Sushruta

Newsletter of Surgical Society of Bangalore

JULY 2021

Table of Contents

Send your News, Articles, Event details, Classifieds, etc. to "editorssb@gmail.com"

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Newsletter of Surgical Society of Bangalore

JULY 2021

Editorial

Dear Esteemed Member of SSB,

'SUSHRUTA' is a monthly newsletter, creating a platform where in the members and surgical postgraduates can publish original articles, case reports, surgical guidelines or any other material of surgical relevance, This will be made available online for all the members.

I request everyone to make use of this platform to disseminate, share or acquire knowledge.

Dr Kalaivani V
Editor SSB KSCASI CC

Dear All,

Kindly encourage this new monthly initiative of the SSB.

Academic Articles

Please send articles, guidelines, humour, stories, trivia, quiz questions and interesting Case report or case series with Review of literature for academic purposes.

Non-Academic

Inviting articles - That may be appropriate and interesting to the SSB members. Examples: life beyond surgery, my daily routine, how I manage stress, interesting place I traveled, books I recommend etc.

Opportunities / Classifieds

Relevant Jobs, Ad's and upcoming events can be included at a nominal fee as per the discretion of the Editorial team.

Feedback / Suggestions

Any other suggestions for improvements, feedback, letters to the editor, inputs are welcome.

Deadline :
Last day of every month.
Send your article to : editorssb@gmail.com
WhatsApp - 8197910166

Please mark all your contributions via emails, WhatsApp with the heading for Sushruta and mention your name, designation and institution.

Request all the SSB members to actively contribute, participate and wholeheartedly appreciate this new initiative "Sushruta - official newsletter of the Surgical society of Bangalore"

Regards,
The Editorial team of Sushruta

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Newsletter of Surgical Society of Bangalore

JULY 2021

Message from the President

Dear Members,

On the occasion of the platinum jubilee of Indian Independence Day, let's take a pledge to build a strong, prosperous, vibrant nation. Let's join hands to support our fellow countrymen in need of help, and strengthen our economy by buying Made in India products as much as possible. Let's stay united to fight against the atrocities towards healthcare personnel.

The monthly clinical meetings will continue on a virtual platform as there is a fear of the third wave of the pandemic. Please attend in good numbers to support the efforts of PG students and the hosting institutions.

Please contribute to our e-news letter SUSRUTHA and enrich it.
Stay safe and stay protected.

Dr. Venkatachala K
President SSBASICC 2021

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Newsletter of Surgical Society of Bangalore

JULY 2021

Best paper - Sagar Hospital MCM

Title – A Prospective Randomized Controlled Study of the effectiveness of training in laparoscopic camera navigation using box trainer in novices

Dr. Saurav Majumdar, Dr. Indraja R, Dr. Abdul Basith, Dr. Niranjan P, Dr.
Ravishankar H.R, Dr. Muni Reddy M

Dr Saurav M

Introduction

Camera navigation in laparoscopy is often considered a simple task and is handled by the less experienced, such as medical students or junior residents. It is, however, a complicated task, requiring specific psychomotor and visuospatial skills. Inappropriate handling of the camera results in poor visualization, which can lead to longer operating time;
surgeon frustration; and can, most importantly, compromise patient safety

Materials and Methods:

It was a randomized control PILOT study conducted in
DEPARTMENT OF GENERAL SURGERY, SAGAR HOSPITAL, TILAK NAGAR, which is a tertiary care teaching hospital in Bangalore, India from December 2020 to April 2021. 20 participants with 11 in control and 9 in intervention randomised using computer generated random numbers were recruited for the study. We had included surgical novices that is, 1st year surgical residents, residents in other departments and nurses with no prior experience in laparoscopic camera handling. The task was to simultaneously maintain optimal distance, horizon, and centering of a laparoscopic image displayed on the screen of a box trainer during the entire course of the exercise

The intervention group received a 10 mins demonstration of the task to be performed and 5 mins to orient themselves to the equipment. A laparoscopic box trainer using a 30-degree 5mm scope connected to a lcd screen was taken. A Maryland forceps was used to move between the points. The Liquid Crystal Display (LCD) screen was divided into 4 equal halves with 2 lines passing through the center of the screen marked as C. A white sheet of paper (15x 15 cm) placed inside the box with 10 marked points on it in a jumbled-up manner.

On day 1 of training, the investigator moved the instrument across the marks. The participants navigated the camera so as to keep the instrument in the center of the screen. The total intervention time was 60 mins per participant. Time taken to complete the 1st and last cycle and total number of cycles completed in 60 mins was recorded. The 2nd day was identical to training 1 except participant had to hold the instrument in the one hand while moving the camera in other hand. The aim again was to move the instrument in one hand through the points while keeping the image in the centre. Total intervention time was 60 min per participant. At the end of Day 2, the participants were assessed for completion of training as per the predesigned training assessment tool (Fig1) designed combining OSATS and GOALS assessment tools by the 1st investigator. If any of the participants attained cumulative score of <18, another additional day of training was added.

