ALS GBI
Association of Laparoscopic Surgeons of Great Britain & Ireland

ALS newsletter

Edited by Michael Rhodes

Editor's Introduction

Welcome to the Summer 2009 ALS Newsletter. The six months since the last newsletter have been very busy for the ALS. Our meeting in November 2008, which took place at the Five Lakes Hotel, Maldon, Essex, near Colchester, broke all records for attendance. 2009 promises to be just as busy with an excellent joint symposium with BOMSS at the ASGBI in Glasgow in May. In November, the main ALS meeting will be held at The River Centre, Tonbridge, Kent. The highlight will once again be the day of live operating with a packed programme and 4 separate hospitals contributing plus a live link to Hong Kong. In addition to our regular meetings the ALS has been very busy working with our colleagues at AUGIS and BOMSS to get the National Bariatric Database up and running. This went live on 1st January 2009. Entry of patients has exceeded our expectations with over 1600 patients entered in the first three months. We continue to try and provide this sort of resource to help surgeons with audit and data collection for revalidation and have started work on other databases. As always, I welcome contributions from our members to the newsletter and if there is a burning topic you wish to write about then please do submit copy to Jenny Treglohan, our Executive Officer at the College.

Finally I should like to take this opportunity to thank Covidien for sponsoring the production of the Summer Newsletter – we are all indebted.

Mr Mike Rhodes, Editor & ALS President Elect

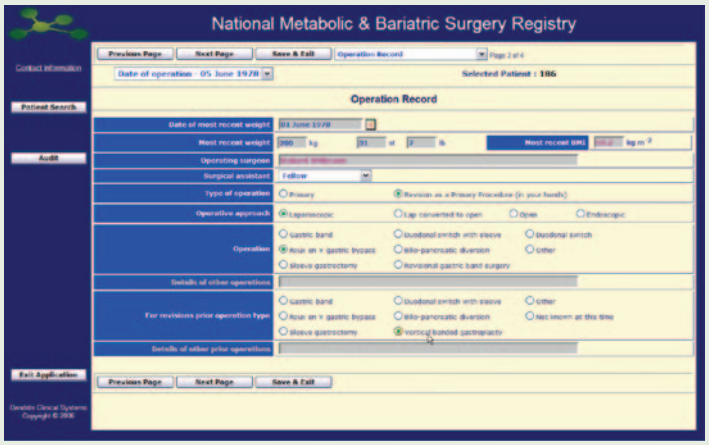
National Bariatic Surgery Registry

In the USA in 2007 over 200,000 bariatric operations were done, overtaking the rate of cholecystectomy for the first time. Here in the UK we have the most obese population in Europe, but our annual rate of surgery probably languishes in 30th or 40th place worldwide. If we are to see a similar explosion of bariatric surgery here, the surgical community has to be able to show to the public and NHS commissioners that we can collect outcomes data that match best international published reports. Thus the idea of a national bariatric surgery registry was born.

Writing, programming and setting up a registry is a big task. On the basis of their excellent track record, Dendrite Clinical Systems Ltd were commissioned by the ALS to do the programming. The resulting database is apparently easily the most complicated database they have constructed – not surprising really as there are 5 primary operations, multiple types of re-intervention and re-operation, and many different steps of logic. We have placed emphasis on ease and speed of data entry while still aiming to capture all clinically important interventions, complications and audit data relating to the in-patient episode.

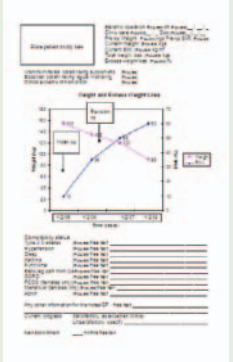
We have included gastric banding, Roux en Y gastric bypass, sleeve gastrectomy +/- duodenal switch, switch alone, bilio-pancreatic diversion and revisional band surgery. The procedures are grouped into primary and revisional (primary in your hands) surgery, and also revisional (eg for band to bypass conversion) and staged procedures (eg for planned sleeve conversion to switch or bypass). All the combinations of primary and subsequent operations are recordable separately for analysis, and hopefully no combination has been left out.

Operation record page



The printable clinic records shown here will chart weight and excess weight loss progression over time with index and subsequent operations linked to the initial weight record. Recorded comorbidity progression will be populated and a free text section will let the GP know if progress is as expected. We have included a 'DNA' audit box as well in the follow up record.

Clinic letter populated from follow up records



We have included basic comorbidity recording so that we can stratify risk in primary and revisional surgery according to age, sex, BMI, history of DVT/PE etc. This will enable us to compare the risk of our NHS population to international data, and perhaps verify the suspicion that many patients are much higher risk than international series would predict. As revisional surgery is recorded separately, this too will be analyzable separately for risk stratification.

article continued on page 2

2009 Travelling Scholarship winners

Ethicon Endo-Surgery (David Dunn) Travelling Scholarship

Mr Ioannis Virlos
MBBS MD MSc FRCSEd FRCS (Gen Surg)

B Braun Aesculap Travelling Scholarships

Ms Emma Bromwich MBChB FRCS (Urol)
and Mr Haris Khwaja DPhil MRCS (Eng)

DATE FOR YOUR DIARY

ALS Annual Scientific Meeting

One Step Beyond

The prevention and treatment of complications of laparoscopic surgery

An International Live Surgery & Academic Conference

The River Centre, Tonbridge, Kent UK • 26 & 27 November 2009
Visit www.alsgbi.org/kent for full information

ALS COUNCIL 2009

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ALS Representative at European Association of Endoscopic Surgeons
Professor Roger W Motson

