



# Sri Lanka Association of Minimal Access & Digital Surgeons

e-Newsletter  
Volume 5  
Issue 1  
April 2024



## Editors

Kuda B Galketiya  
Rifat Jamaldeen

# Message from the President - SLAMADS



My dear friends,

SLAMADS stepped in to the year 2024 with two main objectives. First is to empower surgeons who perform minimal access surgeries in Sri Lanka and the second is to develop regional and international collaborations.



Empowering surgeons, I think are in two main domains. First is to support them to develop technical and non-technical skills. Second is to encourage them to do research related to Minimal Access Surgery(MAS) and promote publication and presentation at international forums. I strongly believe we need more attention to the latter because most of us have not sufficiently inculcated the habit of clinical research and publications.

29<sup>th</sup> and 30<sup>th</sup> March 2024 we organized first joint session with AMASI in Sri Lanka. We completely changed the format of the CME from gigantic lectures to panel discussions and Q & A sessions. These were aimed at senior surgical trainees and practicing surgeons. The feedback we got about this modality of conducting sessions was encouraging and appreciated by the delegates.

The last session on digital surgery on 29<sup>th</sup> was to widen the awareness of these new developments and to encourage digital record keeping and maintaining individual data bases. As we know this is the foundation for research and publications.

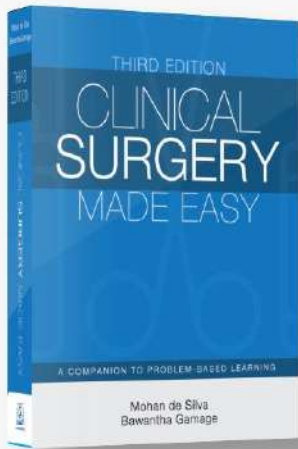
Also, I would like to request all our members to keep video recordings of their surgeries. One can review them regularly and improve quality of surgical techniques and also edit them and submit for presentations and competitions. All these things will improve the visibility of Sri Lankan Surgeons at international forums.

I am happy that our overseas chapters have agreed to get involved more in educational activities this year. I take this opportunity to thank the overseas faculty who conducted SLAMADS webinars in last two months and all the AMASI members including Prof. C.Palanivelu the founder president and Dr.C.J.Varghese the current president of the AMASI for finding time to come to Sri Lanka and participate the two day joint session with us. We conducted these sessions aiming to improve the standard of care given by general surgeons. I hope they got the maximum benefit out of it including the video demonstrations by the master surgeon Prof. Palanivelu.

Thank you

**Prof. Bawantha Gamage**  
**President, SLAMADS**

# Launch of the third edition of **CLINICAL SURGERY MADE EASY-A Companion to Problem Based Learning**



The above book launch took place on the 30<sup>th</sup> of March 2024 at the Auditorium of the College of Surgeons of Sri Lanka

Professor A H Sherifdeen was the chief guest while Professor C Palanivelu and Professor Tan Arulampalam participated as guests of honour.

Professor Mohan de Silva is the editor-in-chief with Professor Bawantha Gamage

joining as co-editor and twenty-four experts contributing to the book, a one stop book with surgical anatomy, patho-physiology, pathogenesis and clinical pathways.

Professor Mohan de Silva is a one of few pioneers who introduced laparoscopy and endotherapy, specially ERCP to Sri Lanka, a first-generation minimal access surgeon who faced the challenge of learning a new technique and train the next generation while learning. He is a patron of Sri Lanka Association of Minimal Access and Digital Surgeons (SLAMADS)

Professor Bawantha Gamage belongs to the second generation of minimal access surgeons of Sri Lanka who was trained locally and in UK and started on a wide range of laparoscopic procedures after board certification. SLAMADS is the brain child of Bawantha and as the founder president has led the association with an active and excellent academic calendar.

**Kuda B Galketiya**

**Editor (SLAMADS Newsletter)**

# Dr KL Fernando I Know



To me KL, as he is affectionally known to many of his close friends, is a unique personality, a rare breed and one of its kind. I have known Dr K L Fernando for well over 40 years from the times when both of us returned home to settle in Sri Lanka



after postgraduate training in the UK in mid 1980 s. K L joined the academic department of North Colombo Medical School and in 1992 he performed the first laparoscopic cholecystectomy in Sri Lanka at Colombo North Teaching hospital. Soon after I joined Colombo South Teaching Hospital; Faculty of Medical Sciences, University of Sri Jayewardenepura.

It was unfortunate that he had to leave Colombo North Medical College when the government took over the Medical School and the turbulence that was created with it. He left to private sector and went on to provide a surgical excellent service to become one of the most sort after surgeons in Sri Lanka. He was well known for his surgical dexterity, taking on complex surgical problems in the private sector which many shunned to handle then, and for his exceptional, patient friendly humanistic approach to the care of his patients.

Together we used to visit frequently to many Indian centers of excellence for minimally access surgery and develop links. These visits and experiences obtained helped to develop personal friendships with Indian experts that helped to establish and advance minimally



access surgery and develop links. These visits and experiences obtained helped to develop personal friendships with Indian experts that helped to establish and advance minimally invasive surgery in Sri Lanka. When I developed Laparoscopic Cholecystectomy services and therapeutic ERCP Services in Colombo South teaching Hospital in Kalubowila, K L was there for me unreservedly.

