ALS GBI
Association of Laparoscopic Surgeons of Great Britain & Ireland

ALS newsletter

Editor's Introduction – Michael Rhodes

Welcome to this our Winter 2009, ALS newsletter. The last six months have been a busy time for ALS as the Council have been involved, both in finalising details for the 2009 Annual Scientific Meeting in Tonbridge and also helping the College arrange an important Status Meeting on Bariatric Surgery on 21 January 2010. This reflects the ALS's continuing support for bariatric surgeons and our desire to work alongside our fellow associations BOMSS and AUGIS to help in education and training in this area of surgery. On top of that plans are already quite advanced for our November 2010 Annual Scientific Meeting in Nottingham – it takes a minimum of two years to finalise the arrangements for a meeting the size of ALS and as always we are really grateful to our Executives, Jenny and Sarah, without whom the Annual Scientific Meetings would never take place.

The last year has seen ALS forge better links with the European Association (EAES) and also The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) in the USA. At both meetings we had a delegation and handed out hundreds of flyers for the Annual Scientific Meeting in Tonbridge. Hopefully this will be reflected in abstract submissions from Europe and USA. It has also been agreed with EAES that the President of ALS will automatically join the EAES Board when he demits office from the ALS post. To that end Mike Parker will be representing us on EAES Board from November 2009 when I take over as ALS President.

I look forward to seeing as many of you as possible in Tonbridge for what I am sure will be an excellent meeting.

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

New Editor's Introduction – Paras Jethwa

Welcome to the Winter edition of the ALS newsletter. Mike is leaving the role of Editorial Secretary to take up the Presidency of the Association and I have taken up this position. I am a relatively newly appointed Consultant at East Surrey Hospital who has a strong and dedicated interest in most aspects of laparoscopic surgery and in laparo-endoscopic single site surgery (LESS/SILS/eNOTES).

Just as the field of surgery is constantly evolving so is our Association and I hope to reflect this in the newsletter and on the website. We have plans for a dedicated video section linked to the website for members to upload interesting or 'how I do it' operating clips, more trainee input and key articles from leaders in their field, which are meant to stimulate both interest and debate. It is our intention to have the website used as a key source of information for forthcoming meetings, industry contacts and courses. Feedback from our members is, as ever, crucial and contributions will be gratefully received.

In this edition Professor Tim Rockall leads with his article on 'Day case surgery. How far can you go?' and there are reports on the recent SAGES meeting in Phoenix, Arizona, DDW in Chicago, ASGBI in Glasgow & the EAES in Prague. A new pilot audit, introduced late in 2008 is also reported and highlights the issues regarding key equipment provision and variability with the NHS.

I certainly hope to meet you all at the forthcoming ALS Annual Scientific Meeting in Tonbridge, Kent for what promises to be another excellent meeting. There will be a dedicated trainees' day followed by live operating from local hospitals. I would strongly encourage you to both attend and, moreover, encourage others to come and be involved with the ALS.

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Day case surgery. How far can you go?

In the context of main stream gastrointestinal surgery it was not long ago that day case surgery was out of the question, largely because of the trauma associated with abdominal access and dogma surrounding the pre and post-operative treatment of recovering patients. Management was designed to observe patients throughout the post-operative period during which complications might conceivably occur. Laparoscopic surgery changed all that.

First there was day case laparoscopic surgery for cholecystectomy (which surprisingly is still not widespread), bilateral inguinal hernia repair, incisional hernia repair, Nissen fundoplication and a whole host of other less common procedures have also been reported. Other specialists have also reported success with day surgery for example day case hysterectomy and nephrectomy.

However cholecystectomy is usually a (relatively) minor procedure and the internal trauma thus minimal. There is no anastomosis to worry about and duct complications are mercifully rare in good hands. Organ function and in particular gut function are mostly unaffected by the surgery and so good recovery in an uncomplicated case comes down to a combination of good anaesthesia and good analgesia. If the patient has no pain or nausea, and has good expectations of an early recovery, discharge on the same day can be accomplished.

What then about more invasive procedures such as colorectal resection, where ileus, concerns about gut function and anastomotic complications exist? Add to this patient expectation of a prolonged recovery, and the fact that average hospital stay in the UK for colorectal cancer resection (mostly performed open) still has a median of 11 days. Laparoscopic surgery and enhanced recovery programmes have undoubtedly changed attitudes, and really good centres regularly report median hospital stays of 3 to 5 days for colorectal resection. Anecdotally however, surgeons may see a patient the morning after a successful operation who is clearly in a fit state to be at home and the question arises – how can you achieve this regularly and in how many patients? It isn't just a question of raising the bar. There are true gains to be made, for the health system and more importantly for the patient. MRSA, C.Difficile, chest infection, UTI, DVT are all related to prolonged catheterisation (vascular/urinary/gastric), reduced mobility and prolonged stay in hospital.

The first series of 23 hour hospital stay for colorectal resection has recently been reported. Using quite stringent inclusion criteria 25% of a consecutive series of 40 laparoscopic colorectal resections were managed within a specifically designed anaesthetic and 23 hour recovery protocol. This included TME resections without ileostomy, high anterior resections, left and right hemicolectomy (9 for cancer, 1 for diverticular disease). All went home with no specific support 23 hours post-operatively with no complications and no readmissions. Patient satisfaction was good. Interestingly this group were not physiologically dissimilar from the 30 standard care patients in the study who had an average stay of 3 days. One can argue that 23 hour post-op stay with one night in hospital is not really day-case surgery (as understood in the UK) but I don't think that diminishes the findings.

