ASSOCIATION OF LAPAROSCOPIC SURGEONS

ALS GBI

INC. ROBOTIC & TECHNOLOGY ENHANCED SURGERY

# Spring 2021 ALSGBI Newsletter

## President's Introduction

**Dear Members & Colleagues**

Welcome to the Spring Newsletter. It illustrates that despite the Covid pandemic (I will try not mention this again) the ALSGBI has tried to remain active producing 2 teaching days and a virtual Annual Scientific Meeting.

I am grateful to all those who have worked hard over the last year to allow these events to take place and I am sure you will enjoy reading about them in the following pages. Particular thanks to the faculty members of the training days and the speciality days of the vASM.

The scholarship reports which are a usual feature of the newsletter are a bit thin on the ground at the moment for obvious reasons but the bursaries are still available so encourage your trainees to apply.

This winter we are planning to hold a more traditional meeting in London – more details will follow, but will also try to build on the success of the virtual meeting last year and try to incorporate some form of virtual element to it. The face-to-face element of the meeting is greatly anticipated.

May I draw your attention to the website where details of future meetings and training days are published. We have established a link with a number of international laparoscopic societies outside of Europe which includes the Indian IAGES and Sri Lankan SLAMADS. We will be publishing their newsletters and training opportunities on the website and hopefully will be able to access their online facilities to augment what we already provide.

Enjoy your read and I look forward to meeting you in December.

**Mr Donald Menzies**
President, ALSGBI

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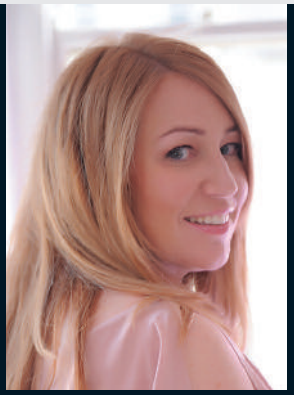

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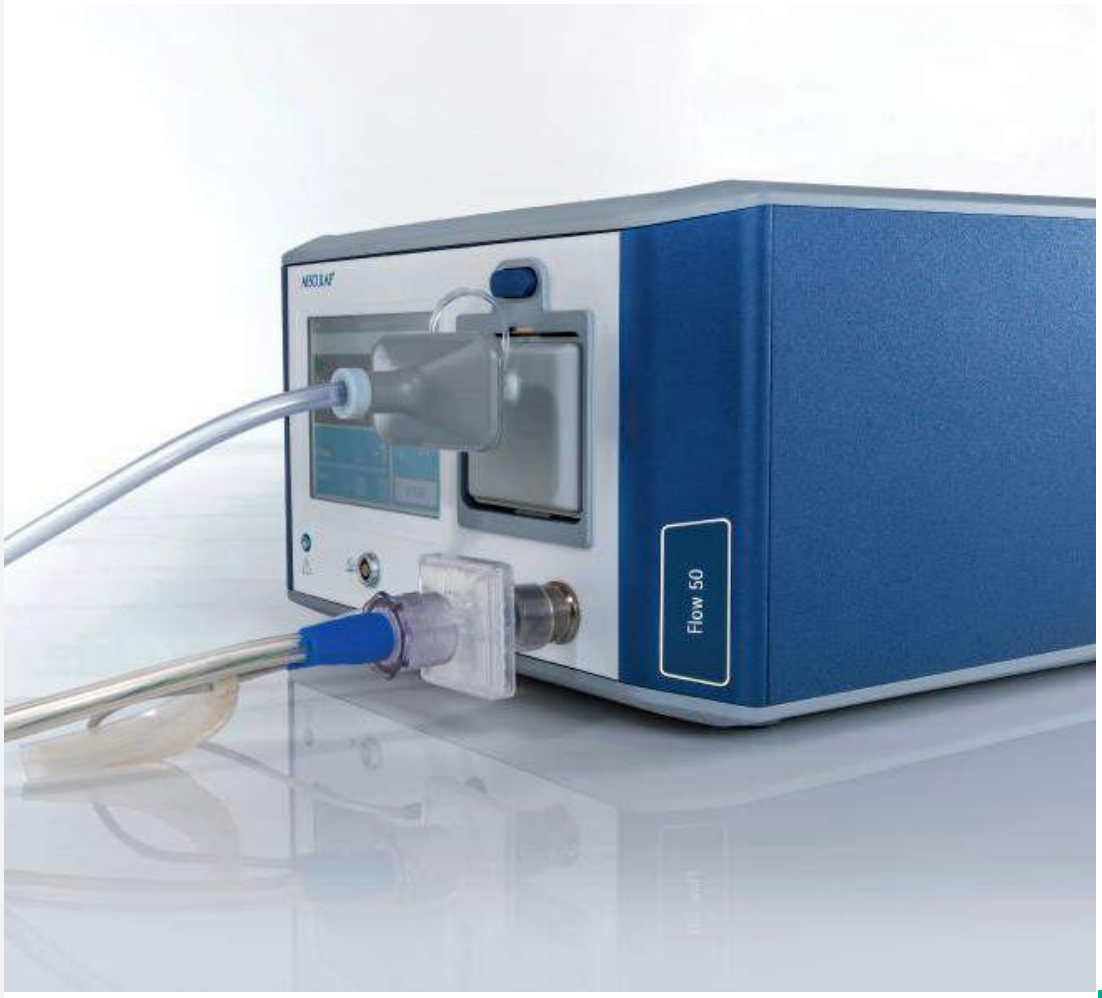


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## Editor's Introduction

It is difficult to remember such strange times in the medical world, and that includes our surgical sphere. We are all 'carrying on' in the hope and expectation that we may soon be able to get down to what we do best: minimally invasive surgery, doing the best for our patients in all circumstances.

The Association has been busy keeping the show on the road evidenced by the meetings that we have highlighted in this issue. The first ALSGBI virtual Annual Scientific Meeting was the source of much discussion, planning and a lot of hard work from the President and his team of contributors who must all be congratulated.

It is particularly pleasing to be able to publish the reports of a number of our overseas Travelling Scholarships, as a timely reminder to the international links forged by the Association in the pursuit of knowledge and excellence. Although this year's Scholarships were put on pause and then carried over this should mean a glut of reports next year.

Examples of our drive for hands-on training opportunities supervised by expert faculties can be seen in the LapPass® training day reports and the first of our Robotic training days, the feedback from these has been universally effusive.

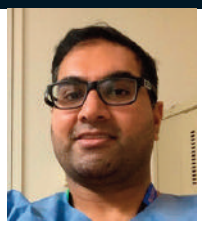
I hope that you find these interesting and stimulating, please visit the ALSGBI website at www.alsgbi.org to see how you might be able to contribute too.

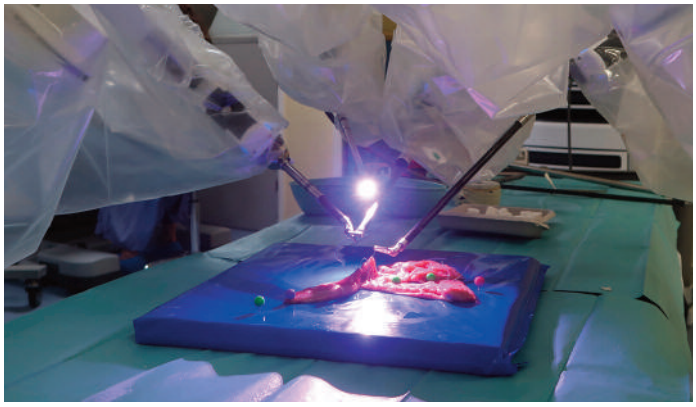
**Mr Neil Keeling**
Editorial Secretary

## Contents

# ALSGBI Robotic Surgery Training Day

## 6 December 2020, The Griffin Institute – NPIMR, Northwick Park, London





As a result of the pandemic, the format of the ALSGBI Annual Scientific Meeting had to deviate from its usual one becoming virtual. However, thankfully we were still able to keep the traditional training day component. In fact, in 2020, ALSGBI were able to host two training days, the more traditional laparoscopic training day, as well as one specifically dedicated to robotics. Having previously had limited exposure to robotic surgery, I was excited to attend ALSGBI's first robotic surgery training day.

Robotic surgery has allowed complex surgery to be performed with greater precision, flexibility and control than previously possible due to the advantages of a three-dimensional, high resolution magnified view, coupled with the degrees of freedom offered by the articulated instruments. In addition, there has been a rapid uptake by a multitude of surgical specialties, including urology, gynaecology, both lower and upper GI surgery to name a few.

The Robotic Surgery Training Day was held at the Griffin Institute at Northwick Park and St Mark's Hospital; a facility that has recently become a world leading centre in translational biomedical research and training. Intuitive Surgical kindly sponsored the course and provided us with three Da Vinci robots, the Xi, X and Si and three further simulators.


The course was very hands-on and had been designed to ensure minimal didactic teaching with a focus placed on development of technical skills. The majority of candidates had also had minimal exposure to robotic surgery prior to attending the course, but with only 8 candidates and 6 very experienced faculty members, everyone developed a rapid acquisition of skills, with candidates never having sat at a console going on to performing a side-to-side anastomosis!

The course was well received by the candidates and the faculty also enjoyed the satisfaction of seeing our progression. Although throughout the year we've learnt to adapt to online platforms, there are certain components of face-to-face teaching that cannot be replicated and I'm thankful to have been able to attend what I hope is the first of many ALSGBI Robotic Surgical Skills courses.

The next step is building on those skills with regular exposure to robotics. One of the projects of ALSGBI Academy is to build a portfolio of accessible laparoscopic facilities nationwide. The aim would be to also expand this to identify access to robotic simulators.

I am very excited about the development of robotic training and the potential next step is to develop a robotic assessment platform for candidates to achieve competencies that would allow for accelerated operative training in a similar manner to that of LapPass®.

I would like to thank the ALSGBI, staff at the Griffin Institute and the faculty for organising the course.

**Mr Ricky Patel**
ALSGBI Academy Chair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# UPCOMING EVENTS

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## ALSGBI Robotic Surgery Training Day
**Sunday 5 December**
THE GRIFFIN INSTITUTE | HARROW | HA1 3UJ

## 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**
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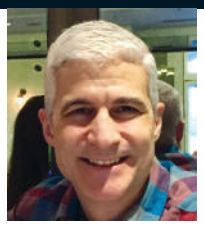
2017



# ALSGBI Virtual Annual Scientific Meeting

7-11 December 2020


What a year 2020 has been. Training has been hit particularly hard by lockdown restrictions. ALSGBI wanted to ensure that despite the difficulties of the year that we would still go ahead with our Annual Scientific Meeting in December. Unfortunately, we were unable to meet face to face, but the travel restrictions did help to produce some ingenious solutions to deliver our meeting to you in a virtual way. It was our opportunity to thank all those of you that have been working so hard during the year to continue to deliver a safe service for patients but to also develop novel ways of ensuring trainees were not cast adrift.

