ALSGBI
Association of Laparoscopic Surgeons of Great Britain & Ireland

ALS newsletter

Edited by Michael Rhodes

President's Introduction

The President wearing the new ALS tie

It is now almost six months since the Annual ASGBI International Surgical Congress in Bournemouth at which the ALSGBI played such a large part on the Thursday. Sessions on NOTES, video presentations, the David Dunn medal and a superb British Journal of Surgery Lecture on the history of laparoscopic surgery given by Professor David Rosin, now Professor of Surgery in Barbados, made it a truly memorable meeting. The David Dunn medal was won by Ms Michelle Slater for her excellent presentation entitled 'Laparoscopic stapled cardioplasty – a new procedure for repeated failed treatment of achalasia'. Let us hope that next year's meeting in Glasgow will be just as enjoyable.

Our Annual Scientific Meeting for 2008 is in the final stages of development and Professor Roger Motson and his highly efficient team in Colchester have put together a wonderful programme entitled 'Back to the Future'. It is six years since we last visited Colchester for our Annual Scientific Meeting and a lot of water has flowed under the bridge since then especially in laparoscopic surgery. The meeting which will be held at the Five Lakes Hotel near Maldon will include live operating from Chicago, Edinburgh and Colchester as well as keynote lectures given by international guest lecturers, Professor J LeRoy from the European Institute of Telesurgery, France and Dr S A Giday MD from Baltimore, Maryland, USA. We shall also be honoured by a visit from Professor The Lord Darzi of Denham who will address the conference on the Thursday afternoon prior to the Annual Conference Dinner. The ALTS are holding a full programme on the Thursday which all those attending will find most interesting and entertaining.

Next year's meeting will be entitled 'One Step Beyond' and will be held in the prestigious River Centre in Tonbridge, Kent. The theme of the meeting will be the prevention and treatment of complications in laparoscopic surgery which all of us should find helpful and instructive. Amongst the various national and international invitees we have confirmation that Heine van der Walt, one of the most accomplished laparoscopic surgeons in the world, will be coming over from South Africa to display his operative skills in the live operating sessions as well as offering us the benefit of his vast experience in the main meeting. The live operating will be coming from hospitals in Kent as well as a link to Michael Li's unit in Hong Kong and should provide us with a fascinating day of education.

For the moment, however, our attention should be directed towards Colchester and I do hope that we shall be seeing as many of you as can attend our forthcoming meeting in November. I would urge you to book early to make the most of the opportunities and to encourage your juniors to come along at least for part of the meeting but preferably for the entire event.

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

Mr Mike Parker, President ALSGBI

16th International Congress of the EAES, Stockholm 11–14 June 2008

The 16th International Congress of EAES was held in Stockholm 11th to 14th June with the theme of 'Endoscopic Surgery – from an enigma to established clinical practice'. Stockholm has a strong laparoscopic profile and indeed was the city where the first laparoscopic procedure was performed by Dr H C Jacobeus at the Royal Seraphim Hospital in 1910. The city is also famed for the site of the annual Nobel Prize Ceremony and the City Hall where this takes place was the venue for the EAES reception.

The programme was varied but with an inevitable increase in the attention given to Natural Orifice Surgery (NOTES). Sceptics abound and probably still outnumber enthusiasts but members attending the sessions could not help but be amazed at the rapidity with which technological innovation is advancing in this area and may well have come away less sceptical than when they arrived. The first UK hands-on course was held very shortly afterwards in the MATTU in Guildford and the building enthusiasm and interest was very evident there also.

The ALSGBI had a stand at the EAES, bravely manned by ALS officers Jenny Treglohan and Sarah Williams who were able to increase the profile of ALSGBI and its Annual Scientific Meeting and generate new members. It would be good to see a greater UK participation at this annual conference which continues to focus on innovative areas of surgery.

Ms Piriyah Sivagnanam, Norfolk and Norwich Hospital

Winner of the best Poster Prize at the 16th International Congress of the EAES, Stockholm

The next International Congress of EAES will be held in Prague on 17–20 June 2009 with the theme of 'New advances and oncological results in Minimal Access Surgery'. I encourage all of you to attend if you can.

