SAVE THE DATE
2016 ALSGBI Annual Scientific Meeting | London
Thursday 10 & Friday 11 November
ALSGBI Laparoscopic Training Day | London | Wednesday 9 November

ALSGBI newsletter

ALSGBI
Association of Laparoscopic Surgeons of Great Britain & Ireland

President's Introduction

Autumn is upon us once again and with it our second newsletter of the year. Many thanks again to Neil for the excellent job in putting this together and I am sure you will enjoy reading it.

The November meeting of the Association will soon be on us and I would urge all of you who have not yet done so to register for the meeting and for a room in the ILEC. I think and hope there is something for everybody, I am sure it will be a thoughtful, interesting and useful meeting.

We continue the traditional format with the live operating on Thursday 10 November which will be hosted from Guildford and has an excellent variety of cases planned. We hope to be able to demonstrate the potential of indocyanine green in delineating anatomy and reducing bleeding and we are also extremely hopeful that we will be able to demonstrate live operating broadcast in 4K for the first time ever in the UK - another first for our society.

At the end of the live operating we have a new format to discuss procurement with a view to doing it better and more effectively within the current cash-strapped health environment. We therefore have arranged a mini-symposium to discuss the challenges that we face with this, with contributions from surgical teams, our hospitals' decision makers and industry. Please get involved and also sign up to the conference dinner, which this year will be at the Queens Club, an interesting and unique venue.

For Friday's scientific session we are delighted to welcome Professor Michael Kendrick our BJS lecturer from the USA and Professor Luigi Boni from Italy as our International guest lecturers. The scientific programme is full and at the Annual Scientific Meeting of the Association we shall discuss how the ALSGBI will respond to the closing of the College next year.

Throughout the congress we shall be running assessments for the LapPass. We are grateful for our industry sponsors for facilitating this, both in supporting training for this and for providing the facilities for summative assessments. Certificates will be awarded there and then for successful candidates who have completed all the assessments.

Our training day on Wednesday 9 November will be held at Imperial College under the stewardship of Mr Paul Leeder and Professor George Hanna. As I write this almost all of the places for the training day have been already filled.

The ALSGBI has been working with AUGIS and Insights Analytics to provide all our members with access to many elements of NHS HES data which is held in our name. This has been co-ordinated by Ian Beckingham and Mark Vipond and although it has been offline for a little while the newly designed site will be introduced at the conference and you will be getting emails from Jenny soon demonstrating how you may log in. This is known as the SWORD database and is a fantastic resource as those of you who have used it will know. It is especially useful when correlating our work in regard to appraisals and the future onus on us to publish our clinical work.

I look forward to seeing you in London and then in Cardiff next year.

Best wishes

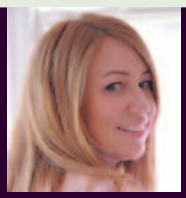
Mr Peter Sedman
President, ALSGBI

Editor's Introduction

Welcome to the Association's Autumn Newsletter, this comes at a time of great political turbulence and financial stress in the NHS, the like of which many of us have not seen before. With such a technology based specialty there are significant challenges for us all. I am sure that these will all feature in discussions when we meet at the next Annual Scientific meeting being held in West London on 10 and 11 November.

This edition features reports of the Travelling Scholarships with Steve Hornby's trip to Melbourne and Vincent Wong's visits to South Korea and Japan. We also hear from Chelliah Selvasekar about the MASNoW meeting which appears to be a well established convivial occasion. We report on the training meeting in East Anglia which together with local industry representatives is also supported as part of the Association's meeting sponsorship programme, we do hope to hear of many more of these local meetings from trainers applying for help with funding via the ALSGBI website.

Mr Neil Keeling
Newsletter Editor



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Thursday & Friday 9 & 10 November 2017
ALSGBI Training Day Wednesday 8 November 2017

ALSGBI North West and Mersey Regional Meeting Report

28 April 2016

Minimal Access Surgery North West (MASNoW) meeting is proud to be recognised as the regional chapter of the ALSGBI in the North West and Mersey area. The MASNoW group was set up 4 years ago by Mr Chelliah Selvasekar (Colorectal Consultant, Christie Hospital) with the aim to improve regional laparoscopic training and to encourage collaborations. The group now welcomes trainees and trainers from all GI subspecialties from across the region to its biannual meetings.

