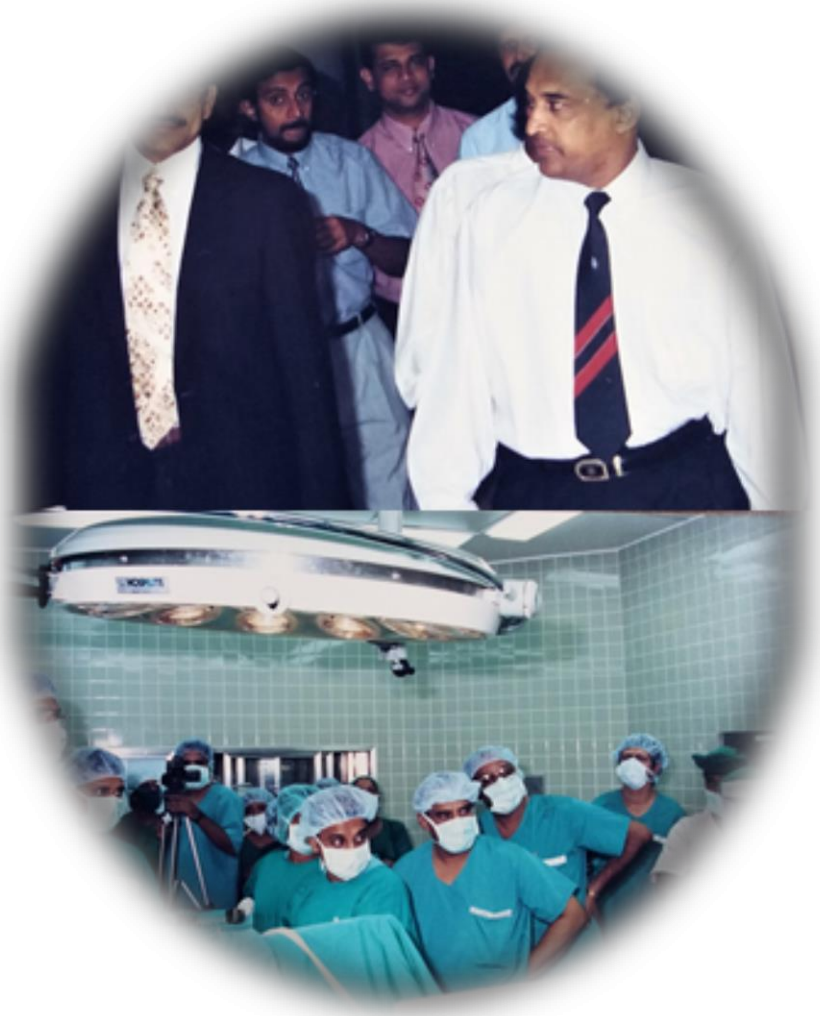
Monthly e-Newsletter



SLAMADS

SRI LANKA ASSOCIATION OF
MINIMAL ACCESS AND DIGITAL SURGEONS

Volume 3 Issue 04

April 2021

Editors

Prof KB Galketiya

Dr BK Dassanayake

Contents

From the Editors

The first report of laparoscopic cholecystectomy from Sri Lanka was in 1992 by Dr KL Fernando.

By mid nineties it was available in a few centers in Colombo and by beginning of the millennium, in Matara, Kandy and Galle. The pioneers faced many challenges to learn and also had to teach while learning.

Dr Gamini Goonetilleke who played a leading role in establishing laparoscopy in Sri Lanka has shared his reminiscences in this Newsletter.

The most important factor which contributed to what we are today is the senior surgeons learning and training the juniors. The current day trainee has many other learning opportunities such as workshops, web based learning, dedicated training units with lap trainers, text books and atlases.

Today laparoscopic services are available in all centers with a surgical unit.

The pioneers began with cholecystectomy and gradually moved in to complex surgeries over many years.

It is a pleasure to note that newly appointed surgeons perform a wide range of laparoscopic surgery, with many such centers reporting their work in SLMADS Newsletters.

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Council meeting - April 2021

The Council Meeting for April was held on 02/05/2021, chaired by Prof Bawantha Gamage

The following were discussed:

Upcoming CMEs:

-Laparoscpic Hernia Workshop at PGH Badulla

-Advanced Laparoscopy workshop at Teaching Hospital Anuradapura

-Webinars

The Presidential induction is to be held in May 2021

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Early Days of Minimal Access Surgery in Sri Lanka

Gamini Goonetilleke FRCS Consultant Surgeon, Past President, The College of Surgeons of Sri Lanka

The year 1992 could be regarded as the watershed in Minimal Access Surgery in Sri Lanka. Dr K L Fernando FRCS, regarded as the 'father' of laparoscopic surgery in Sri Lanka returned to Sri Lanka from UK, where he had training in this new technique..He brought with him equipment and instruments used for laparoscopic surgery and established a Laparoscopic Surgery Unit at the General Hospital Colombo North, Ragama. He was a senior lecturer in surgery at MedicalNorth Colombo the School.

Dr K L Fernando performed the first laparoscopic cholecystectomy at this hospital on 10th June 1992.. He also performed laparoscopic cholecystectomy at private hospitals namely Nawaloka and Asiri Hospitals using his own equipment under difficult conditions as there were no assistants trained in this field. Dr K L Fernando delivered the first oration on this subject in 1994. That was the Sir A M De Silva Oration organised by The College of Surgeons of Sri Lanka; Laparoscopy 81 Consecutive Cases in Sri Lanka. His experience was later published in the Sri Lanka Journal of Surgery in 1995 – *Ref. Fernando KL. Laparoscopic Cholecystectomy: 81 Consecutive Cases in Sri Lanka. Sri Lanka Journal of Surgery.1995;4-17*

In 1992 Laparoscopy was also introduced to Sri Jayewardenapura General Hospital, Nugegoda (SJGH) and operations were being done with the assistance of Sri Lankan Expatriate Surgeons domiciled in US on their visits to Sri Lanka. But this was not a regular feature.. I joined SJGH in 1993. I had no training in this field at that time. In 1994, The Board of the SJGH decided send me and Dr S A W Gunewardena for training at the Gangaram Hospital in New Delhi, India. Following this training we performed laparoscopic cholecystectomy very cautiously. Naturally there was a high conversion rate.

In 1995 the first Laparoscopic Surgery workshop was held in Sri Lanka. This was one of the workshops conducted at the First meeting of The College of Surgeons of Sri Lanka with The Royal College of Surgeons of England held in Colombo. The workshop was held in the Consultants Lounge of The General Hospital Colombo using modules supplied by Karl Storz, Germany. The guests from UK were the trainers at this workshop (Photos attached).

From 1998 onwards surgeons from Sri Lanka started attending laparoscopic workshops in India. One of the main centres was the hospital dedicated to Minimal Access Surgery where Dr C Palanivelu MS, MNAHS, Mch (Gastro), FACS one of the pioneers in laparoscopic surgery in India was practicing this art. The Ethicon animal lab in Chennai managed by Johnson & Johnson was another centre where we learnt the techniques of laparoscopic surgery.