The greater ALSGBI family involves all of you our members, our council, our executive staff and our industry partners. Everyone has worked exceptionally hard to ensure that 2020's ASM was a success. Our special thanks go out to all of you. Despite the difficulties we had a record attendance and have received excellent compliments and support from those of you who were able to join us. We particularly thank our invited speakers and all of you who submitted abstracts and videos this year. These all added to the high quality of the year's meeting. If you haven't had the chance to review all of the days, or the industry exhibition, then please do so now. Access is now available via the ALSGBI website. I think you will all find something valuable, even if not within your identified specialty.

The week commenced on Sunday, with a successful face to face Training Day for budding robotic surgeons. This was put together by the robotic surgery committee at ALSGBI and kindly hosted by The Griffin Institute at Northwick Park. A great day was had by all who attended.

The difficulties of producing a week-long event were compounded by the need for a live stream of high definition laparoscopic and robotic surgery. We were pleased to be able to collaborate with Gurukul Online Campus, who were able to put together an excellent online platform for us. This consisted of a virtual conference, with exhibition space, poster sessions and entrance to the main theatre. Here we were able to present a cornucopia of debate, state of the art lectures and demonstrations of surgery. I hope that the depth and breadth of presented material surpassed the expectations of those attending. Despite the numerous hours put in by both the Gurukul team and the meeting organisers, still last minute hiccups always appear but these were artfully dealt with by our expert team. Always plan for the unexpected!

Our vASM started with a fanfare on Monday. Here we were able to demonstrate the best bits of new technology and robotic surgery. The expert surgery this year was delivered 'as live'. This had the advantage of being able to keep to time but was also not restricted by geography or a sturdy satellite link. The only disadvantage was the lack of jeopardy that we all anticipate and enjoy with a true, live link.

The second day focused on colorectal surgery and teaching. This included an excellent demonstration of how laparoscopic teaching can be implemented virtually. This has huge implications for not only the current situation, but for increasing accessibility to quality training that is not inhibited by geography. We were entertained by laparoscopic experts who skilfully demonstrated that there are more than two ways to crack a colorectal nut!

On Wednesday we were able to present a carefully curated selection of 'State of The Art' presentations for around the world, on the subject of Upper GI Surgery. One of the advantages of hosting a virtual conference was being able to have world class experts rub shoulders virtually and present enviable data on best practice in their own field of work. The virtual platform also allowed a more democratic audience involvement. I'm so pleased our invited speakers were also able to answer audience questions honestly over the chat room function.

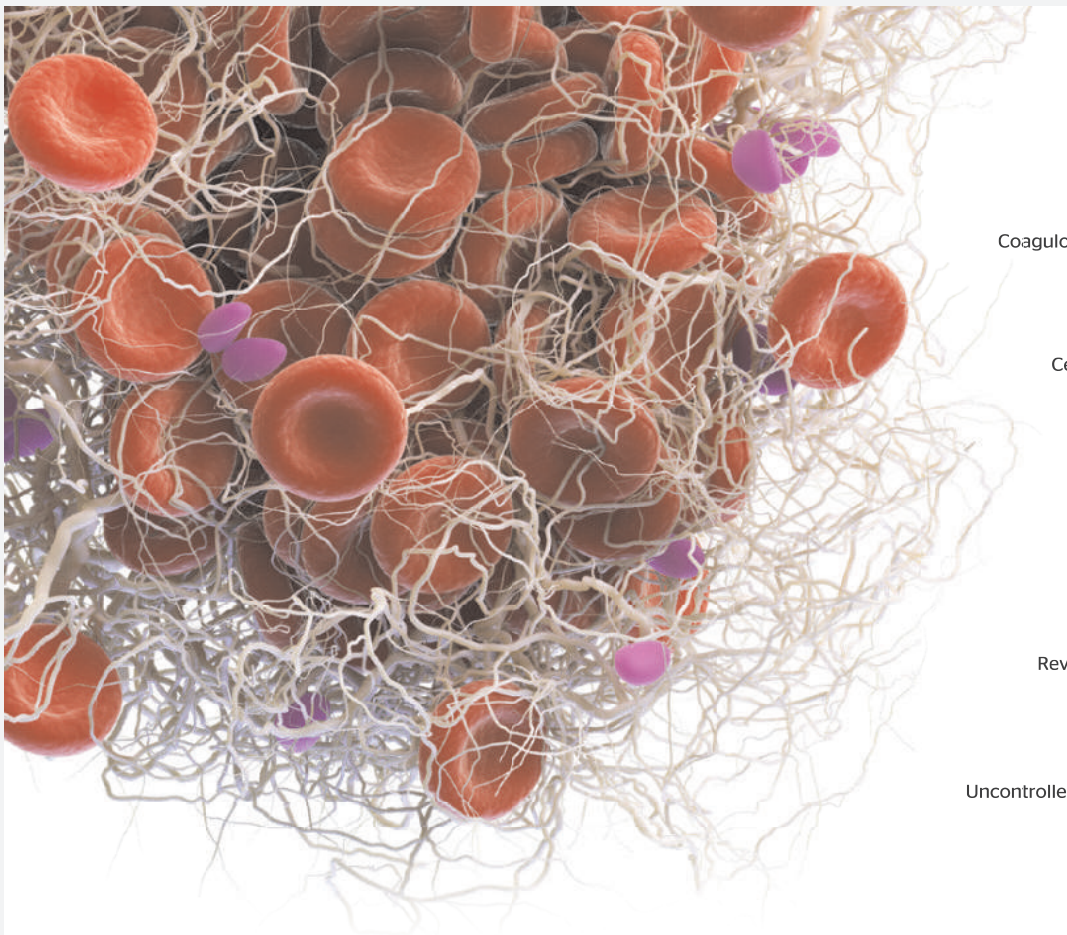
Thursday allowed us to venture in to the specialty area of bariatric surgery. We were honoured to have an expert panel to debate the complexities of revision surgery for what is now recognised as a chronic disease. I'm sure the panel debate provided plenty of food for thought and areas for future discussions.

The vASM was neatly rounded off on Friday with an excellent session on emergency surgery. This is an area that affects us all to an ever-increasing degree. We are cognisant of a strong band of general surgeons who play such an important role in the maintenance of care throughout the Great Britain and Ireland. I hope that ALSGBI provides a natural home for them to remain updated with latest research and technology that can be utilised in day to day practice. The space for laparoscopy in the emergency setting remains one of those areas. The expert presentations and discussions on Friday helped provide insight and practical tips for all of us to implement this best practice in our own hospitals.

Finally, Saturday saw the return of our much-loved annual Laparoscopic Surgery Training Day. With the enormous support of the MATTU team, we were able to provide some of the first face to face training for the year. This was very well received by all those who attended.

Overall, we hope you all enjoyed the vASM as much as we did. We missed seeing you all face to face and look forward to being able to join again with some degree of normality in December 2021. If you have any comments to make regarding the structure or content of future ASMs then please do get in touch. We are after all here for you, our members and for the future of training and education in Laparoscopic and Robotic surgery.

**Mr Paul Leeder**
Director of Education



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¥Patients taking anticoagulants and chronic anticoagulant medications

**Reference: 1.** Bjelovic M, Ayguasonosa J, Kim R, et al. A prospective, randomized, phase III study to evaluate the efficacy and safety of fibrin sealant Grifols as an adjunct to hemostasis as compared to cellulose sheets in hepatic surgery resections. *J Gastrointest Surg.* 2018;22:1939-1949. **2.** Nenezic D. A prospective, single-blind, randomized, phase III study to evaluate the safety and efficacy of Fibrin Sealant Grifols as an adjunct to hemostasis compared with manual compression in vascular surgery. *J of Vasc Surg.* 2019;70: 642. **3.** Marietta M. Pathophysiology of bleeding in surgery. *Transplant Proc.* 2006;38(3):812-814. **4.** Saif R, Jacob M, Robinson S, et al. **Use of fibrin-based sealants and gelatin-matrix hemostats in laparoscopic liver surgery.** *Surg Laparosc Endosc Percutan Tech.* 2011;21(3):131-141.

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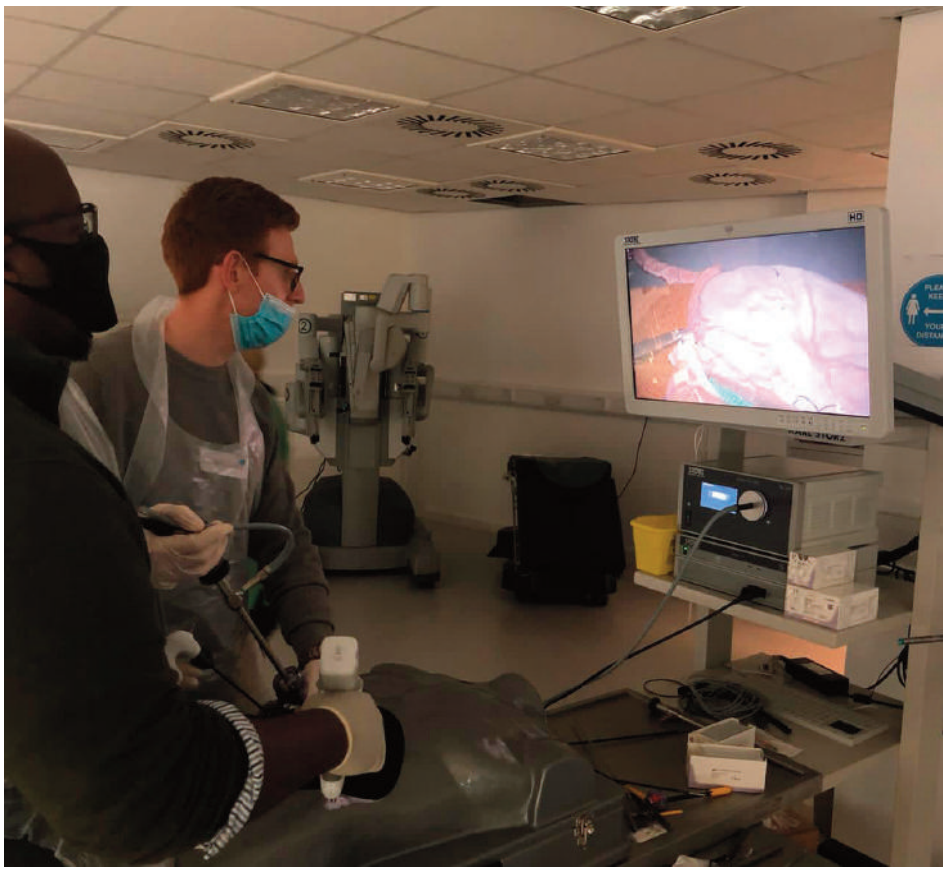
Date of Preparation: October 2020

# ALSGBI Laparoscopic Surgery Training Day

## 12 December 2020, MATTU at The Royal Surrey County Hospital

2020 was a hard year for many people for a number of reasons thanks to a tiny little virus called Covid-19. In particular our trainees have had to take a step back from their usual surgical training in order to man the decks of critical care. So, we were delighted to be able to deliver an excellent hands-on training day for trainees from around the country during a window between lockdowns. We are grateful to Professor Tim Rockall, Director of the MATTU and past ALSGBI President, for making the outstanding training facility that is the MATTU available for our use. The day could not have gone ahead without the organisation of the unflappable Ms Alison Snook, Manager of the MATTU, who ensured we had a wealth of tissue and kit for the trainees to use.



