President's Introduction

It is now almost six months since the Annual ASGBI International Surgical Congress in Bournemouth at which the ASGBI played such a large part on the Thursday. Sessions on NOTES, video presentations, the David Dunn medal and a superb British Journal of Surgery Lecture on the history of laparoscopic surgery given by Professor David Rosin, now Professor of Surgery in Barbados, made it a truly memorable meeting. The David Dunn medal was won by Ms Michelle Slater for her excellent presentation entitled ‘Laparoscopic stapled cardioplasty – a new procedure for repeated failed treatment of achalasia’. Let us hope that next year’s meeting in Glasgow will be just as enjoyable.

Our Annual Scientific Meeting for 2008 is in the final stages of development and Professor Roger Motson and his highly efficient team in Colchester have put together a wonderful programme entitled ‘Back to the Future’. It is six years since we last visited Colchester for our Annual Scientific Meeting and a lot of water has flowed under the bridge since then especially in laparoscopic surgery. The meeting which will be held at the Five Lakes Hotel near Maldon will include live operating from Chicago, Edinburgh and Colchester as well as keynote lectures given by international guest lecturers, Professor J LeRoy from the European Institute of Telesurgery, France and Dr S A Giday MD from Baltimore, Maryland, USA. We shall also be honoured by a visit from Professor The Lord Darzi of Denham who will address the conference on the Thursday afternoon prior to the Annual Conference Dinner. The ALTS are holding a full programme on the Thursday which all those attending will find most interesting and entertaining.

Next year’s meeting will be entitled ‘One Step Beyond’ and will be held in the prestigious River Centre in Tonbridge, Kent. The theme of the meeting will be the prevention and treatment of complications in laparoscopic surgery which all of us should find helpful and instructive. Amongst the various national and international invitees we have confirmation that Heine van der Walt, one of the most accomplished laparoscopic surgeons in the world, will be coming over from South Africa to display his operative skills in the live operating sessions as well as offering us the benefit of his vast experience in the main meeting. The live operating will be coming from hospitals in Kent as well as a link to Michael Li’s unit in Hong Kong and should provide us with a fascinating day of education.

For the moment, however, our attention should be directed towards Colchester and I do hope that we shall be seeing as many of you as can attend our forthcoming meeting in November. I would urge you to book early to make the most of the opportunities and to encourage your juniors to come along at least for part of the meeting but preferably for the entire event.

Finally I should like to take the opportunity to thank Covidien for sponsoring the production of this Newsletter – we are all indebted.

Mr Mike Parker, President ASGBI

16th International Congress of the EAES, Stockholm 11–14 June 2008

The 16th International Congress of EAES was held in Stockholm 11th to 14th June with the theme of ‘Endoscopic Surgery – from an enigma to established clinical practice’. Stockholm has a strong laparoscopic profile and indeed was the city where the first laparoscopic procedure was performed by Dr H C Jacobeus at the Royal Seraphim Hospital in 1910. The city is also famed for the site of the annual Nobel Prize Ceremony and the City Hall where this takes place was the venue for the EAES reception.

The programme was varied but well have come away less sceptical than when they arrived. The first UK hands-on course was held very shortly afterwards in the MATIU in Guildford and the building enthusiasm and interest was very evident there also.

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The programme was varied but with an inevitable increase in the attention given to Natural Orifice Surgery (NOTES). Sceptics abound and probably still outnumber enthusiasts but members attending the sessions could not help but be amazed at the rapidity with which technological innovation is advancing in this area and may continue to focus on innovative areas of surgery.

The next International Congress of EAES will be held in Prague on 17–20 June 2009 with the theme of ‘New advances and oncological results in Minimal Access Surgery’. I encourage all of you to attend if you can.