Professor Tim Rockall, South Thames Representative on ALS Council

Minimally Invasive Gastro-Oesophageal Cancer Surgery (MIGOCS) Registry

The MIGOCS registry received a great boost recently when the Royal Devon and Exeter team of Mr Richard Berrsiford and Mr Saj Wajeed agreed to release their data. Richard and Saj recently published the largest UK series of minimally invasive oesophagectomies, and the addition of their experience to the registry has considerably boosted the value of our data for analysing contemporary practice. Another major step forward was the agreement reached with the Association of Laparoscopic Surgeons, who have agreed to sponsor the registry as part of a suite of prospective databases for minimally invasive surgical procedures. This exciting project has been developed by the ALS President, Mr Mike Parker, and an agreement in principle has been reached with Covidien to fund a Registry Office. Mr Peter McCulloch, Director of the MIGOCS project, has agreed to manage the data suite for ALS, whilst Dendrite Clinical Systems Ltd will provide technical support.

Once the office is established, MIGOCS will officially change its name to the ALS Minimally Invasive Upper GI Cancer Registry, although the acronym will be retained for a transitional period.

Mr McCulloch and Ms Liz Gemmil were invited to the AUGIS consensus meeting on minimally invasive cancer resection in Basingstoke earlier this year, where the proposition that registry entry should be routine for all cases was accepted. Peter McCulloch found it harder going to persuade the delegates that registry entry should lead to consensus development of a randomised trial against open surgery, with few delegates convinced a trial would be possible.

At the EUNE International Meeting in Rome in April, and at EAES in Stockholm a month later, the MIGOCS registry was offered to EU surgeons performing minimally invasive resections. Because verification will be more difficult across Europe, and because European surgeons will not normally be ALS members, this data will be held separately, but joint analysis will be possible. The NICE Interventional Procedures Committee have endorsed MIGOCS as the repository for data for surgeons performing minimally invasive gastrectomy and oesophagectomy in the UK, and we hope that all this will lead to increased numbers of cases being logged in the coming years.

Mr Peter McCulloch, Director of the MIGOCS project

The Laparoscopic Session – ASGBI 2008 International Surgical Congress, Bournemouth Thursday 15th May 2008

The day in the Tregonwell Hall was well attended and a testament to the quality of the day's programme. The day began with our President, Mike Parker, introducing a session devoted to presentations and discussion about the reasoning behind and the development of the laparoscopic colorectal training programme. The session confirmed the ever increasing importance of the place of laparoscopic surgery in improving the practice of colorectal surgery. It was particularly pleasing to hear the support from the Department of Health and The Royal College of Surgeons of England.

The opening session was followed by a memorable British Journal of Surgery Lecture delivered by Professor David Rosin. The breadth of the presentation was impressive including the speaker's own personal role and experience.

The late morning session picked up where the BJS Lecture left off. The session illustrated the emerging modality of NOTES. The opening speaker, Professor Paul Swain, swept through the technology and current state of this novel surgery. The thrill of the presentation reminded many of the audience of the same emotion felt in the early 90s when listening to talks about minimal access surgery. Professor Mike Bailey revealed what is currently being explored in Europe and in particular his own unit in Guildford. The session closed with the double act of Ralph Austin and Tan Arulampalam from Colchester proposing where NOTES may now evolve to and calling for a consensus statement hopefully to be published at the ALS Annual Scientific Meeting in Colchester.

The afternoon was devoted to two scientific sessions, one DVD presentation and the other oral presentations. The DVD session was rich with unusual cases and elegant demonstrations of surgical technique. The two sessions were divided by a presentation from the Travelling Fellow – Oliver Jones of his visit to The Royal Brisbane Hospital. The paper presentations housed the David Dunn Medal Competition. The quality of the presentations was outstanding. The final winner of the David Dunn Medal was Michelle Slater from Reading who described a new technique of Laparoscopic Stapled Gastroplasty devised by Tom Dehn for dealing with repeated failed treatment for achalasia.

