



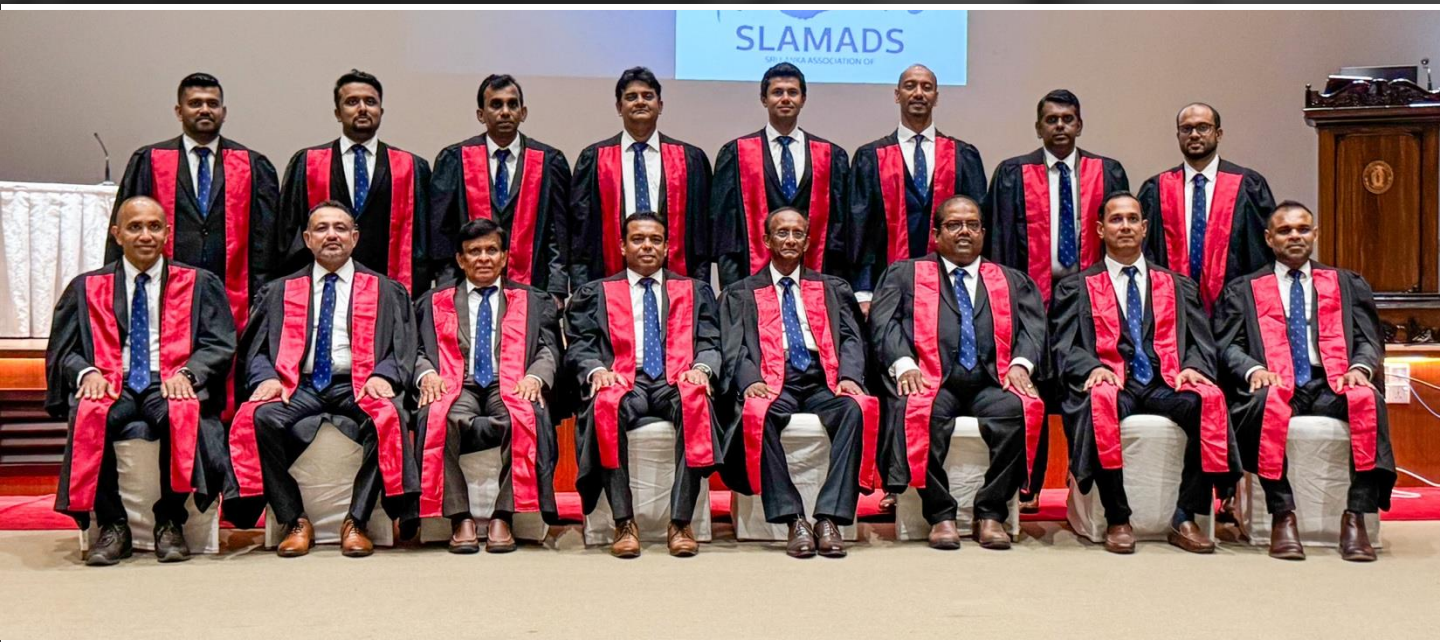
Sri Lanka Association of Minimal Access & Digital Surgeons

E-NEWSLETTER

Volume 06

Issue 01

April 2025



Editors

Kuda B Galketiya

Raayiz Razick

Rifat Jamaldeen

Message from the President SLAMADS



Dear friends,

Greetings from SLAMADS,

I am excited to write to you all as the president of SLAMADS. I express my heartfelt gratitude for the trust you have placed in me to lead this esteemed organization. I take this opportunity to thank immensely the team led by Prof. Bawantha Gamage for leading SLAMADS and bringing it to new heights.



As you all know, SLAMADS has passed five years since its inception. It has played a pivotal role in unifying like-minded individuals who showed some genuine interest in developing minimal access and digital surgery around this island nation and beyond. It has reasonably filled the vacuum and become a platform for the surgeons and trainees to put their trust in and work towards the common goal of taking the practice of minimal access surgery to the next level.

We are committed to taking the available expertise to all parts of the country and staying focused towards staying current with the new developments and standards in our field.

Message from the President SLAMADS



We have been successful in forging long-term relationships with the Association of Laparoscopic Surgeons of Great Britain and Ireland, and the Association of Minimal Access Surgeons of India.

Our membership is growing, and we have a wealth of knowledgeable and skillful surgeons around the country. I invite all of you to join hands and actively take part in SLAMADS activities.

Thank you,

Dr. V. Sutharshan
President
SLAMADS

CONGRATULATIONS



Dr Rohan Jeyarajah

Dr Rohan Jeyarajah has been elected as President of the American Hepato-Pancreato Biliary Association, for the 2025-2026 term.

Dr Jeyarajah, a Sri Lankan, had his undergraduate and postgraduate training in the USA. He is currently serving as Director, Gastrointestinal Services, Director, HPB/AGI Fellowship, and Associate Program Director-General Surgery Residency Program at Methodist Richardson Medical Centre. He is a leading HPB surgeon in the USA, performing complex HPB procedures open as well as minimally access.

He has contributed to CME activities of the College of Surgeons of Sri Lanka as well as the Association of Minimal Access and Digital Surgeons of Sri Lanka and will continue to do so.

Let us congratulate and wish all the best.

ROBOTICS IN SURGERY

Introduction of laparoscopy made a significant change in surgical care providing treatment with reduced morbidity and early discharge from hospital as well as better cosmetic outcome. Initially, surgeons trained in open surgery faced a challenging new learning curve. As technique got established, the next generation of surgical trainees experienced a more supported learning. Very soon minimal access became gold standard for many procedures like cholecystectomy, appendicectomy and fundoplication. For more advanced procedures including cancer surgery, there was an initial uncertainty and controversy. However, when advantage of greater visibility allowing precise dissection was understood, in many centres, laparoscopy has replaced open surgery for complex procedures. The support from technology such as energy devices and staplers has made complex laparoscopic procedures easier to perform. With complex procedures like pancreatico-duodenectomy, radical prostatectomy more precision was considered important. Surgeon fatigue was another factor of concern in long procedures. Technology introduced a slave robot, taking minimal access surgery into a new dimension. The advantages of robotics include 3D image, better ergonomics through additional dexterity by endowristed instruments, elimination of tremor and fatigue of surgeon.

However, this has added another learning curve as well as increased cost to healthcare care delivery. At present benefits to patient care by robot in minimal access surgery is unanswered. Perhaps it is important to identify procedures in which clear patient benefit exists, where higher initial costs and long operating time of robotic surgery can be accepted.

Looking back at laparoscopy similar uncertainty existed which is now ruled out and time will answer questions regarding robotics.

Point of view in this issue is by an expert in HPB who started complex HPB procedures as open, shifting to laparoscopy and now with robotic assist.

The progression of technology cannot be stopped and with increased use of artificial intelligence will the slave robot become a master?

