SAVE THE DATE
ALSGBI ASM 2013 London
14 & 15 Nov
TRAINING DAY 13 Nov 2013

ALSGBI
Association of Laparoscopic Surgeons of Great Britain & Ireland

ALSGBI newsletter

President's Introduction

A lot has happened at the ALSGBI since our last newsletter, not least the highly successful Annual Scientific Meeting in Cork. Now we are focusing on the next meeting in London in November, which will be my last as President of the Association.

It will be the first time that the meeting comes to London and it is shaping up to be a very exciting program. The venue is The Royal College of Surgeons in Lincoln's Inn where we will also hold the training day in the Raven Department of Education. Live surgery will be beamed in high definition from several sites. Live multi-speciality laparoscopic surgery will be beamed in from Guildford MATTU in 3D HD, which will be a unique conference event. In addition we will have a retroperitoneal adrenalectomy performed by Professor Martin Walz from Essen in Germany and a transperitoneal adrenalectomy from the UK.

Dr Jean-Louis Dulucq from Bordeaux, a name very well known and respected in laparoscopic circles, is our visiting speaker who will give lectures on the subjects of laparoscopy in acute pancreatitis and pancreatic cancer and Professor Michael Bailey will deliver the BJS Lecture for 2013.

We would like to see as many high quality abstracts, both papers and DVD's, so if you are involved in research or have a good quality educational DVD I would encourage you to submit it when the time comes. There are bursaries to support training surgeons who have their submissions selected for presentation as well as high value prizes for the best. Make sure you put the dates in your diary now for what I am sure will be a memorable meeting.

Thank you and congratulations to Mr Mark Vipond who after 6 years of dedicated service as Honorary Secretary has now been duly elected as President Elect. I am pleased to confirm that Mr Simon Dexter has now taken on the role of Honorary Secretary. Congratulations and a warm welcome to new members of Council; Mr Mark Gudgeon and Mr Tan Arulampalam who have been elected to represent the South Thames and North Thames regions respectively. Our thanks go to the outgoing representatives for the Thames regions Professor Amir Nisar and Professor Stephen Chadwick. Mr Sean Woodcock now takes over from Mr Simon Dexter as the Northern & Yorkshire Representative. Finally congratulations to Mr Mark Coleman who is the new ACPGBI Representative.

Professor Timothy Rockall, President

Editor's Introduction

Welcome to the Summer edition of the ALSGBI newsletter. Life in UK surgery is never dull. The relentless political drives for change to improve (and secure the next term) affect all of us. As of April 2013 we have a new NHS! Alongside the financial shift of power to clinical commissioning groups there is published guidance as to how we are to deliver a more responsive health service, focused on improving outcomes for patients. This caused me to consider what was I doing before?

The document 'Everyone Counts: Planning for Patients 2013/14' outlines the 'incentives' and 'levers' that will be used to improve services. One of the central tenets of the document relates to better data and informed commissioning. We have already seen the process stumble in the Leeds Paediatric Cardiac Surgery debacle that led to the temporary suspension of surgery and the subsequent resignation of Professor Sir Roger Boyle the former 'Heart Tsar'. In surgery we have the 'misfortune' of having outcomes that are easily measured on a crude basis, but that are often far more complex when analysed in depth. We have however behaved very responsibly as a profession and are far ahead of our medical colleagues in conducting regular M&M meetings, AGMs and, like the cardiac surgeons, have established national databases. The OG (NOGCA) in gastrointestinal surgery, the HPB (HPB Cancer Resection Database) and in bariatric surgery (NBSR) are examples of the efforts made. Whilst not perfect they have advanced our knowledge of 'real world' practice and outcomes that have been published as national reports, available in the public domain. We have established and worked in dedicated units and in all specialties the multi-disciplinary team is pivotal. A laudable result of such action has been a shift in the belief that outcomes should be regarded as the responsibility of 'The Team' and not solely the responsibility of the surgeon.

Our reward for these phenomenal efforts is that in order to demonstrate 'Everyone Counts' in action the data from the units submitting to the national registers/audits will not be published as such. Rather than concentrating on unit outcomes, as services will be commissioned as such, the data will be published as individual surgeon-level data by June 2013. It will not be risk-stratified and certainly

continued on page 2

ALSGBI COUNCIL 2013

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ALSGBI Industry Partners for 2013

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for low-volume, high-risk surgery will have denominators that will make any information meaningless. It will not provide useful information to facilitate 'choice' or 'influence commissioning'. It will merely cast unnecessary dark clouds over individual practices and have a deleterious effect on team-working. I am delighted to include, in this issue, an excellent report on the NBSR by the President of the BOMSS, Mr Richard Welbourn.

For those who would like to know more about the Mid Staffordshire NHS Foundation Trust Public Inquiry there was a session devoted to this topic at the ASGBI International Surgical Congress in Glasgow. This session included presentations by Mr Robert Francis, QC (Chairman) and Sir Neil McKay (Chief Executive, Midlands and the East Strategic Health Authority). This conference allowed delegates to enjoy the ALSGBI session at ASGBI (2 May 2013) where the interesting topic of the role of laparoscopy in emergency surgery was tackled.

On a lighter note, I was delighted with the great success of the most recent Annual Scientific Meeting (ASM) held in Cork last November. The event, hosted by Mr Colm O'Boyle, a great raconteur and old colleague from our Registrar training days in Yorkshire, was always set to be a true spectacle. The articles by Mr Paul Leeder and Ms Jane Bradley-Hendricks are testimony to this. He and his team, along with the ALSGBI support team and our Industry Sponsors, are to be congratulated.

I regard the ALSGBI as a highly progressive Association. One marker of this is the way in which new technology is embraced and utilised to improve communication and access to information. The use of the ALSGBI App at the recent ASM and the establishment of a Twitter feed are to be commended, and a great credit to Mr David Mahon (see page 3). This is an area ripe for further development that can only enrich the Association.

Looking to the future, I was very pleased to see the rallying cry of 'London Calling' as the title for the next ASM, organised by our President Professor Tim Rockall. The conference is to be held at The Royal College of Surgeons of England from 14-15 November 2013. This will be preceded, as usual by the extremely useful training day (13 November). Dates for everyone's diary! It is fabulous to see so much investment back into the College with development of The Raven Department of Education and the work done to improve the Hunterian Museum, which celebrates its bicentenary this year. We frequently travel the world on meetings but rarely visit our own capital. Indeed the last scientific surgical meeting, rather than a course, I attended at the College was the SRS meeting organised by St Mary's in 1992! I look forward to the occasion with great anticipation and excitement and wish to encourage as many members as possible to attend.

Mr Shaun Preston Newsletter Editor, ALSGBI Council

ALSGBI App Version 1.0.1

The ALSGBI recently launched an app for iPhone and iPad, just in time for our congress in Cork last November. Since then, it has been downloaded over 250 times. We recently invited you to complete an online survey about the app, our website and about the congress which has the highest attendance so far at over 250 registered delegates.

