

ALSGBI newsletter



Association of Laparoscopic Surgeons
 of Great Britain & Ireland

President's Introduction



Welcome to the Spring edition of our Newsletter, produced by our new editor, Mr Neil Keeling. We are grateful for his hard work and I am sure that you will find much of interest. There are reports from recent meetings, training courses and fellows who have undertaken travelling fellowships. I would like to draw your attention to the article by Mr Ian Beckingham on SWORD – a new database of procedures and outcomes available to our consultant members. Please register to use the database; instructions are available on the website and there is a video presentation

explaining how the database works. I am sure all will find it useful and we welcome your feedback.

The recent ASM in Aberdeen was a great success and we thank Professor

Zyg Krukowski for his excellent organisation and memorable dinner complete with Scottish pipers. There was a fabulous training day at the Cuschieri Centre, live 3D operating from Aberdeen and excellent presentations. I would like to thank all the operators, speakers and participants. Preparations for the 2015 ASM in Southport in November are under way. A training day and live operating will again feature for the first two days. We are planning a symposium on the use of mesh in laparoscopic surgery as this is causing some controversy at present. The website will provide details of the meeting in due course.

Congratulations to Mr Peter Sedman who has been elected President Elect and to Mr Paul Leeder who takes over as Director of Education. Mr Nader Francis, Mr Ahmad Nassar and Mr Nick Davies have been elected to represent South & West, Scotland and Oxford & Wessex respectively on Council. Our thanks go to the outgoing representatives, Professor Zyg Krukowski (Scotland) and Mr Charles Ranaboldo (Oxford & Wessex).

Mr Mark N Vipond
 President

Editor's Introduction

It is a great pleasure to introduce this Spring Newsletter of the ALSGBI, my first as Editor, and I would like to congratulate Mr Shaun Preston on the high standard of previous editions. I am most grateful to the contributors for their timely reports and hope that it helps bring everyone up to date with what has been happening.

This follows the excellent Annual Scientific Meeting in Aberdeen themed on re-do surgery, more on the meeting in this issue, the session in the wetlab in Dundee was hailed as a great success, reports from those involved are in this issue. Importantly the meeting featured use of the new app to allow the programme and events to be accessed easily from 'phones and tablets without bulky paper programmes I am sure that this will develop further. The live links worked beautifully with Olympus and Storz both providing excellent 3-D images for the audience.

I would like to bring to your attention the website (www.alsgbi.org)

that Mr David Mahon has been developing which has links to a number of cases that have been edited for reference. This is a resource that I think will become invaluable as it expands.

I hope you enjoy the newsletter and if you have articles of interest and relevance that you would like to submit to the Association please contact me via the office at jtreglohan@alsgbi.org

Mr Neil Keeling
 Newsletter Editor



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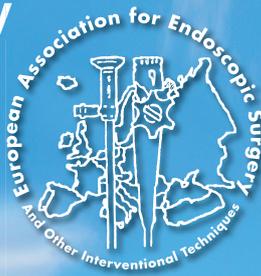
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Northern and Yorkshire Regional Report

13 June 2014, Darlington

There was a Northern and Yorkshire Regional Meeting of the ALSGBI held on Friday 13 June 2014 at the King's Head Hotel in Darlington.

The choice of venue was identified for ease of access for delegates from both regions. Following registration and a welcome by myself, morning sessions started with an industry update presentation from Karl Storz showing the exciting new possibilities of using multi-modal indo-cyanine green (ICG) and the use of a fluorescent laparoscope where the potential uses would be in General Surgery.

This was followed up by a session on up-dates on the laparoscopic practice of Urological surgery which was presented by Mr Joe Cresswell from Middlebrough, Colorectal surgery delivered by Mr Suhail Anwar from Huddersfield, Bariatric surgery delivered by Mr Andrew Mitchell from Darlington, UGI surgery delivered by Mr Simon Dexter from Leeds and Emergency surgery delivered by Mr Mike Pellen from Hull. All stimulated lively discussion and debate with excellent high quality DVD's presented to the audience.

Mr Liam Horgan from Northumbria presented the experience of developing laparoscopic surgery in Tanzania and the links that Northumbria have with the Kilimanjaro Christian Medical Centre. Liam described setting up the laparoscopic unit and the experience of tele-mentoring his African friends and colleagues 5000 miles away. This resulted in the team being awarded the prestigious BMJ Surgical Team of the year 2014.

Industry updates then followed by our friends at Ethicon and also Mr Alistair Reid, one of the ST's in the Northern deanery, discussed training in the region. Surgical trainees in the North-East have access to fantastic cadaveric facilities base at Northern Surgical Training Centre (NSTC) within the Freeman Hospital. A structured skills training programme from CT to senior ST exist that is well received by our trainees.

Following a buffet lunch, Mr Andrew Gilliam from Darlington chaired the trainee oral presentations that covered the spectrum of laparoscopic surgery.

Mr Sadiq Bawa from Northumbria delivered a talk on laparoscopic general surgery, focusing mainly on different hernia surgical techniques.

Mr Simon Dexter from Leeds facilitated the DVD presentations, again of an extremely high standard.

The day finished at 1700 hrs with feed-back and discussion of what shape this meeting should take in the future.

A prize was awarded to Mr Yazan Khalid, currently an ST in the Yorkshire region for his paper entitled "A case matched comparative study of laparoscopic versus open distal pancreatectomy".

An enjoyable day was followed by a social dinner.

I would like to take this opportunity to thank Ethicon Endo-Surgery, Olympus, Covidien and Karl Storz for their generous sponsorship to allow the event to happen. I would like to specifically thank Mr Andy Gilliam for his support and assistance in organising the day.

There were around 40 trainees and Consultant Surgeons alike for the majority of the day and what I learnt is that there is a need and desire to celebrate all that is good laparoscopically within both regions, and to network. I look forward to the next meeting.

