Jacqueline Eckert, PA-C</td>
<td>Clinical Instructor Dr. Cole</td>
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### OR and Clinic Schedules:

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<th>Clinic</th>
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<td>Carneiro-Pla</td>
<td>Camp</td>
<td>Camp</td>
<td>Baker</td>
<td>Camp</td>
<td>GI 8am-9am</td>
<td>Baker/ Cole/ DeMore</td>
<td>Staveley-O’Carroll</td>
<td>Carneiro-Pla NC specialty care</td>
<td>DeMore</td>
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<td></td>
<td>Carneiro-Pla</td>
<td>Camp HCC 2nd floor 8:30am-4pm</td>
<td>Lockett</td>
<td>Cole</td>
<td>Camp HCC 2nd floor 9am-1pm</td>
<td>Carneiro-Pla</td>
<td>Staveley-O’Carroll</td>
<td>Melanoma weeks 1 &amp; 3 HCC 120 7am</td>
<td>Kimchi</td>
<td>Staveley-O’Carroll</td>
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<td>HCC 2nd floor 8am-3pm</td>
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<td>Carneiro-Pla</td>
<td>Camp HCC 2nd floor 8:30am-4pm</td>
<td>Kimchi</td>
<td>Cole</td>
<td>Camp HCC 2nd floor 1pm-5pm</td>
<td>Carneiro-Pla</td>
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General guidelines for residents (for GI and Breast/Endocrine services):

**Service:** GI Surgical Oncology and Breast/Endocrine Surgery

**Primary Hospital:** Ashley River Tower (ART)/ Hollings Cancer Center (HCC)

**Morning rounds start:**

- **Time:** per Chief Resident
- **Location:** ART

**Attending Rounds:** Attending rounds are held at various times depending on the activities on the service. The housestaff or attendings will make you aware when rounds are beginning.

**Clinics and OR to attend:** You will rotate the schedule below on a weekly basis.

<table>
<thead>
<tr>
<th>Day</th>
<th>GI OR (Kimchi)</th>
<th>Endo OR (Carneiro-Pla)</th>
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<tbody>
<tr>
<td>Monday</td>
<td>GI OR (Camp)/</td>
<td>Endo Clinic (Carneiro-Pla)</td>
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<tr>
<td></td>
<td>Breast OR (Lockett)</td>
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<td>Tuesday</td>
<td>GI/Breast OR (Cole/ Baker)</td>
<td>GI Clinic (Camp/Kimchi)</td>
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<td>Wednesday</td>
<td>Breast Clinic (Baker/DeMore)</td>
<td>GI OR (Staveley-O’Carroll)</td>
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<tr>
<td>Thursday</td>
<td>GI OR (Camp/Kimchi/KSOC)</td>
<td>Breast OR (Baker)</td>
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**Service specific conferences which should be attended by third and fourth year medical students even on post call days. (Conferences in addition to the required department conferences):**

**GI Tumor Board:** Held on each Wednesday at 8am in conference room 120 on the first floor of Hollings Cancer Center

**Melanoma Tumor Board:** Held the 1st and 3rd Thursday of the month at 7AM at Hollings Cancer Center conference room 120

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Sarcoma Tumor Board: Held the 2\textsuperscript{nd} and 4\textsuperscript{th} Thursday of the month at 7AM at Hollings Cancer Center conference room 120

Breast Tumor Board: Held on each Thursday 8am-9am Hollings Cancer Center 121

Surg Onc/Breast/Endocrine Teaching Sessions: These sessions will be held different days of the week by Oncologic and Endocrine Surgery division faculty. The calendar is available at the surgical oncology website. Each attending will determine the format of their teaching sessions. These sessions are mandatory for all students and residents.

Operating room: We like to have students scrub in on as many of our cases as possible. We also, though, encourage you to see cases on other services when our service is “quiet” or when there is a case you need to see to fulfill a requirement for the course or when you find a case that interests you. Please make sure that the senior resident on the service know you are scrubbing on a case on another service. Also, let the resident know when that case has finished.

Patient Care: We expect you to follow 2 to 3 patients at the most on the floor. For those patients, we expect you to write a complete progress note daily. We also want you to present the case on rounds with the housestaff and to the attending on attending rounds. Follow those patients to the operating room and take responsibility for assuring that all labs, X rays, and other tests are completed and that you have read all the reports on this testing. Make sure that the attendings and housestaff are aware of any significant results or findings on your patients.