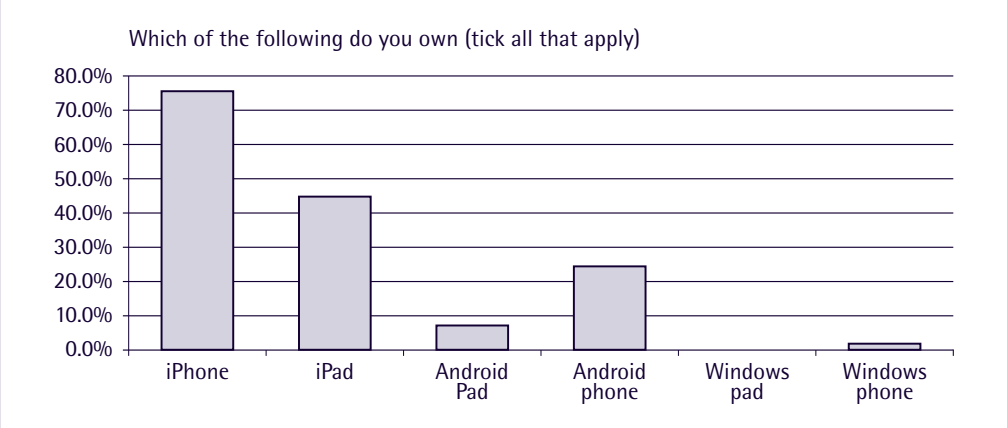
I am happy to report that 9 out of 10 respondents to the survey, who attended the Cork meeting, found it relevant, well structured and felt that they learned a great deal. More than a third of you have already downloaded the app and whilst we have had suggestions for improvement, the majority of you found it helpful and easy to use with good content. Three quarters of our membership have an iPhone and almost half have an iPad. One quarter now has an Android phone and if our membership resembles the general population, this seems set to increase. Given the results of this survey and the population trend, we have started to develop an app for Android and will have this available prior to the next congress in London. We will also take the opportunity to 'freshen-up' our iPhone/iPad app at the same time. This will facilitate regular updates from the executive with the latest news and course information.

We always welcome additional digital content for the website and the app, especially edited DVDs - please feel free to submit anything to jtreglohan@alsgbi.org (or by sending a DVD to the office) who will pass it on to me.

For those who do not have the app and would like to download it, it is available free through iTunes (App Store > Medical > Association of Laparoscopic Surgeons of Great Britain and Ireland). The app is compatible with iPhone, iPod touch and iPad and requires iOS 5.0 or later. The app is optimized for iPhone 5.

Finally, the eagle eyed amongst you may have noticed that the following icon is now visible at the bottom of our website.

follow us on twitter @ALSGBandI



In addition to reading the latest news on the ALSGBI app, clicking this link will allow you to follow ALSGBI on your twitter feed, either on your computer or on your mobile device. It's fun for us but more importantly, it allows us to provide information about news, events and courses to you really quickly. Why not log in and click it now?

David Mahon
Website Director
ALSGBI Council

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ALSGBI Annual Scientific Meeting

Cork, 29-30 November 2012

The ALSGBI Annual Scientific Meeting 2012 found us in the glorious Irish city of Cork, the third largest city in Ireland after Dublin & Belfast. It is on the beautiful west coast and approached by a short aeroplane journey from the UK. Our host for the three days was Mr Colm O'Boyle, deftly supported by his secretary Catriona. Together with the local organisers, our ALSGBI organisers Jenny & Sarah did an admirable job at bringing together an excellent programme of events at an unsurpassed venue.

The meeting was based at the Rochestown Park Hotel - one of Cork's premier conference hotels and an ideal venue for our event. As is tradition, the first day was an Advanced Laparoscopic Surgery Training day, based at the Bon Secours Hospital. A lucky group of twelve trainees had the enviable opportunity of hands on practical laparoscopic training. The delegates had the opportunity to practise upper and lower GI procedures, supported by our Director of Education Pete Sedman and ex-Director of Education at The Royal College of Surgeons of England, Professor Mike Larvin, who has recently taken up a post of Head of School at The University of Limerick. The training day was generously sponsored by Covidien and Stryker.

Day two was the first day of the conference. Following on from a welcome by our President Professor Tim Rockall, we were able to feast on a varied day of operating beamed via satellite from the Bon Secours and Cork University Maternity Hospitals. The meeting's theme and title of 'Rise of The Machines' was demonstrated by local gynaecologist Dr Matt Hewitt. Although there were few gynaecologists in the audience, we all appreciated the amazing display of pelvic anatomy that is offered by robotic 3D laparoscopy. Other surgery of gastric bypass, fundoplication and incisional hernia repair were deftly performed by local and visiting surgeons, all of whom were positively received. An interesting debate ensued in the audience, regarding different techniques utilised in fundoplication and also the optimum pouch size in gastric bypass surgery. Mr Tim Tollens from Belgium gave a beautiful demonstration of incisional hernia repair. If not already adopted, many surgeons in the audience will now consider suture repair of the primary defect prior to intra-abdominal mesh placement. The optimum choice of mesh is still very much up for debate, but a lightweight composite mesh appears to be favoured in general. The satellite links were generously sponsored by Olympus.

Following the President's Drinks Reception, coaches ferried delegates to Cork City Gaol for the Annual Conference Dinner. We were serenaded by the Roaring Forties Band, perhaps hinting at the average age of the audience rather than the genre of music. Following a marvellous meal and the usual acknowledgements by our President, the audience were treated to an insightful speech by Irish Rugby International Mr Frankie Sheahan. His philosophy of 'give yourself a 10 yard line to vent your frustrations before moving on' could be applied in the often highly charged field of laparoscopic surgery.

Day three started with a worthy display of DVD and oral presentations. The winning DVD presentation was of 'Laparoscopic Low Anterior Resection with Inter-sphincteric Dissection And Colo-Anal Anastomosis', given by Mr N Siddiqui. The winner of the David Dunn Free Paper Prize was 'Is Stroke Volume Optimisation Really Necessary In Laparoscopic Colorectal Surgery?', given by Mr A Day. The winner of the best laparoscopic poster prize was 'Female Gender And Diabetes Increase The Risk Of Recurrence Following Laparoscopic Incisional Hernia Repair', given by Mr F McDermott.

An asset of the ALSGBI is the support of laparoscopic theatre staff. Many were able to attend this year thanks in part to the generous bursaries offered by SIGH Ltd. A parallel session on Friday morning was well attended. A large part of the meeting is the collaboration with Industry Partners. Our specialty is very much technology driven and we value both their financial support and the opportunity to review the latest equipment entering the market. Exciting developments include 3D imaging. This was demonstrated for the first time at the 2011 Cardiff meeting and is now standard in many domestic screens. Probably of most practical, immediate use is the development of micro instruments. These promise to make virtually scarless surgery a reality, without compromise of the laparoscopic technique.

The BJS Lecture was given by Professor Lee Swanstrom, Head of Upper GI & Minimally Invasive Surgery in Oregon. He presented a thought-provoking talk on robotic surgery. Robotic prostatectomy is now the primary treatment for prostate cancer in the US. There is little evidence of cost effectiveness unless a unit has the ability to undertake volumes of over 200 cases per year. In the words of Professor Swanstrom 'a bad laparoscopic surgeon can be a good robotic surgeon'.

The debate was taken further by Professor Craig Ramsay, Health Services Research Head in Aberdeen, who has recently completed a review of robotic surgery for NICE. He pointed out that there is no evidence of a reduced learning curve with robotics compared to laparoscopy. At best, outcomes are equivalent to laparoscopy, but more expensive. The move towards robotic surgery is however very much driven by public demand. Whatever your feelings on the subject, we have to be prepared because the robots are definitely coming!

Feedback from the meeting has been excellent. The broad subject material, sessions, hosts and venue have all led to this being one of the most successful ALSGBI meetings to date. We very much look forward to increasing interest and membership and hope you can encourage both your trainees and theatre staff to become members. We look forward to meeting you all when the 2013 meeting comes to our spiritual home at The Royal College of Surgeons in London.

Mr Paul C Leeder
Trent Representative, ALSGBI Council

ALTS @ ALSGBI Annual Scientific Meeting

Cork, 29–30 November 2012

I am delighted to report on yet another extremely successful ALSGBI Annual Scientific Meeting. Each year we think it can't get any better and it surpasses the previous year. Where do I begin?

The delegate numbers were up for a meeting held out of UK; a good indicator that people are keen to attend our Annual Scientific Meeting and prepared to travel to do so. The Irish hospitality prevailed throughout the meeting; everyone was very welcoming and extremely helpful. The content of the meeting was as usual excellent, varied with something for everyone.

The live operating was sponsored by Olympus and transmitted by satellite from the Bon Secours and Cork University Maternity Hospitals to the Rochestown Conference Centre. The 'wow factor' of being greeted by 3 huge screens when entering the lecture theatre set the scene and expectation for a great day of live operating. The image quality was excellent as was all of the surgery performed. Our thanks go to all of the surgeons and theatre staff for putting on such a great day, to Olympus for sponsoring the high definition link and of course to Mr Colm O'Boyle, who as the local organizer, brought it all together.

