ALS GBI
Association of Laparoscopic Surgeons of Great Britain & Ireland

ALSGBI newsletter

President's Introduction

The ALSGBI Annual Scientific Meeting in London is upon us and a great deal of effort from many quarters has gone into what I hope will be a very memorable meeting. The technical requirements for delivering the live surgery from mattu, Guildford to The Royal College of Surgeons of England in 3D HD are considerable and I am very grateful to Olympus Medical and Karl Storz, two of our Platinum Industry Partners, for their dedicated efforts to make sure the popular live day is as high quality an experience as can be achieved. Once again the ALSGBI is putting in place a really cutting edge event, as there will be few if any of the audience who will have experienced a 3D HD live broadcast.

Whenever new technology appears there is always a body of opinion that it is a gimmick and I suspect that this is no exception for 3D. For this particular new technology however the interest levels are very high and I hope that this conference will give surgeons and theatre staff alike the opportunity to evaluate its potential. Whilst we have inevitably been concentrating on the 2013 meeting, plans are already quite far advanced for the 2014 Annual Scientific Meeting in Aberdeen. Professor Zyg Krukowski will be the local organiser and the ever popular training day will be delivered in collaboration with the Cuschieri Skills Centre in Dundee.

On a personal note, this excellent newsletter produced by Mr Shaun Preston, is the last that will be published during my Presidency. At the London meeting I will hand over the responsibility to Mr Mark Vipond. Unlike some responsibilities that are handed over with a sigh of relief, I will hand over this particular one with some degree of sadness as it has been a both a privilege and a pleasure to do this job and I hope that I have served the Association well. The ALSGBI is a thriving organisation with an eager Council, a respected and popular Annual Scientific Meeting and an excellent and productive relationship with its Industry Partners. There is no doubt in my mind that despite the growth of laparoscopic influences within the other Associations, the future of the ALSGBI as an entity is secure.

Professor Tim Rockall, President

Editor's Introduction

Welcome to the Autumn-Winter edition of the ALSGBI newsletter. I am delighted with the contributions made to this issue from the regional members and their representatives on the ALSGBI Council. Whilst we can all read the literature relating to our relevant specialty interests, what we are often blissfully unaware of are the efforts made at a local level to develop services and teach/train our peers and successors. Information on such events can prove both informative and stimulating. Many of the articles in this issue are altruistic, reflect grass roots practice and also demonstrate that the innovative spirit of the Association is alive and well. The useful guidance offered by Mr Ian Finlay on the process of securing and installing integrated theatres within their Trust will undoubtedly help others. The Trent Chapter's ALSGBI Symposium is a fantastic achievement that has brought together a region, with a DVD format, invited speakers and a competitive prize session for trainees and newly appointed consultants. Mr Paul Leeder (ALSGBI Regional Representative - Trent) has provided us with a useful insight, along with his own 'tips and tricks', in the hope of stimulating other regions to follow suit. I very much hope that it does. Mr Sean Woodcock's article shows how much things have changed in the relatively short time since I moved from north to south. There is clearly a great deal of activity in the region, but operating in 'barns', whatever next?

I always enjoy reading the reports of those who have been on the ALSGBI travelling fellowships, especially when they have been to units that I was previously unaware of. Most fellows, however, visit the small number of particularly renowned units in their field of interest. One thing that caught my attention was the suggestion by Mr Will Hawkins, following his fellowship in Sydney, of utilising the information and experience gained personally, supplemented by that of friends and colleagues, to create a guide that could be posted on the ASiT website to help others achieve similar goals. This is an excellent idea and exactly the kind of 'esprit de corps' that I believe all subsequent fellows should foster.

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One other area of interest is the relentless improvement in access to information. Our role surely is to ensure that there is access to good quality information that this is both helpful and informative. NHS Direct has launched a mobile app that enables access to trusted and reliable healthcare advice via a smartphone. The app, which allows earlier access to the available online Health and Symptom Checkers and Patient Decision Aids (PDAs), is available for both Android™ or iPhone® from Android Market and iTunes® respectively. The benefit of such technology has not gone unnoticed and NHS Direct has signed a deal with Healthdirect Australia that will enable them to use these online health and symptom checkers. This is thought to be the first commercial deal of its kind within the NHS. Within our own Association the work to improve access to digital information continues and an update on progress has been kindly provided by Mr David Mahon.

This year's ALSGBI Annual Scientific Meeting is rapidly approaching. The ease of access to London, the use of the Royal College of Surgeons of England as the venue, along with the leadership by our President, Professor Tim Rockall and the organisation carried out by Jenny and Sarah in the office will, I am sure, make for an excellent Meeting. Following on from the success of the 3D video session at the ASM in Cardiff we plan to deliver live cases in 3D form Guildford, where we are regularly using this technology. I hope that as many members, and their affiliates, as possible come to the meeting from 14-15 November 2013 which should be stimulating.

Mr Shaun Preston
Newsletter Editor

The ALSGBI App

More and more of you are accessing our content digitally these days, either on our website or on our ALSGBI iPhone/iPad app. The app is available from Apple's App Store. Work is progressing on an app update which will enable us to keep the content as fresh as possible and by the time of our conference in London this November this update, together with a new version of the app for Android devices, should have been launched. Meanwhile, the conference microsite on our webpages has been optimised to work on handheld devices as well as regular computers so anyone, with any device, should be able to get more information about the meeting – and, of course, register to attend. See www.alsgbi.org.uk/london2013 As always, we welcome additional digital content. If you have anything to submit, please send it to jtreglohan@alsgbi.org or for video, send a DVD to the office. Finally I'm happy to be able to announce that Covidien have kindly agreed to sponsor our app until the end of March 2014. Industry sponsorship helps us to make these types of innovations possible and we are always very grateful for it.

Mr David Mahon
Website Director

Available on the App Store

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Report of the B. Braun Aesculap Travelling Scholarship

Laparoscopic Hepatopancreatobiliary Fellowship at the Department of Digestive Surgery, Institut Mutualiste Montsouris, Paris

B|BRAUN SHARING EXPERTISE

I wish to thank the ALSGBI for the B. Braun Aesculap Travelling Scholarship that allowed my visit to Professor Brice Gayet's department at the Institut Mutualiste Montsouris in Paris. The main motivation for this visit was to gain experience in laparoscopic HPB surgery. Specifically, I wished to learn the techniques (either totally laparoscopic or laparoscopic-assisted) developed to achieve safe major liver and pancreatic resections. I embarked on this mini-fellowship during the last month of my Specialist Registrar training, and prior to taking up the Consultant HPB Surgeon post at the Addenbrooke's Hospital.