The participants of control group did not receive any training except a video describing laparoscopic camera handling and another video demonstrating laparoscopic cholecystectomy.

Following training the participants were asked to hold camera in a short part of an actual laparoscopic cholecystectomy (dissection of gall bladder off the gall bladder fossa) assisting the primary surgeon. Scoring was done by a single observer (2nd investigator who had no knowledge if resident had received training or not).

Primary end point was performance of the residents with respect to a predesigned assessment tool (The total cumulative score in the Objective structured assessment of camera navigation skills (OSA-CNS). (Fig2) Secondary end points were measured in terms of time taken to complete 1st and last cycle and total number of cycles performed in 60 mins.

Results:

The age and sex distribution as well as history of previous videogame experience and the distribution of residents and nurses between the 2 study groups were comparable between the two study groups. However, there was significant reduction in the task completion time between the 1st and last cycles on both day 1 and 2, indicating that the training was adequate. When we compared the post, procedure scores that was assigned by the 2nd observer between the intervention and control group, the mean score attained by those in intervention group was 13.56 and 10.1 in control group. The P value being statistically significant at <0.026, indicating that the training on box trainers did affect the net performance outcome in the intervention group. Although past video game experience is known to improve hand eye coordination, the same was not represented in our study. During feedback, most of the participants felt that the training structure was good and they had learnt something useful, however about half of them felt that the session length was too long.

Sushruta

Newsletter of Surgical Society of Bangalore

JULY 2021

Conclusion:

The three key tasks essential for projection of adequate laparoscopic image includes centering of the image, maintenance of horizon and optimum viewing distance. Loss of visuospatial cues makes it particularly challenging for novices, who are the most frequent in holding the camera during laparoscopic surgery. Hence training tools using simulators provide the stimulus for improvement of technical skills. Box Trainers are particularly attractive especially for novices due to Lower cost, more realism and equivalence to real-life laparoscopy in terms of use of identical equipment. However, since is a pilot study, a larger number of participants are needed to realistically conclude the advantages over traditional practices. Hence, I would like to conclude by saying that Laparoscopic camera training is essential as the cameraperson is the eyes of the operating surgeon and novices gain the most from training and should form an integral part of any surgical training curriculum.

References:

• Alam M, Wilson MS, Tang B, Tait IS, Alijani A. A training tool to assess laparoscopic image navigation task performance in novice camera assistants. journal of surgical research. 2017 Nov 1;219:232-7 • Ganni S, Chmarra MK, Goossens RH, Jakimowicz JJ. Self-assessment in laparoscopic
surgical skills training: Is it reliable?. Surgical endoscopy. 2017 Jun;31(6):2451-6.
• Scott DJ, Bergen PC, Rege RV, Laycock R, Tesfay ST, Valentine RJ, Euhus DM, Jeyarajah DR, Thompson WM, Jones DB. Laparoscopic training on bench models: better and more cost effective than operating room experience?. Journal of the American College of Surgeons. 2000 Sep 1;191(3):272-83.
• Wang X, Zhang K, Hu W, Kuang M, Teo S, Guo Z, Zhao Q, He X. A new platform for laparoscopic training: initial evaluation of the ex-vivo live multivisceral training device. Surgical endoscopy. 2021 Jan 1;35(1)

	1	2	3	4	5
Tip of instrument continuously visible on screen*	Instrument tip frequently out of view		Instrument tip mainly in sight but sometimes out of view		Instrument tip continuously visible on screen
Smooth movement and Dexterity*	Many ineffective and rough movements		Smooth movements, occasional inadvertent movements		Smooth movements and Dexterity
Depth Perception**	Constantly overshoots the target, wide swings, slow to correct		Some overshooting or missing of target but quick to correct		Accurately directs instruments in the correct plane of the target
Bimanual Dexterity**	Ignores non-dominant hand, poor coordination between the hands		Uses both hands but does not optimise coordination between the hands		Expertly uses both hands in a complimentary manner to provide the best exposure
Efficiency**	Uncertain, inefficient efforts, many tentative movements, constantly changing focus		Slow but planned movements		Confident and efficient, maintains focus
Autonomy**	Unable to complete task even with verbal guidance		Able to complete task with moderate guidance		Able to complete task independently without guidance

*OSATS (Objective and Structured Assessment of Technical Skills)