Editors

ROBOTIC HPB SURGERY



Dr. Mehan Siriwardane

MBBS, BMedSc, FRACS, FCSSL(Hon)

ANZHBPA Fellow

HPB Surgeon

We are living in an exciting era for surgery. The pace at which technology is advancing is so rapid that it is often difficult to keep up. This swift progress is shaping how we live, enhancing comfort and convenience, also raises the question of whether these changes will lead us to a better world or take us down paths that might harm humanity. In this context, I believe it is an opportune moment to reflect on one of the significant shifts in surgery: robotic-assisted surgery. Specifically, I will focus on its role in hepatobiliary surgery and explore how surgeons in Sri Lanka might approach this emerging technology.

The Origins of Robotic Surgery:

Robotic surgery began to gain serious momentum in the early 2000s with the introduction of the Da Vinci robotic system. Initially, it found its niche in urology, particularly in prostatectomy, where the ergonomic advantages and enhanced range of motion offered by robotic technology proved to be highly beneficial. This early success is particularly relevant for hepatobiliary surgery, as it transformed a procedure once considered too complex for most urologists, particularly laparoscopic procedures, into a safe and reproducible minimally invasive surgery.

I recall as a non-accredited surgical trainee by 2007, robotic-assisted prostatectomy was already becoming mainstream among urologists in the region. Today, most prostatectomies in Australia are performed robotically, and exposure to robotic-assisted surgery is now a required component of urology training. However, this has not been the case for hepatobiliary surgery. As many of you are aware, hepatobiliary procedures have traditionally been associated with large incisions, high morbidity, and significant risks, often in the context of poor-prognosis malignancies. One might wonder, “Why would anyone venture into this already complex field, particularly with the added challenge of minimally invasive techniques?”

This is a valid concern, and I, too, find myself asking this question on occasion. However, there are valid arguments for incorporating robotic assistance into such procedures. The crucial question is whether the robotic platform is appropriate for this type of surgery and whether its learning curve is safe and feasible.

I do not claim to have all the answers, and any insights I offer are heavily influenced by my personal experience and the various circumstances that have shaped my perspective. That said, I firmly believe that it is the responsibility of surgeons to continually improve their craft for the benefit of both their patients and future colleagues. In hepatobiliary surgery, robotic-assisted surgery represents one of the few attempts to advance in this direction.

The Growing Role of Robotic-Assisted HPB Surgery:

Regardless of one’s stance on robotic-assisted hepatobiliary surgery, it is undeniable that it has become a major component of the surgical approach to hepatobiliary disease in many parts of the world. Training programs in Europe and the United States are now specifically designed to teach surgeons how to perform highly complex procedures, such as the Whipple procedure and major hepatectomies, using robotic assistance.

Point of View



In my own practice, I now perform pancreaticoduodenectomies and major hepatectomies primarily with robotic assistance. The primary contraindications are large tumor size (which is not amenable to minimally invasive surgery) and vascular involvement (which I still feel safer to address through an open approach, although there are surgeons around the world who perform this robotically). There are times when the benefits of better vision, motion scaling (where large movements are translated into fine, precise actions), improved ergonomics, and reduced trauma are truly groundbreaking. However, there are also times when limitations in the robotic tools (particularly for liver transection and fine vessel sealing), distance from the patient, longer surgical times, and space constraints within the robotic platform have led me to convert to open surgery or wish that I had done so. Additionally, the current cost of robotic technology remains prohibitive for many parts of the world.

The Debate and the Future in Sri Lanka:

In Sri Lanka, the discussion around robotic surgery in hepatobiliary procedures is a matter for the future. As the cost of robotic-assisted surgery becomes more manageable this technology will likely become more relevant. Reflecting on the introduction of laparoscopy offers some perspective. What was once considered expensive and out of reach is now being adopted across the country by both experienced surgeons and trainees. The benefits of laparoscopy, which were once unclear, are now evident.

There is a risk that the adoption of robotic surgery could be driven more by industry interests than by actual benefits to patients or the medical community. This situation could represent the necessary growing pains of integrating a new technology into medical practice.

However, through professional communities such as the Minimally Invasive Society of Surgeons, there is an opportunity to guide this process in a thoughtful and structured manner. In our environment which is of similar volume to that of Sri Lanka, we have found that sharing the learning curve, taking a stepwise approach to increasing complexity, and maintaining a strong laparoscopic culture have been helpful in overcoming initial challenges. Robotic-assisted surgery, in many ways, could be viewed as the latest development in laparoscopic surgery, rather than an entirely new form of surgery.

Point of View



What's Next

Ultimately, the jury is still out. Many of the ideas I have presented may never come to fruition, and robotic surgery could be phased out as more data emerges about its efficacy and if the costs remain unsustainable. Currently, however, the landscape does not seem to support such a view, and there are significant industry stakeholders with vested interests in the continued development of this technology. Our role as hepatobiliary and minimally invasive surgeons will be to guide the integration of this technology in ways that benefit our patients. But then again, this has always been our responsibility.

In conclusion, while the future of robotic surgery in hepatobiliary procedures is still uncertain, the potential benefits it offers cannot be ignored. It is an exciting time, and the journey ahead will undoubtedly present both challenges and opportunities for surgeons worldwide.

YOU ARE MY EYE!

What makes a good laparoscopy camera assistant?

Raayiz Razick



A laparoscopy camera assistant plays a crucial role during laparoscopic surgeries. The assistant is responsible for handling the camera that provides the surgeon with a view of the operative field. This involves maintaining a steady and clear view, anticipating the surgeon's needs and responding to subtle cues during the surgery. Mastery in this role requires understanding the anatomy, surgical procedures, and the nuances of camera operation.

One of my trainers frequently emphasized the significance of the camera assistant during laparoscopic procedures by saying, “**You are my eye.**” As most surgical trainees begin as a camera assistant on their path to becoming a minimal access surgeon, it's worth revisiting the skills that are required to become a good camera assistant. The following list is not intended to downplay the significance of the assistant's comprehension of anatomy and the surgical procedure, but to emphasize the skills a camera assistant should master.

Skills to master as a camera assistant

- 1. Spatial Awareness:** Understanding of spatial relationships within the body is essential. In a restricted environment with two-dimensional imagery, spatial awareness is crucial in navigating the camera.
- 2. Anticipation:** Anticipating the operating surgeon's next move is crucial in open as well as laparoscopic surgeries. Giving the optimal view while anticipating the next move makes the operating surgeon's life easy.
- 3. Panning:** Panning the laparoscopy camera is the ability to move the camera's view horizontally or vertically within the surgical field, allowing surgeons to see different areas of the abdomen.

