ALS GBI
Association of Laparoscopic Surgeons of Great Britain & Ireland

ALS newsletter

Editor's Introduction

Welcome to this Winter's ALS newsletter.
Is there and should there be such a thing as a dedicated laparoscopic surgeon? It's now not uncommon to find trainees wishing to pursue a benign/non resectional career and, far from this being the resting place for the jack-of-all-trades (and master of none) this role has never, seemingly, been more in demand. Thus the recent alert from the National Patient Safety Agency (NPSA) highlighted in the Daily Telegraph (p14, 27/9/2010) "Doctors are not spotting potentially fatal complications in keyhole surgery", makes for unsettling reading. The Telegraph reports that [during a five year period] "The NPSA has been informed of 11 cases where the patient died and around 500 more where damage occurred.....". The actual report mentions 48 adverse incidents reported to the National Reporting and Learning Service (NRLS) and Strategic Executive Information System (STEIS) - including 11 deaths relating to deterioration of patients postoperatively. In addition, a review of NHS Litigation Authority (NHSLA) data identified 496 adverse events relating to laparoscopic surgery between April 1995 and April 2010. The denominator for this five-year period is not reported. The Telegraph article states in its report that keyhole surgery, as well as offering smaller incisions and reducing pain is a method of saving money for the NHS as patients go home earlier.

For once an expert was consulted [ex ALS President, Mr Mike Parker] and his comment sought: "This advice... should come as a reminder to all centres offering laparoscopic surgery that the monitoring of patients after their operation must be undertaken consistently and thoroughly. Providing good quality information and the availability of professional support after leaving hospital is basic stuff and will prevent deaths. This type of operation is becoming more widely adopted in the NHS because they have been proven to offer fewer complications and shorter length of stay than the old open procedures they replace – but that should be no excuse for complacency."

We must proactively react to this advice and ensure that we provide the necessary information and support to patients and whilst we, the practitioners, know that laparoscopic surgery serves to lessen the physiological insult, immune response, respiratory & thromboembolic complications and, that the size of the incision is but a small part of this process, it is vital to meet and surpass the expectations of an increasingly watchful populace.

Hardly a day goes by without the popular press & television reporting on the UK and global pandemic that is obesity. Television programmes include "Supersize vs. superskinny", "The Biggest Loser" and this week on BBC 4 "Are you fitter than a pensioner" pitted four "representative" teenagers from the UK against a group of OAPs in a multi sport event (the UK team of teenagers won –just!). Currently UK projections of the expanding need for bariatric surgery far outstrip the availability on the NHS, both from an infrastructure and surgical perspective. With this in mind the recent International Federation for the Surgery of Obesity and Metabolic Surgery (IFSO) Meeting in Long Beach, California provided some very stimulating discussion from the leaders in this field and is reported within. There was considerable emphasis on what was the correct surgical approach in metabolic surgery; to this end London surgeon, Nick Marshall travelled (albeit reluctantly!) to Las Vegas, to meet with Dr Robert Rutledge, an advocate of the mini-gastric bypass.

AUGIS was well supported this year and there seemed to be a significant incorporation of the bariatric fraternity into what was predominantly a resectional Annual Scientific Meeting. Is this the shape of things to come? Some of the best presentations from there are reported.

"To boldy go" is the running title and the emphasis will be on innovation and key advances in the laparoscopic community. We sincerely hope to see many new and old faces at this year's ALS Annual Scientific Meeting in Nottingham on 25 & 26 November 2010.

Mr Paras Jethwa, Newsletter Editor

President's Introduction

It is a great pleasure to commend our latest newsletter to you. The new editor Paras Jethwa has done an excellent job assembling news and short articles, ideal to read in those gaps between cases. In particular I would like to thank B. Braun for sponsoring the newsletter. As always the ALS is at the forefront of surgical innovation with key articles on Single Port Laparoscopic Surgery (SPLS) and also NOTES. The newsletter contains the usual round up of the last 12 months academic meetings as well as details of training courses. I hope it makes an enjoyable read and look forward to seeing you all in Nottingham on 25 and 26 November 2010.

Mr Mike Rhodes, President

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Mrs Jenny Treglohan, Executive Officer
jtreglohan@asgbi.org.uk
Tel +44(0)20 7973 0305
www.alsgbi.org

Mrs Sarah Williams, Business Manager
swilliams@asgbi.org.uk
Tel +44(0)20 7304 4777
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Single Port Laparoscopic Surgery

Twenty years after the chaotic introduction of laparoscopic cholecystectomy it would not be unreasonable to expect the surgical community to have learned some important lessons about how to introduce, evaluate and implement a new technique. Whilst "single port" laparoscopic surgery (SPLS – the ALSGBI approved acronym) is not in the same league as laparoscopic cholecystectomy as a major lurch forward in surgical evolution, it is nevertheless a potentially significant mutation. It is regrettable, therefore, that the initial phase of SPLS shares more of the characteristics of snake oil marketing than the rigorous application of modern health services research.

The reasons for the development and introduction of SPLS merit consideration. Laparoscopic cholecystectomy was a revolution in the management of gall bladder disease and the increase in major complications was tacitly accepted by the profession because of the relative infrequency with which these occurred. Having mastered increasingly complex multiport laparoscopic procedures the concept of carrying out the procedure through a single "port" seemed increasingly attractive. Intuitively one puncture might be expected to result in less pain than multiple punctures, but this advantage can be lost if the single incision is larger and if increased force and angulation are required to complete the procedure. Similarly the reduced risk of incisional herniation, which ought to be associated with fewer punctures, may be negated if there is more trauma to and a slightly larger incision. Although the incision may need to be larger to accommodate proprietary single port devices, the final size of any laparoscopic incision is related to the procedure being performed and the requirement to extract an intact specimen.

Whilst a straightforward single port cholecystectomy can be carried out expeditiously, it is invariably more awkward because of the loss of triangulation and interference of the instruments. Instruments and devices of increasing complexity and ingenuity have been devised to compensate for the limits imposed by single port access which reinforce the mechanical limits of this approach. All have disadvantages, related to either fixed curves or complicated controls for angulation not to mention increased cost. Einstein observed that "Perfection of tools and confusion of goals are characteristics of our time" and some of these increasingly elaborate devices seem to reinforce this sentiment.