- Residents:
  - GI surgical oncology:
    PGY-5 and 2 PGY-1
    Director of the rotation: Dr. Carneiro-Pla
  - Breasts/ endocrine surgery:
    PGY-2.
    Director of the rotation: Dr. Carneiro-Pla
- Students: Usually two 3rd year medical students and occasionally a 4th year medical student.
  Director of the rotation: Dr. Camp

Routine of the services
1. All in patient rounding and notes should be completed prior to 7:15 am. Residents are expected to be in the OR room by 7:15 am each OR day. Residents are expected to contact the appropriate attending to run the patient list prior to starting the first OR case of the day or clinic schedule.
2. Residents are expected to contact the rotation director for any non-vacation time off requests from the service as well as to notify that director in the event that they are ill and unable to come to work. Residents are expected to notify affected attendings and team members regarding upcoming scheduled vacation or out of town meetings so that appropriate case and clinic coverage may be arranged.

3. Residents are expected to immediately notify the rotation director if they are unable to comply with the work hours regulations as detailed by the ACGME and the Department of Surgery or are at risk for a violation.

Rounds

The entire team (GI and Breast/Endo) should round in the morning on all patients at the time determined by the PGY-5. Data should be presented in an organized way and thoroughly reviewed by the team at the bedside each morning with the resident responsible for the patient signing the note written by the medical student. Every patient should have a note in the chart every morning signed by the resident. All patients should be examined each morning. It is the expectation of the service that the PGY 5 chief resident assign specific OR cases (GI Surg Onc and Breast/Endo) to the medical students for the following day so that they can prepare properly the night before.

1. The PGY 5 and interns are responsible for writing notes, orders and discharge instructions on patients from GI surgical oncology. GI surgical oncology consults should be addressed by the interns and PGY 5. PGY 2 should see consults only when available and free from Breast/endocrine duties.

2. The PGY 2 and interns are responsible for writing notes, discharge instructions and orders for the breast/endocrine service. The breast/endocrine consults should be addressed by the PGY 2.

3. Students are responsible for writing notes on their patients in the morning and presenting the case to the corresponding attending during rounds. Students are expected to know labs, complete history, surgeries, vitals, I/O of their patients.

Although the PGY 2 is also part of the GI surgical oncology team, the breast/endocrine rotation have priority over any other activity. If the PGY 2 resident is not engaged by the demands of Breast/Endo, they should join the GI Surg Onc team for activities such as clinic and OR.
Any and all residents are expected to respond to any patient emergency in any of the services.

Consults

There is a call schedule for surgical oncology which includes the GI surgical oncology attendings as well as breast and endocrine attendings. Every consult needs to be seen within 2 hours from the initial call regardless if emergent or not. A consult should be filled in EPIC and forward to the consulting surgeon at that time. The attending should be notified and the consult should be discussed at that time with the surgeons on call. As a guide to the residents, if the surgeon on call is not specialized on the area of the consult during weekdays and working hours, the attending on call will call the next person on call specializing in the area of the consult - such as GI surgical oncology consults to Dr. Staveley-O’Carroll, Dr. Camp, Dr. Kimchi; breast consults to Dr. Baker, Dr. Lockett, Dr. DeMore and Dr. Cole; and endocrine consults to Dr. Carneiro-Pla. If the next person on call on for that consult specialty is not in town, the attending on call will continue on in the call schedule for the next person.

Surgical consults which require an immediate or urgent operation should be directed to the attending on the call schedule for that day. If you have any question about who to contact, always start with the attending listed on call for that day.

Operating Room Experience

**GI surgical oncology:** The Chief Resident and interns will cover the cases at the ART OR

**Breast/Endocrine:** The PGY 2 will cover the breast/endocrine service covering cases at the ART OR. On Mondays the PGY 2 covers Dr. Carneiro-Pla’s cases and on the other days of the week, the Breast cases. On Wed, Dr. Carneiro-Pla’s cases will be cover by a student or PGY 1.

**Clinics:** The clinics schedule is shown on the table above.

**GI surgical oncology:** Chief resident and the interns should attend clinics for Dr. Camp, Dr. Staveley-O’Carroll, and Dr. Kimchi. The Chief resident is required to attend at least one of these clinics a week.