How has this been achieved? Certainly the surgery has to be good and minimally traumatic, but whilst I hesitate to give *too* much credit to the anaesthetists it seems certain to me that fluid management and the correct analgesia protocols are the keys that unlock these possibilities. We now know there is no need to observe patients post-operatively in case of leaks. If patients leak at home, there is no evidence to suggest that this is associated with a poorer outcome than if they leak in hospital. In some respects a representation via A&E often precipitates more appropriate and speedy investigation than if they are languishing on a ward with non specific findings. So, if the morning after surgery your patient has no lines or catheters, no nausea, controlled pain, is mobile and is eating then why not discharge them to a perfectly safe environment called home? Day case treatment in other disciplines such as oesophago-gastric surgery may seem an unlikely prospect at the present time but much could be learnt by the dissemination of techniques to minimise the in-patient care.

A detailed understanding of fluid physiology (especially during the prolonged head down tilt and pneumoperitoneum) and the use of modern anaesthetics and analgesics is critical to the perioperative management of these patients and optimisation of outcomes will only come with close collaboration with your anaesthetic colleagues.

Ann R Coll Surg Engl. 1993 Jul;75(4): 249-51

Br J Surg. 2003 May;90(5):560-2.

BJOG. 2007 Apr;114(4):430-6.

Dis Colon Rectum. 2009 Jul;52(7): 1239-43

Professor Tim Rockall,
Director of Education

The 17th Congress of the EAES – Prague

11–14 June 2009

The 17th EAES Congress under the Congress Presidency of Stasnislav Czudek and the EAES Presidency of Antonio Lacy was, this year, held in the beautiful city of Prague the theme being oncology. If the 16th Meeting in Stockholm last year was overwhelmed with the exciting prospect of NOTES, this conference, both in the scientific sessions and more particularly in the booths, was dominated by single port access. With decidedly mixed clinical enthusiasm for the technology it is clear that many of our Industry Partners have invested heavily in the development of single incision surgery, and it was certainly interesting to see some of the innovations coming through. It would seem that we may all be getting used to operating with a wide variety of shaped instruments and angulating or flexible scopes in the near future. If the prominence at the conference is anything to go by, NOTES in Europe would appear to have taken a short step back.

It was encouraging to see the large numbers of UK abstracts included in the prize sessions but the overall UK attendance, especially once the invited faculty have been excluded, remains disappointingly low. Your Association was once again represented by Jenny Treglohan and Sarah Williams in the ALS booth, there to encourage foreign membership, and attendance at the November Annual Scientific Meeting in Kent. They met with some undoubted success and also provided respite and refuge for all passing ALS members.

Jacques Perissat, the Society's first President back in 1990, gave an interesting personal and historical perspective on the lives and achievements of Phillipe Mouret and Erich Muhe, both giants in the field of laparoscopic surgery. The video sessions were popular and it was notable how the physical quality of the videos has changed, no doubt in line with the increasing use of HD technology.

All ALS members are members of the EAES by default. It is an organisation that covers a population of 300,000,000 people, as much as SAGES, and does truly attempt to bring together technologies, techniques and innovations from all around Europe. In the full knowledge that there are too many conferences and too many demands on us all I would encourage you to attend next year in Geneva if you possibly can.

Professor Tim Rockall, Director of Education

SAGES – Phoenix, Arizona, USA

22–25 April 2009

The Society of American Gastrointestinal and Endoscopic Surgeons' (SAGES) Annual Meeting this year was held in conjunction with International Paediatric Endosurgery Group at the Phoenix Convention Centre, Phoenix, Arizona from the 22nd to the 25th of April 2009. Phoenix is the 5th biggest city in the USA (pop: 1.5 million), is located in the Sonoran Desert, and has the hottest climate of any major city in the United States. The Grand Canyon (3 hours) and Las Vegas (5 hours) are within easy reach, as is the Mexican border (2.5 hours). It was over 30 degrees outside even in April (the record is 50 degrees at the height of summer) but fortunately air conditioning was in use everywhere. Mr Darmarajah Veeramootoo had the priviledge to be a sponsored ALS fellow this year and the meeting was also attended by Mr David Mahon & Ms Piriyah Sivagnanam who give their accounts below. The SAGES meeting certainly seems to have been both stimulating and topical and hosted in true American style!

The 2009 SAGES Annual Meeting

The meeting officially began on Wednesday with a series of postgraduate courses. These are supplementary to the scientific meeting and a large variety of sessions are available, including bariatric, colorectal, hernia, endoscopic and NOTES. For most people, however, the conference began in the evening with an opening drinks reception in the trade exhibition centre. Jenny and Sarah from the ALS were in attendance giving out flyers to anyone who came within their range for the forthcoming ALS meeting in Kent. The following morning had a 'SERF meets turf' 3K run/walk (strictly optional) to benefit the SAGES Education and Research Foundation and then the scientific programme began in earnest with concurrent oral and video sessions as well as posters. The centre also hosted a learning centre, where attendees can gain knowledge and practice skills relevant to minimally invasive surgery under the direction of station coordinators. There were sessions on all aspects of laparoscopic surgery, including NOTES and single incision surgery – which appears to be becoming very popular in the USA – together with less glamorous but equally important sessions on medical education, patient safety and probity.

