

# ALS newsletter



## New Editor's Introduction

Welcome to the Autumn-Winter edition of the ALS newsletter. It is a great pleasure to take over the reins from Paras Jethwa, who has done an excellent job over the last 3 years. Having just demitted from the Council of the AUGIS after 3 years I look forward to this new role at the ALS. As someone who is actively involved in the practice and training of laparoscopic surgery at the Royal Surrey County Hospital & MATTU, Guildford I look forward to the breadth that this position will add to my knowledge, bridging specialties, rather than focusing solely on Upper GI surgery.

After a fabulous summer of sport, the nation has been lifted by the magnificent efforts of Team GB. Is the 'Olympic effect' what is required for the NHS? There is clear recognition that improvements in performance have not come about by accident. Sustained public investment and good organisation led to the development of highly focused groups with one goal: to achieve excellence and win. This has required the recruitment of excellent coaches who have been supported by the highest calibre nutritionists, physios, sports psychologists, and the best equipment provided. The end product is athletes that were not only competitive on a world stage but who believed they could win.

We have excellent 'coaches' within the 'Surgical Team GBI' as acknowledged by the recent award of the Chevalier de l'Ordre de la Legion d'Honneur to our Professor Michael Bailey for his services as a pioneer and teacher of laparoscopic surgery (full article inside). We do however require the appropriate support, political and managerial stability and the best equipment if we are to lead and deliver excellence

as standard. Something I am sure we would all desire as patients and practitioners. The provision of equipment for the training and practice of laparoscopic surgery is however very variable, as is evident from the recently published 2nd National Audit of Laparoscopic Theatre Equipment (2012) ([http://www.alsgbi.org/pdf/ALSGBI\\_National\\_Audit\\_of\\_Laparoscopic\\_Theatre\\_Equipment-2012.pdf](http://www.alsgbi.org/pdf/ALSGBI_National_Audit_of_Laparoscopic_Theatre_Equipment-2012.pdf)). These are however difficult times with major global recession hitting hard across the Euro-zone. I do not believe that we are anywhere near feeling the full impact of the inevitable austerity measures that will be imposed upon us. These will be challenging times that will require all of our efforts if we are to continue to develop our craft and prevent patient care from suffering.

I always enjoy the 'futuristic' sci-fi titles to our Annual Scientific Meeting (ASM). It is however great to see that it does not end there. ALSGBI, in a project lead by Mr David Mahon, are developing an App to facilitate access to the ALS website and to facilitate the enjoyment of our ASM whilst 'mobile'.

We have a fantastic ASM to look forward to this November in Cork. The local organiser Colm O'Boyle has put together an excellent academic and social programme, previewed inside. I would encourage as many of you as possible to attend and enjoy not only the sessions but also the inevitable hospitality of our hosts in Cork. This promises to be an excellent meeting and the Association's second trip to Ireland.

**Mr Shaun Preston**, Newsletter Editor

## President's Introduction

This is the first Newsletter put together by one of our newest members of Council, Shaun Preston and a very good issue it is too. Since the last Newsletter we also welcome another member of Council in the form of Professor George Hannah who has taken on the role of Director of Research. He will also take on the job of representing the ALSGBI at the European Association of Endoscopic Surgeons (EAES). This is a job currently undertaken by Professor Roger Motson who is stepping down from the Council after the ALS Annual Scientific Meeting. Roger is a Past President and has been part of the ALS since its inception. The ALS owes a huge debt of gratitude to Roger for the immense amount of work given to the Association over many years. He will be greatly missed from Council.

George Hanna is well placed to fill this role as he is currently Chairman of the EAES Research Committee. The EAES has recently shown an increasing willingness to engage with the ALS, which is important because our block membership of the EAES makes us a significant part of their total membership. To this end the ALS have been asked to organise a session at the next meeting in Vienna as well

as to nominate speakers for other sessions. We will take this role seriously and hope that it may encourage more of you to attend the meeting.

The most pressing thing on the agenda however is the meeting in Cork. The programme has come together very nicely and we have attracted excellent speakers in Lee Swanstrom from Oregon and IRCAD, Craig Ramsay from Aberdeen and Tim Tollens from Belgium. Please survey the programme online and be sure to attend the meeting, as it will be a great success and a wonderful two days in Ireland. You will also soon be able to download an App. for the forthcoming meeting with all the details.

I look forward to welcoming you there.

**Professor Timothy Rockall**, President



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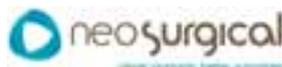
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## Professor Michael Bailey, ALS Past President, awarded Legion d'Honneur from President Sarkozy

There are very few surgeons of each generation upon whom great honours are bestowed. When the recipient is one of the great pioneers of laparoscopic surgery and a Past President of the Association of Laparoscopic Surgeons of Great Britain and Ireland (2003-2005), it is clearly something to be celebrated.



On the 28th March 2012 the highest decoration in France, Chevalier de l'Ordre de la Legion d'Honneur (Knight of the Order of the Legion of Honour) was awarded to Professor Michael Bailey as recognition for his services as a pioneer and outstanding teacher in the field of laparoscopic surgery. The award was presented by President Sarkozy at the magnificent Élysée Palace in Paris; his final public duty ahead of the elections in April of this year. The National Order of the Legion of Honour was established by Napoleon Bonaparte on 19 May 1802 to recognise merit. The Chevalier

status is evident with the medal being worn on the left breast suspended by a red ribbon.

Professor Bailey is the first British healthcare professional to receive a Chevalier de l'Ordre de la Legion d'Honneur. His work was recognised early by the other harbingers in the new field of laparoscopic surgery such as François Dubois (Paris), Philippe Mouret (Lyon) and his great friend and colleague Jacques Marescaux (Strasbourg).

The close association with French surgeons, who were part of the small but extremely select international community of early laparoscopic surgeons, began in 1991. In Lima, Peru live surgery, performed by Professors Michael Bailey and François Dubois was 'beamed' into a cinema filled with surgeons keen to witness this emerging technology. They left the audience spellbound when on the following day the 6 patients, upon who they had performed laparoscopic cholecystectomy, stood and walked through the audience from the seats where they had been 'planted' in the audience. Such early mobilisation is something considered common practice nowadays, but truly unbelievable over 20 years ago.

The following year an invitation from Professor Marescaux to chair the inaugural meeting at IRCAD firmly established his position as a leading surgical educator and opinion leader in the field. The seeds were sown for the establishment of a high quality teaching/training facility in the UK; soon after the Minimal Access Therapy Training Unit (MATTU) was born at The Royal Surrey County Hospital, Guildford in 1993. The need to ensure appropriate, high quality training in laparoscopic surgery was evident following many early complications of the early '90s. The requirement for high-quality training will always remain and all of those who have visited the MATTU will have benefited from the foresight of one man.