Mr Paul Leeder, Director of Education for the ALSGBI, had put together a fabulous programme that allowed trainees to practise a variety of laparoscopic skills. The geography of the MATTU allowed us to arrange a number of different stations in multiple rooms maximising numbers that could attend whilst maintaining appropriate social distancing. The participants were split into two groups of trainees, the CT and ST level trainees. The core trainees had the opportunity to practice the LapPass® skills on the Inovus LapPass® jigs and then to progress to augmented virtual reality laparoscopic appendicectomies and cholecystectomies as well as dry lab suturing. They were also able to have an opportunity to use a variety of stapling devices under the guidance of the experienced Ethicon representatives.

The senior trainees were based in the wet lab and able to practice a number of suturing skills with small bowel anastomoses, gastroenterostomies, fundoplications and circular stapled anastomoses all on offer. There was also a pig liver with an excellent model to allow laparoscopic common bile duct exploration with use of a cholechodoscope and basket retrieval device. There was a never ending supply of fresh animal tissue which allowed them to practise those skills in an environment that gave them the time to practise and ask questions and receive tips and tricks from the excellent faculty.

All of this could not have been possible without the support of Industry. We are eternally grateful to Johnson & Johnson, Storz, Inovus and Boston Scientific for providing a plethora of kit for the trainees to use and practise with. The joy of the annual training day for the trainees is access to expensive kit that they would otherwise have limited exposure to in their own hospitals; thus allowing them the time to understand the products and how to use them correctly. All of this could also not have been possible without the generous support of local surgeons who gave up their Saturday to come along and train. We are very grateful for the help of Professor Tim Rockall, Mr Andrea Scala, Mr Pritam Singh and Mr Paul MacKenzie.

I would strongly encourage trainees to join ALSGBI this year and come along to the conference. You are then eligible to apply for the training day, which as you can see is a fabulous opportunity. It is also worth noting that it is FREE! See you in December.

**Mr Andrew Day**
Welfare Officer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# ALSGBI Laparoscopic Surgery Training Day

## 12 December 2020, MATTU at The Royal Surrey County Hospital


The ALSGBI Laparoscopic Surgery Training day which took place on Saturday 12 December 2020 represented a rare victory for surgical education in an otherwise tumultuous year for training.

Quite rightly, virtual surgical training techniques have come to the fore during 2020. However, ALSGBI were able to safely deliver a face to face laparoscopic training event which took place in the generous surroundings of the MATTU in Guildford, Surrey. All ALSGBI trainee members were invited to apply to attend.

In attendance were 10 core and 12 intermediate level general surgical trainees drawn from areas across from the UK including London, Cardiff and the Midlands.

The day began with a warm welcome from course organiser and ALSGBI Director of Education, Mr Paul Leeder. Other expert laparoscopic faculty included Professor Tim Rockall, Consultant Colorectal Surgeon and Mr Pritam Singh, Consultant Oesophagogastric Surgeon, both based at the Royal Surrey Hospital, Guildford.

An emphasis was placed on high faculty to delegate ratios, minimising plenary time and maximising time spent on skills tasks. Delegates were matched according to training level and allocated to one of two groups. The stations offered are detailed below;

| Group A | Group B |
|---|---|
| LapPass® Training & Assessment | Laparoscopic suturing skills |
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| Laparoscopic cholecystectomy | Linear stapled anastomosis |
| Interrupted suturing | Laparoscopic bile duct exploration |
| Continuous suturing | Circular stapled anastomosis |
| Linear Stapled anastomosis | Hand sewn anastomosis |

Educational resources were offered from each of the generous course sponsors, in particular Johnson and Johnson who had sponsored the course. Inovus provided much of the simulated training opportunities by making their latest Pyxus and LapAR simulators available.

Karl Storz were also present with a multitude of equipment available for interaction with delegates, including their latest flexible video choledochoscopes and 4k immunofluorescence laparoscopes.

Trainees were able to hone laparoscopic suturing and stapling techniques with an abundance of Ethicon suture material and laparoscopic stapling devices.

The aforementioned equipment was employed in conjunction with porcine and synthetic models provided by the MATTU to provide enhanced laparoscopic simulation training.

Delegates from group A were given the opportunity to practise and be assessed according to the ALSGBI 'LapPass®'. This is a nationally recognised certification of laparoscopic proficiency and involves 4 demanding technical skills tasks. LapPass® holders are generally considered to be suitable for escalated laparoscopic surgical training.

The success of this training day is a valuable proof of concept for safe, socially-distanced, face-to-face simulation training in the COVID-19 era.
Selected feedback;

*'Excellent course'*

*'This was a fantastic training day, the faculty were really helpful and supportive and I feel I have gained a lot of useful tips for laparoscopic operating.'*

**Mr Michael Kelly**
General Surgery SpR, London Deanery
**Mr Michael Okocha**
General Surgery SpR, Severn Deanery

# B Braun Aesculap Travelling Scholarship

## 16-17 January 2020, Advanced Cadaveric Robotic Upper GI Course, Strasbourg, France
## 20 January to 1 February 2020, University Medical Centre Utrecht, Netherlands

B BRAUN
SHARING EXPERTISE

The focus of my registrar training was on the management of complex benign and malignant upper GI disease and I developed an interest in robotic-assisted surgery and completed the DaVinci console simulator training. I was delighted to be awarded the B Braun Aesculap Travelling Scholarship in November 2019 to attend the first IRCAD robotic training course for complex benign and malignant upper GI procedures and a subsequent travelling fellowship to visit Professor Richard van Hillegersberg in Utrecht, Netherlands.

I attended the two-day course in January 2020 which took place at the IRCAD academy located in the historic city of Strasbourg, France. The IRCAD academy is a state-of-the-art facility and is a leading research and training institute set on the grounds of the University Hospital of Strasbourg. The academy offers a whole array of training courses for all surgical specialities and is accredited as a comprehensive Accredited Education Institute by the American College of Surgeons. The academy is well known for running courses led and attended by international experts and I was privileged to meet many eminent course delegates and world-renowned mentors from all over the world including Europe, Australia, America and the Far East.

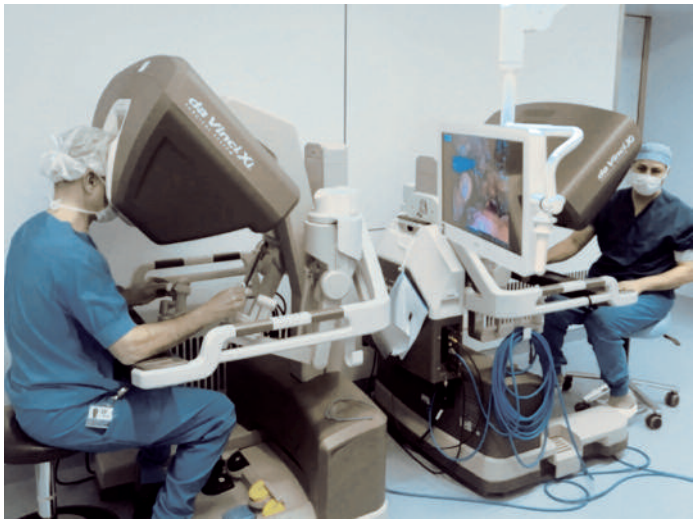
The course was divided into interactive theory sessions on key topics such as 'anatomy' of the robot and how to perform key robotic upper GI procedures followed by practical sessions where I performed these procedures on cadaveric models mentored by the experts. There were also several video demonstrations including a live stream of a robotic D2 total gastrectomy performed at the local hospital by Professor WJ Hyung from Severance Hospital, South Korea who has performed over a 1000 gastrectomies. The sessions gave a real insight into key developments in the field of upper GI surgery as well as an introduction to interesting techniques and processes including how to perform robotic D2 gastrectomy and oesophagectomy with radical three field lymphadenectomy.

There were some key themes that generated a great deal of discussion during the course, including the role of fluorescence-guided techniques in oesophagogastric surgery. Many felt indocyanine green (ICG) should be used before the anastomosis is formed to ensure joining onto a well perfused area on the conduit, whereas others felt it should be used after the anastomosis is formed to demonstrate good perfusion. Professor Hyung presented a different use for ICG, based on work done by his group on gastric cancer. He shared an interesting technique of endoscopic injection of ICG in the areas immediately surrounding the gastric tumour the day before surgery to delineate lymphatic drainage. This approach facilitated intraoperative assessment and guided excision of potentially involved nodes as well as helping to identify nodes within the resected specimen. This work not only showed significant increase in the number of lymph nodes resected but also a greater number of involved nodes in the specimens of the fluorescence-guided surgery group. However, it is not clear if these findings are a result of better lymphadenectomy or simply greater lymph node harvesting from the resected specimens. There were discussions on whether this technique can influence the extent of the resection/lymphadenectomy or even the postoperative staging and help direct adjuvant treatment in an effort to provide better individualised treatment.

Another key topic was what extent of lymphadenectomy should be performed in oesophageal cancer which was addressed by Professor Chao, Chief of the Division of Thoracic and Cardiovascular surgery at Chan Gung Memorial Hospital, Taiwan's largest hospital. He highlighted the latest evidence from the Far East that he felt should guide lymphadenectomy in oesophageal cancer. He suggested that meticulous middle and lower mediastinal lymphadenectomy should always be performed. In addition, upper mediastinal lymphadenectomy should be performed for patients with squamous cell cancer as well as in those that have oesophageal adenocarcinoma invading ≥ 4cm of the distal oesophagus. He also demonstrated a robotic approach to upper mediastinal lymphadenectomy that has significantly reduced the risk of recurrent laryngeal nerve injury.

