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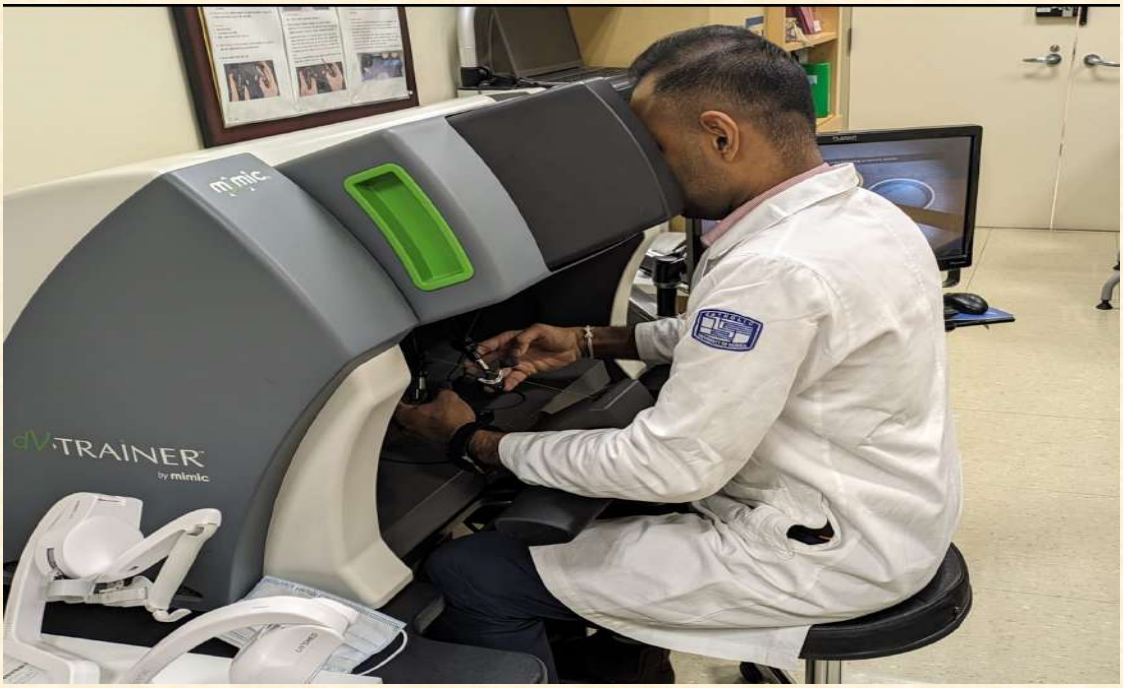

Editors

Kuda B Galketiya

Rifat Jamaldeen

Message from the President - SLAMADS

My dear friends,

Four years after its inception, members of the SLAMADS can all be humbly proud of what we have done and achieved as an association which consists of enthusiastic and talented membership from several subspecialties of medicine.

While education, training, and publishing our work are paramount important aspects of developing MAS in Sri Lanka, we should equally understand the importance of patient safety, to give the expected benefits of MAS to our population. Having understood this clearly, the council of SLAMADS decided to organize a pre-congress workshop at the annual academic sessions of the CSSL on 11th September 2024 in teaching hospital Peradeniya on "Enhancing Surgical Performance".

Endoscopic workshops conducted in the teaching hospital Kandy have become a regular event in the SLAMADS academic calendar. Participants have given very positive and encouraging feedback about this program. We will get this course accredited by the PGIM and make it compulsory for the trainees as we did it for the basic laparoscopic workshop.

Korean Society of Endoscopic & Robotic Surgeons' (KSERS) international training programme is offering regular position to SLAMADS members and our second trainee has got excellent training opportunity for one month in **April 2024.**

Three webinars we conducted over the last three months and the basic laparoscopic workshop for surgical trainees were of international standards and our next task is to start the mentoring programme for surgeons who need a helping hand to fine-tune their laparoscopic skills.

After four years of dedicated service our two secretaries Dr. Rameendra Senarathne and Dr. Udaya Samarajeewa stepped down from the council. Their dedication and tireless work were one of the driving forces behind the SLAMADS and I take this opportunity to wholeheartedly thank and wish them success in their future endeavors.

I take this opportunity to request our membership to visit our website regularly and join the CME programmes that are regularly conducted by SLAMADS and make use of our video library to develop your knowledge and the skills in the field of MAS.

Thank you

Prof. Bawantha Gamage
President, SLAMADS

Evolution of Anti-reflux Surgery

Gastro-oesophageal reflux disease is a common condition and selected patients require surgical intervention.

Philip Allison in 1951, attempted initial hiatal hernia repair by thoracic approach. Nissen's reported on fundoplication in 1956 with a 360° wrap which was accepted as a procedure with good results. While Nissen's procedure improved reflux symptoms, some patients were troubled by dysphagia and bloating. To avoid these side effects, various partial wraps came in to practice. However, these modifications did not solve postoperative dysphagia, for which Donahue and Bombeck pursued, with success, a “floppy Nissen.” DeMeester recognized the benefits of this approach and published successful outcomes in 1986. In 1991 laparoscopic Nissen fundoplication was described by Dallemagne.

Trials comparing laparoscopic total or partial fundoplication have shown equivalently low incidence of heartburn at long-term follow-up.

Most RCTs showed a higher incidence of postoperative dysphagia with total fundoplication compared to partial fundoplication, but settling in a majority. Studies on postoperative esophageal pH testing showed that partial fundoplication resulted in a higher prevalence of acid reflux than total fundoplication at long-term follow-up.

Endoscopic anti-reflux therapies are an alternative for patients unwilling to undergo surgery. Several techniques, such as transoral incisionless fundoplication, nonablative radiofrequency, plication methods, and anti-reflux mucosectomy, have shown encouraging results, but their role in the management of gastroesophageal reflux disease remains controversial.

"Laparoscopic Fundoplication for Gastroesophageal Reflux Disease: Techniques, Outcomes, and Emerging Approaches"

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Key words: fundoplication, GERD, Nissen fundoplication, Toupet's fundoplication, Dor fundoplication, anti-reflux surgery

Abstract

Gastroesophageal reflux disease (GERD) is a prevalent gastrointestinal disorder with varying prevalence worldwide. GERD is defined by symptoms or complications from gastric contents refluxing into the esophagus. Proton pump inhibitors (PPIs) are the first-line treatment, but concerns exist about long-term use, prompting consideration of surgical options like laparoscopic fundoplication. Nissen fundoplication, a complete 360° wrap of the gastric fundus, is commonly used but may lead to side effects like dysphagia. Partial fundoplications, such as the Toupet procedure, aim to mitigate these side effects. Recent studies suggest Toupet fundoplication may have similar efficacy to Nissen but with fewer complications, and new techniques like PoRSHA are being explored for managing large hernias.

Introduction

GERD continues to be one of the most prevalent gastrointestinal tract disorders. A systematic review showed that GERD prevalence ranges from 18.1% to 27.8% in North America, 2.5% to 7.8% in East Asia, and 8.7% to 33.1% in the Middle East[1]. Additionally, GERD prevalence appears to exceed 25% in South Asia and Southeast Europe, while it remains below 10% in Southeast Asia, Canada, and France[2].

GERD is defined as "*a condition in which the reflux of gastric contents into the oesophagus results in symptoms and/or complications*". It is objectively defined by the presence of characteristic mucosal injury observed during endoscopy and/or abnormal oesophageal acid exposure demonstrated on a reflux monitoring study[3].

The cardinal symptoms of GERD are heartburn and regurgitation. Heartburn is the most common GERD symptom and is described as a substernal burning sensation rising from the epigastrium up towards the neck.

Regurgitation is the effortless return of gastric contents upward toward the mouth, often accompanied by an acid or bitter taste. However, GERD may present with a variety of other symptoms, including water brash, chest pain or discomfort, dysphagia, belching, epigastric pain, nausea, and bloating[4].

Proton pump inhibitors (PPIs) are frequently recommended as the first-line treatment for GERD[3]. While PPIs are effective in resolving erosive esophagitis caused by the reflux of gastric secretions into the oesophagus, many patients continue to experience reflux symptoms[5]. Additionally, there is growing concern about the long-term consequences of indefinite PPI use, including vitamin and electrolyte deficiencies, fractures, pneumonia, and C.defficile infection[6].

Surgical Management of GERD

Antireflux surgery effectively controls refractory gastroesophageal reflux disease (GERD) symptoms caused by acid reflux. It achieves this by preventing the reflux of gastric contents through the creation and reinforcement of a mechanical barrier[7].

Indications for Laparoscopic Anti-reflux Surgery for GERD [8]

1. Patients who have side-effects of PPI
2. Patients who are unwilling to take long-term PPI
3. Patients who opt for surgery despite successful medical management.
4. Patients who have complications of GERD.
5. Patients who have extra-oesophageal manifestations.

Types of Fundoplication

Nissen Fundoplication

The first laparoscopic Nissen fundoplication was performed in 1991[9]. The laparoscopic Nissen fundoplication has emerged as the most widely accepted and applied anti-reflux operation. Nissen fundoplication has been the most commonly employed type of anti-reflux procedure for over 50 years.

This technique involves a complete 360° wrap of the gastric fundus around the lower oesophagus, effectively reinforcing the lower esophageal sphincter to prevent reflux. However, this complete wrap can sometimes lead to side effects such as dysphagia, gas bloat syndrome, and difficulty in belching and vomiting.

Partial Fundoplication

To mitigate the side effects associated with the Nissen procedure, various partial fundoplications have been developed. The most notable among these is the Toupet[10] fundoplication, which involves a posterior 270° wrap. Anterior partial fundoplication procedures have also been described, with advocates claiming that these approaches reduce the incidence of dysphagia and other side effects. The 90°, 120°, and 180° anterior fundoplication variants have been described.

Technique of Laparoscopic Nissen Fundoplication

After general anaesthesia, the stomach is decompressed using a nasogastric tube. With the patient in a supine position and legs separated, the operative field is prepared by painting and draping. Deep vein thrombosis (DVT) prophylaxis is achieved through the use of pneumatic compression stockings. The surgeon positions themselves between the patient's legs, while the first and second assistants stand on the left and right sides of the operating table, respectively.

Port Placement

We use a 5-port technique (Figure 1). A 10 mm port is placed at two-thirds the distance between the xiphisternum and the umbilicus after pneumoperitoneum is established using a Veress needle. A 5 mm port is created just below the xiphisternum at the lower edge of the left lobe of the liver to accommodate a Nathanson retractor for liver retraction.