Professor Tim Rockall, South Thames Representative on ALS Council
Minimally Invasive Gastro-Oesophageal Cancer Surgery (MIGOCS) Registry

The MIGOCS registry received a great boost recently when the Royal Devon and Exeter team of Mr Richard Berrisford and Mr Saj Wajeed agreed to release their data. Richard and Saj recently published the largest UK series of minimally invasive oesophagectomies, and the addition of their experience to the registry has considerably boosted the value of our data for analysing contemporary practice. Another major step forward was the agreement reached with the Association of Laparoscopic Surgeons, who have agreed to sponsor the registry as part of a suite of prospective databases for minimally invasive surgical procedures. This exciting project has been developed by the ALS President, Mr Mike Parker, and an agreement in principle has been reached with Covidien to fund a Registry Office. Mr Peter McCulloch, Director of the MIGOCS project, has agreed to manage the data suite for ALS, whilst Dendrite Clinical Systems Ltd will provide technical support.

Once the office is established, MIGOCS will officially change its name to the ALS Minimally Invasive Upper GI Cancer Registry, although the acronym will be retained for a transitional period.

Mr McCulloch and Ms Liz Gemmil were invited to the AUGIS consensus meeting on minimally invasive cancer resection in Basingstoke earlier this year, where the proposition that registry entry should be routine for all cases was accepted. Peter McCulloch found it harder going to persuade the delegates that registry entry should lead to consensus development of a randomised trial against open surgery, with few delegates convinced a trial would be possible.

At the EUNE International Meeting in Rome in April, and at EAES in Stockholm a month later, the MIGOCS registry was offered to EU surgeons performing minimally invasive resections. Because verification will be more difficult across Europe, and because European surgeons will not normally be ALS members, this data will be held separately, but joint analysis will be possible. The NICE Interventional Procedures Committee have endorsed MIGOCS as the repository for data for surgeons performing minimally invasive gastrectomy and oesophagectomy in the UK, and we hope that all this will lead to increased numbers of cases being logged in the coming years.

Mr Peter McCulloch, Director of the MIGOCS project
The day in the Tregonwell Hall was well attended and a testament to the quality of the day's programme.
The day began with our President, Mike Parker, introducing a session devoted to presentations and discussion about the reasoning behind and the development of the laparoscopic colorectal training programme. The session confirmed the ever increasing importance of the place of laparoscopic surgery in improving the practice of colorectal surgery. It was particularly pleasing to hear the support from the Department of Health and The Royal College of Surgeons of England.

The Laparoscopic Session –
ASGBI 2008 International Surgical Congress,
Bournemouth Thursday 15th May 2008

The opening session was followed by a memorable British Journal of Surgery Lecture delivered by Professor David Rosin. The breadth of the presentation was impressive including the speaker’s own personal role and experience.

The late morning session picked up where the BJS Lecture left off. The session illustrated the emerging modality of NOTES. The opening speaker, Professor Paul Swain, swept through the technology and current state of this novel surgery. The thrill of the presentation reminded many of the audience of the same emotion felt in the early 90s when listening to talks about minimal access surgery. Professor Mike Bailey revealed what is currently being explored in Europe and in particular his own unit in Guildford. The session closed with the double act of Ralph Austin and Tan Arulampalam from Colchester proposing where NOTES may now evolve to and calling for a consensus statement hopefully to be published at the ALS Annual Scientific Meeting in Colchester.

The afternoon was devoted to two scientific sessions, one DVD presentation and the other oral presentations. The DVD session was rich with unusual cases and elegant demonstrations of surgical technique. The two sessions were divided by a presentation from the Travelling Fellow – Oliver Jones of his visit to The Royal Brisbane Hospital. The paper presentations housed the David Dunn Medal Competition. The quality of the presentations was outstanding. The final winner of the David Dunn Medal was Michelle Slater from Reading who described a new technique of Laparoscopic Stapled Gastroplasty devised by Tom Dehn for dealing with repeated failed treatment for achalasia.

