SAVE THE DATE
2015 ALSGBI Annual Scientific Meeting | Southport
Thursday & Friday 26 & 27 November
ALSGBI Laparoscopic Training Day | Liverpool | Wednesday 25 November

ALSGBI newsletter

ALSGBI
Association of Laparoscopic Surgeons of Great Britain & Ireland

President's Introduction

Welcome to the Autumn 2015 edition of the ALSGBI newsletter. I am grateful to Mr Neil Keeling in bringing together a bumper edition. You will find a number of articles reporting on recent national and international meetings, travelling fellows report and assessment of 4K technology. The article by Mr Peter Sedman on the laparoscopic passport (LapPass) outlines a new venture for ALSGBI to benchmark competencies for laparoscopic surgeons and will be of interest to trainees and trainers. We plan to pilot its introduction at the forthcoming ASM.

Preparations for the ASM in Southport, 26 and 27 November are complete. Details can be found via the link on the ALSGBI website. There will be live operating on the Thursday from Aintree Hospital with an excellent faculty delivering upper GI, colorectal and abdominal wall surgery. Our visiting BJS lecturer is Professor Steven DeMeester from University of Southern California who will deliver his lecture on recurrent para-oesophageal hernia. He will also take part in a symposium on 'the use and misuse of mesh in abdominal surgery' together with Mr Neil Smart (Exeter), Mr Bruce Tulloh (Edinburgh) and Dr Karen Ellison (MPS) who will provide a medico-legal perspective.

There is a laparoscopic surgery training day on the Wednesday preceding the ASM, free to trainees through competitive application. This will focus on laparoscopic suturing and stapling techniques. Places are limited to 24 and I would encourage early applications.

All in all, there is a balanced programme with something for everyone. Please register and encourage trainees and non-ALSGBI colleagues to attend.

It will be my last meeting as President. It has been a privilege to hold the position for the last two years and I would like to thank Council, all members and Jenny and Sarah for all their support. Mr Martin Wadley and Mr Milind Shrotri will be demitting from Council in November and elections will be held in their respective constituencies, Midlands and North West & Mersey. I encourage you to put your name forward and get involved in the work of the ALSGBI and its future. I wish Mr Peter Sedman a successful presidency and know the Association is in excellent hands and leadership.

Mr Mark N Vipond
President

Editor's Introduction

For our Autumn Newsletter we have a report from Professor Mark Coleman regarding the comprehensive SAGES 2015 meeting in Nashville, USA and it sounds like some of the types of interactive and skill based sessions could be highly valuable for both trainees and trainers in future UK meetings.

Please take time to read the article by Mr Peter Sedman where he outlines the proposed new LapPass Certification process which will be launched at the ALSGBI ASM 2015. This is designed to be a ticket for accelerated laparoscopic training for early years surgical trainees. It is intended to be both challenging and fun but will become recognised both in the UK and internationally as a mark of laparoscopic surgical skill attainment.

On the technology front we have a tantalising first impression of 4k screen technology being used in theatres from the Colchester group. I am sure that we will see much more of this and other innovative advances at the forthcoming ALSGBI ASM in Southport. The exciting and full programme will include the popular interactive live operating links to local experts as well as internationally renowned surgeons.

Mr Neil Keeling
Newsletter Editor

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SAGES

15-18 April 2015, Nashville, TN, USA

Delegates and faculty at the SAGES Lapco TT course 2015

This year SAGES took place in Nashville, nicknamed "Music City, USA". As usual, the interestingly named Gaylord Opryland Convention Center offered a bewildering array of sessions. Not surprisingly, the Americans found no regulatory barriers to an enormous programme of cadaver workshops in the hotel/convention center basement! Where in the UK could that happen? Innovation, patient safety and hands-on training are heavily emphasised in these meetings each year, but it is simply impossible to cover the range and scope of subjects on offer. See http://www.sages2015.org/wp-content/uploads/2014/11/SAGES-2015-Advance-Program.pdf for programme details.

What struck me most at SAGES was the emphasis on interactive panel discussions and hands-on training sessions. There were plenty of didactic lectures of course, but these were either to inspire (Ed Viesturs – one of the only men who has climbed the world's 'above 8000m' mountains) or inform (Horacio Absun on spreading laparoscopic surgery to developing countries). Overall I was highly impressed by the 'delegate-focused' programme and the serious attention to learning outcomes. Flying the flag for Britain at this year's SAGES included presentations by Mr Ian Jenkins from St Marks on colorectal anastomosis and Mr Danilo Miskovic from Leeds on total mesorectal excision.

An enjoyable evening at the BB King Blues Club Nashville

This year's incoming SAGES President (2015-6) is Dr Brian Dunkin from the Houston Methodist Center, Texas. He invited a faculty of LAPCO trainers over to coach the SAGES cadaver faculty the day before a hands-on laparoscopic incisional hernia workshop. The course was intensively evaluated by faculty and delegates alike and noted to be a great success in improving the performance of the faculty. More to follow but the Americans really buy into the English LAPCO Train the Trainers Course and want to roll it out in the 'States.