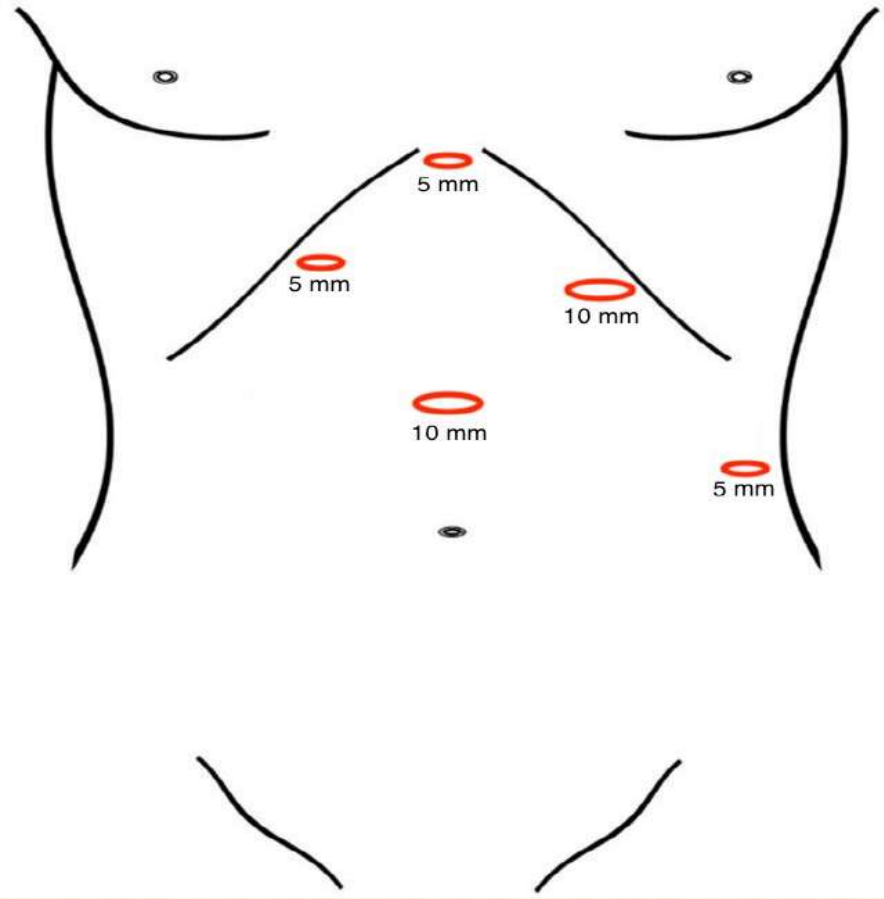

Figure 1 : Port Placement for Laparoscopic Fundoplication

Another 5 mm port is placed in the left midaxillary line aligned with the umbilicus. A 10 mm port is positioned in the left midclavicular line just below the costal margin. Finally, a 5 mm port is placed in the right midclavicular line, below the costal margin, ensuring it pierces the falciform ligament in a manner that avoids liver injury during instrument exchanges. This systematic approach to port placement optimizes access and minimizes the risk of complications during the surgical procedure.

Dissection of the Lower Oesophagus and Posterior Window Creation

The gastrohepatic ligament is divided to visualize the right crus of the diaphragm. During this process, an accessory left hepatic artery or a replaced hepatic artery may be encountered. If such a vessel is identified, a clip is temporarily applied to the artery, and the liver is observed for signs of ischemia over a five-minute period. If no ischemia is detected, the vessel can be safely divided. However, if ischemia is present, the vessel is preserved, as it may be a replaced left hepatic artery originating from the celiac trunk.

Dissection then proceeds towards the medial aspect of the right crus, ensuring that the peritoneal covering over the right crus remains intact. Blunt dissection is carried out between the right crus and the oesophagus, with the posterior vagus nerve identified and preserved. The dissection continues until both crura are visualized. The phreno-oesophageal ligament is carefully divided to expose the oesophagus, with the goal of creating a circumferential dissection around the oesophagus while preserving the vagal nerves.

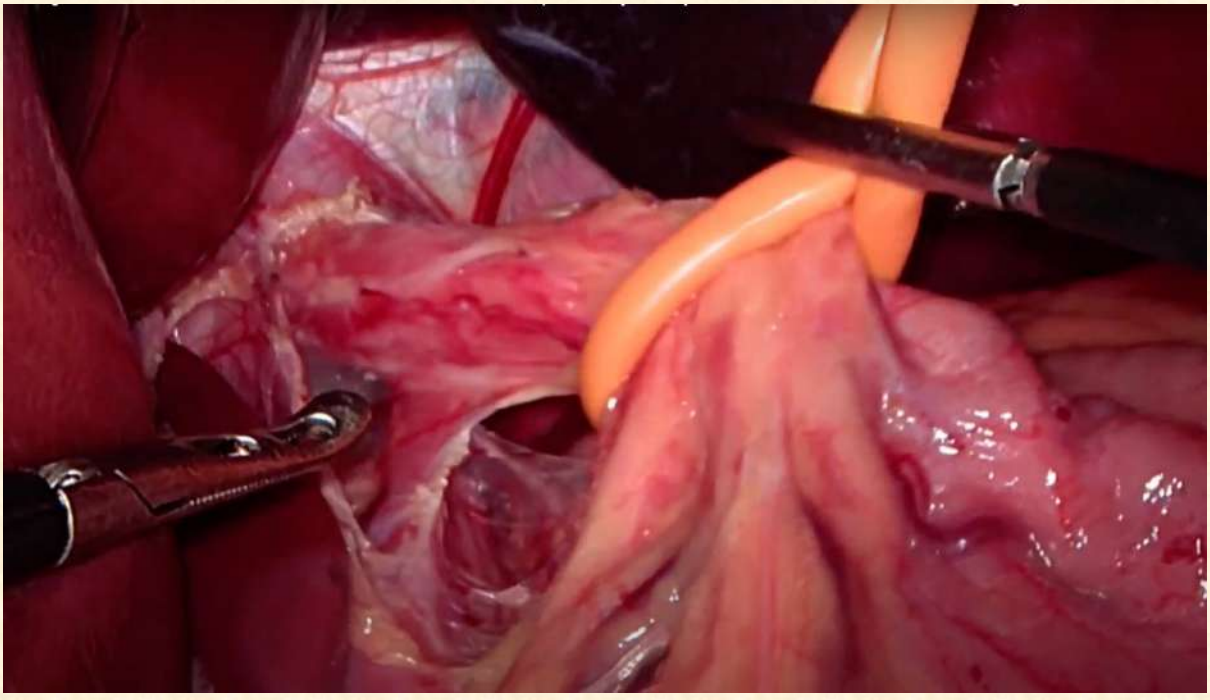

Figure 2 : Placement of Foley's catheter for retraction of oesophagus

A posterior window is then created by dissecting the tissues between the oesophagus and the diaphragmatic crura. This space allows for the placement of a Foley catheter for retraction of the oesophagus, facilitating further surgical steps.(Figure 2)

Assessing Intra-abdominal oesophageal Length

Intrathoracic dissection allows for the lengthening of the intra-abdominal oesophagus. During this step, the oesophagus is mobilized to achieve an adequate length within the abdominal cavity, typically ensuring a minimum of 5 cm under tension and approximately 2-3 cm without tension. (Figure 3) This step is essential to prevent tension on the wrap and to ensure the wrap remains positioned below the diaphragm.

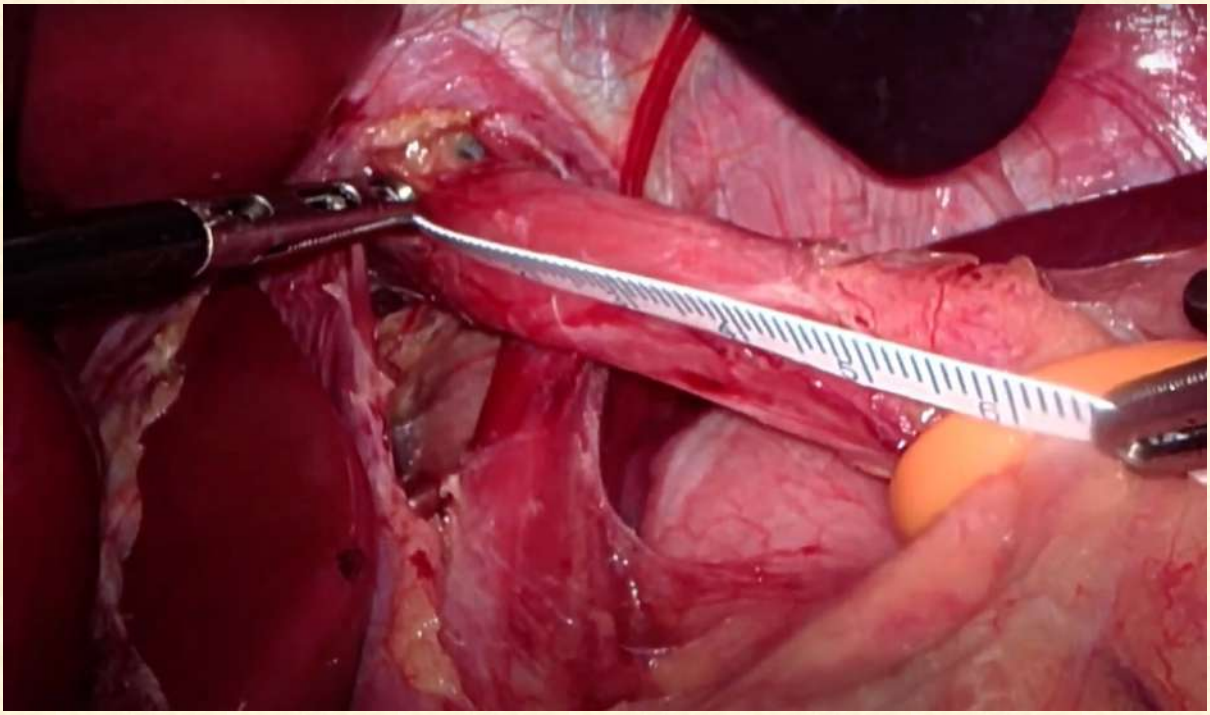

Figure 3 : Assessing length of intra-abdominal oesophagus

Short Gastric Vessels Division

The short gastric vessels are divided till the third vessel to fully mobilize the fundus of the stomach. This division is performed with care to avoid injury to the spleen. The use of an energy source can aid in achieving haemostasis while dividing these vessels. Complete mobilization of the fundus is essential for constructing a tension-free wrap. Division of short gastric vessels significantly reduces tension on the fundus used for the wrap. Two randomized controlled trials compared long-term gas bloat symptoms between patients who underwent division of short gastric vessels and those who did not. The studies found no significant difference in the incidence of gas bloat symptoms between the two groups[11, 12,]. We advocate for the adequate mobilization of the fundus in all patients.

Intraoperative Assessment of the Wrap

The fundus is passed posteriorly behind the oesophagus, creating a 360-degree wrap. The shoeshine manoeuvre is done to ensure no tension on the wrap. (Figure 4)