Despite having recently stepped back from clinical practice, Professor Bailey remains highly regarded as a National and International leader teaching laparoscopic surgery to surgeons from across the world. MATTU is now the UK's largest and most advanced centre of excellence for laparoscopic surgery. Professor Bailey remains President of MATTU and is keen to evaluate emerging technologies with European grants to study natural orifice surgery (NOTES), the UK's first NOTES 'hands on' course and the world's first laparoscopic meeting demonstrating live 3D surgery. He has been Director of the courses in Advanced Laparoscopic Upper Gastro-intestinal Surgery & Hernia Surgery at the European Institute of Telesurgery (IRCAD) from 1992-

present and remains an extremely active member of the teaching faculty not only in Strasbourg but also at the centres in Brazil and Taiwan. His quintessentially English style, sharp wit and keen eye make him the finest moderator of surgical sessions I have ever encountered.

The honour recognises the work of Professor Bailey over the course of his career. The depth and breadth of which can be seen by his contributions to EAES (Chairman of Publications Committee 2004-2008, Member of the Executive Board 2004-2008, Member of Education Committee 1995-1998); ALSGIBI (President 2002-2005, Education Officer 2000-2002, Member of Council 1999-2006); Royal College of Surgeons (Hunterian Professor 1996-1997, Tutor in Minimal Access Surgery 2002-2006, Member of the Court of Examiners and invited Member of Council); and European Association for Transluminal Surgery (EATS) (Vice President and Founding Member); ASGIBI (Member of Council of ASGIBI 2002-2005, twice winner of the Moynihan Prize and medal) and the RSM (President of the Section of Surgery 1991-1992).

A truly visionary surgeon justly recognised.

**Mr Shaun R Preston**

Consultant Surgeon, The Royal Surrey County Hospital



SAVE THE DATE  
ALS ASM 2012 Cork  
29 & 30 Nov 2012



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Local Organiser: Mr Colm O'Boyle

Rochestown Park Hotel | Thursday 29 & Friday 30 November 2012  
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# ALS Annual Scientific Meeting, Cork 2012

## Rise of the Machines

29–30 November 2012

I am delighted to be the local organiser for this year's ALS meeting in November in Cork. Ireland's second city and "Gourmet Capital" was European City of Culture in 2005 and voted one of the top ten best cities to visit in 2010. Facts which must have informed the decision making for Her Majesty's highly successful visit in 2011!

This is only the second time that the ALS has visited Ireland and I hope it will be a memorable conference. As before we will have a full day devoted to live operating, which will take place in the Bon Secours and Cork University Maternity Hospitals. Surgery will be transmitted in real time via satellite to the conference centre at the Rochestown Park Hotel. We have assembled a distinguished local, national and international faculty. The emphasis will be on robotic surgery and on new approaches to existing complex laparoscopic procedures. Doctors Matt Hewitt and Barry O'Reilly from Cork University Maternity Hospital have an international reputation in the field of robotic hysterectomy and urogynaecology. Micheál Ó Riordáin from the Mercy University Hospital will perform a low anterior resection with colonic pouch, utilising the flexible laparoscope. Cristóir O'Sulleabháin will perform a distal

pancreatectomy. Peter Sedman will perform a gastric bypass by fashioning a longitudinal gastric pouch and utilising a hand sewn technique for anastomosis. Oliver McAnena, Tom Walsh and Ian Beckingham will demonstrate new approaches to Nissen Fundoplication, Incisional Herniorrhaphy and Splenectomy. Furthermore we are delighted to have Professor Tim Tollens from the Imelda Hospital in Bonheidein, Belgium to demonstrate his approach to complex incisional herniorrhaphy. He will also be giving the Friday morning lecture on his vast experience with incisional herniorrhaphy. Throughout the live operating we will have regular interaction with erudite and inquisitive moderators hailing from as far afield as Greece and Australia.

Friday will take the usual format of DVD, poster and scientific oral presentations. We are very fortunate to have one of the most widely recognised surgical innovators in the USA, Professor Lee Swanstrom from Oregon to give the BJS Lecture entitled "Surgical Robotics – The Rise of The Machines". He will subsequently be debating with Professor Craig Ramsey from Aberdeen that "This house believes we should be spending more on robots and less on training laparoscopic surgeons".

The meeting will have a significant commitment to trainee teaching and Wednesday 28th November will be devoted to the ALS Advanced Laparoscopic Surgery Training Day when we will have an international faculty of experienced trainers. The dry lab will be located at the Bon Secours Hospital and the wet lab at a UCC facility. The areas covered will include knot-tying, suturing, and the theory of chemical and mechanical haemostasis. There will be practical demonstrations and hands-on operating featuring division of small bowel mesentery, ligation of vessels, and partial splenectomy.

For Laparoscopic Theatre Staff there is a dedicated programme on the Friday, including a presentation from Jane Bradley-Hendricks, on the transition to Assistant Surgical Practitioner (ASP) and Surgical Care Practitioner (SCP) and a practical afternoon assisting practitioners with camera-holding and other laparoscopic-related skills.

The ALS Conference Dinner will take place on Thursday evening in the wonderful surreal ambience of The City Gaol, one of the landmark tourist attractions of Cork. As well as live music we will have Frankie Sheehan, former Munster and Irish International hooker, as the after-dinner speaker. We encourage people to book early



for this event as the Gaol will hold a maximum of only 150 inmates!

For those of you who are bringing partners or who are planning to spend the weekend in Munster there are a variety of attractions: The English market, the Tyndall Institute and Blarney Castle were all part of Her Majesty's itinerary. Furthermore, Cork is a stone's throw from Darina and Rachel Allen's Ballymaloe Cookery School, Middleton Brewery, the port town of Kinsale and "The Old Head" Golf Course, Cobh, the Titanic Museum, Kenmare and the Ring of Kerry and Fota Wildlife park.

Looking forward to seeing you in November.

**Mr Colm O'Boyle**  
Local Organiser

## ALS app



The Association of Laparoscopic Surgeons is pleased to announce

that it has started work on an App for healthcare professionals in collaboration with Internet Concepts. Although our ALS website traffic continues to increase annually, we recognise that more and more of you view electronic content on your mobile devices rather than on a traditional PC whilst stuck at a desk. We are going to embrace this evolution – it is envisaged that the ALS App will be a great resource for simple and easy access to the best of ALS electronic content while you're away from your office and on the

move. In addition to this, as we know that the Annual Scientific Meeting is a major part of what our members want from our society, the App will give you everything you need to make the most of your visit to our congress – from viewing the scientific programme and previewing speakers to checking out the exhibitors and sponsors.

The ALS App will initially be launched for iPhone/iPad, as we know that these are currently the leading devices in use by our members, but if it is the success

that we expect it to be, we shall look toward providing it for other devices as they become more popular. Although the timescale is tight, we are hoping to have something available to launch, even if it is only a preliminary version of the App, in time for our next Annual Scientific Meeting in Cork, Ireland, 29-30 November 2012.

**Mr David Mahon**  
Website Director

**SAVE THE DATE**  
ALS ASM 2012 Cork  
29 & 30 Nov 2012

# ALS Annual Scientific Meeting, Cardiff 2011 To Infinity and Beyond



# SAGES Annual Scientific Meeting and Post Graduate Course

7–10 March 2012, San Diego, California, USA



The Society of American Gastro-Intestinal and Endoscopic Surgeons (SAGES) Annual Meeting is one of the highlights of the North American Surgical calendar. The 2012 meeting was held in March this year in the southern Californian city of San Diego. San Diego is famed for its mild and sunny climate and has a huge conference centre which hosts many medical meetings annually.