We all went to Gaol on the Thursday night. We did not pass go and did not collect £200 (approximately € 234!) but were treated to an excellent evening's entertainment including some 'gaol house rock' from the Roaring Forties band. Fortunately the dinner was not 'themed' and did not mirror that previously supplied to the inmates. Thankfully all 'escaped' back to our hotels at the end

of the night to sleep in comfort, rather than on a very cold hard floor! The dinner was lovely and the entertainment that followed was provided by the former Munster and Ireland rugby player Mr Frankie Sheahan, who kept us amused over coffee with some (clean!) rugby jokes and anecdotes.

Friday was split into two separate sessions the ALSGBI session and an ALTS session. The theme of this year's ALTS was advancing practice for theatre practitioners and progression from a traditional role of theatre practitioner to an ASP (advanced scrub practitioner) or SCP (surgical care practitioner). This was an interactive session with lots of discussion on the roles and how they are developing. There was a

great deal of interest from the Irish practitioners on how these roles work in practice within the UK and the education available to support it. We had a very informative presentation from SIGH Ltd., who had sponsored some of the practitioners present at the meeting. We are extremely grateful for their investment in our members and hope it is something that they will continue to support.

Olympus also provided significant support for the session and gave an excellent presentation on how to get the best out of your stack. Everyone enjoyed this and afterwards felt much more confident in setting up a camera stack and ensuring the system is functioning at an optimal level. Mr Peter Sedman also gave an insightful presentation on the importance of being a good camera assistant and how crucial it is to the safe and expedient progression of an operation.

The delegates were then able to put all their knowledge to good use in the afternoon skills based session. Most delegates started off by thinking the tasks we had set were going to be easy. They soon found that this was not the case! There was a great 'buzz' and the air was thick with competition! Fun was had by all and we once again extend an enormous thanks to Olympus for providing the stacks and setting them up for us.

I hope everyone enjoyed the two days as much as I did and I look forward to another outstanding meeting next year in London. See you all there!

Mrs Jane P Bradley-Hendricks
ALTS Chair Person, ALSGBI Council

The National Bariatric Surgery Registry (NBSR)

The National Bariatric Surgery Registry (NBSR) continues to thrive and evolve. To March 2013 the contributing surgeons have contributed over 29,000 patient operations. This already makes the NBSR one of the largest bariatric registries in existence and is the largest in Europe, with the possible exception of the Swedish Registry (SOREG). Although we think that the operative outcomes of the first 8,000 operated patients, published in the 2011 report, are a clear representation of the results in those patients, there are sceptics from outside the NBSR and the bariatric community. The reason? High rates of non-compliance with practising bariatric surgeons who are clearly not entering their data.

It's well-established from the colorectal cancer registry in the UK that those who do not submit data to established national registries have worse results than those who do. This may reflect the fact that the NBSR started out on a voluntary basis. The NCEPOD report from October 2012 showed that only 57% of the bariatric operations surveyed in July 2010 had been entered into the NBSR. Although 81% of all bariatric patients were entered into either the NBSR or some local database, this is still disappointing coverage, and the bariatric community needs to address this issue, otherwise the validity of our data (and therefore also bariatric surgery as a specialty) will still be questioned.

A driver for this is going to be Sir Bruce Keogh's mandate that individual surgeon-level data is going to be released into the public domain by June 2013 - announced in the Commissioning Board document 'Everyone Counts - Planning for Patients 2013/2014' released in December 2012. Bariatric surgery is one of the 10 surgical specialties mandated to 'take part'. This is a big challenge for all of the 10 specialties and is the biggest jolt that bariatric surgery in the UK has faced. Sensitive discussions are on-going with The Royal College of Surgeons of England and the Healthcare Quality Improvement Partnership (HQIP) on what data are to be released and the process of consent from contributors to allow this to happen.

Another driver is the Commissioning Board's requirement, in the Service Specification for bariatric surgery, that from 1st April all NHS bariatric surgery providers must submit their data to the NBSR. We don't know how this will be policed but it would appear foolish not to see this as an opportunity to propel the NBSR onto the next level and seek appropriate public funding. If we can ensure external validation of our data we have the greatest opportunity to quell those who think that our published data so far are misrepresentative. After the Francis Report about the Mid Staffs scandal we cannot avoid the publication of outcomes.

On a lighter note, we are planning a Version 2 Upgrade for summer 2013 to make data even easier to enter, with only minor adjustments to the data set. We are also planning to publish the 2nd Biennial Report in time for the IFSO Congress to be held in Istanbul this August. Anyone who wishes to contribute please get in touch with the NBSR Committee at the ALSGBI/BOMSS/AUGIS offices (Jenny Treglohan jtreglohan@alsgbi.org, Sarvjit Madhar sarvjit@augis.org) or contact me directly.

Mr Richard Welbourn
NBSR Chairman

Report of the B. Braun Aesculap Travelling Scholarship

In March 2011, thanks to the B. Braun Aesculap Travelling Scholarship, I was able to visit the Centre for Adolescent Bariatric Surgery at the Morgan Stanley Children's Hospital of New York-Presbyterian and to attend the Second World Congress on Interventional Therapies for Type 2 diabetes (T2D) in New York.

The prevalence of morbid obesity in adolescents and young adults has increased in the last two decades mirroring the rise in morbidly obese adults. These younger patients have decreased life expectancy and increased physical morbidity when compared to their non-obese counterparts. They develop conditions including impaired glucose tolerance, T2D, hypertension, dyslipidaemias, heart disease, sleep apnoea and degenerative joint disorders that one would usually associate with much older individuals. Teenagers with morbid obesity also have a higher incidence of low self-esteem, depression, anxiety and other psychological problems. The majority of obese adolescents remain obese as adults.

Bariatric surgery in adolescents is still somewhat controversial as the long-term results and consequences on growth have not been fully elucidated. As part of the guidelines for the management of morbid obesity, NICE advised that surgery could be considered in young people in exceptional circumstances and insisted on the importance of a multi-disciplinary approach to these patients. Although bariatric surgical operations in older and younger patients are similar, the pre-operative workup and post-operative follow-up tend to be more intense and extensive in the young.

The Morgan Stanley Children's Hospital of New York-Presbyterian has a long history and a vast experience in the management of adolescent obesity. This unit has a multi-disciplinary programme for weight management including specialists in paediatric endocrinology, nutrition, psychiatry, diabetes, surgery, gastroenterology and other specialties. In 2006, the centre became one of only a few U.S. centers approved to offer weight loss surgery to adolescents and was one of only four U.S. centers approved by the Food and Drug Administration (FDA) to evaluate the outcomes of gastric banding in this patient group.

The Medical Director for the centre, Dr Jeffrey L Zitsman, kindly allowed me to visit the unit. I was be able to attend sessions with different members of the team and be involved in the pre-operative evaluation, discussions, operation and post-operative care of young adults and adolescents undergoing surgery for morbid obesity. I was made to feel very welcome by the whole team.

As part of their morbid obesity work-up, the adolescents undergo extensive health and metabolic screening, as well as bone age and bone density studies. Patients are given individualised exercise programmes and are evaluated by nutritionists and psychiatrists. Nutritional guidance, dietary management and education are offered not only the adolescents themselves but to the entire family, care givers and often the schools they attend. I was able to be part of the multi-disciplinary team reviewing and assessing these patients. The goal of the team is to help patients lose weight without surgery if possible. Patients who fail to lose 20% of their excess weight after six months and are considered to be able to understand and comply with the post-operative changes would be considered for surgery.