**Breast and Endocrine:** PGY 2 should cover the clinics of Breast/Endocrine if not on the operating room. The PGY2 is required to attend at least 2 Endocrine Surgery clinics (Dr.
Carneiro-Pla) and 2 Breast surgery clinics during their rotation (Dr. Baker, Dr. DeMore, Dr. Cole and Dr. Lockett).

When any of the residents are free from duties with Breast/Endocrine rotation, he/she should attend the GI surgical oncology clinic.

The students’ scheduled for clinics and OR can be found on the following link:

Pending

- **Teaching Conferences: (Coordinator: Dr. Carneiro-Pla)**
  1. GI/breast/endocrine:
     a. Weekly teaching session. Attending instructor, time and location are available on the link: PENDING. The attendance of these lectures is mandatory for all residents and students on the Oncologic and Endocrine Surgery rotation. Each attending uses a different formats, therefore ask your attending if a subject needs to be prepared for this lecture.
Orientation specific for the Breast Surgery Rotation: PGY 2

- **Meetings/Conferences:**
  1. PGY 2 Resident is expected to attend Multidisciplinary Breast Conference on Thursday from 7:30-8:30 in HCC 121.
  2. Residents are expected to cover breast cases in OR and attend breast clinic when not in the OR or teaching session (Cole, Baker, Lockett, DeMore).
  3. Residents are expected to arrange a one day shadowing experience with Dr. Jennifer Harper in radiation oncology. Resident should contact Dr. Harper via email and ask for her availability.
  4. Resident should then notify Breast attendings of the Rad Onc shadowing day and they will be excused from clinic duties for that experience.
  5. Likewise, residents are expected to shadow the breast imaging team in Mammo 3rd Floor of Hollings Cancer Center for a day and to notify attendings of their scheduled day. No prior notification required by the Breast Imaging Team.

- **Operating Room Experience:**
  1. Residents are expected to be in OR by 7:15 am.
  2. The resident is expected to read about the patient's history, preoperative workup, procedure to be performed, and pathology in question. Residents are expected to have reviewed an operative atlas as a means of preparation for operative technique.
  3. Resident may be responsible for dictating the operative note – attending specific. Please clarify with every case your responsibility for this task.

- **Floor Duties:**
  1. The resident will be asked the patient’s medical condition, overnight events, physical examination, laboratory findings and plan of care.
  2. The resident is expected to complete the medication reconciliation form, discharge orders, write the necessary prescriptions and print the discharge instructions from the clinical forms placing it in the chart at the end of the surgery.

  [https://www.musc.edu/cce/ORDFRMS/pdf/breastoutptdcorders.pdf](https://www.musc.edu/cce/ORDFRMS/pdf/breastoutptdcorders.pdf)
  [https://www.musc.edu/cce/ORDFRMS/pdf/mastectomydcorders.pdf](https://www.musc.edu/cce/ORDFRMS/pdf/mastectomydcorders.pdf)
3. Patients with 23 hour admission also need discharge summary.

4. For joint cases with plastics, residents will often need to coordinate care planning with the plastic surgery team to ensure appropriate in patient physical therapy consultation placement, activity restrictions, and follow up care plan. Patients undergoing tissue expander or implant reconstruction are typically admitted to Surgical Oncology whereas patients undergoing flap reconstruction are admitted to Plastic Surgery.

5. Team is expected to perform afternoon patient rounds and to report any concerns or findings to responsible attendings daily.

**Inpatient Breast Care Management Pearls:**

1. All patients who undergo mastectomy and or axillary lymph node dissection require an inpatient physical therapy consultation.

2. All patients with drains require an order for drain teaching and drain log provision in nursing notes.

3. Breast patients’ diet may be advanced aggressively as tolerated to facilitate prompt discontinuation of IV medications and IV fluids.

4. Patient who have undergone an axillary node dissection will need arm precautions (no IV sticks, blood draws, or BP recordings in that arm; this is part of order set in CPOE.)

5. Mastectomy patients should have received a soft cotton mastectomy bra preoperatively. If they have not, the Breast Cancer Nurse Navigator (Denise Kepecs or Jennifer Wood) should be contacted via simon page to assist.

6. All in patients will need a referral for Reach for Recovery (part of CPOE order set). This facilitates the paring of our patients with American Cancer Society resources.