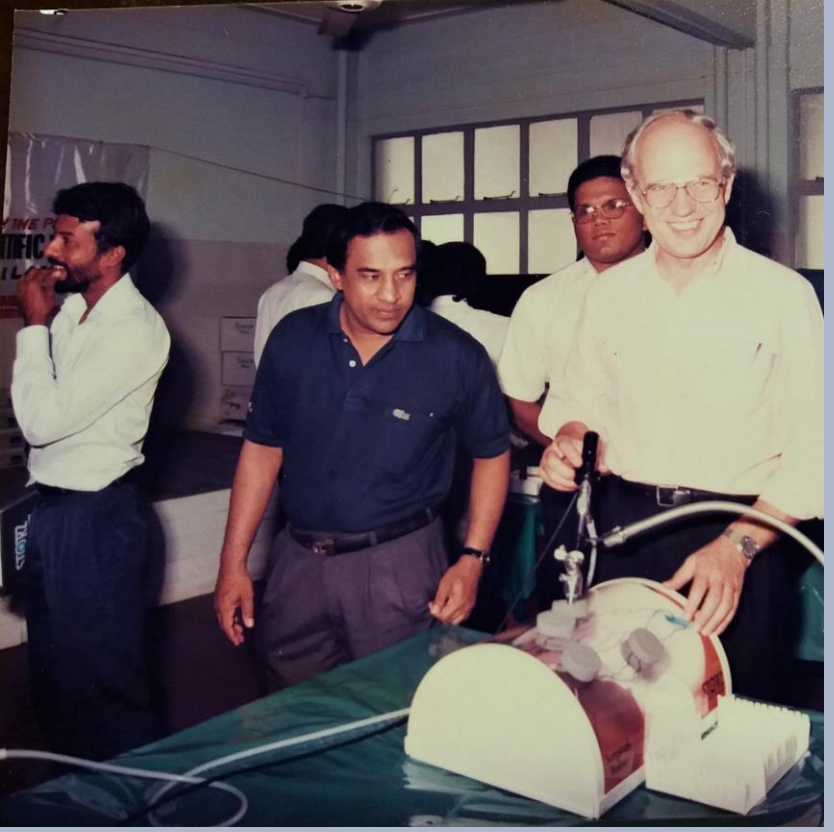
In 1998, I delivered the Sir A M De Silva oration of The College of Surgeons of Sri Lanka: *Symptomatic Gallstone Disease in Sri Lanka and The Early Experience in Laparoscopic Cholecystectomy in Sri Lanka.* This was later published in the Sri Lanka Journal of Sri Lanka. *Reference – Laparoscopic Cholecystectomy – A Six Year Audit in a General Surgical Unit. The Sri Lanka Journal of Surgery 2000,18, 10-15 Goonetilleke G C, Dissanayake T P, Jayesekera S, Samarakoon D, Hathurusinghe H, Perera S.*

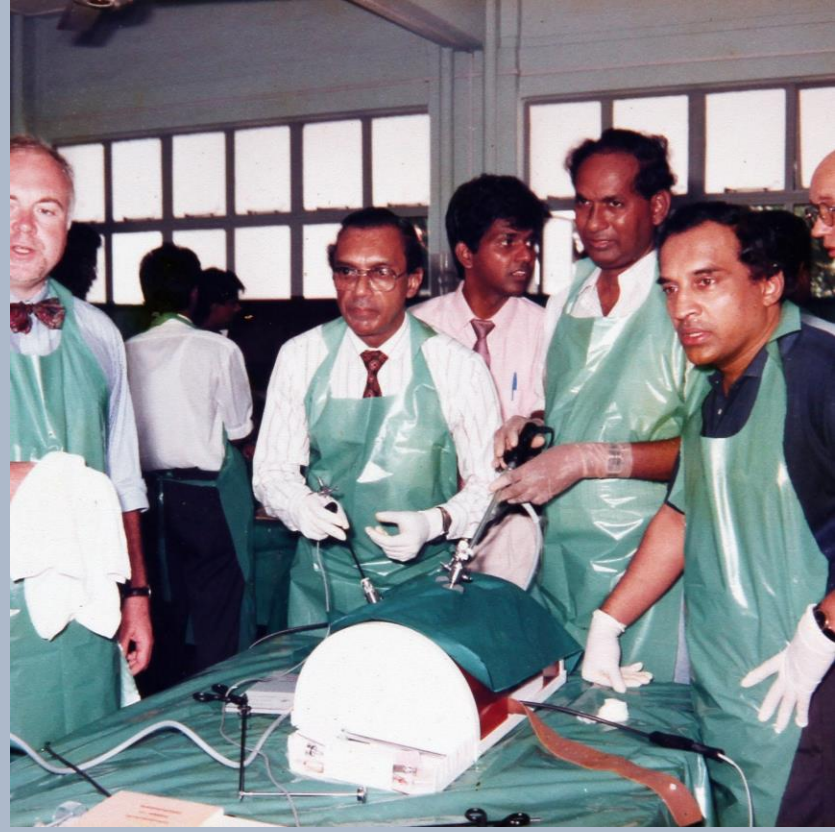
In 2000 the first Video Endoscopic System (Fujinon) was introduced to Sri Lanka at the Sri Jayewardenapura General Hospital, Nugegoda. Following this the first live video endoscopic workshop with two way communication was held at the same hospital with the participation of consultant surgeons and physicians practicing endoscopy in Sri Lanka.

In 2001 the first live demonstration of laparoscopic procedures was held in Sri Lanka. This was organised by The College of Surgeons of Sri Lanka and was held at the SJGH. The demonstration of procedures was by Dr C Palanivelu which in fact was his first visit to Sri Lanka. (Photos attached)

The Harmonic Scalpel was introduced for the first time at SJGH in 2001.

The Ethicon Fellowship was started in 2001. Senior and junior registrars (pre and post MS trainees) were selected for this fellowship. They underwent training in laparoscopic surgery by experts in the field at selected hospitals in India. While the senior registrars were trained for 3 months, the junior registrar’s training was restricted to 1 month.





First Laparoscopy Workshop in Sri Lanka – 1995-Dr Gamini Goonetilleke

The first laparoscopy workshop for surgeons in Sri Lanka was conducted during the first Joint meeting of

The Royal College of Surgeons of England (RCS) with The College of Surgeons of Sri Lanka.

It was held on the 8th April 1995 at the Consultants Lounge, General Hospital Colombo.

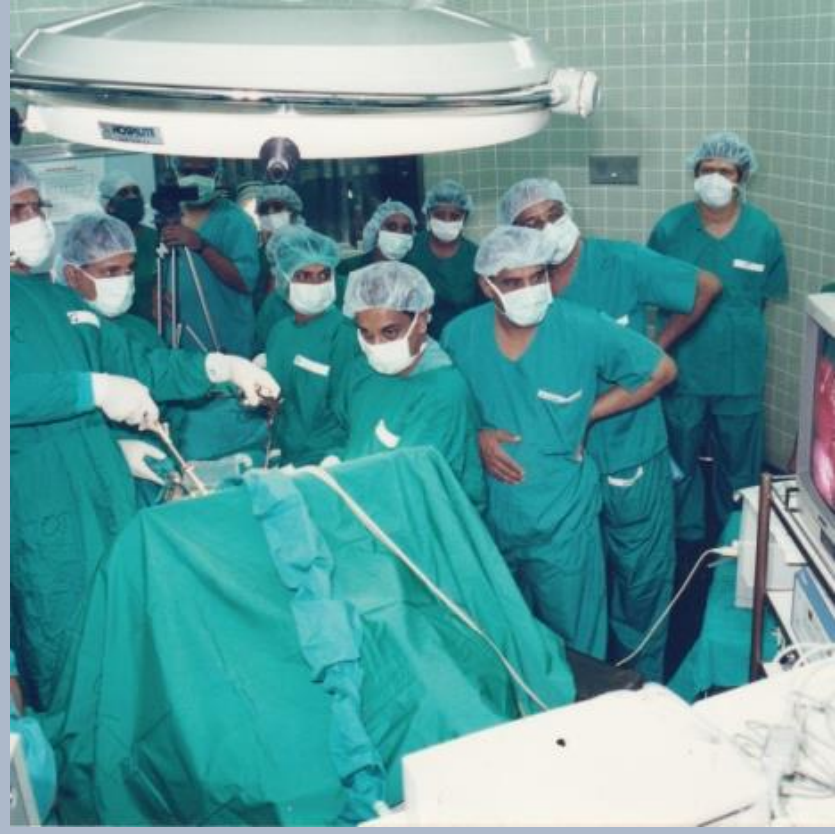
The demonstration of various techniques was carried out by the members of The Royal College of Surgeons of England.

A modular system was used for the demonstration. The workshop was sponsored by Karl Storz, Germany.