**GOALS (Global Operative Assessment of Laparoscopic Skills)

TIME TO COMPLETE TASK_____

Fig1: Custom Tool to assess training completion

1. View completion				
1	2	3	4	5
Frequently presents a peripheral part of the visualization field, with suboptimal size and/or have an unsteady hand		Can centre, size and hold the visualization field steady during most of the procedure		Able to appropriately size, centre and hold the visualization field steady at all time
2. Horizontal alignment				
1	2	3	4	5
Repeatedly looses the horizontal alignment, and are not able to adjust the axis when necessary		Keeps the alignment most of the time, can to some extent correct the axis when the operating field moves		Keeps horizontal alignment and adjust the horizontal axis when the operating field moves
3. Scope orientation				
1	2	3	4	5
Troubles with finding and keeping the correct angle		Keeps an appropriate angle at most times		Angles the scope appropriately at all time
4. Instrument collision				
1	2	3	4	5
Frequent instrument collision due to inability to retract and interchange the laparoscope to avoid instrument collision		Avoid instrument collision most of the time		Avoids instrument collision by retracting and interchange the laparoscope at all times
5. Autonomy				
1	2	3	4	5
Surgeon repeatedly needs to guide and supervise to obtain a optimal operating field		Can navigate independently most of the time, but need some guidance		Is technical independent, and do not need guidance from the surgeon

Fig2: OSA-CNS

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Newsletter of Surgical Society of Bangalore

JULY 2021

Best Poster – Sagar Hospital MCM

A PROSPECTIVE STUDY OF EFFECT OF FRAILTY ON SURGICAL OUTCOMES IN ELDERLY PATIENTS

Dr. Ajit B. Darandale, Dr. Niranjan P., Dr. H V Rajashekara Reddy, Dr. H R Ravishankar

Dr Ajit

Introduction

Frailty is an objective method of quantifying a patient's fitness for surgery.

Frailty is an entity well described in the geriatrics literature as a syndrome of decreased physiologic reserve. It is "the condition of being weak and delicate." Adults aged 60 or older are the fastest growing segment of any population, and correspondingly there will be an increase in the number of surgical procedures performed in the elderly. The traditional surgical risk assessments are subjective and only account for a single organ system or are limited to overt diagnosed comorbidities. The inability of the traditional risk assessments to capture decrements in physiologic reserve stimulated interest in adapting patient frailty as a pre-operative assessment to better capture the functional heterogenesity and operative risk of the elderly and infirmed. When recognized, it identifies community dwelling older adults at increased risk for falls, hospitalization, disability, institutionalization and mortality.

Aim-To study the effect of frailty on the outcomes of elderly hospitalised patients undergoing major surgery

MATERIALS AND METHODS:

Preoperative assessment of frailty included the five components of the Fried Criteria

1. Shrinking
2. Grip strength using hand held dynamometer
3. Exhaustion
4. Low activity
5. Slowed walking speed

Scoring

Each domain yields a dichotomous score of 0 or 1,

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Newsletter of Surgical Society of Bangalore

JULY 2021

NOT FRAIL (0 – 1)
FRAIL (2 – 5)

This is a prospective observational study will be conducted in DEPARTMENT OF GENERAL SURGERY,SAGAR HOSPITAL,Tilak nagar, which is a tertiary care teaching hospital in Bangalore, India, between October 2018 to June 2020.

INCLUSION CRITERIA:

•1. Patients >60 years undergoing elective major surgical intervention (Laparotomy,Laparoscopic/Open Cholecystectomy, Laparoscopic/Open Herniae, Thoracotomy, Video Assisted Thoracoscopic Surgery)
•2. Any sex.

EXCLUSION CRITERIA:

•Parkinson's disease, previous stroke, cognitive impairment or depression
•Those who had poor manual dexterity/inability to grip
•Patients undergoing emergency surgery.
•Not willing to participate in the study.

Results

Out of 108 patients 80 were included in the study, of which 49 were male and 31 were females. 30 patients were found to be frail and 50 were nonfrail. Out of 30 frail patients males constituted 16 (53.33%), while females were 14 (46.67%) which was not statistically significant (p value-0.26). 22 out of 30 frail patients (73%) had comorbidities while 29 out of 50 nonfrail patients (58%) had comorbidities- statistically not significant(p value-0.16). 19 patients in frail group had postoperative complications while only 9 patients in nonfrail landed up in complications which was statistically significant (p value-0.0001). Frail patients had longer hospital stay as compared to nonfrail patients with p value-0.003- statistically significant. We lost 3 patients postoperatively, all belonged to frail group. Association between frailty and complications was calculated using odds ratio-2.11 with 95% CI- 2.79 to 22.15 which signified strong association between frailty and postoperative complications.