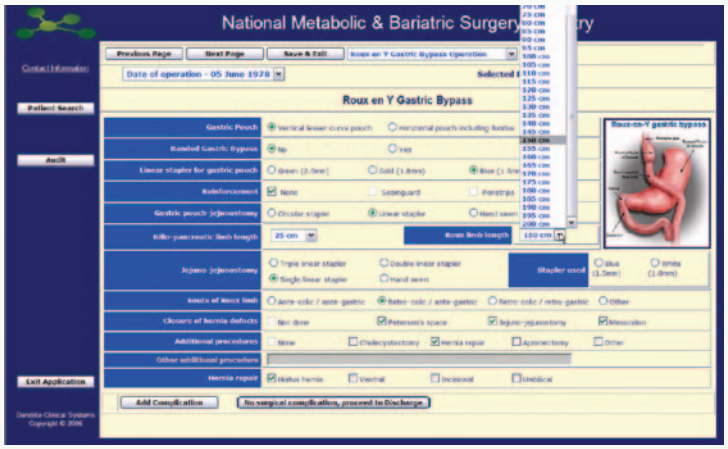
ALTS Representative
Mrs Jane P Bradley-Hendricks

Deputy ALTS Representative
Ms Alice E Jones

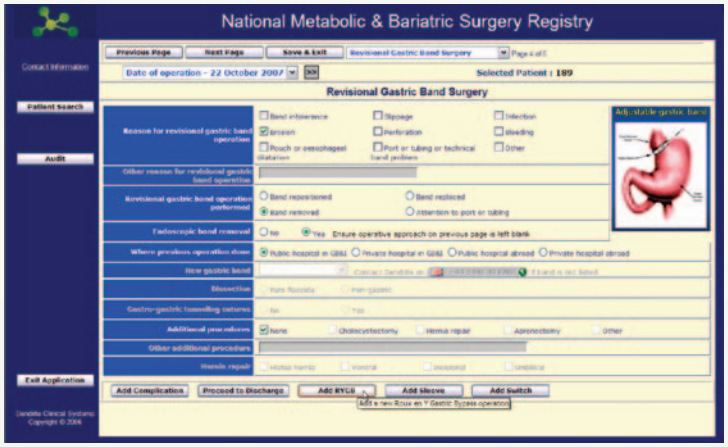
Editorial Secretary
Mr Mike Rhodes

Patients are identified by date of birth and operation date and all data can be entered real-time or later by nurse specialists from pdfs collected in the pre-assessment or follow up clinics. Hover prompts give definitions for each choice when there could be doubt about whether to tick the box, and to guide specialist nurses (and surgeons). For instance, statin therapy isn't included as an indication of, or proxy for, hyper-lipidaemia since so many patients are on 'routine' statins. In beta testing, the initial record can be completed in about 5 minutes, and the same for follow up.

Gastric bypass page – the data populates the printable operation note



Revisional band surgery page

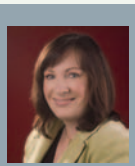


All individual unit data will be known only by that unit and the database committee, who will produce annual reports in the public domain. The committee is formed equally by ALS, AUGIS and BOMSS and is chaired by the BOMSS representative.

Data are free to enter for members of the 3 societies. Let's see how quickly we can overtake cholecystectomy (and the colorectal surgeons) in the UK and establish bariatric surgery for not only having the biggest patients but also the largest volume of surgery in the UK.

Contact Dendrite for individual logins on 01491 411288 or info@e-dendrite.com

Richard Welbourn www.nbsr.org.uk



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The 2008 Annual Scientific Meeting: Back to the Future

20 & 21 November 2008

The 2008 Annual Scientific Meeting for ALS kicked off on Wednesday at the Iceni Centre at Colchester General Hospital with the ASiT Training day. The event was kindly sponsored by Ethicon Endo-Surgery. The day was very well attended by a group of enthusiastic trainees who were treated to a range of lower and upper GI laparoscopic topics and given hands on simulator instruction on advanced laparoscopic techniques.

The main meeting began on Thursday. Proceedings were opened by our President, Mr Mike Parker and local host Professor Roger Motson. Mr Gordon Mackinlay from Edinburgh gave an overview of the contribution of laparoscopic surgery to neonatal surgery and then introduced Mr Fraser Munro who gave an elegant demonstration of a fundoplication in a young child suffering severe reflux disease. The majority of the audience were adult surgeons who were slightly envious of the absence of abdominal fat and the clean planes of the paediatric patient. A brief coffee break led onto the remaining morning of laparoscopic vascular surgery. Mr Keith Poskett introduced Professor Marc Coggia, from Paris, who with Mr Adam Howard, from Colchester, performed a superb abdominal aortic aneurysm repair with an aorto-bifemoral graft. The auditorium was packed and everyone was relieved to know that the patient was going to be able to ejaculate afterwards. The case demonstrated the difficulties facing the laparoscopic surgeon and Professor Coggia gave an adept demonstration of his laparoscopic prowess in overcoming these problems while continuing to teach the operating surgeon (Mr Adam Howard) and the audience how to join a graft to a soggy tube of porridge. Sadly the link to Chicago failed but in the afternoon Professor Roger Motson entertained us all with a laparoscopic anterior resection. The delegates then gave audience to The Lord Darzi who talked about laparoscopic surgery in the new NHS. The day's programme was brought to a close by Dr Alexander Rosemurgy from Florida talking about and illustrating the role and potential of Single Incision Laparoscopic Surgery.

The Conference Dinner included the presentation of the David Dunn Medal to Ms Michelle Slater. The after dinner entertainment set the mood up for most to have a memorable night. Many delegates and wives tried to stay up all night in the bar after but all failed, the last passing out about 04:30.

An early start the following morning saw the abstinate and hepatitic arrive for the 'Meet the Experts' sessions. Delegates were then joined by the more bleary for the morning session of scientific papers. All were of high quality and often exciting some intense discussion.