During this mini-fellowship, I witnessed a wide range of laparoscopic pancreatic and liver resections. It was a pleasure to watch Professor Gayet operate – each laparoscopic step was performed with finesse and ease. Combination of efficient movement and clear intra-operative decision making has allowed him to complete major laparoscopic resections within 4-5 hours. Professor Gayet made use of robot-assisted laparoscopy to perform each of his laparoscopic procedures – this worked very well with the robot precisely moving the laparoscope to his desired view.

My first week was intriguing. Professor Gayet performed a laparoscopic-assisted Whipple's resection for a patient with a head of pancreas mass causing obstructive jaundice. The initial 'posterior' approach to dissection with laparoscopic extended Kocherisation and extension of the posterior dissection to the origin of SMA on the right hand side. This was followed by sampling of the aorto-caval nodes and then coeliac lymph nodes to exclude metastases. Frozen section was performed on both sets of lymph nodes before proceeding further with the resection.

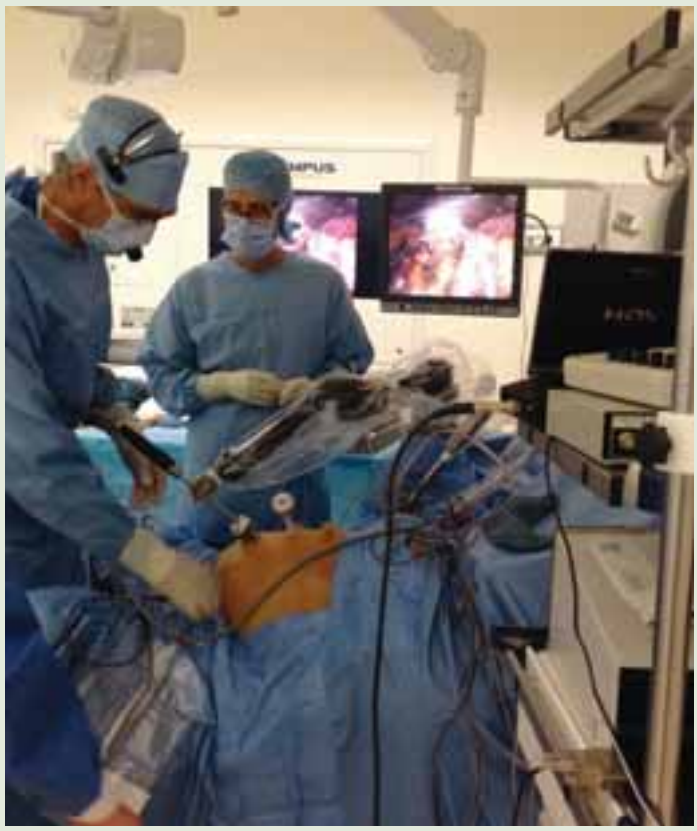
I further witnessed a case of laparoscopic left hepatectomy for colorectal metastases. The liver hilum was dissected clearly with a good laparoscopic view. The left pedicle was subsequently divided with precision. This was followed by the anterior approach to liver transection using a bipolar-ultrasonic device in one hand and bipolar forceps in the other. The whole operation was performed in a 'blood-less' field with minimal blood loss. I suspect the blood loss was also minimised by the low CVP and low pressure capnoeperitoneum. It was impressive to see such a procedure completed with finesse and safety, especially considering that the patient had significant steatohepatitis from previous chemotherapy.

Given that Professor Gayet was also a Professor of Anatomy, his appreciation of surgical anatomy was astounding – this has allowed him to navigate laparoscopically with ease, as for the inexperienced, laparoscopic anatomy can be rather deceiving. Professor Gayet is a meticulous surgeon with careful haemostasis at each stage – with a right-handed harmonic scalpel and his left hand holding a laparoscopic bipolar forceps (Professor Gayet is left-handed). The bipolar forceps prove to be very handy both for gentle tissue handing and haemostasis. At times, the bipolar forceps are also handy in manual compression of any 'bleeders'.

Although I spoke little French, I was able to get-by and quickly settled into the daily routine of the unit. The experience was facilitated by the presence of other overseas visiting surgeons, all hoping to advance their laparoscopic HPB work by learning from the best! When not in the operating theatre there were few ward commitments, as the post-operative care was predominantly managed by a team of gastroenterologists experienced in caring for post-operative surgical patients. I was able to spend some time catching up on my research work. At weekends, I commuted back (via the Eurostar) to London St. Pancras followed by transfer to a train for Cambridge with a door-to-door journey time of 3 and a half hours!

In summary, I was privileged to be accepted as a visiting fellow by Professor Gayet and this experience has changed my perception of laparoscopic HPB resectional surgery. In experienced hands, these technically challenging operations can be achieved laparoscopically with a similar degree of safety as open procedures. The absence of tactile feedback in laparoscopic approach is compensated by the excellent view achieved. In the next year, I plan to make further trips to Paris to watch Professor Gayet performing further laparoscopic liver operations, in particular major resections such as extended hepatectomies. I am indebted to my surgical mentors and colleagues at the HPB Unit in Addenbrooke's Hospital (Neville Jamieson, Raaj Praseedom, Emmanuel Huguet, Asif Jah) for supporting me in this endeavour.

Mr Siong-Seng Liau, MA, MD, FRCS (Gen. Surg)
Winner of the B. Braun Aesculap Travelling Scholarship 2011



Report of the B. Braun Aesculap Travelling Scholarship

In November 2011, I visited Seoul in South Korea on a Travelling Scholarship kindly sponsored by ALSGBI and B Braun Aesculap. My time was divided between two major hepatobiliary centres both with worldwide reputations for excellence and innovation in laparoscopic liver surgery.

There is increasing evidence that in experienced hands, laparoscopic liver resection in selected patients is safe, feasible and leads to accelerated recovery compared to open surgery. Despite initial concerns about the potential risk of major haemorrhage during laparoscopic liver resection, rather the presence of pneumoperitoneum appears to have a beneficial effect by limiting blood loss from low pressure hepatic veins. The indications for laparoscopic liver resection have gradually expanded over the past decade. Solitary tumours less than 5cm in diameter are generally considered suitable for a laparoscopic approach, particularly in the antero-inferior or left lateral segments. Resection of postero-superior segments and major resections are more challenging and are currently performed by few experienced laparoscopic liver surgeons worldwide. In the UK, the proportion of liver resections carried out laparoscopically is small, and the majority of liver surgeons with a laparoscopic interest are currently ascending their learning curve predominantly with minor resections only. At present, therefore, it is difficult for UK surgical trainees to gain sufficient hands-on exposure to achieve independence in laparoscopic liver resection prior to consultant appointment.