The two bariatric operations performed in the centre are laparoscopic adjustable gastric banding and sleeve gastrectomy. As the band is not licensed for use in adolescents, laparoscopic adjustable gastric banding was being performed under guidelines approved by the FDA and Columbia University's Institutional Review Board at the time I visited the unit. The mean pre-operative BMI for adolescents undergoing surgery at the center is 48 kg m-2. Most patients are younger than 17 years and about 40% have evidence of metabolic syndrome pre-operatively. Most of the girls also have irregular periods and polycystic ovary syndrome. Initial results show that after a year after bariatric surgery, most of the patients have lost approximately one-third of their excess body weight. Most patients show improvement in metabolic syndrome as early as 6 months post-operatively.

Patients are followed up very carefully post-operatively and any problems are carefully sought out and managed by the multi-disciplinary team. Patients are followed up for at least 5 years after their surgery. There are at least 6 visits in the first post-operative year and then continues 6 monthly thereafter.

There is ongoing research in the unit evaluating the safety and success rates of bariatric surgery and the natural history of obesity-associated conditions. They are also studying changes in metabolic parameters and gut hormones after weight loss surgery in adolescents.

Whilst in New York, I was also able to attend the Second World Congress on Interventional Therapies for T2D. This had a very interesting scientific programme with international experts in the field of bariatric surgery and T2D including Professor Francesco Rubino, Professor Sir George Alberti and Professor John Dixon. The International Diabetes Federation (IDF) position statement was published during this meeting (www.idf.org/webdata/docs/IDF-Position-Statement-Bariatric-Surgery.pdf). The position statement stated that bariatric surgery is a cost-effective therapy for T2D and obesity with an acceptable safety profile and that surgery for severely obese people with T2D should be considered much earlier in management rather than considered as a last resort.

This Travelling Scholarship has allowed me to visit a high-volume adolescent morbid obesity and bariatric centre in the USA and also attend a related World Congress in the same city. Both have been great experiences that have contributed vastly to my ongoing education and understanding of this fascinating subject. I would like to take the opportunity to thank Dr Zitsman and his team, along with the ALSGBI and B. Braun Aesculap for facilitating this fantastic visit.

Ms Cynthia-Michelle Borg MD FRCS
Winner of B. Braun Aesculap Travelling Scholarship 2010

Association of Coloproctology of Great Britain and Ireland

2013 Annual Meeting

Monday, 1 – Wednesday, 3 July 2013
at the BT Convention Centre, Liverpool, UK

We invite you to join us in Liverpool for our 2013 Annual Meeting.
The three-day programme includes

- The problem stoma
- Pelvic floor symposium
- CME
- Dysplasia, ALMs, DALMs; surgical decision making
- Colonoscopy – striving for excellence
- Consultants' Corner – worst case scenario
- Bowel cancer screening – where are we now and where are we going?
- Videos including laparoscopic colorectal surgery
- Research session
- Flying in the face of evidence
- Internal sphincter resection for low rectal cancer – the Bordeaux experience
- The greatest thing since sliced bread YES / NO Robotics; SILS; HALO
- Anal cancer symposium
- There may be trouble ahead

For more information please visit
www.acpgbi.org.uk/annual-conference-2013/

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ALS Industry Partners' Course Information

B. Braun Medical, Aesculap Endoscopy

Contact: Allan Barr, Clinical Manager, Endo-Surgery, Aesculap Division, B. Braun Medical Ltd
Mobile: +44 (0)7772 115856 | Email: allan.barr@bbraun.com | Web: 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 our 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, colorectal 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.

Date	Course	Venue
12–14 June 2013	Advanced Laparoscopic Colo-Rectal Surgery	Berlin
20–22 June 2013	Advanced Laparoscopic Urology, Prostate	Berlin
1–2 July 2013	Basic Nephrectomy	Berlin
3–5 July 2013	Laparoscopic Training Course Hernia Surgery	Berlin
18–20 November 2013	Advanced Laparoscopic Surgery	Berlin

Olympus KeyMed

Contact: Mrs Tracy Bray, Events Manager, Olympus KeyMed | Direct Line: +44 (0)1702 616333 | Email: info@olympus.co.uk | Web: www.olympus.co.uk

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

Date	Course	Venue
18-20 June 2013	Surgical Energy Masterclass for Theatre Practitioners	Olympus, Southend-on-Sea
24–25 June 2013	Laparoscopic Anti-Reflux Surgery with THUNDERBEAT	IMACS, Maidstone Hospital
4–5 July 2013	Minimally Invasive Oesophagectomy with THUNDERBEAT	IMACS, Maidstone Hospital
15–16 July 2013	Laparoscopic Radical Prostatectomy Cadaveric Workshop	Newcastle Surgical Training Centre
12-13 September 2013	Laparoscopic Anti-Reflux surgery with THUNDERBEAT	IMACS, Maidstone Hospital
26–27 September 2013	Laparoscopic Retroperitoneal Workshop	Eastbourne District General Hospital
3-4 October 2013	Advanced Technique in Benign Oesophageo-Gastric Surgery with THUNDERBEAT	IMACS, Maidstone Hospital
11-12 November 2013	Laparoscopic Colorectal Surgery with THUNDERBEAT	IMACS, Maidstone Hospital
11–12 November 2013	Expert Skills in Laparoscopic Partial Nephrectomy	Newcastle Surgical Training Centre
19–21 November 2013	Surgical Energy Masterclass for Theatre Practitioners	Olympus, Southend-on-Sea

ALS GBI

LIGHT Hernia Course
(Laparoscopic Incisional and Groin Hernia Training)

The STEPS (Seeing, Training, Enhancing, Perfecting, Solo) LIGHT Course, established by ETHICON Products offers training in Laparoscopic Hernia surgery over 3 days split between various training centres in the UK.

Module One
The first module will be held at the MATTU in Guildford. This will involve Observing Live Operating, using Simbionix computer simulators and taking part in a JOURNAL CLUB.

Module Two
Module two will be held at Newcastle Surgical Training Centre and will involve hands on surgery of all techniques learnt to date on fresh frozen human cadavers.

Module Three
Module three will involve Supervised operating in a training centre with patients (2 delegates per session). Venue to be confirmed. Finally, all Modules are compulsory.

Application Process

- Yr ST 7/8 (or equivalent)
- CV including covering letter
- Letter of support from your consultant approving the application and confirming advanced laparoscopic skills.
- Evidence of previous hernia / laparoscopic meeting attendance
- 8 delegate places available

To apply, please send the above to:
Lauren Clarke-Dowson
Johnson & Johnson Medical Ltd,
c/o Universal World Events Limited, Ashfield House,
Resolution Road,
Ashby de la Zouch, Leicestershire, LE65 1HW
E-mail: lclarke2@its.jnj.com
www.agoralive.com/EthiconProducts/Event4

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An invitation

Dear ALSGBI Delegate,

We would like to invite you to attend the ALSGBI Welcome Drinks Reception hosted by Fisher & Paykel Healthcare. The Welcome Drinks Reception is taking place at **The New Zealand High Commission, Penthouse Suite from 20:00 – 22:00 hours on Wednesday 13 November 2013** and is inclusive to registered delegates only. We hope to see you there.

Fisher & Paykel Healthcare

F&P HumiGard™ Fisher & Paykel HEALTHCARE

ALS GBI
Association of Laparoscopic Surgeons & Association of Laparoscopic Theatre Staff of Great Britain & Ireland

ETHICON

stryker

Laparoscopic Training Day
Wednesday 13 November 2013
Kindly supported by Ethicon and Stryker

09:00 hrs -16:00 hrs at The Royal College of Surgeons of England
24 available places

Aimed at ST 1-4 (the course will appeal to trainees who have only performed 4 or 5 hernias procedures)

If you are interested please provide a personal statement as to why you want to attend the course and send it to Mr Peter Sedman, Director of Education, Association of Laparoscopic Surgeons of Great Britain & Ireland @ The Royal College of Surgeons, Room 505, 5th Floor, 35-43 Lincoln's Inn Fields, London WC2A 3PE. Applications to arrive by 27 September 2013. To qualify for a FREE place, trainees must register for the full Annual Scientific Meeting by 27 September (£165) and be current paid-up members of the ALSGBI.