Away from the congress, a few Brits and friends spent a highly enjoyable evening at the BB King Rhythm and Blues Club in Nashville. The food, the company and the live music were memorable.

Next year's meeting will take place in Boston, 16-19 March 2016 and abstract submissions are already open.
Go to http://www.sages.org/meetings/abstracts/ for more information.

Professor Mark Coleman
ACPGBI Representative

4k Laparoscopic Surgery: Our First Experience at Colchester General Hospital

Introduction

The progression of surgical technology available in laparoscopy over the past 20 years has revolutionised the procedures we can offer our patients and the outcomes they can expect. One of the latest advances is the use of a 4k video, a technology more associated with home cinema systems than the operating theatre. We had the opportunity to trial the SynergyUHD4 stack system from Arthrex at Colchester Hospital in July of this year, and we are able to share the feedback of our laparoscopic surgeons.

High Definition (HD) versus 4k

Resolution is one of the most common and recognisable metrics used to describe video quality, defined as the number of distinct pixels that a feed can display in each dimension. Although definitions differ across the World, the majority of laparoscopic theatres are equipped with 'full' HD systems, such as the Storz IMAGE1 SPIESTM or Olympus VISERA ELITETM. These systems project an image with a resolution of 1920 x 1080 pixels, however the new generation of 'ultra' HD systems are able to project 3840 x 2160 pixels (described as 4k given that there are in the region of 4000 horizontal pixels). Assuming the other facets to video quality remain unchanged, there is an assumption that this improved resolution would aid the surgeon in undertaking the highest quality procedure.

Evaluation of the 4k System at Colchester

Colchester is a specialist laparoscopic unit with a 10 strong consultant team across general, colorectal and benign upper GI surgery. The SynergyUHD4 system was trialled for a period of four weeks in the elective setting, with a before and after evaluation from any senior registrar or consultant who operated using it. We were interested in seeing how the new system felt to the surgeon and whether it had the potential to improve surgical quality.

Outcomes

In advance of this trial, our surgeons were relatively inexperienced with 4k laparoscopy. They were all 'satisfied' or 'very satisfied' with the current standard HD system with some believing both depth perception and light reflection could be improved. Feedback following use of the 4k system was mixed, but certainly positive. Approximately two thirds of surgeons noticed an improvement in image quality with many commenting that it improved their depth perception and the ease of dissection. However, it did appear that light reflection was more of an issue as was the assistant complaining of having to hold a rather hot camera head!

Comments and Considerations for the Future

This trial of 4k laparoscopy was certainly exciting with some interesting outcomes. Resolution is only one of several factors that contribute towards image quality, however we were surprised at quite how many surgeons reported an improvement in the ease with which they could operate. Unfortunately, it is beyond the scope of this work to determine whether or not this could improve efficiency (through avoidance of unnecessary operative steps) or reduce mistakes in structure identification; but this is certainly a research question of interest. The issues such as glare and a hot camera head need some work, however, our experience indicates a 4k system may represent a technological progression, which will deliver benefits to the surgeons and consequently our patients. This would need to be confirmed using such a system more comprehensively including a comparison with other emerging technologies including 3D laparoscopy.

Mr Sam Mason
Core Trainee and Faculty, ICENI Centre, Colchester

Mr Tan Arulampalam
Clinical Director, ICENI Centre, Colchester

Disclosure
The authors received no funding from Arthrex for this work.

ALSGBI Trainees Group Update

The ALSGBI continues with its commitment to its trainee members by providing high quality hands-on training events free of charge in addition to supporting trainees financially through various bursaries such as the ALSGBI travelling fellowships and the "Support a Trainee" scheme. On 26 November 2014, 24 trainees attended the internationally renowned Cushieri Skills Centre in Dundee for the ALSGBI Laparoscopic Training Day. Delivered by an unrivalled faculty of laparoscopic surgeons comprising of ALSGBI Council Members and expert local faculty, the event, generously supported by Ethicon, was a huge success. Trainees worked in pairs undertaking a variety of laparoscopic procedures and techniques on human cadavers for one half of the day and porcine models for the other half. With one trainer per pair there was ample opportunity for direct feedback. The Cushieri Skills Centre provided cadavers embalmed using the Thiel soft-fix method which provided an excellent opportunity for practising dissection and tissue plane development. Participants ranged from ST3 through to ST8 and to accommodate varied training needs the programme was intentionally flexible so as to allow participants to select whichever laparoscopic procedures they wished to perform on the Thiel cadavers. These included right hemicolectomy, left hemicolectomy, total mesorectal excision, sleeve gastrectomy, jejo-jejunostomy, gastro-jejunostomy, jejo-jejunostomydelete as repeated, gastric lymphadenectomy, hiatus hernia repair, fundoplication, cholecystectomy, CBD exploration, left and right hepatectomy and splenectomy. Using novel porcine models developed at the Cushieri Skills Centre, participants also had the opportunity to perform simulated laparoscopic ventral mesh rectopexy, trans-anal TME and laparoscopic parastomal hernia repair.