Mr Don Menzies,
Honorary Treasuer

Bariatic Surgery – A beginner's guide

Weight loss surgery has been slow to catch on in the UK, but in the last 2 or 3 years the number of cases performed in the UK has increased dramatically. In the 1980s and 90s, there were fewer than 300 weight loss operations per year in the UK. Surgery was performed via the open route and consisted mainly of Vertical Banded Gastroplasty or Roux-Y-gastric bypass. A few teaching hospitals offered the surgery to a very select number of patients. With the introduction of laparoscopic gastric banding into the UK in 1997 and subsequent introduction of laparoscopic gastric bypass, numbers of cases increased. It was not however, until NICE approved weight loss surgery in October 2002 that the number of procedures performed on the NHS began to increase significantly. It was also at this time that several private providers moved into the market offering affordable weight loss surgery to self pay patients.

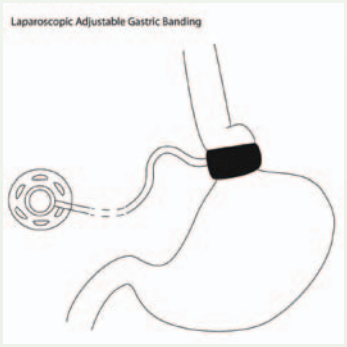
It is estimated that there will be over 8000 procedures performed in 2008 and it is likely this figure will continue to increase. The United Kingdom is one of the most obese nations on the planet and obesity rates are rising rapidly. In 2006, weight loss surgery overtook cholecystectomy as the commonest major general surgical procedure in the USA. There are approximately 50,000 cholecystectomies in the UK each year, so it is clear that the rate of weight loss surgery is likely to rise in the UK. Like any range of surgical procedures, complications arise and are often admitted to the nearest NHS hospital as emergencies. Because much of the surgery for weight loss is undertaken in the private sector by a small range of surgeons, many general surgeons are unfamiliar with this type of surgery. The newspapers have been littered with stories of tragedies after weight loss surgery, some of which might have been avoided had surgeons admitting emergencies been more familiar with weight loss operations and their potential complications. With this in mind, the following is a brief guide to the most commonly performed procedures and management of the commonest complications.

Laparoscopic adjustable gastric banding

This is the most frequently performed operation in the UK. Complications include infection, band slippage, over tightening of the band and band erosion.

Infection

There is a 2% risk of infection at the adjustment port. This portacath is usually located on the upper abdomen and secured to the abdominal wall muscles. Minor wound infections will often settle with antibiotics as they do not take hold deep in the wound and thereby infect the portacath. There is often the temptation to open up superficial wound infections to pack the wound over the adjustment port. This almost always guarantees that superficial sepsis is spread to the portacath which will then need removing. If faced with a superficial wound infection do give antibiotics after taking a swab, but do not widely open the wound. Rather contact the surgeon who placed the band in order that they might see the patient urgently to manage the infection. Do not (as one well meaning casualty officer did) grab the tubing to the port and say 'they've left something in here' and proceed to pull with all your might to remove the foreign body! Should the portacath be clearly infected then it needs removal. This should however be done by the surgeon who placed the band because it is possible to avoid removal of the band itself in about 50% of port site infections. The portacath is removed under GA and the tubing attaching it to the band is cleaned and returned to the peritoneal cavity – after 6 weeks' antibiotic treatment, it may be possible to reattach a new adjustment port elsewhere in the abdomen by laparoscoping the patient and retrieving the tubing one placed in the abdomen weeks earlier.