4. **Zooming:** Zooming in and out during laparoscopy is crucial for surgical precision and safety. Zooming in enhances visualization of fine anatomical structures, aiding in accurate dissection and suturing. Conversely, zooming out provides a wider view, ensuring awareness of surrounding organs and preventing inadvertent injury. This dynamic movement of camera assistance greatly improves surgeon's comfort.
5. **Angled views:** Better views can be shown using 30-degree telescopes by rotating the light cable. Camera angles provide surgeons with enhanced visualization of the surgical field. This gives better depth perception in a challenging space as the imagery is two-dimensional. Also, this provides better illumination as optimal angle shines light on the intended tissues. Extreme angles, such as turning the light cable 180-degrees, are necessary to give optimum viewing angles during deep pelvic dissection during ultra low anterior resection.
6. **Horizon View:** This involves providing a non-rotated view to the operating surgeon. Structures on the 'floor' should always be at the bottom of the screen, while the point of action should remain in the middle of the screen. This reduces eye strain for the team.
7. **Communication:** Camera assistant should communicate with the operating surgeon especially when notable camera adjustments are made such as rotating the light cable or when the telescope needs a 'cleaning job' to remove blind spots or debris.
8. **'Multi-tasking':** During laparoscopy, the surgeon and the camera assistant typically have the most favorable views. So, the camera assistant can utilize his/her free hand to provide surgical assistance in addition to their active role as the cameraman. It is imperative that they develop the skill to rotate the light cable with the index finger of the hand holding the camera while simultaneously using the other hand to handle an additional instrument.

Is it 'essential' to be a good camera assistant to become a laparoscopic surgeon?

The term "essential" may be debated. While not strictly mandatory, the experience as a camera assistant provides invaluable insights and skills that can significantly ease the transition to performing surgeries. The direct observation and involvement in surgeries contribute to a surgeon's learning curve, making it a highly recommended step. However, some surgeons may bypass this role and still achieve competence through other forms of training and experience.

While being a good camera assistant is instrumental in understanding the laparoscopic environment, it is one of many steps in becoming a competent surgeon. It serves as a foundation but must be supplemented with formal education and training. Prospective surgeons must undergo extensive training. Clinical rotations and training workshops further cement these skills, providing comprehensive minimal access exposure to trainees.

The medical field offers diverse pathways, and while one surgeon may benefit greatly from the foundational skills acquired as a camera assistant, another might find equivalent experience through alternative routes such as simulation training or mentorship under seasoned surgeons. While a range of pathways exist in surgical training, serving as a camera assistant remains a highly recommended and beneficial step for aspiring laparoscopic surgeons.



Laparoscopic Whipple's procedure in a resource poor setting

Senal C. Medagedara
Upul de Silva



Pancreaticoduodenectomy (PD), commonly known as the Whipple procedure, is a complex surgical operation involving the removal of the pancreatic head, duodenum, gallbladder, and bile duct that is often performed to treat malignant tumors of the pancreatic head, distal common bile duct and second part of the duodenum. The procedure also necessitates the reconstruction of the gastrointestinal tract and the bilio-pancreatic pathway to restore continuity. PD is recognized as challenging for surgeons due to the complex intra-abdominal dissection and reconstruction of the alimentary tract. PD also carries significant perioperative morbidity and mortality. Proximity of the pancreatic head to the portal vein (PV), Superior mesenteric artery (SMA) and Inferior vena cava (IVC) makes PD a challenging surgical procedure. Successful outcomes depend on meticulous surgical technique, careful patient selection, and comprehensive postoperative care.

In 1935, Whipple was the first to finish the pancreaticoduodenectomy for the patient with carcinoma of the ampulla of Vater, which has since been widely used with certain modifications. In 1994, Gagner and Pomp published the first article introducing the laparoscopic PD. Although laparoscopic PD requires complex techniques and a long learning curve, it probably brought less trauma for patients compared with open PD. Nearly 10 years later, Giulianotti performed the first PD in a robotic manner in 2003.

Minimally invasive pancreaticoduodenectomy (MIPD), including robotic (RPD) and laparoscopy (LPD), is becoming more frequently employed, though most operations are still performed via open approach (OPD).

Preoperative radiographic criteria divide lesions into resectable, borderline resectable and unresectable disease.

- **Resectable Disease**

- No distant metastasis
- No radiographic evidence of PV or SMV distortion
- Clear dissection planes around the celiac trunk, hepatic artery, and SMA

- **Borderline Resectable Disease**

- SMV/PV involvement with distortion, narrowing, or occlusion, but the presence of suitable proximal and distal vessels for reconstruction
- Gastroduodenal artery encasement up to the hepatic artery with short segment encasement or abutment of the hepatic artery without extending to the celiac trunk
- Tumor abutment of the SMA less than 180° of the vessel wall circumference

- **Unresectable Disease**

- Distant metastases
- Tumor encasement of SMA more than 180°
- Celiac trunk abutment
- IVC involvement
- Aortic involvement
- Irreparable SMV or PV occlusion

However, despite the radiological assessment, a diagnostic/staging laparoscopy is performed to detect occult peritoneal disease prior to embarking on PD. In the absence of the peritoneal disease PD is attempted. Both OPD or MIPD starts with a 'Trial dissection' to ensure the resectability before proceeding to irreversible steps such as division of the pancreas and gastric division. This includes creating the retro pancreatic portal tunnel and dissection of the SMV from the uncinate process.

Here we discuss a case of a laparoscopic trial dissection in a resource poor setting. Base Hospital, Mahiyanganaya is in Badulla district in Uva province, which is a A-grade base hospital with two general surgeons. It has a laparoscope, but lacks a vessel sealing device, endo GI staplers and large haemostatic clips to perform major laparoscopic procedures. However, we hired a vessel sealing device (Ligasure) on a temporary basis for the operation.

Case Details

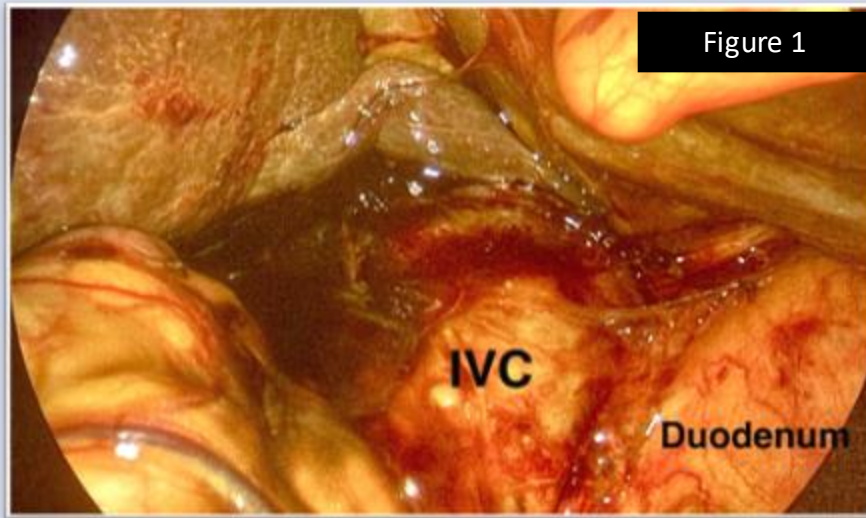
70-year-old previously unevaluated patient who came with loss of appetite, yellowish discoloration of eyes and passing tea colored urine. Her symptoms appeared 4 weeks before seeking medical attention. On examination she was icteric and had a palpable gall bladder. CECT showed a growth at the distal most end of the common bile duct.