Professor Joel Leroy gave a guest lecture on his vision of the future of surgery for colorectal cancer and was followed by the BJS Lecture delivered by Dr Sam Giday, one of the current pioneers of NOTES, who brought the audience up to date with progress in this field.

The somewhat mundane business of the AGM was followed by a far more exciting lecture by Edwin Jesudason about the role of minimal access surgery in the fetus and neonate. The afternoon paper and DVD session completed the scientific section. The David Dunn Medal was selected from the papers presented and after the Industry Partners presentations the prize winners for the poster/papers and DVDs were announced.

The meeting was closed by Mr Mike Parker and Professor Roger Motson who thanked all involved and recommended next year's meeting in Tonbridge.

Mr Don Menzies
Honorary Treasurer

Advanced Laparoscopic Surgery Course

Wednesday 19 November 2008

There is now a long running partnership between ASiT and the ALS and, as in previous years, this included a laparoscopic training course for trainees at the ALS Annual Scientific Meeting in Colchester. This year the course was run as an Advanced Laparoscopic Surgery course and was convened by Mr Tan Arulampalam and Ms Jo Reed at Colchester General Hospital. As a surgical department that aims to perform the vast majority of its elective and emergency workload laparoscopically and with a strong tradition in education, through the Iceni Centre, it proved to be an ideal location to run such a course.

The organisers hoped to start the course with a live link to theatres to join Professor Roger Motson as he performed an elective right hemicolectomy. Unfortunately the anaesthetist chose to cancel the patient on the day of surgery, but the show had to go on and Professor Motson instead transferred an emergency, obstructed patient onto his list. If we had not been told, the delegates would not have known any different. The patient had been adequately decompressed with a nasogastric tube and Professor Motson, with his usual flair, and ably assisted by Mrs Jane Bradley-Hendricks proceeded to show how simple the operation can be in the right hands. Meanwhile, in the lecture theatre the live feed was backed up by Mr Ralph Austin and Mr Matthew Tutton who turned the room into a 'virtual abdomen' to demonstrate in 3D the technique and approach to this operation.

After lunch attention was turned to upper GI surgery as Professor Motson and Mr Don Menzies held a masterclass in approaching the difficult laparoscopic cholecystectomy, backed up with some scare stories explaining why, in Colchester, every patient undergoes an on-table cholangiogram. We were then handed over to Mr Peter Sedman, the lead tutor in minimally invasive surgery at the Royal College of Surgeons of England, who led a simulator session focussing on suturing. Those with experience were forced to be ambidextrous for the afternoon and practice with their non- dominant hand and we all watched our dexterity develop during the session.

Overall it was a very rewarding and confidence building day. We received a standard of training that one would expect from such a renowned centre. It bodes well for the opening of the new ICENI facilities due to open in Colchester later this year. On behalf of all the delegates on the course, I would like to thank every member of the faculty for all their help and the benefit of their expertise. I would also like to thank Karl Storz and Ethicon Endo-Surgery who sponsored the course and funded the delegates' entry to the conference.

Mr Will Hawkins
ALS Trainee Representative and Honorary Secretary of ASiT

ALTS Meeting – Back to the Future

This was the second time that Colchester had hosted the meeting. The last time was in 2000 which was pre Association of Laparoscopic Theatre Staff (ALTS). In fact it was at this meeting that Ms Sue Yelland and Ms Carol Clark hatched the plan that was to become ALTS. It was the first time that they had been to a surgical meeting and realised the great opportunity available for some multidisciplinary team learning.

In 2000 the ALS (or AESGBI as it was then) was a much smaller organisation, and therefore holding it at the hospital was a reasonable option: although for those of you that remember the marquee you may not agree with that!

As the ALS has become such a big organisation it now has to be held in a purpose built conference facility. This can be difficult as trying to adhere to the ethos of moving the meeting around the country can prove problematic as some towns and even cities cannot accommodate the numbers of delegates and exhibitors. We were very fortunate to have the facility of the Five Lakes Hotel in our vicinity so we were able to avail ourselves of the excellent conference facility there, although a few more bedrooms would have been appreciated as there was much bedroom swapping going on to try and accommodate everyone!

The meeting started a year ago for us, with the planning and we had regular weekly meetings to try and keep everything running smoothly. We tried to be innovative and cover topics that had not been covered in the recent past and introduce some new themes that we hadn't touched on at all in the past. The meeting was extremely well attended with more delegates registered a month before the meeting than ever before.

The format for the meeting was the same as before with live operating on the Thursday and this was from a variety of locations. The day commenced with a paediatric nissen fundoplication from Edinburgh this was followed by a laparoscopic aortic aneurysm repair performed in Colchester by Professor Marc Coggia from Paris who was working with the home vascular team, Mr Adam Howard and Mr Chris Backhouse. This was a challenging case and took approx 4 hours. Unfortunately the robotic pancreatic case from Chicago did not happen as their firewall would not let us dial into them. Then there was an excellent demonstration of a lap assisted anterior resection by Professor Motson. The last session on Thursday was a presentation from The Lord Darzi titled 'Laparoscopic Surgery in the New NHS': this was an informative and thought provoking talk.

The day was rounded off nicely with a drinks reception in the exhibition area and then onto dinner. This was extremely well attended and all in all was an excellent evening with lots of entertainment! This culminated in some of us going to bed very late or very early in the morning depending on your interpretation of the time!

Friday kicked off with a session on anaesthesia in laparoscopic surgery, given by one of the local consultant anaesthetists Mr Andrew Eldridge. We then joined the main arena for a very informative talk delivered by Professor Joel Leroy titled 'Vision of the future of surgery for colorectal cancer' The next session was also a joint session with the ALS on the very topical subject of 'NOTES'. The afternoon kicked off with a fascinating lecture about minimal access paediatric surgery, from fetus to child. This was an incredible talk and extremely interesting.