I am extremely grateful to Professor Ho Seong Han (Seoul National University Bundang Hospital) and Professor Ki Hun Kim (Asan Medical Center) for their warm hospitality and for giving me such a fantastic opportunity to learn from their vast experience. Professor Han is a genuine innovator in the field of laparoscopic liver surgery, having performed numerous major hepatectomies, including laparoscopic adult-to-adult live donor right hemihepatectomy, laparoscopic right posterior sectionectomy and laparoscopic central bisectionectomy, all extremely challenging procedures even for experienced open surgeons.

With 400 liver transplants performed annually, the Asan Medical Center (AMC) is the home of the world's largest liver transplant programme, attracting scores of visiting surgeons to learn from their extensive experience of live donor transplants. Professor Kim is also an expert laparoscopic liver surgeon, having performed over two hundred cases, including more than twenty laparoscopic live donor hepatectomies and over seventy laparoscopic hemihepatectomies. During my visit, I had the opportunity to observe numerous cases, including a laparoscopic live donor left lateral sectionectomy as well as a robot-assisted laparoscopic liver resection.

Since my return to the UK, the technical aspects of laparoscopic liver resection learnt in Seoul have proved valuable in developing my own laparoscopic hepatobiliary resection practice. The most common indication for liver resection in South Korea is a small, solitary hepatoma in a thin, young patient. This is in stark contrast to the typical UK patient, who is overweight, elderly with multifocal colorectal metastases in a steatotic liver, commonly damaged by chemotherapy. In my view, it has been these differences in patient demographics that have been the most challenging to overcome, particularly during my learning curve, when patient selection is of critical importance. With nearly twenty minor laparoscopic liver resections under my belt since my scholarship, my next challenge is to master major liver resections.

Mr Robert Sutcliffe
Winner of the B. Braun Aesculap Travelling Scholarship 2011

ACPGBI Newsletter Liverpool Annual Congress

1-3 July 2013

This year's ACPGBI Annual Conference in Liverpool was fascinating and interesting. It took place in the BT Convention Centre, Royal Albert Docks in Liverpool Inevitably the focus of the meeting constantly returned to surgeon specific outcome reporting. After discussions between ACPGBI and HQIP, the date for publication was pushed back from June to September to allow the data to be scrutinized and corrected. Actually, my impression was that, although concerns were expressed, most delegates were supportive of the process and the engagement of the ACPGBI on behalf of members. There was discussion about the publication of data for colorectal surgeons who are non-members, but they should be reminded that the government, through NBOCA (National Bowel Cancer Audit), chose the ACPGBI to act as the default organization to interact with over these difficult and sensitive matters. Individual surgeons were therefore given 2 months to make sure their data was correct prior to publication. There is further information on surgeon outcomes on the ACPGBI website (www.acpgbi.org.uk).

Allied to this process was also much discussion of NBOCA which has now accrued nearly 60,000 cases. In the 2013 report, amongst the wealth of detail was the excellent news that the laparoscopic resection rate in England and Wales has now reached 40%, which reflects very well on the Lapco programme (www.lapco.nhs.uk), the Welsh equivalent and the effectiveness of the Ethicon Endosurgery sponsored Post-CCT Fellowships, which are now administered by the ALSGBI. From October 2013 the ACPGBI will also provide oversight of the fellowship appointments process.

Outside of surgeon outcomes the other matters of interest to ALSGBI members were the international keynote speakers Dr Neal Ellis from Mississippi, USA who gave an interesting lecture on simulation in surgical training and Dr Eric Rullier from Bordeaux, France who talked on laparoscopic ultra-low anterior resection with inter-sphincteric resection and trans-anal minimally invasive rectal excision (TAMIS).

There were also very entertaining 'themed' sessions such as 'The best thing since sliced bread' which saw ALSGBI luminaries Mr Mark Gudgeon and Professor Tim Rockall debate the merits or otherwise of robotic rectal cancer surgery. This session also discussed single incision laparoscopic colonic resection debated by Mr Tony Dixon and Professor Pete Sagar. This plenary session was live and interactive with audience participation and voting via SMS, Twitter and PollEv.com/acpgbi.

At ACPGBI Council meeting there was a unanimous decision taken to implement our own membership database and subscription collection service, currently run by the ASGBI. Our members want a clearer identity for the ACPGBI and also want additional members' benefits which we can only realize by control of our own affairs.

ACPGBI were also very pleased to see the ALSGBI President, Professor Tim Rockall, Executive Officer, Mrs Jenny Treglohan and Business Manager Mrs Sarah Williams present at the meeting, partly to promote the forthcoming ALSGBI meeting in London in November.

We look forward to welcoming ALSGBI members to the next annual meeting which will be the Tripartite meeting with the RSM Section of Coloproctology, the American Society of Colon and Rectal Surgeons (ASCRS), the Colorectal Surgical Society of Australia and New Zealand (CSSANZ), the Royal Australian College of Surgeons and the European Society of Coloproctologists (ESCP). This will take place on 30th June to 2nd July 2014 at the International Conference Centre in Birmingham, UK. Please find more details at the meeting website at www.tripartite2014.org.

Mr Mark Coleman MD FRCS
Chairman of External Affairs, ACPGBI

Report of the Ethicon Endo-Surgery (David Dunn) Travelling Scholarship

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After a couple of years of planning and a lot of paperwork, I travelled to Sydney with my family on the last day of 2011. Arriving from the depths of the British winter we were grateful that Sydney was having the worst summer in generations.

I was here to work on the Upper GI unit at the St George Public and Private Hospitals in Kogarah. St George Public Hospital is one of Sydney's biggest acute hospitals, providing tertiary referral services for the 200 miles of New South Wales' south coast. The Upper GI unit is run by four Visiting Medical Officers (VMOs or consultants) – Dr Michael Talbot, Dr John Jorgensen, Dr Ken Loi and Dr Vytauras Kuzinkovas, three of whom have had training in the UK. Unusually in the competitive environment of Australian healthcare, the consultants work closely together within a multi-disciplinary team at the adjacent private hospital. Together they represent probably the largest non-gastric band orientated bariatric practice in Australia and are Australia's only Bariatric 'Center of Excellence'.

The team had two fellows, Mr Gary Yee (a Sydneysider in the Australian surgical fellowship scheme) and myself. Between us we provided a 24/7 Upper GI on call for the public hospital and rotated between the public and private hospitals every three months.

I started at the public hospital and had not anticipated how much it would challenge some of the principles of my UK training. The unit's strong relationship with industry and their understanding of surgical technology influences their approach to surgical practice, with new products frequently being trialled. All laparoscopic procedures involving the hiatus are approached with the surgeon and their operating ports on the patient's right with the assistant and their ports on the left. Use of a 45 degree scope allows excellent vision and avoids instruments clashing during the procedure. Even though the change in orientation (for someone previously used to the 'French' position between the legs) does take a little getting used to, I continue to use this arrangement in my own consultant practice.