The principal driver for SPLS however, from both patient and surgeon perspective, is almost certainly cosmetic and when a procedure can be accomplished successfully through a single intraumbilical incision the result can be impressive with no visible scarring. There are, however, many ways of minimising the impact of scars not least of which is attention to detail: as Moynihan stated "It would be well if surgeons took a little more pride in the wounds they inflict." It is important however that a desire on the part of patient and surgeons towards "scarless" surgery retains a sense of perspective. Cosmetic procedures are associated with often extensive incisional scars which appear entirely acceptable and considerably greater than following a conventional multiport laparoscopic procedure. The ability to conceal scars may be as important as reducing the number. The majority of patients who are variably hirsute and/or overweight have difficulty in locating, particularly 5mm punctures even a few weeks after laparoscopic surgery.

There seems little doubt that mainstream surgical opinion views the ultimate expression of avoidance of abdominal wall scarring viz: Natural Orifice Transluminal Endoscopic Surgery (NOTES) with extreme scepticism and an activity limited to a few eccentric, albeit expert but perhaps occasionally publicity-seeking areas. The lure of performing, publishing and being recognised in perpetuity as the first to introduce a procedure, be it local, national or international is manifestly seductive to the surgical psyche. When this is allied to commercial pressure to develop a new product line and profit stream, a corrosive cocktail can result in which the patient's interests may lose primacy. Gaining informed consent for a novel procedure becomes an ethical minefield and may have as much to do with the salesmanship and charisma of the surgeon as technical ability and honest portrayal of risk. Surgeons, with more insight than the general public, are palpably more willing to be the perpetrator than the subject of surgical experimentation.

Ideally all single port procedures and outcomes should have been recorded prospectively to accumulate a database sufficient to determine the safety profile. This has manifestly not happened and it is possible that early misadventures, which include deaths, will be conveniently forgotten. What information there is available, however, indicates a three fold increase in complications

and bile duct injury in SPLS cholecystectomy. Selective publication bias is not unique to SPLS but emphasises the need for rigorous data collection in this field. A recent review of SPLS cholecystectomy in the British Journal of Surgery discarded the bulk of published papers and could not identify a single randomised trial.

If such trials are to be carried out what aspects need to be addressed? These would need to include, inter alia, mortality, morbidity, recovery, cosmesis, pain and cost effectiveness. The latter is of particular relevance in the current economic climate and widespread adoption of a novel technique which costs more, takes longer and with, as yet, no documented major benefit and potentially increased risk, is unlikely in the UK. In alternative health systems there have been pockets of implementation which are a consequence of the hierarchical organisation of the medical workforce and the enthusiasm of the departmental head. These have accrued experience and occasionally, as in single port retroperitoneal adrenalectomy, shown promise of having advantages for some patients. In some health services, in which activity equates to institutional and personal income, promoting, a novel procedure to a clientele with scant understanding of relative risk is seductive.

At present there is no good evidence to support the widespread introduction of SPLS. Those enthusiasts promoting the technique must accurately record and honestly report their experience, resist the pressure of surgical hubris to persevere when the insertion of additional ports would simplify the procedure and, should the opportunity present, participate in randomised trials.

Professor Z H Krukowski PhD FRCS FRCP
Aberdeen Royal Infirmary

Natural Orifice Translumenal Endoscopic Surgery (NOTES) – safe implementation through technological innovation

Following the first description of transgastric peritoneoscopy in a porcine in-vivo model by Kalloo et al in 2004[1], the NOTES technique has gained considerable interest, although not without controversy. With the theoretical benefit of decreased post-operative pain, wound infection and hernias, NOTES has now moved from experimental to clinical feasibility studies. In July 2008, a systematic review of clinical applications revealed 49 human cases published in the literature[2], and as of September 2010 there are now well over a thousand published cases of NOTES procedures with several large databases such as the German, EURO-NOTES and NOSCAR registries[3]. The vast majority of these cases have been carried out under appropriate conditions at established centres using hybrid laparoscopic techniques, to ensure safety during the assessment of peri-operative outcomes. It is of paramount importance that feasibility studies in NOTES are carried out safely by experienced multi-disciplinary teams in centres with adequate laboratory and in-vivo experience, under an institutional review board-approved protocol.

It is therefore vital at this stage in the development of NOTES, to reflect on what has been achieved and objectively assess and define the role NOTES may have in the future of minimally invasive surgery. Although reported morbidity has been minimal, what has become very clear from its introduction into clinical practice is the inadequacy of the flexible endoscope as a NOTES operating platform. There are significant problems with navigation, spatial orientation and stabilisation of the flexible endoscope when used outside the constraints of the gastrointestinal lumen. Furthermore, critical operative manoeuvres such as traction and counter-traction for exposure and division of structures are almost impossible using a dual-channel endoscope alone, and there are problems surrounding the sterilisation process for these tools. A multi-tasking platform with the ability to perform suturing and gastrointestinal anastomoses is required to carry out any more complex operations without utilising significant trans-abdominal assistance. Several operative platforms have been introduced with the aim of solving some of the short-comings of the flexible endoscope. The Olympus R-Scope provides instruments channels at the tip which can be moved at 90 degrees to one another, enabling somewhat more advanced tissue manipulation. The Direct Drive Endoscopic System (Boston Scientific, Natick, MA, USA) allows instrument control through ergonomically driven handles, similar to laparoscopic surgery, and the Cobra (USGI Medical, USA) aims to solve the problem of instrument triangulation through three independent arms at the endoscopic tip.

The Spider (Transenterix, NC, USA) allows single access flexible laparoscopy with triangulation of instruments at the tip offering true right and left motion, whilst the Storz video surgical rectoscope (Storz, Tuttlingen, Germany) represents a stable platform for access and resection in trans-anal endoscopic surgery. Unfortunately none of the available platforms available today address all of the requirements necessary to perform complex natural orifice procedures. This is where robotics is likely to play a key role in the future.

To safely perform natural orifice surgery we require a flexible access platform[4], which has the ability to withstand traction forces on tissues without displacement, whilst maintaining the ability to fully navigate within the peritoneal cavity. We will require off-axis visualisation as well as enhanced optics to fully integrate macroscopic to microscopic sensing capabilities. Inter-changeable surgical instruments will be a pre-requisite, with triangulation of these at the operative site enabling suturing and resection of tissue. Image manipulation algorithms will ensure that spatial awareness and orientation is maintained and pre-operative imaging can be used to prescribe dynamic constraints in real-time overlaid on a 3D visual interface, thereby maximising operative safety. We will also require the operating platform to have the ability to securely close the access site with minimal risks of leakage.