The catchphrase for this year's conference 'Tomorrow is All About Today' aimed to emphasise the importance of technology to the practising surgeon. Over four packed days of oral and poster presentations, symposia, live operating and postgraduate courses, the application of technology was a prominent feature in many. One of the early, very well-attended sessions was on Social Media for Surgeons including all you could want to know about the applications of Facebook and Twitter for the busy surgeon. The post-graduate course 'Essentials of Robotic Surgery' was oversubscribed well before the conference began.

Perhaps the highlight for myself and many other visiting surgeons was the session on surgery in space\*. This fascinating two hour session included talks on the current status of the US human spaceflight programme, surgical issues of long term space flight and the limitations and

advances of minimally invasive surgery in weightlessness. All of those who were present during the talk were in awe of the military and NASA scientists and physicians who have pioneered this programme over the last 20 years. It became clear during this session that this is not merely science fiction but a vitally important future programme for NASA, the US Government and US healthcare agencies.

As well as one of the largest surgical conferences in North America, SAGES attracts an increasing number of international visitors. It has long been a popular meeting for Japanese and Asian surgeons and increasing numbers of visitors from Europe and particularly the UK are attending this annual meeting. A number of trainees have presented abstracts from UK institutions. In 2011 in San Antonio, Texas, Raj Veeramootoo from Exeter was awarded the Residents and Fellows Prize for his presentation of the LOGIC trial in minimally invasive oesophagectomy (MIO). At the same meeting James Rink from Gloucester had his presentation on lymph node yield in MIO selected for the Posters of Distinction Session. This year saw a number of UK presentations including oral and poster presentations from Imperial College London, Truro and Worcester amongst others.

The focal point of the annual SAGES meeting is always the Friday evening social event and dinner. The 2011 San Antonio 'rodeo event' with line dancing and horses on the dancefloor may have even been surpassed this year. The 2012 event was held on board the World War II Aircraft Carrier USS Nimitz. The open bar on board the flight deck of an aircraft carrier docked in San Diego harbour beneath a full moon was certainly an experience not to be forgotten.

I would recommend the SAGES meeting to Consultants and Trainees. It provides a fascinating insight into the practise of minimally invasive surgery in North America and if you have any plans to attend only one large meeting in 2013, I could certainly recommend the SAGES Annual Scientific Meeting and Postgraduate Course in Baltimore, Maryland, in April 2013.

\*[http://thesagesmeeting.org/syllabi/Surgery\\_in\\_Space-Editorial-Should\\_SAGES\\_advance\\_MIS\\_in\\_Space.pdf](http://thesagesmeeting.org/syllabi/Surgery_in_Space-Editorial-Should_SAGES_advance_MIS_in_Space.pdf)

## Mr Martin Wadley

Consultant Upper GI Surgeon  
Worcestershire Royal Hospital  
ALS Regional Representative Midlands

## Winner of the ALSGBI Trainee Prize at the ASiT Annual Conference, Cardiff

23-25 March 2012

### Single-incision compared to standard laparoscopic cholecystectomy

Laparoscopy has become the mainstay in cholecystectomy surgery. There have been recent advances in this field through the use of single port laparoscopic surgery. Our aim was to measure outcomes in patients undergoing laparoscopic cholecystectomy by comparing a traditional four-port approach with a single incision technique. It allowed us to understand a patient's perception of the surgery and compare their ratings on various aspects such as pain score, cosmetic appearance and well-being.

#### Abstract

##### Introduction

Single-incision laparoscopic surgery is gaining momentum in general surgery. The aim of this study was to compare outcomes for day case single-incision laparoscopic cholecystectomy (SILC) with standard laparoscopic cholecystectomy (StdLC).

##### Methods

Patients scheduled for day case laparoscopic cholecystectomy were block randomised to SILC or StdLC. Patients were prospectively scored

for pain, well-being, satisfaction with wounds and recovery on a visual analogue scale (VAS) on days one and seven post-operatively.

##### Results

49 patients were included in the study (SILC=24; StdLC=25). There were no differences in age, sex, ASA grade and BMI. Two patients were excluded from the study, one from the SILC group and one from the StdLC group. There was no significant difference in the VAS on day one. However, on day seven the SILC group rated their cosmesis significantly higher than the StdLC



group ( $p = 0.03$ ). There was no difference in pain, well-being or strength between the groups.

##### Conclusion

SILC is feasible, safe and comparable with StdLC. SILC is associated with superior cosmesis.

R Clancy, R Patel, R Spencer,  
N Penney, R Cave,  
A Osbourne, C Wong

# Review of the 20th International Congress of the EAES

20-23 June 2012, Brussels, Belgium



The European Association of Endoscopic Surgery (EAES) annual congress is one of the most fundamental meetings for bringing surgical minds together to discuss technological and clinical integration. The 20th meeting was held in June this year in Brussels, Belgium which is famous for its international politics, culture and waffles makes an attractive setting for any international meeting.

This was the first conference I had attended in Brussels and the venue was fascinating. The Square Meeting

centre has a certain 'Tardis-like' feel as one enters the glass cubical entrance, you realise that it is significantly larger inside occupying a quoted 13,000 sq metres of space. The venue had a modern feel and combined it with sensitive murals by Belgian painters such as Paul Delvaux and Rene Margritte.

The theme for this year's congress was 'Doing the best for our patients' and reflects the underlying principle of beneficence propounded by Hippocrates of old and the GMC today. The difference is that in modern times the focus is not only upon doing good but also achieving the best, and the EAES is a forum that certainly facilitates the convergence of clinical and technological ideas, along with understanding best practice.

The congress spanned four days comprising oral and e-poster presentations, interactive lecture sessions, symposia and interesting post-graduate courses focusing on areas such as single port, robotic and bariatric surgery. One of the most popular aspects to the conference was its inherently interactive nature, one such lecture was on controversies in single port surgery. I was interested to hear the views in favour and of those who felt it offered no advantage to patients. One presentation in another session by Kim et al examined the role of single incision cancer work and found that it was feasible and that lymph node harvests were equivalent. What was clear from the interactive session was that the surgeons who attended felt that single port surgery had a role in certain clinical scenarios with appropriate case selection. What was also interesting to note was the disparity of views and that perhaps the best course of action is to present patients with a choice of procedure.

During the video sessions, the advancement of technology was evident and its application in the technique used for the first robotic-assisted laparoscopic live donor nephrectomy with transvaginal extraction of the graft in a patient with the uterus still in place, was truly remarkable. The stated advantages were less pain, shorter hospital stay and better cosmesis.

Whilst examining the extent of technological advances, the EAES also acted as a forum for more unconventional investigations. An amusing but interesting oral presentation was in relation to whether the colour of gloves

being used by clinicians during peri-operative examination and dressing changes affected patient satisfaction; apparently if you want patients to experience less pain, don't use blue gloves! Perhaps an underlying and important message is that the focus is often on physical stimuli and the psychological and perhaps sub-conscious elements of pain perception are often overlooked.