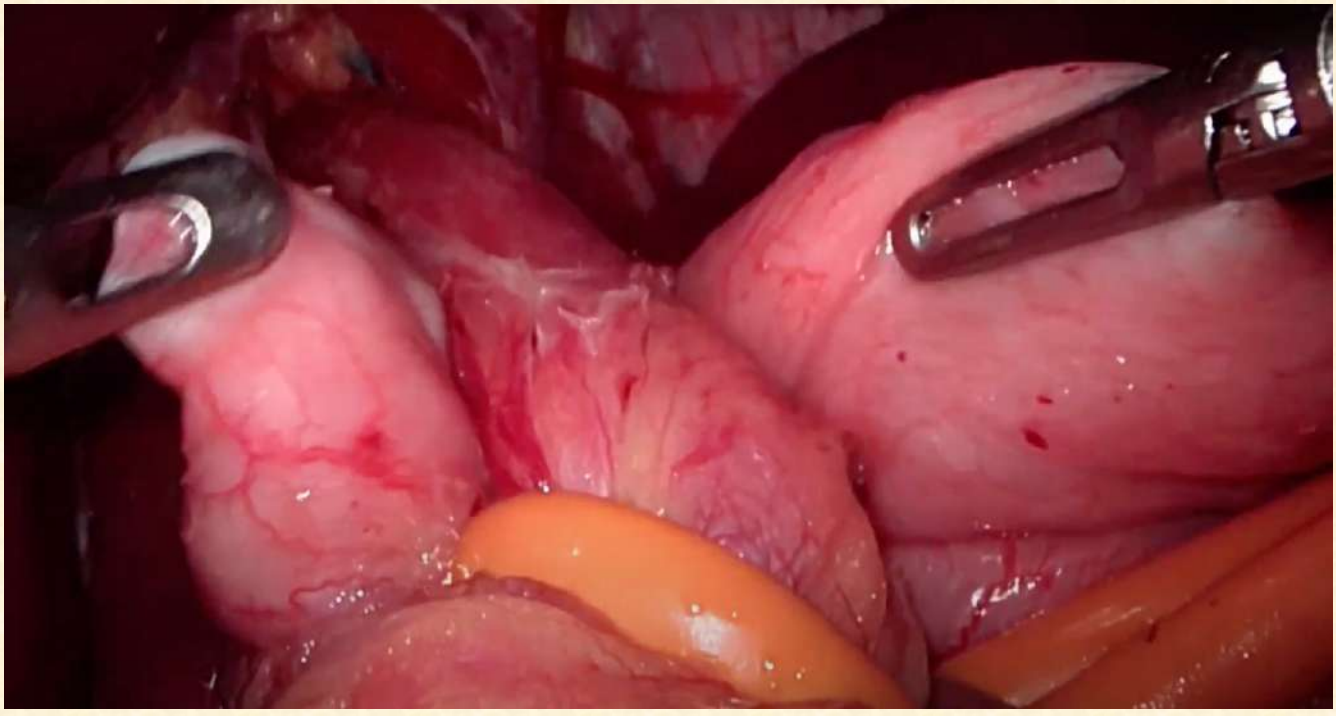

Figure 4 : Shoeshine manoeuvre

Crural Closure

Crural closure is performed to approximate the diaphragmatic crura around the oesophagus without excessive tension, typically using 2-0 Ethibond. This procedure helps prevent hiatal hernia recurrence and ensures the wrap remains in the abdominal cavity. Care is taken to avoid excessively narrowing the oesophageal hiatus, which could cause postoperative dysphagia.(Figure 5) To ensure the crural closure is performed correctly and without undue tension, a 7 French Fogarty catheter balloon is used for measurement[13]. (Figure 6). The Fogarty catheter is placed at the repaired hiatus, and its balloon is inflated with 1 cc of air until it fits snugly in the repaired hiatus. This provides an objective quantitative assessment of the hiatal closure.

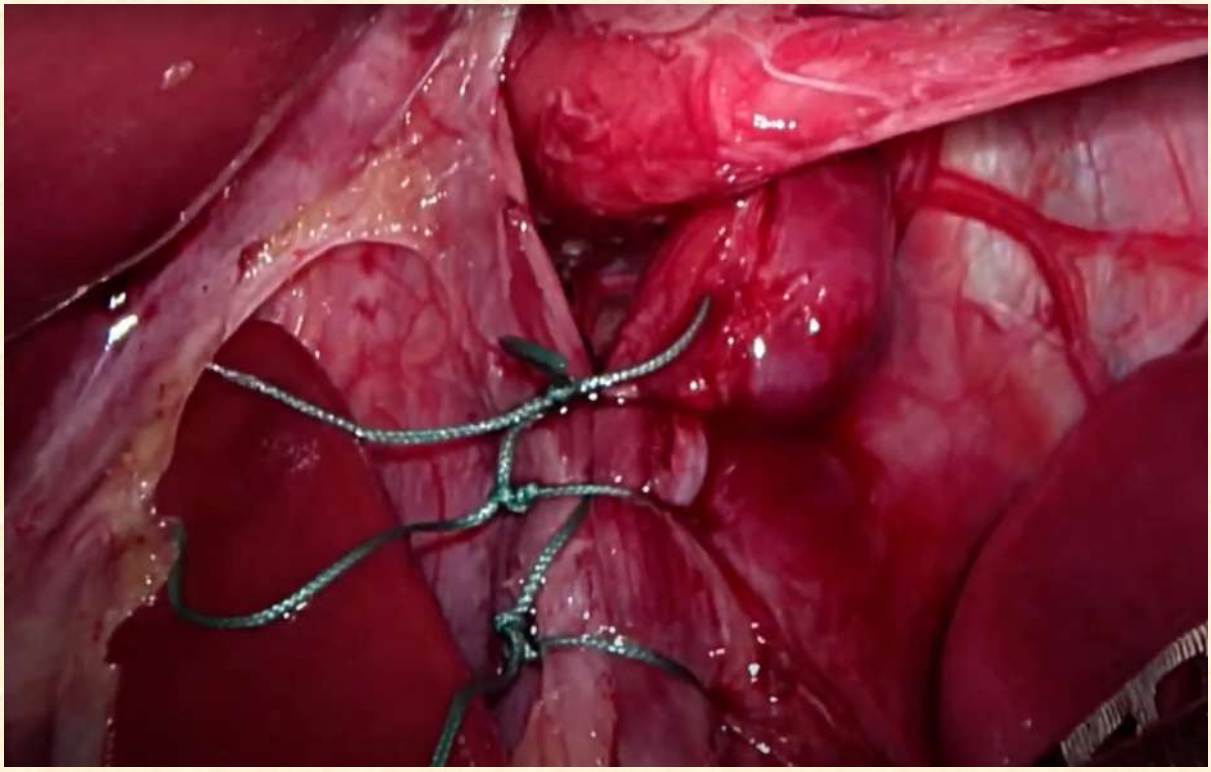

Figure 5 : Crural Closure with 2-0 Ethibond

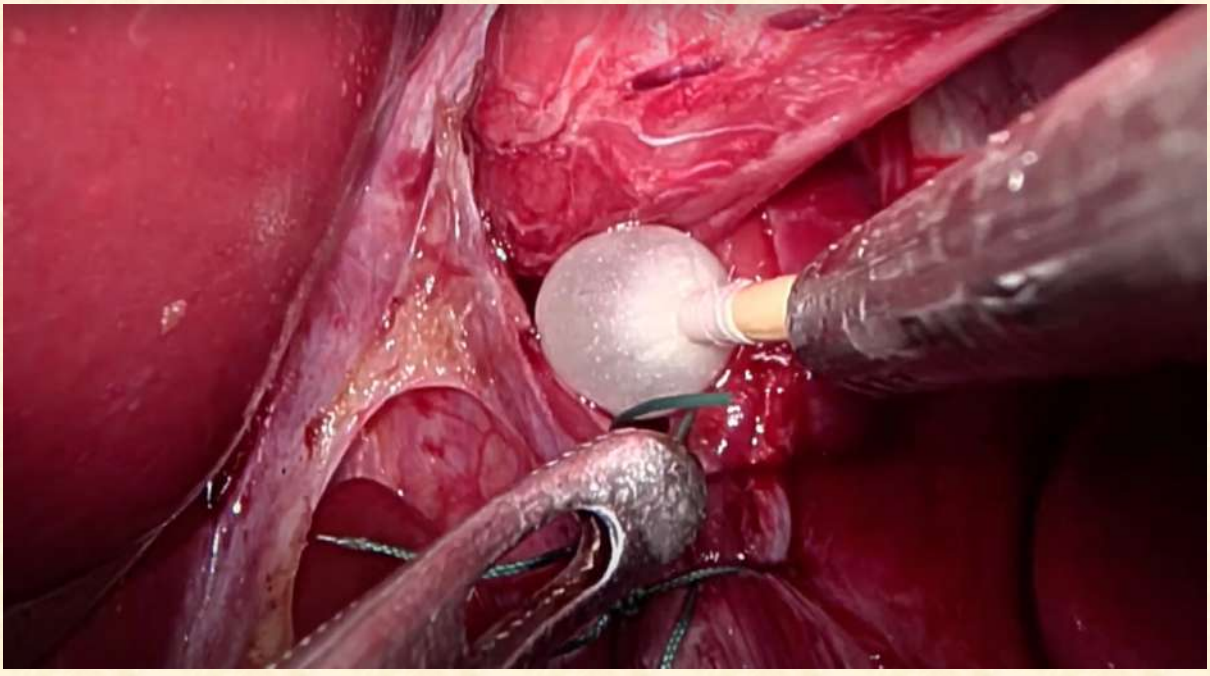

Figure 6 : Confirmation of adequate space for oesophagus with inflated 7 Fr Fogarty Catheter

Postoperative Course

Patients are started on clear liquids immediately following surgery. However, carbonated beverages are specifically avoided due to the risk of gastric distension. Due to oedema at the site of the fundoplication, patients are maintained on a liquid diet for 5 to 7 days, followed by a soft diet for the subsequent 2 weeks. Proton pump inhibitors (PPIs) are prescribed for a minimum duration of 6 weeks postoperatively.

Complications:

Postoperative Nausea and Vomiting:

Patients who retch or vomit in the early postoperative period are at risk of disrupting the crural closure and/or intrathoracic herniation of the fundoplication. Patients with early postoperative vomiting should undergo immediate barium esophagogram to access the integrity of the fundoplication. If a disruption is identified, the patient should be taken back to surgery as early as possible. If reoperation is performed within 4–10 days, the procedure is usually relatively simple, but if it is delayed until adhesions develop, the anatomy may be difficult to discern and manage.

Dysphagia

Dysphagia, particularly with solid foods, is commonly observed in all patients during the first six weeks following fundoplication surgery. This is typically due to postoperative swelling and inflammation, which slows down the passage of food boluses. Dysphagia to liquids is uncommon and may indicate a significant anatomical problem. Initial management includes dietary adjustments (soft foods, increased fluids) and reassurance, with most cases resolving within 2-3 months.

However, between 3% and 24% of patients may experience dysphagia beyond three months[14]. This persistent dysphagia is often attributed to the tightness of the fundoplication around the functional oesophageal pump. Other potential underlying causes include previously undiagnosed conditions such as achalasia, healed peptic strictures, paraesophageal hernias, overly tight crural closure, displacement of the fundoplication into the chest with a recurrent hernia, or slippage of the wrap downward onto the stomach. Patients who had preoperative dysphagia are more likely to experience them postoperatively, regardless of the type of fundoplication performed[15].

Patients with persistent dysphagia require further evaluation. Barium swallow study, oesophageal manometry, and endoscopy are typically employed. If the fundoplication is intact, dilation using a bougie or through-the-scope balloon can activate symptoms in 50% to 66% of cases[16]. For the remaining patients, revision surgery may be necessary to convert a complete fundoplication to a partial wrap. Conversely, patients with slipped fundoplication or paraoesophageal hernias often rquire reoperation.

Gas-bloat syndrome

Gas-bloat syndrome includes a range of symptoms that often occur after fundoplication surgery, where gas cannot escape from the stomach into the oesophagus. The main symptom is bloating, but others include abdominal swelling, feeling full quickly, nausea, upper abdominal pain, gas, and being unable to burp or vomit.

The exact cause isn't clear, but possible reasons include: the surgically altered gastroesophageal junction not relaxing in response to stomach gas; swallowing air (aerophagia); impairment of meal- induced receptive relaxation and accommodation of the stomach with rapid gastric emptying; and injury to the vagus nerve, which delays stomach emptying and disrupts normal burping.

Symptoms are usually worse after total fundoplication[17] compared to partial fundoplication and are most severe right after surgery, often improving within the first year.

Suggested treatments, though not strongly proven to work, include avoiding gas-producing foods and carbonated drinks, eating more slowly to avoid swallowing air, quitting smoking, using gas-reducing medications like simethicone, and taking prokinetic drugs.

