

# Curriculum Vitae

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**Name:** **Marios Karaiskakis**

**Address:** **Office: 21A Stygos, 3117, Limassol, Cyprus**  
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**Personal:** **Birthday: 2/7/1967**  
**Marital status: Married with 3 children**

## **Education:**

### **Undergraduate work:**

1973-1979: Elementary school.

1980-1985: Pancyprian Gymnasium.

1985/86-1987: Military Service – National Guard

### **Graduate work:**

**1987/88 – 1994: *Medical school at Aristotelian University of Thessalonica.***

6/1994-6/1995: Pre-registration at Nicosia General Hospital.

11/1995 – 12/2000: Surgical trainee at Limassol General Hospital – Department of Surgery.

3/2000: Advance Trauma Life Support system.

**12/2000 – 3/2002: *International Research Fellowship on Trauma and Surgical Critical Care at the Department of Surgery, Division of Trauma and Critical Care, Keck School of Medicine, University of Southern California, Los Angeles, California.***

3/2002 – 7/2/2002. Rotation in Orthopedic Surgery – Limassol General Hospital.

7/2002 – 1/2003. Rotation in Vascular surgery – Nicosia General Hospital.

**2/2003: *General Surgeon – Athens University.***

### **Positions Held:**

1. 6/2014 – present. General Surgeon at Ygia Polyclinic Private Hospital
2. 6/2003 – 6/2014. General Surgeon at the Achillion Private Hospital.
3. 9/2004 – 7/2009. First Assistant Surgeon for the Cardiothoracic Department at the Lemosos Medical Center. Head of the Department was Dr. Omiros Artemiou Cardiothoracic Surgeon (on 7/2009 the Department was closed for financial reasons).
4. 7/2002 – 1/2003. Rotation in Vascular surgery – Nicosia General Hospital.
5. 3/2002 – 7/2002. Rotation in Orthopedic Surgery – Limassol General Hospital.
6. 12/2000-3/2002. International Research Fellowship on Trauma and Surgical Critical Care at the Department of Surgery, Division of Trauma and Critical Care, Keck School of Medicine, University of Southern California, Los Angeles, California.
7. 11/2000 – 12/2000. Rotation in Orthopedic Surgery – Limassol General Hospital
8. Surgical training for Specialty in General Surgery – Limassol General Hospital 11/1995-11/2000.
9. Pre-registration house officer 1994-1995 (6 months general surgery and 6 months general medicine) Nicosia General Hospital.

### **Areas of Concentration/ Research Interests:**

General Surgery  
Surgical Oncology  
Trauma  
Surgical ICU

### **Professional Associations**

<b>Organization/field</b>	<b>Title</b>
<i>Cyprus Medical Association</i>	<i>Vice – President</i>
<i>The Standing Committee of European Doctors (CPME)</i>	<i>Head of the Cyprus Delegation</i>
Limassol Medical Association	Member
Cyprus Surgical Association	Member
Cyprus Cardiothoracic Society	Member
Greek Trauma Society	Member

### **Languages:**

Greek – Fluent  
English – Proficient

## **Research & Publications**

*The most important time for research and most of my publications, took place during my Research Fellowship in USA – Los Angeles, California at the University of Southern California – USC – Keck School of Medicine, Department of Trauma & Surgical ICU, under the supervision of two great Doctors that I will always have in my heart, Prof. Demetriades D and Prof Velmahos G.*

### **Journal Articles**

#### **Role of postoperative computed tomography in patients with severe liver injury.**

Demetriades D, Karaiskakis M, Alo K, Velmahos G, Murray J, Asensio J.  
Br J Surg. 2003 Nov;90(11):1398-400.  
PMID: 14598421

#### **Effect on outcome of early intensive management of geriatric trauma patients.**

Demetriades D, Karaiskakis M, Velmahos G, Alo K, Newton E, Murray J, Asensio J, Belzberg H, Berne T, Shoemaker W.  
Br J Surg. 2002 Oct;89(10):1319-22.  
PMID: 12296905