Laparoscopy was the default approach to most surgical problems, giving me experience in laparoscopic anti-reflux/hiatal surgery, ventral and groin hernias and emergency cholecystectomy (with routine cholangiography). There was a limited amount of resectional work but I was generally primary surgeon and was, unexpectedly, performing pancreatic resections independently by the end of the year.

There is very limited funding for bariatric surgery in the public sector, but the incentivised private health system offers it freely. St George Private Hospital performs around 1000 bariatric procedures annually and I was involved in around a third of these. Having evolved their protocols over the years, laparoscopic sleeve gastrectomy is now the default option for most patients, including those requiring revisional surgery after failed gastric bands. All surgeons follow a similar technique, which made it easy to learn, and there was ample opportunity for hands-on experience. Their results are exceptional, with only one leak in the year that I was with them and none reported in their series of almost 200 revisional procedures. Dr Talbot still performs a large number of gastric bypasses with a handsewn gastro-jejunal anastomosis, which was a particularly useful technique to learn. They also have a developing research portfolio which I continue to play an active part in.

Undoubtedly my year in Sydney was hard work but a professionally and personally rewarding one. I found that in Australia there really is a 'no worries' approach to challenging situations which has had a lasting effect on me.

Organising a fellowship in Australia is a tricky process but, for me and many before me, it has opened the doors that I hoped it would. In conjunction with other colleagues who have been through the process we are writing a guide to the paperwork which should appear on the ASiT website (www.asit.org) in the near future.

I would like to convey my gratitude to the ALSGBI for their support through the David Dunn scholarship and to everyone that I worked with at the St George Hospitals in 2012 for making it such a memorable experience.

Mr Will Hawkins
Winner of The David Dunn Travelling Scholarship 2011

Hosting a Regional ALSGBI Meeting

Tuesday 9 July 2013 saw the second Trent Chapter ALSGBI Symposium held at The Radisson Blu East Midlands Airport Hotel.

We have had the long held belief that there is much unsung talent in laparoscopic surgery across the various regions that make up Great Britain & Ireland. Laparoscopic surgery is no longer an elitist enterprise, but is now the mainstay of most surgical practice. A lot of hard working general surgeons are plugging away at the coalface, often developing significant innovations in their own surgical approach to a variety of disorders. We however felt frustrated that there was no easy way of disseminating these new ideas. With this in mind, we decided to set up a local meeting in Trent Region, with the sole intention of enabling surgeons to share their own laparoscopic techniques with colleagues in a non-confrontational environment. The hope was to be able to disseminate these ideas & good practice to other surgeons & trainees alike.

We set up our first 'Tips & Tricks in Laparoscopic Surgery' event in 2012 and following the success of that evening, have now decided to make it an annual event.

When setting an educational meeting, the first thought is when to hold it & how long for. We decided that with limited study leave, we did not want to impinge further on valuable clinical time, but instead to hold it as an evening event. Rather than long powerpoint presentations from experts, we decided to emphasise the clinical aspect, with brief DVD presentations.

Surgeons were invited from throughout Trent region, including Sheffield, Chesterfield, Mansfield, Nottingham, Lincoln, Derby, Leicester and Northampton. This ensured the widest breadth of experience and I hope minimised the feeling of elitism. The key to a successful meeting was identifying a venue that was easily accessible for such a large geographical region and that provided top-notch facilities and refreshment. Good food is mandatory to ensure a satisfied, responsive audience. Alcohol, surprisingly, is not required to generate a healthy debate.

Following the success of our inaugural event, we decided to change the format slightly. The first half of the evening on 9 July was given to a new DVD prize session. New consultants & trainees were invited to submit an 8-minute DVD for presentation. Each was marked on both quality of content and production. We had six submitted presentations on topics ranging from the laparoscopic management of Caecal Volvulus, perforated anastomotic ulcer and an innovative glove port TEMS. All talks were of a very high standard and marking was consistently high. The winning presentation was by one of our regional specialist trainees, Mr Waleed Al-Khyatt, with his presentation on 'Laparoscopic Repair of Giant Hiatus Hernia'. He was awarded the 'Trent Chapter ALSGBI Medal'. This is a new award that we would not have been able to develop without the invaluable sponsorship from our Industry Partners. Karl Storz have generously offered to sponsor the medal for the next five years. The meeting venue & food were all sponsored by Covidien.

The second half of the meeting was given to invited speakers who showed DVDs on hernia repair, oesophagectomy, cadaveric simulation training and emergency surgery. My thanks go to all our presenters who generously gave their time and entertained us with some excellent talks.

Probably the most exciting part for me was to see the debate and exchange of ideas that is generated in a more intimate setting. I feel that everyone went away with at least one new idea to try at home. Feedback again from this year's meeting was excellent, with attendees keen to see more general surgery, particularly emergency surgery, colorectal pelvic surgery and CBD exploration. We elected to hold the meeting during one of our Royal College Laparoscopic Skills courses that was held at Derby. I'm pleased that some of our best feedback was from the course delegates, who were also invited to the symposium. They greatly appreciated the chance to see the techniques they had learnt being put to practical use.

We look forward to running the event again next year and would encourage anyone who is thinking of doing the same in their region. My advice would be:

1. Always plan up to a year ahead.
2. Expect and cater for at least another ten people to turn up who didn't say they were coming.
3. Don't rely on the venue to provide good enough equipment for HD quality video. Bring your own, including a decent sound system.
4. However many times you ask, presenters won't forward their DVDs in advance, or arrive with the required video format. Always have at least one pc and one macbook that you know work with a variety of video formats and connecting cables.
5. Check out the venue before booking to ensure they have the appropriate facilities e.g. good black out curtains for the summer.
6. Don't overfill the agenda as speakers will always run over their allotted time and you will hopefully stimulate a lot of discussion.

Overall, it was a very positive experience that was enjoyed by all and I think has forged some invaluable links across our region.

Mr Paul Leeder
ALSGBI Regional Representative Trent

Laparoscopic management of giant paraoesophageal hernia: technical tips

Giant hiatal hernia (GHH) is a hernia that includes more than 50% of the stomach in the chest. Its incidence varies between 0.3 – 15% of all types of hiatal hernia. A GHH is a type III hiatal hernia that constitutes both sliding and paraoesophageal components. It is more common in women and older patients. Surgical repair is the treatment of choice unless there is a contraindication because of the patient's comorbid condition. For a successful GHH repair essential steps should be considered during surgery. These steps includes a complete reduction of the hernia, excision of sac, tension-free crural repair, assessment of oesophageal length intra-operatively and appropriate use of oesophageal lengthening procedures as well as the management of reflux symptoms with an anti-reflux procedure.