*(Editor's Note: **OSCE -** Identify the Sri Lankan surgical greats participating in this workshop!)*

The first live demonstration of laparoscopic surgery organised by The College of Surgeons of Sri Lanka was held at the Sri Jayawardanapura Genaral Hospital, Nugegoda in July 2001. **This was the first live demonstration of laparoscopic procedures with video conferencing to be held in Sri Lanka**. The procedures were demonstrated by Dr.C.Palanivelu, a well known and world renowned laparoscopic surgeon from India. The following procedures were demonstrated - Cholecystectomy, Inguinal herniotomy, Nissen Fundoplication, Ligation of varicocele, Orchidopexy, appendicectomy and laparoscopic assisted gastro-jejunostomy. There were 50 participants both surgeons and surgical trainees.

The First Live Laparoscopic Surgery Workshop in Sri Lanka – 2001
Dr Gamini Goonathilaka
Consultant Surgeon
President, The College of Surgeons of Sri Lanka – 2001



Proceedings of the workshop.

Of interest is the old generation CRT Monitor screen

A NOTE FROM A PARTICIPANT

-KB Galketiya, Surgeon General Hospital Matara 2001

It was a delight to identify my self seated in the audience. We watched a range of laparoscopic procedures performed by Prof C Palanivelu, tireless from morning to evening. I was a beginner while Dr Gamini Goonetilleke was a senior surgeon. Once returning to Matara, with reluctance, I called Dr Goonetilleke and inquired whether he can kindly provide me the recordings. They were in video cassettes to be watched on TV screen. It was an addiction for me to watch, regularly, the expert at work. Later the Atlas by Prof Palanivelu became my "Guru" to perform complex laparoscopic surgeries.

Prof Palanivelu was later invited to a workshop held at Colombo South Hospital by Prof Mohan de Silva for which I participated and didn't forget to obtain copies of recordings.

This link was further strengthened in 2017 when Prof MD Lamawansa, as President of College of Surgeons of Sri lanka, signed a MOU with the Association of Minimal Access Surgeons of India(AMASI).

Since then, annually a live Laparoscopic surgery work shop and a skills course was conducted at Faculty of medicine/ Teaching Hospital Peradeniya. There are close to fifty surgeons who have obtained the fellowship from AMASI(FMAS).

In 2000 due to COVID the workshop was transmitted live from two centers of India at no cost.

CME Activities in April 2021

CME LECTURES ON MINIMAL ACCESS SURGERY

Kandy Society of Medicine (KSM) Annual Sessions- 08/04/2021

Plenary Lecture – Prof KB Galketiya

Minimally Invasive Surgery in the New Millenium

Symposium lecture – Dr Chathuranga Keppetiyagama

Novel Endoscopic Interventions

WEBINAR ON LAPAROSCOPIC CHOLECYSTECTOMY

by Prof Mohan de Silva - 08/04/2021

HANDS ON ENDOSCOPY FOR SURGICAL REGISTRARS

organized by Prof Bawantha Gamage - 18/04/2021

April 08,2021

KSM Annual Sessions
Prof KB Galketiya and
Dr Chathuranga Keppitiyagama
Chaired by Prof Arjuna Aluvihare
and Dr P Pitigalaarachchi

Webinar on
laparoscopic cholecystectomy
by Prof Mohan de Silva

April 18 2021

Endoscopy workshop at Colombo South Teaching Hospital

Articles and Write-Ins

Case Report

Laparoscopic Assisted Right Hepatectomy

Arinda Darmapala KB Galketiya Buddhika Dassanayake WGP Kanchana D Karunasagara HMSS De Silva DC Danuksha R Perera

Departments of Surgery and Anaesthesia Faculty of Medicine/ Teaching hospital Peradeniya

A 61 year old male presenting with obstructive jaundice was diagnosed to have a hilar cholagiocarcinoma extending more towards right duct. The right hepatic artery was arising from the superior mesenteric artery with possible infiltration.

Laparoscopic assisted right hepatectomy was planned to perform after placing a left Percutaneous transhepatic biliary drain. Laparoscopy was decided as we have hybrid experience of open liver surgery, a variety of advanced laparoscopic surgeries as well as few limited laparoscopic anatomical resections.

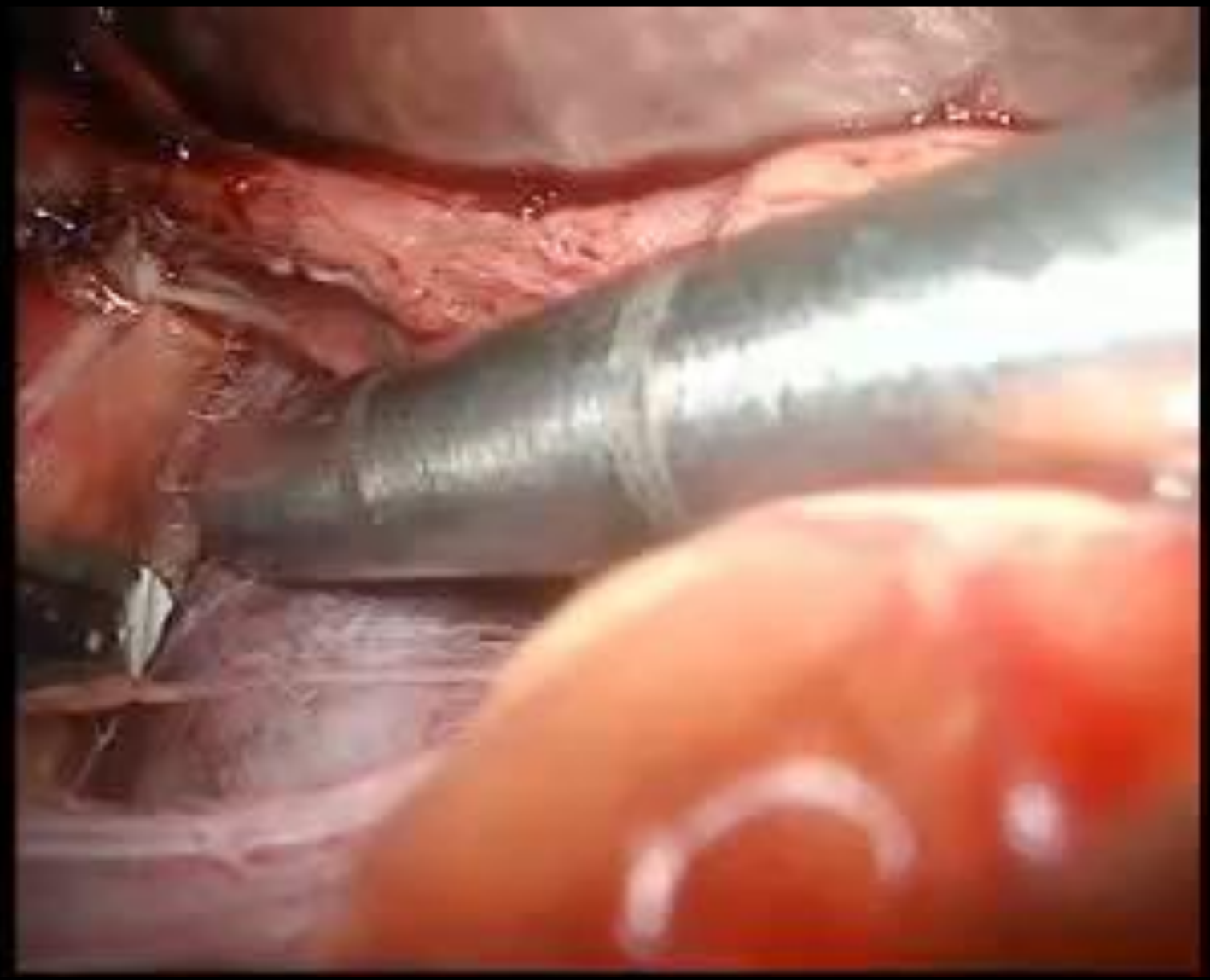
Surgery was performed using five ports. Common hepatic, left hepatic and gastro-duodenal artery were displayed. The portal vein, left and right branches were dissected out and left ligated and divided. The common bile duct(CBD) and the anomalous right hepatic artery just behind CBD were dissected. The CBD was transected and artery clipped and divided. CBD was dissected to hilum left duct hepatic duct followed beyond tumour and divided.