The EAES attracted presenters from Japan, India, Pakistan, Russia, Europe, the USA and Australia, representing its reach to a truly international audience. This year the UK and Irish presentations made up about 1 in 7 of the total, reflecting the significant academic activity in our units. This level of achievement was also reflected in a poster by Murray et al who showed that the UK had the 5th highest number of articles published in high impact journals such as *Surgical Endoscopy*.

Two UK presentations won prizes. The first by Sajid et al, Worthing was a meta-analysis focusing on fluid replacement. Fluid therapy in the peri-operative period has been an area that has undergone significant change and the meta-analysis compared restricted fluid therapy with the unrestricted version. The results found that there was no difference between the 2 theories in relation to morbidity and mortality, the inference being that a targeted approach tailored to each individual patient may be the most appropriate technique.

The other prize was won by Walter et al, Nottingham highlighting the role of transversus abdominis plane (TAP) blocks for pain relief after surgery. TAP blocks were effective for up to 24 hours after surgery and patients required less morphine to ensure adequate pain control. The obvious advantage to TAP blocks are their longevity and repeatability. Both of these topics are of particular importance and relevant to the burgeoning enhanced recovery culture.

Other presentations included those by Mr Ralph Smith, Guildford who focused on 3D surgery and motion tracking for expert surgeons and showed that they benefited during simulation with a subjective reduction in workload. This was complemented by the potential development of holographic images in 3D being investigated by a team at Guys Hospital, UK. The meeting also attracted a range of training grades from consultant to junior trainees. A senior trainee, Miss Amanda Bond, Worthing, was impressed with the 'multidisciplinary nature of the meeting, where biotechnologists, surgeons and industry can come together'.

I would recommend the EAES to Consultants and trainees of all grades. It provides an exciting insight into how newer technologies may develop and influence our clinical practice. This is an important aspect to ensure that we as surgeons can anticipate the applications and embrace them to ensure appropriate training and safe application in our practice.

## M Rafay S Siddiqui

Specialist Registrar in General Surgery  
Royal Surrey County Hospital, Guildford.



## Caption Competition

Entries have to be sent to Jenny Treglohan  
jtreglohan@asgbi.org.uk  
by 30 November 2012 and the winner will  
receive a bottle of champagne.

# Use of Fresh Cadavers for Laparoscopic Surgical Training



Over recent years it has become apparent that surgical training in laparoscopic surgery will require new approaches in order to develop the technical skills of surgical trainees to a high level. No longer are trainees exposed to huge numbers of hours in the Operating Room with high volume exposure to both elective and emergency surgery over a variety of surgical subspecialties. The introduction of shift patterns of work, together with restriction in the number of hours that these trainees can work in any given week, mean that options outside of the operating theatre will

need to be considered as a structured part of postgraduate laparoscopic surgical skills acquisition. Over the past decade, surgical simulators have developed to a degree that they can provide high-fidelity simulation in the re-creation of a number of laparoscopic, endoscopic and endovascular procedures. They have proven useful for the development of certain technical

reconstruction of anatomical models led to an underutilisation of donated cadavers in some Institutions around the UK. Following the 2004 Act of Parliament, the Human Tissues Authority was set up to serve a number of related issues, including the use of cadavers for surgical training. Strict guidelines were put in place to govern the handling, storage, and disposal of these cadavers when used for surgical training.

A number of ways to "soft fix" these cadavers have been tested, some of which show more promise than others. The use of these tissues in the "fresh" state, however, remains the gold standard for surgical technical skills training using cadavers. The tissues show properties similar to those encountered in live patients (apart from the obvious lack of bleeding). The colour, flexibility, anatomy and consistency of the tissues are very similar to living tissues. Pneumoperitoneum, for example, can be achieved at exactly the same intra-abdominal pressures used in the anaesthetised patient.

An additional benefit of this form of surgical training is that the complete operating room set-up can be re-created in a controlled laboratory environment. Use of energy and instrumentation is identical to those which would be used "normally". The operating theatre environment can also be accurately reproduced with team interaction and responses to certain situations.



skills such as laparoscopic dexterity. They are, however, very expensive to purchase, sometimes unreliable, and of limited use when it comes to the development of full procedural skills.

In 2004 an Act of Parliament was passed which allowed, for the first time, UK cadavers to be used for the purpose of surgical training. Prior to this they were primarily used for the demonstration of Anatomy to medical students. An increasing reliance on prosected specimens and computer-based



Subspecialty courses using fresh cadavers have since been delivered across a broad range of surgical disciplines. These include laparoscopic Colorectal surgery, Upper GI surgery, Hepatobiliary surgery, Vascular surgery, Urology (prostatectomy, cystectomy, nephrectomy), ENT, Head & Neck surgery and many aspects of Orthopaedic surgery. In order to achieve this, in an economically viable way, it is necessary to carefully "body map" these cadavers, so that certain courses can be avoided if necessary (generally depending on previous surgery) and certain courses can be combined sequentially.

The content of such courses tends to be light on lecture delivery and concentrate largely on hands-on technical skills development. Expert faculty are generally invited to demonstrate initially "how they do it" and then to teach in the operating room environment, usually with two delegates and one faculty member per table. Feedback from such courses has been universally positive with the advanced trainees in particular, favouring this method of teaching compared with other forms of simulation.

There remains no substitute for time and experience in the operating theatre under the supervision of a dedicated trainer. The reduction over recent years in these precious hours must be accompanied by an increase in the use of other resources available such as fresh cadaveric skills training in order that our future consultant surgeons will have the technical skills necessary to function independently and perform advanced laparoscopic operative procedures to the highest standards.

**Mr Alan F Horgan**

Consultant Colorectal Surgeon, Director, Newcastle Surgical Training Centre

# Complications of laparoscopic surgery: A patient's perspective

Making mistakes is part of human nature. Doctors are human. We make mistakes that harm patients. I have done so.

As a result of failure of timely diagnosis of a jejunal perforation made during laparoscopic surgery, I have gained detailed insight into the consequences of medical error. I also learned more than I ever wished to know about evasion of responsibility after the fact.

## History:

In 2007, I was persuaded to have a laparoscopic repair of an incisional hernia occasioned by a sigmoid colectomy performed some 7 years earlier. During the attempted repair, I suffered a small bowel perforation. Although post-operatively I repeatedly told my clinicians that I thought that a perforation had occurred, the surgeon refused to entertain the diagnosis or arrange investigations until I went into septic shock on post-operative day 7. A second look procedure was followed by two weeks in ITU, a transient cardiac arrest and numerous further interventions. For readers of curious disposition and/or strong digestion, these were: laparotomy, exteriorisation of a perforation as a stoma, abdomen left open, re-laparotomy, closure of second perforation and wide excision of full thickness abdominal wall, 3rd look laparotomy, washout and further excision of full thickness of abdominal wall, radiologically guided percutaneous drainage of subphrenic abscess and finally early closure of proximal jejunostomy because of malnutrition.