Mr Sean Woodcock

Northern and Yorkshire Regional Representative



SURGEONS IN TRAINING

ALS^GBI

Association of Laparoscopic Surgeons
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ALSGBI Annual Scientific Meeting

27–28 November 2014, Aberdeen

The ALSGBI Annual Scientific Meeting is well recognised nationally as the premier live broadcast event in the annual surgical calendar. The 2014 meeting in Aberdeen was no exception with a wide range of reoperative surgery carried out by experts in the field. To top this event there was a pre-congress trainees' day with a difference. I will come on to this shortly, but as Professor Zyg Krukowski stated in his programme notes, "the majority of ALSGBI members who have never ventured further north than Glasgow and Edinburgh, or indeed in some cases Watford, Scotland's third city must seem as remote and attractive as Mondor." Well, considering this fact, there was a reasonable attendance and the venue and organisation were excellent.

The pre-congress trainees' workshop had a major difference this year in that the delegates were given the opportunity to train on cadavers. Mr Peter Sedman organised a truly outstanding day in the Cushieri Skills Centre, Dundee. The trainees were thoughtfully and appropriately divided up into several groups and Mr Ken Campbell and his team from Dundee provided an exceptional series of laparoscopic training models as well as an opportunity to perform cadaveric surgery for both upper and lower GI pathology. The latter gave unrivalled technical training opportunities not usually available. The models devised for laparoscopic parastomal hernia repair and laparoscopic rectopexy were innovative and effective. This training day is invaluable and thanks should go not only to Mr Peter Sedman, Mr Ken Campbell and his team, but also to the two main sponsors, Ethicon and Karl Storz.

Back in Aberdeen the meeting was opened by the President of the Association with some words of thanks and his accustomed wisdom. The menu of live surgery was both varied and complex, which gave the audience much to think about as they watched the surgery in spectacular 3D. The morning's operating included a bariatric case and completion proctectomy. This was followed by a very difficult common bile duct exploration and by incisional and inguinal hernia repairs. The day was "wrapped up" by a fundoplication. The operations demonstrated and showcased the challenges and strategies for dealing with the same. There was reasonable audience interaction and the technical tips that were picked up were invaluable. The format of having two operations simultaneously has both advantages and disadvantages. I do think that the format worked well overall and once again great credit must be given to the hosts at Aberdeen Royal Infirmary as well as Karl Storz and Olympus for collaborating to support this technically challenging part of the meeting. In addition the live operating was interspersed by a two-part DVD presentation of a laparoscopic Whipple's procedure by the surgical giant from Coimbatore, India, Professor Chinnusamy Palanivelu. This was a tour de force and hugely enlightening for the audience not just through the demonstrated but also by the anatomical demonstration during dissection and Professor Palanivelu's commentary.

The delegates were lavished with Scottish hospitality at Trinity Hall first as guests of the Aberdeen City Council for a drinks reception and then dinner. The guests were welcomed to the historic venue by The Deputy Provost, Councillor John Reynolds and after a hearty meal there was an entertaining speech by Mr Doug Duthie and traditional music from the Bucksburn and District Pipe Band.

This set everyone up nicely for the academic discussions on Friday.

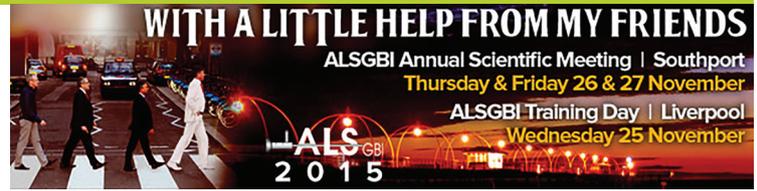
Industry presentations have become a regular and interesting part of the meeting. The DVD session was stimulating as always and there were new tricks to be learnt by all. The erudite Professor Heine van der Walt gave an excellent account of the management of failed anti-reflux surgery and after the free papers Professor Brice Gayet showed us what is possible in the field of intra-gastric surgery. The free papers demonstrated the strength of academic activity amongst the next generation of surgeons and reinforced the ALSGBI's commitment to supporting young surgeons in the field of laparoscopic surgery.

The meeting was a success and great credit to Professor Zyg Krukowski, his team and also to Mrs Sarah Williams and to Mrs Jenny Treglohan for their unending pursuit of excellence in these meetings.

Mr Tan Arulampalam

North Thames Regional Representative





Just back from another successful ALSGBI Annual Scientific meeting. It was the first time we had been to Scotland and what a lovely place Aberdeen is. Unfortunately the weather was as predicted (raining!) but this did not detract from the venue. The AECG was a very suitable conference venue and the staff couldn't have been more helpful, as was everyone we came across. Unfortunately it has been a difficult time for theatre practitioners, what with lack of staff and funding, so we did not have as many ALTS members as we would have hoped. Thankfully SIGH (Surgical Instrument Group Holdings) had been very generous once again with the provision of bursaries.

Professor Zyg Krukowski had put together a very comprehensive selection of re-do laparoscopic surgeries which were challenging for the surgeons operating on the day and the audience found very useful. It was a very interactive day and everyone learnt something new.

The Conference Dinner in the evening was held at Trinity Hall in Aberdeen and what a very impressive place it proved to be. Once again the staff were lovely and the dinner was excellent. We were thoroughly entertained by the after-dinner speaker Mr Doug Duthie, a former Aberdeen police inspector and Chair of Aberdeen College.

The evening was rounded off by the Bucksburn & District Pipe Band. We then boarded the coaches back to the venue hotel where we congregated in the hotel 'reception' and put the world to rights until the "wee" hours of the morning!

Friday dawned bright and far too early! The ALTS day kicked off with an excellent talk from Mr Keith Rowland from Cook Medical which told us everything you ever wanted to know about Biological Hernia mesh.

We then joined the main meeting for an excellent and very impressive talk from Professor Heine van der Walt about the management of failed anti reflux surgery, he has performed around 5,000 surgeries - absolutely amazing!