#### **Nonoperative management of blunt renal trauma: a prospective study.**

Toutouzas KG, Karaiskakis M, Kaminski A, Velmahos GC.  
Am Surg. 2002 Dec;68(12):1097-103.  
PMID: 12516817

#### **Severe trauma is not an excuse for prolonged antibiotic prophylaxis.**

Velmahos GC, Toutouzas KG, Sarkisyan G, Chan LS, Jindal A, Karaiskakis M, Katkhouda N, Berne TV, Demetriades D.  
Arch Surg. 2002 May;137(5):537-41; discussion 541-2.  
PMID: 11982465

#### **Pelvic fractures in pediatric and adult trauma patients: are they different injuries?**

Demetriades D, Karaiskakis M, Velmahos GC, Alo K, Murray J, Chan L.  
J Trauma. 2003 Jun;54(6):1146-51; discussion 1151.  
PMID: 12813336

#### **Normal electrocardiography and serum troponin I levels preclude the presence of clinically significant blunt cardiac injury.**

Velmahos GC, Karaiskakis M, Salim A, Toutouzas KG, Murray J, Asensio J, Demetriades D.  
J Trauma. 2003 Jan;54(1):45-50; discussion 50-1.  
PMID: 12544898

#### **Pelvic fractures: epidemiology and predictors of associated abdominal injuries and outcomes.**

Demetriades D, Karaiskakis M, Toutouzas K, Alo K, Velmahos G, Chan L.  
J Am Coll Surg. 2002 Jul;195(1):1-10.  
PMID: 12113532

**Abdominal insufflation for prevention of exsanguination.**

Sava J, Velmahos GC, Karaiskakis M, Kirkman P, Toutouzas K, Sarkisyan G, Chan L, Demetriades D.

J Trauma. 2003 Mar;54(3):590-4.

PMID: 12634543

**Abstracts**

1: Br J Surg. 2003 Nov;90(11):1398-400.



**Role of postoperative computed tomography in patients with severe liver injury.**

**Demetriades D, Karaiskakis M, Alo K, Velmahos G, Murray J, Asensio J.**

Division of Trauma and Surgical Intensive Care Unit, Department of Surgery, Keck School of Medicine, University of Southern California, Los Angeles, California, USA. demetria@usc.edu

**BACKGROUND:** The role of postoperative computed tomography (CT) in asymptomatic patients with severe liver injury has not been investigated. The aim of the present study was to investigate the nature and incidence of significant liver-related abnormalities detected by postoperative CT in asymptomatic patients with severe liver injury. **METHODS:** This was a prospective study of survivors with severe liver injury (grades III-V) who were treated surgically. The patients underwent CT to evaluate the liver after operation, irrespective of symptoms. **RESULTS:** During the study interval there were 181 patients with severe liver injury, of whom 49 fulfilled the criteria for inclusion. The overall incidence of liver-related complications detected by CT was 49 per cent (necrotic areas in the liver in seven patients, seven bilomas, four abscesses, three perihepatic collections and three false aneurysms). In the subgroup of 17 asymptomatic patients CT revealed four abnormalities: two large bilomas, one false aneurysm and one fluid collection. Two of these patients required therapeutic intervention and the other two remained under observation.

**CONCLUSION:** In view of the incidence of asymptomatic significant liver abnormalities following operative management of severe liver injury, it is recommended that these patients undergo routine postoperative CT. Copyright 2003 British Journal of Surgery Society Ltd. Published by John Wiley & Sons, Ltd.

PMID: 14598421 [PubMed - indexed for MEDLINE]

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2: J Trauma. 2003 Jun;54(6):1146-51; discussion 1151.