Recurrence

The most common symptoms of fundoplication failure are recurrent heartburn and / or dysphagia, with pain and bloating being less frequent. The anatomical causes of primary operation failure can be categorized into three patterns[18]. Type 1A failure, which involves herniation of the fundoplication into the chest, is the most prevalent and occurs in 30%-80% of cases[19,20]. This usually results from the disruption of the crural repair or failure to perform the initial wrap over a tension-free segment of intra-abdominal oesophagus. To avoid these failures, there must be at least 2-3 cm of tension free intra-abdominal oesophagus below the hiatus, and the gastrooesophageal junction must be clearly identified. Type1B failure, known as a slipped Nissen fundoplication, occurs when part of the stomach lies both above and below the wrap. This defect, accounting for 15%-30% of failures[19,20,21] may arise from the stomach slipping through the fundoplication or incorrect positioning of the wrap during the original operation.

Type II failures, presenting as a posterior paraoesophageaal hernia, account for 23% of redo operations in one series[19]. The mechanism is thought to include inadequate hiatal closure or a redundant wrap, with some excess portion of the wrap serving as a lead point in the formation of the hernia.This can be prevented by th “shoe-shine” manoeuvre, which ensures the wrap is not twisted or redundant and is appropriately positioned on the distal oesophagus. Type III failure occurs due to the malposition of the wrap during the initial operation, accounting for about 10% of failures[19, 21]. These patients often present with abdominal pain and worsening regurgitation as a result of their two-compartment stomach.

The most importatnt priniciple during reoperation is to restore normal anatomy before recreating the fundoplication. This requires the complete takedown of the wrap, restoration of the fundus to its normal location, and determination of the degree of oesophageal shortening.

Dysphagia is often the result of an improperly constructed wrap, and to relieve this symptom, the fundoplication must be completely dismantled and correctly reconstructed. Most common symptoms are recurrent heartburn and / or dysphagia, with pain and bloating being less common.

Results

A recent meta-analysis of eight randomized controlled trials concluded that Toupet's fundoplication is equally effective at controlling reflux symptoms and improving quality of life compared to Nissen fundoplication, but with a lower rate of complications[21]. No significant differences were observed between Toupet's fundoplication and Nissen fundoplication in terms of postoperative reflux recurrence, postoperative heartburn, postoperative chest pain, satisfaction with intervention, reoperation rate in both the short and long term, in-hospital complications, short-term esophagitis, gas bloating, postoperative DeMeester scores, postoperative use of proton pump inhibitors, and long-term reoperation rate.

Mesh Usage

The use of mesh in laparoscopic fundoplication remains controversial. However, mesh reinforcement of the hiatus may be beneficial in selected cases, such as redo hiatus hernia repair, large hiatus hernia, or complicated hiatus hernia[22].

A recent systematic review of six randomized controlled trials and thirteen observational studies, encompassing 1670 patients (824 without mesh, 846 with mesh), suggests that mesh reinforcement might offer protection against hiatus hernia recurrence. However, this finding should be interpreted cautiously due to high heterogeneity. Additionally, mesh reinforcement did not significantly reduce large recurrences (>2 cm) or reoperation rates. If synthetic mesh is used, patients must be informed of the risk of mesh erosion[23].

Our protocol is to use mesh only in large hiatal hernias, which are defined as those with >30% of the stomach in the chest, a >5 cm hiatal defect, or a hiatal surface area >10 cm^2.

Posterior rectus sheath hiatal flap augmentation (PoRSHA):

This new surgical technique, called PoRSHA (Posterior Rectus Sheath Hiatal Flap Augmentation)[24], uses an autologous vascularized biological fascial flap (posterior rectus sheath) to reconstruct the diaphragmatic hiatus after standard hiatal hernia repair. It is being studied for the management of large and recurrent paraesophageal hernias. Recent Phase 2a results indicate that it can be safely added to conventional laparoscopic hiatal hernia repair, yielding excellent short-term outcomes.

PoRSHA may offer a novel solution to the persistent high recurrence rates observed with current complex paraesophageal hernia repairs.

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Newly Appointed Office Bearers

Dr Dhammika Rasnayake

Honarary Secretary

Dr Chamila Lakmal

Honarary Secretary

Dr Malitha Nandasena

Council Memeber

Dr Vathsal Bandaranayake

Council Member

Dr Kaushika Gunasekera

Council Memeber

Dr V Sutharshan

Director Education

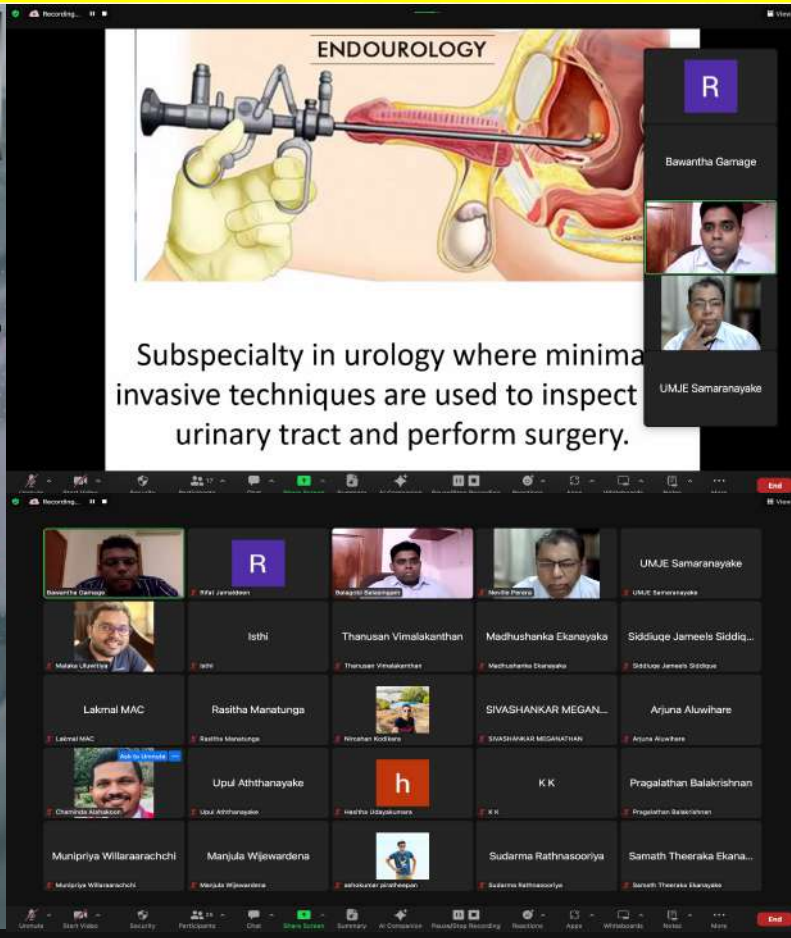
Recently held CME activities

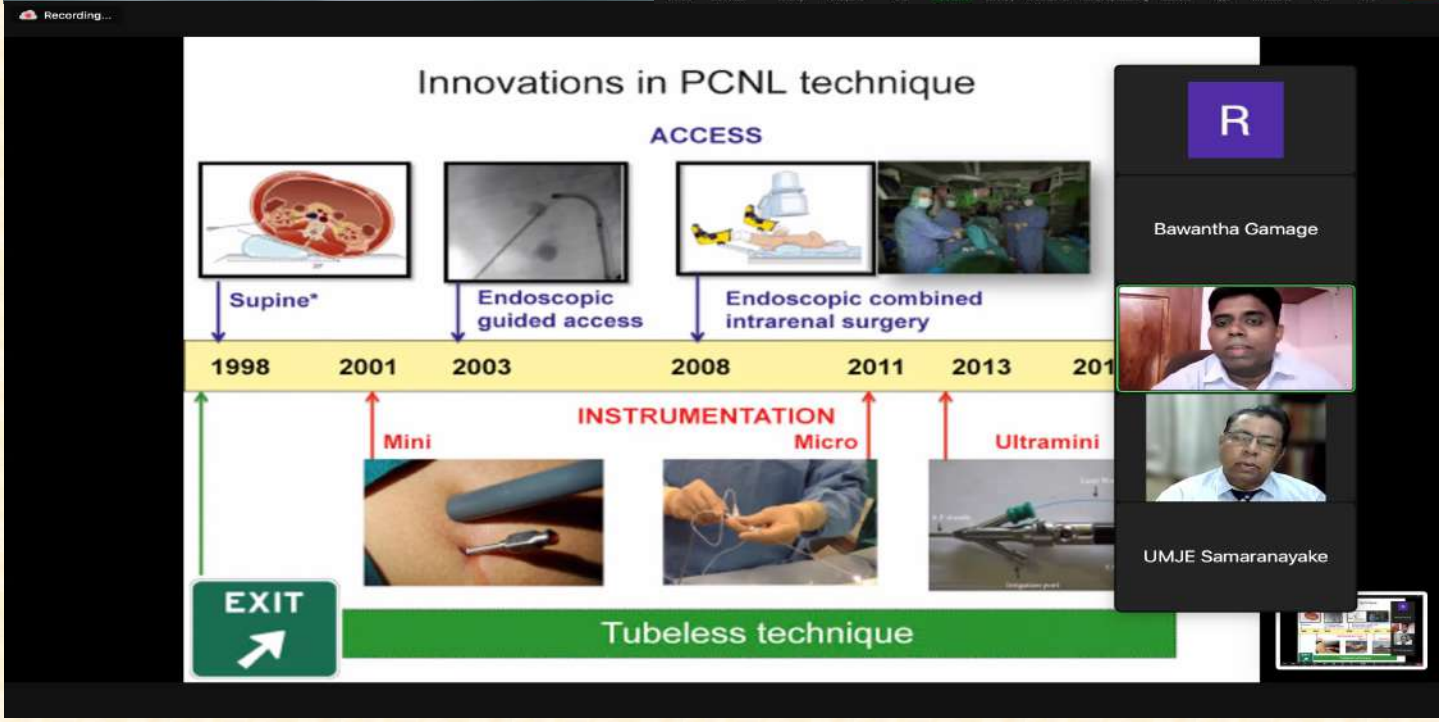
1. Webinar –

Endourology

Laparascopic & Robotics in Urology & recent advances in Benign Prostate Management

Prof Neville D Perera and Dr B Balagobi





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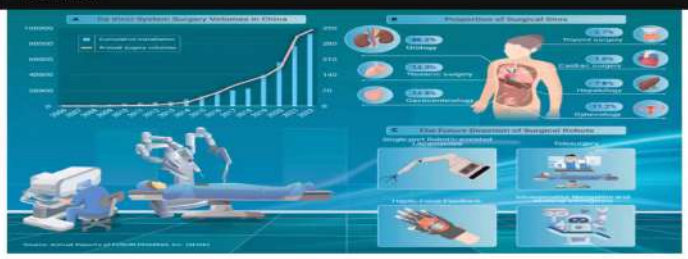


Growth of Surgical Roboties in India

- First robot-assisted surgical procedure took place at Delhi hospital (2002).
- India currently has over 50 surgical robots and it aims to install 100 robots across the nation by 2018.
- Till now, it has trained 360 surgeons and hopes to train a[illegible] days to c[illegible]

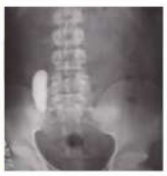
Recording...