7. Foley catheters when used are typically discontinued in the OR or shortly after arriving on the floor.

- **Required Reading:**

  [http://academicdepartments.musc.edu/surgery/education/resident_info/supplement/presentations/mayo1.pdf](http://academicdepartments.musc.edu/surgery/education/resident_info/supplement/presentations/mayo1.pdf)

  [http://academicdepartments.musc.edu/surgery/education/resident_info/supplement/presentations/mayo2.pdf](http://academicdepartments.musc.edu/surgery/education/resident_info/supplement/presentations/mayo2.pdf)
Breast Rotation Pre and Post written test:
All PGY 2 and PGY 4 residents are expected to take the breast surgery post test on the last Thursday of the 2 month rotation during the scheduled teaching session. This test is available to residents below as a tool to help guide their reading during the rotation. The same test will be administered at the close of the rotation. A minimum score of 75% is required to pass the test which is one of the requirements for passing the rotation.

Breast Surgery Rotation Pre/Post Test

Name: PGY:

1. What are common stimulants of breast pain and what is its work up for mastodynia?
2. What is the most common cause of bloody nipple discharge?
3. What is the diagnostic workup for blood nipple discharge?
4. What medications can be utilized to reduce risk for breast cancer?
5. What is the most appropriate imaging work-up for a palpable breast mass in a 40 yo female?
6. What is the most appropriate method to diagnose a breast mass suspicious for cancer?
7. What is the most common treatment recommendation for women with small <4cm unifocal invasive breast cancers?
8. What does that therapy entail?
9. Is there an alternative to this therapy and if so what is it?
10. Which ancillary studies do you order once you have confirmed a breast cancer diagnosis?
11. Describe the tissues removed with a total or simple mastectomy?
12. Describe the tissues removed during a modified radical mastectomy?
13. Describe the tissues removed during a radical mastectomy?
14. Describe the tissues removed with a skin sparing mastectomy?
15. Describe the tissues removed with a nipple sparing mastectomy?
16. Which genetic mutations are associated with increased risk for breast cancer?
17. While taking a family history, which other cancers are important to inquire about to determine risk of hereditary breast cancer?
18. Name an assessment tool that can be used to determine a woman’s risk for breast cancer?
19. What are the two classes of oral medication used to treat breast cancer and in what setting are they used?

20. What are the three classes of intravenous chemotherapy commonly used in the treatment of breast cancer that have been associated with improved overall survival?

21. Please list contraindications for breast conserving therapy?

22. Please list indications for post mastectomy radiation therapy?

23. True or False: it is safe to give breast cancer chemotherapy during pregnancy?

24. How do you determine if you have found all the sentinel lymph nodes?

25. What two medications can be used for sentinel lymph node injection and what is the most concerning side effect of each?

26. What should you do if a palpable breast mass in a woman over 35 years of age has no imaging correlate?

27. What is a concordance report and why is it important?

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**Orientation specific for Endocrine Surgery rotation: PGY 2**

- **Weekly schedule**
  - **Monday:** Full operating room day covered by PGY2
  - **Tuesday:** Rounds in the morning with Dr. Carneiro-Pla followed by full clinic day at Hollings cancer center, third floor, Cooper Pavilion.
  - **Wednesday:** Full operating room day covered by Student or PGY1.
Thursday: Endocrinology and metabolism grand rounds 8:00 on clinical science building on 8th floor endocrinology department followed by rounds with Dr. Carneiro-Pla.

Friday: Full day clinic in North Charleston specialty care if no operating room coverage is needed.

PGY2 is required to attend at least 2 endocrine surgery clinics/month during the rotation.

- Operating room experience:
  1. On Mondays, the PGY2 resident is expected to be in the operating room no later than 7:15 AM to position the patient after intubation, check endotracheal tube with bronchoscope, perform an ultrasound with possible fine-needle aspiration guided by ultrasonography and marked the patient's neck incision site.
  2. The resident is expected to read about the patient's history, preoperative workup, procedure to be performed, and pathology in question.
  3. Occasionally, the residents are asked to help with the dictation of the cases they perform. Example of the most common procedures can be found on the following links:
         - [Parathyroidectomy description](#)
         - [Total thyroidectomy description](#)
         - [Left laparoscopic adrenalectomy anterior approach](#)
         - [Right laparoscopic adrenalectomy anterior approach](#)

Rounds

4. The resident will be asked patient medical condition, overnight events, physical examination, laboratory findings and plan of care.