After coffee we went to the Ethicon stand and had some in-service training on some of their new products. As we were a relatively small group the Ethicon reps were able to address all our needs. This was the first time we had done this and we all felt that it worked very well.

We joined the main meeting once again for another stunning talk about laparoscopic TME this time delivered by Professor Brice Gayet from Paris.

After lunch we had another very interactive session with Jane Bentley from SIGH, again it was an opportunity to ask questions and have a group discussion about various issues which are common to us all. That is one of the great benefits of getting everyone together; we find out that no matter where we work, we all have very similar issues, it is a great forum to discover how others solved a problem.

Once again we joined the main meeting (everyone was kept on their toes!) for another excellent talk from Professor Gayet. We stayed with the main meeting until 15.50 to listen to the Travelling Scholarship presentations and the ALSGBI Awards Ceremony.

We then gathered our suitcases for the long trip home but it had all been worth it and I am looking forward to next year in Southport already: see you there!

Jane P Bradley Hendricks
ALTS Chairperson

Report on the Laparoscopic Training Bursary supported by Stryker-Intermediate Skills in Laparoscopic Surgery Course

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I was thrilled to finally be attending the Intermediate Laparoscopic Skills Course as I'd been trying to fit it in for 2 years after thoroughly enjoying the Core Laparoscopic Skills Course as a CT1. The 2 day course is only held twice a year in the clinical skills unit at the Royal College of Surgeons in London and unsurprisingly places are usually filled very quickly. It focuses heavily on laparoscopic suturing and as pointed out by the course convenor the name can be a little misleading as it is actually the most advanced course in general laparoscopic skills run by the College.

I turned up a little bleary-eyed on the first morning as I'd driven for 4 and a half hours from Cornwall the night before, where I was working as an ST4 in Upper GI surgery. Fortunately this course is almost entirely practical so there was no time for me to drift off at the back of a lecture theatre and after a cup of coffee we were all getting stuck into the first task.

There were 5 members of the faculty and 17 participants in total, most were around the same level as me with one more senior registrar and one keen CT2. As well as attending the core laparoscopic skills course I had done some simple laparoscopic suturing fairly regularly in the final year of my SHO training but then nothing in my first 18 months as a registrar. I felt my skills had become a bit rusty and I wanted to revise the basics as well as learn some of the different methods of tying and needle manipulation I had seen my bosses using.

We started the day with simple suturing and intra- and extra-corporeal knot-tying on a simple model. We went on to do a Nissen's fundoplication simulated with animal tissue and then after lunch used the Harmonic scalpel

to perform a pyloroplasty. I found this exercise particularly useful as I'd never actually seen this procedure before! We finished the first day by attempting a laparoscopic gastro-enterostomy. By this time our shoulders were a bit sore and mine certainly wasn't my finest work, but this was something I'd never thought to attempt before so was pleased at the chance to have a go.

The next day included simulated CBD exploration & t-tube insertion, TAPP inguinal hernia repair, intracorporeal anastomosis with 2 different staplers, insertion of feeding gastrostomy and Heller's cardiomyotomy as well as short sessions on haemostasis and video demonstrations of operations. There was also an opportunity to use the 3D model simulator in the skills room. Everyone was able to appreciate what benefits this brought to laparoscopic operating, in particular when trying to visualise the angle of the needle when suturing.

The day was packed full with activities and we were kept on track by the skilled and experienced faculty who were always on hand to give pointers and encourage us to experiment with different techniques for example in knot-tying by using our non-dominant hand to suture. At the end of the day we did another gastro-enterostomy and I'd felt I'd made real progress as this exercise seemed a lot easier than it had the day before and there seemed to be far fewer gaping holes in my anastomosis!

Laparoscopic suturing is perceived by many consultants and trainees alike to be "difficult" and many have told me that they only learned it during the final few years of their registrar training or fellowships. I believe things have changed substantially in the last few years and it is now an essential skill for anyone who practices laparoscopic surgery. This course is therefore extremely useful and I believe the format of almost exclusively practical sessions and majority of models simulated with animal tissue with a heavy focus on suturing is perfect. At least one participant had virtually no experience of laparoscopic suturing prior to the course and was able to keep up and become proficient by the end. Personally I would now be confident to ask for the laparoscopic needle holders if necessary when operating alone and I would not be worried about shaming myself when operating with my consultants.

I am very grateful to the ALSGBI and Stryker for granting me a Laparoscopic Training Bursary to attend this fantastic course and hope many others are able to have this opportunity in the future.

Ms Lisa Massey
Royal Cornwall Hospital

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Report on the Laparoscopic Training Bursary supported by Stryker- Intermediate Skills in Laparoscopic Surgery Course

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Krashna Patel and Course Director Mr Peter Sedman

I would like to thank the ALSGBI for generously awarding me the Stryker Laparoscopic Skills Training Bursary which I used to attend the Intermediate Skills in Laparoscopic Surgery course held at the Royal College of Surgeons of England in London.

This two day intensive surgical course was primarily aimed at junior registrar surgical trainees with an expert consultant faculty led by Mr Peter Sedman, Consultant UGI surgeon and also the recent ALSGBI Director of Education. The principal focus of the course concentrated on enhancing laparoscopic suturing with utilisation of these techniques within various simulated general surgical procedures. Having just started my first year as



First-hand experience with the 3D laparoscopic stack

a surgical registrar at West Suffolk Hospital in Bury St Edmunds, I was keen to hone my laparoscopic intracorporeal knot tying skills during the course, particularly as my current job is in Upper Gastrointestinal surgery. My other learning objectives prior to the course included gaining confidence in

needle manipulation, laparoscopic stapling techniques and performing various laparoscopic anastomoses to further enhance my surgical proficiency as a registrar.