Acute Band slippage and Band over tightening

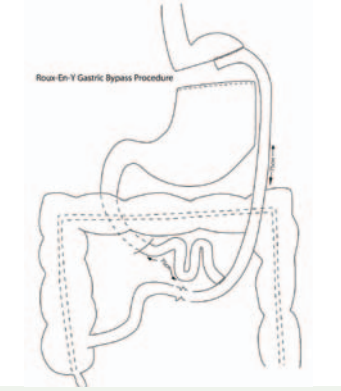
Both these complications present with acute dysphagia and require urgent action. Any band patient who presents with acute dysphagia should have all the fluid removed from their band immediately they arrive in hospital. Band slippage often occurs after vomiting or retching and is much more common if the gastric band has not been secured with gastro-gastric sutures. The history of patients who have been over tightened is usually that they attended for a band adjustment, often without radiology, and experience acute dysphagia within 48 hours of this adjustment. If normal swallowing is restored after removing all the fluid from the band then it is safe to let the patient go home on a liquid diet and contact the surgeon who placed their band. If however the patient continues to have dysphagia or has any signs of sepsis then an urgent gastrograffin swallow is needed. If there is still hold up of contrast at the band after all the fluid has been removed or evidence of a slippage of the stomach proximally through the band, then urgent laparoscopy is indicated. The safest and simplest thing to do at laparoscopy is to remove the band which is achieved by grasping the tubing leading to the band and working along it until the buckle of the band becomes visible. This is then divided with scissors or harmonic scalpel and the band pulled gently off the stomach.

Band erosion

This occurs in 2% of patients and may present with epigastric pain, failure of restriction or heartburn. At upper GI endoscopy the band is clearly visible in the stomach upon retroflexion and looks black in colour. It is rare to need an emergency procedure to remove the band and it may be best to contact the surgeon who placed the band and discuss urgent treatment. If over 50% of the band circumference is visible in the gastric lumen there is equipment to remove bands endoscopically. A second alternative is laparoscopic removal with repair of the gastric defect. Because of intense inflammation and scarring at the site of erosion, immediate reconstruction with Roux-Y-bypass or Sleeve gastrectomy is not advised although Biliopancreatic diversion, where the stomach is divided more distally is an option.

Roux-Y-gastric bypass

This is the second most prevalent operation in the UK and favoured by many of the NHS providers. Like after any major intestinal surgery there are risks of adhesions and internal hernias. In addition there are specific risks with hernias through Petersens space and around the long Roux limb. There are also specific risks related to haemorrhage or stenosis at the gastrojejunostomy.



Gastrointestinal haemorrhage

Haemorrhage may occur at either the gastrojejunostomy or the jejunojejunostomy. This usually occurs within 4 or 5 days of surgery, but with the tendency to discharge patients within 48 hours of laparoscopic bypass surgery, this problem may present to any general surgeon admitting emergencies. Haemorrhage from the gastrojejunostomy can usually be stopped endoscopically, whilst more distal haemorrhage can be difficult to diagnose endoscopically. Any acute GI haemorrhage within a week of bypass should be assumed to come from one of the two GI anastomoses until proven otherwise. Decision making should be the same as for any patient who presents with a GI bleed and surgery should not be unduly delayed simply because the patient has had morbid obesity surgery.

Stenosis of gastrojejunostomy

Symptoms of vomiting or dysphagia will lead to upper GI endoscopy. The

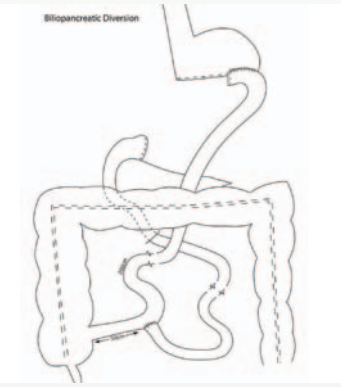
endoscopists will be able to identify the stenosed gastrojejunostomy. This may need balloon dilatation which can be done either at the admitting hospital, or by referral back to the surgeon who performed the bypass.

Intestinal obstruction

Small bowel obstruction related to adhesions is one of the commonest causes for admission on the general surgical emergency intake. The management of patients who have had bypass of any sort is no different than for other post-surgical patients in that any signs of tenderness, tachycardia or pyrexia mandate surgical intervention. Indeed given the propensity to develop internal hernias, especially if potential hernial defects are not closed at the time of the bypass, delay in surgery can lead to extensive loss of small bowel. Laparoscopy or laparotomy and reduction of the hernias and repair of the defects is the treatment in any patient whose obstruction does not settle within 24 hours and immediately in any patient with signs of intestinal strangulation.