The 7th Minimal Access Surgery North West (MASNoW) meeting took place on the 28 April 2016 at Sai Spice restaurant in Chorlton, Manchester. The evening was hosted by Mr Aswatha Ramesh, Consultant Colorectal Surgeon from the University Hospital of South Manchester. The informal educational evening with curry proved to be very popular and the meeting was well attended by 46 consultants and trainees. Delegates listened to consultant expert presentations on Mesh repair in rectal prolapse (Ms Karen Telford), chronic pain in inguinal hernia repair (Mr Aali Sheen), and Trans-Anal Minimal Access Surgery and Full Thickness Colonoscopic Resection (Mr Abhiram Sharma). These were followed by trainee case presentations on Laparoscopic liver resection (Mr Rami Obeidallah, Clinical Fellow), and Laparoscopic decapsulation of a giant splenic cyst (Mr Osama Elhardello, Clinical Fellow). The trainee presentation prize was awarded to Mr Neil Houghton (CT2) who presented an audit on acute gall stone disease management. The evening saw delegates sharing their experience in their local trusts while catching up with old friends and colleagues. We have received excellent feedback and we hope to build on the success for the next MASNoW meeting (ALSGBI North West Regional Meeting) was held on the 29 September 2016 at Sai Spice restaurant, Chorlton, Manchester and hosted by Mr Sajal Rai, Consultant Surgeon, Stepping Hill Hospital, Stockport.

Ms Christina Lo
Senior Upper GI Trainee, Salford Royal NHS Foundation Trust, Salford
Mr Chelliah R Selvasekar
Consultant Colorectal Surgeon, The Christie NHS Foundation Trust, Manchester

Lapco Meeting

13 June 2016, Pelican Cancer Foundation, The Ark Centre, Basingstoke

Lapco International Meeting 13th June Basingstoke
Back row (L to R) Dr Ole Helmer Sjo, Mr Mark Whittaker, Prof David Jayne, Mr Andy Miller, Mr Tom Cecil, Mr Peter Sedman
Front row (L to R) Miss Sharmila Gupta, Dr Brian Dunkin, Dr Roland Valori, Mr Mark Coleman, Mr Brendan Moran

Despite rumours of its demise over recent years, Lapco continues to thrive. The Lapco Train the Trainer's Course, Lapco TT, is the most rigorously evaluated surgical course in the world. In the UK the colorectal version takes place 3 times per year in Manchester, Bradford and Colchester. Faculty development is underway for the British Society of Gynaecological Endoscopists for a laparoscopic hysterectomy program led by Mark Whittaker and colleagues. Successful versions of Lapco are running in the USA for SAGES, led by Dr Brian Dunkin, recent ex SAGES President, and in Norway, led by Ole Helmer-Sjo from Oslo.

In June, the global Lapco group collected together in Basingstoke to describe and celebrate the achievements of Lapco and to discuss future possibilities. Present was Peter Sedman, current President of ALSGBI who chaired a session and, I think it is fair to say, was impressed by the Lapco story and what it could offer the ALSGBI. We also heard from Roland Valori about similar ventures in the world of flexible endoscopy and how the National Colonoscopy TT course has been the model for Lapco TT.

The stand out feature of the program was industry participation not only in the commercial exhibition during breaks but also during the academic sessions themselves. We thank them and look forward to this kind of forward-thinking collaboration in future.

Our thanks also to Mr Tom Cecil, Director of the Peritoneal Malignancy Institute at Basingstoke and local convenor, and the Pelican Cancer Foundation Team led by Chief Executive Sarah Crane.

Lapco still has much to offer the laparoscopic world as the model for transformational change and top quality surgical training

Professor Mark Coleman
Derriford Hospital, Plymouth

Association of Coloproctology Annual Meeting, Edinburgh

4-6 July 2016

A rather grey and drizzly Edinburgh hosted this year's 24th ACPGBI Annual Meeting, fortunately this did not detract from the occasion which again provided an opportunity for members of the society to meet up and top up their knowledge, learn new things, meet old friends and generally put the world to rights. As before the venue was the International Conference Centre in the Exchange, just a stones throw from the Edinburgh Castle.

Opening on Monday 4th with presentation of how the the Delphi Project looked at intraoperative decision making and the use of stomas and TEO course which combined lectures and hands on stations and continued in parallel for much of the day.

After formal opening by the President there were updates on current trials and the customary welcome drinks reception at the venue. Tuesday covered sessions on fistulas, adenomas and rectal cancer. There were parallel sessions for the Dukes Club, the specialist nurses and the now regular appearance of Consultants Corner where some of the afternoon's speakers were put on the spot by Robin Phillips with unusual clinical scenarios. Early Tuesday evening was the opportunity for runners to stretch their legs around Meadows Park, although this reviewer declined this year, having never quite recovered from the shock of being directed up the path to the summit of Arthur's Seat half way through the 5k 'fun run' on a previous similar ACP meeting!

Conference then convened to the Museum of Scotland for a three course dinner and ceilidh dancing.