**Pelvic fractures in pediatric and adult trauma patients: are they different injuries?**

**Demetriades D, Karaiskakis M, Velmahos GC, Alo K, Murray J, Chan L.**

Department of Surgery, University of Southern California, Los Angeles, USA. demetria@hsc.usc.edu

**BACKGROUND:** Many aspects of pediatric trauma are considerably different from adult trauma. Very few studies have performed comprehensive comparisons between

pediatric and adult pelvic fractures. The purpose of this study was to compare the incidence of pelvic fracture, the epidemiologic characteristics, type of associated abdominal injuries, and outcomes between pediatric (age  $\leq$  16 years) and adult (age  $>$  16 years) patients. **METHODS:** This was a trauma registry study that included all blunt trauma admissions at a Level I trauma center during an 8-year period. The incidence and severity of pelvic fractures, associated abdominal injuries, need for blood transfusion, and mortality in the two age groups were compared with the two-sided Fisher's exact test. Stepwise logistic regression analysis was used to identify independent risk factors for associated abdominal injuries in pelvic fractures in the two age groups. **RESULTS:** The incidence of pelvic fractures was 10.0% (1,450 of 14,568) in the adult group and 4.6% (95 of 2,062) in the pediatric group ( $p < 0.0001$ ). In motor vehicle and pedestrian injuries, adults were twice as likely and in falls from heights  $>$  15 ft seven times as likely as children to suffer pelvic fractures. However, age group was not a significant predictor of the severity of pelvic fracture. Only 9.5% of pediatric fractures and 8.8% of adult fractures had a pelvis Abbreviated Injury Scale (AIS) score  $\geq$  4. The incidence of associated abdominal injuries was high but similar in the two age groups (16.7% in adults and 13.7% in children,  $p = 0.48$ ). Motor vehicle crash, pelvis AIS score  $\geq$  4, and fall from height  $>$  15 ft were significant predictors of associated abdominal injuries in the adult but not the pediatric group. The incidence of associated gastrointestinal injuries was similar in the two age groups (5.3% in children and 3.3% in adults,  $p = 0.37$ ). The incidence of solid organ injuries was nearly identical in both groups (11.6% in children and 11.5% in adults). The need for blood transfusions and angiographic intervention was not significantly different between the two age groups. Exsanguination because of bleeding related to the pelvic fracture was responsible or possibly responsible in 42 deaths (2.9%) in the adult group and no deaths in the pediatric group. **CONCLUSION:** Pediatric trauma patients are significantly less likely than adults to suffer pelvic fractures, although the age group is not a significant risk factor for the severity of pelvic fracture. The incidence of associated abdominal injuries is high and similar in the two age groups. Motor vehicle crash, fall from a height, and pelvis AIS score  $\geq$  4 were significant predictors of associated abdominal injuries in the adult but not the pediatric patients. The need for blood transfusion is similar in both groups irrespective of Injury Severity Score and pelvis AIS score. The mortality resulting from exsanguination related to pelvic fractures is very low, especially in pediatric patients.

PMID: 12813336 [PubMed - indexed for MEDLINE]

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**3: J Trauma. 2003 Mar;54(3):590-4.**  **Abdominal insufflation for prevention of exsanguination.**

**Sava J, Velmahos GC, Karaiskakis M, Kirkman P, Toutouzas K, Sarkisyan G, Chan L, Demetriades D.**

Department of Surgery, Division of Trauma and Critical Care, University of Southern California Keck School of Medicine, USA. Jack.a.sava@medstar.net

**BACKGROUND:** Currently, traumatic intra-abdominal hemorrhage continues unchecked during transport and triage, and a simple technique of prehospital hemostasis might improve outcomes. The hemostatic effect of abdominal hypertension has not been studied. **PURPOSE:** To examine the effect of iatrogenic

abdominal insufflation on blood loss and hemodynamic performance after major abdominal vascular injury. **METHODS:** Following laparotomy, a 2.7 mm hole was created in the inferior vena cava of 10 anticoagulated pigs and controlled with a partially occlusive, laparoscopic vascular clamp. After abdominal closure the clamp was released and the pig was randomized to either control (n = 5) or immediate abdominal CO<sub>2</sub> insufflation at 20 cm H<sub>2</sub>O pressure (n = 5). Lactated Ringer's solution was used as needed to maintain a mean arterial pressure of 60 mm Hg. After 15 minutes of hemorrhage and hemodynamic monitoring, the animals were killed and blood loss measured. Mean blood loss was compared between groups using the Student test, as were final values for physiologic variables. Temporal changes in physiologic parameters were compared using analysis of variance. **RESULTS:** Mean blood loss was reduced by 61% in insufflated pigs versus controls (695 +/- 244 versus 1764 +/- 328 cc, p < 0.001). Compared with controls, insufflated pigs had significantly higher mean arterial pressure (64 versus 25 mm Hg, p < 0.001), end-tidal CO<sub>2</sub> (40.8 versus 17.8 mm Hg, p < 0.001), and pulmonary capillary wedge pressure (10.2 versus 5.8 mm Hg, p = 0.026) immediately before the pigs were killed. **CONCLUSION:** Iatrogenic abdominal insufflation significantly decreased blood loss and improved hemodynamics in a porcine model of traumatic venous hemorrhage. Iatrogenic abdominal insufflation may be useful in the prehospital management of abdominal injury.