Biliopancreatic diversion (BPD)

There are at least two centres in the UK performing this type of surgery. Many of the same considerations that apply to Roux-Y-gastric bypass also apply to BPD. One significant late complication from this malabsorptive procedure is protein losing enteropathy and subsequent liver failure. This may occur in up to 10% of patients in the longer term. Patients who have BPD must eat a high protein diet and if for any reason this does not take place then malnutrition and subsequent serious sequelae may occur. If a patient who has had a BPD is admitted with oedema, low albumin and signs of liver failure, then this is a full scale medical emergency. Urgent surgery



to reverse the bypass is often needed. This is best done at the centre where the bypass was performed and is attended with significant mortality.

Sleeve gastrectomy, Vertical banded gastroplasty (VBG)

Sleeve gastrectomy where 80% of the stomach is resected and a gastric tube created over a 32F bougie is being introduced. Apart from obvious possible B12 and iron deficiencies which are easily managed with replacement therapy, this procedure has few specific complications and is likely to grow in popularity.

Vertical banded gastroplasty (VBG) was the most common weight loss operation of the 1970s and 1980s. Most have now been revised or removed. It is possible to get erosion of the Dacron band on the stomach but this usually happens in the first few years after surgery. As very few VBGs have been performed in the UK this century, it is rare to see complications from this now obsolete procedure.

Mr Mike Rhodes, Editorial Secretary

SUMMARY

Complications of weight loss surgery will be a common general surgical problem. Immediate action by the emergency admitting team can make a big difference to both band and bypass patients. Immediate emptying of the gastric band followed by an urgent gastrograffin swallow if indicated will sort out most gastric band patients with dysphagia. Awareness of potential internal hernias and prompt intervention for small bowel obstruction is crucial in bypass patients.

The first dedicated ASiT/Covidien advanced practical laparoscopic course

As part of their growing partnership with their Platinum sponsors Covidien and their expanding educational portfolio, the Association of Surgeons in Training are proud to announce the first dedicated ASiT/Covidien advanced practical laparoscopic course at Covidien's wet labs in Elancourt, Paris. Two courses will be run simultaneously on Monday 15 and Tuesday 16 December 2008 for senior surgical trainees. One course will cover laparoscopic colorectal surgery and the second will cover bariatric surgery. Both will be a mix of lectures from experts in their fields, practical demonstrations and ample hands on experience in the labs. All costs will be covered by Covidien, to include flights, local transfers in Paris, accommodation, meals and refreshments whilst in France.

Each course can accommodate up to 10 senior trainees and we anticipate high demand. The draft programmes can be viewed on the ASiT and ALSGBI websites. Applications to take advantage of this rare opportunity should be made no later than 5pm on Friday 17 October 2008 by emailing your CV and a copy of your relevant logbook to whawkins@doctors.org.uk including the word 'Elancourt' in the message title. Applications would be strengthened by a letter of support from your educational supervisor (preferably the person who has mentored your bariatric/laparoscopic experience. Please note that APPLICANTS MUST BE MEMBERS OF ASiT, you can join ASiT at www.asit.org. Preference will be given to those in the final year of training and those with a letter of support.

Will Hawkins
Honorary Secretary and ALSGBI representative
The Association of Surgeons in Training

ASiT The Association of Surgeons in Training COVIDIEN

Bard

T: 01293 606 604 (Lindsey Blain, Workshop Co-Ordinator)

Bard Davol are hosting the following laparoscopic courses up until the end January 2009

Date	Course	Venue
7 Nov 2008	TEP Hernia Repair without fixation	South Coast
17 Nov 2008	TEP Hernia Repair without fixation	Essex
4 Dec 2008	Laparoscopic TEP and Incisional Hernia Repair	Wiltshire
8 Jan 2009	Laparoscopic Incisional and TAPP Hernia Repair	Essex

Bard Davol now run over 30 courses per year, two thirds of which are Laparoscopic.