Wednesday afternoon saw sessions from the Pelvic Floor Society, update on emergency surgery and discussions on controversies in coloproctology as well as the Presidential handover to Peter Dawson. Stand out talks for me were (surprisingly for a surgeon) Ailsa Hart and her Faecal Transplantation lecture, and Soren Laurberg's reminder of the harm we can do during anterior resection in his BJS Lecture. Other notable sessions were the how I do it presentations including James Mander's LIFT talk and the Emergency Surgery presentations which will cause concern on who will be running the service and where in the next decade.

For this reviewer there were aspects of the meeting that were not ideal, such as being required to pre-book which of the parallel sessions were going to be attended and having the exhibition in the basement and many sessions being held at the top of the venue to a tight schedule which gave limited chances to talk to the exhibitors without being rushed. Points I am sure ALSGBI will take note of.

Mr Neil Keeling
Newsletter Editor

Book Review

Blood, Sweat and Tears - Becoming a Better Surgeon by Philip F. Stahel

ISBN 978-1-910079-27-0

Written by Dr Stahel who is a trauma and orthopaedic surgeon based at Denver Health Level 1 trauma unit in Colorado this is a worthy read for anyone interested in the surgical world. Trained in Switzerland, Berlin and the US Dr Stahel's book is intended to give the reader an insight into how to approach life and in particular a career in surgery of the modern era.

It is not a book of surgical tips and techniques, but a guide of how to survive the pitfalls of poor judgement, poor case selection, lack of empathy and insight. Divided into 5 sections it breaks down the essentials of dealing with the ups and downs of modern surgical practice. It does this with quotations, vignettes and case studies to illustrate aspects of patient care. Some of these cases vary from cringingly dreadful to excellent.

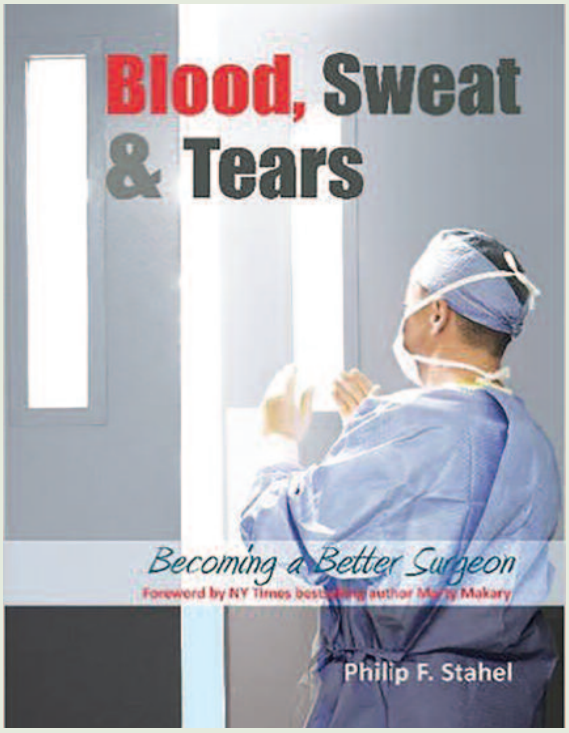
As one would expect it has quite a strong US bias which is addressed by a glossary of terms and acronyms for non medical and non-US readers at the back. The style is a bit clunky and I did not find that it was a particularly easy smooth read but with perseverance the important messages are revealed.

Although one would hope that most thoughtful, intelligent well trained readers will find a lot of reassurance that they tick most if not all of the positive boxes already, there will be many small facets highlighted that we could all improve upon, even when we think we might personally be perfect.

Although it is written to be a suitable read for a wide audience the specific target is the young surgical trainee who must wrestle with the challenge of trying to be perfect, yet human, technically skilled, but empathic and approachable.

I can wholeheartedly recommend the book for those who are seeking surgical Nirvana or even for those who think that they might have found it already.