In a video presentation we demonstrated the important technical tips taken during laparoscopic management of a giant paraoesophageal hernia with organo-axial volvulus in 54-year old women.

Mr Waleed Al-Khyatt,
Mr SY Iftikhar
Department of Upper GI Surgery
Royal Derby Hospital

Report from the ALSGBI Northern and Yorkshire Region

Greetings from the North East! At our last ALSGBI Council meeting we discussed articles of interest for the bulletin and we thought it would be a good idea to hear about what was going on in our various regions. The idea was to get a taste of not just the continual drive for new laparoscopic operations or procedures but the adoption of current good laparoscopic practice into existing hospitals by our members. This ultimately allows patients better access to laparoscopic procedures at their local hospital with all the benefits of the laparoscopic approach. We were also keen to hear about courses and training issues in the region and any other news that we thought would interest our membership.

I'd like to thank those regional members who supplied me with the information to enable me to write this article.

To kick off, I would like to tell you about The Newcastle Surgical Training Centre (N.S.T.C.) hosted within the Freeman Hospital in Newcastle. This is the very first hospital based, anatomical examination unit of its kind in the UK to hold a formal license from the Human Tissue authority enabling it to carry out advanced training for the medical profession using donated human tissue. It has become the first centre in England to receive full accreditation from The Royal College of Surgeons. Professor Alan Horgan was and remains the driving force for the unit which was opened in 2007 and from humble beginnings now hosts over 140 courses per annum. The faculty is mainly formed from regional consultants. The courses usually contain a combination of didactic teaching, DVD, occasional links to see live operating and hands on practical skills using fresh frozen cadavers. I convene the bariatric courses there for the local STs and also host the cadaveric day of the Surgery for Obesity Registrar Training and Educational Development (S.O.R.T.E.D.) course. The facilities are incredible and for all practical purposes delegates are in a fully equipped operating theatre performing proper procedures on human tissue in situ. Watching the delegates operating in this setting is a revelation. Their focus on the task at hand and immersion into the environment as if it was the real thing is a wonderful thing to behold. Feedback from delegates as expected has been excellent.

Current laparoscopic cadaveric courses include: colorectal, incisional and inquinal hernia including the L.I.G.H.T. courses, Tisseel hernia repair, upper gastrointestinal cancer, TME, bariatric surgery including the S.O.R.T.E.D course, gynaecological oncology, breast reconstruction, prostatectomy, partial nephrectomy, cystectomy and liver resection.

With the N.S.T.C. centrally placed, collaboration with the Northern Deanery School of Surgery, has developed a Surgical Skills Training Programme (S.S.T.P.) for Specialty Trainees (STs) in General Surgery, ENT, Urology, Orthopaedics and Plastics within the Northern Deanery. The training groups, split into 3 categories, consist of: Core (CT1 & CT2), Intermediate (ST3 & ST4) and Advanced (ST5 – ST8). Advanced Trainees receive skills training relevant to their chosen specialty. All Northern Deanery CT1s and CT2s included in the S.S.T.P. have the unique opportunity of loaning a laparoscopic Simendo (virtual reality desk top training models) on a weekly basis from the N.S.T.C. This opportunity allows trainees to enhance their laparoscopic skills as they progress through the on-line modules and skills arena. Trainees also have the opportunity to borrow a Simendo camera, allowing them to practice and enhance their camera skills via on-line modules. Electronic accreditation certificates are sent to all trainees upon successful completion of each module.

The programme has received excellent feedback from both trainees and trainers, and is the first of its kind in the U.K., delivering an intensive, individualised, unique surgical training opportunity to Northern deanery surgical trainees. The key aims are to enable trainees to excel in open and minimal access surgery in both the elective and emergency settings. The programme includes fresh frozen cadaveric based skills training and provides ample opportunities for trainees to achieve assessments linked to the I.S.C.P. curriculum fully validated by I.S.C.P. Trainers. One criticism expressed locally about this arrangement is that the training fund for each trainee is used to pay for this. However the use of dedicated local faculty ensures the delivery of cost efficient, high quality training by avoiding the expenses incurred due to travel and accommodation by visiting faculty.

Staying in Newcastle Mr Ben Griffiths at the Royal Victoria Infirmary (RVI) has written in with an update on all things colorectal. They have an established Laparoscopic Colorectal National Fellowship, going strong into its 6th year, with a strong track record of turning out independent laparoscopic colorectal surgeons. The fellows benefit from their dedicated laparoscopic colorectal theatres and advanced range of available equipment. The team are developing acute laparoscopic colorectal surgery pathways for increasing numbers of patients to include those with acute severe colitis, obstructing malignancies and perforated diverticular disease. They have recently conducted a trial of 3D laparoscopic equipment to perform the first 3D TAPP repair of an inguinal hernia in Newcastle. Laparoscopic ventral mesh rectopexy remains a major part of their pelvic floor practice and more complex cases are increasingly being undertaken to include revisional cases, the elderly and males. Recently a laparoscopic ileo-anal mesh pouchopexy was carried out, one of a small number carried out nationally. Laparoscopic IBD surgery is being further developed to include ileo-anal pouch construction.

The colorectal team at the RVI have created an extensive DVD library covering the full range of laparoscopic colorectal procedures. They also have laparoscopic training facilities within the Leazes Wing theatre complex to enable their trainees to practice techniques in between cases.

Mr Andy Gilliam from Darlington has informed me that they have plans for a 23 million pound theatre extension that has been approved, in principle, at board level (draft business case accepted). The extension may well include a "Barn laparoscopic theatre". For those of you, like me, who did not know what a "Barn theatre" was it is a large theatre space containing two or more operating tables. The "Barn" layout is designed to improve theatre productivity, through better team working and sharing floor staff, expertise etc. It is also thought to increase throughput by approximately 10%. I believe that two in North Wales utilise them for elective orthopaedics, and the army has one in Camp Bastion in Afghanistan. Andy has asked if any of the ALSGBI membership has experience of such a theatre in the UK or internationally? I understand some anxieties have been raised by the microbiology team but have been assured that there is no good evidence within the literature to derail the concept. Andy and his upper GI colleagues have also developed a laparoscopic gastric pacing service to ensure provision in this part of the country.

Mr Suhail Anwar from Huddersfield Royal Infirmary has informed me that he has introduced laparoscopic ventral mesh rectopexy and laparoscopic ileo-anal pouch surgery to the Calderdale and Huddersfield NHS Trust. Excellent work that will no doubt benefit his local population.