Aesculap Endoscopy, B Braun Medical

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

Direct Line: 0114 225 9174 | Mobile: 07772 115856 | Email: allan.barr@bbraun.com
W: www.aesculap-academy.com

ALS GBI

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Travelling Scholarships 2009

Ethicon Endo-Surgery has generously funded a scholarship in memory of David Dunn. This scholarship is to the value of £4,000 and it is anticipated that this would enable a surgeon at the end of his/her training, or a consultant within 5 years of appointment, to make a substantial visit to a unit abroad to learn new skills in laparoscopic surgery, with a view to introducing them to the UK. The application should include a CV, full details of the unit and the reasons for the proposed visit, together with a detailed budget of expenditure. The successful applicant will be expected to give a report on the visit at the Spring Meeting of the ALS.

The ALS is also awarding two B. Braun Aesculap Travelling Scholarships of £2,000 each. The purpose of these scholarships is to enable surgeons in training, or young consultants within 5 years of appointment, to extend their experience in minimal access surgery by short visits to one or more centres. The application should include a CV, details of the planned visit or visits, together with an estimate of the costs. The successful applicants will be expected to produce a brief report of their visit at the Spring Meeting.

Candidates for these scholarships should apply to the Honorary Secretary of the ALS, Mr Mark Vipond, ALS at The Royal College of Surgeons of England, 35–43 Lincoln's Inn Fields, London WC2A 3PE. Candidates wishing to be considered for both types of scholarship must make separate applications for each one. The deadline for receipt of applications is Friday 27th March 2009. The names of successful applicants will be announced at the Association of Surgeons meeting in May 2009 in Glasgow.

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 we 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 speciemens 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
30–31 Jan 2009	Advanced Minimally Invasive Paediatric Surgery	Berlin
12–14 Feb 2009	Advanced Laparoscopic Urology, Prostate	Berlin
6-7 Jul 2009	Comprehensive Urological Laparoscopy	Berlin
8-10 Jul 2009	Laparoscopic Training Course Hernia Surgery	Berlin
20-22 Oct 2009	Laparoscopic Training Course Upper GI	Berlin
9-11 Nov 2009	Advanced Laparoscopic Surgery	Berlin
20-21 Nov 2009	Advanced Minimally Invasive Paediatric Surgery	Berlin

Covidien

W: www.covidien.com | T: 01329 224366 (Amy Rooks)
E: amy.rooks@covidien.com

Date	Course	Venue
14 Jan 2009	Hernia	Colchester General Hospital
TBC	Hernia	Southend tbc
5 Dec 2008	Parastomal Focus Day	Redworth Hall, Redworth, County Durham, DL5 6NL

The days agenda will include Parastomal hernia repair films of 'How I do it' using both Permacol and mesh,a review of the current literature, an open discussion on parastomal repair, and a presentation of industry's developments in the field of parastomal repair.

Ethicon Endo-Surgery

W: www.jnjgateway.com | T: 00441506594666
E: hmcfarla@its.jnj.com

Ethicon Endo-Surgery are committed to supporting the safe adoption of new technologies and procedures to ensure both effective health care delivery and patient safety. Hence, we continue to provide and support educational events for health care professionals, and strive to sponsor delegates onto courses that provide the correct learning experience appropriate to their skill level. The STEPS pathway for sequential training provides continual learning, progressing to being preceptored and operating "solo". Please contact your local Ethicon Endo-Surgery Territory Manager who will be delighted to discuss our educational programs with you further. Below is a list of selected courses which all form part of the STEPS sequential process.