Throughout the course, I had the opportunity to put into practice key techniques including how to use, position and dock the DaVinci system as well as port placement and positioning for key procedures. I was also able to operate a DaVinci X system and perform procedures including myotomy, anti-reflux operations, repair of giant hiatus hernia, gastric bypass, gastrectomy and Ivor Lewis Oesophagectomy (ILO) on cadaveric models with mentorship.

From Strasbourg, I went on to visit Professor van Hillegersberg unit at University Medical Centre (UMC) in the idyllic university city of Utrecht, Netherlands. Professor van Hillegersberg is one of the worlds most renowned robotic oesophagogastric surgeons who is credited for being one of the pioneers of robotic oesophagectomy. He started his robotic programme in 2003 and has performed close to 500 robotic oesophagogastric resections since. I was impressed by the state-of-the-art facilities at this tertiary centre that boasts modern, well equipped theatres. Professor van Hillegersberg and his team also had regular access to two DaVinci Xi systems. The team also included Professor Ruurda as well as Sylvia van der Horst, a physician assistant (PA). At the time of my visit, there was also a clinical robotic UGI fellow from Australia who was in the last few months of a year-long fellowship as well as several research fellows. The department was also regularly visited by several teams from across Europe to observe the robotic set up.



*Professor van Hillegersberg performing the thoracic phase of an Ivor Lewis Oesophagectomy with me at the training console.*

The two upper GI surgeons and the PA worked very closely together managing oesophagogastric malignancy which accounts for the bulk of their work. I was able to observe as well as discuss key aspects relating to robotic ILO during my visit. I noted the strong emphasis on procedure standardisation and reproducibility, precision and lymphadenectomy using all four arms of the DaVinci Xi system. They performed the abdominal phase of the ILO similar to how many UK surgeons would perform this with the key difference being the radical nature in which they approach lymphadenectomy. They also used a ruler placed in the abdomen when forming the conduit to ensure and standardise its size. In the thorax, they followed an anti-clockwise approach to mobilising the oesophagus starting at the inferior pulmonary ligament. They used the hook for the majority of the dissection and the vessel sealer mainly to retract and to coagulate the occasional branch vessel. They believe in meticulous lymphadenectomy for the thoracic phase also and they routinely perform upper mediastinal dissection. They also regularly used ICG to assess the perfusion of the conduit prior to performing a 'robotic sewn' anastomosis.

The unit is also renowned for academic excellence and I observed the seamless involvement of the research fellows within the clinical team who regularly attended theatre to collect data and tissue samples. At the time of my visit, they were running multiple studies including investigating the use

*Continued*

# B Braun Aesculap Travelling Scholarship

## 16-17 January 2020, Advanced Cadaveric Robotic Upper GI Course, Strasbourg, France
## 20 January to 1 February 2020, University Medical Centre Utrecht, Netherlands

B BRAUN
SHARING EXPERTISE

of ICG in oesophageal surgery as well as the TIGER study investigating distribution of lymph metastasis in oesophageal cancer. They regularly dissected out the lymph node stations in the specimen and placed them in individual pots for analysis.

*Professor Ruurda dissecting out all the lymph node stations and placing them in individual pots.*

The unit was also involved in multiple other national and international collaborations and I was impressed by the regular stream of publications accepted in high impact factor journals at the time of my visit. I was also impressed by the way the research fellows collated and discussed clinical data and outcomes including complications at a weekly research meeting prior to submission to the national database. This ethos and multidisciplinary team (MDT) approach may explain the quality of the Dutch Upper GI cancer audit (DUCA).

I also observed the role of the PA within the team, who was specifically trained to assist with robotic surgery but also involved in many aspects of the patient pathway from seeing them in clinic with the Professors, MDT meetings, postoperative care as well as research. She was trained to be the main table assistant with a detailed anatomical understanding of the robot and the procedure and regularly positioned the patient, docked the robot and placed the ports. It was interesting to learn that her role was developed by Professor van Hillegersberg as a result of setbacks to the robotic programme caused by limited availability and consistency of senior residents. He explained that Sylvia, who is a well-trained PA provided a constant, helped the progression of the robotic programme as well as supported the trainees.

The visit also afforded me the opportunity to discuss some of the units most notable projects presented by the Professors at the IRCAD course I attended in Strasbourg, including the ROBOT trial. This trial demonstrated significantly longer operative time in the robot group which they attributed to more meticulous and precise dissection. Blood loss, pulmonary as well as cardiac complications were significantly lower in the robot group also owing to the views and precision as well as other well-known benefits of minimally invasive surgery, with comparable costs and survival outcomes. It was also exciting to hear about the unit's future plans for further development including the transcervical approach to oesophagectomy using the SP DaVinci system.

Professor van Hillegersberg and Professor Ruurda are renowned for mentoring and proctoring many teams across Europe including many in the UK and I welcomed the opportunity to observe key aspects of this training and mentorship programme in practice. Their latest recommendations for robotic oesophagogastric training are to observe 20 cases and assist as a table surgeon for 10 cases. This should be followed by performing 15 supervised cases to achieve competence as an independent robotic surgeon and a further 10 cases to complete the learning curve over a period of a year.

I would like to take this opportunity to thank the Association of Laparoscopic Surgeons of Great Britain & Ireland for supporting this fellowship, Professor van Hillegersberg and Professor Ruurda and team for their warm welcome, invaluable experience and learning opportunity. I am also very grateful to mentors in the department of Upper GI Surgery at the University Hospital of Derby and Burton NHS Foundation Trust for their continued support and encouragement to pursue this opportunity.

**Mr Ahmed M El-Sharkawy**
Winner of the 2019 B Braun Aesculap Travelling Scholarship

# B Braun Aesculap Travelling Scholarship

## January 2020, Zane Cohen Centre for Digestive Diseases, Mount Sinai, Toronto

I was awarded the B Braun Aesculap Travelling Scholarship at the 2019 ALSGBI Silver Jubilee Annual Scientific Meeting. Due to my career aspirations of becoming a consultant in colorectal surgery with a specialist interest in inflammatory bowel disease, I chose to visit the Zane Cohen Centre for Digestive Diseases, Mount Sinai, Toronto.

Mount Sinai, Toronto is one the world's leading centres in the management of inflammatory bowel disease and has one of the busiest surgical IBD units in North America performing approximately 2 000 procedures per year. The unit perform a significant number of these laparoscopically including ileoanal pouches. Thankfully, I was able to travel to Toronto in January 2020 when COVID had only just been identified and I'd never even heard of Wuhan.

I arrived the weekend before my observership commenced and was keen to do some sightseeing around Toronto in the limited time I had available. January in Toronto is notoriously cold with average temperatures being -2° to -7°C, but somehow, I'd arrived in a heatwave and it was a balmy 4°C for a whole 48 hours, before rapidly dropping to -15°C.

Although traditionally Canadians have been a nation of ice hockey, basketball has taken over as their favourite sport. As an NBA fan, a visit the Scotiabank Arena, home of the Toronto Raptors was a must, especially as they had only won their first championship the preceding season.

Healthcare in Canada is publicly funded with each of its 13 provinces and territories responsible for funding and administration, however unlike the UK, a further two-thirds also have private insurance.

Mount Sinai was founded in 1922 and moved to its current site in central Toronto in 1953. There are over forty hospitals in Toronto, with 16 of these situated within Old Toronto, the city itself.

My first day consisted of an orientation to the unit and began with an outpatient clinic and I was very taken back by the set up. These clinics take place within the offices of the surgeons with their personal assistants also manning the reception aspect of the clinic. The actual clinic room itself was more like a cupboard with barely room for the patient and the surgeon without me being there. However, given the expertise of Mount Sinai in the management of IBD, patients had flown from across the province of Ontario and further afield.

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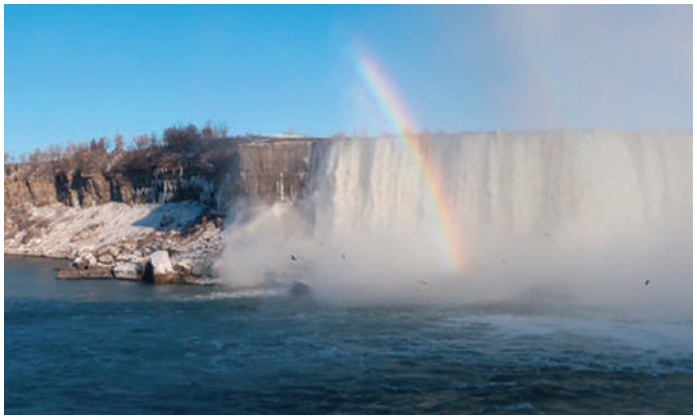
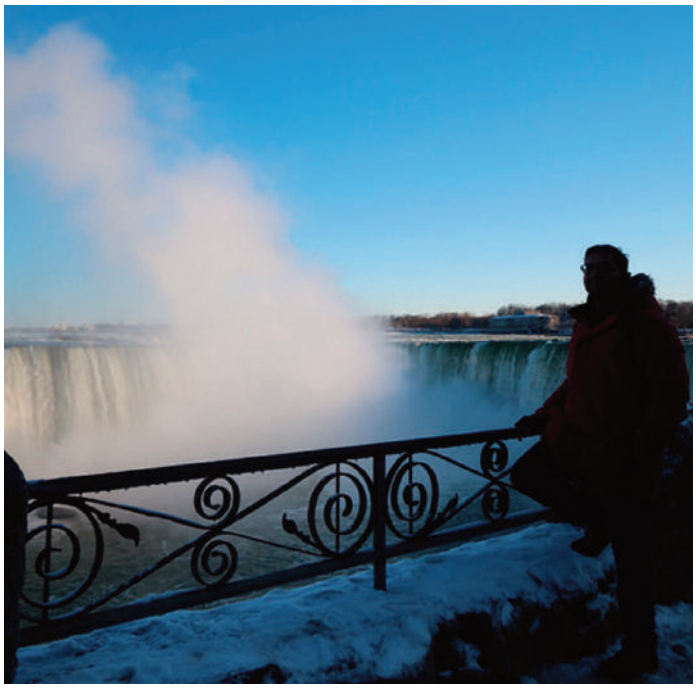


# B Braun Aesculap Travelling Scholarship

## January 2020, Zane Cohen Centre for Digestive Diseases, Mount Sinai, Toronto

One of the more interesting cases I encountered was patient with a Kock pouch (continent ileostomy). It is an operation that has been superseded by the ileoanal pouch, but can still be used in patients in whom ileo-anal pouch has failed or are unsuitable for an ileo-anal pouch due to completion proctectomy or poor sphincter control. The procedure itself involves forming a pouch from the terminal ileum and intusscepted to create a one-way valve mechanism that can be intermittently catheterised.