We then decamped upstairs for a vascular session focused around minimal access vascular surgery looking at EVAR and lap assisted aneurysm repair and the theatre set up for these procedures. This was delivered by the home team, Mr Adam Howard, Mr Sohail Choksy and Ms Rebecca Drane.

We as the home organising team found it an extremely busy 3 days and did not seem to have a minute to spare but the feedback has been worth it as everyone seems to have enjoyed it and some even said it was the best meeting ever!

I think one of the reasons it worked well was that everything was in the same place – exhibition, lectures, dinner and accommodation. Certainly the feedback from the majority of the exhibitors was that it was an extremely good meeting from their point of view.

It was lovely to meet everyone and nice to see so many people. There are ongoing issues with funding and the ALS realise that it is increasingly difficult for theatre staff to get study leave and funding. They have kept the fees reasonable for us to attend the two days, where else can you get 2 study days and lunch for £120?!!!

I look forward to the November meeting this year as I intend to sit back and enjoy.

Hope to see you there.

Jane PB Hendricks, Chair of ALTS

The Laparoscopic Colorectal Surgery Preceptorship Programme 2004–2009

This programme was created to facilitate the transition from open colorectal surgery to safe laparoscopic practice. Although operative surgery demonstrations were being performed prior to 2004 they were no substitute for the hands-on training that one would receive in a normal surgical apprenticeship. A consensus conference occurred in September 2004, when more than 40 surgeons were invited who had an interest in this. A training format was agreed that would allow surgeons to progress more safely than the alternative, independent learning. It was suggested that surgeons wishing to be trained within the programme should see at least 10 laparoscopic resections live, take their theatre staff to a preceptor's centre to see their practice and then perform 2–4 resections with the preceptor assisting them. It was agreed that appropriate audit should be undertaken by preceptees in order to address the clinical governance issues associated with new techniques, and that those surgeons should aim to perform at least two laparoscopic colorectal resections a month in order to develop their expertise. Training was also to be provided regarding the degree of difficulty associated with different laparoscopic colorectal interventions, in order that surgeons could recognise which operative procedures to take on at various stages in their experience. The criteria used to appoint preceptors were that they should have performed more than 100 laparoscopic colorectal resections and wished to put themselves forward for the role. Although there were less than 20 preceptors at the start, this number increased rapidly and by 2009 there were more than 50 preceptors registered. The programme was set up under the auspices of The Association of Laparoscopic Surgeons (ALS) and The Association of Coloproctology of Great Britain and Ireland. It was chaired by myself and administered by Jenny Treglohan and Sarah Williams within the ALS office. Throughout its duration, it has been supported principally by Ethicon Endo-Surgery, but also by Covidien and Karl Storz. We are grateful to these organisations for providing support and to the staff within the ALS for co-ordinating the programme.

During the four years the preceptorship has been active we have asked preceptors and preceptees to log their activity and also fill in confidential questionnaires about their experience. This activity has not always been reported accurately but we know that more than 100 surgeons have registered as preceptees and more than 50 of these surgeons have logged between

2 and 60 training operations with their preceptor. The feedback from the preceptees has been extremely complimentary to both their preceptors and the programme – clearly it has been a worthwhile training experience for most involved. I apologise if by mentioning individuals other surgeons have been missed who have been more active, but I wanted to highlight outstanding contributions from 3 people: Mr Mark Gudgeon has trained 8 surgeons involving 92 operations, Mr Ralph Austin has preceptored 7 surgeons and, remarkably, Mr Raj Kapadia has trained 14. Clearly these individuals have made a great contribution to both their consultant colleagues and patients, by this commitment to colorectal surgery.

It has been recognised that although this work has been laudable, training in which is usually restricted to 4 or less operations can have significant limitations. As a result of funding and also the drive from Professor Mike Richards, the Government Cancer Lead, a National Training Programme will now take this forward. The Clinical Lead for this will be Mr Mark Coleman from Plymouth 07789 873190, Programme Administer Ms Joanne Foley, Tel: 01752 439844, **joanne.foley@lapco.nhs.uk**, Programme Manager Ms Laura Stapleton, Tel: 01752 439845, **laura.stapleton@lapco.nhs.uk**, Fax: 01752 315053 or visit www.lapco.nhs.uk. Surgeons wishing to enrol within this programme should contact the Lapco office. It is also particularly pleasing that this process will be underpinned by a research initiative headed by Professor George Hanna at Imperial College. The research will look at aspects such as the best method of gaining competence in the procedure, optimal techniques in training and also what constitutes surgical competence. All colorectal surgeons who undertake elective resections for cancer are strongly urged to enlist within this training programme in order to offer laparoscopic techniques to their patients in line with the NICE guidelines of 2006. At present, as the National Training Programme is only available within England, the preceptorship programme will still continue in Ireland, Scotland and Wales, with access via the ALS office. I would like to thank all those preceptors who have worked so hard on the programme, transforming the way colorectal surgery is undertaken in the UK and Ireland.

Robin Kennedy
Consultant Surgeon
St Mark's Hospital

National Training Programme in Laparoscopic Colorectal Surgery

In 2007, the Cancer Action Team at the Department of Health for England under the leadership of Professor Mike Richards, National Cancer Director instituted a new training programme in laparoscopic colorectal surgery for colorectal consultants in England. The aim of the programme is to implement the 2006 NICE guidelines that 'laparoscopic (including laparoscopically assisted) resection is recommended as an alternative to open resection for individuals with colorectal cancer in whom both laparoscopic and open surgery are considered suitable' and give suitable patients with bowel cancer in England, access to a fully trained surgeon.

In January 2008, 10 groups were allocated training centre status. In September 2008, Mark Coleman, Consultant Surgeon in Plymouth was appointed the National Clinical Lead. In March 2009 the new National Coordination Office opened in Plymouth with a full time National Programme Manager and Programme Administrator. The new website has been launched (www.lapco.nhs.uk) to coordinate the activities of the National Training Programme.