In February this year the ALSGBI also provided support for the Association of Surgeons in Training (ASiT) Core Laparoscopic Skills course at the 2015 ASiT Conference in Glasgow. This one-day skills course is aimed at junior trainees with basic laparoscopic skills experience. Interactive talks covered laparoscopic setup, patient positioning, instrumentation and ergonomics with practical sessions using porcine models in which participants performed open Hasson port insertion, laparoscopic appendicectomy and cholecystectomy in addition to an introduction to laparoscopic suturing. In addition to supporting the laparoscopic pre-conference courses at the ASiT conferences over recent years, the ALSGBI also provides a prize each year for the best presentation relating to minimal access surgery. Congratulations to Mr Joe Dixon, who was awarded the 2015 ASiT/ALSGBI prize for his presentation entitled "Laparoscopic versus Open T4 Colonic Cancer Resection."

From Autumn 2015 the ASGBI will launch the LapPass – the Laparoscopic Passport. The LapPass is a badge of proficiency in core laparoscopic skills and is available for core and specialty trainees to undertake. Details are in Mr Sedmans's article and on the ALSGBI website.

Finally, the 2015 ALSGBI ASM in Southport (26 and 27 November) provides a fantastic opportunity for trainees to present research and audit projects with generous prizes for best DVD, oral and poster presentations. All oral presented abstracts are published in a supplement to the Surgical Endoscopy Journal and with the ALSGBI "Support a Trainee" scheme each trainee presenter will receive a bursary to contribute towards travel expenses to attend the conference. Again the ALSGBI Laparoscopic Surgery Training Day will take place on 25 November at the MASTER Unit at Broadgreen Hospital, Liverpool with a full day of wet-lab training planned on whole porcine models with expert faculty. Demand for places will be high so register early to avoid disappointment and I look forward to meeting more trainee members in Southport for what promises to be a fantastic meeting.

Mr Jonny Wild
Trainee Representative on ALSGBI Council

2nd Digestive Diseases Foundation (DDF) Meeting

22-25 June 2015, London

The 2nd DDF meeting was held in mid June at the ExCel centre in London. The DDF meeting is unique in the UK as the only meeting that brings together professionals from across all disciplines. This allows the opportunity for interdisciplinary debates and for better understanding different aspects of GI diseases compared to the usual surgical view. This was reflected in a diverse and interesting program with something for everyone.

Building on the successful inaugural DDF in Liverpool three years ago, the meeting entertained around 4000 delegates from the five GI related societies - AUGIS, ACPGBI, BAPEN, BASL and BSG. One of the advantages of such a large meeting is its ability to attract senior medical and political speakers and the plenary session was evidence of this with Sir Bruce Keogh, Medical Director of the NHS opening the DDF plenary session with a talk on the future of the Health Service. His message was that innovation is the future of the NHS and will require the implementation of new technologies and informatics if it is to survive in its current form. He pointed out that although the running costs of the health service are high, much of that money is plowed back into the economy through purchasing of UK products and wages. The future of the tax-funded NHS depends heavily upon a thriving economy as well. Professor Mark Caulfield spoke on the 100,000 Genome project and the development from this of targeted designer drugs to treat specific conditions. Professor Tim Hodgetts spoke on the future of trauma surgery and how this once Cinderella specialty now pioneers much of our medical innovation, particularly in robotics and tele-medicine. Sir Mark Walport spoke on "Science, Government and The NHS Shaping The Nationwide Scientific Agenda". All in all an extremely thought provoking and far reaching set of reviews for the next decade of science, medicine and the NHS.

The following three days covered the breadth of gastrointestinal medicine and surgery and there were lots of debates and mixing of the societies' programmes. The AUGIS plenary session was followed by the BJS prize presentations and the return of Professor Olivier Scatton discussing the rise of laparoscopic live donor liver transplantation. Challenging areas of treatment overlap including CBD stones, achalasia and GORD enjoyed lively cross specialty debates exploring the roles of newer interventions and the choice and sequence of procedures. Dr John Hunter from Portland, Oregon, was a returning favourite and lively speaker.

A joint AUGIS and ACPGBI session provided management guidance, tips and tricks in emergency surgery for anastomotic leaks and iatrogenic perforations

and a talk on management of Booerhaaves syndrome by Professor Muntzer Mughal. A joint AUGIS and BSG session dealt with the management of GI bleeds and an AUGIS and ACPGBI grand round plenary session was appealing to ALSGBI members including talks on laparoscopic approaches to emergency surgery, imaging and audit updates.

Obesity surgery featured heavily at the DDF with BOMSS and AUGIS sessions including grand rounds on how to deal with common complications of bariatric procedures, surgery for metabolic disorders, a choice of procedures for the super obese and the politics and economics of bariatric surgery. A session on 'Severe Obesity from All Angles' was chaired by BOMSS President, Mr Roger Ackroyd and included talks on the psychology of obesity, the role of the dietitian and the role of the gastroenterologist with Mr Sean Woodcock concluding the session with an update on the state of the bariatric surgery in the UK. Professor Francesco Rubino spoke on 'Expansion of The Role of The Bariatric Surgeon' and said: "The age of metabolic surgery has arrived." Professor Philip James spoke on obesity prevention, saying that there has been a "repeated failure of health promotion as a mainstay of policy with regard to food and drink."