## Consequences:

Like most patients who have suffered a serious adverse event, I wanted to know what had gone wrong and why, but also what could be done to protect future patients from similar experiences. I tried to raise this with my colleagues at the hospital but was met with hostility and evasion by the senior management team. Eventually my experiences (and six months' unemployment) drove me to seek legal advice. Some two and a half years after the event, the case was settled and I am free to publish. I am now as recovered as I will be, but am left with a lasting disability<sup>1</sup>. Having a beer belly equivalent to a seven month pregnancy, consisting of guts covered by thin scar, interferes moderately with most daily physical activities and has probably reduced my life expectancy. As regards appearance, my profile incites (suspicious) interest at airport security and the scar sometimes draws interested (sympathetic or horrified) looks on the beach. Admittedly, I was never an Adonis...

## The Evidence Base:

We are (avoidably) ignorant of the incidence and consequences of complications of laparoscopic procedures. As Cuschieri put it, the laparoscopic boom of the 1990s was the "biggest unaudited free-for-all in the history of surgery"<sup>2</sup>.

I set out to explore the extent of our resulting collective ignorance. At my request, ICNARC searched for ITU admissions they could identify as attributable to complications of laparoscopic surgery. They discovered only two in the more than 500,000 cases in their immense database, probably because their coding methods are uninformative on this point. Largely at my insistence the NPSA and NHS LA investigated. The former identified 11 deaths and 37 serious incidents reported to them over a 5 year period. The latter had paid compensation in 327 successful claims for laparoscopic injuries over 15 years. Unfortunately NCEPOD have (so far) not turned their attentions to the problem. However a recent survey of ALS members found 31 reports of deaths and 333 significant injuries in the previous year. The data give hard evidence of misleading coding and extreme under-reporting of harm. (Data summarised in Reference 3).

This is not to deny the very real benefits that laparoscopic surgery offers to most patients and in bed turnover. But there is probably never been a medical advance that did not simultaneously introduce previously unknown hazards for some patients. (The Lawrence curve, representing the uptake and long-term utilisation of therapeutic advances, is an elegant demonstration of this point<sup>4</sup>. It should be and is incumbent on those who seek to introduce, and perhaps profit from, a new medical technology, to identify and take adequate steps to prevent or mitigate the harms that will inevitably accompany it and to offer it only subject to informed consent in well-selected patients.

## Prevention and mitigation:

Iatrogenic injuries are as old as surgery and will not disappear entirely no matter how meticulous the operator. It is obvious even to someone of my limited surgical experience that trocars should be introduced and adhesions divided with care and the abdominal cavity inspected thoroughly at the end of laparoscopic procedures. But there will inevitably be a residuum of "inadvertent enterotomies". Although they will never be entirely abolished, patient selection and timely recognition of injury could save lives and prevent serious harm.

a) Patients who are likely to have adhesions from previous surgery or peritoneal inflammation are at greater, and possibly undue, risk of perforation during peritoneal entry and dissection. They should be warned that conversion to open surgery is likely, and if this occurs it must not be regarded as a failure on the part of the surgeon, who should have a low threshold to pick up a scalpel. Although there are important differences between urgent surgery for small bowel obstruction and elective procedures performed in presence of adhesions the results of a series of 52 patients undergoing laparoscopic adhesiolysis are relevant: a quarter suffered iatrogenic bowel perforation and half underwent conversion to laparotomy<sup>5</sup>.

b) If perforation does occur it is obviously desirable that it be recognised intra-operatively. When visceral contents pool in hidden lacunae within the abdomen, they will be hard to discover. This suggests that the final examination of the peritoneal cavity should be carried out by the senior surgeon, not left to junior staff. The ease of recording videos would make it possible to investigate current practices, and facilitate a register, although audit would require assurances of confidentiality for and some courage from the participating doctors. Limited peritoneal lavage and near-patient testing for constituents of bowel content might also be informative before scope withdrawal in high risk cases<sup>6</sup> as a reference mark.

c) If the perforation is not recognised in theatre, the diagnostic features are likely to be obscured as compared with paradigmatic perforations (such as a peptic ulcer). It will have occurred either under anaesthetic or - if due to delayed necrosis of a diathermy burn, as in perhaps half of all such cases - under post-operative analgesia. The presence of free abdominal gas can be mistaken for leftover insufflated CO<sub>2</sub>. Inflammatory markers may not rise early. (My white cell count and CRP were normal until day 7).

Under these circumstances, a low threshold for early CT scanning or re-scope is necessary. Indeed the guidelines of the ALS have provided a helpful set of criteria for doing so<sup>7</sup>. Negative investigations with their attended costs are not blameworthy. A crude cost-benefit analysis suggests that even if three "unnecessary" procedures were undertaken for every perforation diagnosed, this would be arguably good practice and certainly good health economics.

## Need for candour:

I did not take the decision to sue lightly and did so only after being subjected to considerable unpleasantness when I tried to explore with the hospital, what had gone wrong. Indeed it was only after confirming beyond reasonable doubt (over a period of six months) that the local culture was incapable of admitting error - as a necessary preliminary to learning from it - that I instructed a lawyer. There then followed two years of enforced silence on my part as the case was *sub judice*. During the thirty months after the event, I estimate that at least 75 patients died of complications of laparoscopic surgery, many of them avoidably. Incidentally, the legal costs of my case approximately equalled the value of the substantial settlement because the hospital insisted on trying to defend the case.

The extensive excuses, evasion, denial, and outright falsehoods to which I was subjected during this time are documented on four letters on headed notepaper, signed by four members of the hospital's senior management team. Unfortunately, denial makes failure to learn from medical errors more probable - "To err is human, to cover up is unforgivable, and to fail to learn is inexcusable"<sup>8</sup>. The evasion of responsibility which I encountered is, from numerous anecdotes, common. And it comes allied with two other emerging features of the NHS: suppression of information about mistakes and costs on grounds of "commercial confidentiality" and extended "gardening leave"

and unjust career destruction for some of our whistle-blowing colleagues. It is a dangerous pathology and, as such, deserves a descriptive name. For lack of a better one, I call it malignant managerialism<sup>9</sup>.

It takes courage for a doctor, who has harmed a patient whom they set out to help, to admit their mistake to themselves, then to colleagues and managers and finally to the patient. This must be more difficult when management allows or even encourages them not to do so. I am pleased to say that the responsible surgeon and I had a long and apparently mutually beneficial discussion some time after the legalities were settled. I am sure that he has learned from his error and is unlikely to repeat it. I hope he knows that I bear him no ill will.

### Two final thoughts:

I was ill enough to remain in hospital until my perforation was (belatedly) diagnosed. It is concerning that a significant number of complications probably present after discharge. If experienced surgeons find diagnosis difficult, general practitioners are likely to be even more perplexed. It would be helpful if the ALS approached the Royal College of GPs to explore this problem.

It ought to be inconceivable that new and potentially dangerous medical technologies can be introduced without thorough recording and analysis of the risks and benefits, with the object of minimising the former and maximising the latter. A register of laparoscopic procedures and outcomes has been recommended by many of those who read, write for, and fund this newsletter. I urge you to establish one.