Positioning and port positioning

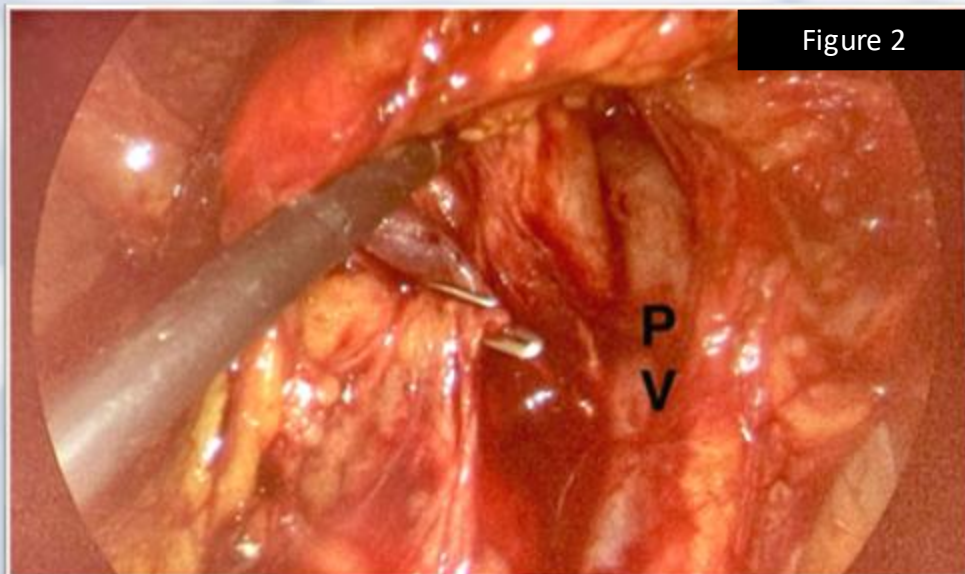
Patient was positioned in French position, legs abducted in a straight fashion and head end elevated. Infraumbilical 10mm port was inserted with open Hassan technique and 12mm pneumoperitoneum was achieved. Another 10 mm working port at the level of umbilicus at left midclavicular line. Two 5 mm ports for retraction were inserted at right midclavicular line at the level of umbilicus and at the anterior axillary line just below the subcostal margin respectively.

Surgical procedure

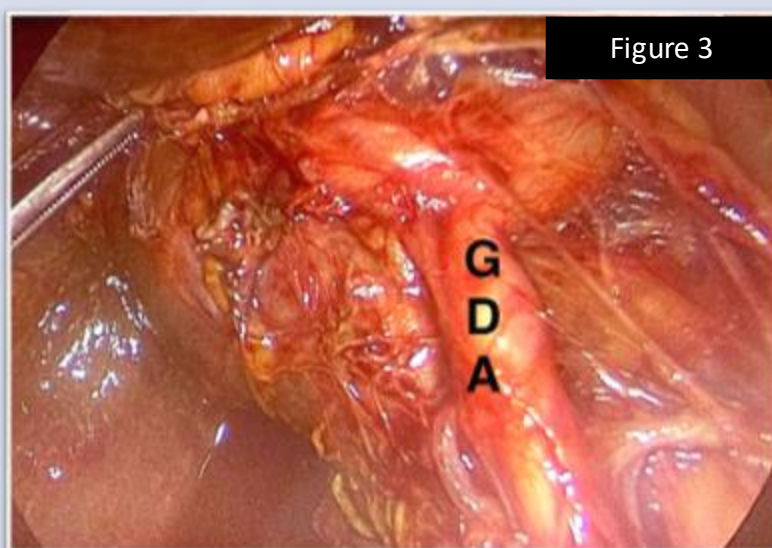
A staging laparoscopy was done. There was no liver metastasis or obvious peritoneal deposits. Dissection started with dividing the gastrocolic omentum. This was continued towards the hepatic flexure and the hepatic flexure was taken down. Then the duodenum was kocharized up to the left border of the IVC. (Figure 1)



Middle colic vein was traced to the Superior mesenteric vein, and to the Portal vein. Peritoneum at the lower border of the pancreas was incised and retro pancreatic tunnel was created inferiorly. (Figure 2)



Pars flaccida was divided and dissection continued towards the right side. Free border of the lesser omentum was dissected subsequently to identify the gastroduodenal artery (GDA) which was identified at the genu of the hepatic artery and traced downwards. GDA was clipped with medium-large titanium clips and divided. (Figure 3).



Common bile duct (CBD) was identified and connective tissue between the CBD and the portal vein dissected, and portal vein viewed superiorly. Retro pancreatic tunnel was completed anterior to the portal vein and a nylon tape was passed behind the pancreatic neck to complete the retro pancreatic tunnel (Figure 4). Then cholecystectomy was performed.



Unavailability of Endo GI staplers hindered the division of the distal stomach to complete the pancreatic division and dissection of the uncinate process from the SMA. Hence, we opened the peritoneal cavity with an upper midline incision. Stomach was divided proximal to the pylorus between non-crushing clamps and the stomach was closed with 3-0 polyglactin 910 sutures in two layers. Then the pancreas was divided at the pancreatic neck. Uncinate was dissected off the SMA. Ligament of Treitz was divided and proximal jejunum was transected. CBD was divided just proximal to the confluence and specimen was delivered.

Reconstruction was done with pancreatoco – jejunal anastomosis with duct-to-mucosa technique using 4-0 polydioxanone, Hepatoco-jejunostomy with 4-0 polydioxanone and a hand sewn gastrojejunostomy with 3-0 polygalactin in two layers. Two tube drains placed one behind the pancreatoco-jejunostomy and the second at the subhepatic space and routine closure was employed.

Total duration of the surgery was four and half hours, where laparoscopic dissection took two hours. Total blood loss was 400ml.

Post procedure

Patient was observed at the intensive care unit. Total parenteral nutrition was commenced and on day 3 oral feeding was commenced with clear fluids. Drains were removed on day 3 and day 5 after checking the drain fluid amylase levels. Oral feeding was gradually increased and nasogastric tube was removed on day 7. Patient was discharged on day 10.

Discussion

Laparoscopic pancreaticoduodenectomy is a complex surgical procedure with a long learning curve. Here we successfully attempted a laparoscopic mobilization of a Whipple procedure in an under equipped base hospital in Sri Lanka. Apart from the complexity of the surgery itself there were few more challenges that we had to experience. Apart from the vessel sealing energy device, which was also hired temporally we did not have free access for other consumables which are necessary for a major laparoscopic surgery like LPD. Most of the assisting junior surgeons had minimal exposure on major laparoscopic surgeries and we had to face technical difficulties with handling the camera and laparoscopic instruments.