Mr Neil Keeling
Newsletter Editor



Report on the David Dunn Travelling Fellowship 2015

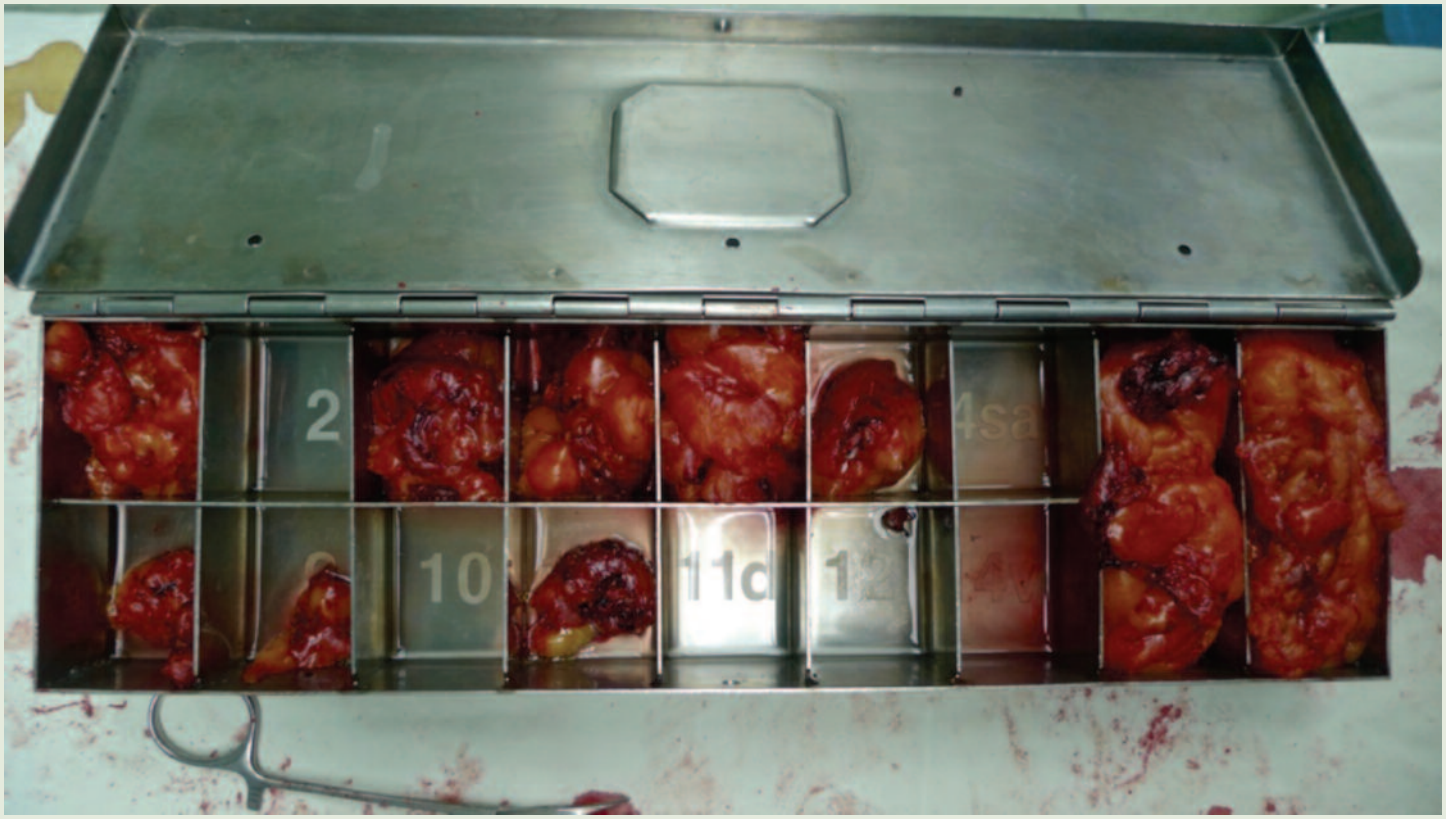


Figure 1: Dissected peri-gastric tissue placed according to the lymph node stations

It was 8 am on a sunny April Monday, I was standing at the lobby of Seoul National University Hospital (SNUH) jetlagged, but excited, I was waiting to meet Dr Yun-Suhk Suh from the Gastric Cancer Centre in SNUH. Led by Professor Han-Kwan Yang, this impressive unit typically performs over 1,000 gastrectomies every year, 60% of which are performed laparoscopically. I had arranged to spend a few days with the unit as part of my travel fellowship.

On introduction, speaking with an American accent, Professor Han-Kwan Yang is warm, welcoming and effusive. Whilst showing me around the theatres he advises me that there were to be two laparoscopic assisted distal gastrectomy (LADG) and an open gastrectomy that day. By the time I have changed into scrubs and found my way to theatre, 1 of the 2 LADG cases was already ongoing.

In contrast with my experience in the UK, the operating surgeon in SNUH was standing on the patient's right while the assisting surgeon was on the patient's left. The camera operator (expertly controlled by the theatre assistant) was standing between the patient's legs. The first part of LADG involved mobilizing the greater curve of the stomach, isolating and dividing the left gastro-epiploic vessels and isolating the right gastro-epiploic vessels. From a trainee perspective, it was interesting to note that the first part was performed independently by the surgical fellows which is equivalent to surgical registrars in the UK. Professor Yang would then continue the operation; dividing the right gastro-epiploic vessels and performing D1+ lymphadenectomy followed by a mini-laparotomy for the distal gastrectomy and a Bilroth 1 anastomosis using a circular stapler. The resected specimen is then handed out to the junior surgeons for dissection of lymph node stations (Fig 1). An LADG will typically take between 1½ – 2 hrs to complete.