The meeting was well received by all who attended and is due to be repeated again in 2018.

Mr Ian Beckingham
AUGIS Representative

The ALSGBI best abstract won the European Cup at the European Association of Endoscopic Surgery (EAES)

3-6 June 2015, Bucharest, Romania

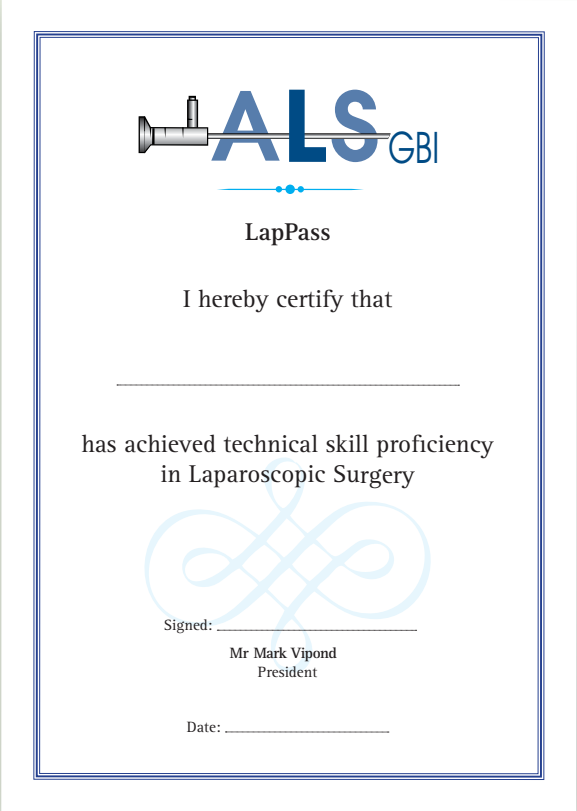
Dr Jennifer Mason, a trainee from Yeovil Hospital who won the 2014 David Dunn Medal for the best abstract at the ALSGBI Annual Scientific Meeting in November 2014 has won the European Cup at the EAES Congress in Bucharest in June 2015. The EAES selected the top presentation from 5 national societies to be presented at the congress for the European Cup, representing Spain, Romania, Lithuania, Israel and the UK. The European Cup session was chaired by the three presidents of the EAES (in the photos): current (Professor Mario Morino; Italy), coming (Professor Eduardo Targarona; Spain), and past (Professor Karl-Hermann Fuchs; Germany).

Dr Jennifer Mason presented her talk on "Factors predicting 30 days re-admission after laparoscopic colorectal cancer surgery within enhanced recovery".

The meeting was well attended by over 1200 surgeons from all over the world and we would like to congratulate Jennifer for the achievement.

Mr Nader Francis
South & West Regional Representative

"LapPass" The ALSGBI certificate of technical skill proficiency in laparoscopic surgery



ALS GBI

LapPass

I hereby certify that

_____

has achieved technical skill proficiency
in Laparoscopic Surgery

Signed: _____

Mr Mark Vipond
President

Date: _____

Laparoscopic surgery is technically demanding and the skills required for proficiency are difficult to acquire. It is not for everyone. However, perhaps more than for any other branch of surgery, simulator training lends itself to practising and perfecting laparoscopic technical skills. From Autumn 2015 the ALSGBI will recognise those trainees who are able to demonstrate proficiency in a defined set of five laparoscopic tasks. These are not easy skills to perfect and the possession of the passport will be a badge of proficiency which will be recognised nationwide and will mark out those who are serious laparoscopic surgeons. In turn, it would be anticipated that trainers will recognise that those in possession of the LapPass will be suitable for accelerated operative training.

The five skills are

1 **Camera holding** (which will be assessed intra-operatively) and four technical tasks which will be demonstrated and assessed in training jigs. These skills are:

2 **Grasping and manipulation**
3 **Creation and accurate deployment of secure endo-loops (e.g. Roeder knots)**
4 **Cutting and dissection**
5 **Intra-corporeal suturing**

A Powerpoint show outlining these tasks and video demonstrations of each them is available on the ALSGBI website at www.alsgbi.org We are not assessing everything (e.g. access is not included) but only those skills we think are the most important and suitable for simulator training.

ACCEPTABLE JIGS

A core principle in the rollout of the "LapPass" is that the training and assessment tools are widely available and that flexibility and innovation in setting these up are encouraged. Provided the assessor is confident that the jigs used accurately reflect the skill level required; a variety of simulators are acceptable. Paradoxically perhaps, the simpler the jig; the more widely available and the easier the assessment may be to conduct. Should high fidelity simulators be available these may be used; as will the commercially available medium fidelity simulators with integral web cams and screens. However low tech solutions may be used such as simple closed boxes in theatre using the OR laparoscopes, stacks and clean instruments between, or at the end of, an operating list (fig. 1): or more simple still - open boxes or jigs with one eye blinded (to reduce the surgeons vision from 3D to 2D) (fig. 2). Even smart phones mounted in cardboard boxes (fig 3) would be acceptable.