Mr Don Menzies,
Honorary Treasurer
Bariatric Surgery – A beginner's guide

Weight loss surgery has been slow to catch on in the UK, but in the last 2 or 3 years the number of cases performed in the UK has increased dramatically. In the 1980s and 90s, there were fewer than 300 weight loss operations per year in the UK. Surgery was performed via the open route and consisted mainly of Vertical Banded Gastroplasty or Roux-Y-gastric bypass. A few teaching hospitals offered the surgery to a very select number of patients. With the introduction of laparoscopic gastric banding into the UK in 1997 and subsequent introduction of laparoscopic gastric bypass, numbers of cases increased. It was not however, until NICE approved weight loss surgery in October 2002 that the number of procedures performed on the NHS began to increase significantly. It was also at this time that several private providers moved into the market offering affordable weight loss surgery to self pay patients.

It is estimated that there will be over 8000 procedures performed in 2008 and it is likely this figure will continue to increase. The United Kingdom is one of the most obese nations on the planet and obesity rates are rising rapidly. In 2006, weight loss surgery overtook cholecystectomy as the commonest major general surgical procedure in the USA. There are approximately 50,000 cholecystectomies in the UK each year, so it is clear that the rate of weight loss surgery is likely to rise in the UK. Like any range of surgical procedures, complications arise and are often admitted to the nearest NHS hospital as emergencies. Because much of the surgery for weight loss is undertaken in the private sector by a small range of surgeons, many general surgeons are unfamiliar with this type of surgery. The newspapers have been littered with stories of tragedies after weight loss surgery, some of which might have been avoided had surgeons admitting emergencies been more familiar with weight loss operations and their potential complications. With this in mind, the following is a brief guide to the most commonly performed procedures and management of the commonest complications.

Laparoscopic adjustable gastric banding
This is the most frequently performed operation in the UK. Complications include infection, band slippage, over tightening of the band and band erosion.

Infection
There is a 2% risk of infection at the adjustment port. This portacath is usually located on the upper abdomen and secured to the abdominal wall muscles. Minor wound infections will often settle with antibiotics as they do not take hold deep in the wound and thereby infect the portacath. There is often the temptation to open up superficial wound infections to pack the wound over the adjustment port. This almost always guarantees that superficial sepsis is spread to the portacath which will then need removing. If faced with a superficial wound infection do give antibiotics after taking a swab, but do not widely open the wound. Rather contact the surgeon who placed the band in order that they might see the patient urgently to manage the infection. Do not (as one well meaning casualty officer did) grab the tubing to the port and say ‘they’ve left something in here’ and proceed to pull with all your might to remove the foreign body! Should the portacath be clearly infected then it needs removal. This should however be done by the surgeon who placed the band because it is possible to avoid removal of the band itself in about 50% of port site infections. The portacath is removed under GA and the tubing attaching it to the band is cleaned and returned to the peritoneal cavity – after 6 weeks’ antibiotic treatment, it may be possible to reattach a new adjustment port elsewhere in the abdomen by laparoscoping the patient and retrieving the tubing one placed in the abdomen weeks earlier.

Acute Band slippage and Band over tightening
Both these complications present with acute dysphagia and require urgent action. Any band patient who presents with acute dysphagia should have all the fluid removed from their band immediately they arrive in hospital. Band slippage often occurs after vomiting or retching and is much more common if the gastric band has not been secured with gastro-gastric sutures. The history of patients who have been over tightened is usually that they attended for a band adjustment, often without radiology, and experience acute dysphagia within 48 hours of this adjustment. If normal swallowing is restored after removing all the fluid from the band then it is safe to let the patient go home on a liquid diet and contact the surgeon who placed their band. If however the patient continues to have dysphagia or has any signs of sepsis then an urgent gastrograffin swallow is needed. If there is still hold up of contrast at the band after all the fluid has been removed or evidence of a slippage of the stomach proximally through the band, then urgent laparoscopy is indicated. The safest and simplest thing to do at laparoscopy is to remove the band which is achieved by grasping the tubing leading to the band and working along it until the buckle of the band becomes visible. This is then divided with scissors or harmonic scalpel and the band pulled gently off the stomach.