ALS GBI
Association of Laparoscopic Surgeons &
Association of Laparoscopic Theatre Staff
of Great Britain & Ireland

Save the date
ALSGBI Annual Scientific Meeting 2013

RCS
ADVANCING SURGICAL STANDARDS

Thursday 14 &
Friday 15 November 2013
@ The Royal College of Surgeons
of England

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ALTS (Association of Laparoscopic Theatre Staff) Members 2013 Bursaries

The ALSGBI is pleased to offer a number of SIGH (Surgical Instrument Group Holdings Ltd) Bursaries. The purpose of these awards is to enable Senior Theatre Staff to attend the 2013 ALSGBI Annual Scientific Meeting in London on Thursday & Friday, 14 & 15 November 2013. The Bursaries will cover the cost of the registration fee for the two days and also accommodation for one night (Thursday).
Bursaries will be awarded to Senior Theatre Staff who can demonstrate significant experience of teaching, defining roles and assisting with procedures in the MAS Teams of their hospitals.

In order to be considered for one of the SIGH Bursaries it is a prerequisite that candidates should be current ALTS members however you may join on application.
Initially email jtreglohan@alsgbi.org to request an application form and membership form if necessary. The completed form(s) must be returned to Mrs Jenny Treglohan, ALS Executive Officer, Association of Laparoscopic Surgeons of Great Britain & Ireland at The Royal College of Surgeons of England, Room 505, 5th Floor, 35-43 Lincoln's Inn Fields, London WC2A 3PE.

The deadline for receipt of applications is **Friday 27 September 2013.** This offer is on a 'first come, first served basis' and only one bursary per hospital will be awarded. Bursaries are NOT available to nurses who have been sponsored in previous years. We look forward to seeing you in November!

SIGH

Is stroke volume optimisation really necessary in laparoscopic colorectal surgery?

There is an ongoing debate surrounding perioperative fluid therapy in surgery, particularly the appropriate volume to administer. Considerable research has been conducted to explore the relative benefits of "restrictive" or "liberal" fluid regimes. The evidence is both conflicting and confusing but what is apparent is that administering the volume of fluid precisely tailored to the individual patients requirement is probably optimal (1). In order to achieve this a goal-directed approach is required.

There is evidence that the use of goal-directed fluid therapy (GDFT) in colorectal surgery is associated with a reduction of length of hospital stay, reduced critical care admissions and morbidity (2). As such the Enhanced Recovery After Surgery (ERAS) group and the ASGBI ERAS guidelines both recommend the use of GDFT in colorectal surgery. NICE have also issued guidelines in 2011 recommending the use of the CardioQ- oesophageal Doppler monitor in major surgery to guide GDFT. However there has been some recent evidence that has questioned these benefits in patients within an enhanced recovery programme suggesting that a formulaic approach to peri-operative fluid administration is adequate (3,4) .

We aimed to identify the quantity of fluid administered by GDFT in laparoscopic colorectal surgery in order to achieve stroke volume optimisation prior to creation of the pneumoperitoneum. Data was drawn from a randomised clinical trial (NCT 01128088) conducted between 2010 and 2011 investigating the surgical stress response. All patients were within an established enhanced recovery programme, received oral carbohydrate loading prior to surgery and no oral bowel preparation. To be eligible to participate in the trial patients had to undergo a laparoscopic rectal or colonic resection without stoma formation. 120 patients were required and randomised to four groups to receive either spinal analgesia or morphine patient controlled analgesia and either crystalloid (Hartmann's solution) or colloid (6% Volulyte) fluid. The volume of fluid administered as guided by the oesophageal Doppler monitor to achieve stroke volume optimisation in the anaesthetic room was recorded.

There was no significant difference between the two fluid groups in terms of age, weight, BMI, P-POSSUM scoring and ASA classification. There was a significant difference ($p<0.0005$) in the mean volume of fluid by weight that was administered: Hartmann's (10 mls/kg) vs 6% Volulyte (7.3 mls/kg). One would expect this as these fluids function differently in the intravascular compartment. However the range of fluid that was required for SV optimisation with both fluid types across the whole cohort was notably variable, see figure 1. 50% of patients in the Hartmann's group and 25% in the 6% Volulyte group required greater than 8 mls/kg of fluid to achieve SV optimisation. A possible concern is that those patients receiving larger volumes of fluid of either type may be in excess of requirements. If this were so a difference in weight gain or rate of post-operative ileus would be expected, but none was identified.

Despite the use of oral carbohydrate loading and enhanced recovery protocols there is a still a large range of fluid required to achieve SV optimisation, with 35% of patients in this study requiring greater than 8 mls/kg. One is unable to predict the exact amount of fluid required on an individual patient basis and therefore fluid administration can only be adequately achieved with a goal-directed approach. Essentially the right amount of fluid at the right time for each individual patient.

Mr A Day, Mr R Smith, Mr W Fawcett, Mr M Scott, Professor T Rockall
The Royal Surrey County Hospital

References:

1. Bundgaard-Nielsen M, Secher NH, Kehlet H. 'Liberal' vs. 'Restrictive' perioperative fluid therapy--a critical assessment of the evidence. Acta Anaesthesiol Scand 2009, Aug;53(7):843-51.
2. Abbas SM, Hill AG. Systematic review of the literature for the use of oesophageal doppler monitor for fluid replacement in major abdominal surgery. Anaesthesia 2008, Jan;63(1):44-51.
3. Challand C, Struthers R, Sneyd JR, Erasmus PD, Mellor N, Hosie KB, Minto G. Randomized controlled trial of intraoperative goal-directed fluid therapy in aerobically fit and unfit patients having major colorectal surgery. Br J Anaesth 2011, Aug 26.
4. Brandstrup B, Svendsen PE, Rasmussen M, Belhage B, Rodt SÅ, Hansen B, et al. Which goal for fluid therapy during colorectal surgery is followed by the best outcome: Near-maximal stroke volume or zero fluid balance? Br J Anaesth 2012, Aug;109(2):191-9.

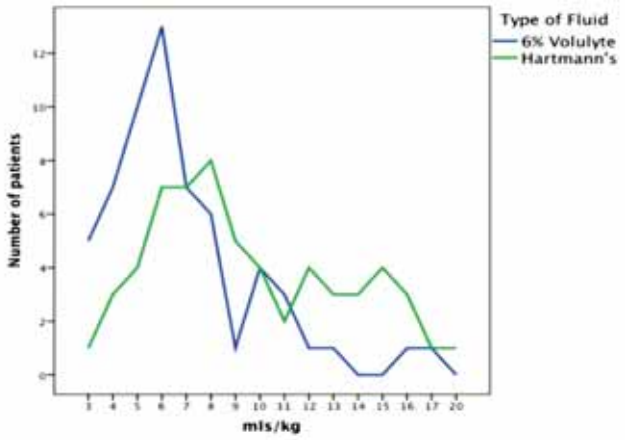

Figure 1: The range of fluid required to achieve SV optimisation with Hartmann's solution or 6% Volulyte.

Caption Competition

Entries have to be sent to Jenny Treglohan
jtreglohan@alsgbi.org
by 1 July 2013 and the winner will receive a bottle of champagne.

BOMSS Annual Scientific Meeting

23-25 January 2013, Glasgow

January 2013 heralded not only a New Year but the 4th BOMSS Annual Scientific Meeting in Glasgow. The meeting was held at the Radisson Blu hotel, a stone's throw from Glasgow Central Station, and was BOMSS's first venture north of the border. The Lord Provost of Glasgow welcomed us with a civic drinks reception and a tour of the impressive City Chambers.

The format of the meeting was, as before, a late start on the Thursday to allow delegates to arrive from afar, and for training day delegates to sleep off their first hangover, dinner on Thursday evening and a full Friday session, winding up at a civilized 3pm.