That afternoon, I was timetabled to attend the 'operating room'. On arrival, I was given a set of visitor scrubs, which were made out of the same material as cheap surgical drapes. One of the male assistant professors described the discomfort wearing them being similar to a cervical smear and therefore took pity on me and thankfully gifted me with a set of his scrubs.

The set up was very different to that in the UK. Although, theatres themselves were similar in size to those within older NHS hospitals, they did not have anaesthetic room and induction of anaesthesia occurred on table while the scrub team prepared simultaneously.

All checks and briefing were performed in theatre once the patient had arrived, including discussion of the surgical plan, which even though I found unusual, the patients weren't taken back by this.

Outside each set of theatres was a store room containing consumables and also sinks for the surgical team to scrub. The surgeons would scrub once the patient was asleep and then enter theatres via opening a no touch door, dry their hands on surgical towels handed to them by the scrub nurse, before having the scrub nurse also don their gown and gloves, much like in the American medical TV shows. One similarity to the NHS however, was that they still have scissors that don't cut!

Surgery is an aetiology-based service with teams structured to manage specific pathologies, such as IBD or oncology rather than the typical format of the UK. During my time at Mount Sinai, I saw a variety of IBD resections and proctology, but disappointingly was unable to see any pouch formations.

One of the assistant professors, Anthony de Buck van Overstraeten had trained and worked in Leuven prior to taking up a position at Mount Sinai. As part of his research, he evaluated the role of modified side-to-side isoperistaltic strictureplasty over the ileocaecal valve as an alternative to ileocaecal resection in patients with extensive terminal ileal Crohn's. I was lucky enough to see an isoperistaltic anastomosis performed and also discuss the role of the procedure with him including the potential ability to subsequently perform endoscopic dilatation should there be subsequent stricturing.

In addition, as part of his previous work in Leuven with Professor Andrei D'Hoore, he also performed laparoscopic ventral mesh rectopexies which is a rarity in Canada with the majority of pelvic floor procedures performed being posterior rectopexies and perineal procedures.

I was able to also observe an IBD board (multidisciplinary team meeting), as well as a colorectal tumour board at the adjacent Princess Margaret Cancer Centre. I was extremely impressed by the educational element of these meetings with explanations for the junior staff attending.

Overall, I was extremely impressed by the high level of teaching and the involvement of senior staff. The format of training is very similar to that of the UK and I'm glad that I was afforded the opportunity to both gain experience of healthcare in another country and also visit one of the most prestigious units managing inflammatory bowel disease in the world. I'd like to thank both ALSGBI and B Braun for the award to allow me to visit Mount Sinai and of course the team at Mount Sinai for hosting me.

I was also able to finish my trip by celebrating my birthday at 360 The Restaurant at the CN Tower, with revolving views of Toronto from 351 metres and also visit Niagara Falls.

**Mr Rikesh Patel**
Winner of the B Braun Travelling Scholarship 2019

# DETAILS OF THE TRAVELLING SCHOLARSHIPS 2021

The **Association of Laparoscopic Surgeons of Great Britain & Ireland** (ALSGBI) incorporating **R**obotic **&** **T**echnology **E**nhanced **S**urgery (RATES) is funding two scholarships in memory of the late Mr David Dunn, a Past President of the ALSGBI.

**The David Dunn Travelling Scholarships** are to the value of £2,000 each*. The purpose of these scholarships is to enable UK-based surgeons in training, or young consultants within 5 years of appointment, to extend their experience in minimal access surgery by short visits to one or more centres. The successful scholars will be expected to give a report on their visits at a future ALSGBI Annual Scientific Meeting and also write an article for the ALSGBI Newsletter.

ALS GBI


All candidates MUST request an application form from Mrs Jennifer Treglohan, Executive Director, ALSGBI at The Royal College of Surgeons of England, 35–43 Lincoln's Inn Fields, London WC2A 3PE or email **jtreglohan@alsgbi.org** and be current members of ALSGBI. The deadline for receipt of applications is 1 November 2021. The successful applicants will be notified by 14 November and will be presented with their certificates at the ALSGBI 2021 Annual Scientific Meeting on 7 December in London. For full information on the ALSGBI visit **www.alsgbi.org**

*Terms & Conditions apply. The funding will be released when the successful applicants are in situ, and the travel must occur within 12 months of the award being made. The successful applicants agree to write a detailed article about their experience and present at the Annual Scientific Meeting.

# Excelling in adversity: The Association of Surgeons in Training (ASiT) Virtual Conference 2021

## 5–7 March 2021

In light of the COVID-19 restrictions on face-to-face events, the ASiT 2021 conference "Excelling in Adversity" was delivered virtually for the first time on Friday 5th – Sunday 7th March 2021.The conference was delivered on the virtual platform Hopin with the help of the team at MedAll. Despite the virtual format the conference programme remained the same with mainstage, breakout and oral prize sessions alongside 1:1 mentoring and the sub-specialty breakout sessions. A record number of courses were delivered across numerous domains. Six of the courses were new additions to the ASiT course portfolio and included a Mini-MBA for surgeons, Introduction to surgical Robotics, Emergency surgery Imaging, Preparing for consultancy, virtual reality in Medicine and Surgery (VRiMS) and the first virtual core laparoscopic skills course. These courses were delivered in collaboration with the trainee speciality associations with generous help from industry. We were able to offer a number of innovative additions to enhance the delegate experience - a virtual photobooth, 1-1 virtual networking and an interactive virtual poster hall.

The Saturday mainstage sessions started with an interactive Q&A discussion with the Surgical Royal College presidents, a key-note lecture from Dame Clare Marx as well as various updates on COVID related surgical training issues. There were sessions on "Technology Enhanced Surgical Training", new Innovations in surgical techniques, a wellbeing campfire chat with Dr Alex George (Government youth mental health ambassador) as well as the annual Silver Suture and Silver Scalpel awards. Mr Christian Asher (2020 Silver suture winner) reflected on his experiences as an exemplary trainer in his talk entitled 'The Shape of Your Training'. The ASiT Silver Scalpel Award, supported by Swann Morton, was awarded to Miss Manjit Dhillon, Oral and Maxillofacial Surgeon at Aberdeen Royal Infirmary for her exceptional efforts as a trainer. The Silver Suture Award, supported by the Faculty of Surgical Trainers was awarded jointly to Mr Tom Lewis (Orthopaedic registrar) and Mr Umar Wali (Trauma and Colorectal registrar) in recognition of their outstanding contributions to surgical training. Mr David O'Regan (Chair of the Faculty of Surgical Trainers (FST) and Miss Lola Giwa (Incoming ASiT President) awarded the prizes. This year we selected Lifebox and The Doctors Support Network as our charity partners. The ASiT Annual General meeting concluded Saturday's formal proceeding welcoming a number of new additions to the ASiT executive from council.

Sunday opened with the prestigious ASiT medal session for the five highest scoring abstracts submitted to the 2021 conference. This prestigious prize was awarded to Mr Arwel Poacher for his work entitled "The Four Year Clinical and Economic Impact of an Extended Screening Program for Developmental Dysplasia of the Hip in Cardiff and Vale University Health Board". The new B.Braun Innovation prize was awarded to Mr Bence Baljer for his work on "Resorbable Composite Materials for Fracture Fixation" and The Prakash Sinha Quality Improvement and sustainability award was awarded to Mr David Hopkins for his work on "Theatre and the environmental impact: if you don't measure it can't be managed". The ALSGBI laparoscopic prize was won by Mr Jeffrey Leung for his work entitled "Quality of Clinical Practice Guidelines for Laparoscopic Surgery: Systematic Review". There were over 40 oral and poster prizes awarded this year.

Baroness Helena Kennedy shared her experiences as Lead for the Independent review of diversity in the RCSEng professional leadership in the "Equality and Diversity" session and Professor Farah Bhatti (WinS Forum chair) gave an inspiring talk celebrating 30 years of the Women in Surgery network. Mr Michael Okocha (ASiT Equality & Diversity Officer) announced the release of the ASiT Equality and Diversity policy as well as the launch of the fifty faces in Surgery campaign. There were sessions on "Social Media in Surgery" and "Working together to better Training" where we heard updates from the GMC, BMA and the ATDG.

Twelve Breakout sessions were delivered across the weekend. These sessions were delivered in virtual breakout rooms which augmented and complemented the content delivered on the main stage. Mr David O'Regan and Professor Bijendra Patel gave excellent live surgical skills and laparoscopic skills demonstrations respectively. There were sessions on flexibility in surgical training, finance for surgeons, planning a successful FY3 & CT3, "How to write a paper" session as well as talks from COVID-19 related collaborative study leads and a National Innovation Dragon's Den ran by the Medtech Foundation. There was also an equality and diversity debate on the topic "Racism is institutional. The individual has to adapt" which was a fascinating debate. GASOC (Global Anaesthesia, Surgery and Obstetric Collaboration) completed the line-up of breakout sessions with interesting panel discussion around Task Shifting and Sharing in Global Surgery - Celebrating Transferable Skill.

This conference was the result of a true team effort. We thank our sponsors, our General Manager, Ms Kristina Gloufchev, the entire ASiT Council, the MedAll team, the volunteers, the numerous course faculty and speakers, surgical subspecialty trainee association presidents and representatives for giving so generously of their time to make ASiT 2021 such a memorable one. Despite the restrictions of COVID-19 we have pushed the boundaries of what is possible. We welcomed >1300 delegates from 27 different countries around globe making it the biggest and most inclusive ASiT conference to date. We look forward the year ahead and welcoming everyone back in 2022!

**Mr Joshua Clements**
ASiT conference Co-ordinator
**Mr Joshua Burke**
ASiT President
**Mr John Mason**
ASiT Director of Education

# Innovation, efficiency and tackling inequalities: Three drivers for NHS success beyond Covid-19



Over the last year, I've had many conversations with NHS managers, policy makers, doctors and nurses. It's impossible to exaggerate how tough this period has been for each of them – especially those on the frontline in hospitals. But hearing the spirit that has got them through these incredibly difficult times has been truly inspiring.

I believe that in times of adversity, people often find clarity. Witnessing the focused way healthcare professionals have dealt with the challenges of an unknown virus, unprecedented capacity struggles and the need to look after one another at work has been beyond impressive.

### Clarity through adversity

My own organisation has faced challenges too – in normal times, colleagues are in theatre each day supporting surgical teams with the medical technology used in operations. A reduction in elective cases and reduced physical interaction with our healthcare partners has certainly proved difficult; all happening at a time when our business was preparing to meet the challenges of exiting the European Union.