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Gastrointestinal haemorrhage
Haemorrhage may occur at either the gastrojejunostomy or the jejunojejunostomy. This usually occurs within 4 or 5 days of surgery, but with the tendency to discharge patients within 48 hours of laparoscopic bypass surgery, this problem may present to any general surgeon admitting emergencies. Haemorrhage from the gastrojejunostomy can usually be stopped endoscopically, whilst more distal haemorrhage can be difficult to diagnose endoscopically. Any acute GI haemorrhage within a week of bypass should be assumed to come from one of the two GI anastomoses until proven otherwise. Decision making should be the same as for any patient who presents with a GI bleed and surgery should not be unduly delayed simply because the patient has had morbid obesity surgery.

Roux-Y-gastric bypass
This is the second most prevalent operation in the UK and favoured by many of the NHS providers. Like after any major intestinal surgery there are risks of adhesions and internal hernias. In addition there are specific risks with hernias through Petersens space and around the long Roux limb. There are also specific risks related to haemorrhage or stenosis at the gastrojejunostomy.

Band erosion
This occurs in 2% of patients and may present with epigastric pain, failure of restriction or heartburn. At upper GI endoscopy the band is clearly visible in the stomach upon retroflexion and looks black in colour. It is rare to need an emergency procedure to remove the band and it may be best to contact the surgeon who placed the band and discuss urgent treatment. If over 50% of the band circumference is visible in the gastric lumen there is equipment to remove bands endoscopically. A second alternative is laparoscopic removal with repair of the gastric defect. Because of intense inflammation and scarring at the site of erosion, immediate reconstruction with Roux-Y-bypass or Sleeve gastrectomy is not advised although Biliopancreatic diversion, where the stomach is divided more distally is an option.
Endoscopists will be able to identify the stenosed gastrojejunostomy. This may need balloon dilatation which can be done either at the admitting hospital, or by referral back to the surgeon who performed the bypass.

**Intestinal obstruction**

Small bowel obstruction related to adhesions is one of the commonest causes for admission on the general surgical emergency intake. The management of patients who have had bypass of any sort is no different than for other post-surgical patients in that any signs of tenderness, tachycardia or pyrexia mandate surgical intervention. Indeed given the propensity to develop internal hernias, especially if potential hernial defects are not closed at the time of the bypass, delay in surgery can lead to extensive loss of small bowel. Laparoscopy or laparotomy and reduction of the hernias and repair of the defects is the treatment in any patient whose obstruction does not settle within 24 hours and immediately in any patient with signs of intestinal strangulation.

**Biliopancreatic diversion (BPD)**

There are at least two centres in the UK performing this type of surgery. Many of the same considerations that apply to Roux-Y-gastric bypass also apply to BPD. One significant late complication from this malabsorptive procedure is protein losing enteropathy and subsequent liver failure. This may occur in up to 10% of patients in the longer term. Patients who have BPD must eat a high protein diet and if for any reason this does not take place then malnutrition and subsequent serious sequelae may occur. If a patient who has had a BPD is admitted with oedema, low albumin and signs of liver failure, then this is a full scale medical emergency. Urgent surgery to reverse the bypass is often needed. This is best done at the centre where the bypass was performed and is attended with significant mortality.

**Sleeve gastrectomy, Vertical banded gastroplasty (VBG)**

Sleeve gastrectomy where 80% of the stomach is resected and a gastric tube created over a 32F bougie is being introduced. Apart from obvious possible B12 and iron deficiencies which are easily managed with replacement therapy, this procedure has few specific complications and is likely to grow in popularity. Vertical banded gastroplasty (VBG) was the most common weight loss operation of the 1970s and 1980s. Most have now been revised or removed. It is possible to get erosion of the Dacron band on the stomach but this usually happens in the first few years after surgery. As very few VBGs have been performed in the UK this century, it is rare to see complications from this now obsolete procedure.