It is hoped that these assessments may be performed in a range of settings from skills labs to operating theatres and in coffee rooms between cases. It is the trainees' responsibility to set up the jigs and the assessor need only be present for the performing of the tasks which, when successful, will take only a few minutes each.

FIGURE 1

Using the existing theatre equipment and a cardboard box at the end of a list.

continued overleaf

FIGURE 2
A three dimensional training jig can be made two dimensional by obscuring one eye. The Ned Kelly or Rooster Cogburn look!

FIGURE 3
A cardboard box can be modified to accept a video smart phone and additional light source. Trocars are not mandatory.

i-phone with zoom video facility in the front of a cardboard box.

Use your imagination and please send us photographs of your ideas. A prize will be awarded to the most innovative solution described!

1 Camera Holding Skills

A minimum of six cases with at least three different surgeons must be assessed and of these at least three should be with a 30° scope and all should be with 2D imaging (for those fortunate enough to have 3D systems available). Up to two cases ideally will involve intra-corporeal suturing (+ 1 mark each if so).

Each case must be no shorter than 45 minutes in operative time and 30 minutes of laparoscopy. Marks will be given for various elements of good camera work and the forms may be downloaded from the website www.alsgbi.org The best three 30° and the best three 0° cases will be used to obtain the requisite score.

Please visit the website www.alsgbi.org for explicit details of the skills required to be demonstrated.

MODEL REQUIREMENTS FOR THE TASKS

2 Grasping and manipulation

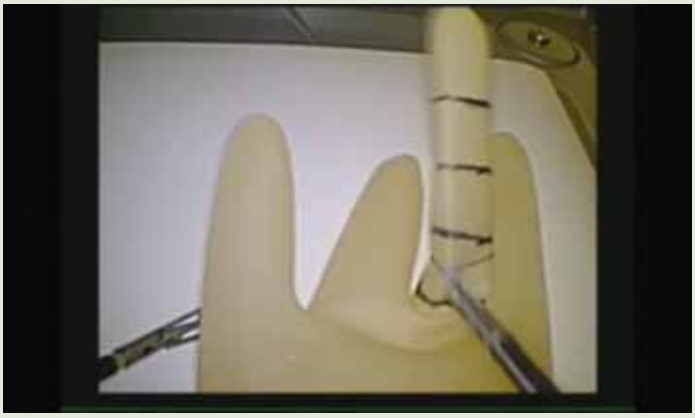
Task 2 requires three matchsticks mounted (a car sponge is a convenient way of doing this but blu-tack or equivalent are alternatives). You will also need a few polo mints, a short length of cord or string and two laparoscopic grasping forceps. This test is designed to assess bimanual dexterity in the 2 dimensional environment. A practical tip is to palm the grasping forceps rather than grasp them in the conventional manner as this allows a freer range of movements, especially in pronation and supination.

Task 2. Grasping and manipulation with mints, cords and matchsticks.
Target time to complete < 4 mins

3 Creation and accurate deployment of secure endo-loops (e.g. Roeder knots)

Task 3 involves creation and deployment of safe endoloops. You will need a surgical glove, lightly inflated, to the point that there are no folds in the fabric of the glove and with four hoops drawn around one of the fingers at 1cm intervals. The glove will need to be fastened to the base of the box trainer. The endoloop needs to be created from a surgical thread no greater than "1" gauge and either monofiliament or braided suture may be used provided a suitable knot is applied (Roeder, Meltzer, etc ... are all acceptable provided they are properly and effectively tied). You will need a knot pusher of some description, a pair of laparoscopic scissors and a grasping forceps to complete this task. The glove should not visibly deflate within 1 minute of amputating the finger tip. A practical tip is to use a braided thread of "0" or "2/0" gauge as these tend to give the best results.

Task 3. Creating and deploying endoloops
Target time: Three loops tied and placed < 8 mins



"LapPass" The ALSGBI certificate of technical skill proficiency in laparoscopic surgery

4 Cutting and dissection

The model for tasks 4 and 5 is ideally a car sponge which is clearly marked in indelible ink in accord with the instructions on the ALSGBI website. You will need a grasping forceps and scissors and for the suturing exercise a pair of needle holders and suture thread sufficient for two knots.

A practical tip for the cutting exercise is to alternate the scissors between left and right hands depending on the part of the circle being excised and to concentrate as much (or more) on the direction of retraction afforded by the *graspers as you do on the scissors. "The graspers do the work and the scissors get the glory".*