Over the course of my brief few days in SNUH, I observed 6 cases of laparoscopic assisted distal gastrectomies (LADG) and an open D2 gastrectomy which was abandoned due to peritoneal metastases. As majority of gastric cancer cases in Korea are diagnosed early, they do not routinely perform omentectomy or D2 lymphadenectomy. Rather, there is a move to tailor the operation to the location and stage of the gastric cancer to preserve organ function.

In addition, Professor Yang and his team has a robotic surgery list every Wednesday. Using the da Vinci surgical system, they normally have a robotic assisted distal gastrectomy (RADG) on the list. It was indeed an eye opener and an experience for me to treasure (Fig 2). Unlike open or even laparoscopic surgery, robotic surgery felt very much like a 3D video game at times with the ability to change and select which instrument to control. It is an exciting frontier for Upper GI surgery and if given the opportunity, something which I would like to explore. However, the prohibitive cost of da Vinci surgical system and the instruments may be difficult to justify in this current austere NHS climate.

Following my brief time in SNUH, I attended the Korean International Gastric Week Congress. Held in the beautiful Jeju island, the 3-day congress was attended primarily by surgeons from Japan, Korea, China and South-East Asia (Fig 3). The congress was focused on the latest advances and research in gastric cancer; including ongoing multi-centre trials such as sentinel lymph node biopsy for gastric cancer (SENORITA) and the recently concluded REGATTA trial for advanced gastric cancer with single metastases. An illuminating talk from the congress which I will certainly remember was by renowned Dr Hitoshi Katai on his experience on managing gastric cancer.

Moving on from Korea, I then spent the bulk of my fellowship in the Cancer Institute Hospital in Tokyo. Headed by Professor Takeshi Sano, they typically performed 14-16 gastrectomies and 2-4 oesophagectomies each week. On my first day there, I was pleasantly surprised to find out that there was another UK observer starting at the same time. Mr Bijendra Patel, an Upper GI consultant from Barts Cancer Institute, who was spending several weeks there as well. It was an ideal arrangement as during our time there, we would often discuss our management approach for individual cases and different surgical techniques while observing the operations. MDTs are held every Wednesday morning at 7.30 am. Conducted mainly in Japanese, the MDTs are not strictly speaking multi-disciplinary as the meetings are attended primarily by surgeons with the junior surgeons presenting the cases and the radiological findings.

During my two weeks with the Cancer Institute Hospital, I observed 3 oesophagectomies and 8 gastrectomies including laparoscopic assisted proximal gastrectomy, laparoscopic total gastrectomy and open total gastrectomy with D2 lymphadenectomy. For oesophagectomy, they would normally perform a 3 stage thoracoscopically assisted oesophagectomy. It was fascinating to see the surgeons meticulously dissecting out the oesophagus and taking care to identify and preserve the recurrent laryngeal nerves. The anatomical knowledge of Japanese surgeons is impressive as they seem to know the name for every single minute blood vessel.

Whilst the Japanese tend to be formal and hierarchical one particular gastric surgeon rather stood out - Dr Naoki Hiki, he is one of the senior gastric surgeons, who likes to have his music playing in theatre and has friendly banter with his juniors and ourselves whilst operating. He is a keen teacher as well; patiently explaining to us about the 'Double flap technique' to prevent reflux following proximal gastrectomy - an interesting technique which requires careful dissection of the anterior stomach wall and according to Dr Hiki, has a good outcome in preventing reflux.

The highlight of my fellowship with the Cancer Institute Hospital has to be when Professor Sano gave a masterclass in open D2 total gastrectomy. It was a joy to behold his deftness in D2 lymphadenectomy with an ultrasonic scalpel, the confidence in the vascular anatomy around the stomach and the efficiency of his surgical craft.

To culminate it all, Mr Patel and myself were treated by Professor Sano to a lovely meal in a French restaurant near Tokyo station. Situated on the 35th floor, the restaurant has an amazing view of the Tokyo skyline. The food and wine were superb too; so much so that I brought my wife to the restaurant the next day.

My fellowship in Seoul and Tokyo has been an amazing exposure to a different surgical culture, attitude and management of oesophago-gastric malignancies compared with the UK. The disease burden, disease type and patient demographics may be different, but the culture of excellence and the refined surgical craft which I witnessed in Seoul and Tokyo are the areas which I seek to emulate in my surgical career. For that, I am truly indebted to ALSGBI and Johnson & Johnson for providing me the travel fellowship grant.

Mr Vincent Kah Hyme Wong
Winner of the David Dunn Travelling Fellowship 2015

Figure 2: (a) Robotic assisted distal gastrectomy. (b) Myself with Professor Yang in the da Vinci Robotic Theatre.