There are many skillful laparoscopy trained surgeons in the country who are working at remote hospitals with poor resources. Underutilization of their skills due to unavailability and maldistribution of resources is a major problem which the public health sector suffers.

ANNUAL GENERAL MEETING 2025





The Sri Lanka Association of Minimal Access Digital Surgeons (SLAMADS) held its Annual General Meeting on February 1st, 2025, at the College of Surgeons in Colombo. The meeting commenced with the reading of the AGM advertisement by Joint Secretary Dr. D. Rasanayake, followed by the approval of the previous AGM minutes and the presentation of the Secretary's and Treasurer's reports, both of which were unanimously accepted. Key resolutions were then discussed and approved, including the expansion of general membership to board-certified medical specialists with an interest in minimal access procedures, the extension of the Immediate Past President's term to two years, and the creation of a "President-Elect" post to ensure a smooth transition of presidential duties.

The AGM also saw the election of new council members, with Dr. V. Sutharshan elected as the new President and Dr. R. Manathunga as the President-Elect. Joint Secretaries, Treasurer and council members were also elected. Outgoing President Prof. Bawantha Gamage addressed the gathering, expressing gratitude for the support received and proposing Prof. KB Galketiya as a patron of the association, which was unanimously approved. The new President, Dr. Sutharshan, then addressed the members, and Dr. D. Rasanayake delivered the vote of thanks.

Additionally, Dr. D. Rasanayake presented preliminary statistics on laparoscopic facilities in Sri Lanka. The meeting concluded with the adjournment at 6 pm.

Office bearers 2025-2026

President	: Dr. V. Sutharshan
President Elect	: Dr. Rasitha Manatunga
Immediate Past President	: Prof. Bawantha Gamage
Joint secretaries	: Dr. M. A. Chamila Lakmal Dr. Dammika Rasnayaka
Treasurer	: Dr. Sanjeev Samaranayake
Patrons	: Prof. Mohan de Silva Dr. K. L. Fernando Prof. Kemal I Deen Prof. K. B. Galketiya

Council members

- Dr Isuru Upanishad
- Dr Achala Samarasinghe
- Dr Buddhika Thilakarathne
- Dr Manjula Pathirana
- Dr Senal Medagedara
- Dr Rasika Bulathsinghala
- Dr Rajiv Nirmalasingham
- Dr Chathuranga Keppetiyagama
- Dr Malith Nandasena
- Dr Ranga Perera

RECENTLY HELD CME ACTIVITIES



SLAMADS live webinar

Minimal Access Fistula Surgery

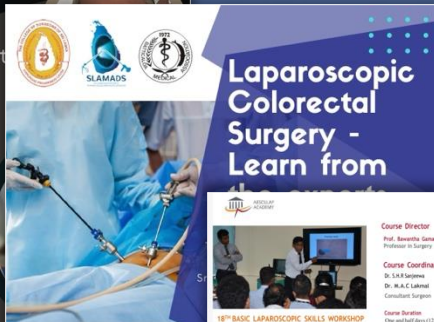
Mr R Rajaganesan
Consultant Colorectal Surgeon
(Pelvic Floor & Proctology Lead
Mersey & West Lancashire Teaching
Hospitals NHS Trust)

26 January, 2025
8:00pm

0776620566

www.slamads.lk

CLICK HERE TO REGISTER



Laparoscopic Colorectal Surgery - Learn from

23rd & 24th January 2025
at The College of Surgeons of Sri Lanka
In collaboration with
The College of Surgeons Sri Lanka

Organized by:
Sri Lanka Association of Minimal Access & Digital Surgeons

DR CHATHURANGA KEPPETIYAGAMA
Consultant Gastroenterological Surgeon

DR RASHTH MANATHI
Consultant Surgeon

Registration fee
Consultants - Rs. 2,000
Surgical trainees - Rs. 1,000
(SR's & Registrars)

Limited to 20 participants only

COURSE COORDINATOR
DR BUDDHIKA THILAKARATHNA
0772009290

15th BASIC LAPAROSCOPIC SKILLS WORKSHOP FOR SURGICAL TRAINEES

Course Director
Prof. Ravantha Gamage
Professor in Surgery

Course Coordination
By S.R.K Sarin
Dr. M.A.C Lakmal
Consultant Surgeon

Course Duration
One weekend (approx 12 hours)

Course Objectives
At the end of the course each trainee should be able to:
1. Develop hand eye co-ordination, manual dexterity, depth perception and visualization of 2D image to 3D visualization
2. Effectively and ergonomically use laparoscopic instruments
3. Describe the anatomy
4. Tie a laparoscopic suture
5. Handle a needle
6. Be able to do a simple laparoscopic cholecystectomy
7. Tissue laparoscopic Bowel Resection

Who Should Attend
The basic course is of greatest benefit for surgical residents who have entered their surgical training and the advanced surgical trainees who want to develop or improve in laparoscopic surgical skills.

Registration

Horizons of Knowledge
Continuing to expand the future.

For more information
Dr. S.R.K Sarin
Dr. M.A.C Lakmal
Course Coordinator
Sri Lanka Association of Minimal Access & Digital Surgeons
Dr. L.A. Samarasinghe, Administrative Manager
Sri Lanka Association of Minimal Access & Digital Surgeons
Dr. R. Rajaganesan, Consultant Surgeon
Dr. R. Rajaganesan, Consultant Surgeon
Dr. R. Rajaganesan, Consultant Surgeon



SLAMADS LIVE WEBINAR

Laparoscopic approach to Inguinal Hernia Repair

Dr Chandika Liyanage
MBBS, MS, MRCS, FRACS, FACS, FRCS
Consultant General, Upper GI & HPB Surgeon
Senior Lecturer & Lead for division of Surgery
University of Sydney, Pubbo Campus

02 MARCH, 2025
7:00pm

0776620566

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MASTERING LAPAROSCOPIC HERNIA

"MINIMAL TOOLS, MAXIMAL MASTERY!"