The Scientific meeting was preceeded by an excellent and greatly oversubscribed Training Day, organized by Mr Sean Woodcock. This was jointly attended by surgical trainees and AHPs, who shared the same programme. Surgical trainees gained much from the mock MDTs and AHPs appeared delighted to be able to fire staplers and dissect stomachs! Our Industry Partners pulled together to provide a fabulous educational environment, which was greatly appreciated.

Mr Alberic Fiennes introduced the main meeting as his Presidential swan song and was rightly applauded for his contribution to the Society, before handing over the reins to Mr Richard Welbourn, the incoming President.

The meeting started with a review of bariatric training and education from various perspectives. Dr Mathias "Mal" Fobi gave a historical review of training in the USA, reminding us not to reinvent the wheel. Our predecessors have much to offer, having previously faced many of the questions which appear new to us now. Mr Alan Osborne presented the trainees' view. His enthusiasm was palpable as he invited us to meet the challenge of training our fellows adequately. Professor George Hanna showed us how the LapCo programme has been used by our colorectal colleagues to disseminate safe laparoscopic colorectal surgery. The scientific analysis of this model for training was thought provoking, and should certainly be considered for assessing bariatric training.

The afternoon session on metabolic medicine began with an update from Professor Mike Lean's internationally acclaimed academic unit at Glasgow University. In addition to his work, which has shaped the accepted definition of metabolic syndrome, his UK Counterweight Programme, has been adopted by the NHS at primary care level. He challenged us to think about the cost-benefit of bariatric surgical intervention for individuals compared to their evidence-based strategies using low-energy liquid diet achieving 10-15% sustained weight loss (enough to achieve diabetes remission) for larger populations. His humorous "health-enhancing sabotage" approaches to fighting calorific vending machines reminded us that simple strategies can also change established behaviours!

Professor Roy Taylor presented some of his research from Newcastle University, updating the delegates on current evidence for the beneficial metabolic changes of gastric bypass, which he has simulated by fasting and significant calorie restriction. Through specialised MR techniques they have shown quantifiable reduction in liver and pancreatic fat in diabetic volunteers proving that the reversal of type 2 diabetes is not necessarily due to foregut exclusion and can be achieved by dietary restriction of energy intake with weight loss.

Finally, in his comprehensive review of metabolic surgery, Dr Torsten Olbers presented the most recent analysis of the Swedish Obesity Subjects Study; a landmark controlled study in the field. This data showed bariatric surgery conferred significant reduction in cardiovascular events and deaths. He reminded us that the study was analysis was performed on an intention to treat basis and, as such, the significance of the findings were impressive when one considers some controls had since availed themselves of bariatric surgery since enrolment.

The early evening talk was provided by Professor David Haslam, Chairman of the National Obesity Forum, and a GP "by trade". He gave a thought provoking and entertaining talk, and highlighted the role of primary care in engaging and identifying patients who would most benefit from weight loss interventions.

Friday's timetable was based around the 2 free paper sessions, and series of breakout sessions to explore a number of relevant topics. The 5 topics chosen for debate were "How to make the

National Bariatric Surgery Register (NBSR) compulsory", "NHS tariffs and can the NHS afford revisional bariatric surgery", "Follow up, by whom, how and for how long", "Most effective use of AHP skills within the MDT" and "What don't we understand about eating behavior". All sessions were mediated and debated and were hence truly interactive.

Dr Mal Fobi gave a sponsored lunchtime seminar on the history and development of his eponymous banded gastric bypass, which continues to provide impressive results. The afternoon wound up after lunch with the presentation of prizes. The winners were: Mr William Carr (best poster presentation, Mr James Brown (best oral presentation), Mr James Young (the training day prize) and Mr Nicholas Carter (best training day AV presentation).

The meeting was the best subscribed to date, with significantly increased representation from our Allied Health Professionals. The BOMSS Annual Scientific Meeting certainly continues to represent the multi-disciplinary working environment in which bariatric and metabolic surgery is performed. If the success of Glasgow can be repeated we can look forward to an exciting BOMSS 2014 meeting in Leamington Spa.

Mr Simon Dexter
Honorary Treasurer BOMSS

Mr Mike Pellen
Year 6 SpR Leeds

HOFBURG

Vienna Convention Centre

Congress President:
Prof. Selman Uranues

Program Committee Chair:
Prof. Nicola di Lorenzo

HIGHLIGHTS

- Postgraduate courses
- Hands-on training
- New technologies
- "How I do it" video session
- Challenges in colorectal surgery
- Laparoscopic surgery of solid organs
- Diverticular disease
- Management of complications
- Pro and contra discussions
- Role of laparoscopy in advanced rectal cancer
- Robotic surgery
- Single vs. reduced port surgery
- Laparoscopy in emergencies
- Free paper sessions: oral, video and poster
- Special awards and grants
- Technical exhibition

To register for the congress,

please go to our website at **www.eaes.eu** and click on the '**EAES Meetings tab**'. From there you will be guided to the online registration or the registration form that can be downloaded. For any questions, please mail to **registration@eaes.eu**.

EAES Membership

If you are interested in becoming an EAES member, please complete and return this reply card or visit our website: **www.eaes.eu** and click on the '**Membership tab**'. For any questions, please mail to **membership@eaes.eu**.

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Reply card to obtain membership application form

Name	
Address	
City + ZIP Code	
Country	
Phone	Fax
Email	
Physician	Resident in Training

21st International Congress of the EAES at the Hofburg convention centre Vienna, Austria, 19 - 22 June 2013

Congress theme: Do better, be better.

PG and hands on courses 19th of June 2013

Technology Symposium I

Morning Program

Articulating, bending and flexible tools:
the new generation of OR instruments
Course Directors: G. Dapri (Belgium), Y. Mintz (Israel)

Technology Symposium II

Afternoon Program

Amazing Technologies
Course Directors: N. Di Lorenzo (Italy), A. Szold (Israel)

Postgraduate Course I

Groin and ventral hernia / AMIC
Course directors: R. Bittner (Germany), R.Fortelny (Austria)

Postgraduate Course II

Colon and rectal surgery
Course directors: M. Morino (Italy), R. Bergamaschi (Norway)

Postgraduate Course III

Diagnosis, surgical approach and outcomes
of motility disorders of the oesophagus
Course directors: G. Zaninotto (Italy), E. Targarona (Spain)

Hands-on I

Morning

Laparoscopic course BASIC
(suturing, knotting, coagulation & hemostasis)
Course directors: A. Fingerhut (France), R. Schrittwieser (Austria)
Maximum attendees: 16. Only available to registered Congress Participants

Hands-on II

Afternoon

Laparoscopic course ADVANCED
(anastomosis techniques, use of stapler, advanced hemostasis)
Course directors: A. Shamiyeh (Austria), W. Brunner (Switzerland)
Maximum attendees: 16. Only available to registered Congress Participants

Program overview 20th, 21st and 22nd June 2013

Consensus conference

The management of Gastro-Esophageal Reflux Disease (GERD)
Coordinator: K-H. Fuchs (Germany)

Lectures

Jacques Périssat lecture

Title: 'Theodor Billroth - the surgeon in his time'
Speaker: W. Wayand (Austria)

Sir Alfred Cuschieri Technology lecture

Title: Mobile technologies and opportunities for surgeons
Speaker: E. Chan (USA)

Key note lecture:

Title: MIS in esophageal cancer
Speaker: M. Cuesta (The Netherlands)

Meet the Professor - Luncheon session

Meet the Professor session is designed to provide the opportunity to attendees to interact with experts in an informal setting

Award sessions

- Karl Storz - EAES award session (for young surgeons)
- Olympus - EAES award session (for reduced port surgery)
- Gerhard Buess Technology award session (for young researchers)
- Video award session
- Poster award session
- Free paper sessions: Oral, Video and Poster
- Technical Exhibition