On Friday, Mark Talamini gave his presidential address 'SAGES Shapes Surgery' where, after the usual 'thank-yous', he gave a history of SAGES from its inception, through the advent of laparoscopic surgery, introduction of guidelines, education including the now mandatory in the USA Fundamentals of Laparoscopic Surgery (FLS) test right up to the current state of play with NOTES technology. This was followed by the Gerald Marks Lecture which was given by John Cameron, President of the American College of Surgeons. It was nice to see that even people in such exalted positions have problems with their slides on occasion, but when it finally got underway he gave an inspiring talk on 'The Surgeon as a Role Model'.

Friday evening hosted the (in)famous SAGES Sing Off. This was held at a local ranch and saw President Mark Talamini entering the rodeo ring on horseback to cheers from the crowd. After a traditional rodeo and BBQ, with games for visitors (including a quick draw competition) there was the sing off itself – an unusual event which is a little like X-Factor for surgeons and something definitely worth seeing at least once for artistic, novelty and sheer comedy value!

Next year SAGES will host the 12th World Congress of Endoscopic Surgery, held in Landover, Maryland (just outside Washington DC) on April 14 –17, 2010.

Mr David Mahon
Musgrove Park Hospital, Somerset

Report on ALS sponsorship for oral presentation at the SAGES 2009 meeting

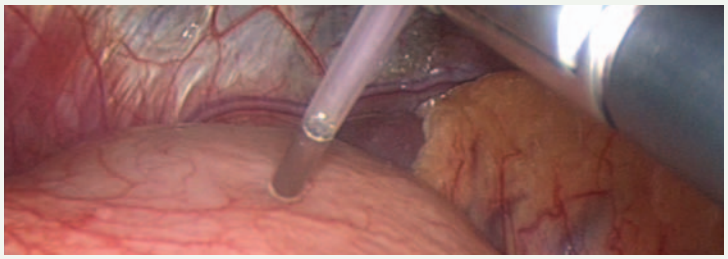
22–25 April 2009

I had the privilege to have both an Oral and a Video presentation at SAGES 2009. The session on Oesophageal/ Gastric Surgery gave me the opportunity to showcase the quality surgery being practised in Exeter, and earn respect from an international panel of experts. I could not help but feel nervous but was awed by the standard and quality of the talks. This was a great learning experience and, without a doubt the best exposure a trainee can hope for. I was able to talk about our experience of Laparoscopic Gastric Ischaemic Conditioning and mentioned the Randomised Controlled Trial (LOGIC Trial), that we have started in Exeter.

The Video Session – the SAGES International Olympic MIS Video Session was a different ball-game. Its purpose was 'to show new and surprising developments from all over the world'. In this session, videos from the world's most skilled surgeons were put under the knife by judges of the International Olympics of Surgery. It was a proud moment to see our name flying the flag for Great Britain on the starting line-up. Though we came just outside the medal places, (Gold: laparoscopic Liver Resection by Prof Gayet, France; Silver: Laparoscopic Pancreato-duodenectomy by Prof Palanivelu, India and Bronze: Completion Proctocolectomy and IPAA by Dr Grams, USA) we won a rapturous applause from the full-house after one of the judges commended our team for showing the perfect training video of a Minimally Invasive Oesophagectomy.

This meeting was a success on all levels – as a great learning experience and also the perfect get-away from the usual routine at Rodeo night! From a personal point of view, it was an opportunity to enjoy the essence of being a surgeon. I would like to thank the ALSGBI for sponsoring my registration towards this meeting and I also thank Force Cancer Charity and the Peninsula NIHR Clinical Research Facility for supporting my project for an MD.

Mr Darmarajah Veeramootoo,
Royal Devon and Exeter
NHS Foundation Hospital,
Exeter



A trainee's perspective on SAGES

The venue was awe inspiring and echoed the Phoenician culture; everything from the unique design using native materials to the artwork that hung throughout the building. This was my first attendance at such a large meeting and I was impressed by the myriad lectures/talks and topics that were on offer in such a vast conference centre.

As per recent vogue, the hot topics included SILS (single incision laparoscopic surgery) and NOTES (natural orifice transluminal endoscopic surgery). Both morbidity and mortality appeared to be improving, as technology continues to advance at an astonishing pace. An interesting session on patient safety, revealed how 'time-outs' and safety checklists had significantly reduced wrong site surgery rates in America. It was interesting to listen to this prior to the WHO checklist coming into operation in the UK. I also found sessions on solid organ surgery, ventral hernia repair, emerging technology, bariatrics and the surgical treatment of type II diabetes/metabolic syndrome particularly interesting.

The stands had a wide variety of innovative exhibits. Personal highlights included a 3-D MRI scanner which allowed the operator to navigate into the depths of the coronary vessels using a Nintendo joystick, the new and improved laparoscopic/endoscopic simulators with phenomenal tactile feedback, robotic simulations and a new transoesophageal device for gastric restriction in the fight against obesity.

I enjoyed the opportunity to try the NOTES and SPA simulators to perform a laparoscopic cholecystectomy, as I had previously been very sceptical (possible secondary to ignorance) as to their role. It was surprisingly easier than I had anticipated, as the instruments could be articulated to 90 degrees using one hand, providing adequate triangulation and degrees of freedom.