### Notes, definitions and references:

- 1) The defect is not technically irreparable. Several very able colleagues have kindly offered to fix it. But, given our experiences, if I put my family through the stress of a large and avoidable operation that carries significant mortality, they would probably disown me.
- 2) Cited by Yuen Soon. ALS newsletter. Summer 2011.
- 3) Arnold F. Understating under-reporting. *BMJ* 2011; 342: d793
- 4) Laurence DR et al. *Clinical Pharmacology* 1997.
- 5) Wullstein C, Gross E. Laparoscopic compared with conventional treatment of acute adhesive small bowel obstruction. *Br J Surg.* 2003; 90(9): 1147-51.
- 6) I am grateful to Mike Parker for his assistance on this point and for inviting me to the annual meeting of the ALS during his presidency.
- 7) Recognition, Management and Prevention of Abdominal Complications of Laparoscopic Surgery.  
[http://www.alsgbi.org/pdf/ALS\\_Complications\\_Management.pdf](http://www.alsgbi.org/pdf/ALS_Complications_Management.pdf)
- 8) Donaldson L. CMO quotes - Patient safety.  
[http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/CMOPublications/QuoteUnquote/DH\\_4102570](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/CMOPublications/QuoteUnquote/DH_4102570)
- 9) Malignant managerialism occurs when the management of a hospital puts the risk to their own and their institution's reputation above candour and learning from mistakes. Under this form of risk management, the risk to patients is the management. Evidence that this disease was rampant in my case is held in a large ring binder in my possession. However it was sight of the minutes of the Morbidity and Mortality discussion of my case that was the final straw. This sought to justify the failure of timely diagnosis largely to "personality issues." That excuse reads like an attempt to blame the victim. (Documents available on request).

### Acknowledgements:

I would like to thank the staff of the relevant ITU (without whose brilliant competence I would not be here) and Mr Muntzer Mughal, the late Professor Philip Schofield and Ms. Siobhan Kelly (Bindman's solicitors) for their help and support throughout a difficult time.

### Competing interests:

I am a doctor, have been, and probably will be again, an NHS patient.

### Biographical note

After a few years as a surgical registrar and research on the biology of angiogenesis, I took various diversions from a conventional career path. These culminated in working with non-governmental organisation and lawyers to document clinical evidence of torture in survivors seeking asylum. I am a trustee of the human rights medical charity, Medact ([www.medact.org](http://www.medact.org))

Mr Frank Arnold FRCS

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# Per-Oral Endoscopic Myotomy (POEM): 'NOTES' on an alternative therapeutic strategy for the management of achalasia

Oesophageal achalasia is a rare motility disorder affecting 1 person per 100,000, and is characterised by the failure of the lower oesophageal sphincter (LOS) to relax appropriately in response to swallowing and the decrease in or absence of peristalsis. The exact aetiology of achalasia remains unknown, however it has been hypothesised that autoimmune-mediated destruction of inhibitory neurons is a possible explanation. Common symptoms associated with achalasia include progressive chest pain, odynophagia, dysphagia, regurgitation and weight loss. The diagnostic workup typically includes upper GI endoscopy (OGD), contrast swallow and oesophageal manometry. The gold standard investigation is oesophageal manometry and in patients with achalasia this may demonstrate incomplete or absent LOS relaxation and the absence of oesophageal peristalsis during swallowing, and sometimes an elevated resting LOS pressure.

Treatment for achalasia is not curative, it is primarily aimed at improving oesophageal emptying by decreasing the functional obstruction at the level of the gastro-oesophageal junction providing symptomatic relief and preventing the long-term development of mega-oesophagus. Treatment options for achalasia include:

- 1 Pharmacological - calcium channel blockers and long-acting nitrates relax LOS but have a short duration and typically provide incomplete symptom relief [1].
- 2 Botulinum toxin - a neurotoxin is injected endoscopically that inhibits acetylcholine release at motor neuron presynaptic terminals and thereby promotes LOS relaxation.
- 3 Endoscopic pneumatic dilatation - considered the most effective non-surgical treatment for the palliation of dysphagia associated with achalasia. A sequential graded approach to pneumatic dilation with noncompliant polyethylene balloon diameters (30, 35 and 40mm) is most commonly used. The pressure required is usually 7 – 15 psi, with balloon inflation maintained for 15 – 60s with confirmation of LOS 'waist obliteration' by fluoroscopy [2]. The most severe complication associated with pneumatic dilatation is oesophageal perforation, which occurs in 4 – 7% of dilatations [3].
- 4 Surgical myotomy - division of the muscle fibres of the cardia for the treatment of achalasia was first described by Ernst Heller in 1913. Over the years several technical issues have undergone clinical assessment; trans-thoracic vs. trans-abdominal, open vs. laparoscopic, extended vs. limited myotomy and whether a concomitant anti-reflux procedure including Nissen, Toupet or Dor fundoplication should be done in conjunction with the myotomy.

Per-Oral Endoscopic Myotomy (POEM) has been recently introduced as a 'scarless' (endoscopic) approach to myotomy. There has been significant variability in the technical approach employed in POEM surgery. The most commonly described technique is that of Inoue et al [4]. This involves submucosal injection of saline at the mid-oesophageal level approximately 13cm above the gastro-oesophageal junction. A standard endoscope with a cap is introduced into the submucosal layer through a 2cm longitudinal incision on the mucosal surface. A submucosal tunnel is then created and extended to 3cm onto the stomach utilising a triangular tip-knife and spray coagulation under direct endoscopic vision, or blunt dissection with the flexible endoscope or standard balloon dilation. Dissection of the circular muscle begins approximately 7cm from the gastro-oesophageal junction using spray coagulation and a triangular tip knife. Division of the muscle continues for approximately 2cm distal to the gastro-oesophageal junction, there is typically narrowing seen endoscopically during passage through the lower oesophageal sphincter (LOS). The outer longitudinal muscles are identified at the limit of the dissected area, and following myotomy, smooth passage of the endoscope through the gastro-oesophageal junction should be seen. The site of entry in the mucosa is then closed with haemostatic clips or fibrin glue.

The attraction of this technique is the minimally invasive nature of the procedure, with no external scarring and less surgical stress, whilst ensuring the creation of a myotomy identical to that created by traditional open or laparoscopic surgery. To date only a handful of small case series have been published that describe the use of POEM procedures in patients with achalasia (Table 1). These publications suggest POEM is an effective treatment for achalasia with a post-operative improvement in dysphagia scores, and a reduction in LOS pressure. The potential negatives associated with POEM are similar to those seen with laparoscopic Heller myotomy, including a risk of oesophageal perforation that is very rare in published reports to date, but is likely to include a significant publication bias. POEM surgery does not allow for a concurrent anti-reflux procedure, and thus critics have suggested that POEM may result in a high incidence of long-term reflux disease. The small number of cases reported, and a lack of comparative data with laparoscopic Heller myotomy, mean that the relative merits, or otherwise, of POEM surgery are still to be clearly determined.

