

Sushruta

Newsletter of Surgical Society of Bangalore

Mar 2021

Dr. Venkatachala K
President Elect.

Dr.Sampath Kumar K
President Elect.

Dr.Harisha N S
Hon. Secretary

Dr. Manish Joshi
Hon. Jt. Secretary

Dr. Ramesh B S
Hon Treasurer



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Newsletter of Surgical Society of Bangalore

Mar 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

Mar 2021

Message from the President



Dear Members,

I must congratulate the Editorial team for bring out e-newsletter "SUSHRUTA" on a regular basis.

After one year gap, we initiated physical monthly clinical meeting in the month of March 2021. I must thank Dr. Sumit Talwar, HOD, Department of Surgery, Manipal Hospital for agreeing to our request and arranging a hybrid physical and virtual meeting. The members were excited to meet up and socialise after a long time. But, unfortunately , the second wave of the pandemic is worse than the first one. Hence, we are suspending physical meetings temporarily. We don't want our members to get infected or carry infection. We must lead by example. Hope that we will be able to hold physical meetings soon. Till then, stay safe, maintain adequate social distancing and follow strict personal hygiene measures.

Dr. Venkatachala K
President SSBASICC 2021



Best Poster:

Online Monthly Clinical Meeting – Presentations

Title : Lymphovenous Anastomosis: A Novel Prophylactic & Therapeutic Method for Lymphoedema



Presenter: Dr. Annika Marwah (I year resident , DNB Plastic Surgery)
Under the guidance of Dr. Ashok BC, Dr. Anantheswar YN, Dr. Srikanth V
Department Of Plastic Surgery, Manipal Hospitals, Bangalore

INTRODUCTION

Lymphoedema is a chronic, progressive, and debilitating condition caused by accumulation of protein rich fluid in the interstitium which leads to swelling, pain, infections and a decrease in patients' quality of life .

Lymphovenous Anastomosis is a novel prophylactic as well as therapeutic method for lymphoedema management.

Under high magnification, lymphatic vessels which are 200-800 μ are anastomosed to small veins, thereby bypassing the obstruction to prevent or relieve lymphoedema.

INFRASTRUCTURAL PRE-REQUISITES

ICG machine , high power microscope , supermicro instruments and micro sutures (10.0 11.0 ethilon micropoint)

Lymphoedema grading based on the lymphogram patterns post ICG injection are-

- Grade 1 –linear channels
- Grade 2 – splashes
- Grade 3- star dusting
- Grade 4- diffuse pattern



TYPES OF LVA

Primary LVA

involves the use of lymphatic-venous anastomoses for primary prevention of secondary lymphedema, performing anastomoses at the same time as axillary and inguinal lymph nodal dissection for the treatment of malignant tumors as axillary and inguinofemoral lymphadenectomy carries a high risk of lymphedema of extremities. called the (lymphatic microsurgical preventive healing approach – LYMPHA technique) which leads to a decrease In Incidence of lymphoedema from 16-52% to 4%.

PROCEDURE

cut end of the lymphatic is identified in the axilla post ICG injection, dilated to match the size of the chosen neighbouring vein and anastomosed using fine sutures. Patency of anastomosis is confirmed by the movement of the dye into the vein which can be visualised under the microscope and confirmed by an ICG lymphogram.

Secondary LVA

is Done for established cases of lymphoedema.

INDICATION -stage 2(splash)and early stage3 (stardust)

PROCEDURE

Includes doing An ICG scan to identify linear lymphatics which are marked and Under local Anaesthesia , through a small incision these lymphatics are connected to veins distal to block.

From the various studies done all over the world and the ongoing study at our institute which is based on serial post op monitoring by volume assessment and ICG,LVA is being proved to be quite a promising procedure to prevent an extremely morbid disease like lymphoedema

Title: Vascularized Lymph Node Transfer (VLNT): A Powerful Tool in Advanced Lymphoedema

Best Paper:



Under the guidance of Dr. Ashok BC, Dr. Anantheswar YN, Dr. Srikanth V
Department Of Plastic Surgery, Manipal Hospitals, Bangalore