PMID: 12634543 [PubMed - indexed for MEDLINE]

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4: J Trauma. 2003 Jan;54(1):45-50; discussion 50-1.



**Normal electrocardiography and serum troponin I levels preclude the presence of clinically significant blunt cardiac injury.**

**Velmahos GC, Karaiskakis M, Salim A, Toutouzas KG, Murray J, Asensio J, Demetriades D.**

Department of Surgery, University of Southern California, and the Los Angeles County and University of Southern California (LAC+USC) Medical Center, Los Angeles, CA 90033, USA. velmahos@usc.edu.

**BACKGROUND:** Uncertainty about the definition and diagnosis of blunt cardiac injury (BCI) leads to unnecessary hospitalization and cost while trying to rule it out. The purpose of this study was to examine whether the combination of two simple tests, electrocardiography (ECG) and serum troponin I (TnI) level, may serve as reliable predictors of BCI or the absence of it. **METHODS:** Over a period of 30 months (September 1999-February 2002), 333 consecutive patients with significant blunt thoracic trauma were followed prospectively. Serial ECG and TnI tests were performed routinely and echocardiography was performed selectively. Clinically significant BCI (SigBCI) was defined as the presence of cardiogenic shock, arrhythmias requiring treatment, or posttraumatic structural deficits. **RESULTS:** SigBCI was diagnosed in 44 patients (13%). Of 80 patients with abnormal ECG and TnI, 27 (34%) developed SigBCI. Of 131 with normal serial ECG and TnI, none developed SigBCI. Of patients with abnormal ECG only or TnI only, 22% and 7%, respectively, developed SigBCI. The positive and negative predictive values were 29% and 98% for ECG, 21% and 94% for TnI, and 34% and 100% for the combination of ECG and TnI. The admission ECG or TnI was abnormal in 43 of 44 patients with SigBCI. Only one patient had initially normal ECG and TnI and

developed abnormalities 8 hours after admission. Forty-one patients without other significant injuries stayed 1 to 3 days in the hospital only to rule out SigBCI and could have been discharged earlier. Besides ECG and TnI, other independent risk factors of SigBCI were an Injury Severity Score > 15, the presence of significant skeletal trauma, and history of cardiac disease. **CONCLUSION:** The combination of normal ECG and TnI at admission and 8 hours later rules out the diagnosis of SigBCI. In the absence of other reasons for hospitalization, such patients can be safely discharged.

Publication Types: Validation Studies

PMID: 12544898 [PubMed - indexed for MEDLINE]

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**5:** Am Surg. 2002 Dec;68(12):1097-103.

**Nonoperative management of blunt renal trauma: a prospective study.**

**Toutouzas KG, Karaiskakis M, Kaminski A, Velmahos GC.**

Division of Trauma and Critical Care, Department of Surgery, Keck School of Medicine of the University of Southern California, Los Angeles, California, USA.