Per-Oral Endoscopic Myotomy is a therapeutic endoscopic procedure and therefore a further area of debate exists as to whether



this is best performed by surgeons, gastroenterologists or a combination of the two. In all likelihood this will be most appropriately determined at a local or national level as significant differences in endoscopic training exist internationally between countries. An argument can be made for endoscopically trained surgeons to perform POEM procedures given their previous experience with surgical myotomy and division of muscle fibres. Further, in the event of oesophageal perforation or further complications, a surgeon will in all likelihood be required to assess the patient to determine further management. The argument in favour of gastroenterologists performing POEM procedures is based upon a greater endoscopic experience in complex therapeutic procedures, in some health care systems, that may shorten the learning curve for POEM surgery. Further additional issues include training in POEM surgery, with a number of courses already run within the United States this may represent the best opportunity for doctors from Great Britain to train in this new technique. Surgeons from the Far East have advocated a step-wise approach to adopting POEM surgery, including learning endoscopic submucosal dissection (ESD) of gastric lesions followed by oesophageal lesions, as ESD utilises many of the endoscopic techniques seen in POEM procedures. The number of gastro-oesophageal ESDs performed within the west is extremely limited and may restrict this approach to learning.

Per-Oral Endoscopic Myotomy is an innovative and potentially important addition to the treatment approaches for achalasia. However currently there is insufficient follow-up to assess the long-term success rate or consequences of POEM.

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## References

1. Stefanidis D, Richardson W, Farrell TM, Kohn GP, Augenstein V, Fanelli RD. SAGES guidelines for the surgical treatment of esophageal achalasia. *Surg Endosc* 2012; 26: 296 – 311
2. Richter JE, Boeckstaens GE. Management of achalasia: surgery or pneumatic dilation. *Gut* 2011; 60: 869 – 876
3. Boeckstaens GE, Annese V, Bruley des Varmmes S et al. Pneumatic dilation versus Laparoscopic Heller myotomy for idiopathic achalasia. *N Engl J Med* 2011; 364: 1807 – 16
4. Inoue H, Tianle KM, Ikeda H et al. Peroral endoscopic myotomy for esophageal achalasia: technique, indication and outcomes. *Thorac Surg Clin*. 2011; 21: 519 – 25
5. Inoue H, Minami H, Kobayashi Y, et al. Peroral endoscopic myotomy (POEM) for esophageal achalasia. *Endoscopy* 2010; 42: 265 – 71
6. Von Renteln D, Inoue H, Minami H, et al. Peroral endoscopic myotomy for the treatment of achalasia: a prospective single center study. *Am J Gastroenterol* 2012; 107: 411 – 7
7. Swanstrom LL, Rieder E, Dunst CM. A stepwise approach and early clinical experience in peroral endoscopic myotomy for the treatment of achalasia and esophageal motility disorders. *J Am Coll Surg* 2011; 213: 751 – 6
8. Costamagna G, Marchese M, Familiari P, et al. Peroral endoscopic myotomy (POEM) for oesophageal achalasia: Preliminary results in human. *Dig Liver Dis* 2012 [Epub ahead of print].

Table 1: Results from Clinical Trials of Per-Oral Endoscopic Myotomy

AUTHOR (DATE)	NUMBER OF PATIENTS	MYOTOMY LENGTH (CM)	LENGTH OF FOLLOWUP (MONTHS)	DYSPHAGIA SCORE IMPROVEMENT	LOS PRESSURE CHANGE (MMHG)
Inoue (2010) [5]	17	8.1 (6.1 in esophagus, + 2 in stomach)	5 (1 – 16)	10 to 1.3 (0 – 4)	52.4 to 19.8 (9.3 – 42.7)
Von Renteln (2011) [6]	16	12 (8 – 17)	3	94% patients with Eckhard score of $\leq 3$	27.2 to 11.8
Swanstrom (2011) [7]	5	7 (6 – 12)	2 weeks	All patients reported immediate dysphagia relief	No postoperative study
Costamagna (2012) [8]	11	10.2 $\pm$ 2.8	1 month	7.1 to 1.1 (Eckardt score)	45.1 to 16.9

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## Laparoscopic Fellowship in the Flanders fields, near Paschendale



Working in a different health system can prove a challenging but ultimately unique and enjoyable experience. I undertook a fellowship kindly arranged by Dr Bart Smet, a prolific Laparoscopic Surgeon, near the historic town of Paschendale, in Roeselare within the Flemish region of Belgium. Although the official spoken language is Dutch, all spoke English, but correspondence was conducted in the local dialect and was initially quite daunting! Heilig Hart Ziekenhuis (Holly Hart Hospital) is a 600-bed hospital and accommodated every aspect of surgery including Cardiothoracic

Surgery and Neurosurgery. Robotic Surgery was well-established and there was ample laparoscopic surgery conducted in all the surgical units. The Department of Abdominal Surgery, comprised three general surgeons but of these Dr Bart Smet and Dr Paul Pattyn were the two main laparoscopic surgeons, performing 700-800 laparoscopic operations annually. The unit was ranked fifth in the Belgian Bariatric Surgery League with 240 laparoscopic gastric bypasses undertaken annually. Other procedures routinely conducted included laparoscopic colorectal, laparoscopic upper GI surgery (fundoplication, splenectomy and even choledochojejunal anastomosis!) and laparoscopic hernia surgery. The third surgeon, Dr Patrick Vuylsteck, continued my exposure to open abdominal surgery

This fellowship allowed plenty of "hands on" exposure. One can spend 5 days a week at theatre if so inclined. Although the Fellowship period was limited to six months I did progress under supervision through increased levels of competency in advanced laparoscopic operations. These included Laparoscopic Gastric Bypass procedures and Laparoscopic Colorectal procedures. Though the day finished at 6pm, my training continued on the simulators where I could perfect my laparoscopic skills. Dr Smet and I devised exercises to ensure my skills were constantly updated and my training envelope stretched. At the end all that hard work paid dividends and helped me to improve my skills and refine my laparoscopic procedures.



I conducted approximately 40 laparoscopic bypasses and 10 laparoscopic colectomies by the end of the six month period.

No fellowship is complete without some exposure to the local environment and culture. Cycling in the Belgian countryside is certainly an activity to treasure. I will always remember the cycling trip to the calm of Ypres, the Great War battlefield, near Paschendale, experiencing the peacefulness and serenity of the memorials. A visit to Bruges is a must where I discovered the delightful warehouse exhibiting all the 780 different Belgian beers! Belgium is famed for its gastronomy and tempting fine restaurants always beckon. The unbridled hospitality I encountered from my colleagues certainly allowed me to sample Belgian cuisine at its finest. I was also lucky enough to see the Tour of Flanders, a religious day for the Flemish people, it is certainly an once in lifetime's experience not to be forgotten.



When the time came to leave it felt strange as I was leaving behind friends. People acknowledged me as part of their team and I certainly was welcomed throughout my stay. And the last night in Roeselare with dining under the stars with my Belgian friends could not have been a better finale to that period. There is no doubt I shall cherish the memories during this Fellowship.