**Summary**

Complications of weight loss surgery will be a common general surgical problem. Immediate action by the emergency admitting team can make a big difference to both band and bypass patients. Immediate emptying of the gastric band followed by an urgent gastrograffin swallow if indicated will sort out most gastric band patients with dysphagia. Awareness of potential internal hernias and prompt intervention for small bowel obstruction is crucial in bypass patients.
Travelling Scholarships 2009

Ethicon Endo-Surgery has generously funded a scholarship in memory of David Dunn. This scholarship is to the value of £4,000 and it is anticipated that this would enable a surgeon at the end of his/her training, or a consultant within 5 years of appointment, to make a substantial visit to a unit abroad to learn new skills in laparoscopic surgery, with a view to introducing them to the UK. The application should include a CV, full details of the unit and the reasons for the proposed visit, together with a detailed budget of expenditure. The successful applicant will be expected to give a report on the visit at the Spring Meeting of the ALS.

The ALS is also awarding two B. Braun Aesculap Travelling Scholarships of £2,000 each. The purpose of these scholarships is to enable surgeons in training, or young consultants within 5 years of appointment, to extend their experience in minimal access surgery by short visits to one or more centres. The application should include a CV, details of the planned visit or visits, together with an estimate of the costs. The successful applicants will be expected to produce a brief report of their visit at the Spring Meeting.

The Aesculap Academy has been offering a broad range of surgical endoscopy courses since 1985. All of our courses are directed by a renowned international faculty. Quality is the key, and all courses are all accredited.

Our state of the art training facilities in Tuttlingen and Berlin offer 6-10 workstations for a maximum of 12-20 participants. Different training modules have been developed for dry and on lab laparoscopy training workshops, across a wide range of surgical procedures, in upper GI surgery, colorectal surgery and laparoscopic urology.

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We have confirmed dates for our English speaking course detailed below, for 2009, with additional courses still in the planning, and dates to be confirmed.

**Aesculap Endoscopy, B Braun Medical**
Contact: Allan Barr, Senior Product Marketing Manager, Aesculap Endoscopy, B Braun Medical
Direct Line: 0114 225 9174 | Mobile: 07772 115856 | Email: allan.barr@bbraun.com
W: www.aesculap-academy.com
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Olympus KeyMed
W: www.keymed.co.uk
T: 01702 616333 (Course Co-Ordination Department)
E: keymed@keymed.co.uk

Date Courses
7 Nov 2008 Hysterectomy - A Day Case Procedure
10–12 Decr 2008 Frontiers in Intestinal & Colorectal Disease
23–24 April 2009 The 2nd Training day for Year 5 & 6 Urology SpR’s

W. L. Gore
W: www.goremedical.com
T: 07717 894303 (Jane Dodson)
E: jdodson@wlgore.com

Date Course Venue
Jan, May & Oct 2009 Laparoscopic Ventral Hernia Repair Workshops TBC

13 Nov 2008 Laparoscopic Incisional Hernia Course
Freeman Hospital

20–21 Nov 2008 Key Skills in Laparoscopic Surgery
Ninewells Surgical Skills Unit, Dundee

24–25 Nov 2008 Laparoscopic Colorectal Surgery Course
St Bartholome’s Hospital, London

24–26 Nov 2008 RCS Core Skills in Laparoscopic Surgery Course
ICENI, Advanced Laparoscopic Surgery Training Centre, Colchester General Hospital

26 Nov 2008 Laparoscopic Upper Gastrointestinal Surgery Course
Ninewells Surgical Skills Unit, Dundee

26–27 Nov 2008 Basic Surgical Skills Course
Newcastle Surgical Training Centre, Freeman Hospital

1–2 Dec 2008 Laparoscopic Stapling/ Suturing Techniques Course
MATUL, Post Graduate Medical School, Guildford

8–10 Dec 2008 Laparoscopic Deoxyphago-Bastric Cancer Symposium
MATUL, Post Graduate Medical School, Guildford

8–10 Dec 2008 RCS Core Skills in Laparoscopic Surgery Course
Darent Valley Hospital, Dartford

15–17 Dec 2008 RCS Core Skills in Laparoscopic Surgery Course
King’s College Hospital, London

1–2 Dec 2008 Laparoscopic Colorectal Surgery Course

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