Figure 3: Professor Han-Kwang Yang, Professor Jimmy So and myself in the Korean International Gastric Cancer Week Congress

Report of the B. Braun Aesculap Travelling Scholarship

Figure 1: Members of the Austin Health UGI and Bariatric Surgery Team (Surg III).

In 2015, kindly sponsored by ALSGBI and the B. Braun Aesculap Travelling Scholarship, I completed a one year fellowship in Laparoscopic UGI and Bariatric Surgery at Austin Health in North East Melbourne. Established in 1882, Austin Health has 980 beds over four sites in the suburb of Heidelberg. The organisation has an operating budget of $700 million and is affiliated to eight separate universities-it is the largest surgical training centre in Victoria.

The UGI Department (SURG 3) offer a full range of benign, malignant and bariatric UGI services and acts as a tertiary referral centre. The Austin offers care to a widely diverse population and frequently encounters unusual and complex problems and I had the pleasure of managing a fair number of 'Austinomas' in my time there.

I was supervised by Ahmad Aly, the Head of Upper GI Surgery at the Austin and the current President Elect of the Obesity Surgical Society of Australia and New Zealand (OSSANZ). Ahmad himself has completed advanced UGI fellowships in both Adelaide and Sheffield, UK. The Upper GI team consists of six consultants, 2 fellows, 2 registrars, 4 interns, 2 dieticians, a nurse liaison, a specialist ward sister and a research nurse.

Figure 2: ANUM (Associate Nurse Unit Manager) Amanda Kerton and I waiting for our oesophageal stent.

A typical working week for the Fellow at the Austin would include; two full day and one half day operating lists, two endoscopy list, two clinics, one MDT meeting, one morbidity and mortality meeting, one pathology meeting and two consultant ward rounds. If that seems like a lot, it is because it is!

Operating lists are split over two sites. Oesophagogastric, pancreatic resection and revisional bariatric work is performed at the Austin Main Hospital with Day case and short stay work such as primary bariatrics, hernias and gallbladders are performed at the Repatriation hospital nearby. The bulk of my work was cancer resection and revisional bariatrics and managing the emergency service.

Over the year I trained in some innovative laparo-endoscopic techniques where procedures such as excision of luminal GISTs, endoscopic mucosal resections and reversal of vertical band

gastroplasties were performed using an endoscope with the camera and operative port passing directly into the stomach. So called 'Transgastric' techniques offer a minimally invasive option to tackle issues that would otherwise require a large gastrostomy. Operating within the stomach is particularly effective when lesions lie at the proximal and distal extremes and allows for a high degree of accuracy when working near the gastro-oesophageal junction.

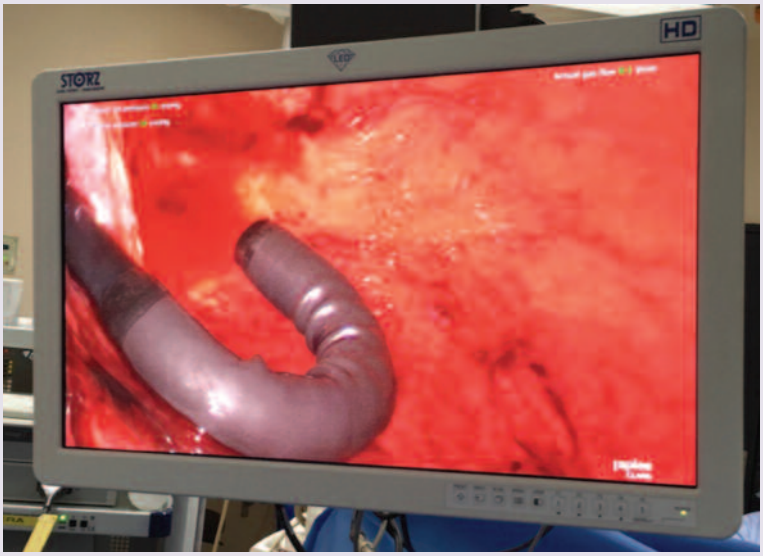


Figure 3: A view of a retroflexed endoscope viewing the site of a GIST excised from close to the gastro-oesophageal junction

As the Upper GI Fellow I was non-resident first on call for General Surgery at least one night a week and approximately one in four weekends. Pre FRACS registrars are not allowed to operate independently without a Fellow or Consultant in the near vicinity. For problems of a specialist oesophagogastric or bariatric nature I was the first point of call around the clock. This is as part of an incredibly supportive consultant team but it makes for a busy out of hours practice.

Additional responsibilities I took on included a very active role in the cancer MDT, the supervision and training of the junior members of the medical team, chairing and delivering formal teaching seminars, providing educations sessions for the nursing staff and short listing and interviewing for other Fellowship positions. Each year the Fellows are expected to produce an audit of the department's activity over the previous year and produce an in depth review of one of the department's key services.