Finally there is plenty of interesting laparoscopic news from the team here in Northumbria. The N.U.G.I.T.S. group continues to host a wide variety of 'hands-on' laparoscopic courses. These are conducted mainly in Hexham, but also at North Tyneside and Wansbeck Hospitals. These include inguinal hernia and incisional hernia repair, the L.I.G.H.T. course and numerous bariatric courses. The team also act as faculty on the numerous laparoscopic courses held at the N.S.T.C. Mr Liam Horgan remains active teaching and training laparoscopic skills both locally and in Tanzania. My colorectal colleagues are performing more and more laparoscopic resections, having been involved in the LapCo training programme. Laparoscopic ventral rectopexies again feature significantly as part of their benign pelvic floor work.

Our Trust is in the process of acquiring North Cumbria NHS University Trust. From a personal point of view this presents a lot of exciting challenges including setting up a bariatric unit based in Carlisle under the auspices of Mr John Wayman. We are currently working with the team to develop a comprehensive "Coast to Coast" bariatric service.

Finally we are building a brand new, purpose built, emergency care hospital in Cramlington. This lies mid-way between our two biggest hospitals within the Northumbria Trust, North Tyneside and Wansbeck Hospitals. The building work has started and the business case for 2 state-of-the-art laparoscopic theatres has been written and presented, but is yet to be approved. Watch this space! There will be an upper GI and a lower GI consultant surgeon on every day. This new facility is scheduled to open in 2015.

I plan to hold a regional ALSGBI day in Hexham next year, hopefully in the Spring. I want to promote good networking in the region amongst consultants and trainees alike. We may all come from different surgical sub-specialties, but we have common ground in our choice and belief in the laparoscopic approach. There are always transferable skills and technical 'tips' that we can learn from each other.

Mr Sean Woodcock
ALSGBI Regional Representative Northern and Yorkshire

Integrated Laparoscopic Theatres – Attaining the Unattainable

Integrated laparoscopic operating theatres are seen as the gold standard facilities for laparoscopic surgery but are sadly lacking from most UK hospitals. Royal Cornwall Hospitals NHS Trust will shortly complete the installation of the last of five Stryker iSuites - integrated laparoscopic operating theatres. The project has been demanding and more complex than any of the involved clinicians imagined; this article aims to pass on a little of what we have learnt to guide colleagues elsewhere in the UK striving to upgrade their operating theatres.

Prior Preparation

Get an idea early on of what you want in your laparoscopic theatres. To this end we sent a team of surgeons, theatre nurses and managers to look at integrated theatres in several other units. The lessons learned informed every stage of the project. One example was the appreciation that sourcing all equipment from a single supplier could be a more reliable and possibly cheaper solution in the long term.

The project must be clinically led but a lone surgeon will not be able to get such a project off the ground. All laparoscopic surgeons of all specialties need to be enthusiastically involved. Decision makers at Trust Board level also need to be convinced early on of the project's merits from the outset. The required ground swell of support takes time to generate.

Having generated support it is important to choose your moment to launch your project - we were fortunate in being able to integrate our project into the early planning stage of a major top to bottom redevelopment of our clinical site.

The Business Case

Each NHS organisation will have a different format and process for developing business cases, but all will focus on the basics: what's in it for the patient and the organisation, and the financial bottom line. Patient benefits derive from the dependence of laparoscopic surgery upon the image delivery technology and the ergonomics of surgery: ergonomically comfortable surgeons looking at an optimally displayed image perform better operations. Organisational benefits are summarized in Box 1.

The financial analysis will be complex, requiring the involvement of your Finance Department early on. Potential savings as listed in Box 1 must be included in the analysis. However, there are "hidden" costs to be included; these will account for around 50% of the total project spend and may surprise the unwary clinician. The most significant of these hidden costs are listed in Box 2.

The Procurement Process

Procurement of a project of this size is complex and will require the involvement of your Trust's procurement / purchasing team from the onset. If your project is predicted to exceed £113,000 ex VAT (which is likely!) then Public Procurement Regulations will apply. These require that the tender will need to be advertised in the Official Journal of the European Union (OJEU) and there will be a prescribed process and prescribed timescale (around 4 – 6 months). At the very start of the process detailed equipment specifications need to be published together with a scoring matrix by which bids will be assessed. At the end of the process unsuccessful bidders will be able to challenge the decisions made if the prescribed process is not adhered to closely. The process is summarised in Box 3.

The Installation Project

Installation will require a project team including all stakeholders: surgeons, anaesthetists, theatre nurses and managers, IT staff, medical physics staff and finance/management representatives in addition to the planning/estates staff. Detailed project management is essential to co-ordinate the supplier's installation team with external contractors and on-going day to day clinical activities. If high quality project management is not available in house then an external contractor should be engaged. "Turnkey" installation is available from suppliers but may limit operational and timetabling flexibility for the contracting Trust.

Decisions need to be taken as to the exact positioning of the monitors and equipment pendants. Whilst the broad layout is likely to be somewhat fixed due to the position of anaesthetic rooms and exit doors etc., exact positions need to be considered down to the centimeter level in order to maximize the utility of your expensive new kit. Suppliers should be able to supply detailed plans depicting the scope and radius of all fixed equipment and this should be looked at in detail by all specialties using the theatre.

Using the theatre

Train all staff in the use and full potential of integrated theatres. Ensure that all staff understand that to get maximum benefit they will need to change many aspects of their practice, for example altering the position of the monitors and the equipment pendant to best ergonomic positions rather than sticking with the previous positions used when equipment all was mounted on a single difficult to position stack.

Any such project is at first daunting. However, the benefits for patients and staff of integrated laparoscopic operating theatres are considerable and I would enthusiastically encourage all to persevere.

Mr Ian Finlay
Upper GI and Bariatric Surgeon
Royal Cornwall Hospitals NHS Trust

Advancing The Art of Surgery into a new dimension

Olympus launches the new 3D Laparoscopic Imaging System

OLYMPUS
Your Vision, Our Future

Prompted by benefits that included subjecting patients to less invasive procedures and facilitating faster recovery times, the use of laparoscopic surgery grew rapidly from the 1990s onwards. It is now utilised in a wide range of clinical applications, including gastrointestinal and other forms of abdominal surgery, urology, and gynaecology.

While the use of laparoscopy grew, surgeons found there were also times when their work was complicated by the lack of depth perception provided by the laparoscopic image. Olympus identified the potential of 3D imaging at an early stage and launched its first 3D laparoscopy system in 1995. However, a lack of brightness and inadequate image quality combined with the very large size of the 3D glasses meant that the device failed to gain widespread acceptance.