**Mr Ioannis Virlos**

Consultant Surgeon, Ealing Hospital



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Solent Training Centre	St Mary's Hospital	Portsmouth	Susan Buchanan		<a href="mailto:susan.buchanan@porthops.nhs.uk">susan.buchanan@porthops.nhs.uk</a>	023 9286 6861
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Northern Skills Institute (NUGITS)	Hexham General Hospital	Hexham	Sue Colley		<a href="mailto:sue.colley@nhct.nhs.uk">sue.colley@nhct.nhs.uk</a>	07830 740667
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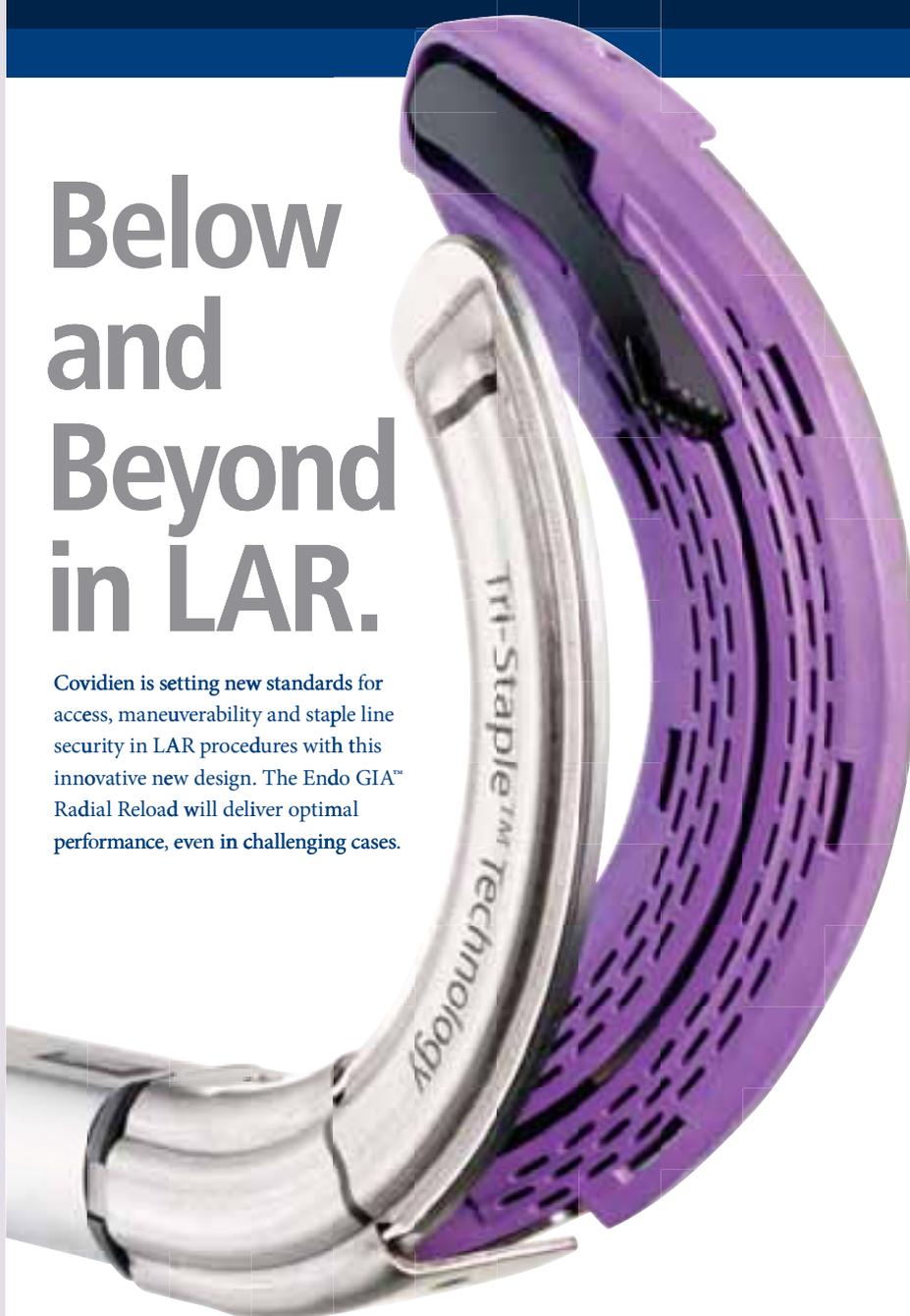
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## Course review: Intermediate Skills in Laparoscopic Surgery



In July 2012, I attended the Intermediate Skills in Laparoscopic Surgery Course held at the Royal College of Surgeons of England. This was generously funded by an ALSGBI Training Bursary sponsored by Stryker. The course is designed for ST3-5 trainees in general surgery wishing to build on their core laparoscopic skills. The programme is delivered over 2 days using practical simulation and interactive discussion. Emphasis is placed on improving fundamentals such as suturing and knot tying and covers several laparoscopic procedures including fundoplication, bile duct exploration, hernia repair and bowel anastomosis.

The course was extremely enjoyable and well-organised. The faculty were very approachable and this allowed for a relaxed training environment. All delegates were given ample opportunity to ask questions, discuss operative techniques and practice on the simulators. The high faculty-to-delegate ratio meant that the course was tailored to the individual so as to maximise the learning potential for each participant. As a clinical research fellow in simulation, I was able to compare the novel simulators with my existing experience and was extremely impressed with the attention to detail and innovative measures employed by the faculty and technical support staff.

I would advise all trainees to attend this course as a means of developing their laparoscopic ability. I would like to thank the ALSGBI and Stryker for awarding me the training bursary which has allowed me to develop further as a future laparoscopic surgeon.

**Mr James Ansell**

Welsh Institute for Minimal Access Therapy (WIMAT), Cardiff

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## ALS<sup>GBI</sup>

Association of Laparoscopic Surgeons &  
Association of Laparoscopic Theatre Staff  
of Great Britain & Ireland

# ALTS (Association of Laparoscopic Theatre Staff) Members 2012 Bursaries

The ALS is pleased to offer a number of SIGH (Surgical Instrument Group Holdings Ltd) Bursaries. The purpose of these awards is to enable Senior Theatre Staff to attend the 2012 ALS Annual Scientific Meeting in Cork on Thursday & Friday, 29 & 30 November 2012. The Bursaries will cover the cost of a return flight, the registration fee for the two days and also accommodation for one night (Thursday).

Bursaries will be awarded to Senior Theatre Staff who can demonstrate significant experience of teaching, defining the roles and assisting with procedures in the MAS Teams of their hospitals. In order to be

considered for one of the SIGH Bursaries it is a prerequisite that candidates should be current ALTS members however you may join on application.

Initially email [jtreglohan@asgbi.org.uk](mailto:jtreglohan@asgbi.org.uk) to request an application form and membership form if necessary. The completed form must be returned to Mrs Jenny Treglohan, ALS Executive Officer, Association of Laparoscopic Surgeons at The Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London WC2A 3PE.

The deadline for receipt of applications is **Friday 26 October 2012**. This offer is on a 'first come, first served basis' and only one bursary per hospital will be awarded. Bursaries are NOT available to nurses who have been sponsored in previous years. We look forward to seeing you in November!

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