INTRODUCTION

Lymphedema is a chronic, debilitating illness caused by build-up of protein rich fluid in the interstitial space, triggering inflammatory, immune and cellular responses, culminating in adipocyte hypertrophy, Fibrosis & Skin changes. Patients experience pain, swelling, recurrent infections, hampering daily activities and affecting quality of life. Causes of lymphedema may be Congenital, Traumatic, Inflammatory, Neoplastic & Others, of which post-filarial, post-mastectomy and congenital cases are commonly seen at our centre. Roughly 30 % of patients after Axillary Lymph Node dissection develop lymphedema, and the risk is higher in patients with higher BMI, total nodal clearance and post-operative radiotherapy. Patients can be assessed and tsgaed with Indocyanine Green Lymphograms and Serial volumetric analysis, and classified from Stage 1 to Stage 4. Vascularised Lymph Node transfer involves tranfer of lymph nodes based on a vascular pedicle from a healthy donor site to the lymphedematous area, leading to lymphatic decompression of the limb by means of Recanalisation, Lymphatic wick and Lymphatic pump mechanisms. It is indicated in Stage 3/4 lymphedema with stardust/ diffuse pattern; no fibrosis, no skin changes. Donor sites for Vascularised Lymph Nodes include the Groin, Omentum, Supraclavicular, Axilla, submandibular regions. Our study is a prospective study following up the cohort of all patients undergoing Vascularised Lymph Node transfer at our centre from 2019 onwards, followed up by Volumetric analyses and Indocyanine Green Lymphograms. 12 patients are being followed up. Preliminary studies showed a 21.25 % average reduction in Volume and wash-out of previously stagnant dye in Subsequent ICG scans post follow-up. Omentum proves to be a useful donor site for Vascularised Lymph Node harvest due to its surface absorption, numerous Lymph Nodes and minimal donor site morbidity by Laparoscopic Harvest and minimal secondary lymphedema.

Key Words:

VLNT, Lymphedema, Vascularised Lymph Nodes, Volumetry, ICG



2nd Prize:

Title: video assisted anal fistula treatment (vaaft): novel sphincter saving procedure for complex fistula in ano: our experience



Dr Sai Chaitra

Sai Chaitral Siju T Abraham¹ Sumit Talwar¹
1.Department of General and minimal access surgery,
Manipal Hospital, Bengaluru – 560017

BACKGROUND:

Video-assisted anal fistula treatment (VAAFT) is a novel minimally invasive sphincter-saving procedure for the treatment of complex fistula in ano. The aim is to describe our preliminary experience with VAAFT for the management of complex fistula in ano.

INTRODUCTION:

Complex fistula in ano management is one of the most challenging anorectal surgeries. Traditional techniques such as Fistulectomy, Fistulotomy, and seton placement are found to be associated with a high risk of incontinence, sphincter damage, and recurrence when used in the management of complex fistula in ano. There is a void in the management of complex fistula in ano, hence there is scope for novel techniques.

MATERIALS AND METHODS:

A retrospective analysis of patients who were diagnosed with complex fistula in ano and underwent VAAFT in General and minimal access surgery department of Manipal Hospital, Bangalore between May 2017 to December 2020. Patients with a radiologically confirmed



diagnosis of complex fistula in ano were advised to undergo VAAFT+ Fistulectomy/Fistulotomy+/- FiLAC. Post-operatively, all the patients were advised for follow-up on POD-3 followed by POD-10 and then monthly follow-up for 1 year.

RESULTS:

A total of 22 patients underwent VAAFT during the study period. The most common presentation was perianal discharge followed by a wound in the perianal region, while about 5 of the patients presented with the recurrent disease, 2 of them underwent >2 surgeries for fistula in ano in the past. Trans-sphincter fistula with 45.4% was the most common type of fistula noticed in the study group followed by supra-sphincter fistula with 36.7%. During the diagnostic step of VAAFT, multiple external openings were noticed in about 50% of the study population, while multiple fistula tracts, secondary branches, and blind-ending cavities were noticed in 81.8% of patients and internal opening couldn't be identified in 2 patients. The mean duration of the hospital stay was 1.23 days. During the immediate post-operative period, 5 patients had severe pain with VAS Score >6 requiring opioids for pain management. None of the patients had postoperative incontinence for either flatus or faeces. Persistence of discharge and external opening noticed in 9% of patients while recurrence was noticed in 18.1% of patients.