Conclusion

Frailty in older surgical patients is associated with higher rate of postoperative complications, prolonged hospital stay and mortality.

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Newsletter of Surgical Society of Bangalore

JULY 2021

A RARE CASE OF BILATERAL PNEUMATOCOELE IN POST COVID PATIENT

-Dr Ajit B Darandale, Dr H V Rajashekara Reddy

Background

The clinical syndrome caused by novel corona virus is termed as severe acute respiratory syndrome coronavirus-2 (SARS-CoV2) and the disease is called as coronavirus disease-19 (COVID-19) . The radio- graphic findings of COVID-19 patients studied in 69 patients showed about 31% presenting with normal chest x-ray and rest presenting with consolidations or ground glass opacities (GGO).A systematic review by Bao et al. showed the CT-findings in COVID-19 can present as GGO (83%), GGO with consolidation (58%), pleural thickening (52%), interlobular septal thickening (48%), and air bronchograms (46%) SARS-CoV-2 infection causing pneumatocele formation and spontaneous pneumothorax in the USA and Japan were reported however none needed surgical intervention. Here we report a cases of post covid pneumatocoeles requiring surgical intervention.

Case details-

A 33 year old male, non smoker with no comorbidities was admitted on 14th April 2021 with covid pneumonia at a private hospital in Bangalore with CT chest severity score of 13/25. He was treated symptomatically with oxygen supplementation and steroids in the wards and was discharged in 2 weeks. A week later he developed acute left chest pain and breathlessness for which he was evaluated with CT chest which showed left pneumothorax and incidentally bilateral pneumatocoeles were noted. Left intercostal tube was placed for the same, he improved and was discharged in a week. On 24th May he again developed breatlessness, multiple episodes of hemoptysis and right sided chest pain. So he was evaluated again at our institute with CT chest which showed large pneumatocoele/loculated pneumothorax on the right and small pneumtocoele on the left. A pigtail catheter was inserted under radiological guidance on the right side, however patient continued to deteriorate with oxygen demand going up to 6 litres/min from 2 litres/min. So decision was taken to operate

He underwent bronchoscopy which showed blood stained secretions in right lower lobe bronchus, there was no active bleed. He underwent right Video Assisted Thoracoscopic Surgery(VATS)+Excision of pneumatocoele+ Excision of multiple brochopleural fistulae using endostaplers. Left ICD was also inserted as a prophylactic measure. Postoperative period was uneventful. Left ICD was removed on postoperative day 2 and right ICD was removed on postoperative day 6. He was discharged on POD7. Histopathology confirmed our diagnosis of pneumatocoele.

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Newsletter of Surgical Society of Bangalore
JULY 2021