Date	Course	Venue
4–5 Nov 2008	Bariatric Course	NUGITS
11–12 Nov 2008	Bariatric Surgery & Interdisciplinary Collaboration in Obesity Treatment	ISCARE IVFas, Prague
13–14 Nov 2008	Bypass	Gothenburg, Sweden
18–19 Nov 2008	Bypass/SAGB	Gent, Belgium
26–27 Nov 2008	Bypass/SAGB	Hallein, Austria
26–27 Nov 2008	MDT Training	LIMIT, Leeds
27 Nov 2008	Roux-en-Y	Brussels, Belgium
27–28 Nov 2008	Bypass	Frankfurt, Germany
3–4 Dec 2008	MDT Training	St Gallen, Switzerland
3–4 Dec 2008	Bypass	Frankfurt, Germany
16–17 Dec 2008	Bypass/SAGB	Gent, Belgium
15 Jan 2009	Advanced Lap Colorectal Course	LIMIT, Leeds
10–11 Feb 2009	Laparoscopic Colorectal Course	ESI, Hamburg
12–13 Feb 2009	Laparoscopic Colorectal Course	ESI, Hamburg

Karl Storz

W: www.karlstorz.de | T: 01753 503500
E: customerservice@karlstorz-ul

Please note that these courses are only supported by Karl Storz Endoscopy, with equipment and personnel, but not organised by the company. Karl Storz Endoscopy are happy to pass on the details of anyone who is interested in attending the courses to the relevant Training Centre Co-ordinator.

Date	Course	Venue
4–5 Nov 2008	Laparoscopic Cholecystectomy Course	MATTU, Post Graduate Medical School, Guildford
5–7 Nov 2008	Laparoscopic Split Liver Surgery Course	Newcastle Surgical Training Centre, Freeman Hospital
6–7 Nov 2008	Advanced Laparoscopy Course (ATSM Level)	MATTU Postgraduate Medical School, Guildford
10–11 Nov 2008	Advanced Laparoscopic Colorectal Surgery Course	ICENI, Advanced Laparoscopic Surgery Training Centre, Colchester General Hospital
10–12 Nov 2008	RCS Core Skills in Laparoscopic Surgery Course	MATTU, Post Graduate Medical School, Guildford
10–13 Nov 2008	EAES Lower Gastrointestinal Laparoscopic Course	Ninewells Surgical Skills Unit, Dundee

13 Nov 2008	Laparoscopic Incisional Hernia Course	Newcastle Surgical Training Centre, Freeman Hospital
20–21 Nov 2008	Key Skills in Laparoscopic Surgery	Ninewells Surgical Skills Unit, Dundee
24–25 Nov 2008	Laparoscopic Colorectal Surgery Course	MATTU, Post Graduate Medical School, Guildford
24–26 Nov 2008	RCS Core Skills in Laparoscopic Surgery Course	St Bartholomew's Hospital, London
26 Nov 2008	Laparoscopic Upper Gastrointestinal Surgery Course	ICENI, Advanced Laparoscopic Surgery Training Centre, Colchester General Hospital
26–27 Nov 2008	Basic Surgical Skills Course	Ninewells Surgical Skills Unit, Dundee
1–2 Dec 2008	Laparoscopic Colorectal Surgery Course	Newcastle Surgical Training Centre, Freeman Hospital
1–2 Dec 2008	Laparoscopic Stapling/ Suturing Techniques Course	MATTU, Post Graduate Medical School, Guildford
8–10 Dec 2008	Laparoscopic Oesophago-Gastric Cancer Symposium	MATTU, Post Graduate Medical School, Guildford
8–10 Dec 2008	RCS Core Skills in Laparoscopic Surgery Course	Darent Valley Hospital, Dartford
15–17 Dec 2008	RCS Core Skills in Laparoscopic Surgery Course	King's College Hospital, London

Olympus KeyMed

W: www.keymed.co.uk
T: 01702 616333 (Course Co-Ordination Department)
E: keymed@keymed.co.uk