Responding to feedback from surgeons, Olympus continued development of the technology with the aim of providing an ability to manipulate the tissue being observed at a level equivalent to what is possible in open surgery. As a result, Olympus has now launched a new 3D laparoscopy system that consolidates the technology it has built up over time, including techniques from the gastrointestinal field such as the deflectable tip.

The new 3D laparoscopic imaging system from Olympus offers improved speed, accuracy and precision for surgical tasks, for novices and experienced surgeons alike, particularly during complex procedures. A greater depth of field and depth perception is realised with a 3D HD imaging system.

However, 3D imaging in surgery is not without technical challenges - a common problem with existing 3D imaging systems is the lack of image rotation when using a 30 degree laparoscope, which is a significant detriment to surgery. Olympus has resolved this technical obstacle with a further development of the unique four-way deflecting 'chip-on-the-tip' video laparoscope – ENDOEYE FLEX 3D.

Two charge-coupled device (CCD) image sensors are located at the distal end of the ENDOEYE FLEX 3D to provide the left and right images respectively.

These two image signals are processed by a special-purpose video system to generate a high-resolution 3D image. This image is then displayed on a 3D monitor and viewed through 3D glasses to provide realistic three-dimensional images.

The ENDOEYE FLEX 3D has a unique deflectable tip which can bend up to 100 degrees in four directions, which can provide not only a front view of the operating field but also other angles, including a 'bird's eye' view giving an unique view of the complete surgical site. This flexibility to view from any angle facilitates surgical techniques that make the most of the space available, even during technically difficult procedures.

The new Olympus 3D laparoscopic imaging system utilises the latest Olympus Universal Platform EVIS EXERA III, which also supports all existing Olympus 2D equipment. This ensures the system is multi-disciplinary and can be used for a very wide range of applications making it a truly 'universal' platform.

To learn more about Olympus imaging systems including the new 3D laparoscopic Imaging System please visit: www.olympus.co.uk/medical

IFABond: Laparoscopic Glue that Works!

Statement from David Lloyd

elemental HEALTHCARE

- Simple to use
- Very effective
- Replaces the need for expensive tacking guns
- Peritoneum can be closed relatively easily

The IFA Bond provides an excellent alternative for mesh fixation in laparoscopic hernia repair. It is relatively simple to use yet very effective. The glue secures the mesh to the pubic bone within seconds and replaces the need for expensive tacking guns. Furthermore, following a TAPP procedure the peritoneum can be closed relatively easily. In addition to being cheaper than current alternatives there are no sharp edges or points of foreign material protruding into the peritoneal cavity. I believe that the IFA Bond will reduce the cost of laparoscopic inguinal hernia repair, reduce the risk of adhesion formation and possibly reduce the incidence of post-operative pain which may be attributable to the use of absorbable or non-absorbable tacks.

David M Lloyd MB, BS, FRCS (England), MD
Honorary Senior Lecturer, University of Leicester
Consultant HPB and Laparoscopic Surgeon,
Leicester General Hospital

Contact Melanie Goodall
on 0844 412 0020 to arrange a trial.

ALSGBI Industry Partners' Course Information

B. Braun Medical, Aesculap Endoscopy

Contact: Allan Barr, Clinical Manager, Endo-Surgery, Aesculap Division, B. Braun Medical Ltd
Direct Line: +44 (0)114 225 9174 | Mobile: +44 (0)7772 115856 | Email: allan.barr@bbraun.com | Web: www.aesculap-academy.com

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

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

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

Horizons of knowledge - Competence to master the future.

Final dates for our English speaking courses are still to be confirmed for 2014, however the general programme is detailed below:

Date	Course	Venue
January 2014	Advanced Minimally Invasive Paediatric Surgery	Berlin
February 2014	Advanced Laparoscopic Urology, Prostate	Berlin
July 2014	Comprehensive Urological Laparoscopy	Berlin
July 2014	Laparoscopic Training Course Hernia Surgery	Berlin
October 2014	Laparoscopic Training Course Upper GI	Berlin
November 2014	Advanced Laparoscopic Surgery	Berlin
November 2014	Advanced Minimally Invasive Paediatric Surgery	Berlin