Despite the abundance of literature on nonoperative management (NOM) of blunt trauma to the liver and spleen there is limited information on NOM of blunt renal injuries. In an effort to evaluate the role of NOM 37 consecutive unselected patients with renal injuries (grade 1, four; grade 2, 12; grade 3, 11; grade 4, six; and grade 5, four) were followed prospectively over 30 months (March 1999 to September 2001). Patients without peritonitis or hemodynamic instability were managed nonoperatively regardless of the appearance of the kidney on CT scan. Six (16%) patients were operated on immediately but only two (5.4%) for the kidney (grades 3 and 5 respectively). Of the remaining 31 patients 26 (84%) were managed successfully without an operation (grade 1 or 2, 12; grades 3-5, 14). Five patients were taken to the operating room after a period of observation (3, 3.5, 9, 36, and 44 hours respectively) but only three for the kidney (grades 4 and 5). The overall failure rate was 16 per cent (5 of 31); the rate of failure specifically related to the renal injury was 9.6 per cent (three of 31). Compared with the patients with successful NOM the five patients with failed NOM were more severely injured (Injury Severity Score > or = 15 in 80% vs 27%,  $P = 0.04$ ), required in the first 6 hours more fluids (4.17 +/- 1.72 vs 1.87 +/- 1.4 liters,  $P = 0.003$ ) and blood transfusions (2.40 +/- 2 vs 0.42 +/- 1.17 units,  $P = 0.005$ ), and more frequently had a positive trauma ultrasound (80% vs 11.5%,  $P = 0.005$ ). We conclude that NOM is the prevailing method of treatment after blunt renal trauma. It is successful in the majority of patients without peritonitis or hemodynamic instability and should be considered regardless of the severity of renal injury. Predictors of failure may exist on the basis of injury severity, fluid and blood requirements, and abdominal ultrasonographic findings and need validation by a larger sample size.

PMID: 12516817 [PubMed - indexed for MEDLINE]

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**6:** Br J Surg. 2002 Oct;89(10):1319-22.



**Effect on outcome of early intensive management of geriatric trauma patients.**

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**Demetriades D, Karaiskakis M, Velmahos G, Alo K, Newton E, Murray J, Asensio J, Belzberg H, Berne T, Shoemaker W.**

Department of Surgery, University of Southern California, Keck School of Medicine, Los Angeles, California, USA. demetria@usc.edu

**BACKGROUND:** Despite significant injuries elderly patients (aged 70 years or more) often do not exhibit any of the standard physiological criteria for trauma team activation (TTA), i.e. hypotension, tachycardia or unresponsiveness to pain. As a result of these findings the authors' TTA criteria were modified to include age 70 years or more, and a protocol of early aggressive monitoring and resuscitation was introduced. The aim of the present study was to assess the effect of the new policy on outcome. **METHODS:** This trauma registry study included patients aged 70 years or more with an Injury Severity Score (ISS) greater than 15 who were admitted over a period of 8 years and 8 months. The patients were divided into two groups: group 1 included patients admitted before age 70 years and above became a TTA criterion and group 2 included patients admitted during the period when age 70 years or more was a TTA criterion and the new management protocol was in place. The two groups were compared with regard to survival, functional status on discharge and hospital charges. **RESULTS:** There were 336 trauma patients who met the criteria, 260 in group 1 and 76 in group 2. The two groups were similar with respect to mechanism of injury, age, gender, ISS and body area Abbreviated Injury Score. The mortality rate in group 1 was 53.8 per cent and that in group 2 was 34.2 per cent ( $P = 0.003$ ) (relative risk (RR) 1.57 (95 per cent confidence interval 1.13 to 2.19)). The incidence of permanent disability in the two groups was 16.7 and 12.0 per cent respectively ( $P = 0.49$ ) (RR 1.39 (0.59 to 3.25)). In subgroups of patients with an ISS of more than 20 the mortality rate was 68.4 and 46.9 per cent in groups 1 and 2 respectively ( $P = 0.01$ ) (RR 1.46 (1.06 to 2.00)); 12 of 49 survivors in group 1 and two of 26 in group 2 suffered permanent disability ( $P = 0.12$ ) (RR 3.18 (0.77 to 13.20)). **CONCLUSION:** Activation of the trauma team and early intensive monitoring, evaluation and resuscitation of geriatric trauma patients improves survival.

PMID: 12296905 [PubMed - indexed for MEDLINE]

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7: J Am Coll Surg. 2002 Jul;195(1):1-10.