The programme is intended to run for 2 years with the aim of training enough colorectal surgeons in LCS to a level of independence in routine colonic resections

The NTP offers a number of pre-clinical and clinical methods of training. The programme recognizes that it needs to be flexible to the needs of surgeons and their varying levels of experience. Many will have already attended masterclasses, cadaver courses or wetlabs. Many will also have extensive experience of laparoscopic procedures such as cholecystectomy, There the programme will need to offer different entry points accounting for level of skill.

It is generally envisaged that around a minimum of 20 cases will be required to reach a level of competence. This may vary in either direction depending on the skill and experience of the individual. A form of assessment of competence has been incorporated into the NTP to provide surgeons in the programme a means of objectively determining that their training has been assessed and recorded by their NTP trainer. This information is intended for use by consultants as part of their appraisal and revalidation.

The NTP will emphasize team training as we recognize that this hastens the ascent up the learning curve. It will offer Enhanced Recovery Courses (link to courses) as data suggests that enhanced recovery programmes help to further reduce hospital stay in patients undergoing bowel resection.

All colorectal consultant surgeons in England who wish to take up Laparoscopic Colorectal Surgery (LCS) are strongly encouraged to apply to be part of the NTP. By visiting the website, all details of the programme including on-line application are available.

Training Centres:

- Newcastle
- Bradford
- Hull
- Nottingham
- Oxford
- Colchester/Guildford/St Marks
- King College Hospital London
- Portsmouth
- Basingstoke/Frimley Park
- South West (Bristol/Plymouth/Yeovil)
- Imperial College London (Education)

All information on the programme and the training centres can be obtained through our website www.lapco.nhs.uk or contact the National Training Programme Administrator on 01752 439844

mark.coleman@lapco.nhs.uk

The website for the The National Training Programme in Laparoscopic Colorectal Surgery (Lapco) is now open.

Lapco has been developed by the Cancer Action Team at the Department of Health to provide Laparoscopic Colorectal surgical training for colorectal consultants in England.

Please visit www.lapco.nhs.uk for more information or contact the Lapco office.

Joanne Foley, Programme Administrator, 01752 439844
joanne.foley@lapco.nhs.uk

Laura Stapleton, Programme Manager, 01752 439845
Laura.stapleton@lapco.nhs.uk

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Lead Clinician
Mark Coleman
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lapco national training programme in laparoscopic colorectal surgery

Bard

T: +44 (0)1293 606 604 (Lindsey Blain, Workshop Co-Ordinator) | E: lindsey.blain@crbard.com | W: www.barduk.com

Date	Course	Venue
15 July 2009	TEP Hernia Repair without fixation (Laparoscopic)	Crewe
10 September 2009	TEP Hernia Repair without fixation/Incisional/Ventral (Laparoscopic)	Salisbury
23 September 2009	Preperitoneal repair via an anterior approach (open)	London
25 September 2009	TEP Hernia Repair without fixation/Incisional/Ventral (Laparoscopic)	Bournemouth
7 October 2009	TEP Hernia Repair without fixation (Laparoscopic)	Crewe
8 October 2009	Incisional/Ventral (Laparoscopic)/Parastomal Hernia Repair (Laparoscopic)	Walsall
4 December 2009	TEP Hernia Repair without fixation/Incisional/Ventral (Laparoscopic)	Bournemouth
9 December 2009	Preperitoneal repair via an anterior approach (open)	London
TBA	TEP Hernia Repair, with fixation (Laparoscopic)	Leeds
TBA	Preperitoneal repair via an anterior approach (open)/Perfix Plug repair	Cardiff
TBA	Perfix Plug repair/Incisional/Ventral (open)	Swindon

Aesculap Endoscopy, B Braun Medical

Contact: Allan Barr, Senior Product Marketing Manager, Aesculap Endoscopy, B Braun Medical

Direct Line: +44 (0)114 225 9174 | Mobile: +44 (0)7772 115856 | Email: allan.barr@bbraun.com | W: www.aesculap-academy.com

The Aesculap Academy has been offering a broad range of surgical endoscopy courses since 1995. All of our courses are directed by a renowned international faculty. Quality is the key, and all courses are all accredited.

Our state of the art training facilities in Tuttlingen and Berlin offer 6–10 workstations for a maximum of 12–20 participants. Different training modules have been developed for dry and wet lab laparoscopy training workshops, across a wide range of surgical procedures, in upper GI surgery, colo-rectal surgery and laparoscopic urology.

Intensive hands-on sessions on animal specimens are supervised within small working groups, providing the best environment for maximum learning, and 1st class practical hands-on experience. Our facilities offer the ideal set-up for an intensive exchange of knowledge.

Horizons of Knowledge – Competence to Master the Future.

We have confirmed dates for our English speaking course detailed below, for 2009, with additional courses still in the planning, and dates to be confirmed.