CONCLUSION:

VAAFT is a minimally invasive sphincter-saving procedure for the management of complex fistula in ano which allows real-time, direct endo-luminal visualization and destruction of the fistula tract while maintaining continence. According to our data, we can say that VAAFT is associated with high success rates, however multiple studies with long-term follow up have to be conducted to demonstrate the clinical effectiveness of VAAFT.

Keywords:

Video assisted anal fistula treatment, complex fistula in ano, Persistence of fistula, Recurrence

DR. K.V. Veerendra Kumar,

Ex. Maj.(AMC)

M.B.B.S., M.S. D.N.B., M.Ch.(Surgical Oncology), PGDHM,PGDMLE.

Former Professor & HOD, Kidwai Cancer Hospital

**4th Main Road, Ganganagar, Bangalore-560032, Phone: 23332723, Cell:
9741008370 Email : veerendra,prof@gmail.com.**



**DR. K.V. Veerendra
Kumar,**

Brief intro:

Born in Bangalore (CSI) and did my primary education in small towns (Channapatana and Kunigal). Studied up to 10th standard in Kannada medium. Later I did my PUC in National college and MBBS in BMC.

After MBBS, joined Military service and served for more than five years which included 2 years of stay in high altitude and retired as Major after Short Service Commission. After my defense service, joined Kidwai Cancer Institute on 07 November 1987 and severed till 28th February 2018.

Joined Kidwai as Assistant Surgeon, did my MS (General Surgery) from Command Hospital and M.Ch. (Surgical Oncology) from Kidwai Cancer Institute. After serving more than 30 years in Kidwai, retired as Prof and HOD of Department of Surgical Oncology.



**with my
colleagues and
students in OPD**

Mentors:

In my former years of life Mrs. Gowri primary school teacher, G. K, Nagaraj, National high school teacher and Dr. H. Narasimhaiah, National college teacher played a major part in introducing me to the world of honesty, rationality, ethicality and leading a happy life not only by word but by setting personal example.

During my MS at Command Hospital AVM Amresh was my mentor who taught me not only Surgery but also accepting mistakes bravely and honestly. My surgical principles as a surgeon are largely taught by him.

During my tenure in Kidwai large part of my service was working with Dr. Prabhakaran who introduced me to Major and Super Major surgeries. I not only learnt to do super major surgeries but also what not to do.



My Family



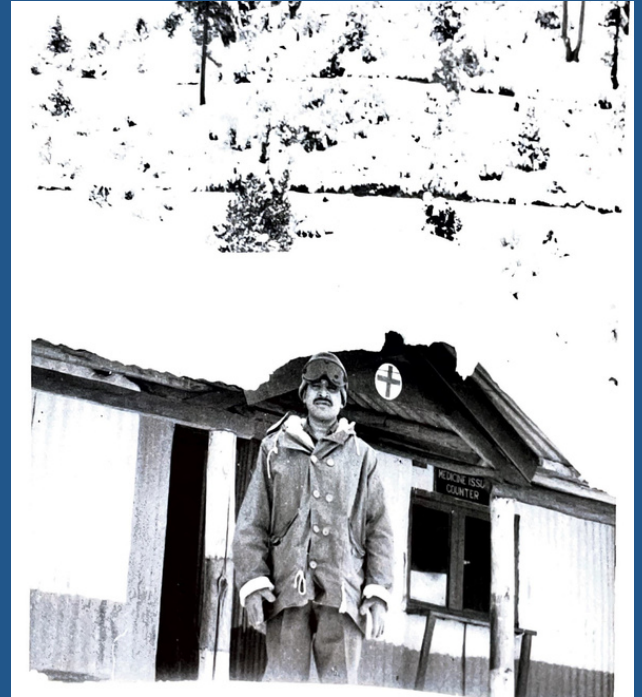
My Parents

Favorite Surgeries:

1. Trans hiatal and Trans Thoracic esophagectomy
2. Lung Resection
3. Mediastinal tumors

Reluctant Surgeries :

1. Right Hepatectomy – extended
2. Difficult and huge pelvic tumors



Receiving Mahadevan Award

Choosing surgery:

Classically it was like a typical Indian arranged marriage – first you marry then you starting loving her, I applied for both Medicine and Surgery at Kidwai but they selected me for the Department of Surgery and later on I was deeply in love with surgery especially Thoracic Surgery.