5. The resident is expected to call Dr. Carneiro-Pla 305-915-4469 if concerns.

6. Discharge summaries are now on EPIC. Please contact Dr. Carneiro-Pla if you don’t have the smartphrase for Endocrine Discharge Summaries. The Interns should complete the discharge summary on the chart and request for cosign to Dr. Carneiro-Pla. Please do not request cosignature for progress note. The PGY2 is responsible for the accuracy of these summaries by communicating the intraoperative plan to the interns.

7. Dr. Carneiro-Pla will do the medication reconciliation and discharge instructions before talking to the patients.

8. Standard approach for patients who underwent cervical exploration:
a. Evaluate patient’s neck in the afternoon after the procedure and on postoperative day one while the patient is sitting up.

b. All patients should have the cervical incision covered by an ice pack at all times with a washcloth to protect the skin.

c. All patients should have incentive spirometry.

d. All patients should have SCDs.

e. All patients should have the head of the bed elevated at least 30° at all times.

f. Patient should be instructed NOT to laydown flat or on their sides.

g. Discussed with Dr. Carneiro-Pla before giving narcotics or IV calcium. PGY2 and interns should make sure the night call team is aware of these guidelines.

h. Patients should NOT be placed on aspirin or anticoagulation without discussing with Dr. Carneiro-Pla.

i. Patients are usually seen in clinic the week after the procedure. Discussed with the attending day of the follow-up appointment.

j. The only medications requiring prescriptions upon discharge are Calcitriol (0.5 mcg po qd usually, 30 days and NO REFILLS), Synthroid on the dose order on postoperative orders) and ergocalciferol (50K U once a week for 6 weeks NO REFILLS).

k. Don't give IV calcium and narcotics without discussing with Dr. Carneiro-Pla first

- Required reading
  1. ATA_MTC_Guidelines_2009 medullary
  2. ATA_DTC_Guidelines_2009 thyroid nodule and thyroid cancer
  3. thy.2009 central neck dissection
  4. AdrenalGuidelines AAES
  5. The National Institutes of Health (NIH) Consensus Development Program Diagnosis and Management of Asymptomatic Primary Hyperparathyroidism
  6. Management of the Clinically Inapparent Adrenal Mass (Incidentaloma)

**Endocrine Rotation Pre and Post written test:**
All PGY 2 residents are expected to take the endocrine surgery post-test on the last week of the second month rotation during the scheduled teaching session. This test is available to residents
below as a tool to help guide their reading during the rotation. A minimum score of 75% is required to pass the test which is one of the requirements for passing the rotation.

Endocrine surgery post rotation test

Name: _____________________________________________________________________

Thyroid disease

1. Give 3 risk factors for well differentiated thyroid cancers:
2. Name 7 malignant tumors which can be found within the thyroid gland:
3. Which is the most accurate diagnostic test in the evaluation of a thyroid nodule?
4. Which thyroid cancers can be diagnosed with a fine-needle aspiration?
5. Which operative procedure should be used to treat the following patients:
   a. 60-year-old female with a 2 cm papillary cancer on the right lobe, no evidence of lymph nodes or lesions on the opposite thyroid lobe.
   b. 30-year-old female with medullary thyroid cancer measuring 3 cm on the left lobe with no evidence of malignant lymphadenopathy on preoperative ultrasound on bilateral lateral neck
   c. 55-year-old male with a 3 cm follicular carcinoma found on postoperative pathology of her right thyroid lobectomy.
   d. 45-year-old female with a mass adjacent to the trachea measuring 3 cm following total thyroidectomy and radioactive iodine treatment for papillary cancer. This patient has detectable thyroglobulin and atypical cells on fine-needle aspiration of this lesion
   e. 65-year-old female with a large anaplastic cancer causing airway obstruction
6. Which are the indications for thyroidectomy in patients with hyperthyroidism (name 4 indications)?
7. Which is the incidence of thyroid cancer in a thyroid nodule?
8. Which is incidence of false negative results during fine-needle aspiration?
9. Following total thyroidectomy for well differentiated thyroid cancer, which are the 2 most important therapies for these patients?

Parathyroid disease

1. How the diagnosis of sporadic primary hyperparathyroidism is confirmed?
2. Which are the indications for parathyroidectomy in patients with sporadic primary hyperparathyroidism?
3. Name 3 causes of secondary hyperparathyroidism in patients with end-stage renal disease:
4. Name 2 operative approaches used to treat sporadic primary hyperparathyroidism:

5. Which is the operative procedure of choice for patients with secondary hyperparathyroidism and end stage renal disease?