Being someone who fears public speaking, I was grateful to have the opportunity to present to a welcoming and non-hostile audience (contrary to my pre-conceptions). Feedback was well structured and the questions were thought-provoking, giving me ideas for further projects. I gained much confidence and learnt a lot about the art of presenting.

It was interesting to speak to other trainees from all over the world at the poster sessions and compare training experiences. Of particular interest was the American resident surgical training programme: practical and well structured. Many institutions now incorporate the FLS (Fundamentals of Laparoscopic Surgery) modules as part of the residency teaching programme. Trainees are trained and assessed on laparoscopic trainers. The feedback given includes information on efficiency of movement, how often instruments touch inappropriately, dangerous manoeuvres etc. A structured teaching programme using laparoscopic/endoscopic trainers would be a valuable tool to training in the UK, especially given the new constraints of EWTD.

The main social event of the week was the gala and sing-off at Corona Ranch. As we entered the venue we were serenaded by a string band and continued to enjoy an outdoor buffet on a warm Phoenix night. Entertainment included a live rodeo, the sing-off and several outdoor activities including a pistol shoot off. Many delegates also ventured on short jaunts to the Grand Canyon, I chose instead to ascend local mountains, including one with a hole to shade from the Arizonian heat and Camelback with panoramic views over Phoenix.

All in all a fantastic experience of education, innovation and fun.

Ms Piriyah Sivagnanam,
Norfolk and Norwich Hospital

Digestive Disease Week – Chicago, Illinois, USA

30 May – 3 June 2009

The DDW continues to be the largest and most prestigious gastroenterology meeting in the world. More than 17000 physicians, surgeons, and researchers from around the world attend this annual meeting. It is the best opportunity to learn about the latest advances in gastroenterology, hepatology, endoscopy, gastrointestinal surgery and cutting-edge technological advances. This year, the DDW was held in the windy city of Chicago. Located off Lake Michigan, Chicago attracts more than 35 million tourists annually. Upscale shopping along the Magnificent Mile and State Street, and thousands of restaurants, as well as Chicago's eminent architecture, continue to draw tourists.

These are the summaries of some of the latest updates from the DDW:

RFA for Barrett's oesophagus with dysplasia:
Histological eradication of Barrett's metaplasia with radiofrequency ablation (RFA) lasts at least two years in nearly all patients. In a major study patients treated with RFA, followed up at two years, 88% of patients had neither intestinal metaplasia nor dysplasia (N J Shaheen, M.D, University of North Carolina). These findings were the latest to emerge from a 127-patient randomized, sham-controlled study. Results for the primary endpoints after one year were reported in the New England Journal of Medicine. All patients with low-grade dysplasia eradicated after one year showed no evidence of recurrence at two years in the per-protocol evaluation, or 97% on an intent-to-treat basis. For patients with eradication of high-grade dysplasia after one year, 88% still showed complete response at two years per-protocol, or 83% on an intent-to-treat basis.

Moderate alcohol consumption may inhibit gallstone development
Alcohol – according to a UK's University of East Anglia review on 25,000 men and women was associated with a reduction in cholesterol and thus gallstones formation. Those in the highest alcohol group had a 32% lower risk than those who drank no or little alcohol. For every unit of alcohol extra drunk per week, the risk of gallstones fell by 3%. Obviously this needs to be balanced against other effects associated with alcohol consumption but I will raise a glass to the investigators!

Stool DNA testing may accurately detect more cancers than previously thought. Researchers at the Mayo Clinic developed the test, which checked a patient's stool for the DNA of cells regularly shed from the surface of several types of tumors. The study included patients with cancers throughout the digestive tract and healthy control subjects. The researchers detected 65% of esophageal cancers, 62% of pancreatic cancers, 75% of bile duct and gallbladder cancers and 100% of stomach and colorectal cancers. Notably, the test was equally successful at detecting early-stage and late-stage cancers.

Use of PPIs and H2RAs may increase risk for hip fractures.
The greatest relative increase in risk for more than two years of PPI use was among people 50 to 59 years of age, whose risk was more than doubled.

Flexible sigmoidoscopy screening fails to significantly reduce colorectal cancer incidence or mortality.
Data from researchers in Norway has shown that within seven years of follow-up, colorectal cancer was diagnosed at a rate of 134.5 cases per 100,000 person-years in people who underwent one-time flexible sigmoidoscopy, compared with 131.9 per 100,000 person-years in an unscreened control group. These data were the end results of a trial in which nearly 55,000 apparently healthy individuals were randomized to either screening with flexible sigmoidoscopy, accompanied in some patients by fecal occult blood testing, or to usual care without screening.

ASGBI 2009 International Surgical Congress – Glasgow

Thursday 14 May 2009

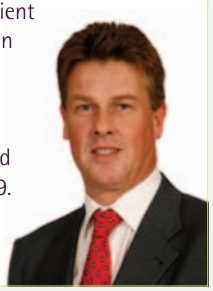
As previously the ALS had its sessions concentrated into the Thursday programme of the ASGBI in Glasgow. The first session comprised ten free papers delivered on a variety of laparoscopic topics ranging through SILS, laparoscopic urology and GI surgery. The Covidien prize of £600 was awarded to Mr Richard Bulbulia from Cheltenham for his paper describing the unit's experience with laparoscopic aortic aneurysm surgery.