Laparoscopic ureteral reimplanation

Supine position a 11mm trocar for camera insertion umbilicus
Ureter is lifted transected as distally as possible
The bladder is filled with 200ml saline
Lateral and anterior peritoneum incised a boari flap is preferred
Spatulated ureter and the bladder flap are anastomosed in a tension free manner with 4-0 polygalactin sutures
A stent is kept indwelling for 6weeks after the surgery

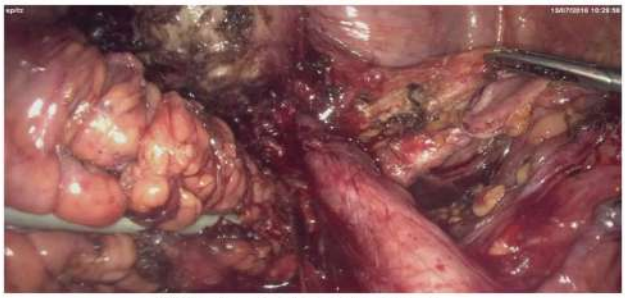
Laparoscopic stone removal

Procedure performed transperitoneal or a retroperitoneal approach
Placement of a stent ureteric catheter
Ureter lifted of the psoas
The ureter is slinged
Using a cold knife the ureter is incised
Spoon may be used for retrieving the stone
Stone may be entrapped in a bag for removal
Ureterotomy is closed with a 3-0 absorbable suture and a drain is placed.



Lich-Gregoir reimplantation

1. **Inflammatory Conditions**: Conditions such as ureteritis (due to stone), tuberculosis, or endometriosis (in women) can cause inflammation and scarring, resulting in ureteric strictures.
2. **Iatrogenic Factors:** Surgical procedures involving the ureter, such as ureteroscopy, pelvic surgeries, or kidney transplantation, may inadvertently damage the ureter and predispose to stricture formation.
3. **Malignancies:** Tumors originating from adjacent structures or metastatic spread can encroach upon the ureter, leading to compression and subsequent stricture formation.

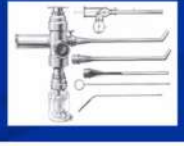


Ureteric anastomotic repair

Recording...

History of Laparoscopic urology

- 1806: Philip Bozzini developed an instrument called a ***Lichtleiter*** (light-guiding instrument)
- 1853: Antoine Jean Desormeaux used Bozzini's Lichtleiter
- 1867: Desormeaux used an open tube to examine the genitourinary tract



Maximilian Nitze (1848 – 1906) invented the first cystoscope (Nitze-Leiter cystoscope) using an electrically heated platinum wire for illumination.

In 1887, he modified Edison's light bulb and created the first electrical light bulb for use during urological procedures.

Original carbon-filament bulb- Thomas Edison

History of Laparoscopy

- 1901: George Kelling, Dresden, Saxony (Germany) performed the 1st experimental laparoscopy, calling it 'Celioscopy'.
- Kelling insufflated the abdomen of a dog with filtered air and used a Nitze cystoscope to look inside.

Bertram Bernheim

- 1911 : First laparoscopy at Johns Hopkins
- 12mm proctoscope into epigastric incision on one of Halstead's patients to stage pancreatic cancer
- Bernheim called his procedure 'organoscopy'
- Findings confirmed on laparotomy

2. Endoscopy Workshop for New Surgical Registrars – NH Kandy

SLAMADS organized an endoscopy workshop for newly passed surgical registrars on 11th May 2024 at the National Hospital, Kandy. The workshop was aimed to provide an insight to basic knowledge and skills on upper and lower GI endoscopy.

Prof. Mohan de Silva embarked on the history and evolution of endoscopy and how modern endoscopy came into practice. He further highlighted the importance of a safe, proficient endoscopist and value of interpreting endoscopic findings, as it plays a key role in diagnosing and treating various gastrointestinal disorders.

Further lectures related to endoscopy were conducted by eminent faculty including Dr. Kaushika Gunasekara, Dr. Chathura Lakmal Piyarathne, Dr. Nandana Dinamithra, Dr. Senal Medagedara and Dr. L R P K B Udapamunuwa.

The Hands-on endoscopy session was conducted in the Central Endoscopy Unit, NH Kandy, where it aimed for trainees to get an insight on endoscopes, accessories and procedures performed by experienced endoscopists.

Trainees were guided through the maintenance and handling of the scopes, techniques, normal and abnormal findings during endoscopy and basic procedures. In addition to the practical training, there were interactive sessions on topics such as indications for endoscopy, patient preparation, sedation techniques, complications and management of complications and use of accessories.

The faculty received immense positive feedback from the trainees who participated and expressed their gratitude for conducting a successful workshop. Many new registrars conveyed the message that the workshop helped to expand their confidence to perform endoscopic procedures. It was also an opportunity for them to meet and indulge in discussions with related experts in the field.

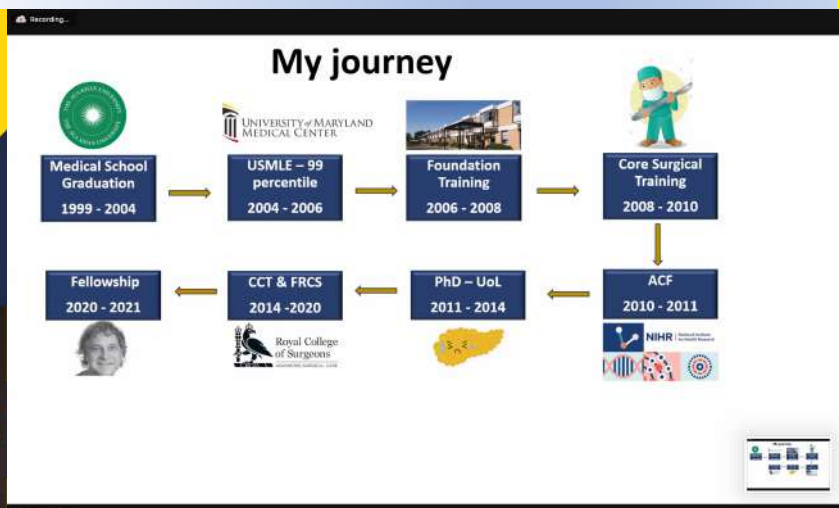
The endoscopy workshop was a tremendous success which provided the new surgical trainees with essential knowledge and basic endoscopic skills that will undoubtedly benefit them throughout their careers.

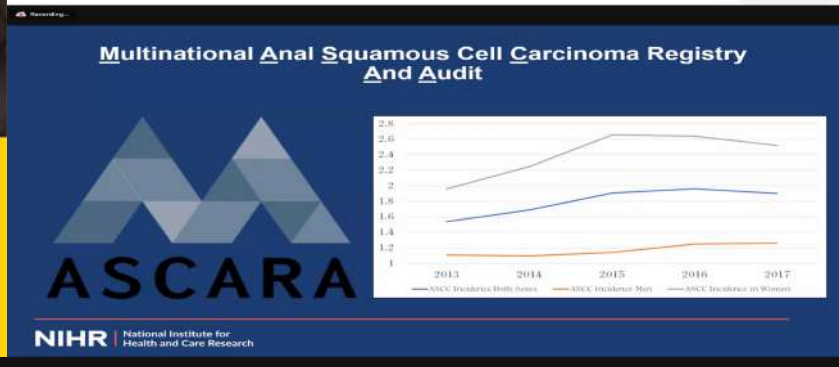
The workshop was organized on behalf of SLAMADS by Dr Chathuranga Keppetiyagama and Dr Nandana Wickramarachchi and co-ordinated by Dr Thushara Wijayaratne.

Dr Nandana Wickramarachchi

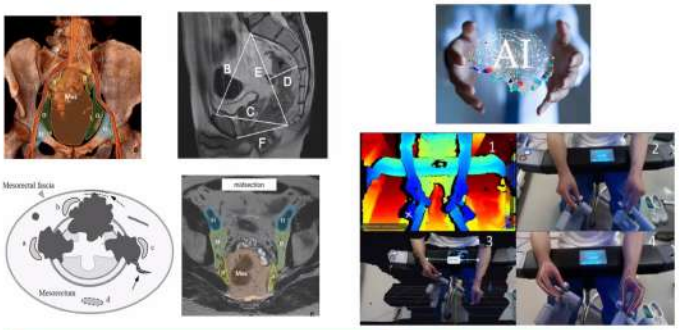
Consultant GI Surgeon – TH Badulla

3. Webinar –
Translational Research in Colorectal Surgery





Hypothesis development - Proctoradiomics



Industrial Collaborations - Pierian Biosciences

CHEMOTHERAPY ChemoINTEL

IMMUNOTHERAPY ImmunoINTEL

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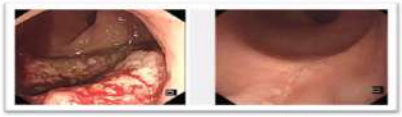
Management of rectal cancer

Neoadjuvant chemoradiotherapy

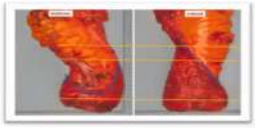
1. 30 %: no response or progression
2. 40 %: partial response
3. 30 %: complete clinical response (cCR)

(option of weight & watch with close surveillance)

Surgery (Total Mesorectal Excision)



Complete clinical response (cCR)



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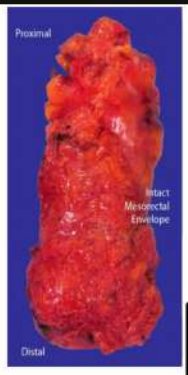
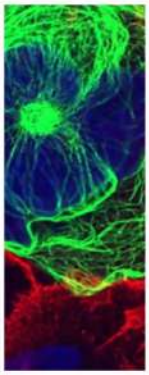
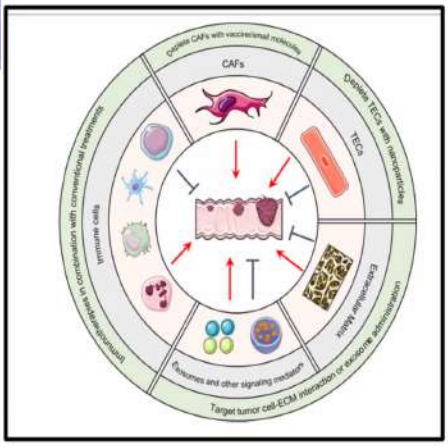
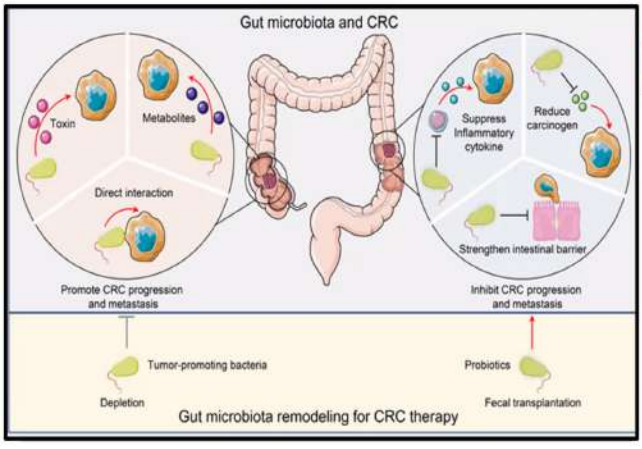


TME vs tme (tumour microenvironment)