**Pelvic fractures: epidemiology and predictors of associated abdominal injuries and outcomes.**

**Demetriades D, Karaiskakis M, Toutouzas K, Alo K, Velmahos G, Chan L.**

Department of Surgery, Keck School of Medicine, University of Southern California, Los Angeles, USA.

**BACKGROUND:** Pelvic fractures are often associated with major intraabdominal injuries or severe bleeding from the fracture site. **OBJECTIVE:** To study the epidemiology of pelvic fractures and identify important risk factors for associated abdominal injuries, bleeding, need for angiographic embolization, and death. **METHODS:** Trauma registry study on pelvic fractures from blunt trauma. Stepwise logistic regression was used to identify risk factors of severe pelvic fractures, associated abdominal injuries, need for major blood transfusion, therapeutic

embolization, and death from pelvic fracture. Adjusted relative risks and 95% confidence intervals were derived. **RESULTS:** There were 16,630 trauma registry patients with blunt trauma, of whom 1,545 (9.3%) had a pelvic fracture. The incidence of abdominal injuries was 16.5%, and the most common injured organs were the liver (6.1%) and the bladder and urethra (5.8%). In severe pelvic fractures (Abbreviated Injury Scale [AIS]  $\geq$  4), the incidence of associated intraabdominal injuries was 30.7%, and the most commonly injured organs were the bladder and urethra (14.6%). Among the risk factors studied, motor vehicle crash is the only notable risk factor negatively associated with severe pelvic fracture. Major risk factors for associated liver injury were motor vehicle crash and pelvis AIS  $\geq$  4. Risk factors of major blood loss were age  $>$  16 years, pelvic AIS  $\geq$  4, angiographic embolization, and Injury Severity Score (ISS)  $>$  25. Age  $>$  55 years was the only predictor for associated aortic injury. Factors associated with therapeutic angiographic embolization were pelvic AIS  $\geq$  4 and ISS  $>$  25. The overall mortality was 13.5%, but only 0.8% died as a direct result of pelvic fracture. The only pronounced risk factor associated with mortality was ISS  $>$  25. **CONCLUSIONS:** Some epidemiological variables are important risk factors of severity of pelvic fractures, presence of associated abdominal injuries, blood loss, and need of angiography. These risk factors can help in selecting the most appropriate diagnostic and therapeutic interventions.

PMID: 12113532 [PubMed - indexed for MEDLINE]

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**8:** Arch Surg. 2002 May;137(5):537-41; discussion 541-2. ARCH SURG  
**Severe trauma is not an excuse for prolonged antibiotic prophylaxis.**

**Velmahos GC, Toutouzas KG, Sarkisyan G, Chan LS, Jindal A, Karaiskakis M, Katkhouda N, Berne TV, Demetriades D.**

Division of Trauma and Critical Care, Department of Surgery, University of Southern California and Los Angeles County/USC Medical Center, 1200 N State St, Room 9900, Los Angeles, CA 90033, USA. velmahos@usc.edu

**HYPOTHESIS:** For critically injured patients, a limited course of antibiotics is as effective as a prolonged course in preventing sepsis and organ failures. **DESIGN:** Prospective nonrandomized study. **SETTING:** Surgical intensive care unit (SICU) of an academic hospital with a level I trauma center. **PATIENTS:** A population of 250 trauma patients who required an operation and SICU stay of 3 days or more received antibiotic prophylaxis by 1 antibiotic for 24 hours (SHORT group, n = 133) or 1 or more antibiotics for more than 24 hours (LONG group, n = 117). **MAIN OUTCOME MEASURES:** Twenty-two outcome variables, including 9 conventional outcomes (eg, sepsis, septic shock, and organ failure) and 13 objective outcomes (days with temperature  $>$ 38.5 degrees C, days with white blood cell count  $>$ 14.0  $\times 10^3$ /microL, positive cultures, cultures with antibiotic-resistant bacteria, SICU and hospital stay, and death). **RESULTS:** The LONG group included more patients with orthopedic injuries (60 patients [51%] vs 52 [39%], P = .05) and orthopedic operations (47 patients [40%] vs 30 [23%], P = .003) than did the SHORT group. No other difference was identified in compared characteristics between the 2 groups. There was no difference in any of the examined outcomes except for a higher incidence of resistant infections in the LONG group compared with the SHORT group (59 patients [50%] vs 47 [35%], P = .02). Patients with resistant infections stayed in the hospital longer (mean  $\pm$  SD, 33  $\pm$  18 vs 15  $\pm$  11 days, P  $<$  .001) and had a higher mortality rate