PG:

I did my MS in Command Hospital. Training was good under then GP Capt. Amresh, if anything I should have studied more.



one of my happy moments
with my young patient



Personal:

Hobbies: Teaching, reading, travelling and economy

Food: My favourite food is Biryani but recommend healthy food to all

Favourite book: Some of my favourite books are Vachanabaratha by A.R.

Krishnashastri , Marayaladeethe? by Belegera Krishnashastri, Fountain Head by Ayn Rand, Final Diagnosis by Arthur Hailey, Good Earth by Pearl S Buck, Roots by Alex Haley.

My favorite place: East India and Europe – Amsterdam and Germany (Leipzig)

Taking stress – Take a long walk

Key to your success – My wife.

Message to young surgeons: Have patience for success, It will not come over night, work hard. Talk to your patients patiently. Most important is enjoy your surgeries. This is the only profession where you enjoy doing your surgery for which you are not only paid but also respected. Hence have faith in your profession and be ethical.



last day of my service with
my colleagues of my Dept.



last day of my service
with OT staff



last day of my service with
my Anaesthesia colleagues

Professional Summary :

After serving >5 years in the army joined Kidwai Cancer Institute (KCI), served here for >30 years as surgical oncologist and finally retired as professor and HOD of department of surgical oncology. I also am a certified robotic console surgeon. I have been involved in various research activities including clinical trials and research on basic science.

I am a member of various oncology societies and served as GC member of European Society of Parenteral and Enteral Nutrition (ESPEN) and president of IAPEN. Served as vice president of IASLC (Indian Association of Study of Lung Cancer) for two terms (4 years). Published and presented many scientific articles both in clinical science and basic clinical research.

I was involved in various administrative responsibilities. I was in charge of the Kidwai Cancer Drug Foundation (KCDF) developed the facility. I have served as in charge RMO, MS, and Director for brief periods.



Speciality Training

- Diploma in Acupuncture at International Academy of Scientific Acupuncture, Bombay, India (6 months), 1980.
- Concept And Clinical Application Of Immunology at Indian Institute Of Science, Bangalore (6 months, Secured 'A' GRADE), 1988.
- UICC workshop on Research Methods in Cancer: Clinical Trials, Epidemiology, Audit at TATA Memorial Centre, Bombay, 1997.
- Training in "Photo Dynamic Therapy" at the National Medical Laser Centre, London, 1998.
- Underwent PEG placement training in Glasgow, UK.
- Certificate course in Essentials of Palliative Care at Kidwai Memorial Institute of Oncology, Bangalore, 2009.

Experience:

Designation Department Institution Duration

Medical officer in the rank of Captain and Major Military Hospitals and Regiments Indian Army Ministry of Defence 1981 -1986

Assistant Surgeon Surgical Oncology Kidwai Memorial Institute of Oncology 1987-1989

Registrar Surgery and Allied branches Command Hospital Air Force 1989-1991

Lecturer/ Assistant Professor Surgical Oncology Kidwai Memorial Institute of Oncology 1991-8/3/2000

Associate Professor Surgical Oncology and Chief of Thoracic Oncology Kidwai Memorial Institute of Oncology 9/3/2000 - 15/6/2013

Professor Surgical Oncology Kidwai Memorial Institute of Oncology 15/6/2013 - 28/2/2018

Education

M.B.B.S: 1981 Bangalore Medical College and Research Institute - Bengaluru, KA, India

MS (General Surgery): 1991 Command Hospital - Air Force Bengaluru, KA, India

Diplomate of the National Board (General Surgery): 1991 Command Hospital - Bengaluru, KA, India

M.Ch (Surgical oncology): 1995 Kidwai Memorial Institute of Oncology - Bengaluru, KA, India

Post Graduate Diploma : Medical Law and Ethics , 2001 National Law School of India University - Bengaluru, KA, India

Post Graduate Diploma : Hospital Management , 2003 Annamalai University - Chidambaram, TN, India