Task 4. Cutting an accurate disc. Target time: < 3 mins

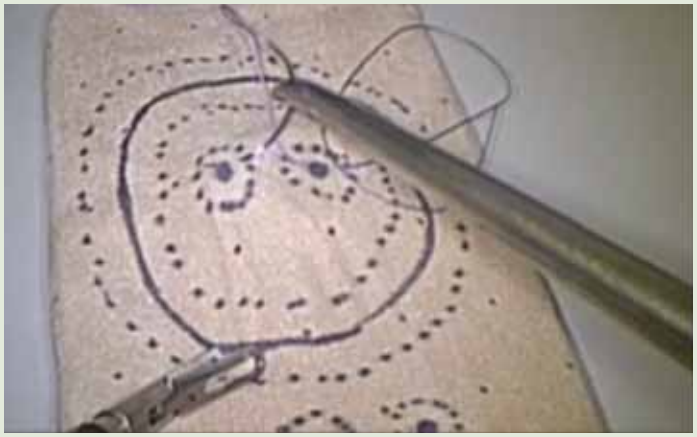
5 Intra-corporeal suturing

Suturing is the single hardest task to perfect. The exercise requires you to secure two safe knots and to bring two parts of the tissue (1cm apart) into apposition under mild tension. This exercise is best performed using a dynamic camera and there are tricks a good cameraman can use to make suturing easier (gentle dynamic zooming in and out) which are not possible on fixed camera jigs.

A short help video on the principles of suturing and knotting (including endoloops) is available on the ALSGBI website.

Task 5. Suturing

Create two secured reef knots to ensure accurate apposition of tissue under slight tension. Target time: 2 sutures < 6 mins



ASSESSORS and ASSESSMENT

All consultant surgeons who normally conduct assessments and appraisals for the ISCP are suitable to act as assessors. It would make sense to ask someone with a laparoscopic sub-speciality to perform the assessments in order to ensure an optimum feedback and all active members of the ALSGBI will be aware of these skills sets and be prepared to help.

We hope you will enjoy acquiring the LapPass. The tasks set are challenging but the skills required are very much clinically relevant and for most people not intuitive. They will require practice, probably over many hours at home or in the lab. They do not intend in any way to avoid the need for courses but much like the Driving Test, lessons will help speedy acquisition of the required proficiency and promote good habits; but on the day you still have to pass the Test itself with, or without, formal lessons.

At the forthcoming ALSGBI meeting in Southport we shall have a training pantechnicon available to provide an opportunity for delegates to complete, be assessed and signed off for tasks 2 to 5 should they choose to do this.

The materials to help complete LapPass are on the website and include the instructions for the tasks, the forms to be completed and general guidance notes for assessors.

Mr Peter Sedman
President Elect

Caption Competition

Here is a snap of our President Elect, one can only imagine how he secured election to the post. Please can you send us your versions of an appropriate caption for the picture, your efforts will be rewarded by a bottle champagne.

Entries have to be sent to Mrs Jenny Treglohan jtreglohan@alsgbi.org by 1 December 2015

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Elemental Healthcare Ltd offer informative workshops on the latest innovation in Endoscopic Fluorescence Imaging – PINPOINT. For more information contact:-
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Colorectal Workshops: Evaluating Anastomotic Perfusion Using Infra-red Fluorescence

These colorectal workshops are held in collaboration with HTC, NIHR, Leeds Teaching Hospitals and Professor David Jayne, demonstrating intra-operative real-time perfusion assessment. The workshops include live operating; a technology overview as well as reviewing research and literature.

Autumn Workshop 2015	The LIMIT Centre, Leeds	Spring Workshop 2016	The LIMIT Centre, Leeds
Winter Workshop 2015	The LIMIT Centre, Leeds	Summer Workshop 2016	The LIMIT Centre, Leeds

To register as a delegate please contact: Dr Neville Young, Programme Manager, Colorectal Therapies Healthcare Technology Cooperative, Level 7, Clinical Sciences Building, St. James' University Hospital, Leeds, LS9 7TF. T: 0113 206 5256 E: mednyo@leeds.ac.uk

Olympus

Contact: Mrs Tracy Bray, General Manager - Events, Olympus | Direct Line: +44 (0)1702 616333 | Email: info@olympus.co.uk | Web: www.olympus.co.uk
Further details of these events and our European courses are available on our website or will be in due course.

Date	Course	Venue
22–24 September 2015	Surgical Energy Masterclass for Theatre Practitioners	KeyMed House, Southend
28–29 September 2015	Laparoscopic Colorectal Cadaveric Workshop	Christie Hospital, Manchester
1–2 October 2015	Advanced Laparoscopic Hiatal Course	Royal Infirmary, Edinburgh
12–13 October 2015	Total Laparoscopic Hysterectomy, Derby – 2 day	Delta Centre, Royal Derby Hospital
24–27 November 2015	Frontiers in Intestinal and Colorectal Disease	St Marks Hospital, London
26–27 November 2015	Laparoscopic Colorectal Surgery Cadaver Course	University of Glasgow, Glasgow
7 December 2015	Total Laparoscopic Hysterectomy, Derby – 1 day	Delta Centre, Royal Derby Hospital
6–8 January 2016	Glasgow Cadaveric Advanced Gynaecology Laparoscopy Course	Southern General, Glasgow

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KARL STORZ Endoscopy (UK) Ltd is now in the 8th year of offering customer-focused training courses in Proctology. For more information, contact:-
Gary Calvert | M: +44 (0)7812 973603 | E: gcalvert@karlstorz-uk.com or Charles Goudie | M: +44 (0)7976 202090 | E: cgoudie@karlstorz-uk.com

Transanal TME Courses supported by Karl Storz Endoscopy (UK) Ltd

These 2-day interactive workshops are aimed at colorectal surgeons experienced in minimal invasive TME as well as transanal surgery, in particular TEM and/or TAMIS.