On the first day, after spending a short period of time practising intracorporeal simple Szabo and Surgeon's knot tying, we progressed swiftly to more technically challenging practical sessions. Course delegates were divided into pairs with their own laparoscopic simulator station. A high instructor:participant ratio ensured very effective supervision and intense feedback as we performed various laparoscopic procedures on porcine models including Nissen fundoplication, feeding gastrostomy insertion, pyloroplasty and continuous-suture gastroenterostomy. The day was supplemented with theoretical tutorials on port site placement and ultrasonic energy sources. Day two involved more intensive "hands-on" simulated sessions including transductal insertion of T-tube with subsequent choledochotomy closure, laparoscopic inguinal hernia repair (TAPP mesh repair) and side-side enteroenterostomy using both continuous suture and stapled anastomosis methods.



Minimal Invasive Surgery Lab at the Royal College

I was fortunate to have first-hand experience in using a fully set up 32 inch 3D laparoscopic imaging system to practice intracorporeal knots. After getting used to wearing the 3D glasses, it was easy to appreciate the increased depth perception especially when mounting a needle correctly for awkward angle sutures. 3D laparoscopic surgery offers a stereoscopic dimension to improve hand- eye co-ordination and reduce operating time. It is an exciting evolving technology in the world of general surgery and will certainly have a part to play in our surgical training years.

Overall, this was a fantastic well-structured surgical course for the junior surgical registrar. Emphasis was put on maximising time practising techniques on the laparoscopic simulators complemented with continual constructive individual feedback from the outstanding supervising faculty. I thoroughly enjoyed the course and feel my confidence with generic laparoscopic skills had reached a new level of competency. I greatly look forward to applying these developed techniques in the operating theatre at work. I would again like to thank the ALSGBI for giving me the opportunity to attend and also Mr Sedman and other faculty members for running a fantastic course!

Mr Krashna Patel
West Suffolk Hospital

Report of the B. Braun Aesculap Travelling Scholarship



Firstly I would like to extend my thanks to B. Braun Aesculap for enabling this Travelling Scholarship to happen. If it was not for their support, the trip would not have been possible.

To an extent, the ALSGBI Annual Scientific Meeting in 2009 was the beginning of this process as I assisted Professor Heine Van der Walt with his live operating seminar for the Tonbridge meeting. I remember the awed silence in the auditorium as he single-handedly cured the South East of England of GORD in the space of a morning.

Having developed an interest in Upper GI & laparoscopic surgery through my training, it made sense to spend some time with such an internationally renowned surgeon. My aims were to gain further exposure to re-operative hiatal surgery and advanced laparoscopic surgery, and to see how a foreign surgical practice is run.



Professor Heine Van der Walt is a remarkably talented individual, not only a very skilled surgeon, but a motorbike fanatic, mechanic and qualified computer programmer. These traits are very evident in his practice at Unitas hospital in Pretoria, South Africa. The unit that he has set up from scratch is entirely private, receiving referrals from all over South Africa and the world. He has programmed all of the computer software himself such that note taking is obsolete as every endoscopy, consultation and operation is automatically archived, letters emailed, prescriptions printed. The level of IT capability humbles that of any UK department I have worked in. The programmes are written by a clinician, so there is no unnecessary computer jargon. Every entry has a purpose, nothing is wasted.

His practice involves laparoscopic and open surgery, benign (especially reflux and bariatrics) as well as resectional. The skills he has developed in each of these are of undoubted benefit to the others. The learning curve of laparoscopic cancer resections (where an average UK surgeon may see 20-30 cases per year) could take many years to achieve, but this is accelerated rapidly by exposure to other advanced laparoscopic surgery at the hiatus or indeed bariatrics. This is especially



poignant at a time when we are pigeon-holing UGI surgeons in the UK into benign or malignant practices. The laparoscopic skills are interchangeable and indeed actively useful for both.

He employs 10 members of staff to make his practice run efficiently. Coming from the public sector in the UK it is an eye-opening experience. An average day commences with rounds at 0700, followed by a 25 patient clinic in the midst of which he performs 15-20 endoscopies. He moves between 5 clinic and endoscopy rooms. When he leaves one clinic room, the next endoscopy is lying on the bed, cannula placed ready for the procedure. There is no unnecessary administration, no red-tape just a highly efficient system geared to maximising the surgeons available time. Every afternoon he performs surgery, and an operating list typically contains 5-8 cases. These are not day case inguinal hernias however. On my first day he performed four funduplications and three re-do funduplications in an afternoon. The day after that two RY-gastric bypasses, a laparoscopic distal gastrectomy, two funduplications and a laparotomy. He has 2 theatres running in parallel and the efficiency contrast with UK theatres is stark. In a day, he covers at least the workload of 2 days of NHS time. One caveat to this is that, being private patients, he performs all of the procedures himself and therefore is not held up by training requirements. However, there is an unbelievable archive of operations, complications, international Powerpoint presentations and laparoscopic simulators to keep the trainees happy. Additionally, he never fails to find time to discuss cases and teach his four steps of laparoscopic suturing.

Theatres run until all of the cases are finished. The theatre equipment is state of the art, and very similar to that used in the advanced laparoscopic units in the UK. Each theatre has a surgical assistant, usually a local GP with an interest in surgery. The theatre sisters are "old school" nurses, the setup and discipline in the

theatre immaculate. Staff are paid by the case, everyone has an incentive to be efficient..... nobody starts looking at the clock at 4 o'clock in the afternoon wondering if the last case will be cancelled. Of course it helps that the surgeon can perform a fundoplication in less than 20 minutes and a bypass in a little over half an hour. This is partly down to individual skill, but also practice accumulated over some 12000 anti-reflux operations and 1000 bypasses. It is inconceivable that a British surgeon will ever achieve this level of experience on a schedule of one operating list per week.

Are there any downsides? Yes, a few. South Africa continues to be a relatively dangerous country to visit for the unwary tourist. It is not safe to walk around at night and security issues dictate that accommodation and travel is quite expensive. Being a private practice, there is no operating for a visiting trainee. However the opportunity to assist and watch an expert in his field comes along rarely, and in a matter of weeks I doubled my career exposure to anti-reflux surgery, especially re-operative surgery. Finally both the England cricket and rugby teams were soundly beaten by South Africa during my trip, and they didn't let me hear the end of it.



As an UGI surgical trainee at the time, I feel the trip was most useful in the latter stages of training, a means to question and refine small technical points and subtle decision making that Heine Van der Walt has honed over 25 years of experience. Whilst it would have been interesting to experience the vastly different public healthcare system, there was no time available in the busy schedule. The difference between the "have's and have not's" in South Africa remains considerable.

I would like to iterate my thanks to the ALSGBI and B. Braun Aesculap for this tremendous opportunity. I hope such fellowships will continue, and broaden the horizons of UK trainees. I am sure in coming years this will continue to benefit the Association as well as the National Health Service hugely.

Mr Andrew Davies
Winner of the B. Braun Aesculap Travelling Scholarship 2012

BOMSS Annual Scientific Meeting

22-23 January 2015, Newcastle

The 6th Annual Scientific Meeting (ASM) of BOMSS was held in the Gosforth Park Marriott Hotel on 22 and 23 January. It has become an increasingly popular meeting with a year on year increase in delegates. The 6th ASM didn't disappoint as a record 335 delegates attended the event!

The multidisciplinary nature of bariatric surgery was reflected in both the attendees and the scientific programme. There were 2 parallel free paper sessions with surgical and AHP topics divided up, but the AHP sessions were still attended by some of the surgeons. The rest of the programme was typically inclusive and dealt with the full range of issues affecting bariatric surgery patients and the professionals involved in their care.

The first day covered such diverse topics as the 2nd NBSR report, primary care aspects of

bariatrics, the impact of the operations on diabetes and the metabolic syndrome, new technologies, sleep apnoea, Vitamin D and the psychology of obesity. The media perspective of bariatric surgery was presented by Anna Hall, documentary director of "Weight Loss Ward", which has brought our own Peter Small into the living rooms of around 6 million viewers! We were also updated on the progress of the 'ByBand' study, including confirmation of a new sleeve gastrectomy arm. We were also treated to a potpourri of DVD's, always guaranteed to produce a few wincing from the audience...

The international speaker was Professor Wei Jei Lee from Taiwan, who is very much a driving force of bariatric surgery and science in the Asia-Pacific area. His overview

of predictive factors of success in metabolic surgery was detailed and incisive.

Day two included a "bad day at the office" session, with some uncomfortable cases presented by surgeons and psychologists. Finally, we were given an overview and update of the impact of different gut interventions on Type 2 diabetes by Professor Francesco Rubino, who is recognised as a true pioneer in this area.

The social programme took place in the hotel and was fully attended as the evening entertainment was included within the registration. After a drinks reception and an excellent and well-lubricated meal there was no shortage of willing participants in a Ceilidh. The local organisers, Mr Sean Woodcock and Mr Peter Small, were omnipresent on the dance floor as they rightly

celebrated the success of the meeting.

The enthusiasm of industry support for the meeting was obvious and the exhibition area was busy throughout the breaks. Trainees were well represented and the quality of papers was notable, particularly in the council prize and poster sessions. The Council Prize went to Mr Andy Beamish for "Bone health in adolescents following Roux-en-Y gastric bypass". The Poster Prize went to Mr William Knight for "Management of the bariatric gallbladder. Is there a need for special treatment?"

It is clear that the BOMSS ASM is going from strength to strength, and I would suggest an early diary entry for next year's meeting in Cardiff on 28 and 29 January 2016.

Mr Simon Dexter
Honorary Secretary, ALSGBI



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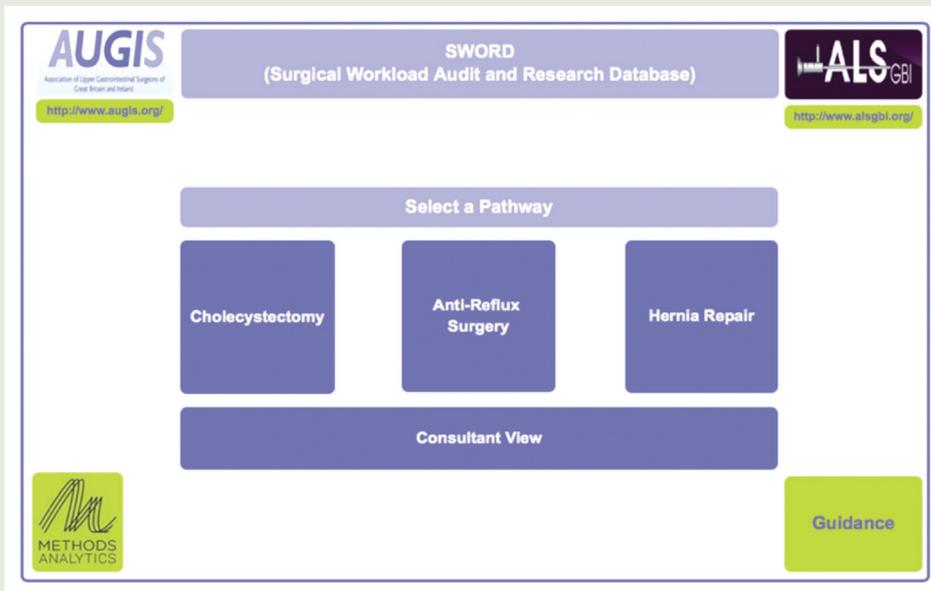
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SHARING EXPERTISE

SWORD (The Surgical Workload Outcomes Audit Database)



ALSGBI and AUGIS have been working hard for the last year to produce a robust and accurate database for our most commonly performed operations. Over the years we have seen attempts at self-reported databases but these will always be flawed by the problems of low uptake and selective reporting, meaning that they are of very limited value. In addition they have proved expensive to run and most have been discontinued.



The Surgical Workload Outcomes Audit Database (SWORD) is an internet based website which you will be able to access from the ALSGBI or AUGIS websites. It runs on HES data and identifies all NHS operations performed in England. Phase one shows data on cholecystectomy, anti-reflux surgery and hernia surgery. The data is sorted by Consultant attribution coding (ie all work performed in your name) and grouped into hospital trust and regional levels. The data on the website is updated quarterly and is only accessible to

ALSGBI and AUGIS Consultant members. It is pseudonomised (ie each Consultant has an individual code but that code will only be given to that Consultant) – you will be able to request your own ID code to identify your data, by emailing the ALSGBI / AUGIS offices.

The data allows you to see activity using a mixture of a standard dashboard data (eg re-operation rates, readmission rates, length of stay, day case rates) and data related specifically to that procedure (eg for cholecystectomy – proportion of cholecystectomies carried out within 10 days of an episode of pancreatitis or cholecystitis). You will also be able to compare yourself to your peers locally and also to the national averages. In the Consultant view you will be able to screen print summary sheets of your activity for that year for your appraisal folder.

The number of procedures available will gradually increase over the next year (there are 5 more already nearing completion) and we are exploring its applicability to Cancer operations as well.

FAQ's

1. How do I get access to the database and my pseudonomised number? Over the next few weeks you will receive an email telling you what to do. Please wait until you receive the email before contacting the ALSGBI office.
2. The numbers in my log book don't match those on the SWORD database? There are a number of possible reasons for this. Remember that the HES data collects all cases done under your name ie including those done as emergencies or electively by your registrar. The next generation of HES data will be able to identify operating surgeon as well as Consultant in charge but this field is not available yet.

3. The database shows that I have performed an operation I don't perform
This is a coding error at entry level. One thing this database will inevitably do is to engage us more with our nursing and admin staff to ensure that the correct patients and operations are attributed to the correct surgeons.
4. My operative numbers appear too low - I have performed operations that do not appear to be in the dataset
Most codes are fairly standard now but some, particularly Bariatric procedures, have been developed since the original code-books and different ways of coding those operations have arisen in different hospitals. In each operation group there is a section which shows you the codes that have been included and which excluded. SWORD will highlight what we are being coded for and give us the opportunity to talk to coders within our trusts to ensure that the correct codes are used and also therefore that the trusts receive the appropriate remuneration for the procedure.
5. I perform NHS work in a private hospital - will this be recorded? SWORD captures all NHS work performed in any setting - NHS trust, ITC or private hospitals. It does not collect any information on private patient activity whether performed in the NHS or private hospitals
6. I am concerned over the validity of HES data HES data is already collected and used by many organisations. It has become increasingly more accurate as doctors have become more involved with coding and trust re-impbursement has been linked to HES coding. The unique point about SWORD is that for the first time it allows Consultants to access the data that is being collected and stored about themselves and this in turn will allow them to influence future data collection and ensure it is more accurate.
7. Will this database be used by the public / NHS England / my trust to review my results and performance?

SWORD is password protected and individuals are only directly identifiable with their own pseudonomised code which is not given to anyone else. At the moment SWORD is only available to ALSGBI and AUGIS members, although other surgical societies may join in due course. There are no plans for this database to be shared with any other agencies at present. Any individual could request this same data on any individual surgeon or trust under the Freedom of Information Act if they wanted too, but not via SWORD.

Mr Ian Beckingham
President, AUGIS



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KARL STORZ IMAGE 1 SPIES™ Named Innovation of the Year by the Society of Laparoendoscopic Surgeons

The Society of Laparoendoscopic Surgeons (SLS), the largest society of minimally invasive or laparoscopic surgeons in North America and possibly the world, has named KARL STORZ IMAGE 1 SPIES™ as an Innovation of the Year for 2014.

KARL STORZ provides innovative imaging solutions to enhance surgeons' capabilities so they can deliver exceptional levels of patient care. The new IMAGE 1 SPIES™ system is the company's latest solution to optimise the surgeon's view of challenging anatomical areas during complex surgeries. In these days of "me too" products, this award clearly demonstrates that KARL STORZ is still very much an innovator, leading the field in imaging technology.

Combined with new FULL HD three-chip camera heads, IMAGE 1 SPIES™ includes the CLARA, CHROMA and SPECTRA modes, which activate proprietary image enhancement algorithms to provide optimum image quality.

SPIES CLARA™ ensures optimal illumination of the endoscopic image in all areas. Dark areas are brightened dynamically, with each pixel being compared to the luminance information from its surrounding environment and, where appropriate, brightened. In this way, dark areas and deeper structures can be optimally visualised.

SPIES CHROMA® enhances the colour contrast, without altering the surgeon's natural colour perception. Each pixel's environment is analysed with regard to the spatial colour changes and is emphasised accordingly. Colour changes and structures are thus represented more clearly, with the borders between different tissue types becoming easier to define. SPIES CLARA™ and SPIES CHROMA® can be utilised together to optimise image quality.

SPIES SPECTRA™ is designed to enhance certain areas of the colour spectrum with a colour shift. With this information, and using only white light from a standard endoscopic light source, it can support the surgeon in tissue differentiation: the background appears green so blood vessels and capillaries are highlighted, while the surgeon maintains a large amount of natural colour perception.

This year, KARL STORZ IMAGE 1 SPIES™ will evolve with additional camera heads, 3D FULL HD technology, more developments in spectral imaging and completely new technologies, all based on its modular design, which provides a sustainable and future-proof platform.

Written and distributed by: KARL STORZ Endoscopy Ltd
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ALSGBI Industry Partners' Course Information



Karl Storz Endoscopy (UK) Ltd

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.