In my personal opinion, had Dr K I Fernando continued to have a conducive environment at North Colombo Medical Faculty, to contribute with his exceptional surgical talents, the history of Colombo North Medical Faculty would have been very different. Young KL I knew was natural sincere leader who is extremely confident of his ability who would always lead from the front.

I vividly remember trying to develop the first live therapeutic ERCP workshop in Colombo in 2004 where Prof Nagiswar Reddy, Dr Amith Meydeo and Dr T S Chandrasekar, the top Indian experts then was to be present. This was a first of its kind in Sri Lanka. He was keen to transmit this live to the auditorium of Hotel Tran Asia from the Endoscopy unit at Colombo South Teaching hospital through Swarnavahini transmission tower. We did a dry run with K L with his small television set on the roof top of Trans Asia trying to pick my signal, doing an endoscopy at our hospital. Hotel people were totally amused and confused!

Apart from his excellent surgical craftsmanship skills he had a borne talent in masonry and carpentry. At early stages of introduction of therapeutic laparoscopic and endoscopic services in Sri Lanka, K L invented many instruments and systems for surgeons in training and also for his personal use.



Many of us have visited his workshop at home. In this workshop he made 10 endo-trainers entirely designed by him in 2009. These were designed with a movable camera so that camera holder can also be partly trained to hold a zero-degree camera. This facility was not available in most commercially available endo-trainers. All of these were made in such a way that each of them could be packed in a carrier box so they can be transported easily. In 2009 he managed to take all 10 of them and about 40 porcine livers preserved in his own invented freezing system which could keep them in fresh state for 72 hrs., to Hambanthota and Monaragala with practicing laparoscopic surgeons. The team conducted Laparoscopic skills workshop in both places where more than 40 delegates including surgeons in the region attended. This initiated Regional Assisted Mentoring Programme (RAMP) of the CSSL.



Around 2014 or so he started exploring Buddhist philosophy with scholar monks. He went on to study Archeology and obtained a Diploma in Archeology from University of Kelaniya. His latest interest is another unique one; studying Calligraphy to read old brahmin letters in the ancient rock carvings. He has now developed expertise in this field and has commenced research writing. Several of his papers are already accepted internationally.

K L Fernando is a man who is confident of himself. With his humble personality, he is a sincere friend to all who knows him who will extend his hand whenever he is called upon.

That is the KL I know.

**Emeritus Prof. Mohan de Silva**

**University of Sri Jayawardenapura**





From the Editors:

## Bariatric Surgery

On 1 April 2016, the United Nations (UN) General Assembly announced 2016–2025 as the United Nations Decade of Action on Nutrition, to address all forms of malnutrition, undernutrition and obesity. This is led by WHO and the Food and Agriculture Organization of the United Nations (FAO).

However, the target of prevention of undernutrition and obesity is not achieved as at 2024, but still a growing problem.

Obesity has surgical solutions but not undernutrition, except in cases of intestinal failure.

Bariatric surgery is the most effective treatment for obesity. Treating obesity goes beyond cosmesis, in a high percentage of cases achieving remission of comorbidities associated with obesity and reducing mortality. Comorbidities associated with obesity are coronary heart disease, type 2 diabetes, cancers (endometrial, breast, and colon), hypertension, dyslipidaemia, stroke, sleep apnoea, respiratory problems, osteoarthritis, and gynaecological problems [menstrual irregularities and infertility]

Even though obesity has a higher incidence in developed countries, a recent rise is seen in developing countries as well. It is interesting to note that in developed countries bariatric surgery is not funded by public system, except in few selected patients.

Currently, laparoscopy is preferred over open surgery for bariatric surgical procedures. In future will it be more endoscopic?

Point of view

# Bariatric Surgery – Addressing a Heavy Burden



**Janaka Lovell (BMedSci,MD)**

General Surgery Trainee, Alfred Health

**Margaret Dunkley (MMBS, FRACSI)**

General Surgeon/ Australian Metabolic and Obesity Surgery ( AMOS) Clinic

Bariatric Surgeon Mildura Base Hospital

Obesity is a condition whereby there is an ingestion of a surplus calories in excess of the body's physiological energy requirements which is then stored as adipose tissue.

The medical complications and chronic health manifestations of obesity are significant. The consequences of sex hormone imbalance, increase free fatty acids and mechanical stress can lead to significant disability and mortality. Furthermore, it is a major financial burden. In 2014-15 obesity and its complications cost the Australian government \$AUD 8.65 billion (1).

Obesity is a sensitive issue for many and most obese people will have already attempted multiple weight loss interventions.

A straightforward and reproducible method to measure obesity (although imperfect as it does not account for muscle mass) is the body mass index (height in kilograms divided by square of height in meters) (see figure 1).

It is important to note that South Asian, Chinese and Japanese population groups may have excess body fat at lower weights and be at a greater risk of ill health than other ethnic groups, so a lower BMI threshold (23 kg/m<sup>2</sup>) may be considered overweight. Conversely, Pacific islander populations tend to have a higher proportion of lean body mass, so a higher BMI threshold may be considered.