What may surprise some is that the technologies behind these innovations have been explored for some time at a number of academic centres and industrial partners worldwide. However, when comparing surgery with other high-technology and high-performance industries such as aerospace, aviation and defence, it becomes evident how far behind in the implementation of computer-assistance and robotic control we really are. As surgery strives to become more minimally invasive, it is inevitable that we will come to rely more and more on technological innovation, with a likely heavy emphasis on surgical robotics to decrease the cognitive burden placed on surgeons during minimally invasive operations. It is therefore vital to stress the importance of adopting innovative processes as they are presented to us and not only accepting but embracing change in this era of rapid technological advance, and furthermore we must ensure that adequate resources are available to translate innovative ideas to the clinical setting.

For NOTES therefore to realise its full potential, surgeons have to wait for technology to catch up with ideological innovation before embarking on more complex procedures than the hybrid transvaginal feasibility studies currently taking place. In this regard, our effort should be directed to cultivating and motivating technological innovation rather than venturing out heroic effort with inadequate instruments that may put patients at risk. As frustrating as this may be, it is of vital importance not to proceed with surgical interventions which are not supported by the technology currently at our disposal, as jeopardizing patient safety at the early stages of clinical applications may put at risk the realisation of the full benefits of NOTES.

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Mr M H Sodergren, Mr G Z Yang, Professor A Darzi
Institute of Global Health Innovation, Imperial College London, United Kingdom

Review of 18th International Congress of the EAES

16-19 June 2010, Geneva, Switzerland

The 18th Congress for the European Association of Endoscopic Surgeons was held in Geneva, Switzerland. It was a great privilege for me to be able to attend having received a generous EAES grant sponsored by B. Braun. It proved to be the perfect forum to both present our current educational research, and to gain an up-to-date insight into new techniques and procedures being performed in laparoscopic surgery. The conference centre was within walking distance from the airport, and unlike many such meetings, which are often held on the outskirts of suburbia, it was only a short trip into town. There was also the added bonus of free public transport granted simply for being a tourist, which was great as Geneva is expensive. I would be denying my British roots if I failed to mention the weather, and the incessant pelting rain could not be attributed solely to wind swept "spray" from the impressive jet d'eau. Despite this, it was a great few days, a welcome break from the world of research, and the inspirational presidential address from Professor Fingerhut set to Rossini's William Tell overture, which played on loop, would have been disappointing to miss. I also had the opportunity to see my current boss present in the presence of his old mentor, Professor Sir Cuschieri. It was very interesting to note that regardless of any individual career development or success, that once someone becomes your mentor, despite the passage of time, the ingrained respect for them and their opinion does not fade, and old roles are resumed, and once again you seek the reassurance from them that your presentation was "alright". Thank you B. Braun once again.

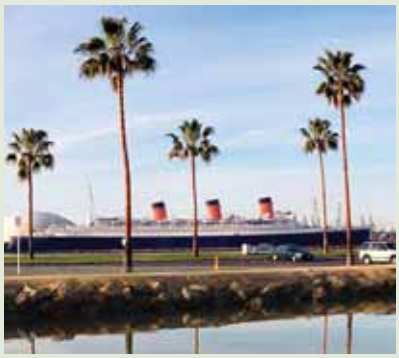
Miss Susannah Wyles
Charing Cross Hospital, London

IFSO XV SEPT 2010

3–7 September 2010, Long Beach, Los Angeles, California, USA

Long Beach, California, was the venue for this years Annual International Federation for the Surgery of Obesity and Metabolic Surgery (IFSO) meeting. The town, despite being only 20 miles from Downtown LA, has an air of calmness and serenity. It is the permanent home of the Queen Mary, previous holder of the trans-Atlantic crossing record and is a stepping stone to San Diego and La Jolla.

Whilst checking into the conference hotel I struck up a conversation with a grey haired Australian. He asked me why I was in LA, my reply "I've come to learn about surgery on fat people" or words to that effect. "Let me introduce myself, I'm Harry Frydenberg, President of IFSO". Best to create a bad impression than no impression at all I thought.



California seemed to be a good choice for this meeting judging by the average citizen we saw, many of whom were too immobile to walk or had mobility scooters, they seemed to be as static as the afore mentioned Queen Mary.

IFSO has grown since its inception in 1996 of 265 delegates to over 2000 this year, which reflects the explosion of this speciality. There was a strong scientific program and key lectures from leaders in the field on topics with a strong emphasis on metabolic surgery, innovation and the technical considerations necessary to achieve best results.

There were sessions on the role of integrated pathways, surgery and follow up with a multi-national faculty adjudicating. Whilst there was an overwhelming consensus that results were optimal when a multidisciplinary approach was adopted, entrenched views on the very best procedure prompted some interesting exchanges; practitioners of restrictive & malabsorptive surgery (RYGB/BDS) produced some very impressive long-term results; conversely, the data supporting the role of sleeve gastrectomies as a stand alone procedure was poor, with a weight regain after 36 months and revisional procedures almost inevitable. However its role in the Asian sub continent was strongly proposed with early data indicating a difference in this group of patients' metabolic response. While the majority of the faculty had moved towards surgical malabsorption, advocates of the lap band made a convincing argument for its use as a first of procedure in the lower BMI group and in those where there is a high expectation of meticulous follow up and thus compliance. I was fortunate enough to bump into Dr Robert Rutledge who, while seen to be on the fringes of the surgical community, is a key advocate of the mini gastric bypass. I was invited to watch him operate in Las Vegas later that week. This is reported later in this newsletter.

As one would expect from this type of meeting the issues regarding management of complications and weight gain following surgery were addressed and keenly debated. Adding multiple procedures seemed to have found favour amongst some, especially the mainland European contingent with bands added to bypasses and sleeves in cases of refractory weight gain, whereas lengthening of the bypass limbs, whilst more of a technical tour-de-force certainly led to better overall results. There were a number of superb video presentations dealing with complications and complicated cases and some marked modesty from those presenting.

Presentations and relevant links are available on the IFSO site and I would recommend visiting this as a useful education resource.

The next meeting in 2011 is nearer to home in Hamburg at the end of September, and I would urge those with an interest in this field to attend and to become part of the debate in this rapidly expanding field.

Mr Paras Jethwa
East Surrey Hospital

A visit to Dr Robert Rutledge, Bariatric Surgeon, Las Vegas, Nevada, USA

Mr Nick Marshall, Consultant Upper GI & Bariatric Surgeon, Newham General Hospital

Last month I had the opportunity to visit the IFSO meeting (3-7 September 2010) in Long Beach, California. The meeting was very well attended by bariatric surgeons intent on learning about the most recent developments in bariatric surgery. One particular surgeon I was pleased to see was Mr Robert Rutledge, who was presenting an impressive collection of posters on bariatric surgery. I was kindly invited to attend an operating list he was conducting to ask him about his practice.