Date	Course	Venue
6–7 July 2009	Comprehensive Urological Laparoscopy	Berlin
8–10 July 2009	Laparoscopic Training Course Hernia Surgery	Berlin
20–22 October 2009	Laparoscopic Training Course Upper GI	Berlin
9–11 November 2009	Advanced Laparoscopic Surgery	Berlin

Covidien

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Date	Course	Venue
Hernia Surgery & Soft Tissue Repair		
7 September 2009	Laparoscopic Incisional Hernia Clinical Immersion Course	Edinburgh Royal Infirmary, Edinburgh
7 October 2009	Retroperitoneal Hernia Repair	MATTU, Royal Surrey County Hospital, Guildford
28 October 2009	Laparoscopic Hernia MasterClass	ICENI Centre @ Colchester General Hospital
7 December 2009	Laparoscopic Incisional Hernia Clinical Immersion Course	Edinburgh Royal Infirmary, Edinburgh
Association of Surgeons in Training (ASiT)		
28 October 2009	Colchester Laparoscopic Hernia MasterClass for Higher Surgical Trainees	ICENI, Colchester UK
Colorectal		
6–8 July 2009	New Delegates Part 1 Oxford Laparoscopic Colorectal Clinical Immersion	John Radcliffe Hospital, Oxford
9–10 July 2009	Peripherique Course	Elancourt Education Centre, Versailles, France
7–8 September 2009	Part 2 Oxford Laparoscopic Colorectal Clinical Immersion Surgical Training Course	John Radcliffe Hospital, Oxford
20–24 September 2009	Basingstoke Frimley Park Laparoscopic Colorectal Surgery Clinical Immersion Training Course	North Hampshire Hospital & Frimley Park Hospital
12–13 October 2009	Laparoscopic Anterior Rectopexy MasterClass & Pelvic Floor MDT Surgical Training Course	John Radcliffe Hospital, Oxford & Frenchay Hospital, Bristol
19–20 October 2009	Part 3 Oxford Laparoscopic Colorectal Clinical Immersion Surgical Training Course	John Radcliffe Hospital, Oxford
30 November–1 December 2009	Part 4 Oxford Laparoscopic Colorectal Clinical Immersion Surgical Training Course	John Radcliffe Hospital, Oxford
Liver		
1–3 July 2009	Pelican & AUGIS UK Liver Surgeon Training Course	North Hampshire Hospital, Basingstoke & Elancourt Education Centre, Versailles, France
Multi Speciality		
TBC September 2009	N/W Multi Specialty Laparoscopic Surgery Course	Elancourt Education Centre, Versailles, France

Ethicon Endo-Surgery

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Date	Course	Venue
Bariatric		
10–11 September 2009	ByPass Course (Surgeons)	Gothenburg, Sweden
16–17 September 2009	MDT Course	St Gallen, Switzerland
12–13 October 2009	Bariatric Surgery & Interdisciplinary Collaboration in Obesity Treatment (Prague)	Iscare I.V.F. a.s, Prague
15–16 October 2009	MDT/Bypass Course	Oslo
3–4 November 2009	Bariatrics SAGB Course (Surgeons & Nurses) (NUGITS)	NUGITS
5–6 November 2009	Advanced Laparoscopic Gastric Bypass and Logistics Course	Aleris, Oslo
12–13 November 2009	ByPass Course (Surgeons)	Gothenburg, Sweden
12–13 November 2009	Minimally Invasive Operating Techniques in Bariatric Surgery ESI, Hamburg	(ESI Hamburg Course)
25–26 November 2009	MDT Course	St Gallen, Switzerland
3–4 December 2009	MDT/Bypass Course	Oslo
Laparoscopic Colorectal		
7 July 2009	Masterclass - Prof T Rockall Laparoscopic Colorectal	Royal Surrey University Hospital, Guildford
13–14 July 2009	Laparoscopic Colorectal Cadaver Laboratory Course	Freeman Hospital, Newcastle
7 September 2009	Laparoscopic Colorectal Surgery Course (Introduction)	Colchester General Hospital
29–30 September 2009	Laparoscopic Colorectal Course	ESI, Hamburg
21–22 October 2009	Laparoscopic Colorectal Course	ESI, Hamburg
4–5 November 2009	Laparoscopic Colorectal Course	ESI, Hamburg
9–10 November 2009	Laparoscopic Colorectal Course	MATTU, Guildford
9–10 November 2009	Laparoscopic Colorectal Course (Advanced)	Colchester General Hospital
7–8 December 2009	Laparoscopic Colorectal Cadaver Laboratory Course	Freeman Hospital, Newcastle

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Date	Course	Venue
8–10 July 2009	RCS Core Skills in Laparoscopic Surgery Course	North Tyneside Hospital, North Shields
9–11 July 2009	RCS Core Skills in Laparoscopic Surgery Course	Royal College of Surgeons, London
13–14 July 2009	Laparoscopic Cholecystectomy Course	MATTU, Guildford
15 July 2009	Laparoscopic Extra-peritoneal Hernia Course	MATTU, Guildford
19–21 August 2009	RCS Core Skills in Laparoscopic Surgery Course	Birmingham Heartlands, Birmingham
1 September 2009	Laparoscopic Colorectal Surgery for Surgical Trainees	MATTU, Guildford
7 September 2009	Laparoscopic Colorectal Surgery (Intro)	ICENI, Colchester General Hospital
8–9 September 2009	Laparoscopic Colorectal Cadaver Course	Nottingham City Hospital, Nottingham
14–16 September 2009	RCS Core Skills in Laparoscopic Surgery Course	MATTU, Guildford
17–18 September 2009	Key Skills in Laparoscopic Surgery	Ninewells Surgical Skills Unit, Dundee
22–30 September 2009	EAES Upper Gastrointestinal Laparoscopic Course	Ninewells Surgical Skills Unit, Dundee
28–29 September 2009	Intermediate Laparoscopic Surgery Course	Ninewells Surgical Skills Unit, Dundee
29–30 September 2009	Laparoscopic Hepato-Biliary Surgery	MATTU, Guildford
7 October 2009	Laparoscopic Extra-peritoneal Hernia Course	MATTU, Guildford
12–13 October 2009	Laparoscopic Stapling/Suturing Techniques Course	MATTU, Guildford
13–14 October 2009	Bile Duct & Adv Laparoscopic Surgery Course	ICENI, Colchester General Hospital
21 October 2009	Laparoscopic Hernia Repair Course	ICENI, Colchester General Hospital
21–23 October 2009	RCS Core Skills in Laparoscopic Surgery Course	North Tees Hospital, Cleveland
22–23 October 2009	Key Skills in Laparoscopic	Ninewells Surgical Skills Unit, Dundee
28–30 October 2009	RCS Core Skills in Laparoscopic Surgery Course	Derriford Hospital, Plymouth
9–10 November 2009	Laparoscopic Colorectal Surgery Advanced Course (2-day)	ICENI, Colchester General Hospital
9–10 November 2009	Laparoscopic Colorectal Masterclass & Anaes. Course	MATTU, Guildford
10 November 2009	Lap Colorectal Surgery Course & Anaesthesia Therapy	MATTU, Guildford
11 November 2009	Laparoscopic Upper Gastrointestinal Surgery	ICENI, Colchester General Hospital
16–18 November 2009	Basic Surgical Skills Course in General Surgery	MATTU, Guildford
16–19 November 2009	EAES Lower Gastrointestinal Laparoscopic Course	Ninewells Surgical Skills Unit, Dundee
17–18 November 2009	Laparoscopic Colorectal Cadaver Course	Nottingham City Hospital, Nottingham
26–27 November 2009	Key Skills of Laparoscopic Surgery	Ninewells Surgical Skills Unit, Dundee
7-8 December 2009	Laparoscopic Cholecystectomy Course	MATTU, Guildford
14–16 December 2009	Laparoscopic Upper Gastro-Intestinal Symposium	MATTU, Guildford