Live Surgery workshop

- eTEP
- 3D Mesh
- Macroporous vs Standard
- IPOM

15th March 2025
Saturday
8.00am -12.00 noon
NH Kandy - OTU

Registration link

Registration fees
Consultants Rs 3000
Trainees Rs 1000

For More information
Dr Achala Samarasinghe
0772689723

SPONSORED BY SURGISHADMA

Webinar

Minimal Access Fistula Surgery

26th January 2025

Mr. R. Rajaganesan
Consultant Colorectal Surgeon
Mersey & West Lancashire Teaching Hospitals NHS Trust





slamads
live
webinar

Minimal Access Fistula Surgery

Mr R Rajaganesan
Consultant Colorectal Surgeon
(Pelvic Floor & Proctology Lead
Mersey & West Lancashire Teaching
Hospitals NHS Trust

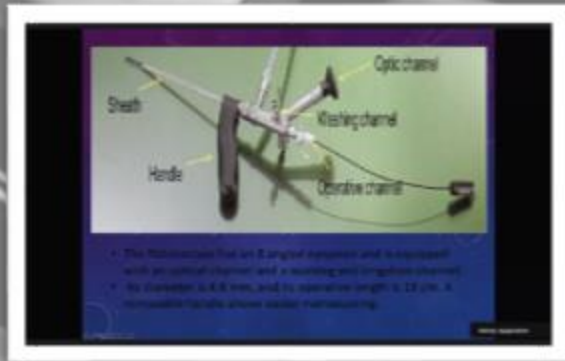
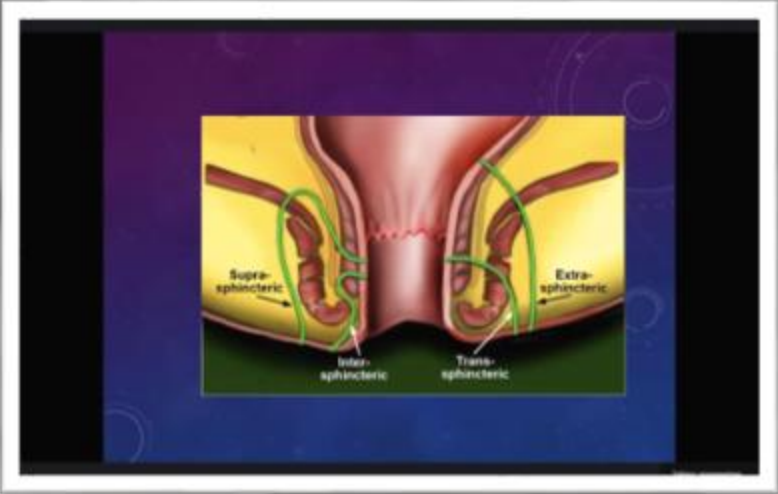
 26 January, 2025
8:00pm

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VAAFT- DIAGNOSTIC PHASE

AIM: Correct localization of the internal opening

External opening made slightly wider for about 1-2cm

Endoscope inserted via the external opening

Follow path: move right left up and down

Grasped transversally with inserted finger



CONCLUSION



51 cured (82%) (17/62) required 1 or more operations

16x re-do VAAFTs
10x EUA +/- H&D
1x Coloplast plug in fistula
1x EUA & 30% of anal fistula

Workshop

Laparoscopic Colorectal Surgery – Learn from the experts



30th January 2025

Laparoscopic Colorectal Surgery - Learn from the experts

Organized by
The College of Surgeons of Sri Lanka
In collaboration with
Sri Lanka Association of Minimal Access
and Digital Surgeons
&
Batticaloa Medical Association

- Live surgery - Laparoscopic Anterior Resection
- Laparoscopic Right Hemicolectomy

DR CHATHURANGA KEPPETIYAGAMA
Consultant Gastroenterological Surgeon

DR RASITHA MANATHUNGA
Consultant Oncological Surgeon

Thursday, 30 January, 2025
08:00 am onwards
At Oncosurgery Theater, TH Batticaloa

Registration fee
Consultants - Rs. 2,000
Surgical trainees - Rs. 1,000
(SR's & Registrars)

• Limited to 20 participants only

COURSE COORDINATOR
DR BUDDHIKA THILAKARATHNA
0772009290

REGISTER NOW

• Lunch will be provided

Workshop on 'Laparoscopic Colorectal Surgery – Learn from the experts' was held on January 30, 2025, at the Oncosurgery Operation Theatre of Teaching Hospital, Batticaloa. Organized by the College of Surgeons of Sri Lanka, SLAMADS, and the Batticaloa Medical Association, it featured knowledge sharing, interactive discussions, and live demonstrations of surgical procedures led by experts.

Following members of SLAMADS led the panel of experts

Dr. Rasitha Manathunga
Consultant Oncological Surgeon

Dr. Rasika Bulathsinghala
Consultant Gastroenterological Surgeon



The workshop offered participants a unique chance to learn advanced laparoscopic techniques. Twenty participants, including consultants and surgical trainees, attended the session. These enthusiastic participants came from all parts of the eastern province, covering all three districts.



The workshop featured live surgeries, hands-on learning, and discussions. Attendees enjoyed the practical approach and expert guidance. Dr. Buddhika Thilakarathna, the coordinator, ensured smooth execution. Participants appreciated the well-organized arrangements, including lunch and amenities. The workshop emphasized collaboration, knowledge sharing, and hands-on learning to enhance surgical skills. It advanced laparoscopic surgical practice in Sri Lanka's periphery.



Participants highlighted the importance of such workshops, as they provide high-quality training without the need to travel to Colombo during busy schedules. This approach reduces logistical challenges and ensures equitable access to advanced surgical education nationwide. We propose organizing similar programs to empower surgeons and elevate surgical care nationwide.

We extend our heartfelt gratitude to the faculty, organizers, and participants for making this event a grand success.



Workshop 18th Basic Laparoscopic Skills Workshop for Surgical Trainees





18th BASIC LAPAROSCOPIC SKILLS WORKSHOP FOR SURGICAL TRAINEES

23rd & 24th January 2025
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

The basic course is of greatest benefit for surgical registrars who have started their surgical training and for advanced surgical trainees who want to develop or improve in laparoscopic surgical skills.



Horizons of Knowledge
Competence to master the future.

The Academy Academy offers a world-class registration for surgical training of registrars, under training staff and staff in the medical, dental and medical management. The LAM Academy is a member of the International Association of Laparoscopic Surgeons (IALS) and is a member of the International Association of Laparoscopic Surgeons (IALS).

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For more information
Dr. S.H.B. Sanjewa
Dr. M.A.C. Lakmal
Course Coordinator
Consultant Surgeon
011-27292654
Mr. S. A. Dayananda, Administrative Manager
The College of Surgeons of Sri Lanka
No. Independence Avenue, Colombo 07, Sri Lanka.
Tel: Fax: +94 (11) 2622961 / 2622960

Course Director
Prof. Bawantha Gamage
Professor in Surgery

Course Coordination
Dr. S.H.B. Sanjewa
Dr. M.A.C. Lakmal
Consultant Surgeon

Course Duration
One and half days (12 hours)

Course Objectives
At the end of the course each trainee should be able to:

- Develop hand eye co-ordination, manual dexterity, depth perception and translation of 2D image to 3D working environment
- Effectively and ergonomically use laparoscopic instruments
- Describe the newer energy sources for laparoscopic surgery
- Use a laparoscopic surgeon's knot
- Handle a needle intracorporeally and take bites from tissues
- Be able to do interrupted and continuous suturing with good tissue approximation
- Form laparoscopic cholecystectomy in porcine liver block.