NM: *Dr Rutledge, you have not followed the route of performing Roux-en-Y (RNY) bypasses, but developed an alternative procedure. What were the steps leading to this procedure?*

RR: I have been involved in bariatric surgery for my entire surgical career. My background includes 20 years, from 1978 to 1998, spent at the University of North Carolina at Chapel Hill in the Department of surgery. I started as a resident and advanced to full Professor of Surgery, Chief of the Section on Surgical Informatics and Assistant Chief of Staff.

In 1988 I began an early interest in laparoscopic surgery & was an early adopter of laparoscopic surgery at UNC. In 1997 I visited with Dr Michel Gagner and learned his approach to laparoscopic RNY bypass and began to perform the surgery using his technique. I had always had some aversion to the relatively more complex RNY and this continued as I began performing the RNY laparoscopically.

One evening I was on call for trauma when I saw a patient with multiple gun shot wounds that required emergency surgery. The injuries were extensive and required a distal gastrectomy, distal pancreatectomy, splenectomy and repair of multiple enterotomies. The patient was reconstructed with an ante-colic Billroth II gastrojejunostomy. I was struck by the fact that the same type of reconstruction would be applicable for my gastric bypass patients.

I recognised, as all general surgeons do, that a BII anastomosis adjacent to the oesophagus is "Never" appropriate because of problems with bile reflux esophagitis but the antrectomy and BII was/is and continues to be a standard part of the general surgeons' armamentarium.

I thus started performing a laparoscopic gastric bypass with a long narrow gastric pouch (Collis gastroplasty) and BII Anastomosis at the junction of the body and the antrum of the stomach. I performed 64 such cases at UNC and I was so impressed with the results that I quit my job to promote the use and adoption of the Mini-Gastric Bypass (MGB).

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NM: *Many people have raised concerns regarding bile reflux and its consequences following this type of bypass. What do your figures and research say to offer reassurance to those worried by this possibility?*

RR: That is a very good question.

Physicians realised in the 1880s that gastrectomy could be used to treat trauma, peptic ulcers and gastric cancer. Billroth introduced what is now known as the "Billroth I" in 1881 when he operated on a 43-year-old woman with gastric cancer. Billroth removed a segment of distal stomach and anastomosed the gastric remnant to the duodenum. Three years later (1884), he performed the "Billroth II", where a larger portion of the stomach was removed and attached to a loop of jejunum - the "Billroth II."

The Billroth II has been in use by general surgeons for over 100 years. Studies show that the Billroth II type connection does increase the amount of bile that is present in the gastric pouch. Careful review of these studies shows that the concerns about the BII anastomosis may be classified into three general areas.

The three areas of concern are

1. Risk of gastric cancer,
2. Risk of Oesophageal cancer and
3. Risk of Bile irritation and gastritis or ulcer.

When people raise concerns about the MGB they often confuse these three concerns. I think it is helpful to review each concern separately.

The risk of gastric cancer.

Several studies have raised concerns that there may be an increased risk of gastric cancer in patients undergoing the BII gastrojejunostomy; there are several large scale population-based studies which showed no additional risk of gastric cancer. The two studies that I find most compelling are the large scale population-based study reported from Finland and the large scale long-term population-based study from Omaha VA study done by the Mayo Clinic. In both of these large scale long-term population-based studies the risk of gastric cancer in these patients was not increased.

A good and very well-done study looking at this question was published in the New England Journal by Schafer et al. This study performed by the Mayo Clinic studied residents of Minnesota, who had surgery for ulcers between 1935-1959. These patients were followed for over 5,635 person-years. They found gastric cancer in only two of the patients in the surgical group, as compared with an expected rate of 3 people.

If the critics of the MGB are concerned about gastric cancer their efforts would be much better focused on changing patients diets and asking them to avoid hot dogs and baloney sandwiches as opposed to avoiding a MGB.

Oesophageal cancer

A new concern raised by some of the critics of the MGB is that the gastrojejunostomy will allow bile to reflux into the oesophagus and might contribute to an increased risk of oesophageal cancer. In keeping with the rest of the Western hemisphere gastric cancer incidence is decreasing in the USA but, this is in contrast to the very significant increase in Oesophago-Gastric Junction disease.

The increased risk of oesophageal cancer in the United States is unquestionably related to the increasing risk of gastro oesophageal reflux disease (GORD). Gastro-oesophageal reflux disease is a serious problem throughout the world and in fact leads to the widespread prescription of proton pump inhibitors. As a demonstration of just how widespread and serious GORD is one of the most commonly prescribed drugs in the world are PPIs.

A recent study by Akiyama et al assessed the risk of erosive esophagitis and Barrett's oesophagus after distal gastrectomy in a case-controlled study. They demonstrated that distal gastrectomy was not a risk factor for the development of erosive oesophagitis or Barrett's oesophagus. This lack of a positive association between distal gastrectomy and erosive esophagitis and Barrett's oesophagus may suggest that pancreatic-biliary reflux with a limited amount of acid is not sufficient to damage the oesophageal mucosa.

Dyspepsia and marginal ulcer

The rates for ulcer in RNY and MGB bypasses are similar. In a recent study by Garrido et al (2010) 118 morbid obese subjects were submitted to Roux-en-Y gastric bypass. Preoperative upper gastrointestinal tract endoscopy was negative for H. pylori. All subjects received Esomeprazole for 60 days after surgery; gastrojejunal ulcers were observed in 9 (7.6%) subjects at 2 months.

When a patient presents with marginal ulceration, perforation and or bleeding following a RNY it is routinely treated as an acid peptic complication and therapy usually follows normal anti-ulcer regimens. MGB patients also often present with dyspepsia and can have marginal ulceration, bleeding and/or perforation. Some RNY surgeons and others confronted with a BII MGB patient with marginal ulcer will conclude that the cause is "Bile Reflux" and seek to treat the bile reflux as the aetiologic agent.