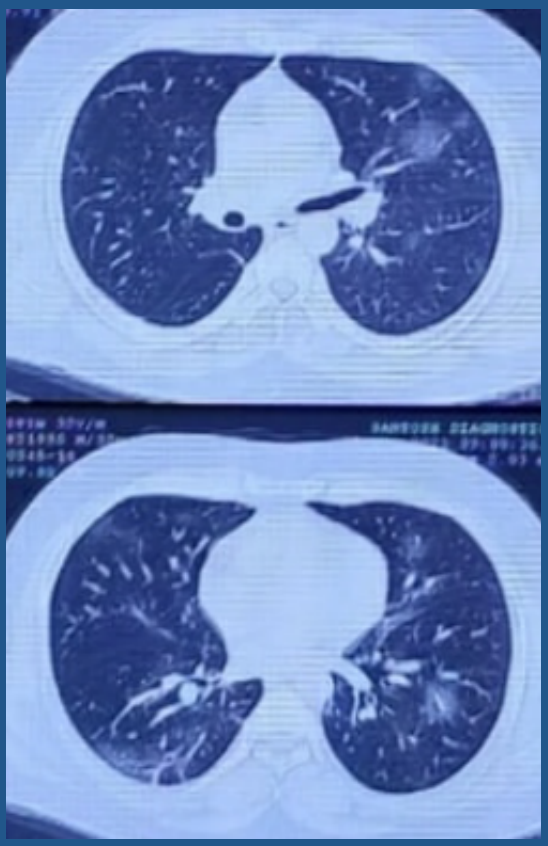


Fig. 1A- Multiple ground glass opacities-
Covid pneumonia

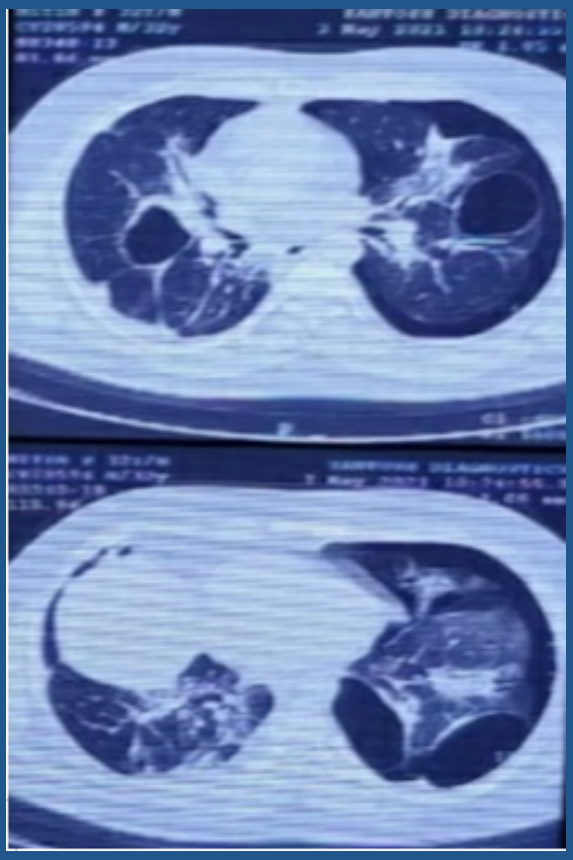
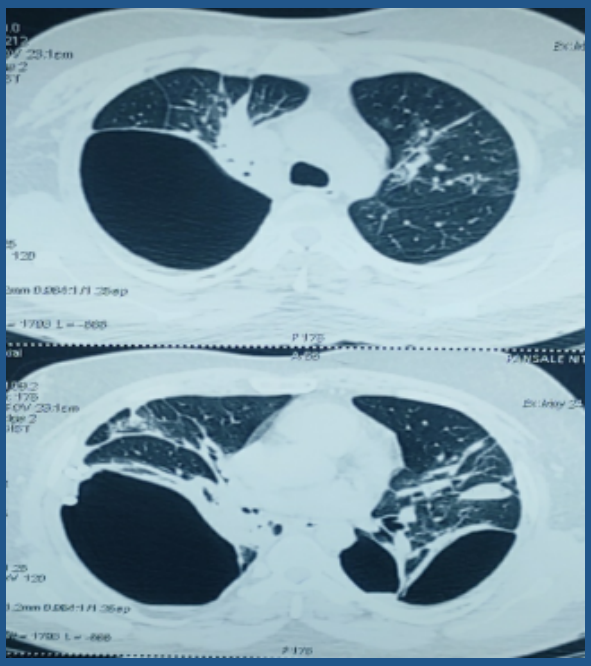


Fig. 1B- Left pneumothorax with incidentally noted
bilateral pneumatocoeles



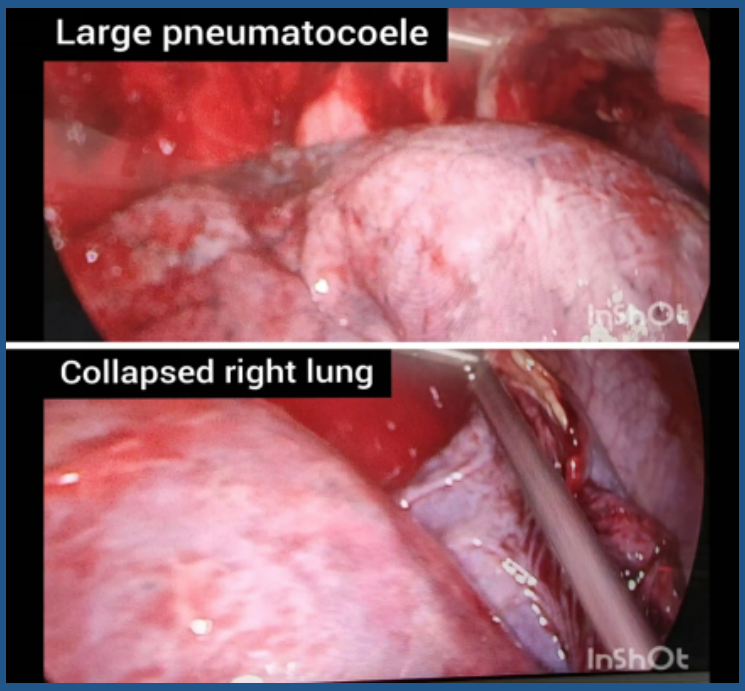


Fig. 1C- Large right pneumatocoele with small left pneumatocoele
Fig. 1D- Large right pneumatocoele compressing the lung seen during VATS