Figure 1: BMI index and weight categories

UnderWeight	< 18.5 kg /m <sup>2</sup>
Ideal	18.5 to 24.9 kg/m <sup>2</sup>
Overweight	25 to 29.9 kg/m <sup>2</sup>
Obese - Class I	30 to 34.9 kg/m <sup>2</sup>
Obese – Class II	35 to 39.9 kg/m <sup>2</sup>
Obese – Class III	40 to 50 kg/m <sup>2</sup>
Super Obese	> 50 kg/m <sup>2</sup>

While the focus of this editorial is on the weight loss surgery, the approach to obesity management is multi-pronged.

The 3 pillars of obesity management consist of lifestyle, pharmacological and surgical interventions.

## 1. Lifestyle management (2)

This is an essential component of all weight loss strategies. This involves the reduction of caloric intake and increase of energy expenditure.

The Australian government recommends 2.5-5 hours of moderate intensity physical activity or 1.25-2.5 hours of vigorous physical activity per week. In addition to this, Australian dietary guidelines have 5 principal points to maintain a healthy weight:

- Be physically active and choose amounts of nutritious food and drinks to meet energy needs
- Enjoy a wide variety of nutritious foods from the five food groups (grain foods, vegetables, fruit, dairy, lean meats/poultry/fish/eggs and legumes).
- Limit intake of foods containing saturated fat, added salt, added sugars and alcohol
- Encourage, support and promote breastfeeding
- Care for your food; prepare and store it safely

There are also dietary plans that are designed to produce energy deficits:

- Reduced energy diet (RED) -> energy deficit of 480-960 kcal/day
- Low energy diet (LED) -> energy intake of 1000-1200 kcal/day
- Very low energy diet (VLED) -> energy intake to 800 kcal/day. VLEDs are low in carbohydrate which induces a mild ketosis to create an anorexic effect after 2-3 days. VLED can be an initial weight loss strategy when supervised lifestyle interventions have been unsuccessful after reducing weight or when rapid weight loss is required (e.g. prior to surgery). This dietary strategy can have adverse effects and is contraindicated in pregnancy/lactation, those who have had a recent cardiac event or stroke, severe psychological condition or age > 65.

## 2. Medical management (3)

There are multiple medications to help facilitate weight loss in conjunction with low calorie targets (figure 2).

Name (Trade Names)	Year Approved	Mechanism of Action / Clinical Effect	Average placebo-subtracted weight loss (%)	Achieved $\geq 5\%$ Weight Loss, Intervention vs. placebo (%)
<i>Approved for short-term use*</i>				
Phentermine (Adipex, Lomaira) (39)	1959	Sympathomimetic / Suppresses appetite	4.4 at 28 wks	49 vs. 16 at 28 wks
Diethylpropion (40)	197 1979	Sympathomimetic / Suppresses appetite	6.6 at 6 months	67.6 vs. 25.0
<i>Approved for long-term use</i>				
Orlistat (Alli, Xenical) (41)	1999	Intestinal lipase inhibitor / Reduces fat absorption by up to 30%	3.8	50.5 vs. 30.7
Phentermine-topiramate (Qsymia) (26)	2012	Combination sympathomimetic and carbonic anhydrase inhibitor / Decreases appetite and binge eating behaviors	8.6	70 vs. 21
Bupropion-naltrexone (Contrave) (42)	2014	Combination of a dopamine and norepinephrine re-uptake inhibitor and mu-opioid receptor antagonist / Decreases appetite and cravings	4.8	48 vs. 16
Liraglutide 3.0mg (Saxenda) (28)	2014	GLP-1 receptor agonist / Decreases appetite, increases fullness, increases satiety	5.4	63.2 vs. 27.1
Gelesis100 (Plenity) (43)	2019	Superabsorbent hydrogel particles of a cellulose-citric acid matrix / Increases fullness. Considered a medical device but functions as a medication.	2.0 at 6 months	58.6 vs. 42.2
Setmelanotide (Imcivree)	2020	Melanocortin-4-receptor agonist / Decreases appetite	Not applicable 12.5-25.6 <sup>†</sup>	Not applicable 64-90 <sup>†</sup>
Semaglutide 2.4 mg (Wegovy)	2021	GLP-1 receptor agonist / Decreases appetite, increases fullness, increases satiety	12.4	86.4 vs. 31.5

Figure 2: TGA approved medications for weight loss, their clinical effect and average weight loss

### 3. Surgical management (2)

Weight loss surgery is effective management strategy to treat obesity and its secondary comorbidities. There is extensive evidence demonstrating the long-term benefits of obesity surgery versus other non-invasive treatments (4).

Indications for weight loss surgery is as follows (5,6):

- BMI greater than or equal to 40 without co-existing medical problems and for whom bariatric surgery does not confer an excessive risk
- BMI 35-39.9 with an obesity related comorbidity (diabetes, hypertension, obstructive sleep apnoea, fatty liver etc.)
- BMI > 30 with poorly controlled diabetes or dysmetabolic syndrome X (hypertension, elevated BSLs, high triglyceride, hypercholesterolaemia, excessive fat deposits on the abdomen, waists and hips)
- In the Asian population, a BMI > 27.5 should be considered for weight loss surgery

There are 3 fundamental mechanisms leading to weight loss after weight loss surgery. Most modern procedures have an element of each (7).