Right triangular ligament was divided mobilizing the right lobe of liver. The inferior vena cava was dissected off dividing few small tributaries enteric right lobe.

Division of liver parenchyma was performed using ultrasonic dissector bipolar and water jet. Once substantial amount of transection was done we decided to complete resection and anastomosis by open. The time spent up to opening was four hours with a blood loss of 300ml.

Two videos of portal vein and IVC dissection are attached

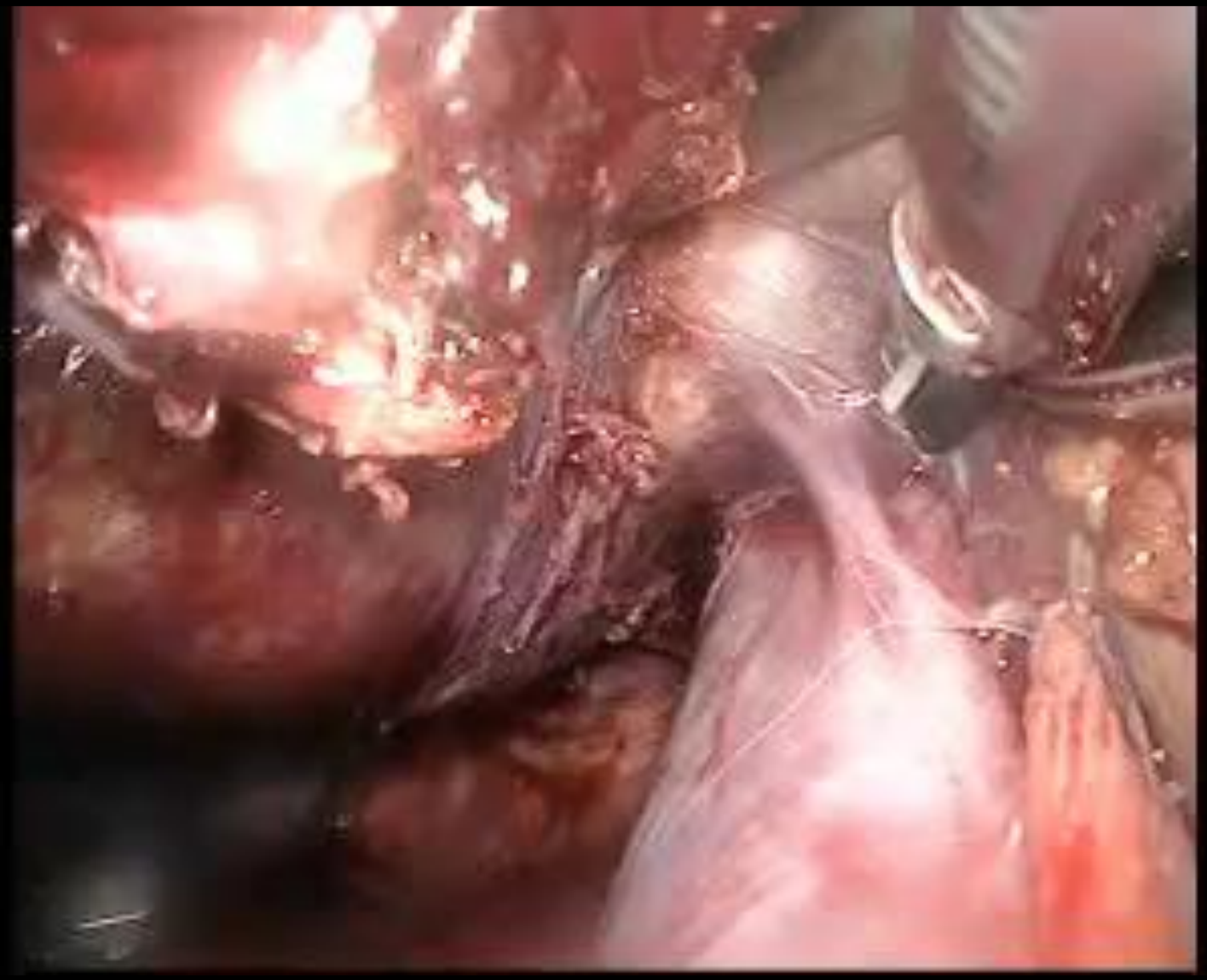
Portal Vein Dissection



If the Video does not display on your device, please click the link below

https://drive.google.com/file/d/1IKpzFKkFdpPzD5po0asSY0oI7lHU_4HX/view?usp=sharing

IVC Dissection



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Write-In

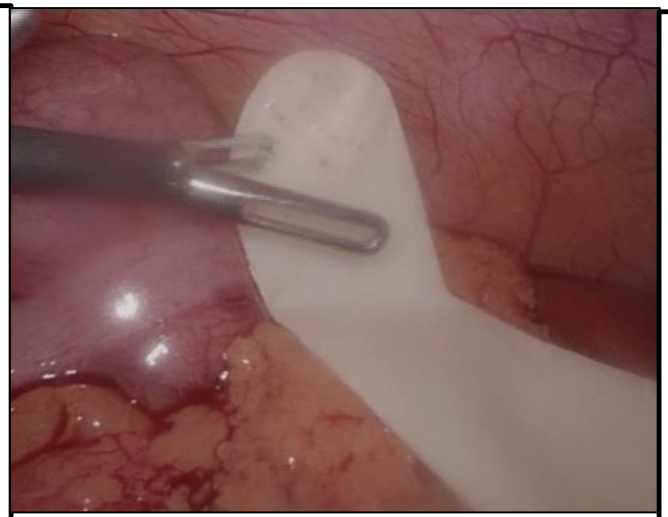
A Low-Cost Method of Specimen Retrieval in Laparoscopic Appendicectomy

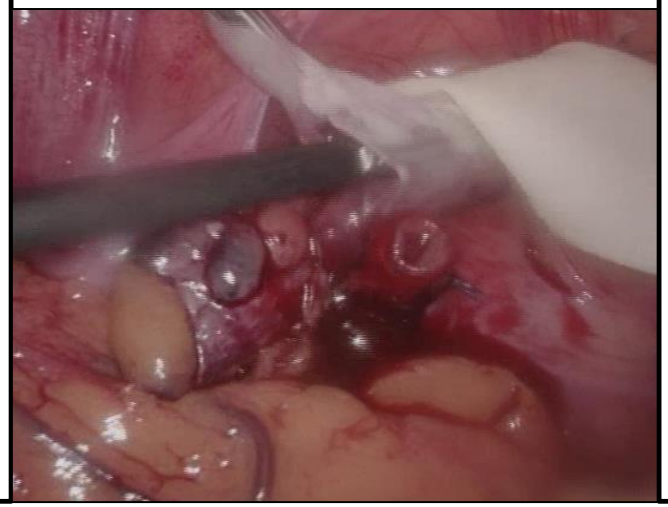
Bandula Samarasinghe

Department of Surgery, Faculty of Medicine/ Teaching Hospital Peradeniya

Laparoscopic Appendicectomy, being minimally invasive, less painful and faster in recovery, has become the standard operation for acute appendicitis. The standard worldwide way of retrieval of appendix is with a retrieval bag (Endo Catch™). Thus the specimen can be removed without contaminating the rest of the peritoneum, ports and incisions.

This is a relatively expensive single use bag which is difficult to afford developing countries like ours. In addition a 5mm telescope is also required to monitor this procedure.





Instead a finger of a sterile surgical glove can be used to retrieve the appendix. The specimen is placed inside the glove. Then the covered finger of the glove is retrogradely fed into the 10 mm umbilical port. When the 10mm port is removed, the glove finger with the specimen is outside the body. This allows a safe, reliable way of retrieval of the specimen at a very low cost.