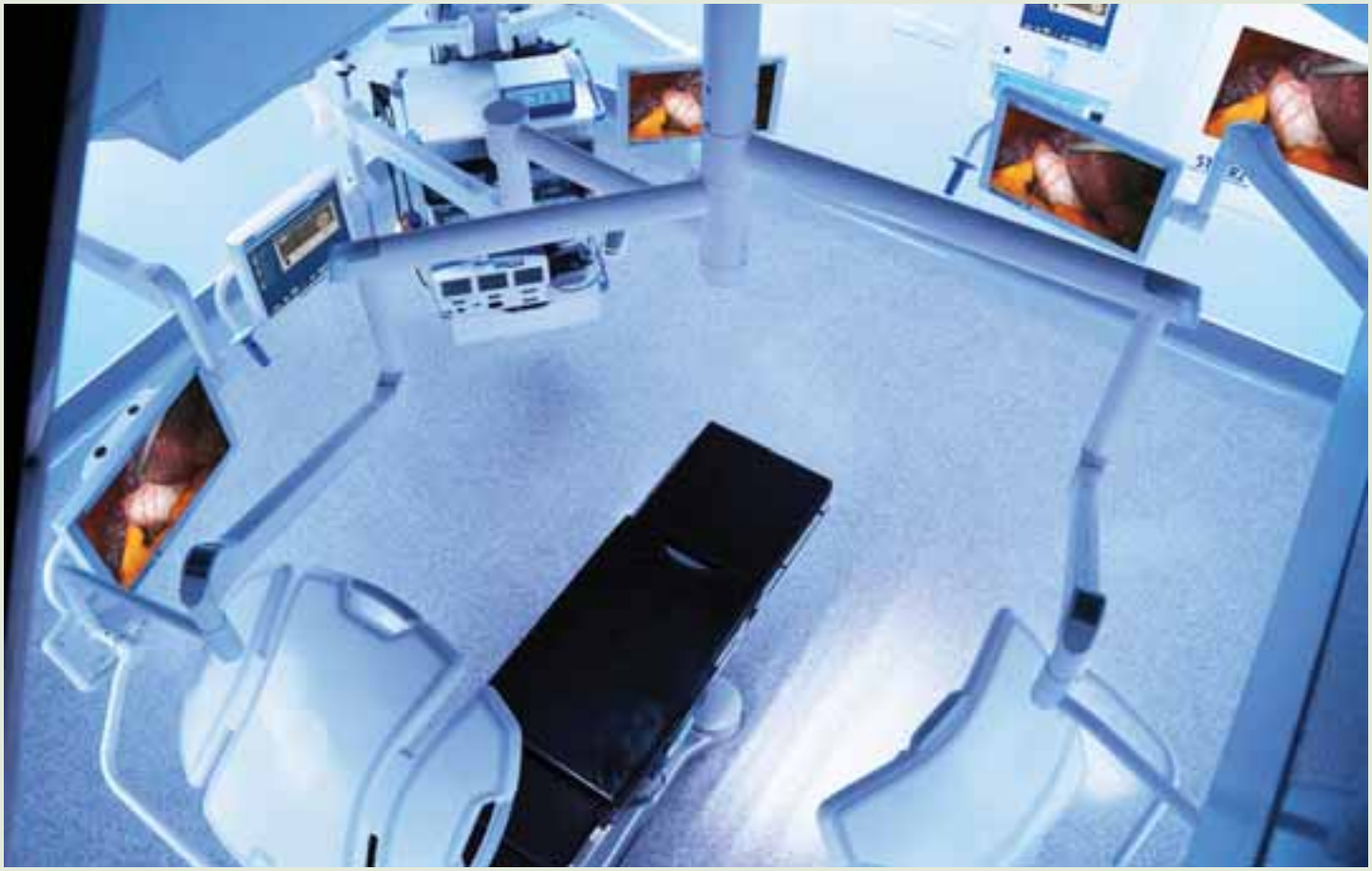
Olympus KeyMed

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

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

Date	Course	Venue
26-29 November 2013	Frontiers in Intestinal & Colorectal Disease	St Mark's Hospital, Harrow
18-19 December 2013	International Surgical Energy Masterclass	Sharjah Medical Institute, UAE
27-28 March 2014	Laparoscopic Management of Adnexal Pathology	Wythenshawe Hospital
18-19 June 2014	Surgical Energy Masterclass	Olympus, Southend-on Sea

Admiring the view – KARL STORZ at The University Hospital of Wales



KARL STORZ's recent work at the University Hospital of Wales literally takes its reputation to new heights. The project, which involved completely refitting existing theatres with the KARL STORZ OR1™ NEO operating theatre, and resurrecting a redundant viewing gallery, has succeeded in creating a resource that puts UHW at the forefront of laparoscopic operating and training. Jared Torkington, Consultant Colorectal Surgeon and Clinical Lead with the Welsh Laparoscopic Colorectal Training Scheme, says: *"You can see the pride on people's faces when they come to work in such a modern and exciting environment."*

The impressively renovated glass atrium viewing gallery is situated above the operating theatre. Students and visitors can look down through the glass and see the entire operating set-up on the table below, or look up at one of the three video monitors in the gallery and view the operation in detail. Communication is two-way via a wireless microphone.

There are a number of HD cameras in the operating theatre, and any or all images can be relayed up to the gallery from the touch panel in theatre, or selected in the gallery itself. A particularly interesting feature is that two of the theatre's seven HD cameras can be moved into various positions during the operation via iPad control in the gallery, allowing guests to focus on a particular chosen element of the operation. KARL STORZ believes that this is the only operating theatre in the world currently offering control of the cameras, lighting, video routing and audio, all via the handheld iPad device.

At UHW, KARL STORZ has succeeded in creating a unique operating and training environment that offers the best of both worlds – close-up interactive observation, but at a significantly safe distance from the sterile field.

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ALSGBI
Association of Laparoscopic Surgeons &
Association of Laparoscopic Theatre Staff
of Great Britain & Ireland
Save the date
2014 ALSGBI & ALTS Annual Scientific Meetings
Abstract submission opens May 2014
Aberdeen | Thursday 27 & Friday 28 November 2014
ALSGBI Laparoscopic Training Day
Dundee | Wednesday 26 November 2014
www.alsgbi.org

HumiGard™ – protection against desiccation with humidified CO_2

Innovative technology improves patient outcomes

INNOVATIVE technology designed to reduce the harmful effects of establishing a pneumoperitoneum has been developed by Fisher & Paykel Healthcare. The HumiGard Surgical Humidification System has been designed to reduce unnecessary cellular damage by warming and humidifying insufflation gases, protecting tissue against the harmful effects of dry, cold CO_2. A growing volume of clinical evidence supports the use of such protective measures in laparoscopic surgery.

HumiGard is a simple tool that optimally heats and humidifies surgical gas from the insufflator, then maintains the heat and humidity until it reaches the patient. It is both easy to set up and simple to use.

Warming gas increases its capacity to hold water vapour. Accordingly as cold, dry insufflation gases naturally warm within the patient, evaporation and cooling take place. When insufflation gases are optimally humidified and warmed prior to entering the patient it prevents drying and desiccation, preserving the serous fluid as well as maintaining core body temperature. This leads to various patient benefits including:

- **Decreased time in recovery.**
  In comparative studies, the amount of time patients spend in recovery rooms has been shown to be less than one hour in 88.9% of cases using warmed and humidified insufflation, versus 33.3% for patients treated using standard dry gas.
- **Decreased risk of intra-operative hypothermia.**
  A meta-analysis of ten randomised controlled clinical trials conducted by Sajid et al, 2008, showed that the incidence of hypothermia was significantly lower for patients in heated, humidified groups.
- **Decreased potential for adhesion formation.**
  A number of animal studies have illustrated that decreasing peritoneal injury and inflammation can significantly impact adhesion formation.
- **Reduced post-operative pain.**
  Benavides et al, 2009 illustrated that the use of humidified and heated insufflation gas resulted in decreased morphine equivalent consumption, less self-reported pain on visual analogue scale and reduced post-operative shoulder tip pain in bariatric patients.

The integrity of the middle egg is protected with exposure to warmed, humidified CO_2

*Search **'Impact of laparoscopic gas'** on YouTube to see desiccation of the peritoneum simulated using an egg. Like raw eggs, the peritoneum (the large serous membrane that lines the abdominal cavity) is moist, delicate and susceptible to the adverse effects of the cooling and drying caused by CO_2.*

The simulation demonstrates what happens to mesothelial cells of the peritoneum when exposed to dry, cold gas; dry, warmed gas; and humidified, warmed gas.

See the egg test for yourself at Stand 3, ALSGBI ASM

HumiGard is one of a number of pioneering solutions from Fisher & Paykel Healthcare that have advanced the capabilities of healthcare professionals in over 120 countries around the world. With more than 40 years' experience in the medical research field, Fisher & Paykel Healthcare is a New Zealand-based world leader in the humidification of medical gases.

F&P HumiGard™

For more information about HumiGard, contact your local F&P representative on +44 1628 626 136 or visit www.fphcare.com.

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