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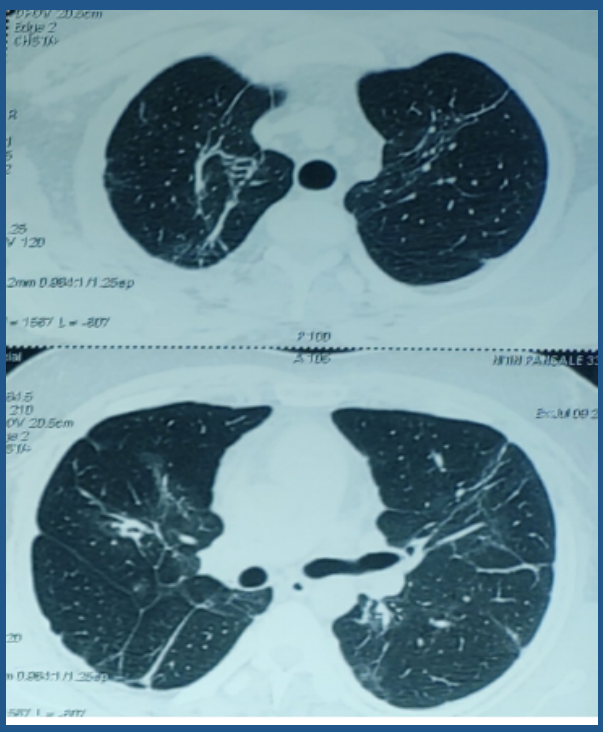
Newsletter of Surgical Society of Bangalore
JULY 2021

Follow Up-
Patient is doing well on 2 months of follow up. Repeat CT showed complete spontaneous resolution of left pneumatocoele as well.

Fig.1E-Follow up CT Chest complete resolution of both pneumatocoeles



Discussion-

Pneumatocoeles are air-filled, thin-walled cystic lesions in lung that commonly develop after a severe infection like empyema. The common noninfectious etiologies include trauma, positive pressure ventilation and hydrocarbon ingestion.The pneumatocele in some instance can dissect through the pleural membrane and cause pneumothorax. CT scan is the usual investigation performed to diagnose pneumatocoele. Most of the pneumatocoeles resolve spontaneously, however nonresolving symptomatic pneumatocoeles may need active surgical treatment.

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Newsletter of Surgical Society of Bangalore

JULY 2021

Interview with Surgeon - Dr Rajakumar Deshpande

Vasudeva Rao Rajakumar Deshpande

+91 9845363050 +91 8618753700 dvr6891@gmail.com

Profile

Minimal Access Spine Surgery
Skull Base Surgery
Cerebrovascular Surgery

Experience

Director, Brain & Spine Care, Department of Neurosurgery, Fortis Hospitals, Bengaluru, Karnataka, India 560076
President, Minimally Invasive Spine Surgeon's Association of Bharat (MISSAB), India.

Education

M.Ch. in Neurosurgery at National Institute of Mental Health and Neurosciences, (NIMHANS), Bengaluru, Karnataka, India.
Skull Base Fellowship at Wayne State University, Detroit, Michigan, USA.

Skills

Leadership roles in departmental and hospital administration
Founded and leading a National minimally invasive spine society
Organising National conferences and courses to train neurosurgeons and orthopaedic surgeons
Conducting Operative and Cadaver workshops

References

Complete anatomic reduction and monosegmental fusion for lumbar spondylolisthesis of Grade II and higher: use of the minimally invasive "rocking"technique, Neurosurg Focus, 43(2);E12, 2017
Patent applied for " StandAlone Tethered Interlocking Cage - Lumbar"

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Newsletter of Surgical Society of Bangalore

JULY 2021

Interview with Surgeon – Dr.Rajakumar Deshpande, M.Ch

Dr.Rajakumar Deshpande, M.Ch

Director,NeurosurgeryFortis Hospitals,
Bangalore

Born in Mandya long ago.

Early education in Vijaya High School, Bangalore and National College, Bangalore.

Medical training in Government Medical College, Mysore.

Neurosurgical training at National Institute for Mental Health and Neurosciences, Bangalore.

Skull Base clinical fellowship at Wayne State University, Detroit.

My special interests are:

1.Skull Base surgery
2.Cerebrovascular surgery
3.Minimally invasive Spine surgery

My ‘reluctance to operate’ – where patient has very little benefit from the procedure.

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Newsletter of Surgical Society of Bangalore

JULY 2021

Surgeries which I love to do:

Sellar/Suprasellar area tumors
Cerebello-pontine angle
Intraventricular tumors
Trans-nasal endoscopic approach for intracranial tumors
Aneurysm clipping
Awake brain surgery
Minimally invasive complex spine

I chose surgery as I have excellent eye-hand coordination and 3D memory for anatomy.