But despite these difficulties, we too have managed to find the clarity required to focus on what matters. As the virus hit, we were clear that we needed to focus solely on the ways we could support the health system and ultimately our patients.

I'm proud of what we have achieved through virtually supporting surgical teams, a revamped digital HCP training programme, supporting the reconfiguration of NHS surgical services, the introduction of digital tools as well as donations to the frontline.

But the intention of this article is not to boast about the ways we have supported, but to explore how we can make the most of our collective learnings and current mindset to support the NHS as it recovers from this pandemic in the months and years to come. There are three interconnected areas that have served us well across the last year and should drive us to success going forward, both for our industry as well as the NHS itself: Innovation, Efficiency and tackling Health Inequalities.

### The time for innovation

The pandemic has demonstrated how quickly things can happen when there is critical need for innovation at speed, – whether it be procuring PPE, reconfiguring hospitals or developing a vaccine. We need to have that same sense of urgency in reducing the surgical backlog and improving public health when the challenge of Covid-19 subsides.

The Government has an opportunity to embrace innovation more than ever before – to take advantage of its new position outside of the EU and create a mindset and regulatory landscape where the UK is an attractive market for innovation at speed. Of course, the MedTech industry must continue to innovate in a timely manner, but the NHS must be supported to be able to embrace and adopt new technologies that increase patient outcomes and reduce patient length of stay.

### Data and efficiency

Collaborating to harness valuable data to make informed decisions for patients is key. Data is fundamental for understanding the burden of disease and unmet need, as well as delivering new treatments and quality, safe, personalised healthcare. We must allow data to flow freely so the best decisions can be taken, whilst protecting the privacy and trust in the patients we serve.

And we must use this data to become more efficient, reduce variability in surgical procedures and produce care that is smarter and less invasive. At JJMD we use tools like our Surgical Process Institute to support surgeons to follow step-by-step procedures for surgery, and C-SATS which allows for surgeons to provide crowdsourced feedback to each other on videos of procedures to encourage best practice.

We are focused on making sure that Value Based Healthcare is at the front of our plans for 2021. Our teams partner with hospitals and STPs on theatre efficiency management, reconfiguration of services, waiting list management, patient pathway improvement and engagement programmes. We are focused on supporting value, efficiencies and better patient outcomes, alongside the MedTech that we are known for.

### Tackling health inequalities

Most importantly; when we are redesigning services, it is crucial that we have long-term public health challenges front of our mind, committing to tackling health inequalities right across the country. A preventative approach in disease state areas like Atrial Fibrillation and Stroke is crucial. But we must also make sure that proven care pathways and technologies are accessible right across the UK, 24/7 for people, ending the postcode lottery many face when it comes to getting the best care.

Obesity is one area that has been put in the spotlight as it is a risk factor for COVID-19 hospitalisation; but we know that obesity is linked with similar trajectories for other health conditions such as diabetes, stroke, cancer and heart disease. Government must commit to its Obesity strategy and must recognise metabolic disease to include everything from prevention through to treatment, including redesigning weight management services that are fit for purpose and including surgical options. If done properly, these direct interventions can reduce the level of other complications in society that have obesity at their core.

### A collaborative future

The public health crisis we have faced in the last year has certainly taught our industry lessons. It has allowed us to grow, to learn new skills and to adapt our focus to what matters most. Within the NHS, the speed of activation has been exceptional, and I applaud those who have achieved this. When the pandemic eases, as it will in the coming months, it is imperative that we continue to work together with urgency, to make the most of upcoming innovation and technology, to embrace the data, tools and partners that allow us to work more efficiently, and to tackle the public health inequalities that have such a cost on individual and public health in society. We will need to continue to have clarity and laser focus on what matters most, and how we can best achieve our collective goals.

**Hugo Breda**
Johnson & Johnson, Managing Director UK and Ireland

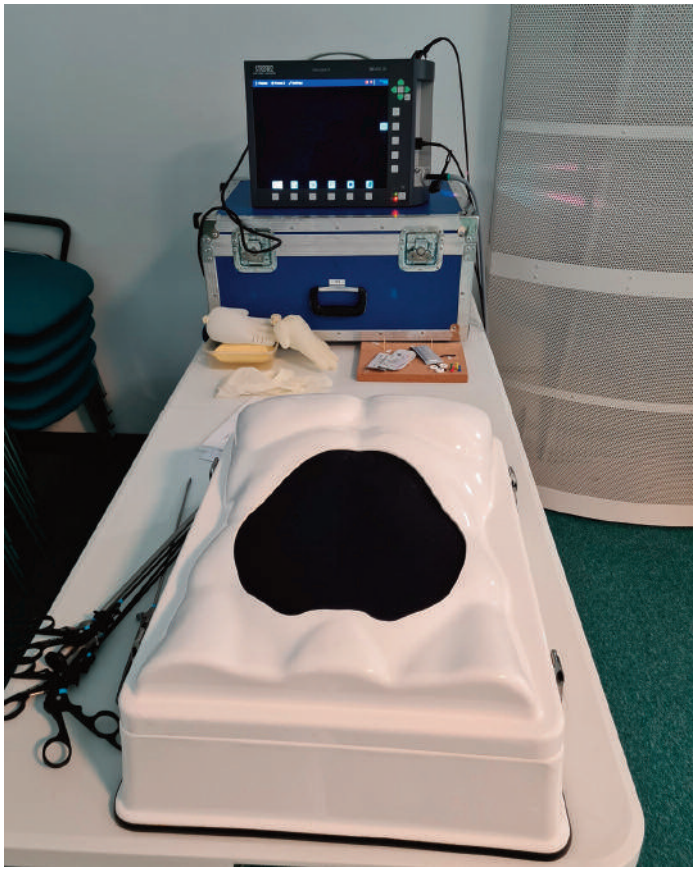
# ALSGBI LapPass® Regional Training Day

## 30 March 2021, Whiston Hospital

We were delighted that Minimal Access Surgery North West (MASNoW), the regional chapter of ALSGBI in the North West and Mersey area, were able to run the LapPass® course face-to-face after numerous previous cancelled events over the last year.

Delayed courses have significantly impacted surgical training, as is well documented, so we were very pleased to have finally been able to run the course on 30 March.

In a socially distanced fashion, we were able to welcome 20 candidates ranging from FY2 up to ST4. There were also 7 faculty members who kindly taught and assessed the delegates, giving up their own time. We were able to offer a mixture of teaching and formal assessments based on what the individual candidates wanted to get out of the course.



It was a great success and three of the candidates managed to complete all LapPass® 4 tasks with a further two candidates completing three of the tasks, which was testament to the high standard of delegates on the course. In addition, the vast majority of the remaining candidates passed at least one of the tasks. The trainers were very impressed with the skills demonstrated and it was evident that delegates had taken time to practice prior to the course, making it a more valuable experience for them.

Informal verbal feedback was very positive from both candidates and trainers; and we are looking forward to the formal feedback in the next few weeks.

The national LapPass® subgroup for ALSGBI is working towards rolling out LapPass® nationally, either face-to-face or virtually. Following the running of a successful LapPass® course, it is a move in the right direction, and a positive sign for the hopeful implementation of LapPass® courses across the country in the coming months and years.

MASNoW would like to thank our candidates for their hard work, and bearing with us following the numerous cancellations. The course could not go ahead without the kind sponsorship from Ethicon and ALSGBI; the help of Karl Storz with providing equipment; and of course, the consultants and senior registrars who kindly give up their time to teach and assess. Inovus were also kind enough to attend and preview their new equipment, taking time to demonstrate to delegates and faculty alike. MASNoW would like to extend a huge thanks to everyone for their support and hard work and we are looking forward to another LapPass® course in the North West in the near future.

**Ms Grace Bennett**
ALSGBI Academy Representative

# Eso-SPONGE®

## Endoluminal Vacuum Therapy for the treatment of Anastomosis Insufficiency and perforations in the upper GI tract

B|BRAUN SHARING EXPERTISE

Anastomotic leakages or other defects in the upper gastrointestinal tract can have serious consequences for the affected patients. Different parameters, like the size, location, time to diagnosis of the lesion, but also the general condition of the patient, have a significant influence on the clinical outcome of the patient. Often this situation is accompanied by symptoms of sepsis and a significant morbidity rate with a corresponding substantial mortality rate. For this reason the treatment of this clinical situation is often a challenge for the clinician.
Besides surgical examination and the endoscopic stent system, good experiences have been obtained with the Endo-SPONGE® therapy for the lower gastrointestinal tract. Endoluminal vacuum therapy for the upper gastro intestinal tract in now available with the Eso-SPONGE®.

### TREATMENT CRITERIA

Eso-SPONGE® THERAPY PRINCIPLE

Treatment of anastomotic leaks or perforations in the upper gastrointestinal tract* by means of negative pressure including intraluminal or intracavitary therapy of paraoesophageal and mediastinal septic focus or localised abscesses endoscopically accessible.

* For use in the upper gastrointestinal tract understood as esophagus, stomach and duodenum, and endoscopically accessible within the range of the overtube length.

### Eso-SPONGE® TREATMENT

Intraluminal and intracavitary therapy possible, see below instructions for intracavitary positioning of the Eso-SPONGE®.

**STEP 1:** The wound cavity should be measured (length and diameter) with an appropriate endoscope (leave the overtube at the distal part of the endoscope to be used in the next step). Cut the sponge slightly smaller than the cavity.

**STEP 2:** Push the overtube over the endoscope and introduce it under visual control using the endoscope as a guide until the tapered end is near the end of the cavity, leaving enough space for the sponge to deploy.

**STEP 3:** After leaving the overtube in the required position, place the drain of the sponge inside the pusher and introduce the sponge, previously impregnated with sterile hydrogel based on glycerol, through the overtube.

**STEP 4:** Push the Eso-SPONGE® to the mark with the pusher. The sponge is now at the end of the overtube (uncut sponge).

**STEP 5:** Advance gently until the sponge is expelled from the overtube, the resistance will fade once the sponge is released. Withdraw the overtube and pusher together.