(13% vs 1%,  $P < .001$ ) compared with patients without resistant infections. Prolonged prophylaxis by multiple antibiotics was an independent risk factor of resistant infection (odds ratio, 2.13, 95% confidence interval, 1.22-3.74;  $P = .008$ ).

**CONCLUSIONS:** The prophylactic administration of more than 1 antibiotic for more than 24 hours following severe trauma does not offer additional protection against sepsis, organ failure, and death, but increases the probability of antibiotic-resistant infections.

PMID: 11982465 [PubMed - indexed for MEDLINE]

### **Conference Presentations**

1. Management of the acute mesenteric ischaemia. An interesting case of protein-S deficiency. Limassol Medical association.  
M. Karaiskakis MD. 1996.
2. Etiology and management of the acute mesenteric ischaemic disease.  
2o Hellenic-Cypriot surgical conference.  
M. Karaiskakis MD. 1996
3. Etiology and management of the acute pancreatitis. A two-year prospective study at the Limassol General Hospital.  
Hellenic-Cypriot conference for pediatric and general surgery.  
M. Karaiskakis MD, M. Kakas FRCS, 1997.
4. Trauma management in Cyprus. Current conditions and plans for the future.  
3o Hellenic-Cypriot surgical conference.  
S. Stavrou MD, M. Karaiskakis MD, 1998.
5. New techniques for the inguinal hernia repair. A two years retrospective study at the Limassol General Hospital.  
3o Hellenic-Cypriot surgical conference.  
M. Hadjikosta MD, M. Karaiskakis MD, 1998.
6. Surgical management of thyroid diseases. A two years retrospective study at the Limassol General Hospital.  
3o Hellenic-Cypriot surgical conference.  
M. Hadjikosta MD, M. Karaiskakis MD, 1998.
7. Management of a multi-injured patient. An interesting case.  
Annual Trauma meeting at Pafos general Hospital.  
M. Karaiskakis MD. 1997
8. Management of a multi-injured patient. Liver trauma. An interesting case.  
Annual Trauma meeting at Pafos general Hospital.  
M. Karaiskakis MD. 1998
9. Management of a multi-injured patient. Liver trauma. An interesting case.  
Annual Trauma meeting at Pafos general Hospital.  
M. Kakas FRSC, M. Karaiskakis MD. 1998
10. Management of a rare disease - Pseudomyxoma peritonei. An interesting case.  
Limassol Medical association.  
M. Karaiskakis MD. 1999
11. Management of a multi-injured patient.  
Limassol Medical association.  
M. Karaiskakis MD. 1999
12. Cancer Registry. A software with complete information on cancer.  
4o Hellenic-Cypriot conference.  
M. Karaiskakis MD, 1999.

13. Surgical management of the unsuspected gallbladder cancer after laparoscopic surgery.  
4o Hellenic-Cypriot conference.  
M. Karaiskakis MD, 1999.
14. Management of the peritoneal surface malignancy using intraperitoneal chemotherapy and cytoreductive surgery.  
4o Hellenic-Cypriot conference.  
M. Kaks FRSC, M. Karaiskakis MD, 1999.
15. Penetrating heart trauma. An interesting case.  
Annual Trauma meeting at Pafos general Hospital.  
M. Karaiskakis MD, 8/2000
16. Management of a multinjured trauma. Presenting the events and management after a major bus accident.  
Annual Trauma meeting at Pafos general Hospital.  
M. Karaiskakis MD, 8/2000.
17. Toutouzas KG, Karaiskakis SM, Kaminski A, Velmahos GC. Non-operative management of blunt renal trauma: a prospective study. Annual Meeting of the Southern Chapter, American College of Surgeons, Santa Barbara, California, January 2002.
18. Sava JA, Velmahos GC, Karaiskakis M, Toutouzas KG, Sarkisyan G, Kirkman P, Demetriades D. Abdominal insufflation prevents exsanguinations following porcine vena caval injury. Society of University Surgeons Annual Meeting, Hawai, February 2002.
19. Demetrios Demetriades, MD, Ph.D, Marios Karaiskakis, MD, konstantinos Toutouzas, MD, Kathleen Alo, RN, George Velmahos, MD, Ph.D, Linda Chan, Ph.D. Pelvic Fractures: Epidemiology and Predictors of Associated Abdominal Injuries and Outcomes.