Awards

- YOUNG SURGEON'S GOLD MEDAL awarded By Rotary Club, Bangalore for Best Paper “Changing trends in surgical oncology”.
- DR. MAHADEVAN'S GOLD MEDAL FOR BEST PAPER “Transhiatal Oesophagectomy-surgical technique & training” awarded by Karnataka State Chapter - Association Of Surgeons Of India.
- DR. JOGLEKAR'S GOLD MEDAL FOR BEST PUBLISHED PAPER in INDIAN JOURNAL OF SURGERY “Role of adjuvant radiotherapy in soft tissue sarcoma- A retrospective analysis from Regional cancer centre”

Teaching experience

- Training Nurses - 32 Years
- Under Graduate In Medicine - 27 Years.
- Post Graduate In Surgery - 23 Years.
- Teacher for super speciality courses in M.Ch., Surgical Oncology. - 21 years
- Faculty Member of various postgraduate courses in Continuing Medical Education in Surgery, Surgical Oncology, Medical Oncology.
- Chairman and Examiner to M.Ch. Surgical Oncology. (Rajiv Gandhi University Of Health Sciences).

Participation in Clinical Trials

- Photo Dynamic Therapy In Oral Cancer.
- Inj. Gemcitabine In Lung Cancer.
- Inj. Gemcitabine In Breast Cancer - Randomized.
- Inj. Gemcitabine In Pancreas Cancer - Randomized.
- Docitaxel V/ S Docitaxel + mRNA Inhibitor In Advanced Lung Carcinoma.
- Role of Giftinab in Advanced Lung Cancer.

Participation in Nutrition training and conference

- 7th congress of PENSA 2001 at Bali, Indonesia.
- PENSA 2003 at Goa India.
- Clinical Nutrition Symposium 2007, Bangalore.



- Total Nutrition therapy Course, 2010 at Mumbai.
- Clinical Nutrition Expert Meeting, 2010, at Siem Reap, Cambodia.
- Guest Lecture at UAS, Bangalore on Micro Nutrients and Cancer, 2010.
- Guest Lecture to teachers of UAS on Nutrition 2011.
- ESPEN training program on nutrition therapy (12 credit course 2012).
- ESPEN conference as GC member Leipzig, Germany.

Guest Lectures

- Current concepts in the management of breast carcinoma – Bangalore City Chapter – Association of Surgeons on India.
- Epidemiology and risk factors in breast cancer - Karnataka State Chapter – Association of Surgeons of India, 1999.
- ‘Tobacco and Cancer’ – Indian Medical Association – Bangalore , 1998.
- Prevention of Oral Cancer – Karnataka State Chapter – Association of Surgeons of India, 2000.
- Faculty member in who training program on “Early Detection Techniques and Cancer Awareness” – at Bangalore, Mandya, Gulburgha- district of Karnataka, 2001.
- Faculty member at Ethicon Institute of Surgical Training for stapling technique, 2002.
- Cancer awareness program conducted by various organisations including Indian Society of Cancer.

Membership and Positions

Life Member : Indian Society Of Oncology.

Life Member : Indian Association Of Surgical Oncology.

Life Member : Association Of Surgeons Of India.

Life Member : Surgical Society Of Bangalore.

Life Member : Oncology Group, Bangalore & Editor

Life Member : International Association Of Palliative Care, Indian chapter.

Life Member : Karnataka Cancer Association

President : Indian Society For Parental & Enteral Nutrition

G.C. Member : European Society For Clinical Nutrition And metabolism (ESPEN)

Vice President : Indian Society For The Study Of Lung Cancer

Member : The International Association For The Study of Lung Cancer (IASLC)

Member : European Society For Medical Oncology (ESMO)

Member : European Society of Surgical Oncology (ESSO)