- Restriction: Limits caloric intake by reducing the stomach's reservoir capacity through resection, bypass or creation of a proximal gastric outlet
- Malabsorption: Decreases the effectiveness of nutrient absorption by shortening the absorption length of the functional small intestine by bypass of the small bowel absorptive surface area or diversion of the biliopancreatic secretions that facilitate absorption
- Neurohormonal: Involve complex interactions between the brain and hormone productions in the gastrointestinal tract, pancreas, liver and adipose tissue. For instance, reduced ghrelin, peptide YY, GLP1 and CCK promote an anorectic state.

## Operation Types (8)

The four most frequently conducted weight loss operations are described below. These are routinely performed laparoscopically.

### 1. Laparoscopic Sleeve gastrectomy

This is the commonest weight loss surgery procedure. Most of the greater curvature of the stomach is removed and a tubular pouch is created with laparoscopic linear staplers. The antrum is divided 2-6cm away from the pylorus and a sleeve is created around a 32-40Fr bougie.

The remaining tubular stomach is small in its capacity conferring a restrictive effect and is resistant to stretching due to the absence of the fundus. There is an additional neurohormonal effect of decreased ghrelin levels while GLP1 and PYY levels increase, promoting less hunger. Changes in gastric motility may also occur to reduce emptying and increase satiety.

This procedure is technically easier to perform versus a Roux En Y gastric bypass (RYGB) as it does not require any anastomoses. Another benefit is that it reduces the risk of internal herniation and protein/mineral malabsorption compared to a RYGB. However gastric leaks are more common due to the stomach becoming a high-pressure organ with a sphincter at either end.

The expected weight loss is 60% of excess body weight at 2 years.

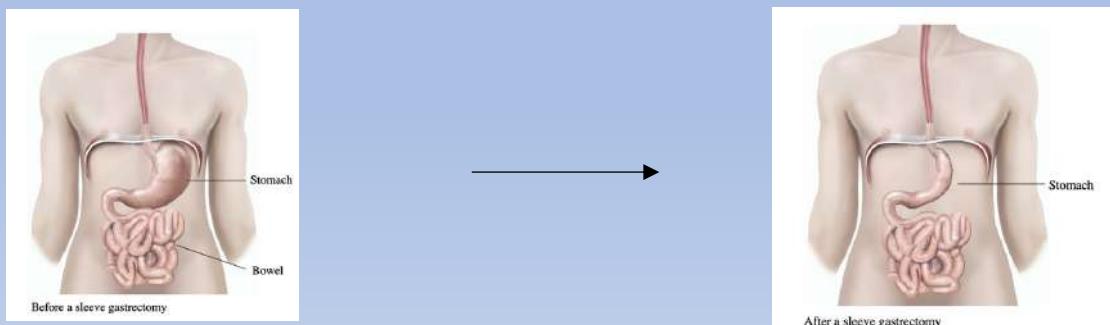


Figure 3: Before and after a sleeve gastrectomy.

Image: <https://amos.clinic/weight-loss-procedures/weight-loss-surgery/sleeve-gastrectomy/>

## 2. Single anastomosis gastric bypass

This procedure is also referred to as the minigastric bypass. It involves the division of the stomach between the antrum and body on the lesser curvature. The stomach is then further divided in the cephalad direction. The resultant gastric pouch is anastomosed to a loop of jejunum as an antecolic and antegastric loop gastrojejunostomy.

There is no consensus on the standard length of the biliopancreatic limb. Most studies have used a 150-200cm biliopancreatic limb distal to the ligament of Treitz for the afferent limb.

Weight loss mechanisms combine a restrictive and malabsorptive properties for weight loss. It is also postulated that insulin sensitivity and hunger is abated secondary to neurohormonal effects.

The expected weight loss is 68-85% of excess weight at 5 year follow up.