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Date	Courses	Venue
2–3 July 2009	2nd Training Day for Surgical SPR's	Olympus Keymed House, Southend
10–11 September 2009	Urology ST3 Course	Olympus Keymed House, Southend
14–16 October 2009	Endoscopic Surgery Nurses' & Technicians Training Course	Olympus Keymed House, Southend
22–23 October 2009	Senior Urology Registrars Course	Olympus Keymed House, Southend
Dates TBC	Frontiers in Intestinal & Colorectal Disease	Olympus Keymed House, Southend

Details of these course are available on our website or will be in due course.

WL GORE

W: www.goremedical.com | T: +44 (0)7717 894303 (Jane Dodson) | E: jdodson@wlgore.com

Date	Course	Venue
8 October 2009	Laparoscopic Ventral Hernia Repair Workshop	King George Hospital, Essex

Ethicon Endo-Surgery (EES UK)

Ethicon Endo-Surgery (EES UK) are delighted to continue working with clinicians, health care professionals and recognised training centres to deliver training programmes to facilitate the safe adoption of new surgical procedures and the correct application of new technologies. Our aim is to focus on 'team training' to ensure that all key stakeholders in the surgical unit are aware of the implications upon service delivery and patient care when a change in practice occurs. Thus the courses we offer form part of a wider sequential training approach to deliver instruction for those who assess, treat and care for the patient throughout the treatment pathway.

Consider joining the British Obesity & Metabolic Surgery Society (BOMSS)

BOMSS is a rapidly growing society keeping pace with the obesity epidemic. We have recently made some exciting new changes to the way we operate and would welcome new members – especially those who are practising or about to learn bariatric surgery. The advantages of membership include a collegial environment to learn more advanced bariatric techniques and a forum to discuss management of these sometimes difficult patients. Help is available from our large faculty for training purposes and shortly we will be publishing BOMSS standards which will help your unit in being recognised by commissioners. Being a BOMSS member will likely become compulsory if you are contemplating starting a new service or in maintaining your current commissioning. If you are interested please contact Sheila Hodgson at the AUGIS office on +44(0)20 7304 4773 or sheila@asgbi.org.uk for application details.

John Baxter, President – BOMSS

Industry Partners

Biologic Grafts in Laparoscopic Hernia Repair

2009 is the start of a new era for biologics, with three new companies marketing collagen materials. The discussion will move on from the benefits of natural materials versus synthetic to the degrees of cross-linking and the elasticity of the biomaterial.

Surgisis Biodesign has been available in Europe since 2001, although new sizes and applications have emerged recently. Over one million patients worldwide have benefited from this technology, supported by over 400 publications. Most other biologics are sourced from porcine dermis, which contains elastin. Unless dermis is cross-linked like leather, it can stretch. Cross-linking makes a material resistant to collagenase, but renders the device inert, similar to synthetic mesh. Although they may not encapsulate, shrink or adhere to the viscera, cross-linked grafts show minimal incorporation.[1] Surgisis Biodesign is not cross-linked.

The ideal 'mesh' should be strong, easy to manipulate, biocompatible, non-carcinogenic, sterile and should support the growth of new tissue.[2] It should leave a permanent repair without a permanent foreign body. Biodesign signals the body and remodels into strong native tissue, indistinguishable from the surrounding area, yet with more tensile strength.[3] It causes minimal adhesions when placed intraperitoneally.

Recent publications on the use of porcine small intestine submucosa in laparoscopic hernia repair have found it to be a safe and feasible alternative in contaminated or potentially contaminated fields with minimal recurrence rate. Franklin et al 2 placed the material into 133 defects, thirty-nine cases were in an infected field and the rest in a potentially contaminated field. Eighty-five percent 5-year follow-up was achieved, during which they identified 7 recurrences, 11 seromas (all resolved), and 10 patients reporting mild pain. Mean follow-up was 52 ± 20.9 months.