My experience is as follows:

1. Like the RNY, the MGB Billroth II patients have a high incidence of marginal ulcer/gastritis (3-5%)
2. Because of the high incidence of risk of marginal ulcer, bleeding and or perforation - All RNY/MGB patients should be aggressively counselled pre and post operatively to avoid ulcerogenic foods and medications (i.e. smoking, alcohol, aspirin etc.)
3. All RNY and MGB patients need continuous monitoring post op for signs and symptoms of dyspepsia, bleeding and aggressive early treatment of acid peptic marginal ulceration/gastritis
4. Continued follow up with the MGB surgeon is critical to aides in directing care (avoid unnecessary conversion to RNY by the uninitiated)
5. In rare cases that fail such therapy, the revision of the MGB to divert the stream of bile can be effective. In my series of 6,000 cases, biliary diversion (using 15 minute Braun side to side jejunojejunostomy) was necessary in 4 patients over a span of 13 years

NM: *I understand that this form of bypass has the opportunity to be tailored to the patients requirements and can be subsequently modified or even reversed.*

RR: Yes I think so. Common sense suggests that a longer bypass should increase weight loss after gastric bypass. Although several studies have concluded that longer bypasses do not increase weight loss, the sample sizes in these studies were quite small. My own research has analysed the association of bypass limb length and weight loss my own large series of MGB patients.

I have analysed 3,883 of my patients that underwent MGB and completed 1 year of follow up. Bypass limb length was modified based on starting weight. Weight loss following MGB surgery follows a logarithmic decline through the end of the first year. Bypass limb length varied from 0.5 - 3 metres. Weight loss increased as bypass limb length increased ($p<0.0001$). This is the largest study of bypass length and weight loss after gastric bypass. Prior negative studies with small sample sizes may have suffered from a Type II error. My study demonstrates that both pre-op weight and limb length are significantly associated with weight loss and that every additional foot of bowel bypassed is associated with a mean increase of 6.9 kgs to the expected one year weight loss.

NM: *What would you like to say to the surgeons in the UK regarding the merits of your modification of the gastric bypass procedure versus "traditional" bariatric procedures?*

RR: As a reminder the Billroth II is still frequently the preferred form of surgery & in a recent study by Ozao-Choy et al the BII was the preferred means of reconstructing the GI tract following gastric resection.

In another study by one of the leaders of bariatric surgery Dr Pories was the senior author on a paper evaluating the effects of RNY and BII on diabetes. In the study the rate of RNY and BII were the same. The MGB uses the BII connection and its concerns appear to be minor or insignificant for the majority of patients.

Many thanks for your thoughts on this rapidly evolving area of surgical practice.

Review of 14th Annual Scientific Meeting of AUGIS, Oxford

9-10 September 2010

The 14th Annual Scientific Meeting of the Association of Upper Gastrointestinal Surgeons (AUGIS) was held in Oxford on the 9-10 of September, with many of the great and the good of Upper GI surgery in attendance. After braving the notorious Oxford traffic, the sight of dreaming spires was perhaps the perfect inducement to readying ourselves for the lectures and presentations ahead.

After settling down in the atmospheric surroundings of the Jacobean-style Examination Halls, we were treated to some interesting keynote lectures by Professor Paul Johnson (Oxford) on Islet cell transplantation, Mr Sri Kadirkamanathan (Chelmsford) on gastric pacing and by Dr Harry Fydenberg (Melbourne) on advances in metabolic surgery. This was the first time in the UK we had seen trial data for Endobarrier™, which (we are reliably informed) promises to be a major advance in the surgical treatment of type II diabetes mellitus.

The new technologies in Upper GI surgery symposium provided two major highlights. This year's AUGIS invited speaker was Professor Ugo Boggi from the University of Pisa in Italy. Professor Boggi made headlines earlier this year having performed Europe's first robotic renal transplant. We were treated to an excellent presentation with video footage of robotic pancreatic surgery he has performed. Professor Boggi continues to push the boundaries of robotic surgery and one can only marvel at the range and complexity of the cases he has managed to treat in this manner. Our second major highlight came from Mr Barry Paraskevas (London), whose lecture on single port laparoscopic surgery was both fascinating and inspiring. Mr. Paraskevas is a pioneer of single port laparoscopic surgery in the UK and he regularly uses the technique in his general surgery practice. He has the largest case series in the UK for single port laparoscopic surgery and his lecture provided everyone with valuable technical tips and tricks. Both lectures demonstrated the cutting edge of surgical technological innovation in clinical practice and the future appears to be small scar or no scar! The drinks reception at Christ Church, alma mater of no less than 13 Prime Ministers, was a perfect end to the day (well for those who didn't attend the dinner!).

The second day as always was split into concurrent sessions. We nailed our flag to the bariatric mast, which focused on the management of complications, the importance of audit and outcome reporting, with promotion of the new National Bariatric Surgical Registry as a means of achieving this. An enlightening talk on defensibility and risk management was given by the MDU, with the take home message being that apologising to your patient is not an admission of liability, and may stop you getting sued! Highlights of the OG and HPB sessions included talks on pancreatic transplantation by Professor Peter Friend (Oxford), resection of colorectal liver resections by Professor Rene Adam (Paris), Endoscopic Mucosal Resection (EMR) for Upper GI tumours by Dr Pradeep Bhandari (Portsmouth), options for achalasia management by Dr Oliver Busch (Amsterdam), and the buzz topic of the moment, enhanced recovery by Dr Don Low (Seattle).

AUGIS 2010 was an enjoyable experience, with a renowned international faculty, an inspiring venue, a good mixture of high powered basic science research and surgical technology presentations, and ample opportunities to catch up with old friends and colleagues. We would highly recommend attending next year's meeting.

Mr Ashok Menon
SpR General Surgery
South West Thames
Mr Sacheen Kumar
SpR General Surgery
North East Thames

ALS GBI

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

Laparoscopic Training Bursaries 2011

The ALS is awarding 15 generously funded Stryker Training Bursaries for a value of approximately £1,000 each during 2011 (7 Training Bursaries to be awarded in February 2011 and 8 in September 2011). The purpose of these awards is to enable aspiring young consultants within 2 years of appointment, and senior registrars within 3 years of CCST, to extend their training in minimal access surgery by attending a Laparoscopic Surgery Skills Course, of their choice, held at The Royal College of Surgeons of England in the prestigious Raven Department of Education. Please note the award does not cover travel or accommodation expenses.

In order to be considered for one of the Stryker Training Bursaries, candidates should initially email jtreglohan@asgbi.org.uk to request an application form. The completed form must be returned to Mr Mark Vipond, Honorary Secretary of the Association of Laparoscopic Surgeons, at The Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London WC2A 3PE detailing why the Stryker Training Bursary would be beneficial. A full list of available courses can be downloaded from www.rcseng.ac.uk (visit the education section and search using the term laparoscopic). The deadline for receipt of applications is Friday 18 February 2011 for the first 7 awards.