7-8 October	ICENI Centre, Colchester
1-2 December	ICENI Centre, Colchester

The above courses are facilitated at the Evelyn Surgical Training Centre, Cambridge. To register as a delegate on a TaTME Course, please contact Daisy Martlew, ICENI Centre, Colchester.

Daisy Martlew, ICENI Centre Co-ordinator | E: daisy.martlew@anglia.ac.uk
Colchester Hospital, Turner Road, Colchester, Essex CO4 5JL

Transanal Endoscopic Operations (TEO®) Courses supported by Karl Storz Endoscopy (UK) Ltd

These one day events incorporate live surgery, procedural presentations and hands-on simulator training and are aimed at consultants wishing to undertake TEO® in their hospitals

17 November	Queen's Medical Centre, Nottingham

Courses are available via the Duke's Club Website, www.thedukesclub.org.uk for Trainees

To register your interest as a delegate on a TEO® Course, please contact Dan Danby, KARL STORZ Course Administrator, specifying which course you are interested in and we will be in touch.

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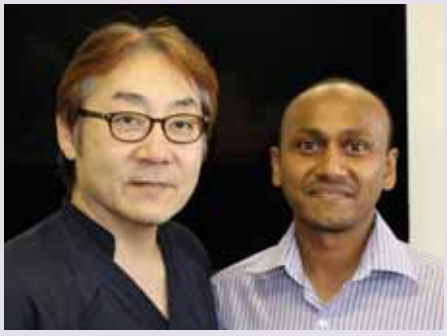
East & Far East
Report on David Dunn Travelling Fellowship 2013

Having started as a Consultant Surgeon at Broomfield Hospital in February 2012 I have been keen to develop advanced minimal access techniques for oesophago-gastric resections. As such I was fortunate to visit the units of Professor Ichiro Uyama at Fujitha Health University, Japan and Professor Palanivelu at GEM Hospital, Coimbatore, India as part of the David Dunn Travelling Fellowship.

Japan

First stop in Japan was at National Cancer Centre (NCC), Tokyo. This institute is a solemn institution at the centre of numerous clinical trials for gastric cancer. Vast majority of the surgery is open. During this week, I attended three gastrectomies, one open & shut case (peritoneal metastasis) and



one oesophagectomy. I was introduced to Professors Katai, Fukagawa & Morita and able to attend their Friday morning MDT (conducted in English). I intended to make most of my Japan rail card and travel on the famed Shinkansens (high speed trains) aided by very useful advice from Professor Morita for my travels to North Japan.

I travelled to Fujita University in the second week, spending 2 weeks with Professor Uyama's unit. His contemporaries at the NCC regard Professor Uyama as the 'Emperor' of laparoscopic gastrectomies.

The atmosphere and hierarchical nature at Fujita was a total polar opposite to that I saw at the NCC. There appeared to be a lot of banter between colleagues and also between different levels of hierarchy. Despite all this, it was obvious that Professor Uyama was highly revered by the whole department. The department seemed to be a buzz with activity, excitement and pride. In the next two weeks, I observed 5 total & 3 sub-total gastrecomies (all laparoscopic) and one robotic total gastrectomy. Professor Uyama has developed a great laparoscopic technique for both D2 dissection as well as a linear stapled oesophago-jejunal anastomosis. The technique is very standardised; a junior registrar would be performing a total gastrectomy. The Professor was approachable, open to questions and very willing to teach and discuss. He took time to go through the differences in the port placements between laparoscopic and robotic gastrecomies. He even

hosted dinner after a marathon 7hr robotic gastrectomy and before leaving in the early hours of the following morning to travel to the USA.

I found the attitude and approach of the Japanese surgeons unique & interesting. They are skilful, patient, systematic and meticulous. There is never a race against time and yet they have an uncanny ability to combine humility with confidence. They are very dogmatic, yet at the same time pragmatic. Despite their regimented approach, there always seems to be room for innovation. The two Japanese words that describe their attributes are 'kata' and 'gambatte'. The former means 'method' and the later means 'fight on'.

India

My next leg of the fellowship took me to Coimbatore in Southern India where I visited Professor Palanivelu at GEM Hospital. He is one of the most renowned laparoscopic surgeons in India. He attracts politicians and celebrities to his

hospital. During my visit, one of the state's cabinet ministers had a laparoscopic cholecystectomy.

GEM hospital is set up to do minimal access operations for every conceivable GI pathology. For the length of my visit of 2 weeks, there wasn't a single open operation.

Details of each operation are religiously recorded into a database. Every operation is recorded and edited pretty much straight after by the fully staffed on site audio-visual department. Not surprisingly, Professor Palanivelu has published widely. He started to perform totally Minimal Access Oesophagectomy in 1997, almost 2 decades ago and published a series 130 cases in 2006. A thoracoscopic approach is now the established standard technique in their unit. They haven't had to open a chest for a number of years. So much so that the hospital doesn't even keep a rib retractor!