Li et al, Front Med - 2022

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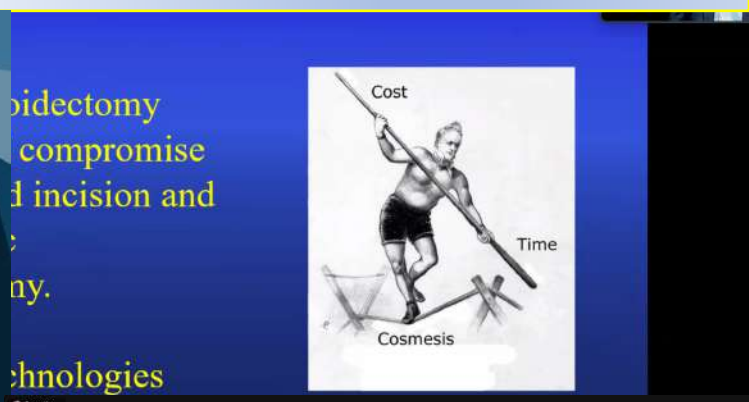
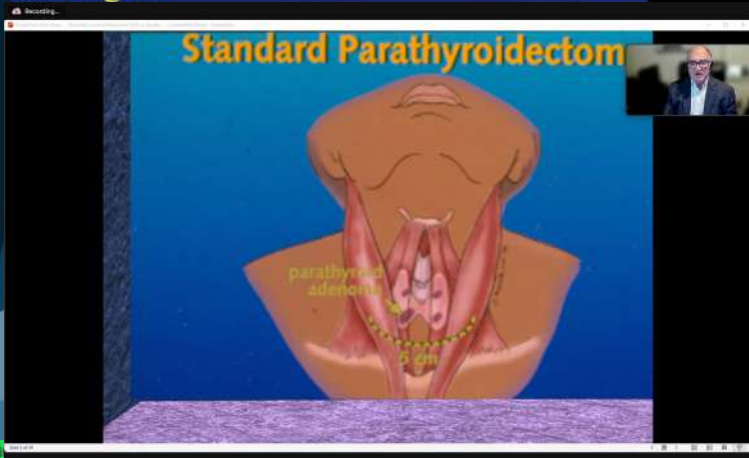
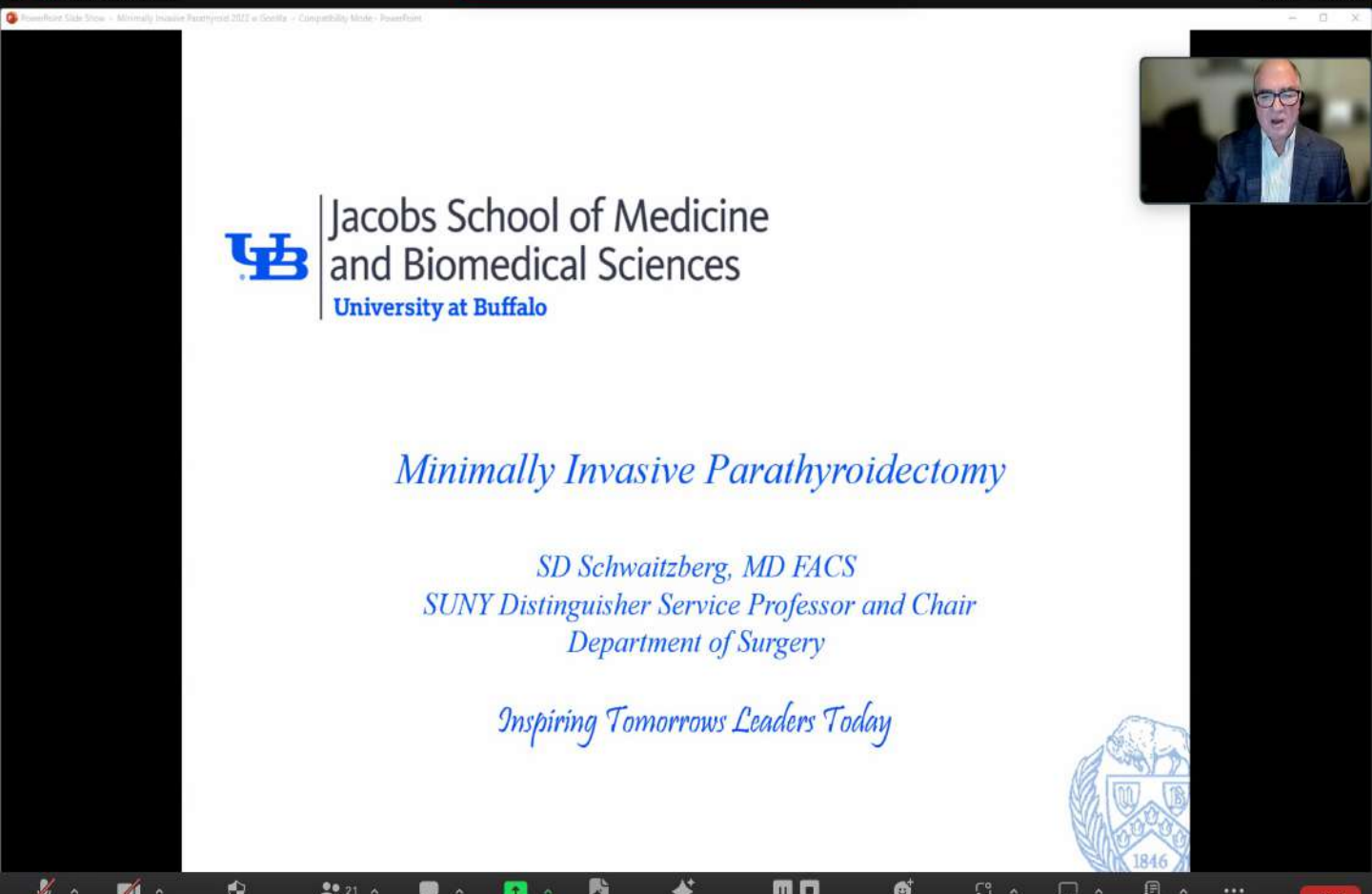
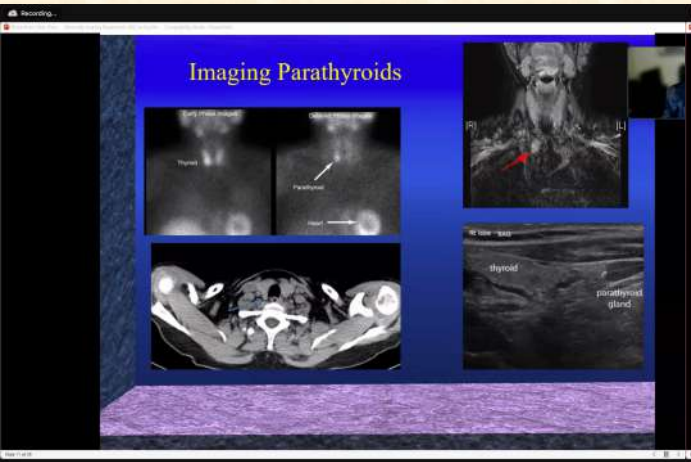
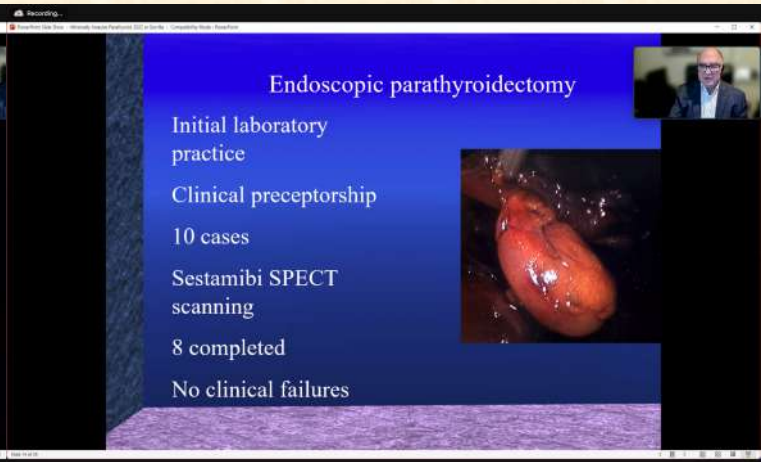
3. Webinar –
Minimally Invasive Parathyroidectomy
By Steven D. Schwaitzberg