The next session continued a successful format introduced at the previous meeting in Colchester. Ten DVD presentations highlighted a wide range of operations and laparoscopic techniques and generated much debate with the audience. The Covidien prize for best DVD was awarded to Mr Adrian Harris from Huntingdon for his demonstration of laparoscopic repair of Morgagni hernia.

The morning was completed by Mr Greg Wynn, the 2007 David Dunn Ethicon Travelling Scholar, delivering a whistle stop tour of Hong Kong and his experience of laparoscopic surgery in the former colony.

The winners of the 2009 Travelling Scholarships were announced with the David Dunn Ethicon Travelling Scholarship awarded to Mr Ioannis Verlos; and the two BBraun Travelling Scholarships awarded to Miss Emma Bromwich and Mr Haris Khwaja.

For the afternoon the ALS moved to the 600-seat Lomond Auditorium for a symposium on bariatric surgery. This was jointly hosted by our colleagues from BOMSS and introduced the National Bariatric Register. Dr George Fielding from New York swept the whole audience along with his experience, vision and enthusiasm for laparoscopic bariatric surgery (together with his candid admission that he was a happy recipient of such surgery). Further presentations came from Mr Duff Bruce highlighting the situation in Scotland, Mr Simon Banks discussing the commissioning process and Professor Michael Lean describing the bariatric MDT. Mr Simon Dexter presented the results of bariatric surgery and Dr Nicolas Christou from Montreal demonstrated how this all translates into health gain.



The President of ALS, Mr Mike Parker, thanked all the speakers and encouraged all to attend the forthcoming ALS Annual Scientific Meeting in Tonbridge, Kent 26 and 27 November 2009.

Mr Mark Vipond, Honorary Secretary

BARIATRIC SURGERY

TGVR may be viable alternative to traditional gastric bypass

Researchers at Brigham and Women's Hospital and the Cleveland Clinic Foundation explained that the transoral gastric volume reduction (TGVR) prevents the stomach from relaxing to accept food, by sewing together the anterior and posterior walls of the stomach, thus reducing feelings of hunger. Endoscopic suturing procedures have produced losses of more than 60% of excess weight in obese teens at 18 month follow-up, and up to 40% after nine months in adults. Transoral stomach suturing using an endoscope under general anaesthesia, allowed 12 obese adolescents (14 to 17 years) to lose a mean of 62.2% (SD 15%) of their excess body weight within six months (Roberto Fogel, M.D, Hospital de Clinicas Caracas, Venezuela).

Another group from Imperial College London reported that an implanted plastic (polyethylene) food bypass tube, extending from the base of the esophagus to 100 cm (about 40 inches) into the small intestine, led to excess weight losses averaging 40% in a 12-week pilot study. Commenting on the various studies, Cedars-Sinai's Kai Nishi, MD, said, 'It will take these trials to determine which of these is optimal for safety and efficacy'. Nonetheless, 'transoral methods for reducing gastric volume or bypassing the stomach altogether as treatment for obesity are gaining steam.'

Duodenal switch surgery may provide more benefit for super obese patients with obesity-related medical problems, according to a University of Chicago study that included 350 super-obese patients. Three years after performing this procedure, the rates of resolution for duodenal switch and gastric bypass were: diabetes, 100% vs. 60%; high blood pressure, 68% vs. 38.6%; high cholesterol, 72% vs. 26%; acid reflux; 48.5% vs. 76.9%.

Next year the DDW is held in New Orleans, LA, USA (May 1st–6th 2010).

See you there!

Mr Edward Cheong
Norwich and Norfolk Hospital

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Date	Course	Venue
4 December 2009	TEP Hernia Repair without fixation/Incisional/Ventral (Laparoscopic)	Bournemouth
9 December 2009	Preperitoneal repair via an anterior approach (open)	London
TBA	TEP Hernia Repair, with fixation (Laparoscopic)	Leeds
TBA	Preperitoneal repair via an anterior approach (open)/Perfix Plug repair	Cardiff
TBA	Perfix Plug repair/Incisional/Ventral (open)	Swindon

B Braun Medical, Aesculap Endoscopy

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Final dates for our English speaking courses are still to be confirmed for 2010, however the general programme is detailed below.

Date	Course	Venue
January 2010	Advanced Minimally Invasive Paediatric Surgery	Berlin
February 2010	Advanced Laparoscopic Urology, Prostate	Berlin
July 2010	Comprehensive Urological Laparoscopy	Berlin
July 2010	Laparoscopic Training Course Hernia Surgery	Berlin
October 2010	Laparoscopic Training Course Upper GI	Berlin
November 2010	Advanced Laparoscopic Surgery	Berlin
November 2010	Advanced Minimally Invasive Paediatric Surgery	Berlin

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Date	Course	Venue
Hernia Surgery & Soft Tissue Repair		
7 December 2009	Laparoscopic Incisional Hernia Clinical Immersion Course	Edinburgh Royal Infirmary, Edinburgh
Colorectal		
30 November–1 December 2009	Part 4 Oxford Laparoscopic Colorectal Clinical Immersion Surgical Training Course	John Radcliffe Hospital, Oxford

Ethicon Endo-Surgery

T: +44 (0)1506 594666 (contact Mrs Helen McFarland) | E: hmcfarla@its.jnj.com

Date	Course	Venue
Bariatric		
25–26 November 2009	MDT Course	St Gallen, Switzerland
3–4 December 2009	MDT/Bypass Course	Oslo
Laparoscopic Colorectal		
7–8 December 2009	Laparoscopic Colorectal Cadaver Laboratory Course	Freeman Hospital, Newcastle