## **Other Scholarly Activities**

### **Conference Organizing**

I have participated in organizing various Conference like

- Limassol Medical Association Annual Conference
- Surgical Society Annual Conference

### **Editorial Boards**

Since last year I am participating in the Editorial Board for the,

- *Cyprus Medical Association Newspaper*
- *Cyprus Medical Journal (we are now in the process to submit our journal to PubMed)*

## **Experience**

### **Administrative**

- **Cyprus Medical Achievement Awards (CMA Awards).**

I am in the organizing committee Cyprus Medical Achievement Awards, something new for the Cyprus Medical society that we hope will give more respect to the medical profession.

- **Infection Control System (for the Ygia Private Hospital)**  
I am developing a Web Application under the supervision of the Infection Control Committee of the Ygia Private Hospital for registering and analysing all the infectious cases (Hospital and Non Hospital infections) trying to minimize the risks of severe infectious outbreaks.
- **Continues Medical Education – CME**  
As a member of the Scientific Committee of the Cyprus Medical Association, I participate in the evaluation process for CME rating the various conference in Cyprus.  
We are now in the process of developing a Web Application (to run as a SaaS Software) for the complete electronic management of the CME for our members.
- **eHealth & mHealth programs.**  
I represent Cyprus at the CPME Committee for eHealth & mHealth. The role of this committee is to study and suggest the rules and regulations for developing eHealth & mHealth applications. We are trying to suggest the minimum requirements.

## **Extra Curricular Activities**

### **Computer programming.**

#### **I love creating Websites (Medical websites).**

We have setup a Dedicate Server and we are now in the process to develop a Website to all our Scientific Associations as part of our service at the Medical Cyprus Association. We offer this as free or at a minimum cost (to cover our cost).

- **Website for the Cyprus Surgical Society (<http://www.cysurg.org>)**
- **Website for the Pathological Society of Cyprus (<http://cymed.org> - under Construction)**
- **Website for the Association of Private Doctors Cyprus (<http://cvenik.org>)**

#### **Web (Database) Applications (to run as SaaS Applications).**

On the other hand the Real Power of the Internet is to create and use Web Applications –i.e. Applications that run as SaaS Software. Applications that can be used from almost any computer been able to open a web browser. Is functioning on the Cloud and the information is held on the Cloud, so the user can use it from anywhere.

- **Web Application – Membership Management Software for the Cyprus Medical Association (running as a SaaS software). (<http://www.medical-data-center.org/DoctorsList2013/LoginMenu1.a5w>)**
- **Web Application - Electronic Management of Continues Medical Education (CME) for Cyprus Medical Association (running as a SaaS software). (<http://www.medical-data-center.org/DoctorsList2013/CMELogin.a5w>)**
- **Web Application – Infection Control System (for YGIA Private Hospital) (BETA) (running as a SaaS software). (<http://www.medical-data-center.org/Infection/>)**

### **Mobile Applications.**

This is the new era. Everybody now uses some form of mobile device (mobile phones and/or tablets). So I started designing and have already published (on Beta) applications for Android and iOS as well as HTML5 for windows devices.

- Google Play store  
(<https://play.google.com/store/apps/details?id=com.goodbarber.cyma&hl=en>)
- For iOS - Waiting for Apple validation
- Windows Mobile – HTML5 - <http://cyma.goodbarber.com>