6. Which is the operative procedure choice for patients with multiple endocrine neoplasia 1?

7. Describe all the areas that should be explored intraoperatively when a parathyroid gland is missing:

8. Which are the tumors associated to multiple endocrine neoplasia 1?

9. Which are the tumors associated to multiple endocrine neoplasia 2A and 2B?

Adrenal disease

1. Which is the biochemical workup used to evaluate an incidentaloma?

2. Which are the biochemical and clinical differences between paragangliomas and pheochromocytomas?

3. Which is the management of pheochromocytoma?

4. Which is the management of an adrenal adenoma?

5. Described the management of a 6 cm incidentaloma:

6. How the diagnosis of primary hyperaldosteronism is made?

7. Which is the management of a 60-year-old patient with primary hyperaldosteronism and a right adrenal mass?

8. Which is the management of a 30 year-old female with primary aldosteronism and a 2 cm mass on the right adrenal and a 0.5 cm mass on the left adrenal?

9. Describe the steps of a left laparoscopic adrenalectomy using the anterior approach:

10. Describe the steps of the right laparoscopic adrenalectomy using the anterior approach:

11. Describe indications for adrenalectomy for a non-functioning adrenal mass:

12. When an adrenal mass biopsy is indicated?

Orientation specific for GI Surgical Oncology : PGY 1-5

- Tumor Boards:
  
  GI Tumor Board: HCC 120 every Wednesday at 4PM
  
  Melanoma Tumor Board: HCC 120 1st and 3rd Thursday 7AM.
Sarcoma Tumor Board: HCC 120 2nd and 4th Thursday 7AM.
Tumor Boards should be attended unless resident and students are in OR at that time.

Reading: Melanoma

Critical Topics:

1. Surgical margins-trials, AJCC staging, pathologic factors
2. Lymph node mapping
3. Lymph node dissection-techniques and complications
4. Limb perfusion-technique, results
5. Surgical treatment of metastatic disease
6. Ocular and anal melanoma
7. Adjuvant therapy results
8. Treatment of advanced/metastatic disease
9. Bioimmunotherapy

References:


Reading: Sarcoma

Critical Topics:

1. Pathology, classification, staging

2. Retroperitoneal sarcoma-surgical approach

3. Limb sarcomas

4. Advanced surgical techniques-forequarter, hemipelvectomy, limb-sparing

5. Limb perfusion trials

6. Chemotherapy for sarcoma

7. Radiation therapy for sarcoma

8. Surgery for metastatic disease

References:


Reading: Stomach

Critical Topics:

1. Diagnosis, pathology, staging of adenocarcinoma
2. Surgical techniques and extent of lymphadenectomy

3. Results of neoadjuvant and adjuvant therapy trials/studies

4. Gastric lymphoma and carcinoid

5. GIST—surgical and medical management

References:


Reading: Pancreas

Critical Topics:

1. Pancreaticoduodenectomy-advanced techniques
2. Surgical considerations for body tail tumors
3. Cystic neoplasms of the pancreas
4. Neoadjuvant and adjuvant therapy for respectable pancreatic adenocarcinoma
5. Treatment of locally advanced/metastatic pancreatic adenocarcinoma
6. Islet cell tumors

References:


Reading: Hepatobiliary

Critical Topics:

1. Surgical treatment for benign tumors
2. Screening, diagnosis, staging, and surgical issues for HCC
3. Transplantation for HCC
4. Treatment of advanced HCC-TACE, chemotherapy
5. Surgical treatment of colorectal cancer liver metastases
6. Neoadjuvant and adjuvant treatment results for colorectal liver metastases
7. Portal vein embolization-indications, results, techniques, complications
8. Hilar and intrahepatic cholangiocarcinoma-diagnosis, treatment, outcomes
9. Gallbladder cancer-staging, surgical issues, adjuvant therapy
10. Surgical treatment of non-colorectal cancer liver metastases

References:


Reading: Colorectal

Critical Topics:

1. Surgical approach-open vs. laparoscopic
2. Rectal cancer surgery-anatomy and techniques
3. Management of local recurrence of rectal cancer-extended resections, outcomes
4. Managing patients who present with resectable and nonresectable stage IV colorectal cancer
5. Screening, role of endoscopy in treatment
6. Genetics and familial syndromes-APC, HNPCC, and others
7. Results of adjuvant therapy trials for stage II and III disease
8. Chemotherapy options for stage IV disease
9. Role of radiation therapy in colorectal adenocarcinoma.

References:


