ASSOCIATION OF LAPAROSCOPIC SURGEONS

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Autumn 2020 ALSGBI newsletter

President's Introduction

Hello readers. Welcome to the Autumn issue of the ALSGBI newsletter. It has been a strange and difficult 7 months for everyone. It will continue to be so for some time yet. The newsletter is normally full of reports from the year's earlier meetings and courses but this year there have been very few. We do have reports from pre-lockdown meetings but all the Associations' Annual Meetings this year have been cancelled or converted to meetings held via on-line platforms. Training has been particularly severely hit with all face-to-face and hands-on courses cancelled. Webinars and Zoom/Teams meetings have proliferated in an attempt to keep a level of training in place but I think we would all agree that virtual events are not a truly comparable replacement for the real thing. With this in mind the ALSGBI has worked extremely hard to try and do our best to provide an Annual Scientific Meeting that will be as close to 'the real thing' as possible. I have been very impressed by the programme developed by our vASM organisers. Congratulations to them all. Details of the vASM programme are presented in this newsletter. Spread over 5 days there is content of interest to all minimal access surgeons and trainees. We are particularly proud of our planned training days at each end of our week's symposium. These will be two of the very few face-to-face teaching events of this year with carefully constructed safety measures. At the time of writing we are hopeful that these will go ahead.

Thank you to our Industry Partners who have had as difficult a year as the rest of us. Despite this they have given generous support to the Association and continue to play a vital role in our existence.

Particular thanks to B. Braun, Ethicon, Intuitive and Karl Storz for their amazing support as Platinum Partners; to Arthrex and Olympus as Gold Partners; to AMS, Boston Scientific, CMR Surgical, Kebomed, LawMed and Operating Room Systems as Silver Partners. A second thank you goes to Ethicon and Intuitive for funding of the 2 training days.

Enjoy the newsletter and if you have an urge to contribute to next year's publication please contact the ALSGBI's Jennifer Treglohan and Sarah Williams.

Mr Donald Menzies
President, ALSGBI

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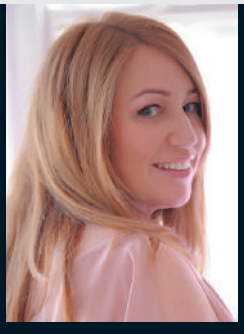

Mrs Jenny Treglohan
Executive Director
jtreglohan@alsgbi.org
Tel +44(0)20 7869 6941
Mob +44 (0)7973 232038
www.alsgbi.org

Mrs Sarah Williams
Director of Fundraising
swilliams@alsgbi.org
Tel +44(0)20 7869 6940
Mob +44 (0)7854 858714
www.alsgbi.org

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Editor's Introduction

It is six months on from our last newsletter and the world health situation is starting to feel a bit like it is repeating itself. Hopefully we will be able to cope better as we learn and understand more about SARS-CoV-2. I wrote my last introduction whilst Covid-19 pandemic was reaching its first peak, we were in lockdown, clinics were closed, theatres on emergency only and were all fumbling to become competent with Zoom and Teams formats to keep channels of communication open. Now I suspect we are all very slick and confident with these formats and many organisations have been holding their ASMs virtually on a variety of platforms.

The ALSGBI is no different and will be hosting this year's meeting online between 7-11 December. Importantly it is free to members and promises lots of stimulating presentations, talks, discussions and videos that I can thoroughly recommend.

An exciting new development is a Robotic Training day in the Griffin Institute in Harrow on Sunday 6 December as well as the Laparoscopic Surgery Training Day for trainees which is still scheduled to take place at MATTU in Guildford on Saturday 12 December.

Details of these events are inside the newsletter and I hope you enjoy reading of the good work carried out in the ALSGBI name.

The society has always placed great emphasis on training and supporting our trainees and I have been very impressed by the efforts taken by many of our senior members to maintain quality training in times where the operating training opportunities have been limited. With no current end to the pandemic in sight these efforts must be redoubled to ensure our trainees do not lose out. I hope that we continue to receive reports of fantastic experiences in world-class units from our overseas fellowship winners. Please remember that we want to hear about these and other events and feature them in forthcoming newsletters, please send them to:
Mrs Jenny Treglohan, Executive Director, jtreglohan@alsgbi.org
Mrs Sarah Williams, Director of Fundraising, swilliams@alsgbi.org

Mr Neil Keeling
Newsletter Editor

ALSGBI Annual General Meeting Agenda

Wednesday 16 December 2020 at 11:00hrs GMT

1 Apologies for Absence (Mr D Mahon)
2 Minutes of the ALSGBI AGM held on Friday 15 November 2019 at the Royal Armouries, Leeds (Mr D Menzies)
3 Honorary Secretary's Report (Mr D Mahon)
   a ASGBI International Surgical Congress, Glasgow, 5-7 May 2021
   b EAES Congress, Barcelona, Spain 7-10 July 2021
   c ALSGBI Annual Scientific Meeting, ILEC London, 6 & 7 December 2021
   d ALSGBI Laparoscopic Training Day, MATTU, The Royal Surrey County Hospital, 5 December 2021
   e ALSGBI Council and Regional Election Results
      i New Diversity and Equality Representative
      ii Irish Regional Representative
   f Travelling Scholarship Winner
4 Honorary Treasurer's Report (Professor T Arulampalam)
   a Membership Fees
5 Director of Education's Report (Mr P Leeder)
   a LapPass®
6 President's Report
7 Election of President Elect
8 Any other Business

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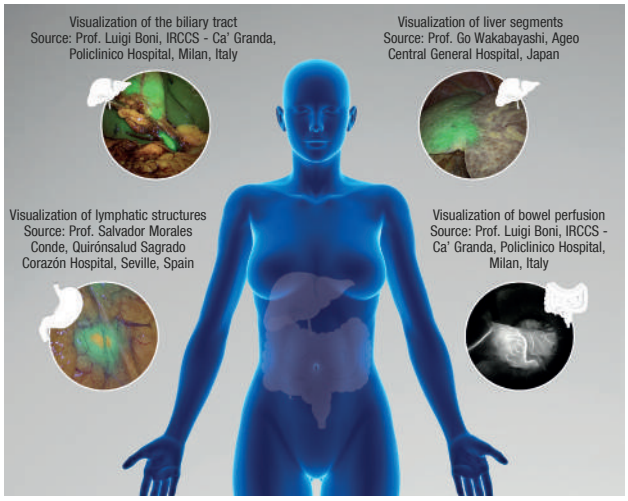
Mr. Thomas Groot-Wassink, Ipswich Hospital



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Marilyn Kennedy, Lead Nurse Manager, Theatres, QEH Hospital NHS Foundation Trust, Kings Lynn

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ALSGBI Academy Trainee Committee Report

I have the pleasure of introducing the new ALSGBI Academy, the ALSGBI trainee group.

For those that I have not had the pleasure of meeting yet, I am a ST8 in Colorectal surgery based in the North West. For the last few years, I have acted as the trainee lead of the Minimal Access Surgery North West (MASNoW), ALSGBI's regional group. I took on the role of ALSGBI trainee lead earlier this year with the aim of creating a shadow council with a focus on trainee requirements that I felt were not currently being fully met. The advantage of starting a new project was the opportunity to realise a vision to create a team that would not only increase ALSGBI's appeal to trainee members, but also assist trainees' development by acting as a reliable resource for education, research and future training opportunities.

2020 has been an odd year to say the least and its been frustrating not to be able to see friends, family and colleagues who we would normally encounter at national meetings. Educational events have come to a standstill and I empathise with those that have been unable to progress during this time. That said, innovation has allowed us to progress in the world of medicine with alternative management decisions, which may also change to become the 'gold standard'.

The use of video-conferencing has allowed us to communicate with colleagues over the globe with relative ease and I can only see this becoming an integral educational tool. Despite lockdown measures, with the use of video-conferencing, we have been able to progress with the development of this trainee committee.

We adopted the name ALSGBI Academy as we felt that it promoted inclusivity amongst the trainee community and also a sense of shaping future training opportunities. I was very impressed by the number of trainees that were keen to be involved in this project. Currently we have around 30 trainee members directly involved.

I chose to divide the group into sub teams with eight specific tasks. Each group is being led by a sub team leader with ALSGBI Council members overseeing the task.

1 **Observership & fellowship opportunities**
Steven Dixon, ST8 North West (Mersey); Neil Keeling
The aim is to create a single point database of fellowships available in the UK with contact details and a 'TripAdvisor' type review from previous fellows. So far 124 potential fellowships in colorectal, upper GI, HPB and endocrine surgery have been identified.
Subsequent development will also look at creating a resource for observerships.

2 **Identification of laparoscopic training facilities within each deanery**
Dana Sochorova, CT2 North West (Mersey); Jawad Ahmad
A questionnaire has been developed to assess facilities nationwide to subsequently develop a resource for trainees to access to identify ease of access to laparoscopic simulators and box trainers.

3 **Research/higher degree opportunities**
Ishaan Maitra, ST6 North West; Jim Khan; YKS Viswanath
The aim is rather similar to that of the fellowship group. So far 25 MD/PhD programmes have been identified.
Again, there would be a "TripAdvisor' type rating, with details including on call commitments and funding.

4 **Research collaboratives**
Tamsin Morrison ST6 East of England; Nader Francis
The group was set up to develop national research projects relating to minimal access surgery in conjunction with regional research collaborative groups.
To date we have promoted three studies: the PanSurg SSAFE study looking at the effect of COVID-19 on wellbeing of healthcare staff; the impact of COVID-19 on junior doctors; and our own study a Snapshot Audit on the Current Practice of Minimal Access Surgery during the COVID-19 pandemic.

5 **LapPass® promotion**
Michael Kelly, ST3 London; Grace Bennett CT2 North West
Chelliah Selvasekar; Paul Leeder
The team have focused on methods of increasing uptake nationally and over the last few months we have been unable to offer face to face courses. In the North West, we are hoping to proceed with our October course in Manchester and are also looking into the possibility of performing remote training and assessment.

6 **Training videos**
Satish Koli ST4 Wales; Andrew Day
There are currently two videos up on our website on making your own box trainer and LapPass® skills, which have been marketed on social media (Twitter & Facebook).
Our aim for future videos is to focus on laparoscopic procedures ranging from obtaining pneumoperitoneum to tips and tricks of resectional surgery, as well as educational presentations.

7 **Surgical podcasts**
Hannah Barrow ST3 North West (Mersey); Tan Arulampalam
We felt that there was a gap in the market regarding good quality British surgical podcasts. The group will be predominantly led by Professor Arulamapalam with input from all the trainees.
This would be divided into three main areas and will be recorded every two weeks:
- Heritage – addressing the training of consultants; litigation and racism and sexism within the workplace
- Clinical – an expert corner
- 'The surgical handover' – where trainees will discuss patients in a formal handover fashion in an educational manner.

8 **Social media**
Kunal Rajput CT2 North West (Mersey); Simon Higgs
The ALSGBI website has a dedicated trainee section with all of the above areas and we are promoting our content through our social media channels (YouTube, Facebook & Twitter)

I'd like to thank all the members of the ALSGBI Academy and congratulate them on the extensive work that they have carried out during a particularly challenging time, however I'm very excited about the future of the group.

Mr Rikesh Patel
ALSGBI Academy Chair

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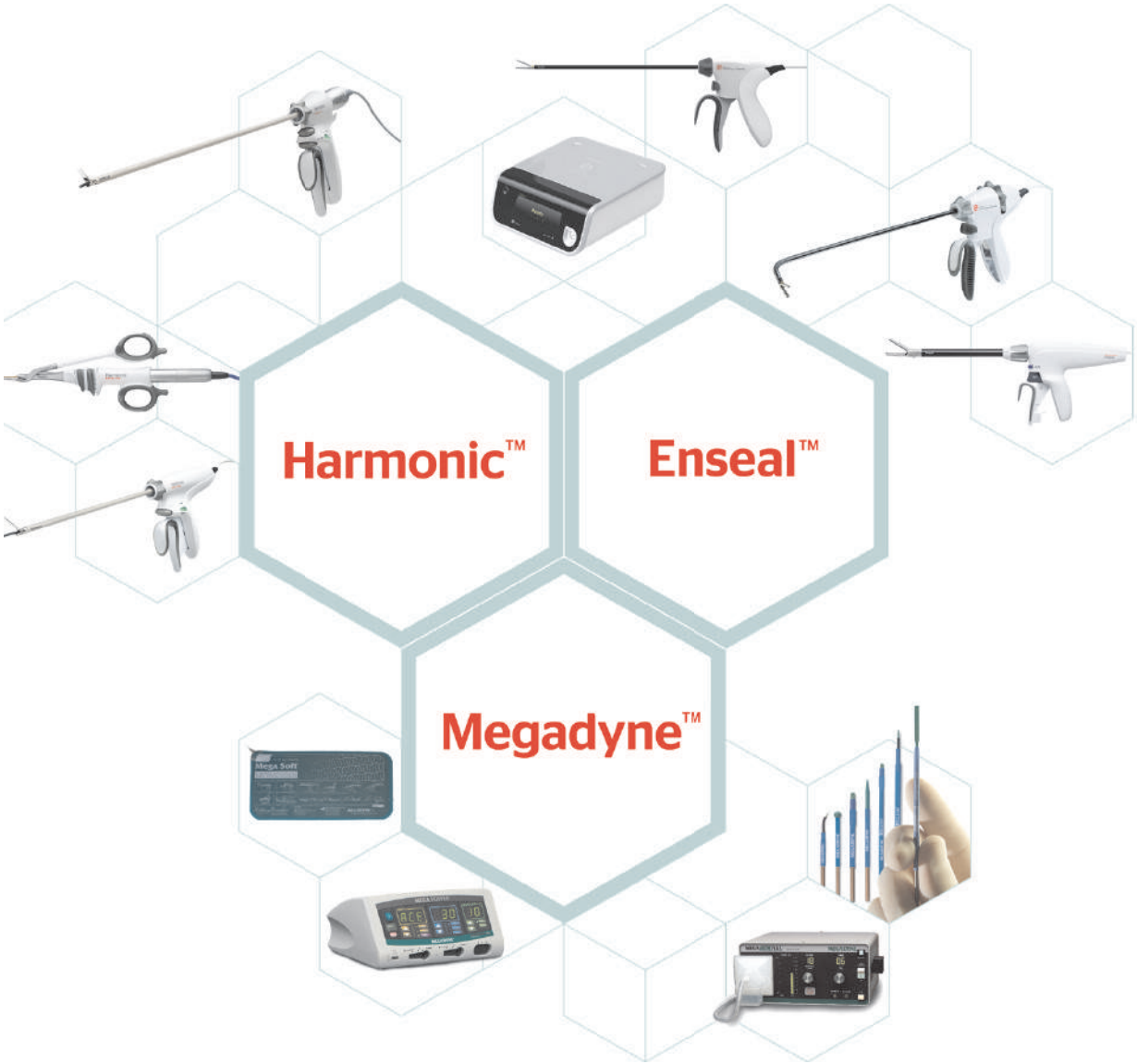

* Upon review of product catalogs and websites (Advanced Energy, Core Energy, Surgical Smoke Evacuation) for the respective manufacturers: Medtronic, Olympus, Intuitive Surgical, Conmed. Ethicon (2017). C2598 (088146-180227).

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Surgery in the Covid-19 World – a very personal view

It is curious that for centuries surgeons have practised their craft in the presence of serious life-threatening illness with varying degrees of regard for their own personal welfare, from the Bubonic plague era, tuberculosis, pre-antibiotic bacterial sepsis, HIV/AIDS and now Covid-19.

What has caused the latter to be so different from these other conditions? To be infected by any of these carried a major risk of life threatening illness or even death. There remain many other conditions that affect medical practitioners in hot spots in certain countries, there have been many instances where a mother unknowingly infected with Ebola will undergo an emergency caesarean section and 2 weeks later the entire theatre team is dead. Is it because that it is a sinister relative of a well known, but not feared, version of our every day cold virus? Is it because we know so little about it? Is it because a global pandemic of a not totally dissimilar viral pathogen killed 50 million people having infected 500 million world wide within the collective memory of the present population?

As I type this there have been 35 million documented cases and over 1million deaths in less than a 10 month period at a time in our history where medicine has been in ascendancy. A pathogen that cannot be seen, will not trouble the immune system of around 75% through whom it passes but can kill in predictable and unpredictable ways in equal measure.

Undoubtedly the modern world, with instant communication and dissemination of news across the world which can take milliseconds spreads fear and concern to the general public.

When Covid first struck in the UK it seemed that doctors were very vulnerable, particularly those who were older and from black and ethnic minority backgrounds. Who can forget the first was Mr Amged El-Hawrani an ENT surgeon from Derby who died on 28 March he was 55 years old and the first of many.

Less than a week later one of my colleagues in an adjacent office to mine popped his head round the door and said he was feeling a bit off colour and was heading home. He was on the respiratory ward with fatigue and breathlessness on IV antibiotics within a few days whilst another recently retired colleague had just been put on a ventilator. Meanwhile the news continued to flash up ever increasing numbers of hospitalisations, ITU admissions and deaths, seemingly seeking to find younger and healthier examples of victims. In our department we were puzzled as to where the virus had come from, none of our 'suspect' patients had tested positive and we had been socially distancing carefully, using our initially somewhat primitive and patchy supply of PPE as we saw fit. In fact we had been preparing for these eventualities for what seemed like weeks. Elective operating had stopped, face to face clinics halted, any patients that could go home (or to their nursing home….) were packed on their way to keep them safe and to make space for the deluge for the dead and dying. A temporary mortuary was set up in the consultant's car park, of all places, in grim preparation for what was to come.

It was 5 days after my colleague had gone home that I too felt a little off. I had a sore throat and runny nose and my old sports injuries started to ache. Hmm, can't be Covid as I don't have a cough, don't have a temperature and can still taste and smell normally. Hopefully not 'flu, as I had actually given in to pressure and had my first ever (Tetravalent - no less) flu jab at the beginning of the season. Like many I tried to organise a test for the next morning, just in case. Sorry no tests unless you are admitted or the relative of someone else known to be isolating. Ok, carry on with phone clinics and normal life as one can during lockdown. Three days later something not right, mild abdominal colic loose stools and the odd palpitation and a twinge in my lower left chest. Still can't be Covid as I still don't have a cough, breathlessness, temperature and I can still smell the new fruit growing on our lemon tree, must be ok?

Whether it was having completed two more telephone clinics that made me somewhat grumpy, but when our chief exec. was doing his usual wander round on this occasion chatting to one of our excellent new consultant colleagues, they found me in a frowsy disposition. Despatched to our Rapid Assessment area within 2 hours I had a physical exam, CXR, ECG, bloods, gases and the delightful double swabs. I was advised that everything was normal except for some crackles in my chest (simple chest infection, surely?) and to go home and self-isolate and wait for the results with strict caveat to call if unwell. Mean-time the pm is still in hospital and in Thomas's ITU and he is also 55, same age as our deceased ENT colleague. I consoled myself that BJ was a bit plump and probably not very fit (my BMI is only just under 26, that is not….oh!).

Wednesday morning comes. "Hello Neil, Ravi here." Hi Ravi! "Neil I've got your Covid swab back, it's positive, you need to self isolate for a week and the whole family for 2 weeks, ok?" Er, yes ok. "Any questions? Do you need any help?" Er, no I'm ok just got to do some organising, bye.

So began the wait for the day 8-10 crash, the septic storm, the rapid deterioration, off to hospital, then ITU - who knows? A pattern experienced by many thousands of individuals over the next few weeks many with tragic outcomes. I remained fortunate and nothing really happened. I stayed at home, popped Paracetamol (but not Aspirin or Ibuprofen – what would it do?) drank no alcohol, drank lots of water and pottered at home, each day wandering out in the garden, smelling every flower that I could, filling my lungs with as much fresh air as I could. Yes I was fortunate and privileged to be able to do this and to be able to carry on doing it. My wife, to whom I am most grateful, made me stay at home for 2 weeks, just to be sure, knowing that normally I would be out of the house back to work the instant the clock struck 'time out'!

Coming back to work was just as weird as it had been before. Differences were that the PPE supplies were much more available although from many different sources and ever changing types and suppliers (how many Fit Tests?), although all of it made in China, ironic huh?

We are now trying to cope with the huge backlog of work that has built up during the elective hiatus. More worrying is the answer as to why we are still missing large numbers of cancer patients. Those that would normally have presented during these Spring and Summer months, has cancer stopped developing? Have the patients all died of something else or are they waiting in the hundreds waiting for their diagnostic tests that were put on hold to give space to Covid care. Hundreds of CT pneumocolons, gastroscopies and colonoscopies are still outstanding.

As it transpires, in our part of the world, we were spared heavy numbers of serious cases and fatalaties, in the first wave, at least. We had only 23 ITU admissions, 2 of whom died, one being my retired cardiologist colleague. There were a number of patients that did not meet the criteria for ITU and did in fact die either at home, in the respiratory wards or their care homes. Whether this will remain the case in subsequent waves (after all 'Spanish Flu' took 4 different peaks to reap its harvest) we will have to see.

I still fear being in the situation that some of our colleagues and friends both in the UK and abroad were in during March, April and May. Those trying desperately to cope under extreme pressure with inadequate resources, combatting an unseen and changing foe, it infects easily, does not kill many people and thus ensures that it passes on and on, thriving on that most human of behaviours, social contact. Hopefully in health care we will be able to manage better now that adequate PPE is more abundant. More treatment modalities and options are now available and likely to be effective maybe as the virus becomes better understood, even if there is no silver bullet yet (sorry Mr Trump). Whether the damage to the national economy and livelihoods can sustain the healthcare costs that have been accrued remain to be seen or is Covid-19 a preparation, a dry run, a rehearsal for the next global pandemic?

Mr Neil Keeling
Consultant Surgeon (aged 56¼)

How the Pandemic can help us Tackle Other Public Health Priorities

By Hugo Breda, Managing Director, Johnson & Johnson Medical Devices companies

Throughout history, we often see that the most tumultuous periods bring with them the brightest moments of innovation. In healthcare that is certainly true. It was world wars that led to the invention of the orthopaedic splint, the widespread development of antibiotics and even played a part in the formation of the NHS itself.

As we continue to grapple with the "new normal" in a COVID-19 world, amidst the daily updates on positive cases, loss of life and the impact on economies across the globe, it can be hard to focus on positives. There is no denying the devastating ongoing impact of the pandemic, but I would urge the government and healthcare sector to take a step back to focus on the opportunities before us and certain challenges that, if we don't tackle now, will continue to place a strain on patients and our NHS for generations to come.

As the Government, NHS and industry seek to reform the way healthcare is delivered, particularly when considering the role of the newly created Institute for Health Protection, we need to look at the entire patient journey from prevention through to treatment and follow up. This must include tackling how services are delivered to vulnerable groups of patients to even out the inequalities in the healthcare system that COVID-19 has highlighted, such as age, gender, ethnicity and socioeconomic deprivation.

For me, one of the key questions now is how do we prevent, or more efficiently treat diseases that increase burden on the NHS, drive costs and put patients' lives at risk in the first place?

One of the biggest population health challenges that has been identified as paramount to the pandemic is obesity, and its implications in the severity of Coronavirus illness. I was pleased to see the recent government announcement about a range of new measures being introduced as part of its new obesity strategy; however, obesity is not a new challenge in the UK – with almost two-thirds (63%) of adults in England being overweight or living with obesity and obesity-related illnesses costing the NHS £6 billion a year.

The urgency of tackling obesity has certainly been brought to the fore by evidence of the link to an increased risk from COVID-19. I believe it is now the duty of the government, industry and healthcare practitioners to seize the opportunity this brings and drive meaningful, lasting change. We need to collaborate to identify and implement a "whole-systems approach" to successfully challenge obesity – one that looks at prevention right through to treatment, including surgical intervention.

Being one of the world's largest healthcare and medical devices companies, we also see the impact obesity puts on other services. Obesity is a gateway condition to 400 other illnesses including cardiovascular disease and type 2 diabetes and increases the risk of 14 different types of cancer. The strain it put on patients' joints means a greater demand on orthopaedic services; the increased risk of having obesity brings with it increased risk of cardiovascular disease, diabetes, stroke and cancers – all specialties adversely impacted by COVID-19 that are now grappling with huge waiting list challenges or influxes of patients with advanced stage diseases who were too afraid or unable to access treatment sooner.

At Johnson & Johnson Medical Devices we are now supporting many of these specialties with service re-design to help them tackle the backlog in the short term but also make lasting reform to be more efficient and safely treat more patients in the long run. We have developed a range of recovery packages and digital solutions based on listening to the changing needs of NHS Trusts and Sustainable Transformation Partnerships (STPs) so we can co-create value-based services and solutions together. This has enabled us to forge many new partnerships with the NHS - helping them understand and create efficiencies within their systems with the to ultimate aim of improving outcomes for their patients.

We are also collaborating to maximise best practice aligned to GIRFT (Getting it Right First Time), tailoring bespoke solutions based to a Trust's needs to introduce and streamline everything from product utilisaton and digital tools, through to theatre utilisation, patient engagement, and resource management tools that help to unlock capacity, free up resources and help the millions of patients who need treatment.

Whilst COVID-19 has undoubtedly put one of the biggest strains on services the NHS has seen, it has shown how, when truly needed, it can be agile and quickly reform, serving multiple archetypes. From our work, it is clear that empowering Trusts across the country to do things differently can create lasting, positive change.

I believe this gives the NHS its best ever chance of beating the traditional winter pressures and managing a second COVID-19 wave of hospital admissions whilst maintaining other specialty services.

But I believe these learnings also bring new opportunities to change the way we treat population health more broadly - as resources continue to be pumped into the NHS, it would be a huge waste not to capitilise on this now. As we collaborate to reform services, we must also focus resources more broadly on the prevention of disease in the first place through education and pathways, promoting healthy lifestyle choices ,and measures that will have a positive impact on prolonging life among the population as a whole.

This devastating pandemic could in fact be a watershed moment in creating the social and political motivation to reform existing services for the long term and build a system that values everyone's health equally - placing as much emphasis on the prevention of disease, just as much as treating those who are sick.

What an achievement to be able to reflect back on when we remember the early 2020s - yes, it was the era of COVID-19, but it was also the period in time that saw meaningful change in tackling some of our biggest health challenges of the 21st century.

For further information contact
ahawcrof@ITS.JNJ.com

2020 ASiT International Surgical Conference

7-8 March 2020, ICC Birmingham

ASiT 2020 International Surgical Conference was held at the ICC Birmingham between 7-8 of March and was attended by a large number of surgical trainees and trainers alongside industry partners. ALSGBI had a presence at the meeting with an exhibition stand and the facility to run the LapPass® training.

ALSGBI council members Mr David Mahon, Mr Altaf Awan and Mr Jim Khan attended the meeting and were able to interact with the trainees and provided information on LapPass® curriculum, training and assessment. There was a keen interest from the medical students, foundation doctors and core surgical trainees.

Andrew, one of the final year student said, "It's an amazing opportunity to practice laparoscopic skills under the guidance of the expert faculty". Those trainees who had exposure to robotic were very quick to compare the ergonomics of laparoscopy and robotic surgery. LapPass® is gaining increasing popularity amongst surgical trainees and being recognized as a benchmark for basic certification in laparoscopic skills. Further information on the dates and venues for taking LapPass® can be found on the ALSGBI website.

Mr Jim Khan
ALSGBI Council Member

Now in its 44th year, the Association of Surgeons in Training (ASiT) International Surgical Conference took place at the International Conference Centre (ICC) in Birmingham from the 6–8 March. We had a record number of over 1000 medical students, trainees and consultant registrations from the UK, Republic of Ireland, Europe and further afield to participate in the highlight of ASiT's annual calendar.

The conference took place in the unprecedented uncertainty of the early COVID situation. Delegate, speaker and the wider community's health and safety were prioritised. Expert professional advice was consulted and followed and clear advice was issued to delegates and speakers. Thankfully, with this guidance, and the support of the Surgical Royal Colleges, the conference proceeded with huge success.

The theme of the conference, Optimising Performance, was conceptualised by outgoing President Deirdre Nally to challenge the surgical community into constantly improving technical and non-technical performance at an individual and also team-based levels. It also highlights how our clinical teams, training schemes and health services can be developed to enhance how we function and deliver excellent patient care. As with all previous conferences, ASiT 2020 provided delegates with an opportunity to engage with a range of concepts, presentations, debates, breakout sessions and courses that were designed to optimise the delegates' ability to develop and grow as surgical leaders in healthcare.

On Friday, with industry support, we hosted 13, fully subscribed pre-conference courses. These diverse courses catered for all interests: In addition to popular courses such as Core Laparoscopic Skills Course, RCSEd NOTTS and the subspecialty courses, this year ASiT introduced new interactive courses such as the STARSurg GRANULE Course that aimed to teach students how to recruit patients into RCTs; and also the CRASH Course that empowered delegates with the ability to deal with major trauma patients and mass casualty incidents.

Talks and presentations on Saturday and Sunday addressed the burning issues in Surgical Practice, Surgical Education and Human Factors. All four Surgical Royal College Presidents attended the conference to answer questions and address the concerns of delegates. Well-renowned speakers delivered outstanding presentations. Our keynote speaker, former TEDx Speaker Professor Megan Reitz addressed 'Speaking truth to power'; 'The environmental and human footprint of surgery' was considered by Professor Bhutta and the future of robotic surgery was examined by world experts including Jim Khan and Ben Challacombe. Teamwork, human factors, trainee performance and the Improving Surgical Training Project were also addressed over the weekend.

Mentoring sessions and the ASiT Speciality village were available to delegates offering career advice and guidance on career progression. For the first time, a Surgical Escape Room was staged which was very popular and well received by the delegates. The Conference also catered to trainee and surgeon wellbeing: there was a fun run; multiple yoga sessions; a breakout session by Emma Deacon - a wellbeing company director and coach; as well as an academic consensus session designed to identify and address the factors contributing to burnout in surgery

One highpoint of the weekend was the Charity Dinner held at the beautiful Birmingham Botanical Gardens. This black tie event raised over £1500 for our chosen charity partner, AMECA – a charity that supports the delivery of sustainable healthcare initiatives in African countries. Furthermore, the night also celebrated excellent trainers: Mr Rob Coggins was awarded the ASiT Silver Scalpel Prize while Mr Christian Asher won the Silver Suture Award, both recognised for going above and beyond as trainee-trainers.

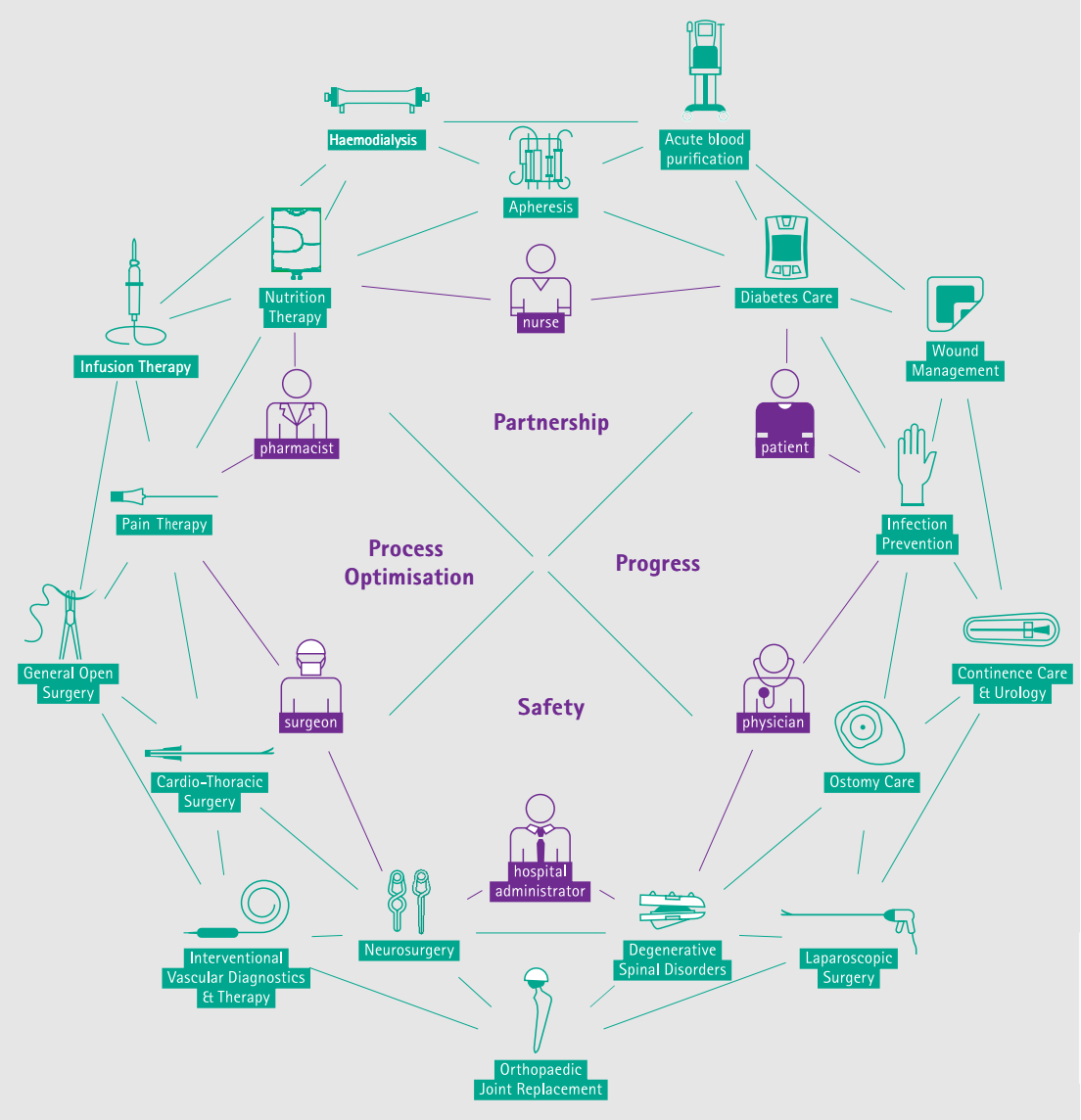
ALSGBI were represented at the ASiT 2020 Conference in the exhibition hall where trainees had the opportunity to learn and practice laparoscopic skills on high fidelity simulators and members of ALSGBI Council were present to assess and award the nationally recognised LapPass® to competent delegates. ALSGBI also kindly sponsored a prize which, this year was awarded to Bronwyn Woodburn. ASiT really appreciates our constructive collaboration with ALSGBI and look forward to working together in future to advance minimally invasive surgical techniques.

From the positive feedback, it is evident that ASiT 2020 was yet another successful conference, with high quality educational value. Incoming President Joshua Burke now takes up the reigns of this well-oiled trainee organisation to provide leadership and representation for all trainees during this challenging time.

We look forward to working with the ALSGBI Committee in the future to ensure surgical trainees receive the best quality training possible.

Miss Niroshini Rajaretnam
ASiT Vice President

B BRAUN
SHARING EXPERTISE



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THANK YOU

During these difficult times whilst we may not be able to meet in person, we continue to think about our customers needs and strive to protect and improve the health of people around the world.

Experience with Glue for Mesh Fixation in Laparoscopic and Open Abdominal Wall Hernia Repair

Controversies in Emergency and elective Hernia Surgery
International Bariatric Club (IBC) - Oxford University Hot Topics in Surgery Webinar
2 June 2020

The International Bariatric Club (www.ibcclub.org) was delighted to host Mr. Paul Wilson, Consultant Surgeon, to lecture on his experience with using glue for mesh fixation in abdominal wall hernia repair on June 2, 2020 as part of the 6th IBC Oxford Webinar.

This article is a summary of Mr Wilson's webinar presentation and has been written by Mr Matyas Fehervari, SpR in General Surgery at Imperial College London and Mr. Haris Khwaja, Director of IBC Global Education and Consultant Upper GI/Bariatric Surgeon at Chelsea and Westminster Hospital and Imperial College, London, United Kingdom.

The link to the webinar is https://youtu.be/zHSJ_xaIXCg

Mr Wilson has 5 years' experience using cyano-acrylate glue (Liquiband Fix8TM) for mesh fixation in laparoscopic hernia repair and he has recently started to use glue for open hernia repairs.

There are several complications of penetrative fixation of meshes in hernia surgery such as stapalgia, nerve or vascular injury, muscle bleeding with consequent hematoma, mesh migration and mortality due to cardiac tamponade. Several types of tacking devices are currently in use for mesh fixation. Some of these devices use absorbable tacks whilst others deploy permanent tacks but most are deeply penetrating to the tissues.

Mr Wilson presented a case of bilateral laparoscopic inguinal hernia repair which he performed with a mechanical tacking device 12 years ago. This patient developed chronic pain and bladder irritation 9 years after the surgery. Removal of the tacks 12 years after the repair led to complete resolution of the symptoms.

The international guidelines for groin hernia management published in 2018 by the Hernia Surgeons Group suggested that consideration of alternative, atraumatic mesh fixing devices such as glue may be beneficial in the reduction of postoperative chronic pain.

Mr Wilson uses the glue, Liquiband Fix8 that has a better fixation strength than traditional tackers. His experience indicates that this device is easy to use and requires minimal adaptation of technique provides a good peritoneal closure and reduces immediate postoperative pain leading to little use of analgesia. In the webinar he demonstrates the technique of peritoneal closure with this device on during a TAPP inguinal hernia repair. He recommends applying the glue to the following anatomical regions during laparoscopic TAPP inguinal hernia repair: upper boarder of peritoneal opening, pectineal ligament and pubis, inferior epigastric vessels and the floor of the hernia and suggests encircling the hernia defect. His expert opinion is that this could help to reduce the hernia recurrence. He has published a case series of 247 Laparoscopic TAPP hernia repairs (inguinal, femoral, Spigelian etc.) with the Liquiband Fix8 device in the journal Hernia in 2018 (1). In this series, the authors diagnosed 6 (2.4%) patients with groin seromas and 3 (1.2%) patients with chronic pain. They experienced port side bleeding in 2 (0.3%) cases, incisional hernia in 2 (0.3%) cases and a groin hernia recurrence in 1 (0.4%) case over a median follow up of 29 months.

Mr Wilson demonstrated the technique of intraperitoneal only mesh (IPOM) abdominal wall hernia repair using the Liquiband Fix8 using biological and composite meshes. He presents his case series of IPOM repairs using glue fixation which was published in Hernia in February 2020 (2). The outcome of this technique was evaluated in 138 hernia repairs over 40 months with a median follow up of 32 months. The authors used various meshes including polypropylene, composite and biological meshes. The outcomes demonstrated a low complication rate including a single (1%) seroma, 3 (2%) hernia recurrences and 2 (2%) patients suffering from chronic pain. Mr Wilson suggests there are several advantages of mesh glue fixation including reduced pain, hospital stay, less complicated surgical technique and low rate of adverse events and recurrence.

Mr Wilson also shares his experience with open abdominal wall hernia repair using glue fixation with both polypropylene and biological meshes. He uses the glue to obliterate the dead-space between the defect and the mesh and has used this technique for perineal hernia repairs too.

Finally, he presents a case of a 71-year female patient who developed multiple hernias following an abdomino-perineal resection for rectal cancer. This patient developed a midline, parastomal and perineal hernia simultaneously. Following preoperative Botox injection 4 weeks prior to surgery he performed a laparoscopic anterior component separation. This was followed by a midline laparotomy and adhesiolysis. The perineal hernia was repaired with a bovine mesh glued to the pelvic side walls. The parastomal and incisional hernia was fixed with biological mesh using a modified Sugarbaker technique for the parastomal hernia. Both hernias repaired with a mixed glue/suture mesh fixation technique. A follow up CT scan 9 months after the operation demonstrated intact repairs at all hernia sites without sign of recurrence.

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2. Wilson P. Laparoscopic intraperitoneal onlay mesh (IPOM) repair using n-butyl-2-cyanoacrylate (Liquiband Fix8) for mesh fixation: learning experience and short-medium term results. Hernia. 2020.

Submitted by
Mr A Slowly, AMS
For further information contact
Andrew.Slowly@admedsol.com

Wigan LapPass® and Laparoscopic Simulation Course

19 September 2020

The COVID-19 pandemic has had a significant impact on the working lives and training opportunities of junior doctors. Teaching sessions and theatre lists have been cancelled due to clinical pressures, staff absences and the need to socially distance. In an effort to mitigate against the impact on training, we developed a series of weekly laparoscopic skills sessions for foundation doctors and core surgical trainees. Eleven trainees enthusiastically signed up to the sessions scheduled on Thursday afternoons (instead of their weekly teaching). However it quickly became clear that we faced significant challenges and barriers. At the start the training was limited by having only two laparoscopic box trainers and the need to find a suitable spot in the hospital (the education centre being off limits due to COVID) in which to hold the sessions.

Without protected teaching time the trainees were frequently called away due to clinical pressures and those on night shifts, zero days or annual leave were unable to attend.

The trainees had access to the training kits and were encouraged to practise between teaching sessions but rarely managed to, being too busy on work days, unwilling to make the journey into the hospital on days off, or simply unable to set up the box trainer to practise in an already cramped doctors' office with constant interruptions. There was one notable exception: through commitment to regular practice at home Stephen achieved in only two weeks the standards required to pass the four LapPass® tasks and together we developed a new approach.

Six interested trainees were provided with a home-made laparoscopic box trainer, instruments, equipment and a webcam to set up at home. Group teaching sessions were delivered via Zoom in the evening at a time convenient for trainer and most trainees, without the stress and interruptions of the work environment and with no difficulty in observing social distancing. The quality of sessions was maintained and in many respects improved: trainees did not have to wait their turn to use the equipment, the trainer could supervise multiple trainees at one time on a single screen from the comfort of his own home, and he was not tempted to take over from the trainee to demonstrate a technique, forced instead to articulate feedback verbally. The trainees were empowered and motivated to take responsibility for their own training.

We found that the value of laparoscopic simulation training to trainees was so great that we decided to make it available further afield by developing the Wigan LapPass® and Laparoscopic Skills Course. Kindly funded by ALSGBI, free of charge to trainees in the North West region, and consisting of a one-day face-to-face component followed by a four-week distance supervised training programme, the course received twenty-four applicants for the eight places available. Taking place on Saturday 19 of September, it was the first face to face training course since the COVID outbreak.

One week prior to the course we held a Zoom meeting to introduce the participants, the course programme and the rules so that we could use the time on the day entirely for skills practice.

The course was held in the very well equipped education centre at RAEI and the morning session was focused on the four LapPass® tasks using the Inovus kits. All equipment was provided and set up in advance, and the course proceeded at a fast pace, with social distancing measures in place and a faculty of two consultant surgeons.

In the afternoon we split into two groups. One group used their newly acquired skills to perform an appendicectomy on two commercially available models. The second group went to an operating theatre reserved for the course in to be trained in using the 30° laparoscope and electrosurgical devices. Both skills are essential to the safe practice of modern laparoscopic surgery, but neither is routinely formally taught.

For the 30° laparoscope training we found inspiration from the University of Texas Southwestern Simulation Centre. Stephen very skilfully constructed a training model consisting of six shielded targets. To acquire a target successfully, the direction of the scope, its distance from the target, rotation of the camera, rotation of the light cable, and stability of the image all had to be performed with accuracy and all participants found this training model very intuitive.

We also developed a novel model for practising use of electrosurgery simulating the dissection of the mesoappendix on animal tissue, a critical step in appendicectomy which cannot be taught on commercial models. The LigaSureTM device was introduced and every participant successfully used it to dissect their "mesoappendix".

Anonymous participant feedback was excellent. All answered "agree" or "strongly agree" to each of six positive quality indicator statements, and all would "definitely" recommend the course. Common themes in the free text responses included praise for the hands-on nature of the course, the training provided in using electrosurgery, and the quality of the tuition. We passed a big "thank you" to Cheryl Dagnall, the Education Centre Manager, who attended all day on Saturday to support the course.

Participants based in the North West were provided with laparoscopic simulator kits to take home and set up using their own computers, and at the time of writing we have successfully held two remote training sessions using Zoom for further practice on LapPass® tasks.

It is our passion for surgical teaching and patient safety that motivated us to develop the course and training programme. We want to promote the ethos that one must be competent in the risk-free environment of the simulator before performing procedures in the real patient, and the popularity of and feedback on the course suggest that trainees agree. We have demonstrated that not only is there an appetite for this type of training among trainees, but also that inexpensive and readily available materials may be used to construct simple and reproducible training models, and that socially distanced training is not only possible but brings an enhanced trainee and trainer experience.

Mr Marius Paraoan
Consultant Colorectal Surgeon and Course Organiser

Dr Stephen Marsh
Foundation Year 2 Doctor and Course Co-organiser
Royal Albert Edward Infirmary
Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

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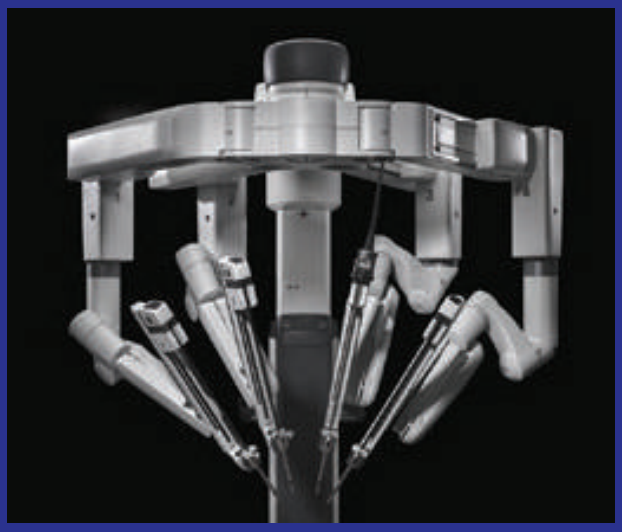

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6th Northern Laparoscopic and Robotic Video Symposium

2 October 2020

This symposium was our first virtual one, that witnessed 406 registrations worldwide. Another excellent symposium, hosted virtually via Zoom platform by the organising faculty. The venue was a conference room at Ballantyne Hotel, Darlington on 2nd October 2020. The event was kindly sponsored by industry (Ethicon and Medtronic).

The main learning objectives;

- Understand minimally invasive principles of lateral lymphadenectomy at APER
- Get an update on personalized minimal surgery and sentinel node tailored surgery for early gastric cancer
- Identify and understand salient aspects of Robotic HPB and colorectaltraining
- Foster clinical (surgical) knowledge with regards 'Robotic TME'
- Acquire an update on complications after bariatric surgery
- Learning messages from each of 9 registrar presentations

This year conveners were Mr Gopinath Bussa and MrTalvinder Gill with other MCh faculty Mr Venkat Shanmugam, Mr Anil Reddy, Mr Andrew Gilliam and Professor Viswanath YKS. The invited international/national faculty included Professor Avanish Saklani A, Mr Jawad Ahmad, Mr Jim Khan and Ms Deena Harji. The day included a series of video talks covering Robotic Colorectal Surgery, HPB, Bariatric Surgery and Minimal Access Surgery. The highlight of this years symposium was 'presentations on Robotic HPB and Colorectal surgery' training. The meeting concluded with presentations from trainees in the North East followed by prize giving.

We look forward to hosting the 7th Northern Robotic and Laparoscopic Annual video symposium in October 2021. The committee is grateful to Mr Venkat Shanmugam, as the digital lead, who drove the Zoom platform.

We thank all sponsors and faculty for their continued support.

Professor Viswanath YKS
Professor of Surgery
Mr Gopinath Bussa
Consultant Upper GI Surgeon
Mr Talvinder Gill
Consultant Colorectal Surgeon

B Braun Aesculap Travelling Scholarship

Academic Medical Centre (AMC) in Amsterdam, 17 June-30 June 2019

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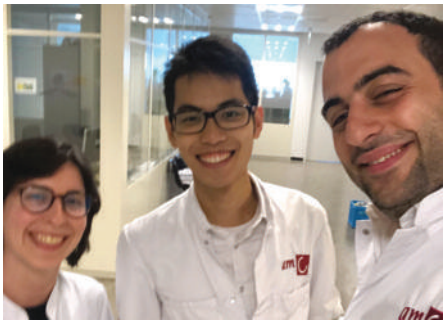
SHARING EXPERTISE



I visited the Academic Medical Centre (AMC) in Amsterdam for 2 weeks in June 2019 as part of a travelling fellowship with Professor Pieter Tanis, Professor Roel Hompes, Dr. Buskens, Dr. Van Der Bilt and Professor Willem Bemelman. The AMC is a world-renowned centre, particularly for Colorectal Surgery. It is a tertiary referral centre that receives all the complex pelvic surgery work from across the Netherlands, including pouch surgery and wider complications. In fact, they do not perform primary uncomplicated colorectal cancer or Inflammatory Bowel Disease (IBD) work. They have a very proactive team that are keen to share their expertise.

I rented an apartment halfway between the hospital and the city centre. I started my fellowship, as every day starts at AMC, with a full surgical department handover at 07:30. This included all general surgical specialities (colorectal, upper GI, HPB, breast, trauma) as well as paediatric surgery and neurosurgery. I met my fellow visitors: Maria, a resident from Portugal; Jose, a resident from Mexico; and Robin, a medical student from Hong Kong. It was a shame the handover was done in Dutch, however we got the rough gist of what was happening.

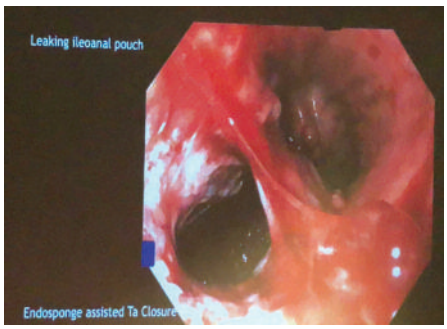
During my two weeks, I attended eight and half theatre sessions and was involved in 23 very varied cases. These included major colorectal resections for complex pathology, pouch surgery, several pelvic exenterations, omentoplasty, resection of a large local recurrence involving the iliac crest, and management of anastomotic leaks with the trans-anal approach using an Endo-sponge. I attended 2 IBD clinics, 2 colorectal cancer clinics, 2 cancer MDTs and 2 IBD MDTs. I also attended 10 handover meetings, a research meeting, a proctoring session via Proximie and an international 2-day IBD conference, which was run by the AMC team and included live surgery.

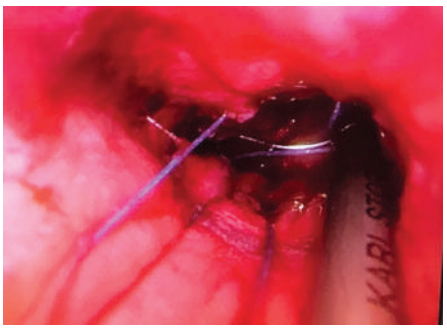
I noticed a number of differences between the practices in AMC and the North East of England where I trained. These included team structure, very large research teams, heavy use of the trans-anal approach, not defunctioning many anastomoses, managing leaks proactively via the trans-anal approach with the Endo-sponge, use of ICG to assess the omentoplasty, using ESD during endoscopic resections, routine use of suprapubic catheters peri-operatively, state of the art integrated touch-less theatres, not using CT scanning as part of routine cancer follow up, team clinics, telephone clinics and the widespread use of the white coat!

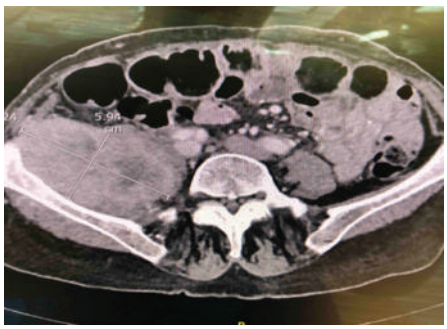
I learned a lot of valuable lessons while I was at AMC and I've already transferred some of these back to the UK, namely using a bridge in an emergency stoma and using ICG to assess the omentum. I feel that it was certainly a very exceptional educational experience that exposed me to a completely different system and structure and definitely allowed me to meet my prior objectives - and more. I made long lasting connections with everyone there and will continue to collaborate with the team at the AMC in the future. I would strongly recommend any senior colorectal trainee to visit AMC in the future.

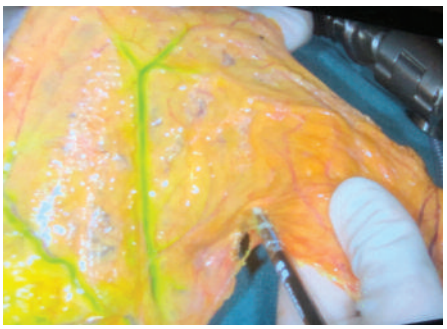
On the weekends, my wife came to visit, and we explored Amsterdam and its beauty, we also visited nearby beaches and cities, including the lovely Leiden. I had a fantastic two weeks and I would like to express my gratitude to the team at AMC, the ALSGBI and B Braun for making it possible.

Mr Fadlo Shaban, MBChB ChM FRCSEd
Winner of the B Braun Aesculap Travelling Scholarship 2019









News Item from Olympus

As we all know COVID-19 has impacted everyone's lives this year and changed the way in which we all now work and interact with each other; for us this meant that face to face training was no longer possible. With this realisation our Professional Education team knew it was important to rapidly adapt and change our training offering to ensure that we could continue to support the needs of our customers throughout the pandemic.

Blended and interactive learning has always been something our Professional Education team were keen to introduce and with the impact of COVID-19 this accelerated the need for this facility. To ensure the swift transfer over to virtual training they worked to an incredibly short timeframe to create a new completely immersive training environment that allows delegates the flexibility to train in any environment and continue to advance their clinical knowledge.

To find out more about the hub please visit www.olympus-virtualhub.co.uk.

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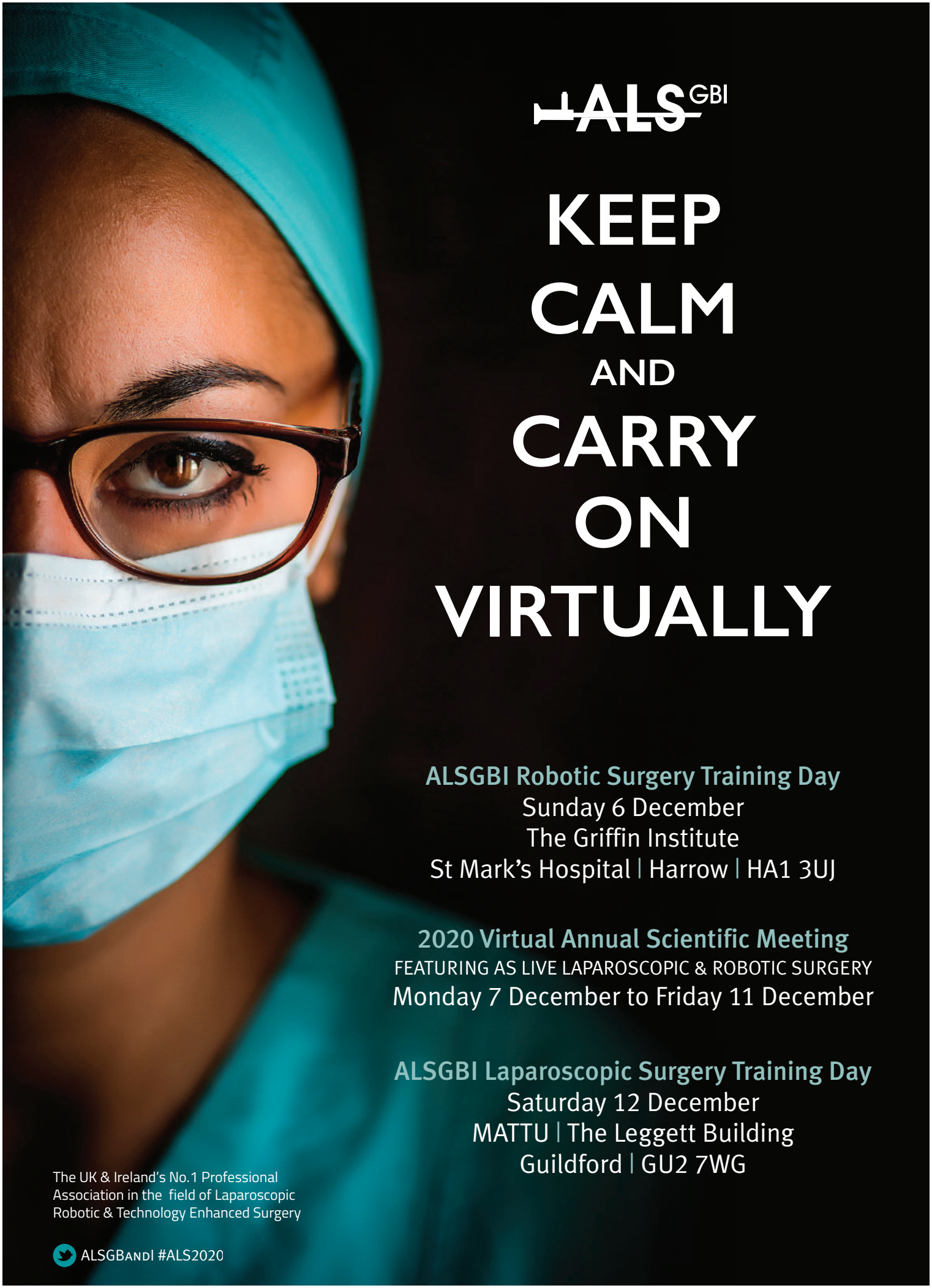
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ALSGBI Scientific Programme

Monday 7 December 2020

THE SCIENTIFIC PROGRAMME MAY BE SUBJECT TO CHANGE AT SHORT NOTICE

TIMETABLE

	TECHNOLOGY SYMPOSIUM **ALSGBI Technology Team:** Mr Jawad Ahmad (Coventry) Professor Irfan Ahmed (Aberdeen) Professor Nader Francis (Yeovil) Mr Jim Khan (Portsmouth) Mr Chelliah Selvasekar (Manchester)
16:00 – 16:05	**PRESIDENTIAL WELCOME & INTRODUCTION** Mr Donald Menzies (ALSGBI President)
16:05 – 16:10	**PLATINUM PARTNER'S PRESENTATION** **Chairman:** Mr Donald Menzies (ALSGBI President) **EXPANDING ACCESS, REDUCING TOTAL COST OF CARE: INTUITIVE INNOVATION IN A NEW ERA OF SURGERY** Mr James Westbury, Senior Marketing Manager, Intuitive INTUITIVE
16:10 – 16:30	**ROBOTIC RECTAL SURGERY & THE FUTURE** Professor David Larson, Colorectal Surgeon Mayo Clinic, Rochester, USA **Chairman:** Mr Jim Khan (Portsmouth)
16:30 – 16:40	**Q&A** **Chairman:** Mr Jim Khan (Portsmouth)
16:40 – 17:00	**ROBOTIC COLONIC SURGERY & THE FUTURE** Dr Marcos Gomez-Ruiz, Colorectal Surgeon Servicio de Cirugía General y Digestivo Hospital Universitario Marques de Valdecilla Santander, Spain **Chairman:** Mr Chelliah Selvasekar (Manchester)
17:00 – 17:10	**Q&A** **Chairman:** Professor Nader Francis (Yeovil)
17:10 – 18:10	**'AS LIVE' ROBOTIC LOW ANTERIOR RESECTION** Mr Jim Khan (Portsmouth) **Chairmen:** Professor Nader Francis (Yeovil) Mr Chelliah Selvasekar (Manchester)
18:10 – 18:24	**SWORD** (**S**urgical **W**orkload, **O**utcomes & **R**esearch **D**atabase) **UPDATE** Mr Ian Beckingham (Nottingham) **Chairman:** Mr Donald Menzies (ALSGBI President)

TIMETABLE

18:24 – 18:40	**VIDEO SESSION (2 VIDEOS)** **Chairmen:** Mr Jawad Ahmad (Coventry) Professor Nader Francis (Yeovil)
18:24 – 18:32	**VIDEO 01** MINIMALLY INVASIVE DUAL CAVITY DOUBLE CROWN TECHNIQUE FOR DIAPHRAGMATIC HERNIAS – THE 'BIRMINGHAM' TECHNIQUE **Presenter:** Miss Ellen Jerome, University Hospitals Birmingham, UK
18:32 – 18:40	**VIDEO 02** COMMON BILE DUCT EXPLORATION: A TRAINING PERSPECTIVE AND TECHNICAL ASPECTS **Presenter:** Mr Medhat Aker West Suffolk Hospital, Bury St Edmunds, UK
18:40 – 19:00	**FREE PAPERS FROM SUBMITTED ABSTRACTS (2 PAPERS)** **Chairman:** Professor Irfan Ahmed (Aberdeen)
18:40 – 18:50	**FP 01** ROBOTIC RESECTIONS FOR LOCALLY ADVANCED CANCER POST NEOADJUVANT RADIATION: SINGLE CENTRE EXPERIENCE **Presenter:** Mr Ahmed Pervez Christie NHS FT, Manchester, UK
18:50 – 19:00	**FP 02** THE IMPACT OF LAPAROSCOPY ON EMERGENCY SURGERY FOR ADHESIONAL SMALL BOWEL OBSTRUCTION: PROSPECTIVE SINGLE CENTRE COHORT STUDY **Presenter:** Mr Alexander Darbyshire Queen Alexandra Hospital, Portsmouth, UK
19:00	**PRESIDENT'S ROUND-UP OF THE DAY** Mr Donald Menzies (ALSGBI President)

Notes

FREE PAPER SESSION
Each 7 minute presentation will be followed by a 3 minute discussion.

VIDEO SESSION
Each 5 minute video will be followed by a 3 minute discussion.

TIMINGS
The scientific programme may be subject to change at short notice.

ALSGBI Scientific Programme

Tuesday 8 December 2020

THE SCIENTIFIC PROGRAMME MAY BE SUBJECT TO CHANGE AT SHORT NOTICE

TIMETABLE

	COLORECTAL SURGERY SYMPOSIUM **ALSGBI Colorectal Team:** Professor Tan Arulampalam (Colchester) Mr Andrew Day (Redhill) Mr Neil Keeling (Bury St Edmunds)
16:00 – 16:05	**PRESIDENTIAL WELCOME & INTRODUCTION** Mr Donald Menzies (ALSGBI President)
16:05 – 16:10	**PLATINUM PARTNER'S PRESENTATION** **Chairman:** Professor Tan Arulampalam (Colchester) **EFFICACY OF B. BRAUN ENDO-SPONGE® EVT IN THE MANAGEMENT OF ANASTOMOTIC LEAKS FOLLOWING LOW ANTERIOR RESECTION** Dr Dawn Cooper, Lead Medical Science Liaison, B Braun Medical Ltd
16:10 – 16:40	**LapPass® ONLINE LAPAROSCOPIC TRAINING AND FEEDBACK - WITH VOLUNTEER TRAINEE** Professor Bijendra Patel Consultant Upper GI & Laparoscopic Surgeon Barts Health NHS Trust and University College London Hospitals NHS Foundation Trust (UCLH) **Chairman:** Professor Tan Arulampalam (Colchester)
16:40 – 16:50	**SPLENIC FLEXURE MOBILISATION - MEDIAL FIRST** Mr Henry Tilney, Consultant Colorectal Surgeon Frimley Park Hospital, Camberley **Chairman:** Mr Andrew Day (Redhill)
16:50 – 17:10	**'AS LIVE' SPLENIC FLEXURE MOBILISATION MEDIAL FIRST** Mr Henry Tilney (Camberley) **Chairman:** Mr Andrew Day (Redhill)
17:10 – 17:20	**SPLENIC FLEXURE MOBILISATION - LATERAL FIRST** Mr Nick Reay-Jones, Consultant Surgeon and Coloproctologist, East and North, Herts NHS Trust Lister Hospital, Stevenage **Chairman:** Mr Neil Keeling (Bury St Edmunds)
17:20 – 17:40	**'AS LIVE' SPLENIC FLEXURE MOBILISATION LATERAL FIRST** Mr Nick Reay-Jones (Stevenage) **Chairman:** Mr Neil Keeling (Bury St Edmunds)
17:40 – 18:14	**PANEL DISCUSSION AND Q&A** Professor Tan Arulampalam (Colchester) Mr Nick Reay-Jones (Stevenage) Mr Henry Tilney (Camberley) **Chairmen:** Mr Andrew Day (Redhill) Mr Neil Keeling (Bury St Edmunds)

TIMETABLE

18:14 – 18:24	**TRAVELLING SCHOLARSHIP PRESENTATION** **Chairman:** Professor Tan Arulampalam (Colchester) **LAPAROSCOPY IN TRAUMA: A CAPE TOWN PERSPECTIVE** Mr Edward Fletcher (London)
18:24 – 18:40	**VIDEO SESSION (2 VIDEOS)** **Chairman:** Mr Neil Keeling (Bury St Edmunds)
18:24 – 18:32	**VIDEO 03** LAPAROSCOPIC APPROACH IN EMERGENCY GENERAL SURGERY MANAGEMENT OF MECHANICAL SMALL BOWEL OBSTRUCTION SECONDARY TO NECROTISING PANCREATITIS **Presenter:** Dr Javed Latif, University Hospitals of Derby and Burton, Derby, UK
18:32 – 18:40	**VIDEO 04** TIPS AND TRICKS IN LAPAROSCOPIC AND ROBOTIC SURGERY EFFECTIVE METHOD TO USE SURGICAL MATERIALS IN MINIMAL ACCESS SURGERY **Presenter:** Mr Rajesh Kochupapy (TK) Gem Hospitals, Chennai, India
18:40 – 19:00	**FREE PAPERS FROM SUBMITTED ABSTRACTS (2 PAPERS)** **Chairman:** Mr Andrew Day (Redhill)
18:40 – 18:50	**FP 03** INTRODUCTION OF LAPAROSCOPIC IVOR LEWIS ESOPHAGECTOMY AS HYBRID PROCEDURE AND COMPARISON WITH OPEN ESOPHAGECTOMY A PROPENSITY-MATCHED RETROSPECTIVE STUDY **Presenter:** Mr Antonios Spiliotis University Clinic of Saarland, Hamburg, Germany
18:50 – 19:00	**FP 04** COMPARISON OF INTRA-ABDOMINAL ABSCESS FORMATION AFTER LAPAROSCOPIC AND OPEN APPENDECTOMY FOR COMPLICATED APPENDICITIS A RETROSPECTIVE STUDY **Presenter:** Dr Francesk Mulita Department of General Surgery General University Hospital of Patras, Greece
19:00	**PRESIDENT'S ROUND-UP OF THE DAY** Mr Donald Menzies (ALSGBI President)

Notes

FREE PAPER SESSION
Each 7 minute presentation will be followed by a 3 minute discussion.

VIDEO SESSION
Each 5 minute video will be followed by a 3 minute discussion.

TIMINGS
The scientific programme may be subject to change at short notice.

ALSGBI Scientific Programme

Wednesday 9 December 2020

THE SCIENTIFIC PROGRAMME MAY BE SUBJECT TO CHANGE AT SHORT NOTICE

TIMETABLE	
	UPPER GI SURGERY **STATE OF THE ART SYMPOSIUM** **ALSGBI Upper GI Team:** Professor Irfan Ahmed (Aberdeen); Mr Altaf Awan (Derby) Mr Paul Leeder (Derby)
16:00 – 16:05	**PRESIDENTIAL WELCOME & INTRODUCTION** Mr Donald Menzies (ALSGBI President)
16:05 – 16:10	**PLATINUM PARTNER'S PRESENTATION** **Chairman:** Mr Paul Leeder (Derby) **NEW TECHNOLOGIES FROM KARL STORZ** Mr Troy Quintrell, UK Business Development Manager, Laparoscopy KARL STORZ Endoscopy (UK) Ltd
16:10 – 16:30	**LAPAROSCOPIC GASTRO-OESOPHAGEAL CANCER SURGERY SAFE, RADICAL SURGERY** Professor Mark Van Berge Henegouwen; Professor of Gastrointestinal Surgery Amsterdam University Medical Centre (UMC), Netherlands **Chairman:** Mr Paul Leeder (Derby)
16:30 – 16:40	**Q&A** **Chairman:** Mr Paul Leeder (Derby)
16:40 – 17:00	**ROBOTIC PANCREATIC SURGERY – THE NEW NORMAL** Mr Jawad Ahmad, Consultant HPB Surgeon University Hospitals of Coventry & Warwickshire **Chairman:** Mr Altaf Awan (Derby)
17:00 – 17:10	**Q&A** **Chairmen:** Professor Irfan Ahmed (Aberdeen) Mr Altaf Awan (Derby)
17:10 – 17:30	**THE PERFECT ANTIREFLUX PROCEDURE** Professor David Watson, Head of University Department of Surgery, Flinders Medical Centre Adelaide, South Australia **Chairmen:** Professor Irfan Ahmed (Aberdeen) Mr Paul Leeder (Derby)
17:30 – 17:40	**Q&A** **Chairman:** Professor Irfan Ahmed (Aberdeen)
17:40 – 18:10	**'AS LIVE' LAPAROSCOPIC BILE DUCT EXPLORATION** Mr Altaf Awan (Derby) **Chairman:** Professor Irfan Ahmed (Aberdeen)
18:10 – 18:20	**PANEL DISCUSSION & Q&A** Professor Irfan Ahmed (Aberdeen) Mr Altaf Awan (Derby); Mr Paul Leeder (Derby) **Chairman:** Mr Donald Menzies (Colchester)

TIMETABLE	
18:20 – 18:30	**TRAVELLING SCHOLARSHIP PRESENTATION** **Chairman:** Professor Irfan Ahmed (Aberdeen) **UPPER GI ROBOTIC SURGERY, UMC UTRECHT THE NETHERLANDS** Miss Christina Lo (London)
18:30 – 18:38	**VIDEO SESSION (1 VIDEO)** **Chairman:** Mr Altaf Awan (Derby)
	VIDEO 05 ENHANCED VIEW TOTAL EXTRA PERITONEAL METHOD FOR INCISIONAL HERNIA REPAIR **Presenter:** Mr Rajesh Kochupapy (TK) Gem Hospitals, Chennai, India
18:38 – 18:58	**FREE PAPERS FROM SUBMITTED ABSTRACTS (2 PAPERS)** **Chairman:** Mr Paul Leeder (Derby)
18:38 – 18:48	**FP 05** A SYSTEMATIC REVIEW AND META-ANALYSIS OF ANTERIOR VERSUS LATERAL APPROACH FOR LAPAROSCOPIC SPLENECTOMY **Presenter:** Mr Jigar Shah North Manchester Care Organisation, UK
18:48 – 18:58	**FP 06** IMPACT OF TOUPET VERSUS NISSEN FUNDOPLICATION ON DYSPHAGIA IN PATIENTS WITH GASTROESOPHAGEAL REFLUX DISEASE AND ASSOCIATED PREOPERATIVE ESOPHAGEAL DYSMOTILITY: A SYSTEMATIC REVIEW AND META-ANALYSIS **Presenter:** Mr Jigar Shah North Manchester Care Organisation, UK
18:58 – 19:00	**ANNOUNCEMENT OF THE TOP 2 POSTERS FOR PRESENTATION** **Chairman:** Mr Donald Menzies (ALSGBI President)
19:00	**PRESIDENT'S ROUND-UP OF THE DAY** Mr Donald Menzies (ALSGBI President)

Notes

FREE PAPER SESSION
Each 7 minute presentation will be followed by a 3 minute discussion.

VIDEO SESSION
Each 5 minute video will be followed by a 3 minute discussion.

TIMINGS
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ALSGBI Scientific Programme

Thursday 10 December 2020

THE SCIENTIFIC PROGRAMME MAY BE SUBJECT TO CHANGE AT SHORT NOTICE

TIMETABLE

	BARIATRIC SURGERY SYMPOSIUM **ALSGBI Bariatric Team:** Mr Marco Adamo (London) Mr Simon Dexter (Leeds); Mr Simon Higgs (Gloucester); Mr David Mahon (Taunton) Mr Colm O'Boyle (Cork)
16:00 – 16:05	**PRESIDENTIAL WELCOME & INTRODUCTION** Mr Donald Menzies (ALSGBI President)
16:05 – 16:10	**PLATINUM PARTNER'S PRESENTATION** **Chairman:** Mr Donald Menzies (ALSGBI President) **FROM SALES TO SERVICE: SUPPORTING THE NHS TO RESUME SERVICES THROUGH THE COVID-19 PANDEMIC** Mr Joseph S. Cook, Service & Solutions Lead, UK & Ireland, ETHICON
16:10 – 17:00	**'AS LIVE' MINI GASTRIC BYPASS** Mr Ahmed Ahmed (London) **Chairmen:** Mr Simon Higgs (Gloucester) Mr Colm O'Boyle (Cork)
17:00 – 17:10	**Q&A** **Chairmen:** Mr Simon Higgs (Gloucester) Mr Colm O'Boyle (Cork)
17:10 – 18:12	**SYMPOSIUM ON SLEEVE REVISION** **PANEL DISCUSSION & Q&A** Mr Shaw Somers (Portsmouth) Mr Marco Adamo (London) Mr Simon Dexter (Leeds) **Chairman:** Mr David Mahon (Taunton)
18:12 – 18:22	**TRAVELLING SCHOLARSHIP PRESENTATION** **Chairman:** Mr David Mahon (Taunton) **INTERNATIONAL COLORECTAL FELLOWSHIP 2018-2019** **MAYO CLINIC** Mr James Ansell (Cardiff)

TIMETABLE

18:22 – 18:30	**VIDEO SESSION (1 VIDEO)** **Chairmen:** Mr Simon Dexter (Leeds) Mr Simon Higgs (Gloucester)
	VIDEO 06 LAPAROSCOPIC EXCISION OF GASTRO-GASTRIC FISTULA AFTER PERFORATING ULCER IN ROUX EN Y GASTRIC BYPASS **Presenter:** Dr Alwahaj Khogeer University College Hospital, London, UK
18:30 – 18:50	**FREE PAPERS FROM SUBMITTED ABSTRACTS (2 PAPERS)** **Chairmen:** Mr Marco Adamo (London) Mr Colm O'Boyle (Cork)
18:30 – 18:40	**FP 07** STAPLE-LESS VERSUS STAPLED LAPAROSCOPIC SPLENECTOMY A PROSPECTIVE RANDOMIZED CONTROLLED STUDY **Presenter:** Mr Omar Lasheen, Pennine Acute Trust Royal Oldham Hospital, Manchester, UK
18:40 – 18:50	**FP 08** EFFECTIVE IMPLEMENTATION AND ADAPTATION OF STRUCTURED ROBOTIC COLORECTAL PROGRAMME IN A BUSY TERTIARY UNIT **Presenter:** Dr Dana Sochorova The Royal Liverpool University Hospital, UK
18:50 – 19:00	**POSTER PRESENTATIONS: THE TOP 2** **Chairmen:** Mr Simon Higgs (Gloucester) Mr David Mahon (Taunton)
19:00	**PRESIDENT'S ROUND-UP OF THE DAY** Mr Donald Menzies (ALSGBI President)

Notes

FREE PAPER SESSION
Each 7 minute presentation will be followed by a 3 minute discussion.

VIDEO SESSION
Each 5 minute video will be followed by a 3 minute discussion.

POSTER PRESENTATIONS, THE TOP 2
Each 3 minute presentation will be followed by a 2 minute discussion.

TIMINGS
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ALSGBI Scientific Programme

Friday 11 December 2020

THE SCIENTIFIC PROGRAMME MAY BE SUBJECT TO CHANGE AT SHORT NOTICE

TIMETABLE

	GENERAL SURGERY & EMERGENCY DAY SYMPOSIUM **The ALSGBI Team:** Mr Jawad Ahmad (Coventry) Mr Donald Menzies (Colchester) Professor YKS Viswanath (Middlesbrough) Mr Graham Whiteley (Bangor)
16:00 – 16:03	**PRESIDENTIAL WELCOME & INTRODUCTION** Mr Donald Menzies (ALSGBI President)
16:03 – 16:05	**INTRODUCTION** Professor YKS Viswanath (Day Team Leader)
16:05 – 16:20	**EMERGENCY MINIMALLY ACCESS SURGERY – HPB SURGERY** Miss Claire Jones, Consultant General, HPB & Minimal Access Surgeon, Mater Hospital, Belfast
16:20 – 16:35	**EMERGENCY MINIMALLY ACCESS SURGERY – COLORECTAL** Miss Sarah Mills, Consultant General Colorectal & Minimal Access Surgeon Chelsea & Westminster Hospital, London
16:35 – 16:50	**EMERGENCY MINIMALLY ACCESS SURGERY – UPPER GI** Miss Nilanjana Tewari, Consultant General Upper GI & Minimal Access Surgeon University Hospital, Coventry **Chairman:** Mr Jawad Ahmad (Coventry)
16:50 – 17:00	**Q&A** Miss Claire Jones (Belfast); Miss Sarah Mills (London) Miss Nilanjana Tewari (Coventry) **Chairman:** Mr Jawad Ahmad (Coventry)
17:00 – 17:15	**ROLE OF VATS FOR RETAINED TRAUMATIC HAEMOTHORAX; THE CAPE TOWN TRAUMA CENTRE PERSPECTIVE** Dr Sorin Edu, Senior Trauma Consultant Groote Schuur Hospital University of Cape Town, South Africa **Chairman:** Professor YKS Viswanath (Middlesbrough)
17:15 – 17:20	**Q&A** Mr Stuart Mercer (Portsmouth) Professor YKS Viswanath (Middlesbrough) **Chairman:** Mr Graham Whiteley (Bangor)
17:20 – 17:35	**ACUTE LAPAROSCOPY GENERAL SURGERY EMERGENCIES** Mr Stuart Mercer, General Upper GI & Minimal Access Surgeon Queen Alexandra Hospital (Portsmouth)
17:35 – 17:50	**MANAGEMENT OF BLEEDING & TROUBLES DURING ROBOTIC HPB SURGERY** Mr Jawad Ahmad, Consultant General HPB & Minimal Access Surgeon (Coventry)
17:50 – 18:05	**EMERGENCY LAPAROSCOPIC REPAIR OF INCARCERATED TRAUMATIC DIAPHRAGMATIC HERNIA-DURING COVID-19 TIMES** Mr Anantha Madhavan, Senior Upper GI Trainee & Professor YKS Viswanath, Upper GI & Minimal Access Surgeon, James Cook University Hospital (Middlesbrough) **Chairman:** Mr Graham Whiteley (Bangor)

TIMETABLE

18:05 – 18:15	**Q&A** Mr Jawad Ahmad (Coventry) Mr Anantha Madhavan (Middlesbrough) Mr Stuart Mercer (Portsmouth) Professor YKS Viswanath (Middlesbrough) **Chairman:** Mr Graham Whiteley (Bangor)
18:15 – 18:40	**AS LIVE 'VIRTUAL' EMERGENCY LAPAROSCOPIC (SINGLE PORT) COLORECTAL SURGERY** Mr Talvinder Gill, Colorectal Consultant & Ms Oroog Ali, Senior Colorectal Trainee, University Hospital of North Tees (Stockton-on-Tees) **Chairman:** Professor YKS Viswanath (Middlesbrough)
18:40 – 18:50	**Q&A** Ms Oroog Ali (Stockton-on-Tees) Mr Talvinder Gill (Stockton-on-Tees) **Chairmen:** Mr Jawad Ahmad (Coventry) Professor YKS Viswanath (Middlesbrough) Mr Graham Whiteley (Bangor)
18:50 – 18:55	**CLOSE** Professor YKS Viswanath (Middlesbrough) **Chairman:** Mr Donald Menzies (President)
18:55 – 19:00	**ALSGBI AWARDS CEREMONY** **Chairmen:** Mr Donald Menzies (President) Mr David Mahon (Taunton) Announcement of the 2020 Travelling Scholarship Winner Announcement of the 2020 Video of the Year Competition Winner of the 2020 David Dunn Medal Winner of the 2020 Journal of Surgical Simulation Award Winner of the 2020 ALSGBI Best Laparoscopic Video Prize Winner of the 2020 ALSGBI Best Laparoscopic Poster Prize Winner of the 2020 Industry Challenge will be announced on 1 January 2021!
19:00	**PRESIDENT'S ROUND-UP OF THE vASM** Mr Donald Menzies (ALSGBI President) **NEXT YEAR'S CONFERENCE WILL TAKE PLACE ON 6 & 7 DECEMBER AT THE IBIS LONDON EARLS COURT (ILEC)**

How robotic surgery can help to alleviate COVID pressures

Mark Slack, Consultant Gynaecologist & Chief Medical Officer/Co-founder, CMR Surgical

Without question, COVID-19 has changed the way in which we approach all branches of medicine, including surgery. The impact of elective surgery grinding to a halt at the start of lockdown is still being felt and will be for a long time to come. Now, more than ever, it is crucial that patients can recover more quickly following surgery and spend as little time as possible in hospital. It is important that as a surgical community, we continue to push to ensure that safe, surgery can continue.

As practitioners of laparoscopic surgery, we recognise the benefits a laparoscopic approach can offer – we know that laparoscopic surgery drastically reduces the recovery time for a patient, the risk of infection minimising a potential return to surgery and reduced pain, meaning patients can get out of hospital sooner, return home faster and free up beds. In some cases, using manual laparoscopy can be cumbersome and open surgery may be the preferred approach, but in a time where we know that helping patients to recover quickly, and freeing up bed space is of the utmost importance, using a surgical robotic system such as such as Versius can combat some of the barriers faced in manual laparoscopy, preventing the need for open surgery. Versius provides enhanced visualisation and greater precision and dexterity than its manual laparoscopic counterparts, allowing you to act with the freedom of robotic surgery while still thinking laparoscopically. Versius, can also facilitate complex cases that would otherwise be performed openly and by performing those procedures robotically we can deliver the benefits of laparoscopy to more patients.

At a time when our NHS faces unprecedented challenges, there has never been a more important time to protect surgeons so that they can combat growing elective lists, and work to get as many patients as possible the care they need. In data collected last year, an alarming 76% of surgeons in the UK reported musculoskeletal pain from performing surgery. Many laparoscopic techniques often require the surgeons to stand in awkward positions for long periods, increasing physical fatigue and reducing a surgeon's mobility. Muscular stiffness, back, neck and shoulder pain, and reduced dexterity are widely acknowledged side-effects of conducting minimal access surgery (MAS). Operating with Versius puts less physical strain on a surgeon – all components ranging from the arms, instruments, handgrips to the open console at which the surgeon is seated/stands at during surgery which, amongst other outputs, alleviates the physical impact of other forms of minimal access surgery.

I believe, rather than look at the benefits of robotic surgery during COVID, we should be looking at how we can get the best surgery to patients and limit the impact that cancelling elective procedures is having on surgical care. Surgical robotics offers an option for getting laparoscopic surgery to more patients – which can only bring benefits to the surgeon, hospital, and ultimately and most importantly the patients. This is only more important today.

CMR SURGICAL

Terminal disinfection of surfaces & air by UVC light

Finsen Tech is an international EPA registered manufacturer and provider of UVC products and services contributing to the prevention and reduction of HCAI's (Healthcare Associated Infections) by delivering scientifically proven, cost effective rapid high disinfection technologies. Finsen Tech produces the world leading Telescopic High Output Rapid UVC robot, THOR UVC®.

THOR UVC® uses shortwave UV light, which at 253.7 nanometres is proven to kill all known superbugs in just minutes. Pathogens such as Cdiff, CRE, VRE, Candida Auris, Ebola, Coronavirus and Norovirus, will be denatured and destroyed.

THOR UVC® generates more UVC power than older generation UV technologies, this high unrivalled output is critical in killing the new strains of superbugs. Its' telescopic reach is significantly higher than its predecessors, obliterating pathogens from floor to ceiling while ensuring even those hiding in shadowed areas are not missed. The robot disinfects a 360-degree area, irrespective of obstacles and senses clutter and reduces shadows, delivering a peak germicidal dose to all areas.

How can UVC disinfection aid in the fight against the spread of COVID-19?

Finsen Tech are now able to verify with confidence that THOR UVC® can eradicate COVID-19, in minutes.

What products and services does Finsen Technologies offer?

THOR UVC® is a revolutionary total room disinfection robot. It is used to terminally clean both air and surfaces and will eradicate and eliminate 99.9999% of healthcare associated infections (HAI's) in minutes. THOR UVC® has many unique features, it has emitters that go from floor to ceiling eliminating areas of shadow. It is also the only UVC system available worldwide that provides 3 pre-treatment room scans, ensuring that the most efficacious disinfection cycle is delivered each and every time.

The Hyperion cabinet decontaminates non-invasive medical equipment and electronic devices using a clinically proven UVC light technology. Proven to kill pathogens in 60 seconds. The Hyperion cabinet is not just for hospital use it can provide an ideal decontamination solution within hotels, restaurants, offices etc. Hyperion is a unique surface decontaminator, clinically effective against all problematic pathogens. It is unique in that it delivers 360° UVC decontamination and penetrates hard to reach areas of objects which can often be missed when cleaning by hand.

Unlike other decontamination technologies, the Hyperion UVC cabinet does not use chemicals or gases and operates at room temperature and pressure. It is an ideal solution for decontaminating sensitive medical and electronic equipment that cannot be processed in an autoclave or washer-disinfector.

Saving Time, Saving Lives, Saving Money

For further information contact
charlie@kebomed.co.uk

Boston Scientific Earns Dual Recognition for Ethical Business Practices and Corporate Culture in the face of COVID 19

In the face of COViD 19 Boston Scientific has worked on numerous projects guided by our core values. Our priority has been and is to protect and aid the health and safety of our employees, customers and patients. We have contributed more than $13M to aid COVID-19 relief efforts globally through monetary and supply donations, and by providing engineering and manufacturing expertise and resources. This includes donations of PPE and medical equipment to local hospitals and government agencies. The company also provided support to children, families and the most vulnerable through direct financial contributions to local community and global non-profit. Through collaboration with hospitals, universities and industry peers, we found ways to address the demand for PPE and ventilators. We have been working with the University of Minnesota Bakken Medical Device Center to develop an emergency resuscitator the design files are openly available so that other interested organizations can manufacture.

We helped address PPE shortages by producing face shields across several sites and working with an international coalition of medical experts, clinicians and industry leaders, we designed and developed the Pneumask™ Face Shield donated to hospitals across the globe.

At Boston Scientific, we have always found our purpose in working alongside healthcare providers to solve some of healthcare's toughest challenges. Our commitment is unwavering, regardless of the obstacles we face today, and we will emerge from this challenging time stronger, together.

To further reinforce our ethos Boston Scientific has been named one of America's Most Just Companies by Forbes and Just Capital, and a Culture Champion by the MIT Sloan Management Review and Glassdoor Culture 500. These recognitions reflect the company's ongoing commitment to doing right by employees, customers, communities and the environment and being held accountable for it.

With the 38th spot on the JUST 100 the second year the company has appeared on the list Boston Scientific ranks number one overall for advancing diversity, equity and inclusion, and is commended for supporting employees, responding to social injustice issues, combating climate change and ethical

In one of the largest systematic studies of corporate culture ever conducted, researchers at MIT measured feedback from more than a million employees to identify companies with the most robust corporate cultures. In the end, Boston Scientific is one of 21 companies named as a Culture Champion.

"Of all the corporate cultures we studied, Boston Scientific jumped off the page with its multidimensional strengths," said Charlie Sull, one of two lead researchers of the Culture 500. "To combine deep patient centricity and a genuine commitment to diversity is a rare thing in a company, and these are just two of the areas in which Boston Scientific excels culturally."

According to research from Catalyst, companies with diverse and inclusive cultures are twice as likely to meet or even exceed their financial targets and are six times more likely to innovate.

"At Boston Scientific, our inclusive culture is geared toward meeting the needs of our customers and patients. It's not a question of doing the right thing instead of focusing on the bottom line; it's about doing the right thing as the best way to achieve sustainable, long-term growth," said Mike Mahoney, Boston Scientific chairman and CEO. "There is always more we can do, and we are pushing ourselves further year over year."

For further information contact
Mark.Walker@bsci.com

Boston Scientific
Advancing science for life™

ASSOCIATION OF LAPAROSCOPIC SURGEONS
ALSGBI
INC. ROBOTIC & TECHNOLOGY ENHANCED SURGERY

SAVE THE DATE

The UK & Ireland's **No.1 Professional Association** in the field of Laparoscopic and Robotic Surgery

UPCOMING EVENTS

IBIS LONDON EARLS COURT (ILEC)

2021

ALSGBI Laparoscopic Surgery Training Day
Sunday 5 December
MATTU | THE LEGGETT BUILDING
GUILDFORD | GU2 7WG

ALSGBI Annual Scientific Meeting
Monday 6 & Tuesday 7 December
ILEC CONFERENCE CENTRE | LONDON SW6 1UD

Association of Laparoscopic Theatre Staff Meeting (ALTS)
Monday 6 December
ILEC CONFERENCE CENTRE

Contact Details

General Enquiries: Mrs Jennifer Treglohan
Tel +44 (0)20 7869 6941 | Mob +44 (0)7973 232038 | jtreglohan@alsgbi.org
Industry Exhibition Enquiries: Mrs Sarah Williams
Tel +44 (0)20 7869 6940 | Mob +44 (0)7854 858714 | swilliams@alsgbi.org
www.alsgbi.org