If I get to relive PG life, I would definitely concentrate on additional aspects of training:
1.Cadaver dissection
2.Gaming – improves eye-hand coordination
3.Writing Journal papers

Personal:

Beyond surgery, my interests are:
1.My family
2.Cars/Bikes
3.Photography
4.Reading

Favorite food

1.South Indian definitely
2.Anything vegetarian
3.Always coffee – preferably black

Favorite books

– too many in different genre.

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Newsletter of Surgical Society of Bangalore

JULY 2021

Favorite travel

1.Forests, especially for photography
2.Explore different countries when opportunity arises
3.Himalayas – awesome place. No better place on earth.
4.Drive anywhere, just be on the road

To tackle stress:

1.Don't operate unnecessarily
2.Stress is inability to perform adequately in a given manner in a given time.

Message for younger surgeons:

1.STOP – if you are not adequately trained.
2.Spend a lot of time in training – Inadequate skill is very common.
3.Don't chase money; we get more than we deserve many times!
4.Chase your dream to excel; be sensible at that.

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Newsletter of Surgical Society of Bangalore

JULY 2021

Surgical Society of Bangalore Association of Surgeons of India City Chapter

1st Floor, I.M.A. House, Alur Venkata Rao Road, Bangalore - 560 018.
Web : www.ssbasicc.org, Email : cmeinsurgery@gmail.com, Mob : 9243108442

PROF.B.HANUMAIAH MEMORIAL NATIONAL CONTINUING SURGICAL EDUCATION PROGRAMME ON A VIRTUAL PLATFORM

22nd - 26th NOVEMBER 2021

HIGHLIGHTS FOR THE VIRTUAL CSEP - 2021

- MORE EMPHASIS ON CLINICALS & CASE PRESENTATION
- INTERACTIVE SESSIONS WITH EXTERNAL & INTERNAL FACULTY WHO ARE EXAMINERS FOR POST - GRADUATES
- ENTRY THEORY PREPARATION & EXIT OPERATIVE SURGERY
- DR.NITHYANANDA SHETTY ENDOWMENT LECTURE
- STATE LEVEL SURGICAL QUIZ - QUIZ MASTER DR.C S RAJAN
- PROF.B.HANUMAIAH MEMORIAL ORATION
- PROF.M.AUTHIKESHAVALU MEMORIAL ORATION
- MILLENNIUM GOLD MEDAL AWARD - 2021

HURRY UP! REGISTER EARLY RS.500/-

-: FOR REGISTRATION & PAYMENT :-

State Bank of India
Tippu Sultan Palace Road Branch
Chamarajpet, Bengaluru-18.
Account No.: 57035392030
IFSC Code : SBIN0070242

Share the payment transaction ID or screenshort to cmeinsurgery@gmail.com

DR.VENKATACHALA K
PRESIDENT

DR. HARISH N S
HON SECRETARY

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Newsletter of Surgical Society of Bangalore

JULY 2021

Surgical Society of Bangalore A.S.I.C.C.
Millennium GOLD MEDAL AWARD – 2021

www.ssbasicc.org

Dear Doctor,

Applications are invited from young practicing surgeons for the Award of Surgical Society of Bangalore ASICC Gold Medal & Certificate of Merit. Eligible candidates (see below) should send the details of the scientific paper by email on or before 30th September 2021 to be presented at the special session to be held during the annual CSEP in November 2021.

We request the heads of the departments of all the teaching institutions to encourage young surgeons to participate in this contest.

ELIGIBILITY

1. The Candidate must have completed M.S. / DNB in General Surgery with 5 Years Post M.S/DNB Experience OR 2 Years Post M.Ch. Experience.
2. The Candidate must be below 45 years of Age.
3. The Candidate must be an eligible member of the Associations of Surgeons of India & Surgical Society of Bangalore ASICC.
4. The Candidate must be a practicing Surgeon in Bengaluru.

PRESENTATION

Duration of Presentation is 10 min. / (8 min Presentation – 2 min Discussion).

APPLICATION DETAIL

1. Title of the Subject, Full Text of the paper in not more than 1500 words, should be submitted to the Secretary, Surgical Society of Bangalore ASICC office, at I.M.A.House on or before 30th SEPTEBER 2021. [by email]

2. The Application should be accompanied by a brief Bio Data of the candidate which should include A.S.I Membership Number.

3. Office Address: - Surgical Society of Bangalore ASICC – I.M.A. House, Alur Venkata Rao Road, Chamarajpet, Bangalore – 560 018.
   - Office Time: 11 – 4 PM
   - Mobile - 9243108442
   - Email:- ssbasicc1974@gmail.com, cmeinsurgery@gmail.com
   - website:- www.ssbasicc.org

PROGRAMME

1. Date and Time of session will be intimated to the individual candidates.
2. Senior Professors in Surgery and Senior Surgeons will be the Honorary Judges.
3. The Millennium Gold Medal Award 2021 Paper Presentation will be held on 23rd Tue Nov 2021
4. The Name of the Successful Young Surgeon will be announced on 27th November during the CSEP 2021.