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Details of all courses supported by Karl Storz Endoscopy can be found on the following training centre websites:-
Royal College of Surgeons of England, London – www.rcseng.ac.uk/education/courses
MATTU, University of Guildford – www.mattu.org.uk
ICENI, Colchester General Hospital – www.colchesterlaparoscopic.com

Olympus KeyMed

W: www.olympus.co.uk | T: +44 (0)1702 616333 (Course Co-Ordination Department) | E: info@olympus.co.uk

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

Date	Courses	Venue
7–8 January 2010	3rd International Laparo-Endoscopic Single-Site Surgery Workshop	Erasmus Medical Centre, Skills Lab
25–26 February 2010	4th International Laparo-Endoscopic Single-Site Surgery Workshop	Erasmus Medical Centre, Skills Lab
4–5 March 2010	5th International Laparo-Endoscopic Single-Site Surgery Workshop	Erasmus Medical Centre, Skills Lab
25–26 March 2010	Hands on Cadaveric Course	Bristol University
7–8 June 2010	Wet Lab in Laparoscopic Urology	Erasmus Medical Centre, Skills Lab
Dates TBC	Urology ST3 Course	Olympus KeyMed House, Southend

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Date	Course	Venue
TBC May 2010	Laparoscopic Ventral Hernia Repair Workshop	King George Hospital, Essex
TBC October 2010	Laparoscopic Ventral Hernia Repair Workshop	King George Hospital, Essex
Date TBC	Masterclass Laparoscopic Ventral Hernia Repair	Niymegen, Netherlands
Date TBC	Laparoscopic Gastric Bypass Course	Hallein, Austria
Date TBC	European Bariatric Workshop	Dendermonde, Belgium

Caption Competition

Entries have to be sent to Jenny Treglohan (jtreglohan@asgbi.org.uk) by 8 January 2010 and the winner will receive a bottle of champagne.

Pilot study of laparoscopic theatre equipment in Kent & Wales

The Association of Laparoscopic Surgeons of Great Britain & Ireland (ALS) launched a national audit of hospital laparoscopic theatre equipment in late 2008.

There has been a significant development in technology since the introduction of laparoscopic general surgery in the UK in 1990. The last decade has seen a massive increase in the variety of laparoscopic operations performed worldwide. Almost all gastro-intestinal or abdominal operations done as open procedures have now been performed laparoscopically. This increase in laparoscopic operations has also led to an exponential increase in the percentage of day-case operations especially in United Kingdom. Patient expectations and aspirations have also been a major factor in this development in addition to the enthusiasm of individual surgeons who have developed a multi-disciplinary approach to provide laparoscopic techniques for most operations. This has resulted in shorter hospital stay in addition to all the major advantages of laparoscopic surgery such as smaller scars, less pain, rapid recovery and return to normal activities including work. The rapid technological developments that have occurred in the field of laparoscopic surgery have resulted in some operating theatres having inferior equipment which might affect the ability of surgeons to carry out complex laparoscopic procedures safely.

This audit was therefore initiated by the President of ALS focusing on the safety aspects of theatre equipment and patient care. ALS has launched this national audit to assess all the individual hospitals in the United Kingdom

1 To assess the availability of specialist laparoscopic equipment
2 The quality of equipment used (includes age <5yrs or >5yrs)
3 To check if systems are in place for the maintenance of equipment
4 To assess systems of replacement (contracts) for damaged or old equipment.

This audit takes into account the type of laparoscopic theatres, camera systems, types of trocar and energy sources.

All aspects of the audit were assessed against the type and levels of complexity of operations performed in the individual hospitals.

The ALS initially chose to pilot this audit in all the hospitals of Kent and Wales prior to the launch of a national audit later in 2009. The methods of grading of the equipment and ranking of the individual hospitals have been discussed and agreed by the ALS Council in 2008. The ranking system of the hospital equipment was devised with three grades or levels as gold, silver & bronze ratings with gold representing the availability of the best equipment, with systems in place for maintenance and bronze the other end of the spectrum with old or outdated equipment. The non-responders have been identified with an asterix. In some cases where the information was not clear, one audit member has contacted the responding hospital member to verify details. Random inspections of hospitals will also be taking place to maintain a quality control of the audit.

KENT

Hospital	Grade	Returned
William Harvey Hospital, Ashford	Silver	Completed
Kent & Canterbury Hospital	Silver	Completed
Queen Elizabeth the Queen Mother Hospital, Margate	Gold	Completed
Darent Valley Hospital, Dartford	Silver	Completed
Kent & Sussex Hospital, Tunbridge Wells	Silver	Completed
Maidstone Hospital	Gold	Completed
Medway Hospital, Gillingham	Silver	Completed
Princess Royal University Hospital, Orpington	Silver	Completed
Buckland Hospital, Dover		
Nuffield Health Hospital, Tunbridge Wells	Silver	Completed
The Somerfield Hospital, Maidstone	Silver	Completed
Benenden Hospital	Gold	Completed
Fawkham Manor Hospital, Longfield	Silver	Completed
The Chaucer Hospital, Canterbury	Silver	Completed
The Chelsfield Hospital, Orpington	Bronze	Completed
The Sloane Hospital, Beckenham	Bronze	Completed
Pembury Hospital, Tunbridge Wells	*	
Spire Alexandra Hospital, Chatham	*	Declined
Spire St Saviours Hospital, Hythe	*	Declined
Spire Tunbridge Wells	*	Declined