Oelschlager, Pellegrini et al noted that laparoscopic paraoesophageal hernia repair is associated with a high recurrence rate. Repair with synthetic mesh lowers recurrence but can cause dysphagia and visceral erosions. They randomized to primary repair (n = 57) or primary repair buttressed with SIS (n= 51) At 6 months, 4 patients (9%) developed a recurrent hernia →2 cm in the SIS group and 12 patients (24%) in the 1° group. They concluded that adding a biologic prosthesis reduces the likelihood of recurrence at 6 months, without mesh-related complications or side effects.[4]

Laparoscopic inguinal hernia repair with biologic material has not been performed extensively, but is associated with reduced pain and discomfort. Edelman's small early study compared SIS with polypropylene mesh and found that recurrences, seroma and discomfort compared equally, concluding that SIS mesh can be used for laparoscopic inguinal hernias.[5] He saw no recurrences in 23 patients at 2 year follow up. He further studied ten athletes found to have 'Sports' hernias. There were no major complications. All athletes returned to full activities in 4 weeks. Only 1 patient did not show improvement in his symptoms. No patient developed a recurrent hernia.[6] Recently, Agresta published his work using TAPP hernioplasty and applying a Surgisis mesh fixed by a fibrin sealant. He concluded this type of mesh might be tailored to not only the sportsman or the patient with a contaminated surgical field, but may also be used in young patients, where there is a fear of leaving behind a long-term foreign body.[7]

The ongoing Lapsis trial compares laparoscopic and open ventral hernia repair and a classical versus collagen mesh (Surgisis Gold). It has already enrolled more than two hundred patients. The European Hernia Society Register of Biologic Prostheses (ERBP) is just beginning, and looking for participants www.herniaweb.org/activities/erbp.php

Cook Medical is an industry partner with the ALS.

Founded in 1963 and operated as a family-held private corporation, Cook was one of the first companies to help popularize interventional medicine, pioneering many of the devices now commonly used worldwide to perform minimally invasive medical procedures. Today, the company integrates minimally invasive medical device design, biopharma, gene and cell therapy, and biotech to enhance patient safety and improve clinical outcomes in the fields of aortic intervention; interventional cardiology; critical care medicine; gastroenterology; radiology, peripheral vascular, bone access and oncology; surgery and soft tissue repair; urology; and assisted reproductive technology, gynaecology and high-risk obstetrics. For more information, visit www.cookmedical.com/biodesign

Keith Rowland, BSc(Hons), DipM, MCIM, Cook Medical

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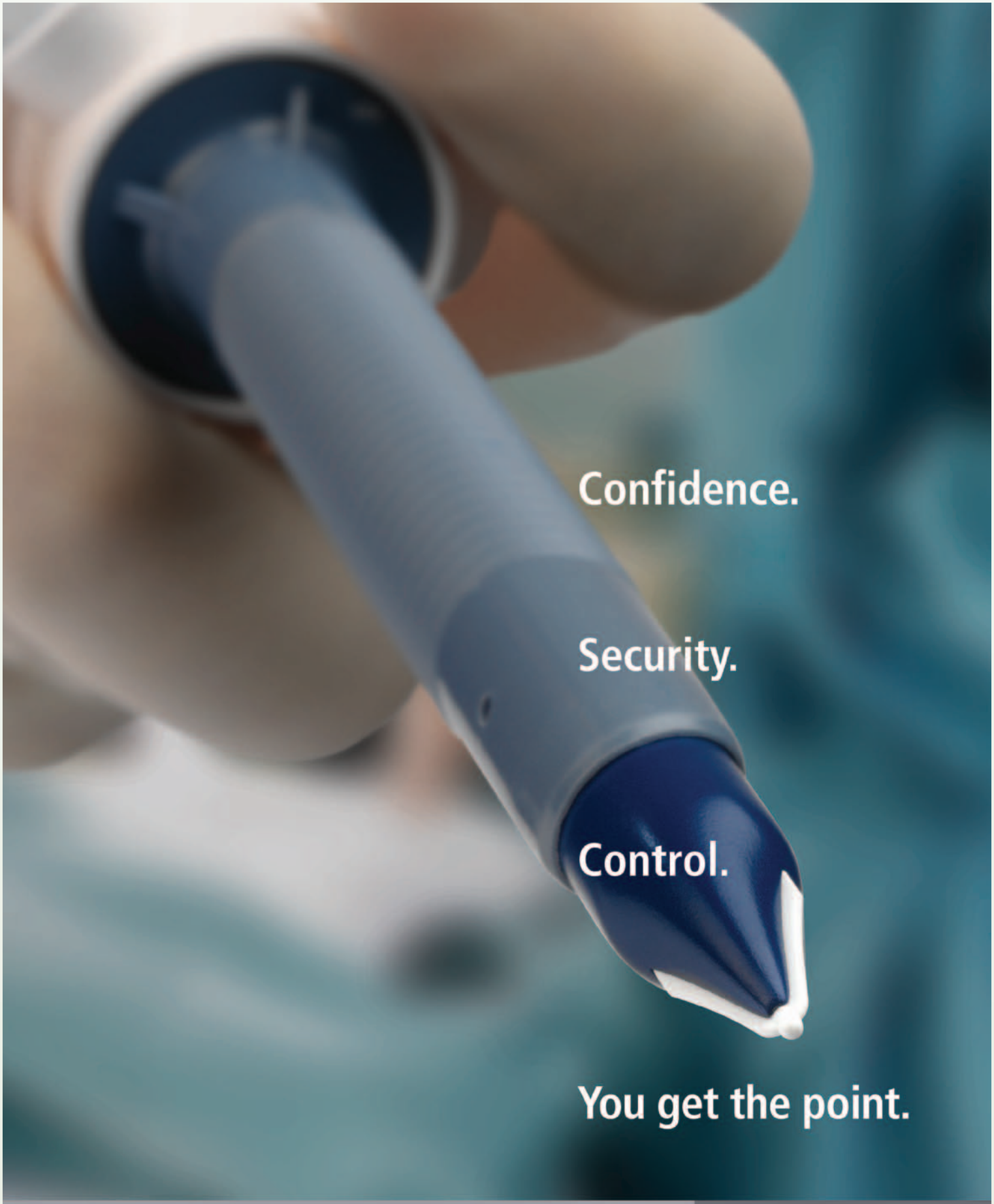

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