Registration

Name to appear on Certificate of Attendance (Prof/Dr/Mr/Ms)

Designation: _____ Department: _____

Hospital / Institution: _____

Address: _____

Postcode / City: _____

Tel: _____ Fax: _____

REP: _____

Postal: _____

Vegetarian: ☐ Yes ☐ No

Course Capacity
Limited to 20 participants only

Course Fee:
Local participants - LK\$2,000/-
Foreign participants - LK\$3,000/-

- Admission to Workshop
- Workshop Manual
- Meals as stated in the programme

Please fill out the form individually

Closing Date for Registration
Closing date for registration will be on 20th January 2025.
Due to limited space, an early registration is highly recommended and registration from a first come first served basis.

Liability
The Organizing Committee shall not be held liable for personal accident or losses or damage to private property of registered participants

Confirmation of Registration
Confirmation of registration will only be issued upon receipt of a completed Registration Form with full payment.

Agenda
Day 1
BASIC PRINCIPLES IN LAPAROSCOPIC SURGERY
How to become a safe Laparoscopic Surgeon
Laparoscopy setup & basic principles of camera holding
Technique of safe entry and creation of pneumoperitoneum
Anesthesia and problems of pneumoperitoneum
Practical Session 1 Depth perception and hand-eye Coordination
Practical Session 2 Laparoscopic Dissection skills
Safe Dissection of The Gall's Triangle
Tissue approximation techniques in laparoscopic surgery
Practical Session 3 Suturing and Knotting
Day 2
Energy devices in Laparoscopic surgery Basic
Master Video session, Laparoscopic Appendicectomy/Laparoscopic Cholecystectomy
Practical Session IV - Lap Cholecystectomy on porcine specimen
Practical Session V - Lap Cholecystectomy on porcine specimen
Ergonomic in Laparoscopic Surgery
Common problems during lap cholecystectomy is how to overcome

Please sign and return this form to the Organizing Committee



The 18th Basic Laparoscopic Skills Workshop was held successfully at the College of Surgeons' skills lab over two days, from January 23rd to 24th, 2025. Twenty surgical registrars participated in the intensive two-day course, which covered a range of topics including carefully selected lectures and hands-on training in both dry and wet labs. The trainees also had ample time to practice suturing techniques



The trainees thoroughly enjoyed the course, expressing their satisfaction with the content and practical skills they gained. B Braun International generously sponsored the workshop, and SLAMADS would like to express its gratitude for their valuable contribution and efforts in organizing this valuable training opportunity.







Webinar

Laparoscopic Approach to Inguinal Hernia Repair

2nd March 2025


Dr. Chandika Liyanage


Consultant General, Upper GI & HPB Surgeon
University of Sydney, Dubbo Campus




SLAMADS
LIVE
WEBINAR
Laparoscopic approach to Inguinal Hernia Repair

Dr Chandika Liyanage
MBBS, MS, MRCS, FRACS, FACS, FRCS
Consultant General, Upper GI & HPB Surgeon
Senior Lecturer & Lead for division of Surgery
University of Sydney, Dubbo Campus

 **02 MARCH, 2025**
7:00pm




 **0776620566**

 **SLAMADS.LK**


CLICK HERE TO REGISTER

TAPP

- GA, Prophylactic Antibiotic
- Arms tucked in pillow cases
- Trendelenburg position
- CO₂ Pneumoperitoneum
- One 12 mm and two 5mm ports



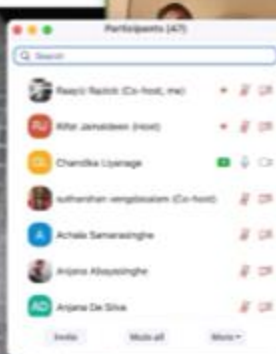




Left hand pushes up against the deep ring, right sweeps the structures superomedially, superficial to the iliac vessels



Difficult Hernias

- Large indirect sac
 - Division of the sac within the canal and closure of the proximal
 - control the deep ring by passage of the mesh under the cord, (why I prefer DP2)



Workshop Laparoscopic Approach to Inguinal Hernia Repair

15TH March 2025



MASTERING

LAPAROSCOPIC HERNIA

"MINIMAL TOOLS, MAXIMAL MASTERY!"

Live Surgery workshop

- ✓ eTEP
- ✓ 3D Mesh
- ✓ Macroporous vs Standard
- ✓ IPOM

15th March 2025
Saturday
8.00am -12.00 noon
NH Kandy - OTU

Registration link



Registration fees
Consultants Rs 3000
Trainees Rs 1000

+

For More information
Dr Achala Samarasinghe
0772689723

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Prof. Bawantha Gamage

Founder president of SLAMADS
took part as faculty



GEM TELEVERSTY

KEYHOLE CHRONICLES: LIVE SURGERY AND INSIGHTS

BY TELEVERSTY, A GEM HOSPITAL INITIATIVE

WE ARE PROUD TO ANNOUNCE THAT GEM HOSPITAL IS LAUNCHING INITIATIVE AIMED AT ADVANCING SURGICAL EDUCATION

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3 PM

FEB 26 2025

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PRACTICAL ASPECTS IN RECTAL CANCER SURGERY - FEATURING LIVE SURGERIES IN MALE AND FEMALE PELVIS

TO WATCH AND ENGAGE WITH THESE ENRICHING SESSIONS

TIMING	TOPICS	SPEAKER
5:00 PM TO 6:00 PM	LIVE SURGERY - LOW ANTERIOR RESECTION IN MALE AND FEMALE PELVIS	DR S RASAPINDAN
6:00 PM TO 6:30 PM	HOW FOR CAECITOMIA RESECTION- WHAT SHOULD A SURGEON KNOW?	DR SRINATH
6:30 PM TO 6:35 PM	SNY FOR CAECITOMIA RESECTION- WHEN TO STOP?	DR SHAMAR S
6:35 PM TO 6:45 PM	ANASTOMOSE LEAK FOLLOWING LOW ANTERIOR RESECTION- WHAT WOULD YOU DO?	DR HARSH NAYAK
6:45 PM TO 7:00 PM	DISCUSSION	

MODERATOR

DR RANDEEP SHARMA - ASST PRESIDENT, MUMBAI
DR ANA VEDRAN - SURGICAL ONCOLOGIST, MUMBAI
DR C. J. WINDHART - ASST PRESIDENT, MUMBAI
DR ANURAG WITTY - ASST SURGICAL, SURGICAL, GASTROENTEROLOGY, MUMBAI
DR BAWANTHA - COLORECTAL SURGEON, SRI LANKA
DR SRI - SURGICAL, GASTROENTEROLOGY, PUNJAB, INDIA

JOIN US AS GEM HOSPITAL CONTINUES TO LEAD THE WAY IN INNOVATIVE MEDICAL EDUCATION!