Pictorial Case Report

Spontaneous Intramural Oesophageal Dissection – Case Report of a Rare Entity

Samarajeewa U , Pragalathan B
District General Hospital Trincomalee

Spontaneous Oesophageal dissection (OD) is a rare condition with very few cases reported in the literature. Usually, spontaneous OD is common in women during their seventh or eighth decade of life who are on anticoagulation.

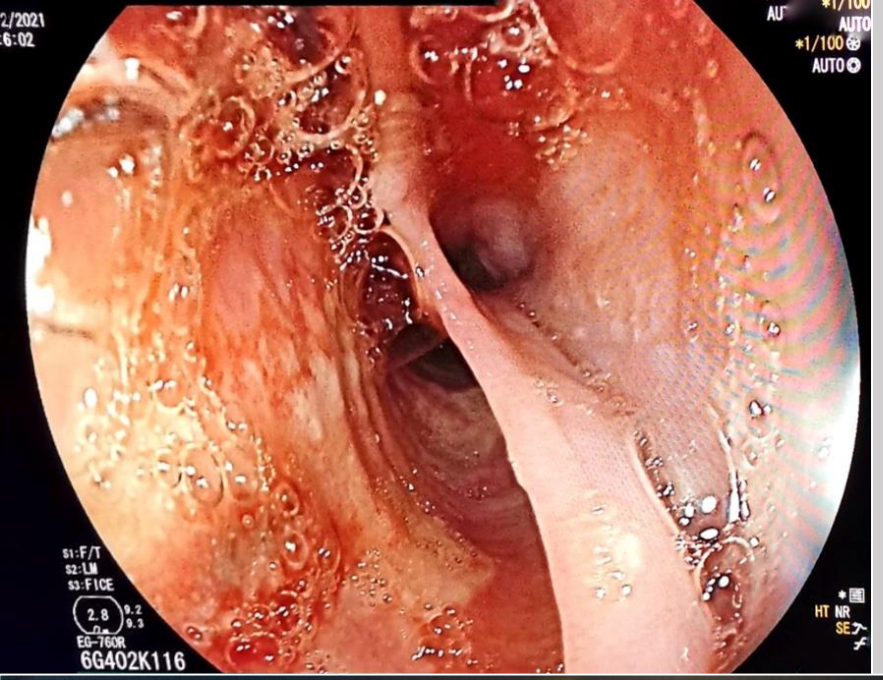
The symptoms of OD are dominated by dysphagia and/or odynophagia, chest or back pain, and nausea. The diagnosis of OD is typically confirmed with barium or water-soluble contrast oesophagography, computed tomography (CT), standard endoscopy and endoscopic ultrasound.

Management of this condition is purely conservative once a leak is excluded .

A 66-year-old known diabetic & hypertensive female who is on dual anti platelet, presented to the clinic with sudden onset of progressive dysphagia for 2 months duration with a history of pain in the mid chest region following ingestion of cuttlefish 2 months back. There is no past history suggestive of esophageal stricture, upper gastrointestinal malignancy or esophagitis.

Upper GI endoscopy reveals submucosal dissection with luminal narrowing from 19cm to 35cm. Esophagogram reveals separate column of contrast coursing parallel to the oesophagus without leaking of contrast. CT scan of the chest reveals false lumen extending from neck to the upper abdomen with true lumen compressed. *(Images attached)*

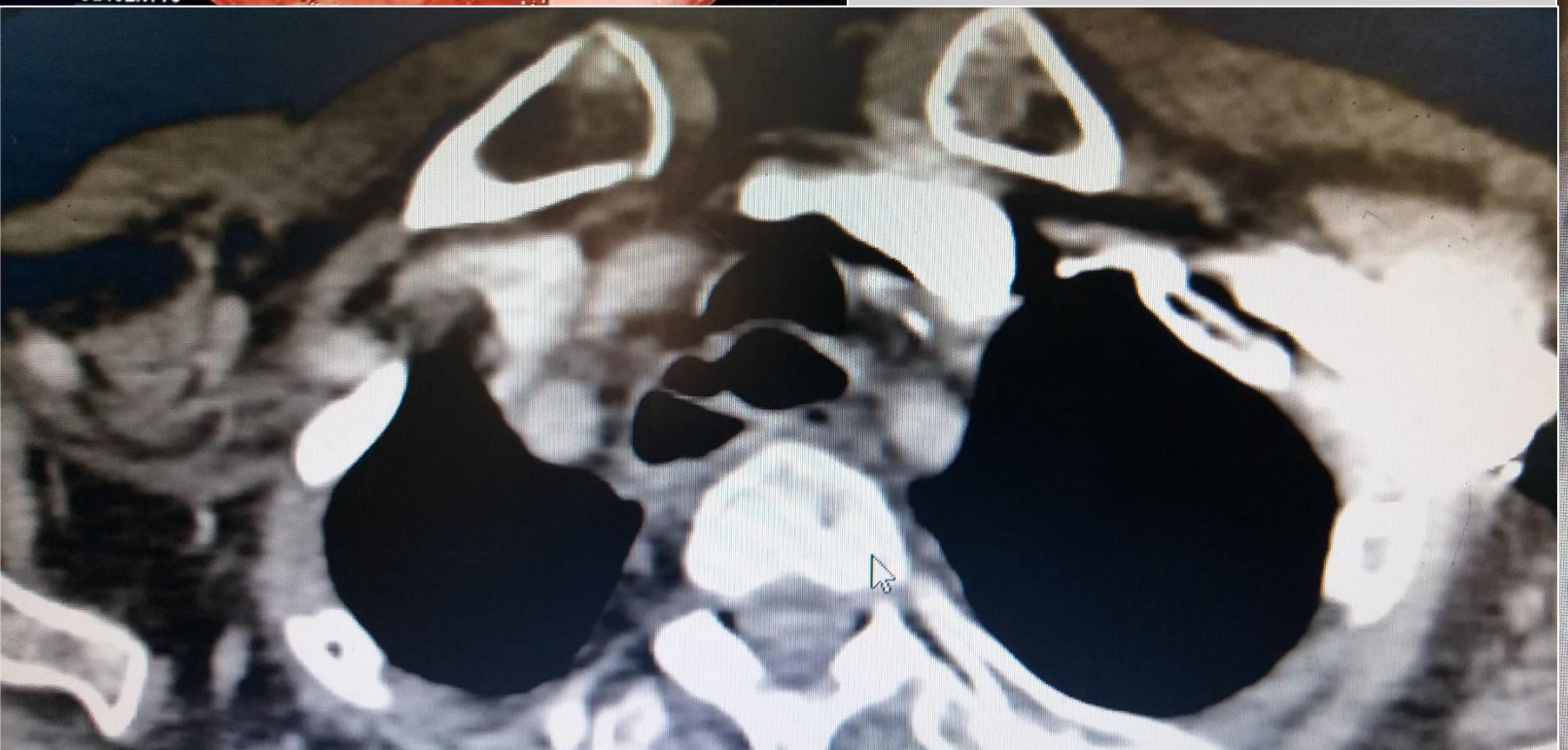
She was managed conservatively with PPI, antiemetic and soft diet. She was discharged in good condition with a follow-up assessment plan.