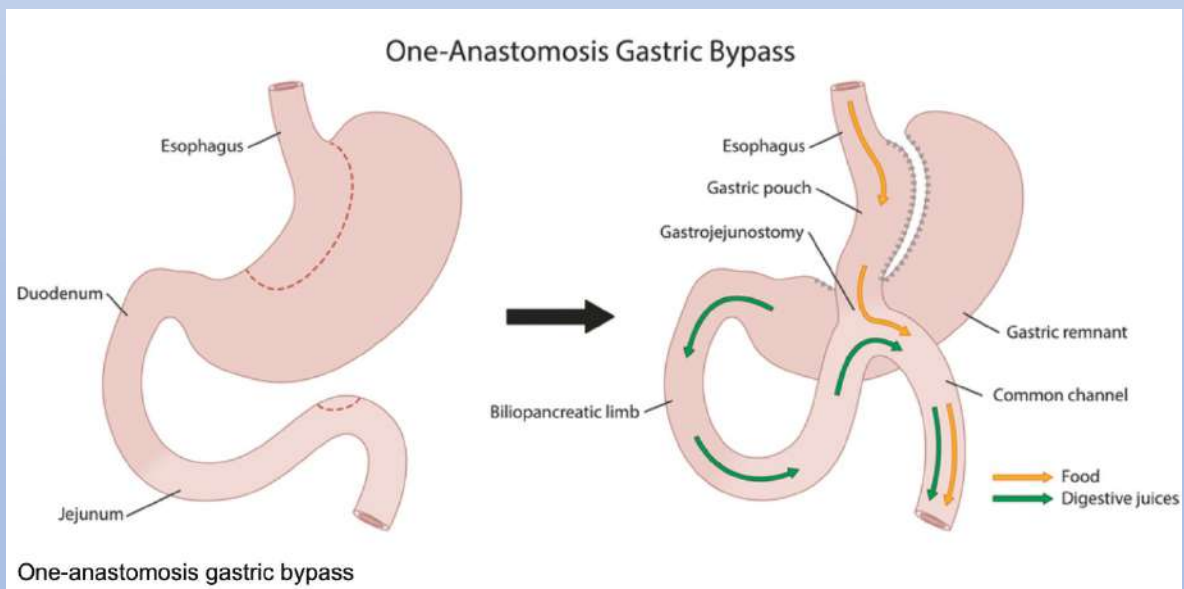


Figure 4: The single anastomosis gastric bypass

Image: [https://www.researchgate.net/figure/One-anastomosis-gastric-bypass\\_fig3\\_364642052](https://www.researchgate.net/figure/One-anastomosis-gastric-bypass_fig3_364642052)



### 3. Roux En Y gastric bypass

The RYGB involves formation of a small proximal gastric pouch of approximately 30mls volume which is divided and separated from distal stomach. This pouch is then anastomosed jejunum (roux/alimentary limb) that is 75-150cm in length. This small gastric pouch and the narrow anastomotic outlet serve to restrict caloric intake.

Small intestine is divided at distance of 50-150cm to ligament of Treitz to create a biliopancreatic limb that transports secretions from the gastric remnant, liver and pancreas.

The biliopancreatic limb and roux limb are then connected 75-150cm distally from the gastrojejunostomy to form a common channel. Major digestion and absorption of nutrients then occurs in this channel, where pancreatic enzymes and bile mix with ingested food.

Notably, the longer the roux limb the, the shorter the common channel and greater the effect of malabsorption. The ideal roux, biliopancreatic limb and common channel length have not been determined.

This operation combines malabsorption, restriction and neurohormonal effects as the mechanism of weight loss. Note that this procedure creates mesenteric defects which can result in internal herniation.

The expected weight loss from a RYGB is approximately 70% of excess weight at 2 year follow up.

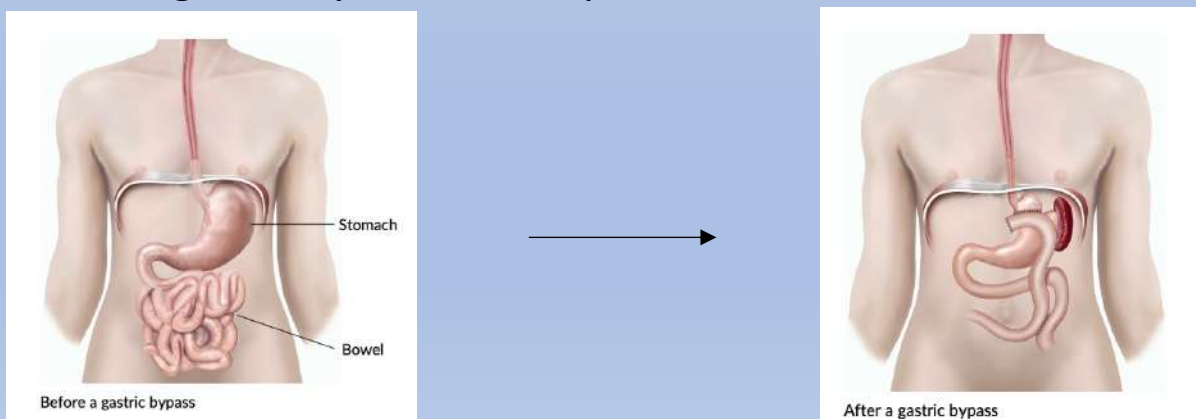


Figure 5: Before and after a Roux En Y gastric bypass

Image: <https://amos.clinic/weight-loss-procedures/weight-loss-surgery/gastric-bypass-roux-en-y/>

## 4. Adjustable gastric banding

Adjustable gastric banding is a purely restrictive procedure compartmentalizing the upper stomach by placing a tight adjustable prosthetic band around the entrance to the stomach.

The band is a soft locking silicone ring connected to an infusion port in the subcutaneous tissue.

The port may be accessed with relative ease by a syringe and needle. Injection into the port leads to a reduction in the band diameter resulting in an increased degree of restriction. The goal of band adjustment is to give the patient a restriction of 1 cup of dried food and satiety for at least 1.5-2 hours post meal.

The expected weight loss from gastric banding is 50-60% of excess weight at 2 years.

Notably, this procedure is performed less often in contemporary bariatric practices, due to its relatively modest amount of expected weight loss, coupled with high rates of revision.