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Scientific Sessions

- European Cup (national societies)
- Video based minimal invasive surgery pelvic floor disorders
- Special features for splenic and adrenal surgery
- 3D systems - video festival
- Face to face (interactive with voting system)
- NOTES: new techniques, new devices and human applications
- Established NOTES hybrid procedures in clinical practice
- Face to face (interactive with voting system)
- www for surgeons
- Technologies that will kill surgical dinosaurs
- Established procedures in single access surgery
- Special tools for reduced port surgery
- Minimally invasive treatment of hepatic lesions (EAES-ELCD)
- Laparoscopic surgery of the pancreas
- Esophageal cancer and its treatment
- Controversies in surgery for esophagogastric benign diseases
- Intraoperative challenges in laparoscopic rectal cancer surgery
- Defining the role of minimally invasive surgery in inflammatory bowel disease
- Bariatric / metabolic surgery – How I Do It (video session)
- Minimally invasive hernia repairs (EAES - AMIC)
- Controversial issues in rectal cancer
- Clinical advances in robotic surgery
- Laparoscopy in emergencies (EAES - ELCD)
- Black video session: Major complications during laparoscopic surgery
- How to avoid complications during lap surgery (EAES - ELCD - ALS)
- Abdominal emergencies (EAES - IATSIC)
- Tips and tricks in hernia surgery (AMIC)
- Bariatric and Metabolic Emergencies for the non-Bariatric Surgeons (AMIC)
- How do I do it – video session (AMIC)
- Introduction of Minimally Invasive Surgery into UK Cancer Services (ALS)
- Minimally invasive surgery worldwide:
  the role of professional scientific organizations

For more information, please refer to: www.eaes.eu

Product innovation marches to a different beat
Olympus launches The Sonicbeat - A new laparoscopic device

Every year sees the birth of new technologies and innovations within the medical marketplace. This year is no exception, with Olympus launching its SONICBEAT device in the UK. Part of Olympus' enhanced range of energy products, the SONICBEAT is the sister product to the acclaimed THUNDERBEAT that has taken the medical device market by storm.

Launched at the beginning of 2012, THUNDERBEAT is the world's only integrated surgical device which combines advanced bipolar and ultrasonic energies in a single instrument. Such a combination of energy forms allows a fastest-in-class cutting speed together with high levels of haemostasis, including the ability to seal vessels of up to 7mm diameter. Consequently, THUNDERBEAT may contribute to operating department efficiency through reduced instrument usage, fewer instrument exchanges, uninterrupted operation flow, and total theatre time savings.

The latest SONICBEAT harnesses ultrasonic energy alone but its design is based upon the same principles as THUNDERBEAT. In particular, a 'wiper jaw' mechanism and fine tip design allow faster cutting, easier dissection, more homogenous grasping force, plus equivalent sealing and homeostasis when compared to existing ultrasonic energy devices. The design also minimises mist, allowing a clearer laparoscopic view which may further improve operating theatre efficiency.

In addition to the obvious clinical benefits of the SONICBEAT, cost-efficiency is another central attribute and one likely to strike a chord within both the public and private health sector, where spending is under the microscope. Pressure on the NHS to cut expenditure and the need for private practices to drive profits puts a particular emphasis on cost-conscious purchasing. So while THUNDERBEAT and its obvious efficiency is undoubtedly the device of choice for advanced laparoscopic surgeries, the economical SONICBEAT is particularly well suited for intermediate procedures. Used in combination, the platform provides access to new technologies without necessarily increasing overall spend on energy devices.

Both THUNDERBEAT and SONICBEAT are driven by the latest Olympus Surgical Tissue Management System generator platform, a device with an intuitive touch screen interface which is also equipped to provide conventional diathermy energy. Further efficiencies can therefore be realised through generator standardisation across an operating department.

Simona Esposito, Head of Surgical Energy at Olympus said: "Olympus is committed to bringing cutting edge technology to the market. The launch of our new SONICBEAT device is further evidence of our dedication to providing the very best surgical devices, while presenting cost-effective solutions."

To find out more about Olympus' enhanced range of energy products, including the new SONICBEAT device, please visit: www.olympus.co.uk/medical

Cook Common Bile Duct Exploration

Although Cook Medical is known for the Biodesign biologic graft, the company's roots lie in catheter technology. In 1963, Bill Cook attended the RSNA meeting in Chicago with some radiopaque tubing and a blowtorch. Through his collaboration with some of the pioneers of angiography and interventional radiology, the world's largest privately-owned medical device company was formed. Cook Medical will celebrate its 50th anniversary this summer.

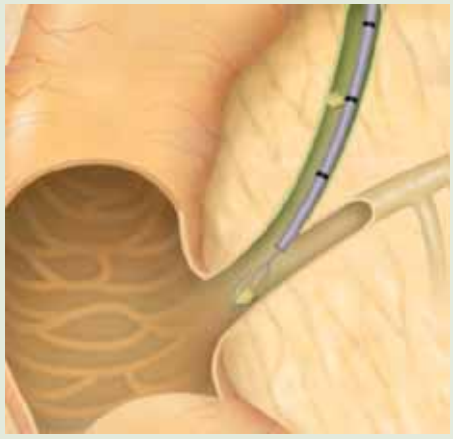
There are now more than 15,000 products, 10 business units, and over 10,000 employees worldwide.

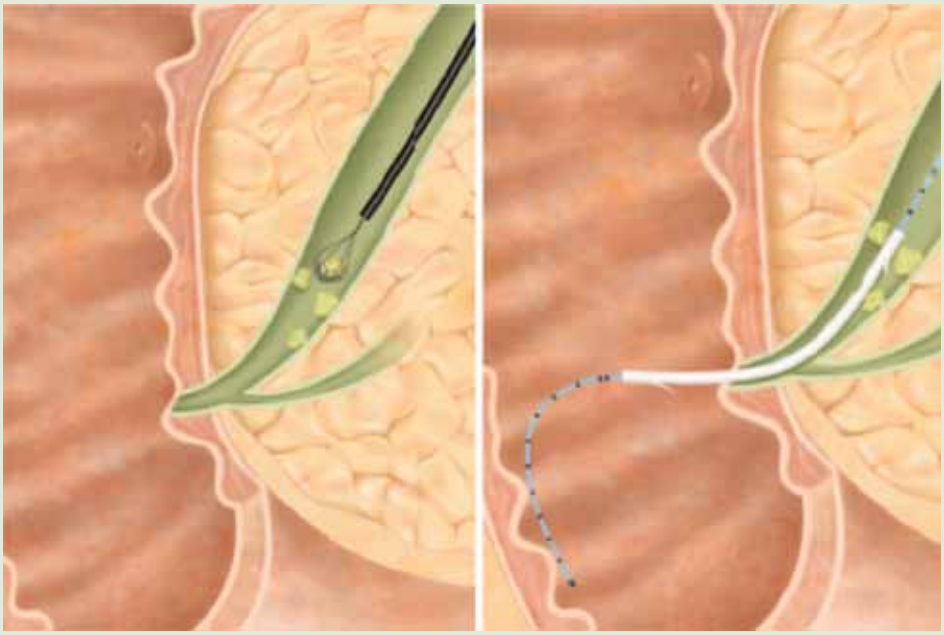
The same catheter technology, developed around the Seldinger over-the-wire technique, led Cook into many other areas of medicine and surgery, including Aortic Intervention, Endoscopy and Urology.

Cholangiography and Common Bile Duct Exploration are often neglected in the development of specialist equipment, but cooperation with surgeons such as Olsen, Berci, Nathanson and Fanelli has produced some dedicated devices, where otherwise products intended for Urology have been used.

There is evidence that a laparoscopic approach to common bile duct stones reduces post operative pancreatitis and hospital stay. It also avoids the delay and morbidity of post-operative ERCP, and preserves the Sphincter of Oddi.