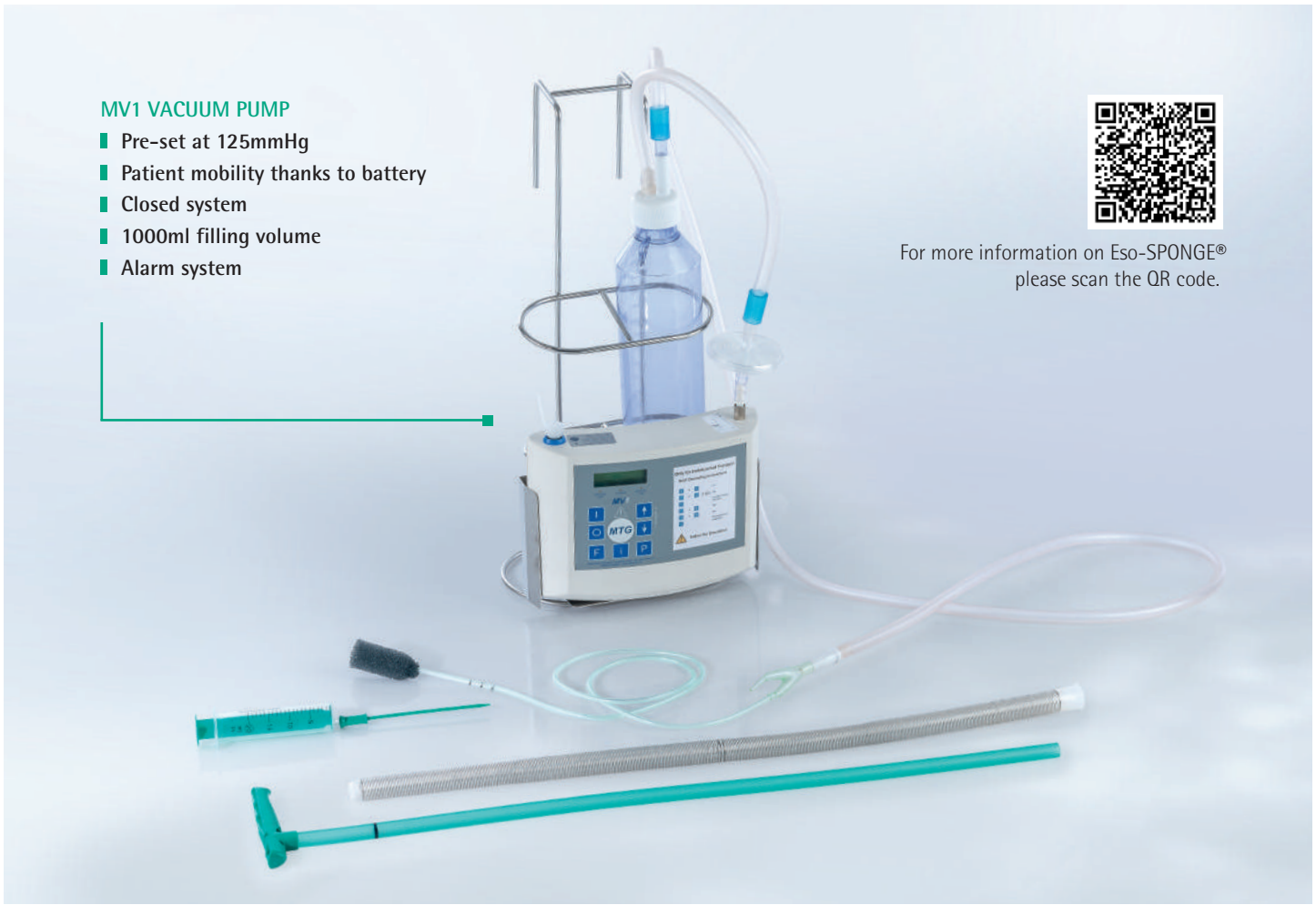
**STEP 6:** The sponge will now expand in the leakage cavity. Check the position of the sponge using the endoscope to make sure that the sponge has not migrated and apply appropriate correction by means of endoscopic grasping forceps if necessary.

**STEP 7:** Transnasal channelling: Feed a 16 CH gastric tube in through the nose and out through the mouth. Cut off the atraumatic tip.

**STEP 8:** Connect the drain to the gastric tube in front of the mouth. Pull the stomach tube together with the drain back through the nose.

**STEP 9:** Disconnect the gastric tube. The drain is now transnasally channelled.*

* Remove of the sponge only through the mouth and never through the nose (!)



# Eso-SPONGE®

## Endoluminal Vacuum Therapy for the treatment of Anastomosis Insufficiency and perforations in the upper GI tract

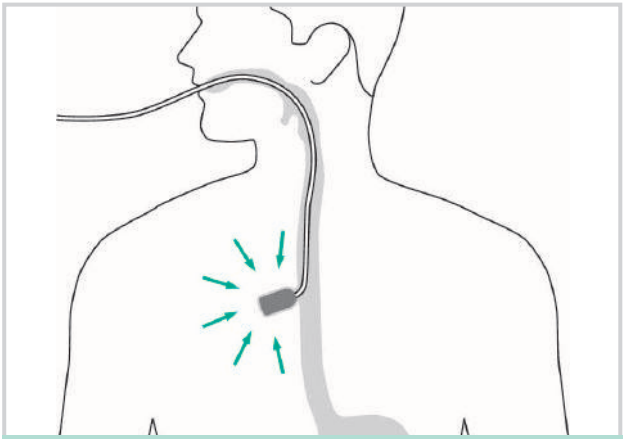
B BRAUN SHARING EXPERTISE

### CONNECTION TO THE VACUUM SOURCE

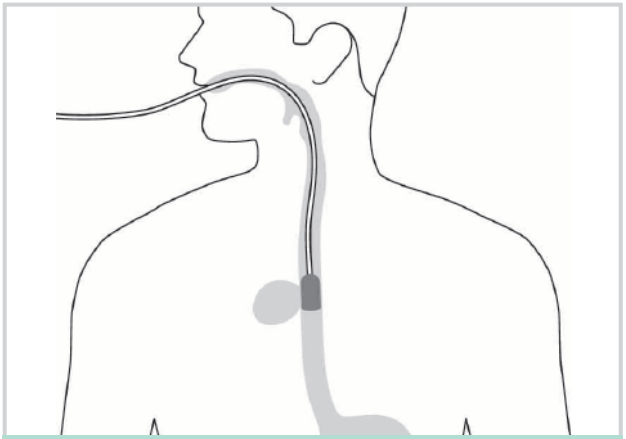
How to use the variable speed medical vacuum pump MV 1 (MTG Sulzbach, Germany – distributed by B. Braun):
**Fig. A:** a) The redon drain must be introduced in the Y-connector to the minimum depth marked by dashed line.
(b) The connection of the secretion bottle must be introduced in the Y connector to the minimum depth marked by dashed line.
**Fig. B:** Connect the filter using a Luer Lock to the pump. Then attach the cylinder hose from the secretion bottle to the filter. Suction is applied, if possible, under endoscopic inspection of the sponge at a negative pressure of 50 to 125 mmHg. Regular checking of the system is mandatory. The system must be changed every 48-72 hours and, where appropriate, a new sponge inserted.

### RECOMMENDED PLACEMENT OF THE SPONGE

- Place the sponge preferentially in the cavity created by the leak or perforation: Intracavitary positioning.
- When intracavitary placement is challenging or not possible it is an option to place the sponge in the lumen in front of the defect:



A Intracavitary positioning



B Intraluminal positioning

### PRODUCT AND ORDERING INFORMATION

Eso-SPONGE®
- Overtube (2 sizes available)
- Pusher
- Irrigation set
- Y-shaped connector
- Slide clamp

NOT INCLUDED IN THE SET:
- Sterile hydrogel (glycerol based)
- Gastric tube CH 16
- Variable speed medical vacuum pump

| ART.-NO. | NAME | DIAMETER OVERTUBE | CONTENT |
|---|---|---|---|
| 5526550 | Eso-SPONGE® 13mm | Inner: 13mm Outer: 17mm | 1 intervention set |
| 5526540 | Eso-SPONGE® 15mm | Inner: 15mm Outer: 19mm | 1 intervention set |

Vacuum source (MV1, MTG Sulzbach)

| ART.-NO. | NAME | CONTENT |
|---|---|---|
| MTG19116 | MV1 | 1x Low vacuum pump |
| MTG18022 | Bacterial filter | 20 units |
| MTG18032 | Collecting bottle | 15 units |

For further information on Eso-Sponge and its **NEW INDICATION: Preventative Therapy to reduce the risk of Anastomotic Leakage in the Upper G I Tract,** please scan this QR code.

# Spotlight on Theatres for a Net Zero NHS

*"It is estimated that 20%-33% of all hospital waste is generated by the operating theatres and a single operation can generate more waste than a family of four produces in one week.[1,2]"*

The Net Zero NHS report stated that "The health and care system in England is responsible for an estimated 4-5% of the country's carbon footprint so has a major role to play in supporting this. The NHS has therefore committed to reaching net zero as soon as possible." It's incredible to think that 4% of the total carbon footprint of the UK is the equivalent of the total carbon emissions of Croatia.