18 – 20 May	ICENI Centre, Colchester
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 C04 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

28 April	Queen's Medical Centre, Nottingham
21 May	WIMAT, Cardiff
15 September	WIMAT, Cardiff
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.

Dan Danby, Course Administrator, KARL STORZ Endoscopy (UK) Ltd,
E: ddanby@karlstorz-uk.com | T: +44 (0)1753 503500 | F: +44 (0)1753 578124
415 Perth Avenue, Slough, Berkshire SL1 4TQ

Arthrex mobile cadaveric training labs



Arthrex is a Global leader in the orthopaedic and sports injury market, recognised for the innovation, technology and excellence of its products as well as the service, support and training we provide to our customers.

As many delegates will have seen at the ALSGBI Scientific meeting in November, Arthrex has launched its Synergy 4K camera, the first Ultra High Definition (UHD) 4K camera into the surgical

market. With four times the resolution of current HD cameras, the Synergy 4K camera enables surgeons to see tissue structures and anatomy in incredible detail, not previously seen before.

From the introduction of our first camera system, Synergy HD3 and now Synergy 4K, Arthrex has placed itself at the forefront of innovation and technology. Unlike current hardware systems currently available, our systems are software

driven and integrated into one box containing a LED light source with over a 30,000 hour expected lifespan, a data capture unit with USB outputs and the camera unit to which our fully autoclavable cameras with their 7 year autoclave warranty are attached. All of this is controlled by a fixed tablet with easy to use and intuitive interfaces.

In addition to this, each camera stack can stream password

protected video locally into the theatre to tablets and smart phones and through the hospital network to support training and education etc. Each system is also able to connect directly into the hospital PACS system so that images and data can be sent directly to the patients notes.

Whilst being a leader in camera imaging systems we are also pioneering new and innovative ways to help surgeons train. We are unique in Europe in having three mobile cadaveric training labs that travel to hospitals and congresses etc to support training and enhancing skills. In addition to this, Arthrex has invested in a new 40 bay cadaveric training facility in Munich, each equipped with our market leading visualisation technology.

Whilst having a global leader in orthopaedics at a General Surgery meeting might have surprised you, we were pleased that our fresh approach to providing market leading imaging technology and training facilities met with such approval.

Arthrex is pleased to be an industry partner with the ALSGBI as we expand and develop our commitment to supporting excellence and the best possible outcomes for patients across all surgical disciplines.

PINPOINT Endoscopic Fluorescence Imaging Brighter than any other



PINPOINT Endoscopic Fluorescence Imaging provides illumination beyond the limits of the human eye, confidently visualising and assessing tissue perfusion in real-time and improving patient outcomes.

In combination with high-definition white-light video, fluorescence imaging provides the ability to visualise blood flow in vessels, tissues and organs throughout the body.

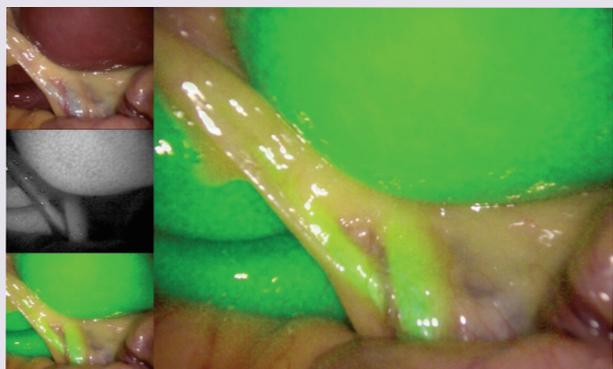
- **SIMULTANEOUS IMAGING** Fluorescence and white light
- **HIGH DEFINITION IMAGING** Superior resolution (1080p full HD)
- **ONE BUTTON TRANSITION** Superb usability

PINPOINT offers brilliant, high-definition, white-light video with the added advantage of SPY Fluorescence imaging technology, which has been demonstrated as beneficial in a variety of surgical applications, including:



Reducing Anastomotic Leak Rate Colon Resection

PINPOINT assesses tissue perfusion and assists surgeons in making informed decisions which positively affect outcomes. Studies show that only 1.4% of lower anterior resections resulted in an anastomotic leak rate when PINPOINT was used (reduced from 12.6%).¹



Laparoscopic Cholecystectomy Avoid Common Bile Duct Injury

Identifying vital biliary anatomy, especially in difficult cases, is easier with PINPOINT. The system also enables to you confirm the integrity of the cystic duct and artery at the completion of surgery.

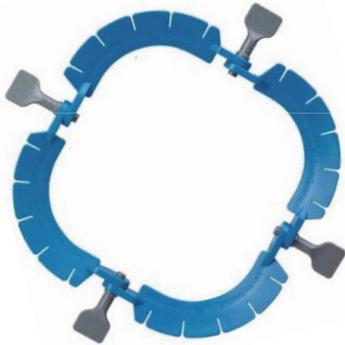


Find out more, view PINPOINT in action and download some of the clinical studies at www.elementalhealthcare.co.uk/news

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

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The SurgiQuest AirSeal® Platform

The solution for stable pneumo-rectum and better visualisation during transanal surgery.



Since the inception of Transanal surgery (TAMIS/TaTME), a transanal 'SILS' type platform has been coupled with a conventional laparoscopic insufflator. However, surgeons have repeatedly encountered two notable obstacles to attaining a good transanal, endoscopic field:

1. An excessive build-up of diathermy smoke, in an already restricted operative field.
2. Unstable pneumo-rectum causing rectal bellowing.

Constant pauses to vent smoke and clean the camera are frustrating and time consuming. An unstable surgical field hampers dissection and identification of the correct tissue planes; potentially putting pelvic side wall structures, nerve bundles and the mesorectal

package at risk of damage.

Coupled with a transanal platform, the SurgiQuest AirSeal® insufflation management system provides a highly effective solution to both of these problems.