WALES

Hospital	Grade	Returned
Morriston Hospital	Silver	Completed
Singleton Hospital	Gold	Completed
Neath Port Talbot Hospital	Bronze	Completed
Nevill Hall Hospital, Gwent	Bronze	Completed
West Wales General Hospital, Carmarthen	Silver	Completed
Princess of Wales Hospital	Silver	Completed
Royal Gwent Hospital	Silver	Completed
University Hospital of Wales	Silver	Completed
Prince Philip Hospital, Lanelli	Silver	Completed
BMI Werndale Private Hospital, Carmarthen	Silver	Completed
Spire Cardiff Hospital	Silver	Completed
St Joseph's Hospital, Newport	Bronze	Completed
Withybush General Hospital, Haverford West	*	
Wrexham Maelor Hospital	*	
Ysbyty Gwynedd Hospital	*	
Royal Glamorgan Hospital	*	
Prince Charles Hospital, Mid-Glamorgan	*	
Bronglais District General Hospital, Aberystwyth	*	
Glan Clwyd Hospital	*	
Spire Yale Hospital, Wrexham	*	
Sancta Maria Hospital	*	

KENT

In the Kent region there are 10 NHS hospitals and 11 private hospitals. One NHS hospital in Dover (Buckland) has been excluded as the hospital replied that they do not perform any surgery. The results of the audit in Kent are in the table far left.

WALES

The Wales region has 16 NHS & 5 private hospitals of which nine NHS & three private hospitals responded The results of the audit in Wales are in the table above.

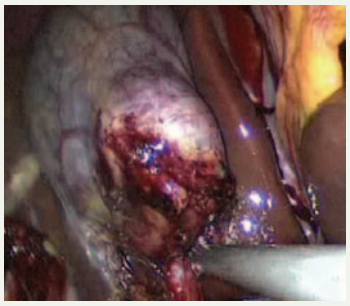
Conclusion

This ALS pilot study has identified three hospitals with Gold rated Laparoscopic equipment in Kent & one in the Wales region. The audit will now be rolled out nationwide and the results will be available on the ALS website by November 2009.

Mr Chandra Cheruvu, West Midlands Regional Representative

Single incision surgery – Evolution or a true revolution?

The concept of performing 'scarless' surgery via either a natural orifice (e.g. per gastric/rectal/colonic) or by means of an embryological orifice (e.g. transumbilically) seems to have captivated the attention of the surgical community. As commented upon by Professor Rockall in his report from this year's EAES and attendees to SAGES, a great deal of emphasis has been placed on single incision surgery, both from industry and laparoscopic practitioners.



Certainly it has already proven itself to be significantly more accessible to the current generation of surgeons – both technically and in terms of equipment – by comparison to N.O.T.E.S. – which remains, in the vast majority of centres, a technology that has not made the leap from the laboratory to the operating theatre. Judging by the number of abstract submissions to this year's ALS Annual Scientific Meeting single incision surgery has been readily adopted and embraced by UK surgeons, and at present has made a sizeable impact on our surgical consciousness!