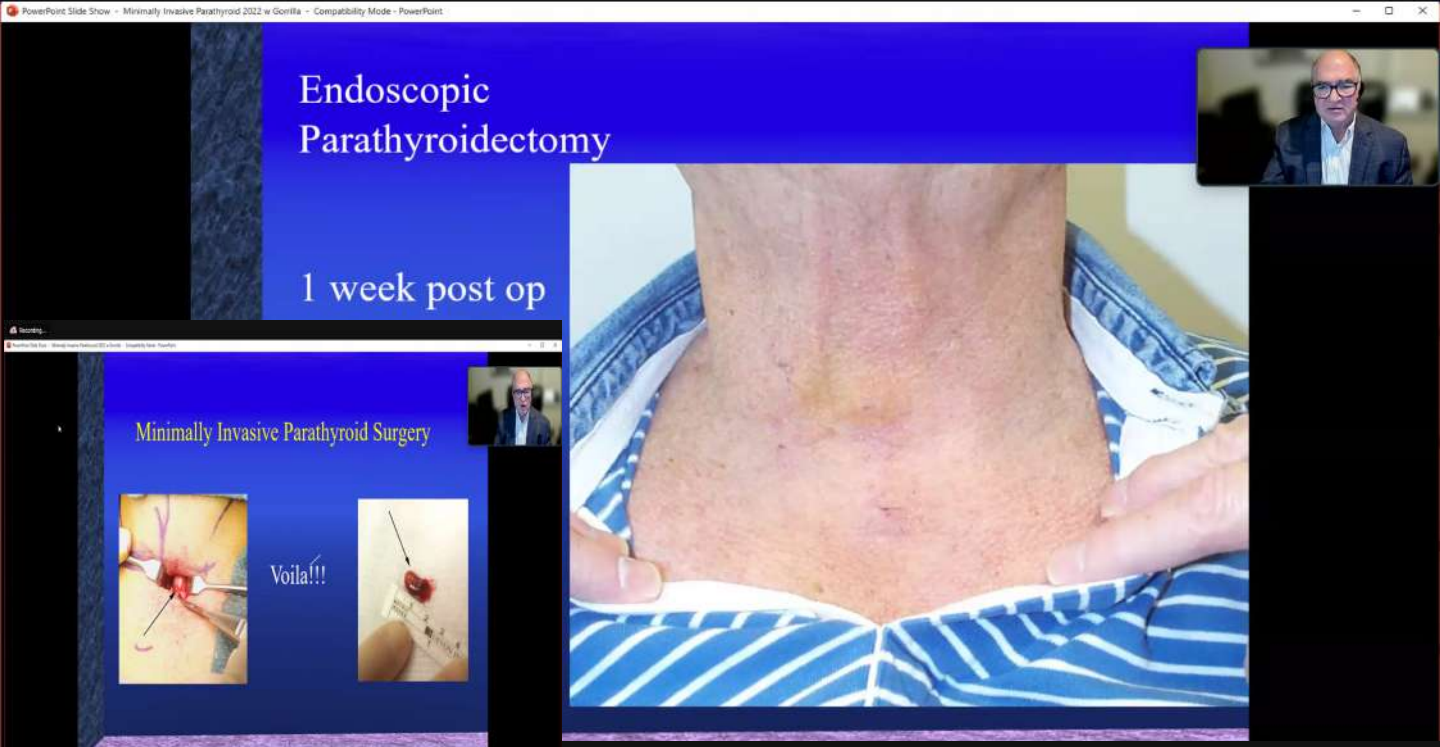


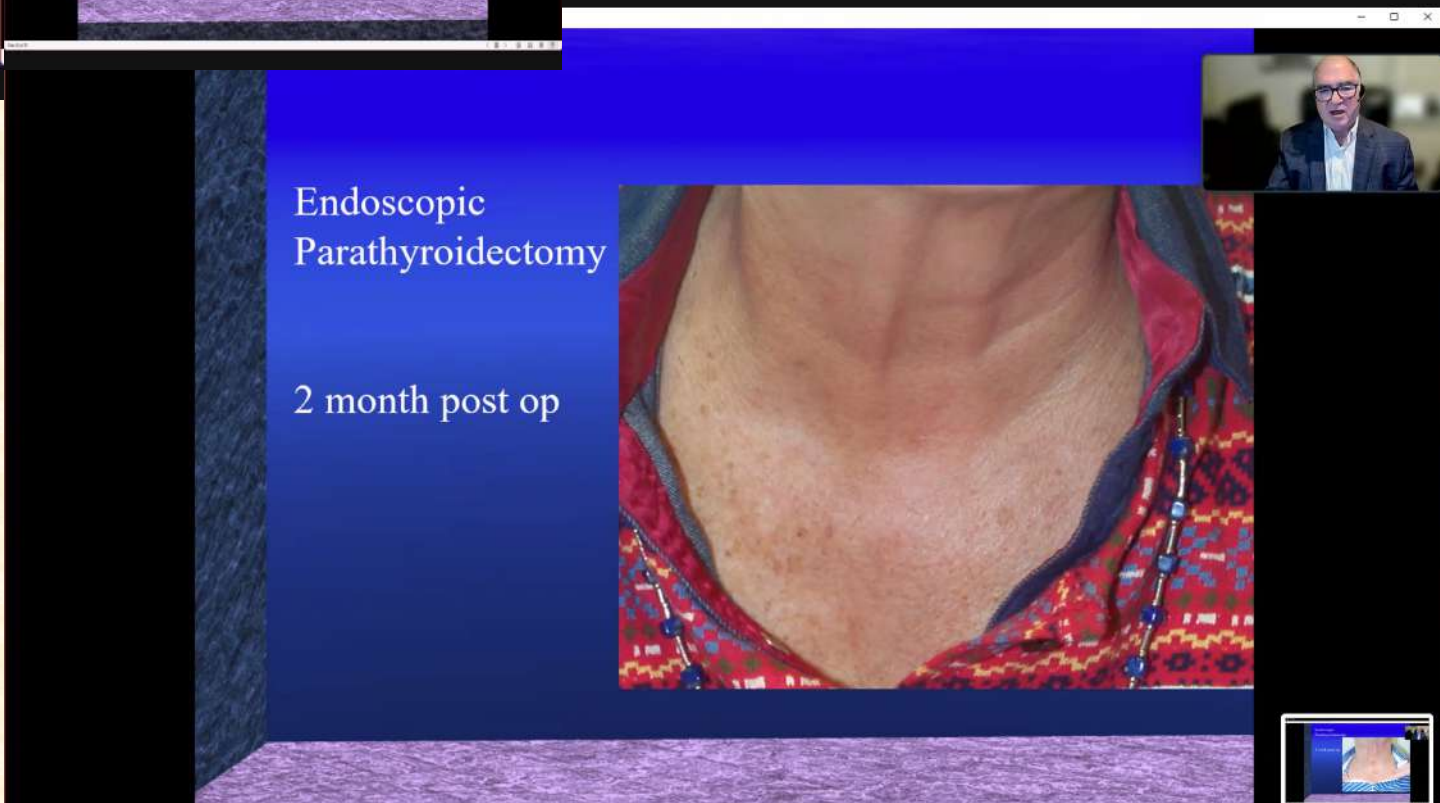




Recording...

PowerPoint Slide Show - Minimally Invasive Parathyroid 2022 w Gorilla - Compatibility Mode - PowerPoint





2. 17th Basic Laparoscopic Skills Workshop For Surgical Trainees

The 16th Basic Laparoscopic Skills Training Workshop was held successfully in the skills lab at the College of Surgeons premises for a two-day duration (25th and 26th July 2024).

20 surgical trainees participated in the training workshop. The course consisted of carefully selected lectures and hands-on training in dry lab and wet lab skills to enhance the basic knowledge and skills of the trainees. Extra time was allocated for suturing practice for the trainees.

New lectures were introduced to cover video capture, editing, and storage.

The course was positively commented on by the trainees, and they were happy about the content and the practical skills.

B Braun International sponsored the workshop, and SLAMADS will appreciate their contribution and effort in organising the workshop.


The College of Surgeons of Sri Lanka


BASIC LAPAROSCOPIC SKILLS WORKSHOP FOR SURGICAL TRAINEES
B BRAUN
SHARING EXPERTISE
BMI
Approved.
MD part II examination

KSERS International training program (ITP)

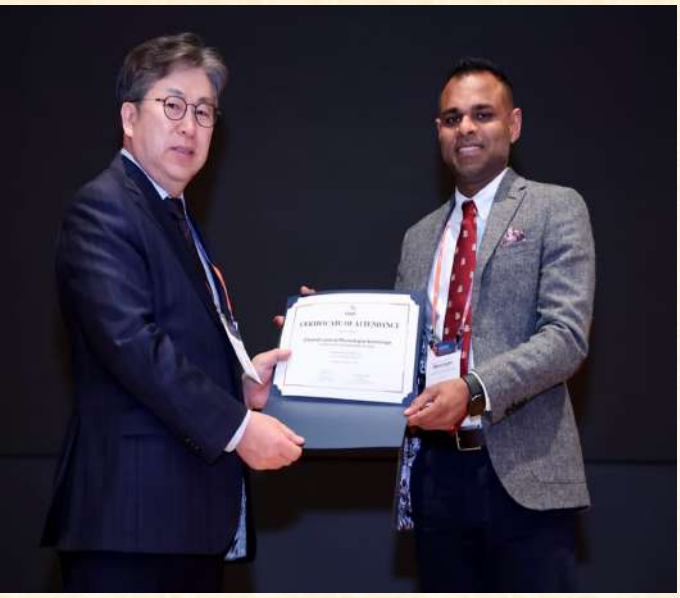
The Korean Society of Endoscopic & Robotic Surgeons (KSERS) had a 1-month International Observership Program for selected candidates from around the world.

The KSERS selected institutions worldwide according to the candidates' preferences, contacted the chairman of the institution and provided financial support for selected candidates. The amount of the scholarship was 2,000,000 won.

SLAMADS was selected as one of the institutions in the recently held observership program and Dr Chamila Lakmal was awarded the full scholarship to attend the KSERS ITP in 2024.

Young surgeons and trainees are encouraged to apply and get benefitted from such collaborative programs in future through SLAMADS.

Dr Lakmal shares his experience in the following article:



It is with immense pleasure that I share my incredibly rewarding experience participating in the one-month International Training program (ITP) of the KSERS at the Department of Colorectal Surgery at Seoul St Mary's Hospital of the Catholic University of Korea. The program kicked off with the annual KSERS 2024 conference. The knowledge exchange on new advancements in the field was truly inspiring. I was fortunate to present three oral presentations and a poster session in the conference.

As the conference happened at Daejeon, it offered a glimpse into Korea's beauty beyond Seoul.

Following the conference, I arrived at Seoul St Mary's Hospital and The Department of Colorectal Surgery welcomed me with exceptional warmth and support.

The theatre sessions were consistently outstanding, offering daily opportunities to learn new and innovative techniques. Witnessing a significant number of advanced laparoscopic and robotic colorectal surgeries performed live was an invaluable experience.

Professors In Kyu Lee, Yoon Suk Lee and Bae are exceptional trainers, were always readily available to provide explanations and answer my questions.

The dedicated training center further enhanced my experience. I completed the robotic simulation course and honed my laparoscopic skills, particularly with articulated instruments.

Special thanks to June for her constant support.

The comfortable hospital accommodation and delicious Korean cuisine at the cafeteria ensured a pleasant stay. While focused on the program, I also enjoyed exploring Seoul on weekends.

Overall, this program stands out as the most exceptional training experience I have encountered, and I would like to thank KSERS for selecting me for the programme and Prof Bawantha Gamage and SLAMADS for the collaboration with KSERS.

Special thanks for the support and guidance of Ms Jihyeon Yoon from KSERS and Minji from SSMH. I highly recommend this program and sincerely hope to see future participation from Sri Lanka.

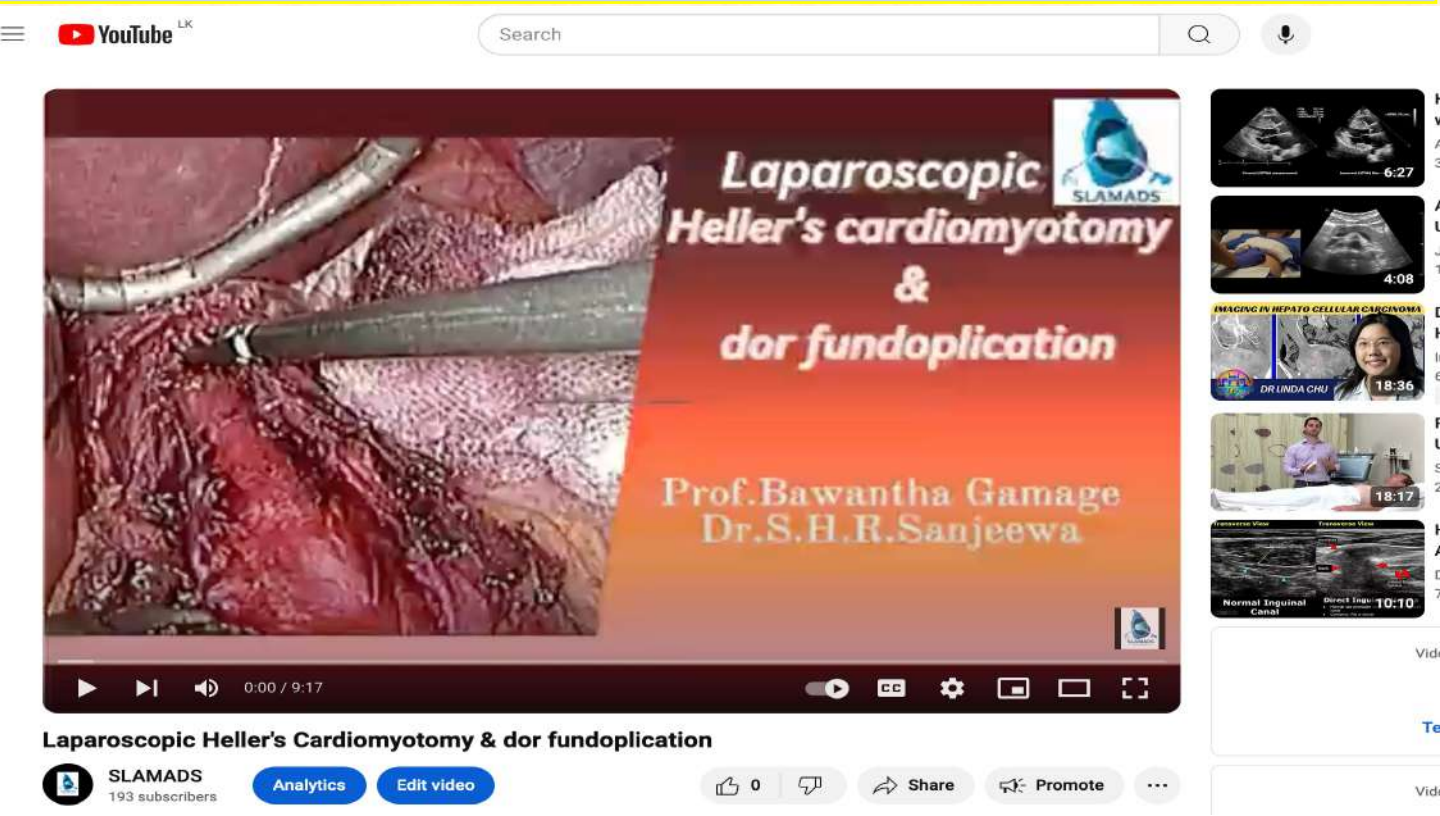
MAC Lakmal
General Surgeon – Acting
Teaching Hospital- Badulla