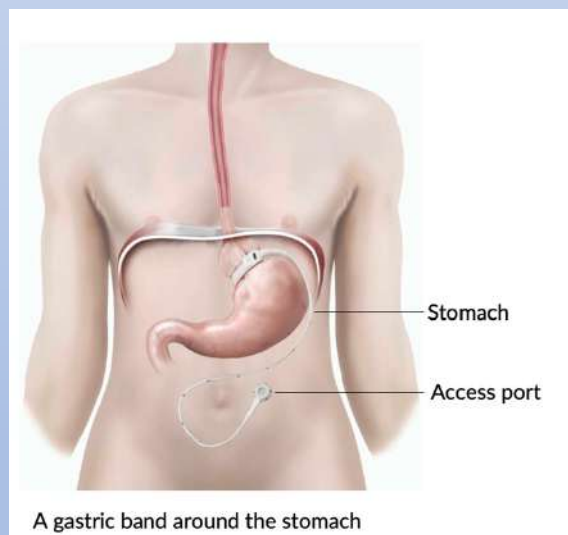


Figure 6: The adjustable gastric band

<https://amos.clinic/weight-loss-procedures/weight-loss-surgery/lapband/>

More information on the holistic approach to weight loss can be found at: <https://amos.clinic>

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# Recently held CME activities

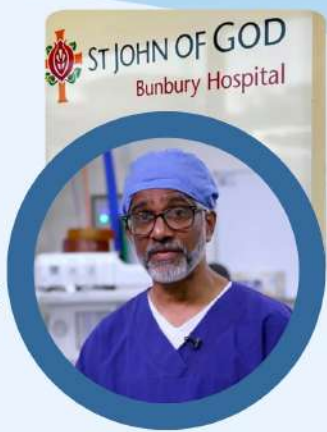


## 1. Webinar – Science and Current practice of Bariatric Surgery



### WEBINAR

Science and current practice of Bariatric Surgery



**Dr. Senarath Werapitiya**  
MBBS MS FRCS  
Consultant General Surgeon  
Specializing in Bariatric Surgery



GUEST SPEAKER



21st Jan, 2024  
7:00 pm (IST)



Keep the Date  
Free!

[slamads.lk](http://slamads.lk)

For Registration & Zoom Link  
[Click Here](#)

The inaugural webinar of 2024 took place on January 21<sup>st</sup> via Zoom platform. Hosted by SLAMADS, the webinar featured Dr Senarath Werapitiya, a distinguished Consultant General Surgeon specializing in Bariatric Surgery at St John of God, Burnbury Hospital, Australia, as the guest speaker. The webinar delved into the topic of “Science and Current Practices in Bariatric Surgery”, during which Dr Werapitiya generously shared insights from his extensive

experience in the field, offering valuable clinical Pearls. Additionally, he expressed his enthusiasm for engaging with our trainees and discussed the possibility of organizing fellowship programs for them in the future. This event has opened up exciting opportunities for our community.

**BARIATRIC SURGERY**  
Science and current practice

- Trends of obesity
- Pathophysiology
- Indications for bariatric surgery
- Development of bariatric surgery
- Current practice**
- Complications
- discussion

# 2. 16<sup>th</sup> Basic Laparoscopic Skills Workshop For Surgical Trainees

**16<sup>th</sup> BASIC LAPAROSCOPIC SKILLS WORKSHOP FOR SURGICAL TRAINEES**

01<sup>st</sup> & 02<sup>nd</sup> February 2024  
at The College of Surgeons of Sri Lanka

Organized by:  
Sri Lanka Association of Minimal Access & Digital Surgeries  
in collaboration with  
The College of Surgeons Sri Lanka

**Who Should Attend?**  
This course is of great benefit for surgical trainees who have attended their surgical training and for advanced surgical trainees who wish to develop or improve in laparoscopic surgical skills.

**Registration**

Name to appear on Certificate of Attendance (Full Name Only)

Designation (Department)

Employed Institution

Address

Province (C/S)

Tel. Fax

Mail

Specialty  Yes  No

**Closing Date for Registration**  
Change date for registration will be on 15<sup>th</sup> Jan 2024. Thereafter, no entry registration will be accepted and registration fees will not be returned.

**Eligibility**  
The Organizing Committee shall be the final authority on the personal details of trainees and will be responsible for providing necessary documents to the participants.

**Faculty**

- Dr. K. L. Fernando, Consultant Surgeon
- Prof. Kemal Demir, Professor in Surgery
- Dr. Maheshwari Gunasekera, Consultant Surgeon
- Dr. Suresh Kumarage, Consultant Surgeon
- Dr. Raveendra Seneviratne, Consultant Surgeon
- Prof. Thajana Wijayaratne, Professor in Surgery
- Dr. Aranjith Peiris, Consultant Surgeon
- Dr. S. R. S. Seneviratne, Consultant Surgeon
- Dr. Sandeep Seneviratne, Consultant Surgeon
- Dr. S. R. S. Seneviratne, Consultant Surgeon
- Dr. Wasantha Wijayaratne, Consultant Surgeon
- Dr. Pramod Chandrasekera, Consultant Surgeon
- Dr. Kesava Katsalunga, Consultant Surgeon
- Dr. Aravinda Udayaratne, Consultant Surgeon
- Dr. Chatteranga Rajapattirana, Consultant Surgeon
- Dr. Ranjith Manthiriga, Consultant Surgeon