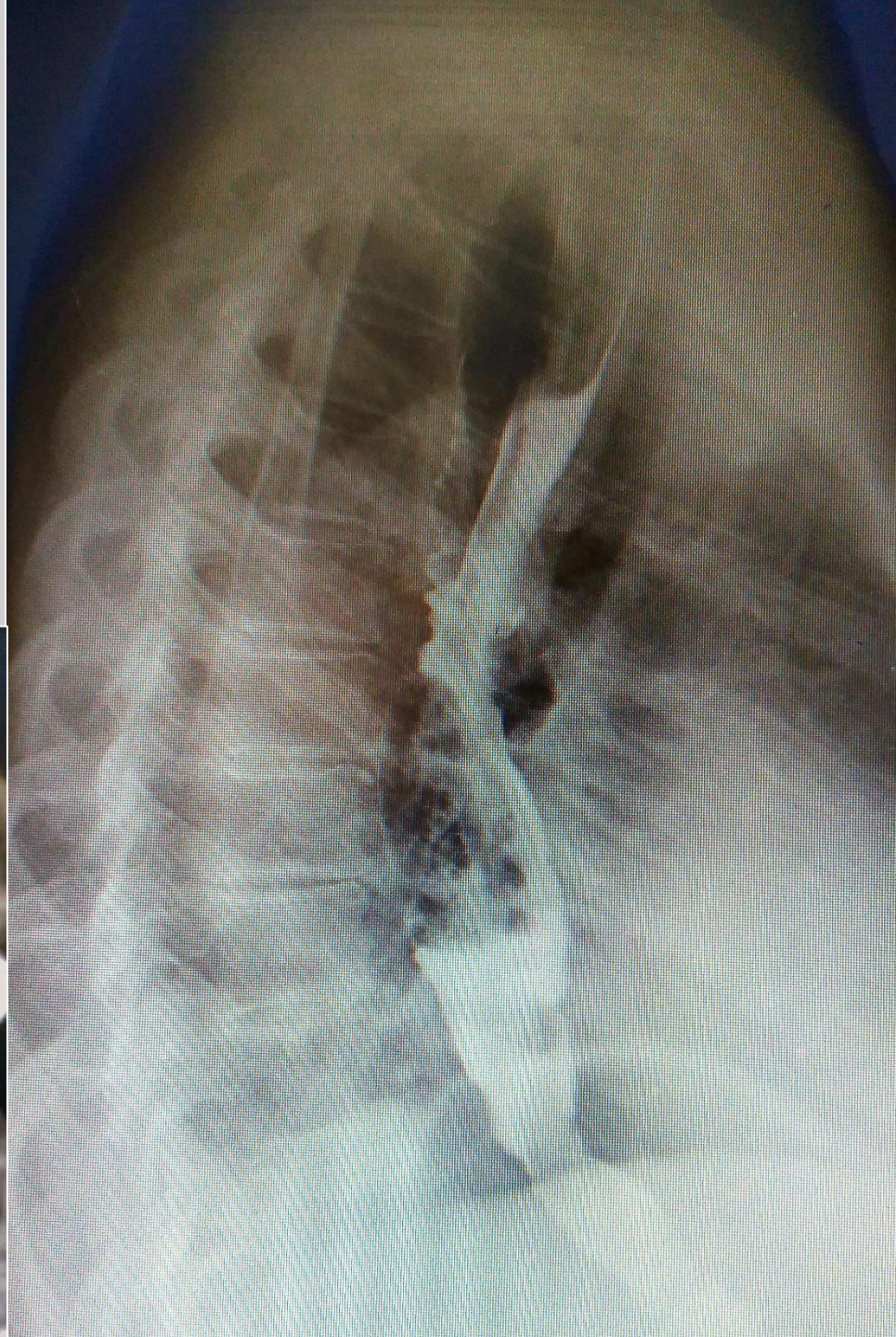


Left: Endoscopic view

Right: Oesophagogram

Below: Cross-Sectional CT view of the dual lumen





Case Series

Endovascular Revascularization : It is Possible in a Low Resource Setting!

Galappaththy CJG, Rathnayake J, Samarasinghe B

Division of Vascular Surgery, Department of Surgery, Faculty of Medicine, University of Peradeniya

Chronic limb threatening ischaemia needs revascularization to avoid immediate major amputation and/or death. Bypass surgery and endovascular revascularization are the known methods of revascularization. Patients with short occluded/ stenosed arterial segments as well as patients who are unfit for surgery(poor cardiac function, absence of a suitable vein etc) are suitable candidates for endovascular revascularization.

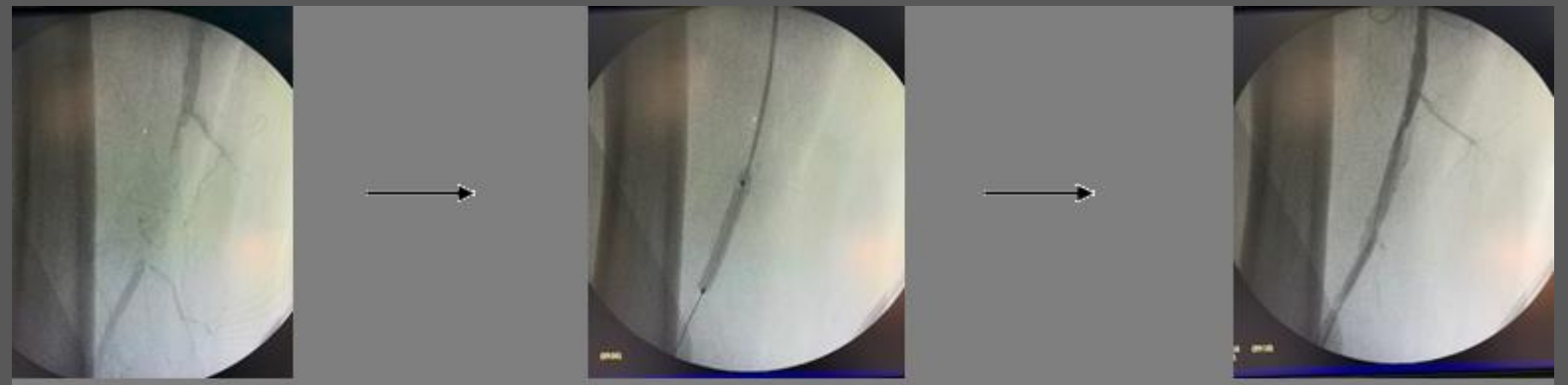
A DSA suite with a full array of endovascular equipment (stents , balloons etc) are essential for endovascular interventions. In a low middle income countries like Sri Lanka this is a major limiting factor.

At Peradeniya, we are trying to overcome those limitations and have already started performing endovascular revascularizations with minimal resources. At present, we are using a C arm fluoroscopy (no DSA), a balloon and a wire.

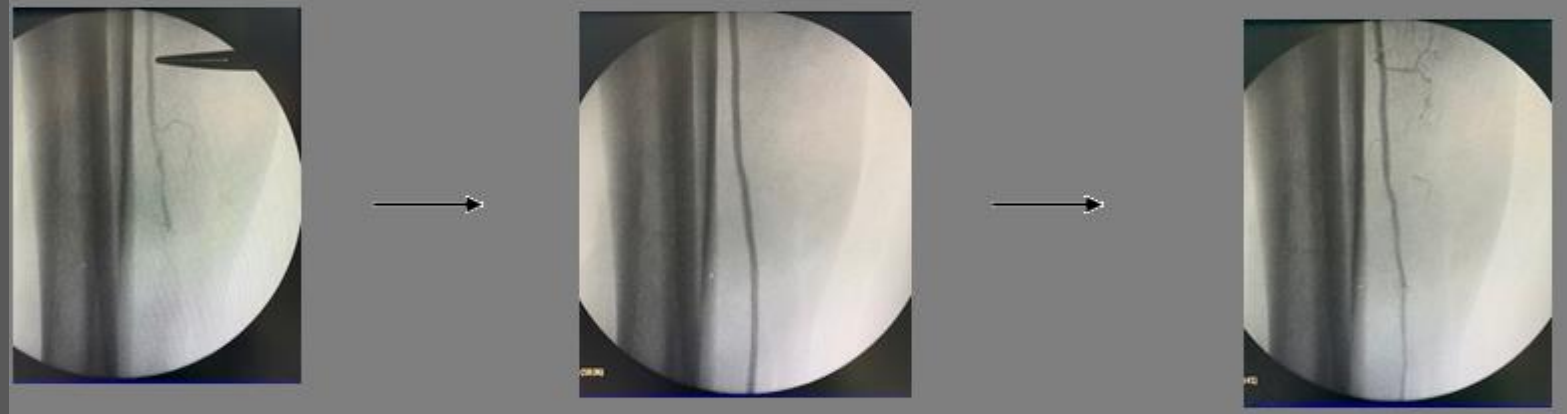
Following are three patients who underwent successful angioplasty using above resources. All lesions were accessed using ultrasound guided arterial puncture and percutaneous sheath insertion.