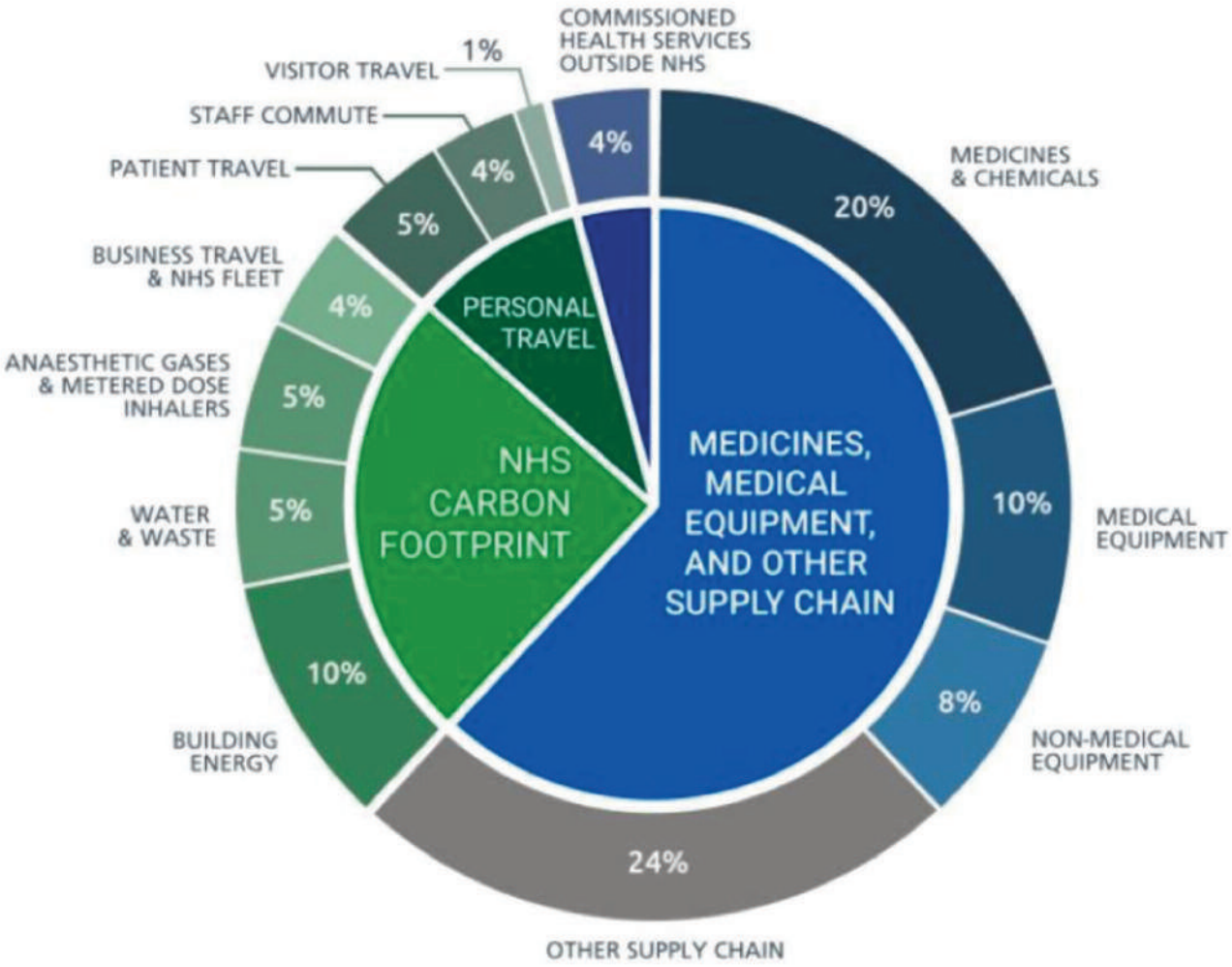



*Figure 1. Graph source: Delivering a 'Net Zero' National Health Service, NHS England & NHS Improvement, Oct 2020*

## Medical equipment accounts for 10% of total NHS emissions

Some of the easily identifiable targets for sustainable improvements in operating theatres seem obvious; waste; energy; water; travel and anaesthetic gases. But as this graph shows [Figure 1] medical equipment has the equivalent impact to $CO_2$ emissions as energy. These 'easy to identify' areas are often a focus. Perhaps because of readily available guidance and support, they tend to appear in many targets and activities approached by Sustainability Officers and departments.

However, one of the most polluting areas of the hospital is the Operating Theatre. Although Operating Theatres physically occupy a relatively small area in hospitals, they generate a disproportionate amount of waste. In the US, it is estimated that 20%-33% of all hospital waste is generated by the operating theatres and a single operation can generate more waste than a family of four produces in one week.[1,2]

A recent study conducted by Ms. C Rizan of Brighton & Sussex UHNT found that major carbon hotspots within the examined operating theatres were electricity use, and procurement of consumables. It was also calculated that:

*"A typical surgical operation generates 150-170kg $CO_2$, which is the equivalent of driving from London to Edinburgh in a petrol car.[3]"*

*Continued*

# Spotlight on Theatres for a Net Zero NHS

## How can operating theatres address this?

Elemental has formed partnerships with a number of organisations to launch the exciting Green Surgery Challenge. This is an opportunity for the UK's surgical community to recognise the value of sustainable healthcare for surgical conditions: to share and promote ways of practising that are less harmful to the environment and our planet and build social sustainability continuing to transform surgery for the future. Applications for this challenge closed on 1st March and 6 successful teams will be selected to receive mentoring from sustainable healthcare specialists at the Centre for Sustainable Healthcare to hone a specific question, devise a project, implement the project and measure the outcomes over a 10-week period. All 6 teams will present their work at a high profile judging and award event held in partnership with the Royal College of Surgeons, England.

GREEN SURGERY CHALLENGE

The Green Surgery Challenge was founded by Elemental Healthcare, The Centre for Sustainable Healthcare and the NIHR MedTech Co-operative in Surgical Technologies. It is supported by the Royal College of Surgeons England, Royal College of Surgeons Edinburgh, AHSN Network, the Sustainable Healthcare Coalition, the Association for Perioperative Practice, and Brighton and Sussex Medical School.

## 98% of 1.3 million NHS staff support this commitment

Reducing the carbon emissions of the NHS is a shared responsibility. The Net Zero report identified that 98% of 1.3 million NHS staff are supportive of the commitment to reduce carbon emissions and Sir Simon Stevens has also made it clear to the supply chain that Suppliers should join the national campaign for a 'Greener NHS'. The report also details that to decarbonise the supply chain the NHS should make more efficient use of supplies and identifies the use of consumables as an area for consideration, proposing that single use devices could be replaced by refurbished, reusable or perhaps even resposable (semi-disposable) instruments. Resposable™ devices reduce waste by 70% compared to fully disposable alternatives.[4]

For some time, we have been making significant efforts personally to reduce our impact on the environment and it is now our responsibility to extend these practices into our working lives.

*Where surgical instruments are equally effective, cost less than what is currently used and have the crucial benefit of dramatically reducing the $CO_2$ footprint then it is important to consider change. Some changes present bigger challenges than others but with increased focus and support by the Greener NHS, a Net Zero NHS by 2040 is in our sights.*


1 *A quantitative, qualitative, and critical assessment of surgical waste. Surgeons venture through the trash can. Tieszen ME, Gruenberg JC. 1992. s.l. : JAMA, 1992, Vols. 1992;267:2765-8.*

2 *Wastage of supplies and drugs in the operating. Esaki RK, Macario A. 2009. s.l. : Medscape Anesthesiology 2009, 2009.*

3 *The Carbon Footprint of Surgical Operations: A Systematic Review Rizan C et al, Annals Surgery 202:272(6):986-995.*

4 *Reducing Plastic Waste in the Operating Theatre - Resposables (Jan 2020, 1st ed.)*

# A Challenging Year

A challenging year would be an understatement and your Association has been at the forefront in that challenge. Firstly, everyone at Lawmed would like to express our sincere thanks to you and your colleagues for rising to the unprecedented problems thrown up by the Pandemic!

We have learned many lessons from adversity and were fortunate to work through it with many hospitals, surgeons and their surgical teams enabling them to conduct safe surgery using our technology. In particular we know that AirSeal played a vital role allowing surgery to be performed at the lowest possible pressure, (between 7-8 mm Hg equivalent safely). When this was combined with our plume evacuation and unique 0.01micron filter system it was a powerful combination that aligned with the directives of ALSGBI, SAGES and other surgical Societies enabling you to perform the safest possible laparoscopic surgery.

We as a company realise that the surgical community and Hospitals face even bigger challenges going forward as surgery resumes. Our strategy at Lawmed is to align with your needs and provide you with the surgical "tools" to lessen the impact on patients, hospitals, surgeons and clinical staff. Our aim is to provide you with products that reduce the impact on the patient, the impact on the surgeon, the impact on resources of the hospital.

We want to provide you with ability to operate at lower pressures, with smaller diameter instruments, speed up the operation, reduce post op pain and reduce the length of stay. We also want to reduce the burden on your surgical colleagues and we have recently been working with a product that may help going forward. We are relaunching a "newer version" of "Freehand" Robotic Arm, which we believe will add to the operational efficiency of the hospitals and help you with your surgical teams.

Our "Low Impact Surgery" concept will be a strategic focus for us and we believe this will strongly align with some ERAS principles and those of ALSGBI and EAES. We do believe that Lawmed can really impact the patient/surgeon journey positively. Recently a publication by "Denost" and his team in Bordeaux demonstrates some clear benefits of operating at Low Pressure (c. 7-8 mm Hg equivalent) in colorectal surgery. We now have 61 publications showing the distinct advantages of using AirSeal Intelligent Flow System, many of which refer to low pressure laparoscopy, LOS, post op pain, reduced opioid consumption and even reduction in post op ileus as a complication.

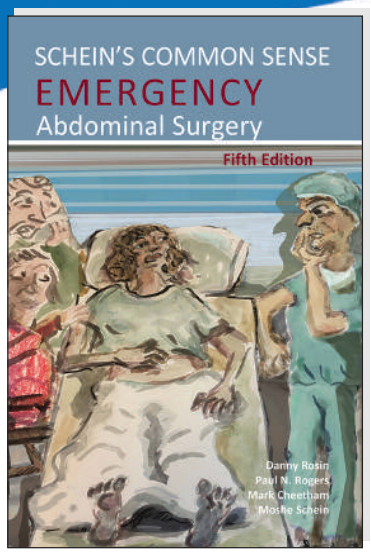
Many thanks again to your Society for the support we received during the pandemic and beyond. We wish you and your patients well in the coming months/years going forward. We look forward to seeing you later in the year.

**John Black**
LAWMED Ltd
www.lawmed.co.uk

LAWMED

**Advancing surgical possibilities**

# HOT OFF THE PRESS...

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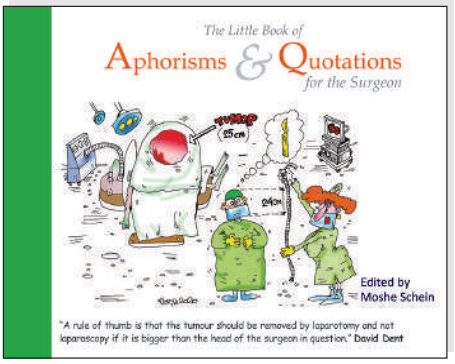


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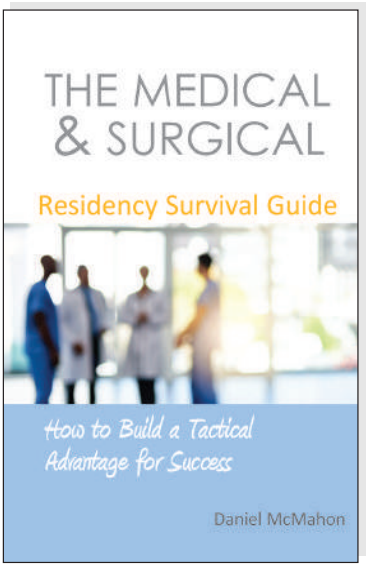


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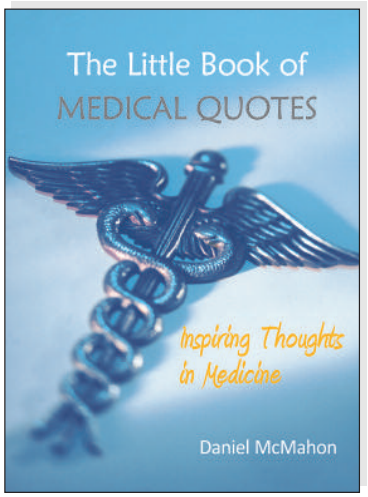


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