The successful applicants will be expected to produce a brief report of their course for publication in the ALS Newsletter. Any further enquiries should be emailed to jtreglohan@asgbi.org.uk / Tel +44(0)20 7973 0305.

A further request for the 8 remaining Stryker Training Bursaries will be communicated in August 2011.

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Laparoscopic Training Bursaries Reports

Laparoscopic Skills Course

I was delighted to be awarded the 'Laparoscopic Training Bursary' in 2010 generously sponsored by Stryker. This allowed me to attend the 'Core Laparoscopic Skills Course' held at the Royal College of Surgeons of England (Jun 2010).

This was a three day course and was superb in every respect. The daily activity was divided into various components with special emphasis on hands-on-experience.

The participants were taught about the basic laparoscopic techniques, laparoscopic appendicectomy, intra-corporeal suturing & laparoscopic cholecystectomy backed up by lectures and practical demonstrations.

It was very well organised and technically challenging. All participants had an opportunity to perform the procedure under supervision & were given personal attention & individual feedback. The participant/supervisor ratio was good and instant feedback made the course worth attending.

Personally, I feel more confident in doing laparoscopic procedures as the course did help me a lot in developing my laparoscopic skills, hand-eye co-ordination and tissue handling. I have also received commendable feedback from my supervisors regarding my improved skills after the course and I would recommend this course to all the trainee's at my level.

In conclusion, I feel fortunate and grateful for receiving the bursary as it certainly helped a lot in my training. These schemes are commendable and should be encouraged to help young trainees further their career ambitions and training skills.

Mr Khurram Siddique
William Harvey Hospital, Ashford

Facilitating learning in the Human Simulator and Operating Theatre Course

This new 2 day course is aimed at surgeons wanting experience and guidance on how to develop simulated training in their own institutions. A combination of classroom theory and role play was used to allow delegates to conceive and manage training sessions which ranged from low fidelity classroom simulation to high fidelity mock operating room simulation. This was achieved through effective planning and design, team briefing, supervision and ultimately debriefing and feedback.

A particular focus of the course was to underline the importance of non-technical skills for surgeons during practical tasks. Audio-visual recording not only allowed analysis of performance for those selected to be the simulation participants but also an "on-air" experience for those in the faculty team operating the equipment with all the technical difficulties this entails. Delegates were encouraged to explore the different outcomes that were possible when managing another team presented with a difficult situation in the operating theatre. This sometimes involved the subtle decision as to whether to intervene or let the simulation develop under its' own steam which was a fascinating entity in its own right.

In summary, a cutting edge course for those interested in this fast evolving and increasingly important area of training.

Mr Greg Wynn
Colchester University Hospital

Through the Keyhole

A selection of recently published articles

Laparoscopic Surgery Imposes Strain on Surgeons
Patients Benefit While Surgeons Suffer: An Impending Epidemic
J Am Coll Surg. 2010;210:306-313

To what extent does laparoscopic surgery impose strain on a surgeon's body? The authors surveyed 2000 laparoscopic surgeons, of whom 317 (16%) surgeons supplied information about physical symptoms attributable to laparoscopic surgery. Of this group, 272 surgeons (86%) experienced symptoms attributable to laparoscopic surgical procedures; most of the symptoms occurring during or soon after the procedure. As might be anticipated, surgical volume was the strongest predictor of symptoms. Instrument design, table set-up, and monitor location were other factors listed as contributing to symptoms.

Laparoscopic Colorectal Surgery Produces Better Outcomes for High Risk Cancer Patients Compared to Open Surgery
Annals of Surgery. 2010;252(1):84-8

This prospective study was designed to examine the feasibility and safety of laparoscopic resection in high risk patients with colorectal cancer. Between 2006 and 2008 consecutive patients undergoing elective surgery for colorectal cancer were stratified into high and low risk groups. High risk was defined as ≥80 years, ASA≥3, preoperative radiotherapy, T4 tumour and BMI ≥30. Outcomes included median length of stay, lymph node yield, resection margins, 30-day hospital readmission, postoperative mortality and major postoperative complications requiring reoperation within 30 days of surgery. A total of 424 patients underwent elective laparoscopic (224) and open (200) resections. Overall mortality rate for lap resection was 0.4% vs. 2% for open resection. Median length of stay was 4 (2–33) versus 10 (1–69) days ($P < 0.0001$), and rate of complications requiring reoperation was 2 of 224 (0.8%) compared with 10 of 200 (5%) ($P = 0.02$). Among the 280 (66%) "high risk" patients, 146 had laparoscopic resection (8 conversions; 5%) and 134 had open resections. Median hospital stay was 4 (2–33) days in the laparoscopic group versus 11 (1–69) days in the open group ($P < 0.0001$). Complications requiring reoperation were 2 of 146 (1.4%) after laparoscopic resection versus 7 of 134 (5.2%) after open resection ($P < 0.09$). Readmission rate after laparoscopic resection was 12.3% versus 5.2% after open resection ($P = 0.06$).

Critical appraisal of single port access cholecystectomy
British Journal of Surgery. 2010; 97(10),1476-1480

24 studies including 895 patients were identified from Medline and analysed. None was randomized. The feasibility seems to be established, with a conversion rate of 2 per cent but SPA was not standardized and there was much technical variation. The learning curve could not be determined. Median follow-up time was 3 (range 0·25–12) months. The overall published complication rate was 5·4 per cent and the biliary complication rate 0·7 per cent. The rate of umbilical complications ranged from 2 to 10 per cent. SPA cholecystectomy seems feasible, but standardization, safety and the real benefits for patients need further assessment. Uncontrolled wide adoption of this approach may be responsible for a rise in biliary complications.

A response to this paper was written by Mike Rhodes, President of ALS

Is oesophageal manometry a must before laparoscopic fundoplication? Analysis of 46 consecutive patients treated without preoperative manometry.
J Minim Access Surg. 2010 Jul;6(3):66-9.

The study was limited to patients with positive findings on upper GI endoscopy done by ourselves and "typical" symptoms (heartburn, regurgitation, and dysphagia) of GORD. Laparoscopic Nissen's fundoplication was performed when clinical assessment suggested adequate oesophageal motility and length. 1 patient, who had negative endoscopic findings, underwent a 24-hour pH-monitoring before surgery. Outcome measures included assessment of the relief of the primary symptom responsible for surgery in the early postoperative period; the patient's evaluation of outcome and quality of life after surgery. Relief of the primary symptom responsible for surgery was achieved in 85% of patients at a mean follow-up of 28 months. 39 patients were asymptomatic, 2 had minor gastrointestinal symptoms not requiring medical therapy, 3 patients had gastrointestinal symptoms requiring medical therapy/ PPIs and in 2 patients the symptoms worsened after surgery. Clinically significant complications occurred in 6 patients. Their conclusion was that oesophageal manometry was not mandatory for laparoscopic fundoplication in selected patients with typical symptoms of GERD and upper GI endoscopy suggestive of large hiatus hernia.