**Agenda**

**Day 1**

**BASIC PRINCIPLES IN LAPAROSCOPIC SURGERY**

How to become a safe Laparoscopic Surgeon

Laparoscopy: safe entry and creation of camera holding

Technique of safe entry and creation of camera holding

Advantages and problems of peritoneoscopy

Practical Session 1

Practical Session 2 (Laparoscopic) Exercise skills

Safe Dissection of The Cecal Torus

Tricus approximation techniques in laparoscopic hernia

Practical Session 3 (Laparoscopic) Inguinal and Hernia

**Day 2**

Energy devices in Laparoscopic Surgery: Basics

Alapar: Video Series - Laparoscopic approach to Cholecystectomy

Practical Session 4 - Lap Cholecystectomy on peritoneoscopy

Practical Session 5 - Lap Cholecystectomy on peritoneoscopy

Practical Session 6 - Lap Cholecystectomy on peritoneoscopy

Practical Session 7 - Lap Cholecystectomy on peritoneoscopy

Practical Session 8 - Lap Cholecystectomy on peritoneoscopy

Practical Session 9 - Lap Cholecystectomy on peritoneoscopy

Practical Session 10 - Lap Cholecystectomy on peritoneoscopy

Practical Session 11 - Lap Cholecystectomy on peritoneoscopy

Practical Session 12 - Lap Cholecystectomy on peritoneoscopy

Practical Session 13 - Lap Cholecystectomy on peritoneoscopy

Practical Session 14 - Lap Cholecystectomy on peritoneoscopy

Practical Session 15 - Lap Cholecystectomy on peritoneoscopy

Practical Session 16 - Lap Cholecystectomy on peritoneoscopy

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Practical Session 44 - Lap Cholecystectomy on peritoneoscopy

Practical Session 45 - Lap Cholecystectomy on peritoneoscopy

Practical Session 46 - Lap Cholecystectomy on peritoneoscopy

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Practical Session 97 - Lap Cholecystectomy on peritoneoscopy

Practical Session 98 - Lap Cholecystectomy on peritoneoscopy

Practical Session 99 - Lap Cholecystectomy on peritoneoscopy

Practical Session 100 - Lap Cholecystectomy on peritoneoscopy

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 (1st and 2nd February 2024).

21 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.

I would like to specifically thank Dr. K. L. Fernando for the time and effort he took to refurbish the lap trainers before the workshop.

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



# Recently held CME activities



## 3. Webinar – Developments in Colorectal Surgery



### WEBINAR

#### Developments in Colorectal Surgery



#### Prof. Shakil Ahmed

MBBS LMSSA(Lon), LRCS(Eng), LRCP(Lon),  
MRCS(Ed), MRCS (Glas), FRCS, PhD  
Consultant Colorectal Surgeon



11th Feb, 2024  
7:00 pm (IST)



Keep the Date  
Free!

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The second webinar arranged by SLAMADS in the year took place on February 11<sup>th</sup>, 2024. Professor Shakil Ahmed, a distinguished Consultant Colorectal Surgeon and Honorary Clinical Professor at the University of Liverpool, England, served as the guest speaker. Additionally, he holds the position of Robotic and Minimally Invasive Surgery (MIS) Lead for ALSGBI. The webinar focussed on advancements in Colorectal Surgery. Prof. Ahmed eloquently traced the evolution of colorectal

surgery, emphasizing significant milestones and discussing current evidence-based practices, particularly in immunotherapy for colorectal cancer. Furthermore, he briefly touched upon the prospects of Digital Surgery, providing insights into the future direction of the field.

Webinar February 2024

### Development in Colorectal Surgery

**Professor Shakil Ahmed**  
Consultant Colorectal Surgeon and Honorary Clinical Professor  
Clinical Director LUHFT Colorectal Surgery  
CGG Colorectal Chair, Merseyside and Cheshire Cancer Alliance  
Robotic and MIS Lead - ASGBI  
Liverpool University Hospital NHS Foundation Trust, University of Liverpool.

UNIVERSITY OF LIVERPOOL

Liverpool University Hospitals  
NHS Foundation Trust

# Recently held CME activities



## 3. SLAMADS-AMASI JOINT CME SESSION

Once again, another successful SLAMADS-AMASI Joint CME session took place, surpassing the excellence of last year's event. The theme "Empowering Frontiers in Laparoscopic Surgery" guided the two-day program held on March 29th. The day featured four sessions dedicated to significant areas: HPB, Lower GI, Upper GI, and Digital Surgery.

8:00 am - 8:30 am	Registration
8:30 am - 10:30 am	Laparoscopic Cholecystectomy - Management of Complications Moderator: Dr. Rasika Bulathsinhala Panelists: Dr. Tamonas Chaudhuri, Dr. Biswarup Bose, Prof. Mohan De Silva, Dr. Vijaya Sanarajewe, Dr. V. Sutharshan
10:30 am - 12:30 pm	Optimizing outcomes of Laparoscopic Colorectal Surgery AR/APR & R/ Hemicolectomy Moderator: Prof. Pramod Chandrasinghe, Dr. Rasika Ganesekere Panelists: Dr. Dr. Sultana, Dr. Prakash Kurumbos, Prof. Biswarup Bose, Dr. Rajitha Manatunga, Dr. Kesara Rathnayaka, Dr. Eranga Ganesekere
12:30 pm - 1:30 pm	LUNCH
1:30 pm - 3:30 pm	Fundoplication & Cardiomyotomy: Tips & Tricks - Video Based Q&A Session Moderator: Dr. Chathuranga Kapteyigama, Dr. Ramesha Seneviratne Panelists: Dr. CJ Wijesena, Dr. RV Patankar, Dr. R Parthasarathi, Dr. Kulenka Kodasinghe, Dr. Manjula Pathirana
3:30 pm - 4:45 pm	Digital Surgery: AI & Digital Technology to Optimize Current Practice in Surgery Moderator: Dr. Dinesh Therothila, Dr. Vinodan Attalagama Panelists: Prof. Chrys Hennessy, Dr. R Parthasarathi, Prof. Biswarup Bose, Dr. Rajman Sorjewa, Dr. Charnika Ranayake