The technique of resection has changed over the years. A 3-stage Mc Keown type resection was common in the past. With increasing incidence of lower oesophageal & OG junction tumours, 2-stage Ivor-Lewis resection with intra-thoracic anastomosis is now the commonest operation. Thoracoscopic part of the operation was initially performed in the prone position. Now it is done in a left lateral semi-prone position. Professor Palanivelu performs a linear stapled or hand sewn

oesophago-gastric anastomosis. He prefers the latter and does it with PDS suture. The posterior layer is interrupted and the anterior layer is closed with a continuous suture.

I had the opportunity to have a number of discussions with Professor Palanivelu. While GEM hospital attracts a number of rich and famous patients, the vast majority of the patients still come from the neighbouring villages. Professor Palanivelu developed the minimal access technique, after failing to convince the farmers and manual labourers to have laparotomy & thoracotomy for oesophagectomies. Lack of social support system means that these patients need to return to their jobs at the earliest, with minimal loss of function. Hailing from India, I totally understand this issue.

'Necessity, mother of innovation' has been the principle of so many things that come of out India.

I have had the most amazing experience visiting the busiest hospitals in Japan & India headed by world-renowned surgeons. I am ever so grateful to ALSGBI for awarding this coveted fellowship to me and Ethicon for sponsoring this fellowship.

Legend for the photos: All the photos are self explanatory apart from the Photo no. 4: Brihadeeswarar Temple, 66m tall, completed in 1010 AD.

Mr N V Jayanthi

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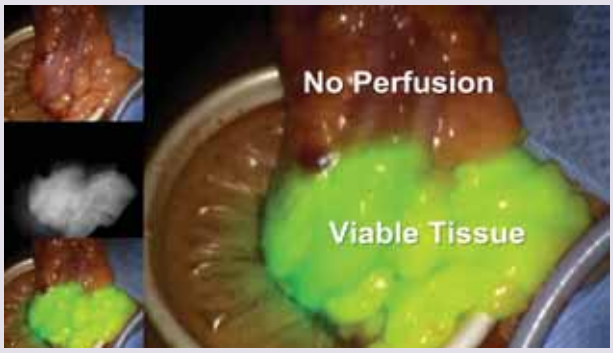

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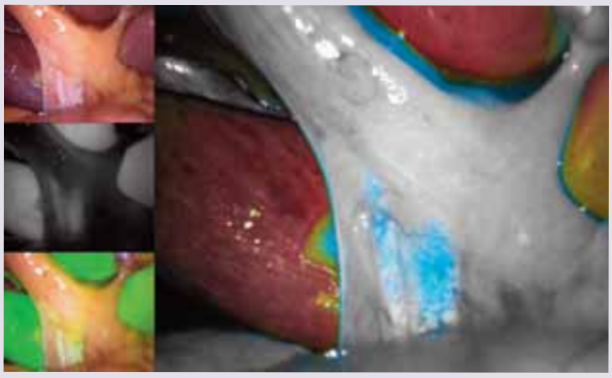

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1. Jafari MD, Wexner SD, Martz JE, McLemore EC, Margolin DA, Sherwinter DA, et al. Perfusion assessment in laparoscopic left sided/anterior resection (PILLAR)
II: A multi-institutional study. Ann Surg. Sep 2014
Detection of sentinel lymph nodes in minimally evasive surgery using ICG and near-infrared fluorescence imaging for uterine and cervical malignancies, Jewell et al. Feb 2014

Teleflex turns its attention to Percutaneous Surgery

Teleflex

Teleflex Incorporated, a leading global provider of medical devices for critical care, urology and surgery, acquired the assets of Mini-Lap Technologies, Inc., a leading developer of next-generation minimally invasive surgical instruments, in December of 2014. The transaction provides Teleflex a platform technology, additional marketed products that address various segments of the surgery market, as well as pipeline products.

MiniLap® instruments, with their slim 2.3 mm shaft diameters for the graspers and 2.4 mm shaft diameters for the MiniPolar probes, can be percutaneously inserted into the abdomen using an integrated needle tip. The grasper jaws or probe can then be deployed to grasp or coagulate tissue. The patented deployment design allows grasper jaws to open up to 12.5 mm to grasp difficult structures, like distended gall bladders.

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The MiniLap® System complements Teleflex's diversified range of Weck® brand surgical instruments, which include Weck Hem-o-lok polymer locking clips and the Weck Vista® Access portfolio, which provides confidence, clarity and control during general and advanced laparoscopic procedures. For closure, surgeons can rely on the innovative design of the Weck EFx® Endo Fascial Closure System, which provides reproducible fascial closure in varying body types with a controlled suture delivery.

About Teleflex Incorporated

Teleflex is a leading global provider of specialty medical devices for a range of procedures in critical care, urology and surgery. Our mission is to provide solutions that enable healthcare providers to improve outcomes and enhance patient and provider safety. Headquartered in Wayne, PA, Teleflex employs approximately 12,200 people and serves healthcare providers worldwide. Additional information about Teleflex can be obtained from the company's website at teleflex.com.

Not all products are available in all regions, contact your Regional Sales Representative for local information.

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