Figure 4: My wife Clare and I enjoying a wine tour in the stunning Yarra Valley.

The Austin provided a very reasonable study budget and during the year I was able to complete a mini visiting fellowship in advanced upper GI surgery at the Prince of Wales Hospital, Hong Kong with Professor Phillip Chiu.

The Fellow's salary is augmented by 2 regular operating lists assisting two of the department's consultants at the neighbouring private hospital. I found these lists very helpful as I saw them as an opportunity to attend a regular masterclass in a low stress environment. How much one gets to do surgically at these lists is largely down to the individual consultant but they provided an excellent chance to get to know my supervisors and were enormously informative about practicing surgery outside of the public hospital setting.

According to the Economist Intelligence Unit global "liveability" study, Melbourne is the number one city to live in on the planet. In the study Melbourne scores a 97.5 out of a possible 100 and my wife and I can certainly attest to this being entirely fair.

Melbourne is a vibrant, warm and exciting city that made us feel welcome from the moment we landed. The culinary and live sports are second to none. Whilst the city is sprawling there is a very tangible sense of community wherever you go and we felt safe everywhere we went. We lived in the bohemian suburb of Fitzroy, which is 12 minutes tram ride from the central business district and 12 minutes drive from the Austin Hospital. Tripadvisor lists there being 207 restaurants in Fitzroy alone and the newly gentrified area is steeped in the rich history of the city. It is a crazy little village within a city and we filled our free time with arts and music and some of the most amazing food we have ever tasted. And the coffee, don't start me on the coffee.

The countryside surrounding the city that we visited including the Yarra Valley and Wilson's Promontory are some of the most spectacular and rich in wildlife that you could hope for.

Melbourne is a long way from home and whilst getting there and setting up a life is one of the biggest challenges we have faced as a family, it turned out to be one of the most joyful and rewarding years of our lives.

There are lessons that I learned and pitfalls that I faced and I would advise anyone entering into an Australian Fellowship to go and sit down with someone who has done one recently. A particularly excellent resource is the Association of Surgeons in Training Guide to Australian Fellowships authored by Will Hawkins, a document I would have been lost without.

The role of the 'Australian Fellow' is much closer to that of a junior consultant than a senior registrar. At the Austin you are very much treated as a colleague by the consultants and there is an initially imperceptible but retrospectively obvious, withdrawal of active supervision as the year goes on. I got the impression that my colleagues at the Austin took great pride in providing a very specialised 'finishing school', which I certainly found totally invaluable in bridging the gap from Registrar to Consultant.

Mr Steve Hornby
Winner of the B. Braun Aesculap Travelling Scholarship 2015

Laparoscopic Surgery in Zambia

Gemma Conn supervising in dry lab

In March 2016 I visited the University Teaching Hospital of Lusaka, Zambia (UTH) for the second time as part of the charity 'Out to Africa'.

Out to Africa is a charitable project initiated by Tom Browne, Consultant Vascular Surgeon at Broomfield Hospital, Chelmsford, Essex. The project aim is to link various departments in Broomfield Hospital with their peers in the unit in Lusaka. The programme is intended to establish long-term relationships between the two organisations that will bring mutual benefits through shared learning. There are already well established links with anaesthetics and physiotherapy departments.

Zambia is a landlocked country in Southern Africa. The capital, Lusaka, is in the south-central part of Zambia. The population is concentrated mainly around the capital and the Copper belt Province to the northwest, these are the core economic hubs of the country. Zambia has a relatively stable political establishment and is a progressive country. For example, its per capita GDP is more than that of countries such as India. While rural Zambia is poor and lacks even the basic health needs, Lusaka the capital is the metaphorical heart of the country and is one of the fastest growing cities in southern Africa. UTH is the largest hospital in the country and an apex medical institution. It attracts the great and good of the country in the field of the medicine. Zambia's brightest medical students graduate from here and very motivated and able doctors work at the UTH.

Many wonder and question if laparoscopic surgery is really necessary in Zambia, while people die of poor sanitation, lack of clean drinking water, malnutrition and infectious diseases. Laparoscopy is perceived to be something sexy and expensive and that Zambia needs improvements in basic health provision, not laparoscopy. Whilst working in rural Zambia (and Africa in general) is seen as heroic in the west, laparoscopy is seen as a luxury and, at present, unnecessary for this part of the world.

There is a huge shortage of blood products for transfusion (due to a combination of shortage of donors and a high incidence of HIV). Transfusion rates for elective open surgery are high, for example about 70 – 80% of patients having open cholecystectomy receive blood transfusion.

Furthermore, the wealthy fly to South Africa to have elective laparoscopic surgery, while the poor have open surgeries in Zambia. This has significant economic implications. Not only does the money leave the country, but the poor who are dependent on their labour to earn daily bread end up staying in the hospital for longer after elective open surgery.