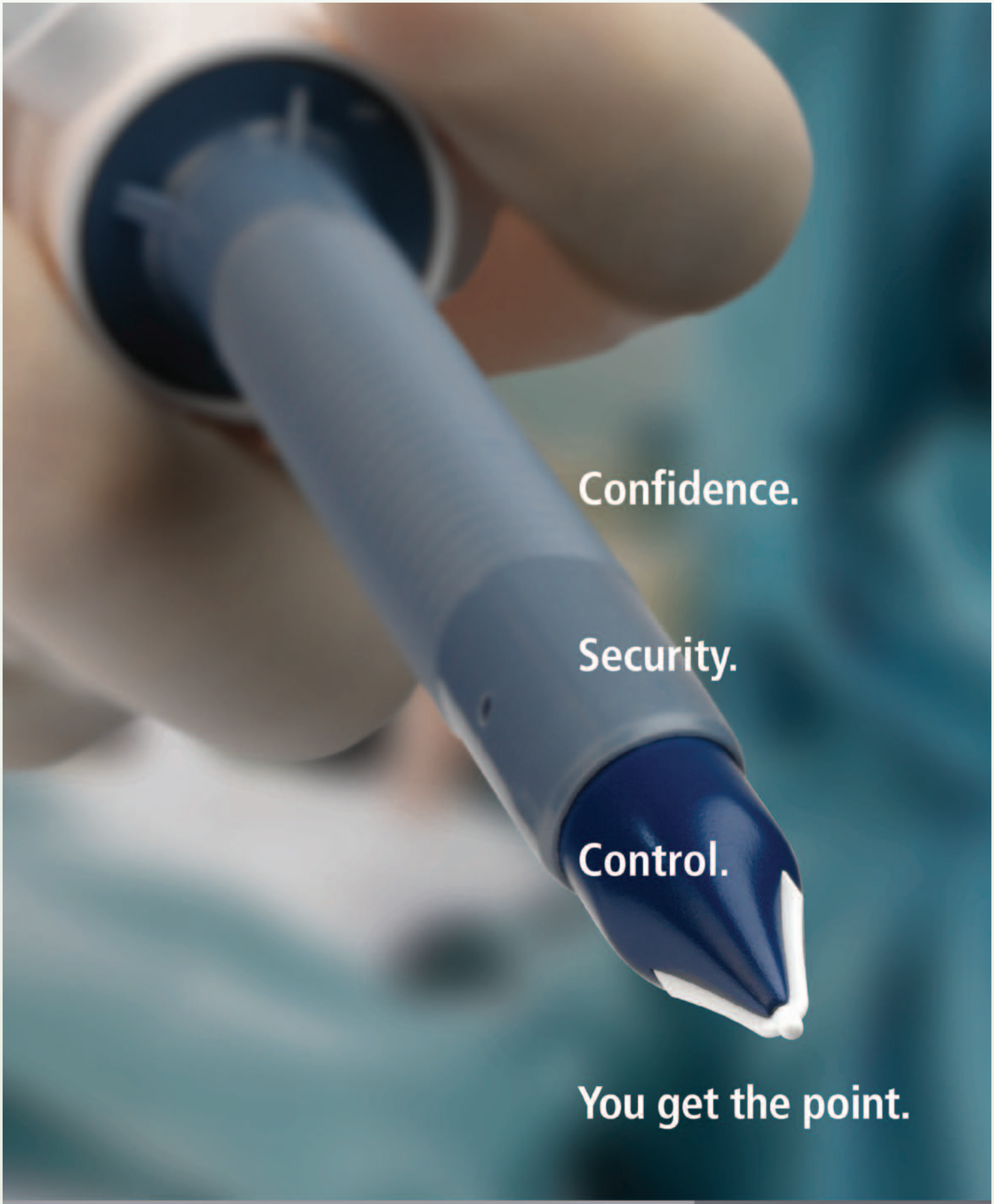
Date	Courses
7 Nov 2008	Hysterectomy - A Day Case Procedure
10–12 Decr 2008	Frontiers in Intestinal & Colorectal Disease
23–24 April 2009	The 2nd Training day for Year 5 & 6 Urology SpR's

WL GORE

W: www.goremedical.com
T: 07717 894303 (Jane Dodson)
E: jdodson@wlgore.com

Date	Course	Venue
Jan, May & Oct 2009 Dates TBC	Laparoscopic Ventral Hernia Repair Workshops	TBC

Industry Partners



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