COLORECTAL WEBINAR

Novel Imaging Technologies in Colorectal Surgery

FEBRUARY 27, 2025
7:00 PM (SG/PH) | 4:30 PM (SRI LANKA TIME)

FACULTY

DR ALFRED ALLEN BURNARD - Philippines
DR ANDREW DEAS ABELLA - Philippines
PROF. BAWANTHA GAMAGE - SRI LANKA
A-PROF. FREDERICK KAH - Singapore

PROGRAM

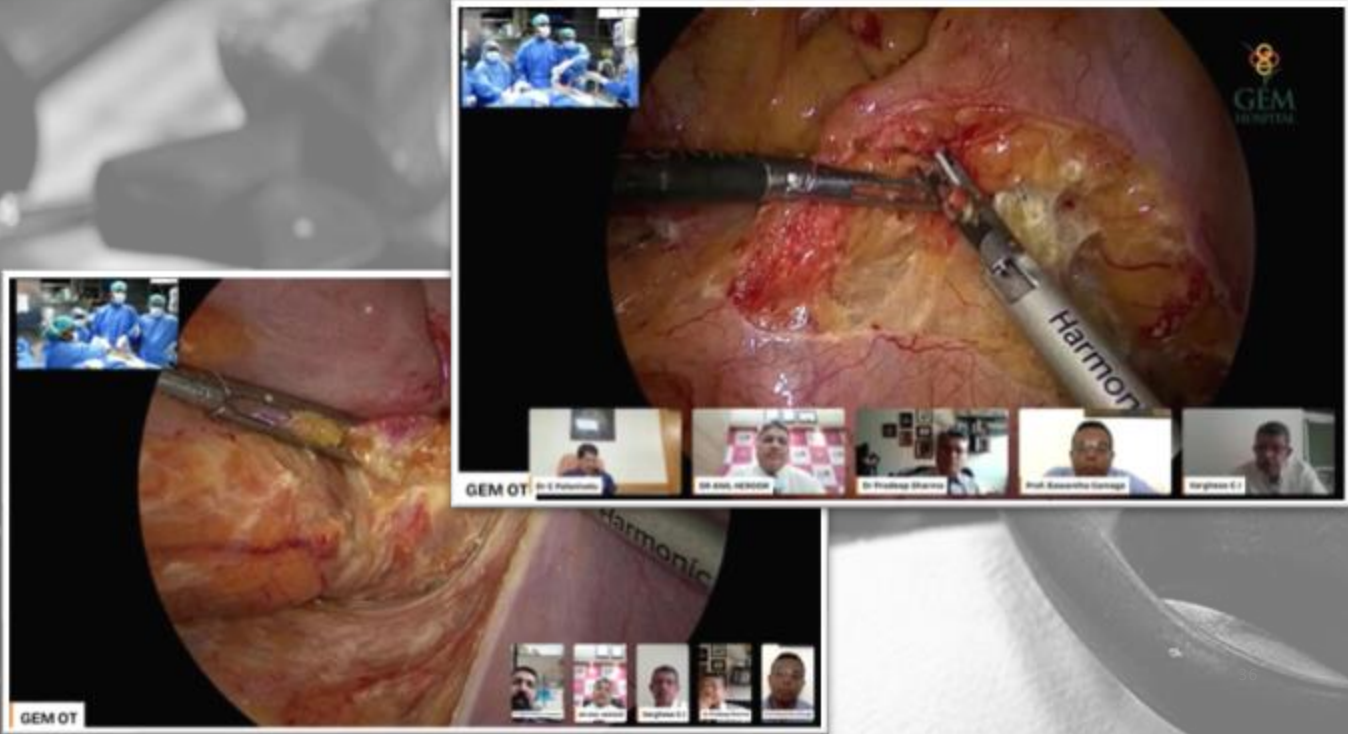
Prayers	Dr. Andrew Abella
Course Introduction	Dr. Alfred Lorenza De Tada
Introduction to 1st speaker	Dr. Bawantha Gamage
Laparoscopic Total Mesorectal Excision (TME)	Dr. Alfred Lorenza De Tada
Introduction to 2nd speaker	Dr. Frederick Kah
Yellow Enhancement in Colorectal Surgery	Dr. Andrew Abella
Questions and answers	Dr. Alfred Lorenza De Tada
Introduction to 3rd speaker	Dr. Alfred Allen Burnard
LIVE SURGERY - Laparoscopic Colon Surgery with Indocyanine green (ICG) and Yellow Enhancement	Dr. Alfred Allen Burnard
Closing Remarks	Dr. Andrew Abella

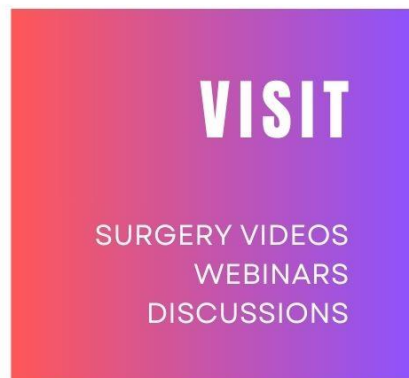
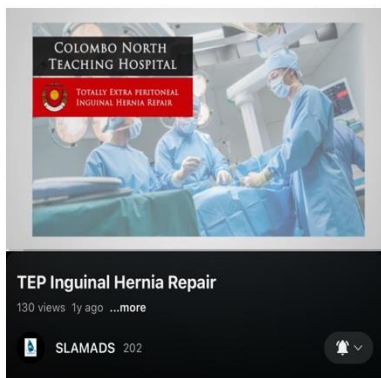
FOR INQUIRES PLEASE CONTACT:
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SRI LANKA ASSOCIATION OF MINIMAL ACCESS AND DIGITAL SURGEONS


LIVE WEBINAR
**SCOPE OF
MINIMAL
ACCESS
SURGERY
IN CHILDREN**

DR. MATHULA HETTIARACHCHI
MBBS, MD, MRCS
Consultant Paediatric Surgeon
Senior Lecturer in Surgery
SBSCH, Peradeniya
University of Peradeniya






REGISTRATION


**CLICK HERE TO
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**APRIL 6TH, 2025
8PM**
zoom platform

MASTERCLASS ON
**Minimal Access
Esophagectomy**
And Live Surgical demonstration



25 April 2025


At 08:30 AM
to 2.30 PM






Onco-Surgical Theater
- National Hospital
Galle

Resource Persons :


Dr Rasitha Manatunga
Dr Dileepa Mahaliyana
Dr Minoli Joseph
Dr Chathuranga Keppetiyagama
Dr Dhammika Rasnayake
Dr Rasika Bulathsinghala




ORGANIZED BY







REGISTRATION



CONSULTANTS RS 3000
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COURSE COORDINATOR - DR RASITHA MANATUNGA
 DR KELANI PERERA - 071 8220 521

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