Therefore, I do not see any reason why an apex medical centre in the capital city of a progressive sub-Saharan African country shouldn't develop laparoscopic surgery and lead the way.

My remit in the Out to Africa programme was to demonstrate and impress upon the young minds about the benefits of laparoscopic surgery. I travelled to Lusaka with Tom Browne & Gemma Conn, one of our colorectal surgeons. Tom is an altruistic visionary and his passion for this project is impressive to say the least. Gemma had spent 6 months in rural Zambia before she was appointed as a consultant and feels an emotional connection with the country. She was excited to join us on this project for the first time.

My visit to UTH last year was very interesting as well as a learning experience for me. Having noted a number of issues, mainly in the lack of some basic laparoscopic equipment, I made contact with Medtronic (then Covidien) representatives who kindly supported the project by providing laparoscopic equipment for the workshop.

The workshop consisted of a combination of lectures and dry lab sessions in the morning followed by live operating in the afternoon. Whilst live operating provided confidence that cholecystectomy and hernia repair can be performed safely and effectively through a laparoscopic approach, lectures and dry lab work gave opportunity for all the delegates to develop their laparoscopic skills. All the delegates were assessed using a modified version of LapPass on the final day.

Venkatesh Jayanthi operating

Delegates consisted of postgraduate surgical trainees and one consultant Gynaecologist. A couple of the delegates were sceptical about laparoscopy, the rest were keen, inquisitive and enthusiastic. During the course of the workshop, it was satisfying and encouraging seeing even the

sceptical ones changing their minds and truly believing that laparoscopic surgery is an effective approach. I was particularly impressed with the significant improvement of their laparoscopic skills within even a few days. Everyone thoroughly enjoyed the experience and passed the modified LapPass assessment without any problems.

Although the workshop generated a huge amount of confidence and interest in laparoscopic surgery, the main stumbling block will be to keep the enthusiasm going in the future. This is a difficult task and various factors such as political will, reluctance to invest in laparoscopic equipment; misconceptions of senior surgeons about laparoscopic surgery play a role.

To continue the enthusiasm of the young surgical trainees, Tom Browne had discussions with our trust and arranged to appoint Zambian postgraduate surgical trainees to Broomfield Hospital for a fixed term. These jobs were advertised, applicants shortlisted and interviewed. It was a great experience to interview these bright minds that are almost certainly would be the future of Surgery in Zambia.

Spending a period of time in a UK hospital, which is a centre for colorectal and oesophago-gastric cancer surgery will give them an opportunity to see full benefits of laparoscopic surgery. This will hopefully enable these young surgeons to take the knowledge and skills back to UTH and to be the driving forces behind development of laparoscopic surgery in Zambia.

Tom Browne delivering a lecture

Whilst the project is challenging and frustrating at times, I found the whole experience exciting, stimulating and extremely satisfying. I am thankful to Tom Browne for inviting me to be part of this noble project.

Mr N Venkatesh Jayanthi
Consultant Upper GI Surgeon

ALSGBI Industry Partners' Course Information

Olympus

Olympus Medical is committed to Professional Education and has an extensive programme planned for the next 12 months, incorporating a range of events. Any enquiries, please forward to our Event Management department at education@olympus.co.uk or call us on 01702 616333.

ALSGBI East Anglian Laparoscopic Training Day

The West Suffolk Hospital Laparoscopic Skills Training Day was a free one day course giving trainees the opportunity to practice laparoscopic skills on porcine tissue. The event was held at West Suffolk Hospital, in Bury St Edmunds on Friday 13 of May 2016.

Ten trainees attended, with a staff to candidate ratio of 1:2 allowing intensive feedback and facilitation. Aimed at trainees of varying seniority, from FY2 to ST5, and was advertised to candidates across London and East of England Deaneries. The course has run successfully on a previous occasion and it is anticipated that this will become an annual event.

The session consisted of 5 wet stations on porcine models covering laparoscopic cholecystectomy, gastro-jejunostomy, fundoplication, entero-enterostomy, laparoscopic suturing, laparoscopic stapling and energy devices. In addition, trainees had the opportunity to practice open techniques on porcine models including small bowel anastomosis, excision rectum and anastomosis using stapling devices. Lastly, a dry station was also available so that trainees laparoscopic competency could be assessed using the ALSGBI Laparoscopic Passport model. We were able to offer the course free of charge, with kind sponsorship from Ethicon and Karl Storz who supplied the tissue, stacks and instruments.

We received excellent feedback, with trainees commenting "Great 1:2 trainer to trainee ratio, great facilitation;" "Relaxed atmosphere, lots of consultant support;" "Excellent supervisions, animal models, equipment."

Miss Sabrina Rossi
Cambridge Academic Surgical Unit

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