Long-term outcome and survival with laparoscopy-assisted pylorus-preserving gastrectomy for early gastric cancer.
Surg Endosc. 2010 Sep 16

Laparoscopically assisted pylorus-preserving gastrectomy (LAPPG) is a function-preserving operation with minimal invasion for early gastric cancer (EGC). This study aimed to investigate the long-term outcome and survival with LAPPG. From January 2005 to July 2008, 188 patients with EGC underwent LAPPG. The surgical and long-term outcomes and survival were assessed retrospectively.
RESULTS: The accuracy of the preoperative EGC diagnosis was 92.6%. The median follow-up period was 38 months (range, 2-63 months). Two patients experienced gallstones, and three patients experienced a second primary EGC. One patient with T3N0 gastric cancer died of peritoneal metastasis, and four patients died of other causes. The overall 3-year survival rate was 97.8%, and the disease-specific 3-year survival rate was 99.3%. The LAPPG procedure is safe in terms of satisfactory long-term outcome and survival for patients with EGC in the middle third of the stomach.

Predictors of failure of the laparoscopic approach for the management of small bowel obstruction
Am Surg. 2010 Sep;76(9):947-50

Small bowel obstruction (SBO) is a common cause of hospital admission. Our objective is to determine variables that correlate with failure of the laparoscopic approach for SBO. Twenty-three consecutive patients underwent diagnostic laparoscopy with curative intent for treatment of SBO by a single surgeon over a 3-year period. The laparoscopic approach was successful in 18 patients (78%); there were five (22%) conversions to laparotomy. The causes of obstruction included adhesive band in 16 patients; and small bowel lymphoma, metastatic esophageal cancer, small bowel gangrene, Meckel diverticulum, gallstones ileus, and incarcerated incisional hernia in two. Using the Fisher two-sided test, no significant predictor for conversion was identified using gender, American Society of Anesthesiologists class, previous bowel obstruction, history of adhesiolysis, abdominal distention, pelvic surgeries, chemotherapy, radiation, malignancy, chronic obstructive pulmonary disease, asthma, coronary artery disease, hypertension, or hypercholesterolenemia. The Wilcoxon two-sided test did not show significance for age, weight, number of previous abdominal surgeries, or small bowel diameter. The postoperative hospital stay was significantly shorter in the laparoscopic group compared with those who needed conversion (3 vs. 9 days) with $P = 0.0019$. No mortality was noted in any patients. The laparoscopic is safe and feasible for the management of SBO. We believe that the laparoscopic approach should be offered to all patients with SBO unless there is an absolute contraindication to laparoscopic surgery.

Laparoscopic Repair of Large Hiatal Hernia Without Prosthetic Reinforcement: Late Results and Relevance of Anterior Gastropexy. J Gastrointest Surg. 2010 Sep 8.

Laparoscopic treatment of large hiatal hernias seems to be associated with a high recurrence rate that some authors suggest to bring down by performing prosthetic closure of the hiatus. However, prosthetic repair remains controversial owing to severe and still underestimated complications. The aims of this study were to assess the long-term functional and objective results of laparoscopic treatment without prosthetic patch, and to identify the risk factors of recurrence.
METHODS: From November 1992 to March 2009, 89 patients underwent laparoscopic treatment of a large hiatal hernia without prosthetic patch, involving excision of the hernial sac, cruroplasty, fundoplication, and often anterior gastropexy. The postoperative assessment consisted of a barium esophagram on day 2, an office visit at 2 months with a 24-h pH study, an esophageal manometry, and then a long-term prospective yearly follow-up with a barium esophagram at 2 years.
RESULTS: Out of the 89 laparoscopic procedures, four required a conversion (4.4%). Seventy-seven patients underwent a Boerema's anterior gastropexy (86.5%). The morbidity rate was 7.8%, and the mortality rate was nil. Eleven patients (12.3%) were lost to follow-up. We had 91.5% of very good early functional results and 75.3% of good results after a mean follow-up of 57.5 months. Fourteen recurrences of hiatal hernias (15.7%) were identified, four of which (28.6%) occurred early after surgery. Three factors seemed significantly associated with recurrence: the absence of anterior gastropexy ($p = 0.0028$), the group of younger patients ($p = 0.03$), and a history of abdominal surgery ($p = 0.01$).
CONCLUSION: Large hiatal hernias can be treated by laparoscopy without prosthetic patch with a satisfying long-term result. Performing anterior gastropexy seems to significantly reduce the recurrences.

Introduction of laparoscopic bariatric surgery in England: Imperial BMJ.');" BMJ. 2010 Aug 26;341

Abstract
OBJECTIVES: To describe national trends in bariatric surgery and examine the factors influencing outcome in bariatric surgery in England.
DESIGN: Observational population cohort study.
SETTING: Hospital Episode Statistics database.
PARTICIPANTS: All patients who had primary gastric bypass, gastric banding, or sleeve gastrectomy procedures between April 2000 and March 2008.
MAIN OUTCOME MEASURES: 30 day mortality, mortality at one year after surgery, unplanned readmission to hospitalwithin 28 days, and duration of stay in hospital.
RESULTS: 6953 primary bariatric procedures were carried out during the study period, of which 3649 were gastric band procedures, 3191 were gastric bypass procedures, and 113 were sleeve gastrectomy procedures. A marked increase occurred in the numbers of bariatric procedures done, from 238 in 2000 to 2543 in 2007, with an increase in the percentage of laparoscopic procedures over the study period (28% (66/238) laparoscopic procedures in 2000 compared with 74.5% (1894/2543) in 2007). Overall, 0.3% (19/6953) patients died within 30 days of surgery. The median length of stay in hospital was 3 (interquartile range 2-6) days. An unplanned readmission to hospital within 28 days of surgery occurred in 8% (556/6953) of procedures. No significant increase in mortality or unplanned readmission was seen over the study period, despite the exponential increase in minimal access surgery and consequently bariatric surgery.
CONCLUSIONS: Bariatric surgery has increased exponentially in England. Although postoperative weight loss and reoperation rates were not evaluated in this observational population cohort study, patients selected for gastric banding had lower postoperative mortality and readmission rates and a shorter length of stay than did those selected for gastric bypass.