Pre Angioplasty | Angioplasty | Post angioplasty

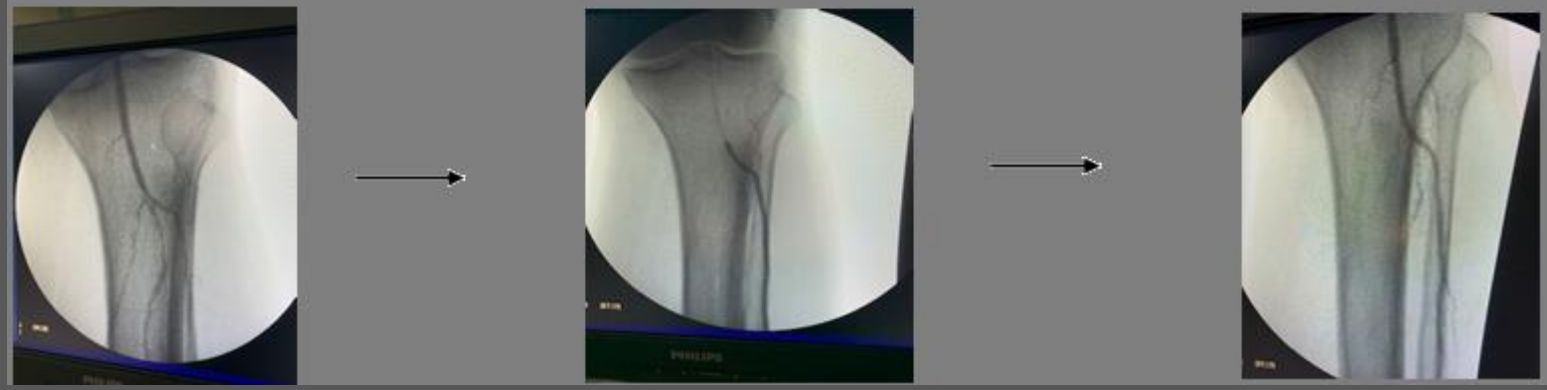
1 64 year old male with right foot ischaemic wound. No suitable veins for Bypass. He had a superficial femoral artery angioplasty. He has a healing wound now.



2 70 year old male with ischemic cellulitis. As a result he developed extensive wounds in the leg (Therefore unable to Explore his tibial vessels for a bypass).He underwent successful Posterior Tibial Angioplasty.



3 65 year old male with left foot ischaemic wound. Highly comorbid with ejection fraction of 20%. Underwent a successful Anterior tibial angioplasty. He is doing well.



Write-In

Endovascular Radiology In a Hepatopancreatobiliary Unit

Udupihille J, Pussepitiya K, Rosairo S, Sithique F, Hevawitharana B Dayarathne KMPL, Hassen F, Kumara RMMSK[1]
Dassanayake BK, Dharmapala AD,Galketiya KB, Galappaththy CJ, Kanchana P, Karunasagara D [2]

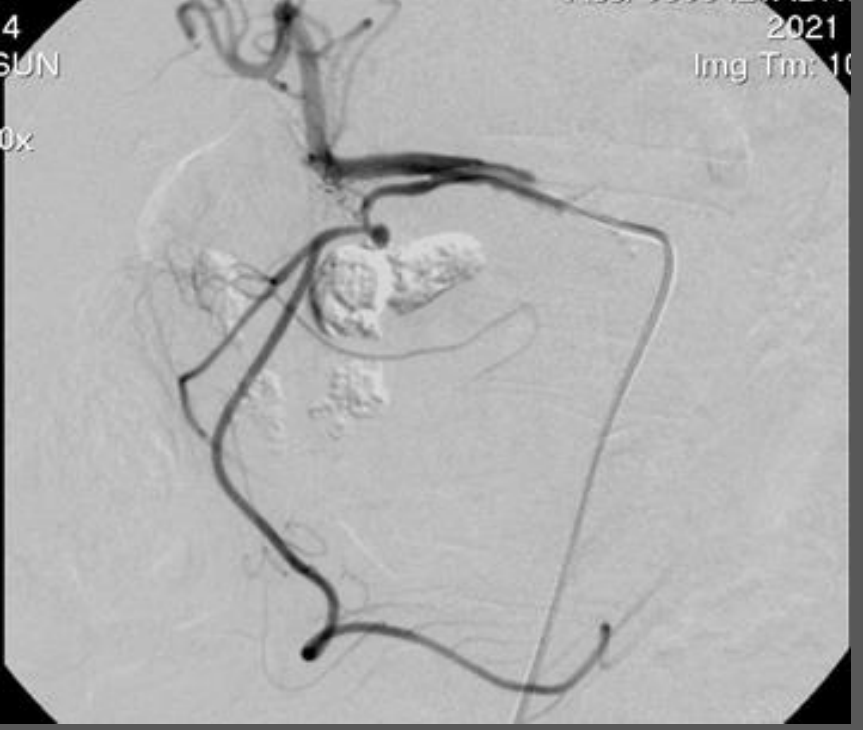
1. Department of Radiology 2. Department of Surgery,
Faculty of Medicine, University of Peradeniya
Teaching Hospital Peradeniya

Interventional Radiology is integral to a modern Hepatopancreatobiliary (HPB) Service. In addition to biliary and pancreatic drainage procedures, both arterial and venous vascular radiological procedures using Digital Substraction Angiography (DSA) are required. These may help avoid surgery in some cases, or deal with surgical complications in others.

Examples of two staple endovascular HPB procedures offered by the Interventional Radiology team at TH Peradeniya are described here: one arterial and one venous *(images attached).*

Case 1: A 56 year old female with Chronic pancreatitis was referred with a bleeding pseudoaneurysm of the gastroduodenal artery (GDA). Although arterial phase CT did not show an active bleeder, rapidly dropping Haemoglobin prompted a DSA, which showed contrast extravasation at the GDA. This was embolised along with the anterior and posterior pancreaticoduodenal arteries, in order to prevent a retrograde bleeder from the superior mesenteric arc. Bleeding settled and the patient is stable at 3 months follow-up.

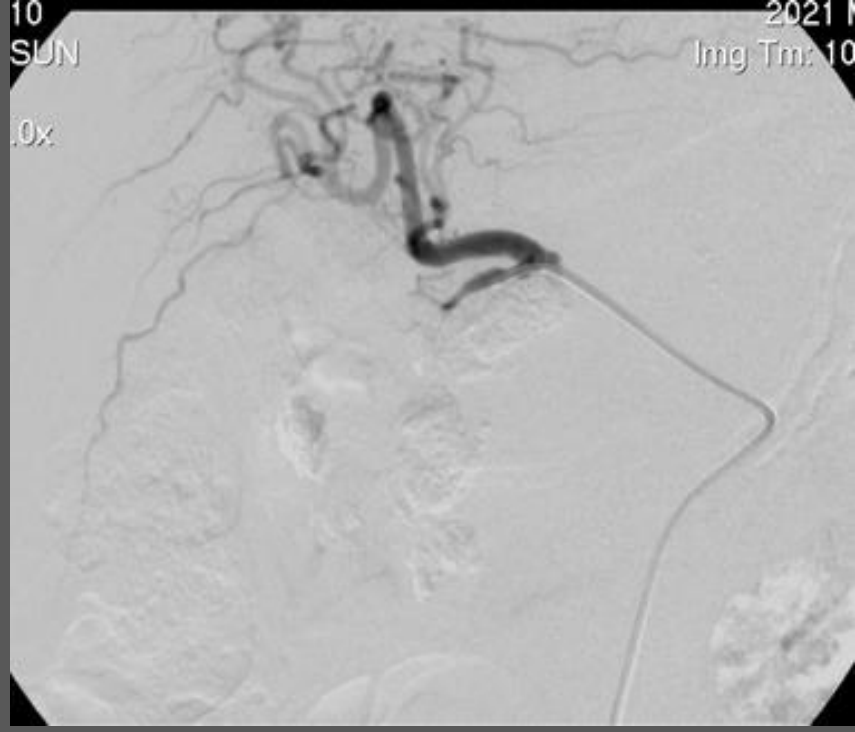
Case 2: A 67 year old male developed hepatic venous outflow obstruction following an Extended Left Hepatectomy for a hilar cholangiocarcinoma. This led to congestion of the intestine. An emergency transjugular hepatic venous stenting was done using DSA, to prevent a potential Budd-Chiari Syndrome from occurring. Gut oedema showed marked reduction within 24 hours.