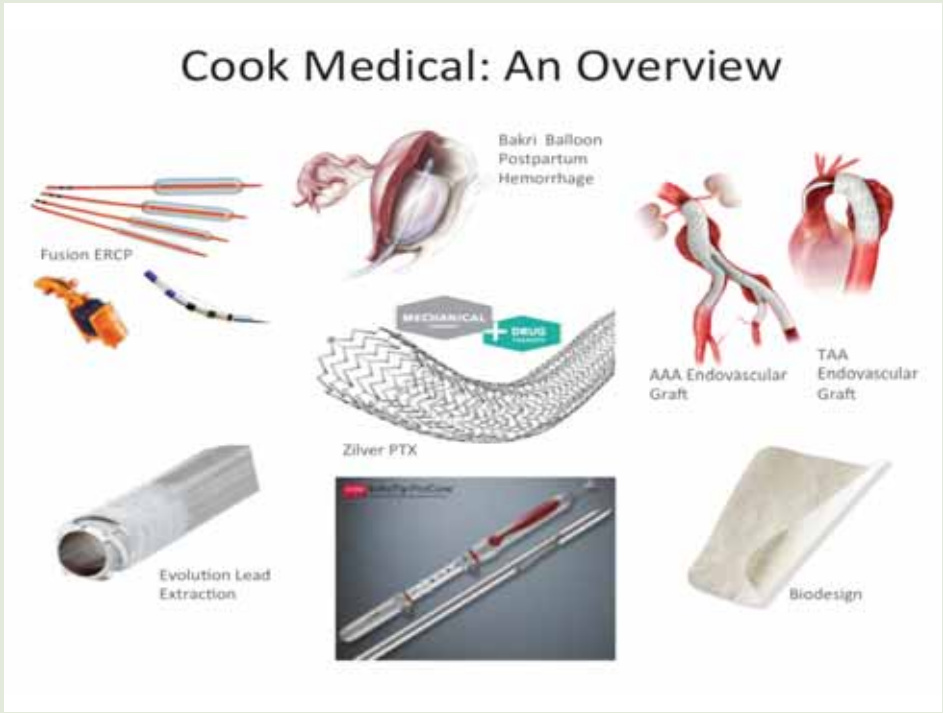
The approach is often defined by the availability of choledochoscopes. In their absence, stones in the common bile duct may be accessed with a basket under fluoroscopic control, although it is necessary to have the ability to flush with contrast medium at the same time. Nathanson's Transcystic Common Bile Duct Exploration Pack is an option, including a 5.5 Fr radiopaque catheter and a stainless steel flat wire basket.





A transcystic approach is possible with a 3mm choledochoscope, whilst a 5mm scope requires a choledochotomy. A basket and a drain may be all the accessories required for the CBD route. For access through the cystic duct, you may need an introduction sheath, hydrophilic guide wire, dilatation balloon and tipless basket. If you cannot achieve total stone clearance and the patient is to be send for endoscopic extraction, it might be useful to maintain post-operative drainage with a temporary stent.

To learn more, please visit www.cookmedical.com and search for common bile duct exploration.

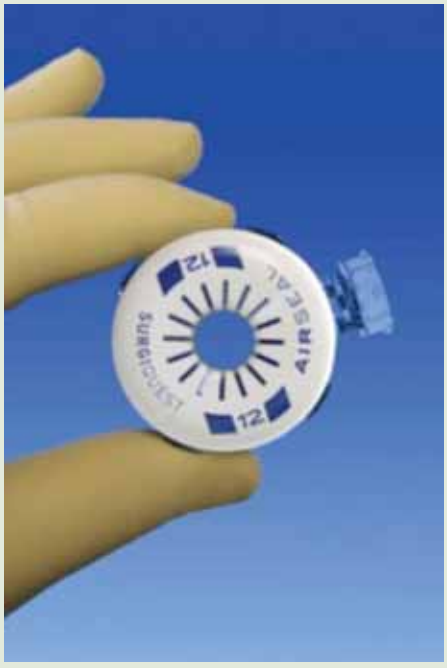


Stable Pneumoperitoneum, Automatic Smoke Evacuation Valveless Access

Lawmed is delighted to begin their sponsorship of the ALS by formally announcing an exclusive partnership with the leading, US based, surgical technology company, SurgiQuest®. Surgiquest's proprietary technology, Airseal®, is the world's only intelligent and integrated insufflation and access system.

SurgiQuest set out to develop a radically different laparoscopic trocar design that eliminated the circular seals and duckbill valves that had plagued conventional trocars since the early 1990's. They immediately recognized that the technology had the capability to transform laparoscopic surgery not only by eliminating the problems associated with conventional trocars such as scope fogging, fragmented specimen removal, and seal disintegration but by enabling the use of multiple instruments down a single port.

The development process quickly identified additional benefits that went well beyond eliminating these problems. They found that conventional insufflators lacked the capabilities to operate the new valve-free trocars, so the company developed their own insufflator that was able to create and maintain an invisible air barrier within the trocar cannula's housing. The new unit utilised a revolutionary, re-circulatory flow design that created a surgical pneumoperitoneum that was far more stable than anything surgeons had previously experienced. They also discovered that it automatically evacuated surgical smoke and plume from the field of vision. The combination of this valve-free trocar and re-circulatory insufflation unit became the foundation of AirSeal®, the world's first and only integrated access system for laparoscopic and robotic surgery.



The arrival of Airseal means that surgeons can now operate without fear of losing pneumoperitoneum even in the most challenging situations, including colpotomy in total laparoscopic or robotic hysterectomy or the continuous use of suction to remove blood or irrigation fluid. In addition to these operative benefits, anesthesia teams reported that patients seemed more stable and are easier to ventilate during procedures where the AirSeal system is used. Based on these early reports, the company is now studying key anesthesia metrics including Peak Pressures and End Tidal CO2 to assess the technology's impact on pulmonary compliance.

An initial prospective comparison between the AirSeal System and a conventional laparoscopic trocar/insufflation system identified that the use of AirSeal reduced both overall procedure time by approximately 15% and carbon dioxide (CO2) absorption by the patient (urology 2011;77:1126-1132), believed to be a significant contributor to post-operative shoulder pain. The company is now researching these and other metrics in prospective, randomized studies in a number of surgical procedures.

As a company, SurgiQuest is focused on how its technology can improve not only how surgical operations are performed but by how patients respond to surgery itself, both during and after the procedure.

For further information about the Airseal system please visit www.surgiquest.com or contact John Black john@lawmed.co.uk

Mr John Black
Lawmed

Membership Application Form

MEMBERS RECEIVE DISCOUNT ON CONFERENCE REGISTRATION

I wish to apply for membership of the Association of Laparoscopic Surgeons of Great Britain & Ireland (ALSGBI) & the Association of Laparoscopic Theatre Staff (ALTS). **Please complete in BLOCK CAPITALS**

Name (please print) _____

Proposed by (Name of Consultant) _____

Consultant's telephone number _____

My preferred mailing address _____

_____ Postcode _____

Hospital _____

Specialty _____ Grade _____

Telephone (home) _____ Telephone (work) _____

Mobile _____ Date of Birth _____

Email address _____

MEMBERSHIP FEES • PLEASE TICK PREFERRED BOX

Full Member with EAES membership and journal	£215	☐
Full Member without EAES membership or journal	£145	☐
Overseas Member with EAES membership and journal	£190	☐
Overseas Member without EAES membership or journal	£115	☐
Trainee Member with EAES membership and journal	£125	☐
Trainee Member without EAES membership or journal	£88	☐
Senior Member with EAES membership and journal	£73	☐
Senior Member without EAES membership or journal	£33	☐
Auxiliary Member (ALTS)	£33	☐

Signature _____ Date _____

Cheques should be made payable to 'The Association of Surgeons & Sub Specialties'. Please note that the ALSGBI can obtain a proposer's signature on your behalf. This form, when completed, should be returned to:

The Honorary Secretary of the Association of Laparoscopic Surgeons of Great Britain & Ireland @
The Royal College of Surgeons of England, Room 505, 5th Floor, 35–43 Lincoln's Inn Fields, London WC2A 3PE
Enquiries +44(0)20 7869 6941

Alternatively visit www.alsgbi.org and join online which is quick and easy!