Auditorium, CSSL  
WWW.SLAMADS.LK  
Dr Rifat Jamaldeen +94776420566

Registration Fee  
Consultant (Non-Member) Rs 5000  
Consultant (SLAMADS Member) Rs 4000  
Trainees (Non-Member) Rs 2000  
Trainees (SLAMADS Member) Rs 1500

Departing from traditional lectures, the sessions adopted a format of video-based discussions followed by interactive Q&A segments.

Under the moderation of Dr. Rasika Bulathsinhala, the HPB session assembled an expert panel including Professor Mohan de Silva, Dr. V. Sutharshan, Dr. Tamonas Chaudhuri, and Dr. Biswarup Bose from AMASI. Topics ranged from indications and



access to challenging gall bladder cases and associated complications, touching upon bile duct injuries.

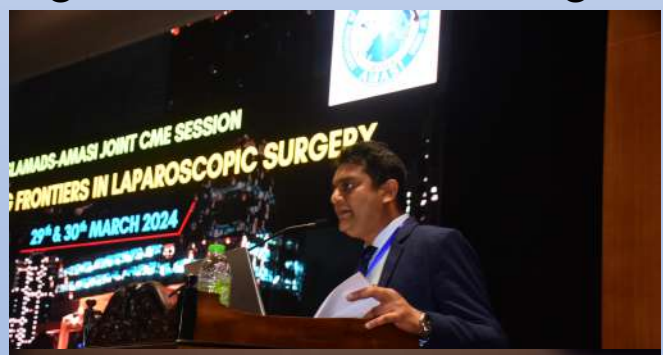


Prof. Pramod Chandrasinghe presented a case of rectal cancer, delving into pre-operative MRI for local staging with consultant radiologist Dr. Eranga Ganewaththa. The discussion extended to the meticulous steps of laparoscopic Anterior resection, consulting panelists from Prof Bawantha Gamage, Dr Rukman Sanjeewa & Dr OV Sudheer.



Dr. Kaushika Gunasekera led the second part with a case of caecal malignant growth, focusing on laparoscopic Right Hemicolectomy with input from Dr Rasitha Manathunga, Dr Kesara Rathnathunga & Dr Prakash Kurumboor.

The Upper GI session, moderated by Dr. Chaturanga Keppetiyagama, explored the management of gastro-oesophageal reflux disease, particularly laparoscopic fundoplication, featuring a panel including medical gastroenterologist Dr. Kuleesha Kodisinghe and surgical experts, Dr Manjula Pathirana, Dr Rasika Bulathsinhala and Dr CJ Varghese, Dr R Parthasarathi & Dr Roy Patankar.





Dr Rameendra Senaratne navigated through the various aspects of Achalasia cardia management. The panel shared there experiences on Minimally Invasive Heller's Cardiomyotomy.



The final session, "AI & Digital Technology to Optimize Current Practice in Surgery," moderated by Dr. Gayan Ekanayake and Dr. Niroshan Atulugama. The panelists consisted of Prof Chrys Hensman from Australia, Dr Rukman Sanjeewa, Dr Dhammika Rasnayake, Dr R Parthasarathi, captivated participants with discussions on e-Logbook systems, digital transformation in surgical practices, and future technological advances in surgery.





# A day with the MASTER

- Why I chose Laparoscopy?
- Making of the Master
- Innovations and Improvisations
- Minimally Invasive Cancer Surgeries
- History Made- First time in the world surgeries
- Future of Surgery and career guidance

A day long Video Based Lectures by world renowned

**Prof. C Palanivelu**

8:30 AM - 2:00 PM

30TH MARCH 2024

Auditorium, CSSL

The second day featured a series of video-based lectures by Prof. C Palanivelu, aimed at inspiring the Sri Lankan Surgical community, particularly the younger generation, to embrace Minimal Access Surgery. Prof. Palanivelu shared insights from his career journey, covering topics like the choice of laparoscopy, innovations, historical surgical milestones, and the future of surgery.



Feedback from the Sri Lankan surgical fraternity and trainees was overwhelmingly positive, expressing fulfillment and encouragement to incorporate Minimal Access Surgery into their practices. SLAMADS eagerly anticipates organizing similar enriching events in the future.





Tied Together



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chance to elevate your  
wardrobe for just Rs 3000 !!

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Available at CSSL



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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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[yourrifle6@gmail.com](mailto:yourrifle6@gmail.com)