

bated in each province with respect to health care. For example, the limits of on-call requirements recently tested in the Quebec courts have created wide interest in other provinces faced with similar issues. Furthermore, from an educational viewpoint, a closer association can be mutually beneficial. For example, for the 2001 meeting, the Quebec Association of General Surgeons will forgo their usual fall meeting to join with the CAGS. This joint venture should pave the way for future cooperative efforts with provincial associations when the Canadian Surgery Forum goes to other provinces.

This year, the Canadian Surgery Forum will hold its first stand-alone meeting in Quebec City. For its first

year, it was fortunate to be able to unite the CAGS with the Canadian Society of Colon and Rectal Surgeons, the Canadian Association of Thoracic Surgeons, the Canadian Society of Surgical Oncology, the Quebec Association of General Surgeons, the James IV Association of Surgeons, the Surgical Biology Club, the Canadian Association of University Surgeons and the Canadian Undergraduate Surgical Education Committee. Next year the Trauma Association of Canada will join. It is hoped that other surgical societies will be attracted in the future and that one day all surgical forces in this country will share the same venue for their annual meeting, thus making it an unavoidable

event for every Canadian surgeon.

No doubt it will take a few years for this concept to mature, but already the Canadian Surgery Forum is creating much interest. The size of the meeting will permit the Forum to visit cities in every province in the future and to consider holding the meeting in resort locations. Corporate support for this type of meeting is also important. There is very positive feedback from corporate sponsors. They see this as a good way to simplify and rationalize their presence and to stage exhibits while maximizing their exposure to surgeons.

If this sounds like a nationalist plea for all surgical forces in Canada to unite for an annual scientific and social assembly ... it is! ■

SESAP Questions Questions SESAP

Category 6, Items 36 and 37

A 24-year-old man loses control of his motorcycle and hits a light pole. He is alert. Blood pressure is 118/70 and pulse is 120. On physical examination, a laceration of his perineum extends into the rectum and is bleeding profusely. There is pain and lateral movement with pressure on his iliac wings. Fluid resuscitation is initiated.

36. The initial operative procedure in this patient should NOT include

- (A) irrigation, debridement, and packing of the perineal laceration
- (B) diverting colostomy with distal colon washout
- (C) ligation of the hypogastric vessels
- (D) external pelvic fixation
- (E) exploratory celiotomy

37. Postoperatively, he has received six units of blood products and 4 L of crystalloid solution, but remains tachycardic and oliguric. The next step in management should be

- (A) pelvic angiography
- (B) intravenous furosemide
- (C) application of pneumatic antishock garment (PASG)
- (D) re-exploration with packing of the pelvis
- (E) abdominal computed tomographic (CT) scan

For the 2 incomplete statements above, select the answer that is best out of the 5 given for each item. For the critique of Items 36 and 37, see page 257.

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