Latest at Video Gallery

Laparascopic Heller's Cardiomyotomy & dor Fundoplication

Prof Bawantha Gamage

Dr S H R Sanjeewa



Laparoscopic Heller's Cardiomyotomy & dor fundoplication

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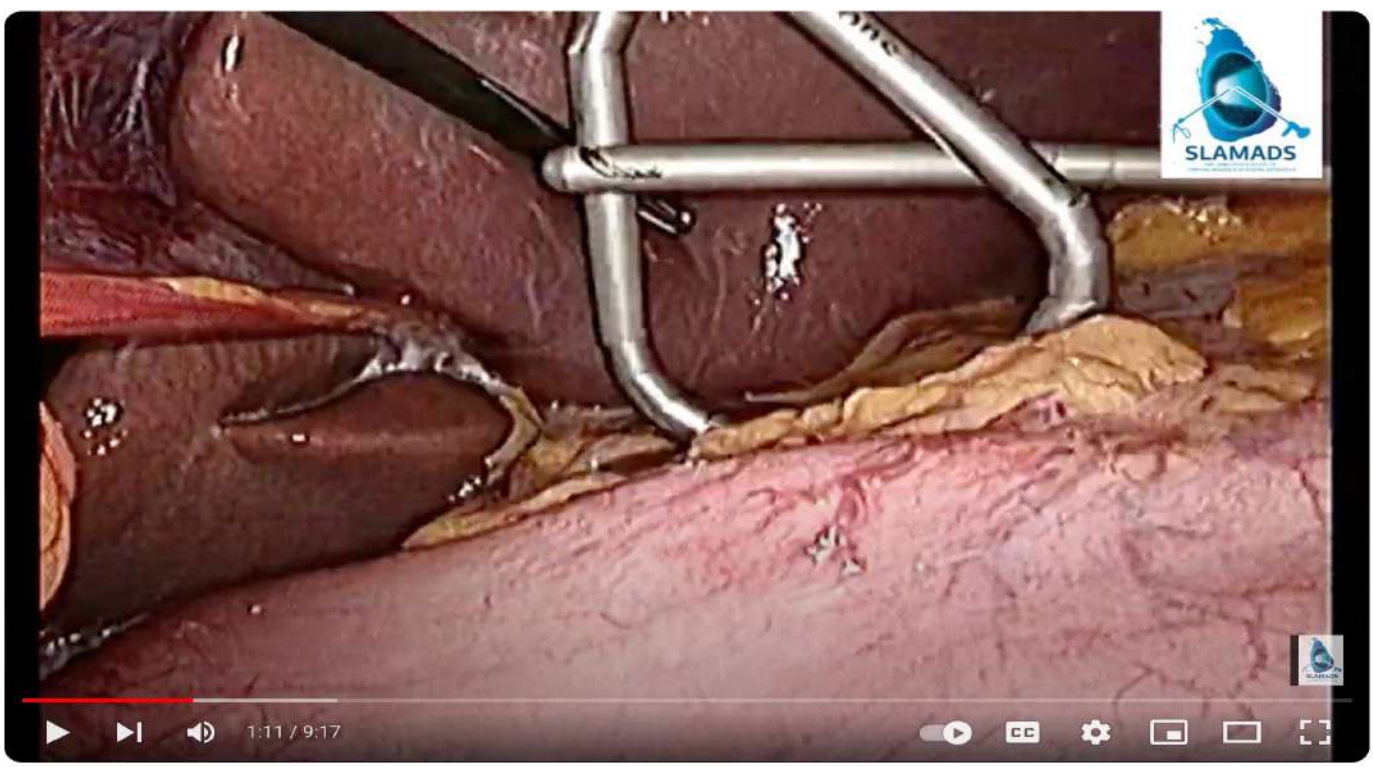

Laparoscopic Heller's Cardiomyotomy & dor fundoplication

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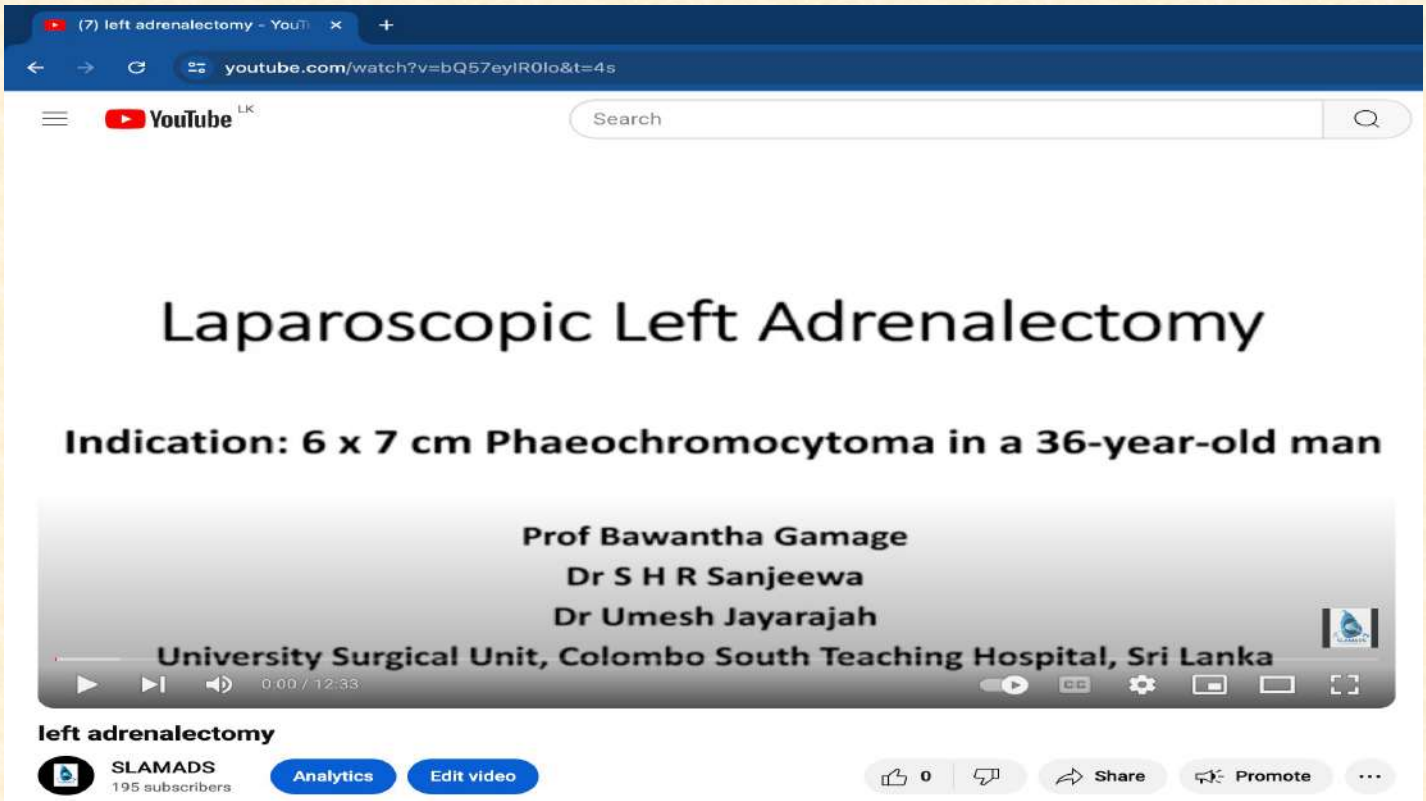
Latest at Video Gallery

Top Honors for Laparoscopic Mastery at AMASICLICK 2024

Prof. Bawantha Gamage's video on laparoscopic adrenalectomy has clinched the top prize at AMASICLICK ,an international competition for best laparoscopic videos, during the 19th AMASICON 2024 in the “Other Category”. The winning video earned a cash award of ₹25,000 for its outstanding demonstration of advanced surgical techniques.

The video was on Laparoscopic Adrenelectomy as is available at our website. https://slamads.lk/video_library

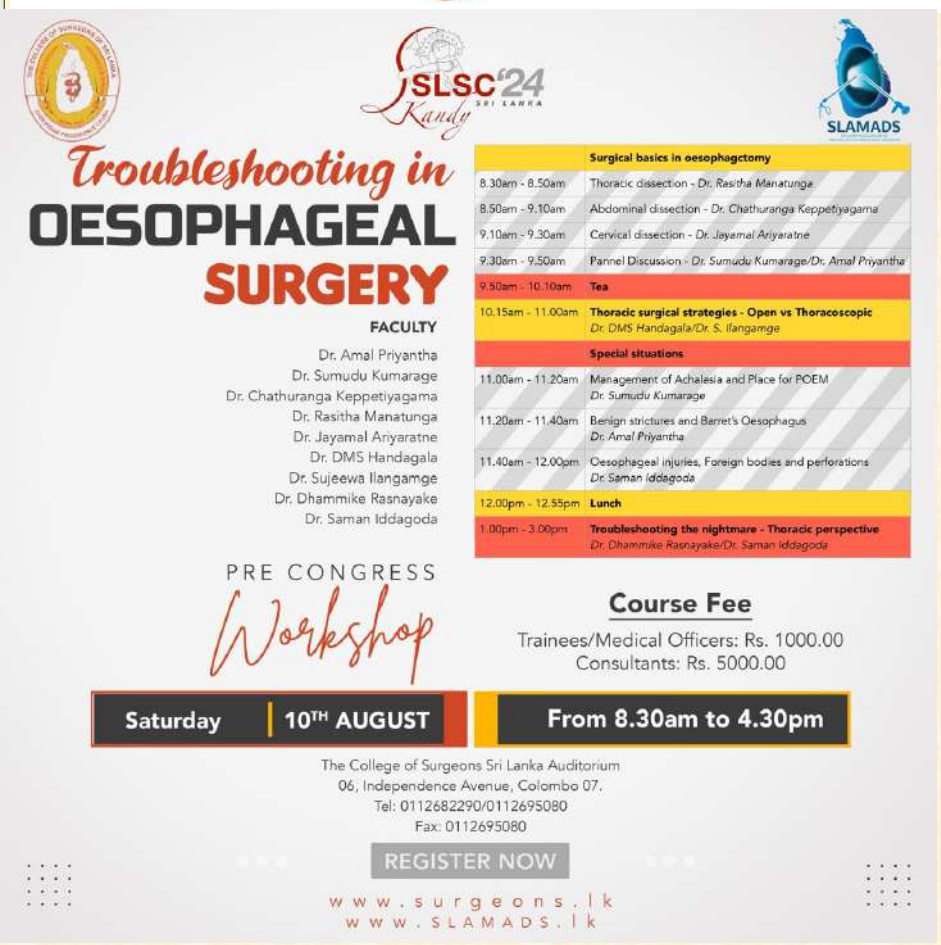
SLAMADS congratulates the team and encourages members of SLAMADS to participate in subsequent competition as well send there work to SLAMADS.



Upcoming Events

Visit our Website at https://slamads.lk/events

- Pre-congress workshops
- Breakfast Sessions
- Plenary on Artificial Intelligence in surgery



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We urge all surgeons and trainees to write brief reports to us on

- Surgeries performed by MAS with learning points
- Range of procedures done at your institute as well as facilities available

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