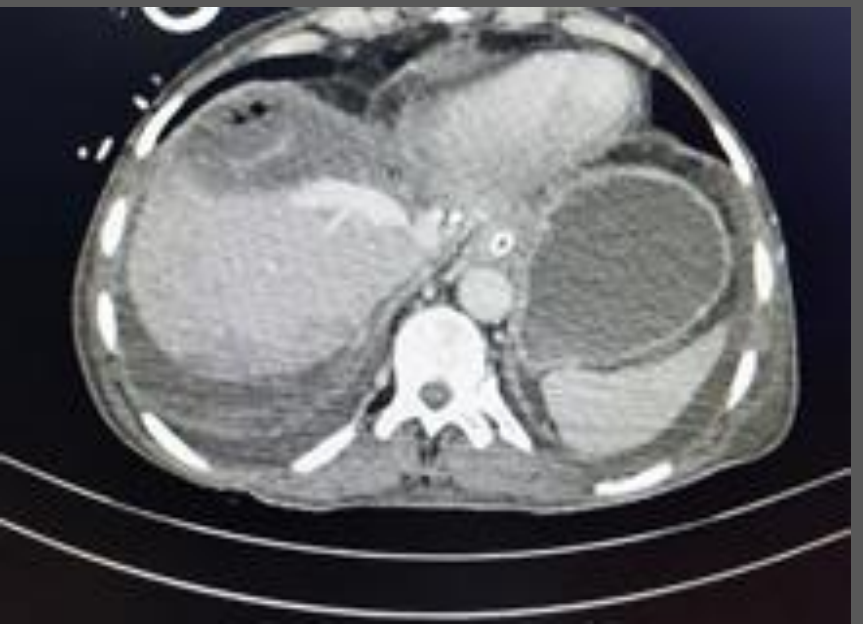
LEFT: GDA aneurysm with a contrast leak and large pancreatoduodenal branches

RIGHT: Post embolization DSA

BELOW:
A: Pre Procedure CT with narrowed single (right) hepatic vein
B: Transjugular access of right hepatic vein
C: CT Post-stent placement



A



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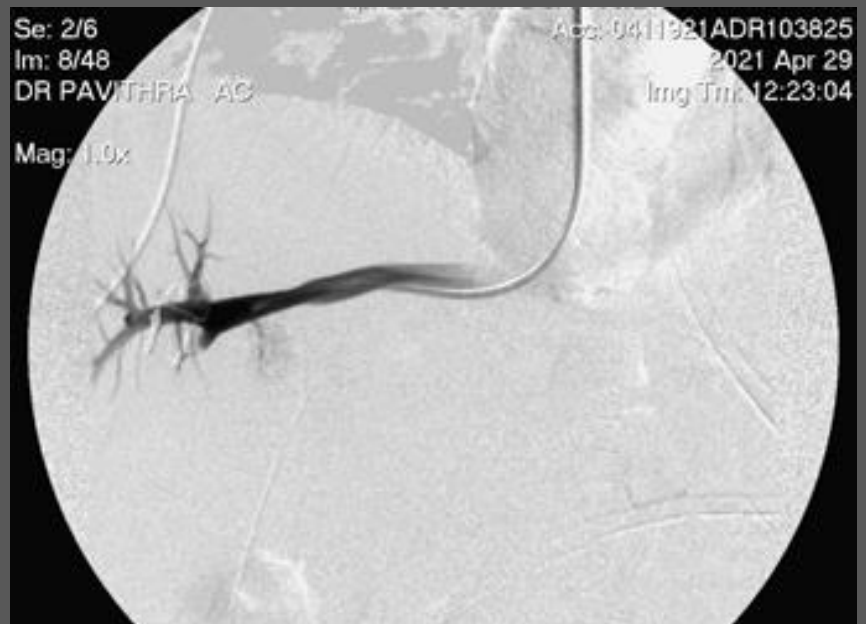

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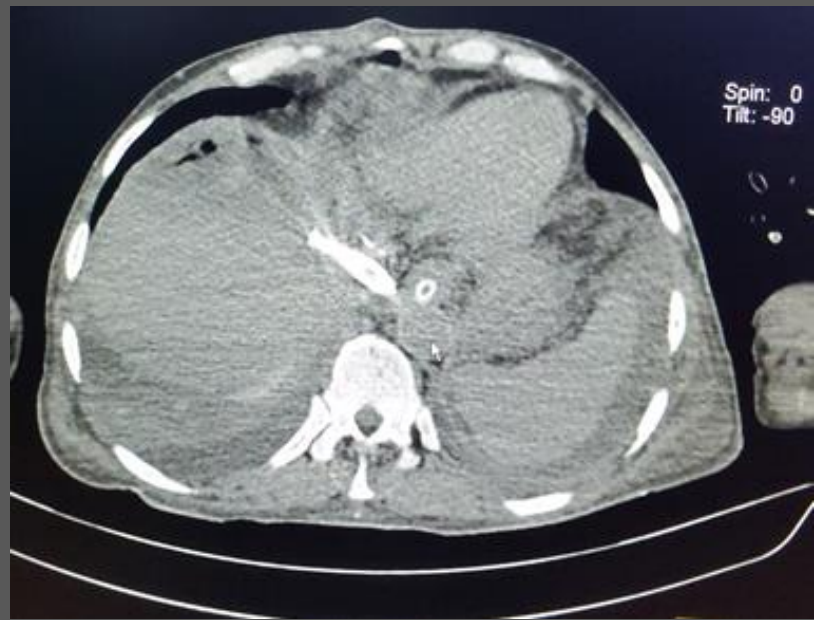

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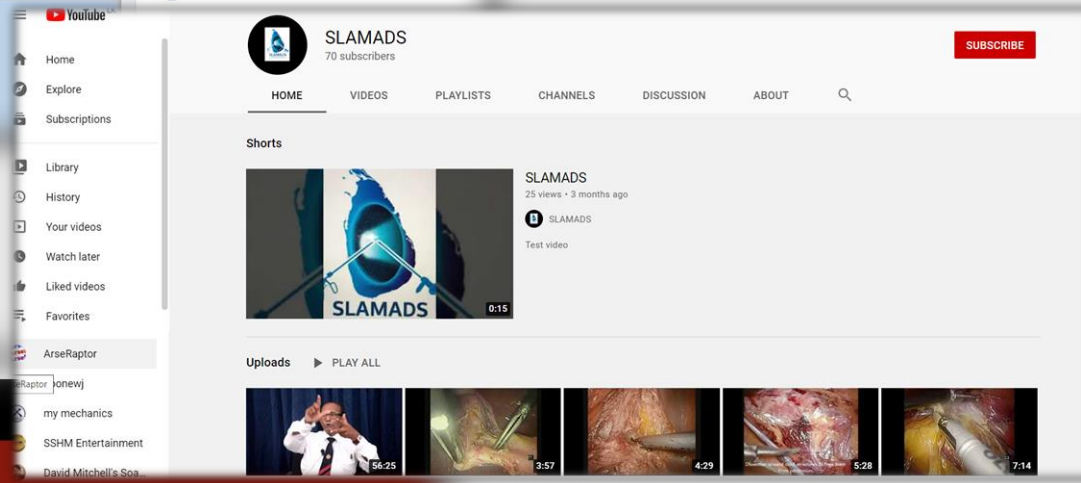
We are online!



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