Conventional insufflators are one-way pumps. Typically, they insufflate for 3 seconds, rest for 1 second to measure pressure, and then re-insufflate to maintain the "set" pressure. This stop/start mode of action causes cyclical pressure fluctuation and the resultant rectal bellowing. Furthermore, they provide no mechanism for outflow of gas, the only way that smoke can be evacuated is by venting or the actual removal of the transanal platform.

Uniquely, AirSeal® creates a recirculatory flow of gas, smoke is

automatically extracted from the surgical field and clean gas (filtered to 0.01microns) is returned. Because the AirSeal® System recirculates CO2 rather than continually adding fresh, cold gas there is a tendency to assimilate patients' pelvic (or abdominal) ambient temperature and moisture resulting in significantly less fogging of the camera view.

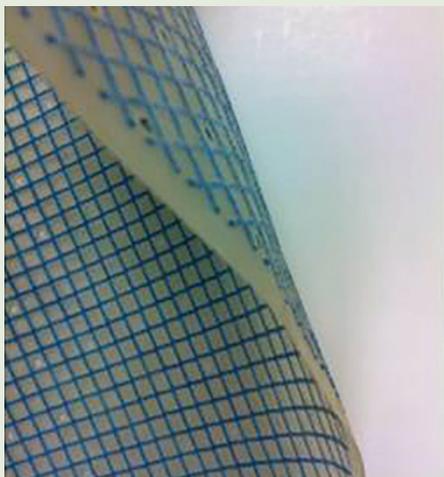
AirSeal's® constant circular flow rate eliminates the bellowing effect in the rectum. The system responds immediately to the slightest changes in the set pressure by automatically adjusting flow rate in real time. This action eliminates loss of pneumo-rectum or pneumoperitoneum as the case may be.

Leaders in this field of surgery feel that the adoption of AirSeal®

results in significant time savings by minimising these potentially hazardous distractions, allowing them to focus on the important aspects of surgical dissection.

Of course, the AirSeal® System is not new to surgery, having been successfully studied and used to great effect in intra-abdominal applications. The benefits of automatic smoke evacuation, stable pneumoperitoneum (even under constant suction/aspiration, leakage, or trocar dislodgement) are clearly apparent to all laparoscopic surgeons. The reduced oscillation of pressure and the facility to operate at lower pressures have been shown to significantly reduce CO2 gas absorption by the patient with resultant benefits.

Zenapro: a hybrid synthetic mesh/ biologic graft for laparoscopic incisional hernia repair



Mesher have evolved considerably over the last 50 years, now a confusing number are available with differing composition, weight and price. It is clear that there is no single ideal mesh for every patient and every hernia procedure.

Mesher have reduced recurrence to an acceptably low level, but this is often traded off for other complications. Infection is not uncommon, increasing morbidity, readmission and overall cost. Adhesions are a risk with laparoscopic intraperitoneal placement: uncoated synthetics can cause obstruction, bowel adhesions

and fistulas. Chronic pain has been reported in up to 30% of cases. These complications can have an impact on healthcare costs.

Permanent synthetics are available in various weights and pore sizes. The inflammatory response leads to encapsulation until eventually the interstices fill with scar tissue. In addition to the complications listed above, erosions can be a problem, especially if used around the oesophagus or in the pelvic floor. Contamination is a concern as well, so permanent meshes are only selected for clean cases, or perhaps with caution in clean contaminated settings such as after enterotomy or cholecystectomy. Choi et al concluded "There is a significant increase in risk of postoperative occurrences following VHRs using mesh in clean-contaminated and contaminated cases relative to clean cases. We recommend avoiding the use of mesh in any level of contamination." *Ann Surg* 2012;255:176-180

Uncoated heavyweight meshes may reduce recurrence and form a strong adherence to the abdominal wall, but often dense adhesions to the viscera. Composite or barrier coated synthetics have been introduced to minimise these.

Bioabsorbable or biosynthetic meshes provide a matrix for tissue ingrowth and are then absorbed. The structure can be controlled to extend the absorption time to give a longer term temporary support.

Biologic grafts, derived from an extracellular matrix, for example porcine dermis or small intestine submucosa, are scaffolds for tissue remodelling. Ideally they should form a permanent repair without leaving a permanent foreign body, reducing the risk of inflammation and infection. They are mainly used in complex hernias where there is concern about erosion or infection. Dermal products can stretch, so some of these are chemically cross-linked, but this prevents them from becoming fully incorporated or remodelled. However, biologic grafts are more expensive than synthetic mesh, and should not be used as a bridge.

Zenapro is a unique hybrid of synthetic mesh and biologic graft, indicated for clean and clean-contaminated environments, and can be placed as an IPOM. An ultra-lightweight large pore polypropylene mesh is embedded in layers of small intestine submucosa, protecting the viscera from the polypropylene and remodelling to incorporate the mesh. Leaving behind a minimal amount of foreign body, it maintains a density equivalent to a heavyweight mesh.

Because bridging is possible, Zenapro is particularly suited to laparoscopic ventral hernia repairs, although it can also be used in open procedures, placed in onlay, underlay, or sublay tissue planes.

<https://zenapro.cookmedical.com/>

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1. Comparing mean number of insertions for 5mm trocars out of 10 insertions with a quality index score of 50 or higher for 2824 (64 insertions) to COOK/MEDICAL/1923/CF204/CF10 (53 insertions), NBS17V930006 (64 insertions) in benchtop tests, P<0.05. Data on file Study PRC04910. Comparing mean number of insertions for 12mm trocars out of 15 insertions with a quality index score of 50 or higher for 26123 (166 insertions) to CCF2/CO29/CFB3/CF7/ACF873/CO47 (04 insertions), NBS21V930102P (16 insertions) in benchtop tests, P<0.05. Data on file Study PRC05628. Quality index score of 50 or higher indicates a less than 20% chance of having to rewipe the endoscope lens due to trocar induced smudging. ISL 12135

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