Single-incision Laparoscopic Surgery (SILS) in general surgery: a review of current practice.
Surg Laparosc Endosc Percutan Tech. 2010 Aug;20(4):191-204.

Froghi F, Sodergren MH, Darzi A, Paraskeva P.
Department of Biosurgery and Surgical Technology, Imperial College London, UK.
Abstract
Single-incision laparoscopic surgery (SILS) aims to eliminate multiple port incisions. Although general operative principles of SILS are similar to conventional laparoscopic surgery, operative techniques are not standardized. This review aims to evaluate the current use of SILS published in the literature by examining the types of operations performed, techniques employed, and relevant complications and morbidity. This review considered a total of 94 studies reporting 1889 patients evaluating 17 different general surgical operations. There were 8 different access techniques reported using conventional laparoscopic instruments and specifically designed SILS ports. There is extensive heterogeneity associated with operating methods and in particular ways of overcoming problems with retraction and instrumentation. Published complications, morbidity, and hospital length of stay are comparable to conventional laparoscopy. Although SILS provides excellent cosmetic results and morbidity seems similar to conventional laparoscopy, larger randomized controlled trials are needed to assess the safety and efficacy of this novel technique.

Systematic review and meta-analysis of laparoscopic Nissen (posterior total) versus Toupet (posterior partial) fundoplication for gastro-oesophageal reflux disease.
Br J Surg. 2010 Sep;97(9):1318-30.

Broeders JA, Mauritz FA, Ahmed Ali U, Draaisma WA, Ruurda JP, Gooszen HG, Smout AJ, Broeders IA, Hazebroek EJ.
Department of Surgery, Gastrointestinal Research Unit of the University Medical Center Utrecht, Utrecht, The Netherlands.
Abstract
BACKGROUND: Laparoscopic Nissen fundoplication (LNF) is currently considered the surgical approach of choice for gastro-oesophageal reflux disease (GORD). Laparoscopic Toupet fundoplication (LTF) has been said to reduce troublesome dysphagia and gas-related symptoms. A systematic review and meta-analysis of randomized clinical trials (RCTs) was performed to compare LNF and LTF.
METHODS: Four electronic databases (MEDLINE, Embase, Cochrane Library and ISI Web of Knowledge CPCI-S) were searched and the methodological quality of included trials was evaluated. Outcomes included recurrent pathological acid exposure, oesophagitis, dysphagia, dilatation for dysphagia and reoperation rate. Results were pooled in meta-analyses as risk ratios (RRs) and weighted mean differences.
RESULTS: Seven eligible RCTs comparing LNF (n = 404) with LTF (n = 388) were identified. LNF was associated with a significantly higher prevalence of postoperative dysphagia (RR 1.61 (95 per cent confidence interval 1.06 to 2.44); P = 0.02) and dilatation for dysphagia (RR 2.45 (1.06 to 5.68); P = 0.04). There were more surgical reinterventions after LNF (RR 2.19 (1.09 to 4.40); P = 0.03), but no differences regarding recurrent pathological acid exposure (RR 1.26 (0.82 to 1.95); P = 0.29), oesophagitis (RR 1.20 (0.78 to 1.85); P = 0.40), subjective reflux recurrence, patient satisfaction, operating time or in-hospital complications. Inability to belch (RR 2.04 (1.19 to 3.49); P = 0.009) and gas bloating (RR 1.58 (1.21 to 2.05); P < 0.001) were more prevalent after LNF.
CONCLUSION: LTF reduces postoperative dysphagia and dilatation for dysphagia compared with LNF. Reoperation rate and prevalence of gas-related symptoms were lower after LTF, with similar reflux control. These results provide level 1a support for the use of LTF as the posterior fundoplication of choice for GORD.

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Lindsey Blain, Workshop Coordinator – Bard Davol Bard Limited, Tilgate Business Park, Brighton Road, Crawley, West Sussex, RH11 9BP

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	Lap Inguinal (TEP) + Lap incisional	Observing
Midlands	Lap Incisional / Parastomal	Observing
North East	Lap Inguinal (TEP)	Observing
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4th- 5th July 2011	Comprehensive Urological Laparoscopy	Berlin
6th - 8th July 2011	Laparoscopic Training Course - Hernia Surgery	Berlin
21st - 23rd November 2011	Advanced Laparoscopic Surgery	Berlin

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Date	Course	Venue
TBC April 2011	Laparoscopic Ventral Hernia Repair Workshop	King George Hospital, Essex
TBC October 2011	Laparoscopic Ventral Hernia Repair Workshop	King George Hospital, Essex

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

Date	Courses	Venue
1 December 2010	One-Day Video Editing Course	KeyMed House, Southend-on-Sea
2 December 2010	One-Day Video Editing Course	KeyMed House, Southend-on-Sea
16–17 December 2010	10th International Laparo-Endoscopic Single-Site Surgery Dry Lab Workshop	IMACS Centre, Maidstone
24–25 February 2011	Advanced Laparoscopic Biliary Surgery	Royal Infirmary of Edinburgh
27–28 June 2011	Ambulatory Gynaecology Course	Royal Hallamshire Hospital

Caption Competition Winner

"The president doing his weight training"

Mr Graham Kerr, Mantis Surgical

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Travelling Scholarships 2011

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 their visit at a meeting of the ALS. This sponsorship is funded by an unconditional grant in line with the ABHI Code of Business Practice and adheres to Health Care Compliance Guidelines.

The ALS is also awarding two Aesculap Endoscopy 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 a meeting of the ALS.

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 15 April 2011. The names of successful applicants will be announced at the Association of Surgeons congress in May 2011 in Bournemouth.

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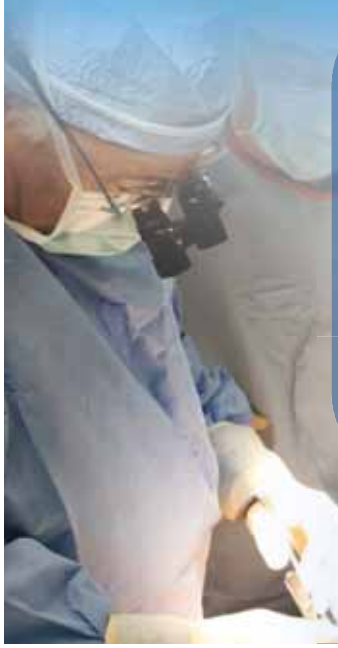

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