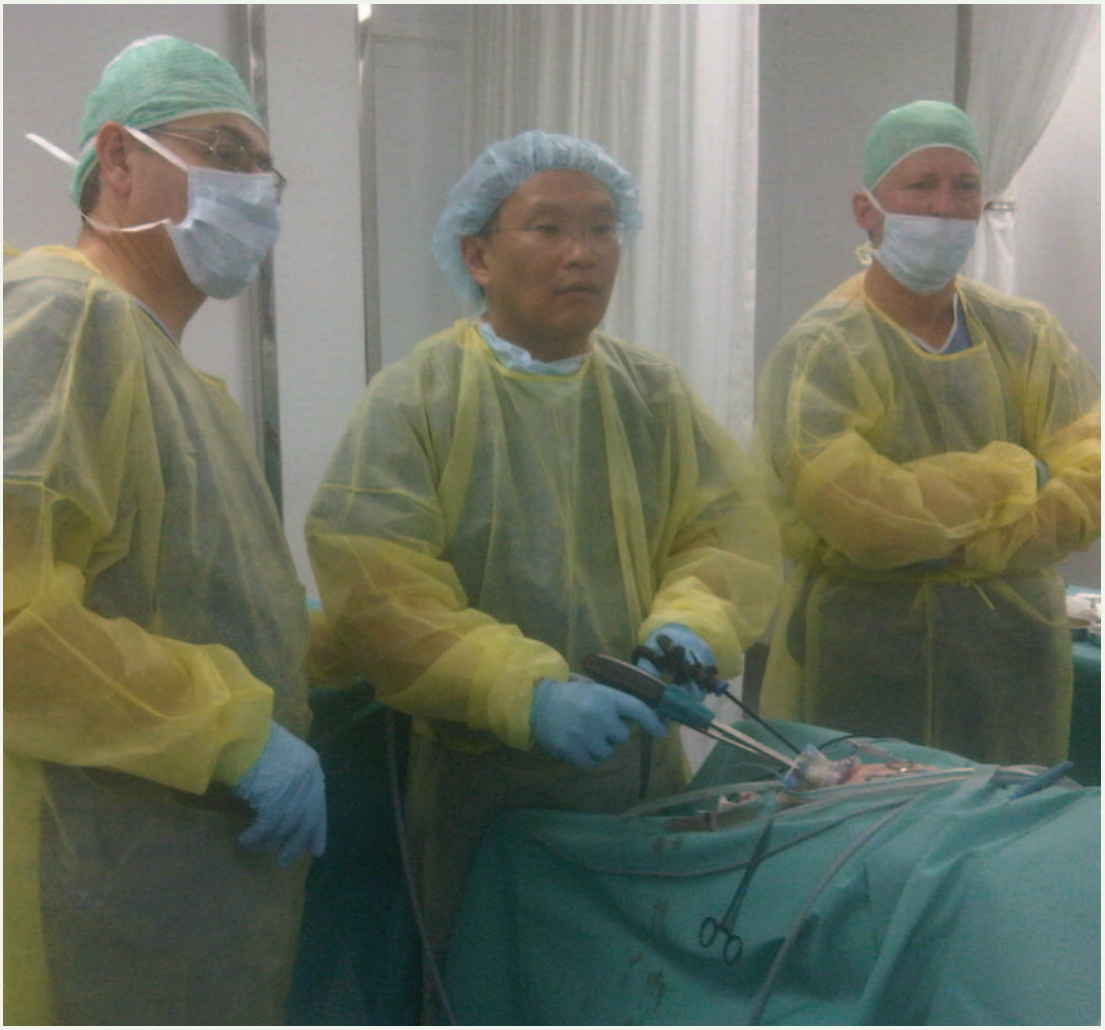
At a recent training course experienced laparoscopic biliary surgeons raised concerns that, if adopted without adequate training, this [form of surgery] had the potential to significantly increase major injuries and complications. The current situation was compared to the early years of laparoscopic cholecystectomy in the UK where this pattern was seen before adequate training was instituted. As a 'veteran' of some 40 single incision cases, I think this is somewhat pessimistic and does not take into account the current inherent levels of skills demonstrated by UK laparoscopic practitioners, the very marked enhancements in instrumentation and visualisation and the worldwide experience of this technique. Industry has been quick to recognise the need for improvements with roticulating and pre bent instruments that allow safer triangulation of target organs and new camera systems offer deflecting tips (Olympus Endoeye) or variable view camera systems (Storz Endochameleon). Whether this type of surgery becomes our new 'gold standard' or a flash in the pan, the real and significant advances evident will benefit all aspects of laparoscopic surgery.

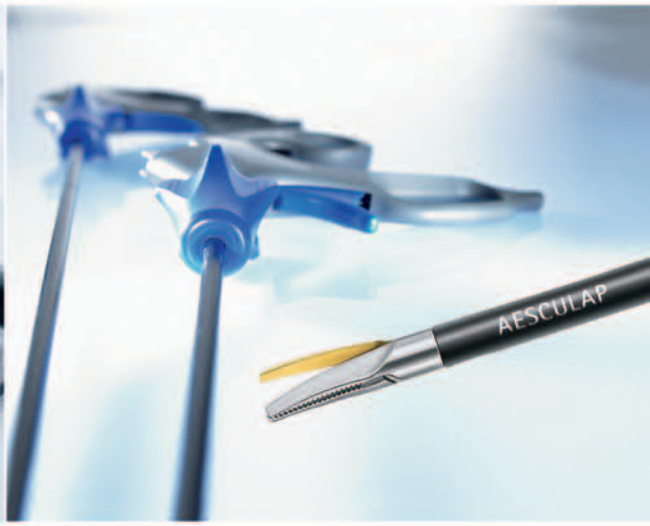
Whether this is an overall significant improvement in patient care or merely a cosmetic consideration remains to be proven. Needless to say all patients that I have operated upon via a single transumbilical approach have been delighted with their lack of visible scarring and are happy to ignore any increase in minor complication or post-operative discomfort. At present no objective evidence exists to demonstrate this procedure as having an additional benefit but, no doubt, evidence will be produced to support or debunk this hypothesis over the coming years.

Several things have become clear when starting to undertake single site laparoscopic surgery; it should be done after an immersion course (contacts on website) or with the assistance of another surgeon already experienced in this technique. Ensure you have a senior person to help/hold the camera (another Consultant is ideal) and ensure the right equipment is to hand. Failure of progression or demonstration of the relevant anatomy will necessitate conversion to a 'conventional' laparoscopic approach but inserting another port is not an admission of failure! Safety, as with all forms of surgery, remains paramount. To this end a registry of these procedures, and a team of dedicated mentors from a variety of specialities, has been proposed that aims to provide support and training for these new procedures and, moreover identify best practice at a very early stage. I look forward to reporting on these developments over the forthcoming months.

Just as in meetings in the USA and Europe this year there will be a strong showing of these technologies at the ALS this November which I am sure will prove both controversial and thought provoking. With the chance to post videos on the ALS website (in the forthcoming months) all your submissions will be gratefully received. I am sure that single incision will feature heavily and I look forward to this site going live soon. We may look back in years to come and fondly remember single site laparoscopic surgery as the *Betamax* of surgical evolution or will it become our *Blu-ray* – hitec, very precise and soon to be the standard others are compared to? Only time and our collective work will tell. We as an organisation can lead the way and ensure that this new development is safely and responsibly implemented.

Mr Paras Jethwa, Editorial Secretary





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