Dr. VENKATACHALA K
President

Dr. HARISH N S
Hon. Secretary

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Newsletter of Surgical Society of Bangalore

JULY 2021

Surgical Society of Bengaluru A.S.I.C.C.

www.ssbasicc.org

TRAVELLING FELLOWSHIP IN LAPAROSCOPY - 2021

Dear Doctor,

Warm greetings to you,

Surgical Society of Bangalore ASICC offers Travelling Fellowship in Laparoscopy to an eligible candidate on once a year basis.

- ***Applications are invited from eligible candidate which should be sent to the***
  Office Address:- Surgical Society of Bangalore ASICC – I.M.A. House, Alur Venkata Rao Road, Chamarajpet, Bangalore – 560 018.
- **Office Time: 11 – 4 PM / Mobile – 9243108442.**
  Email: ssbasicc1974@gmail.com, cmeisurgery@gmail.com, website: www.ssbasicc.org
- **The eligibility criteria are as follows.**

1. The award is aimed to encourage practicing member surgeon to visit another center in India for learning or upgrading his / her skills in Laparoscopic Surgery during 2021-22
2. The course in Laparoscopy should be of good reputation & standing for at least three weeks duration.
3. Postgraduate students are also eligible to apply for (Traveling Fellowship) who are Associate member of SSBASICC.
4. The Post M.S., General Surgery Candidate should be a member of the Surgical Society of Bangalore ASICC, with a special interest towards Laparoscopy.
5. The award would be given only once in a year and only once to a member.
6. The award will carry approximately Rs 5000/= as the award money and a citation.
7. The application for the award along with the details of the proposed training may be submitted to the Honorary Secretary with a brief Bio- Data, routed through the competent forwarding authority.
8. The award will be decided by the Executive Committee members of the corresponding year.
9. The decision of the committee would be final.
10. The award will be presented by the President – SSBASICC during the major event during 2021-22
11. The awardee should submit the Fellowship utilization report to the SSBASICC within 1 month of the visit.

The last date for receiving the Application for Travelling Fellowship in Laparoscopy is 30th SEPT 2021.

The Chosen Applicants Name will be announced on the "Annual Oration Day" which is scheduled to be held on 27th November 2021.

Dr. Venkatachala K
President

Dr. Harish N S
Hon. Secretary

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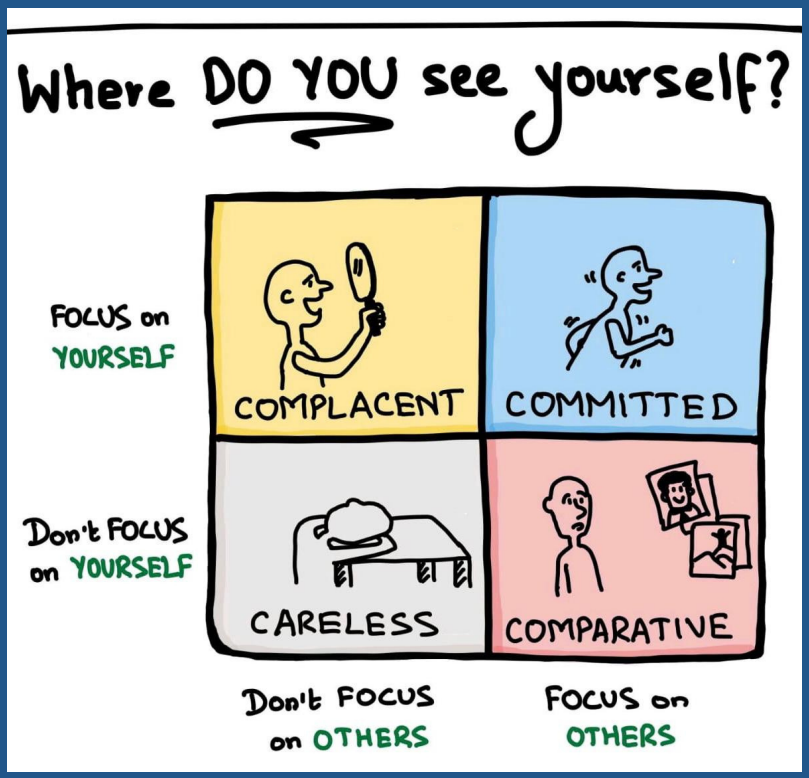
Newsletter of Surgical Society of Bangalore

JULY 2021



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Sushruta

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