Papers presented and Published

1. Management perspective of male breast cancer – a 10 years study – 5th National Cancer Congress of the Indian society on oncology – 1992.
2. Soft Tissue Sarcoma of Trunk and Extremities – An analysis of 190 Cases - 10th Asian Pacific Federation Congress of International College of Surgeons – 1993.
3. Sacral Chordoma – Experience at a Regional Cancer Institute – 10th Asian Pacific Federation Congress in International College of Surgeons – 1993.
4. Soft Tissue Sarcoma – Clinico – Pathological study and effect of R.T. on local control – XVI International Cancer Congress – 1994.
5. Sacral Chordoma – An Indian experience – XVI International Cancer Congress – 1994
6. Retrospective analysis of Stomach Cancer – VII National Cancer Congress – 1996
7. Transhiatal Oesophagectomy – 15 year experience – Association of Surgeons of India – 1997
8. Written a chapter in ‘Monograph on Thyroid Cancer’ published by Japan International co-operation agency – 1997
9. Transhiatal oesophagectomy stricture dilation using Foleys Catheter – a novel method – IX Biennial National Conference of Indian Society of Oncology – 2000.
10. Surgery for oesophageal carcinoma – Transhiatal Oesophagectomy result of 150 cases – Surgical Society Karnataka State Chapter – 2002.
11. Concurrent Chemo Radiation in Oesophageal carcinoma – Karnataka State Chapter of Surgical Society – 2003.
12. Transhiatal Oesophagectomy complications. – International work shop in Oesophageal Cancer – Cochin – 2003.
14. Lung resection – Technique, complications and results – Surgical Society of Bangalore – 2004.
15. Simple dilatation of anastomotic strictures following Oesophagectomy in unsedated patients – eur. J. Surg. Oncology 2006 july 7 ; 16831532.
16. Genome wide mRNA profiling of esophageal squamous cell carcinoma for identification of cancer biomarkers – Cancer Biology & Therapy 2009.



17. Over-expression of periostin and lumican in esophageal squamous cell carcinoma. *Cancers* 2010, 2(1), 133-142; doi:10.3390/cancers2010133
18. "Quantitative tissue proteomics of esophageal squamous cell carcinoma for novel biomarker discovery" has been accepted in *Cancer Biology and Therapy* journal.
19. Hormone receptor status of women with breast cancer, an Indian scenario— study of hospital cancer registry data - paper presented
20. At Mahatma Gandhi National Institute of Research and Social Action (MGNRISA) Hyderabad, India 2010
21. Poster presentation of Castleman's disease of the Pleura - a case report and giant solitary fibrous tumor of the pleura - a case report and review of literature at 14th world conference on lung cancer held in Amsterdam 2011
22. Castleman's disease of the pleura: a case report has been published in *General Thoracic and Cardiovascular surgery*
23. Predictability of response to anti-EGFR treatment with respect to assessment of receptor status in different geographical population with lung cancer (NSCLC) presented at American Association for Cancer Research in Jan 2011 at San Diego, USA.
24. Giant solitary fibrous tumor of the pleura - the *Indian Journal of Chest diseases & allied sciences*. Vol. 54 2012
25. Evaluation of protein expression pattern of stanniocalcin 2, insulin-like growth factor-binding protein 7, inhibin beta a and four and a half lim domains 1 in esophageal squamous cell carcinoma. *Cancer biomarkers: section a of disease markers* 2012;12(1):1-9.
26. Sacral chordomas: a 10 - year study. *Australas radiol* 42: 1, 42-46, 1998.
27. "Simple dilatation of anastomotic strictures following oesophagectomy in unsedated patients", *European Journal of Surgical Oncology*. 2006. 32, 1015-10128.
28. "Relationship between risk factor and dietary intake of oesophageal cancer patients". *Journal of Human Ecology*. 2005. 17, 39-42.
29. "Effect of intervention on the nutritional status of selected cancer patients. *Journal of Human Ecology*". 2004. 16, 189-192.
30. "A Comparison of Postoperative Early Enteral Nutrition with Delayed Enteral Nutrition in Patients with upper gastrointestinal malignancies: A study at tertiary cancer center in south India". *IJSR - International Journal Of Scientific Research* volume-6 | issue-3 | march - 2017 • issn no 2277 - 8179
31. "Breast Cancer with Synchronous Renal Cell Carcinoma: A Rare Presentation", *JCDR, Journal of clinical and diagnostic research Oncology Section* DOI : 10.7860/JCDR/2016/20362.8683, Year : 2016 | Month : Oct | Volume : 10 | Issue : 10
32. "Are all palpable lymph nodes positive in penile cancer? retrospective study", *International Surgery Journal Int Surg J*. 2016 Nov;3(4):2083-2086
33. Papillary Carcinoma in Median Aberrant Thyroid (Ectopic) - Case Report



Contralateral exploration and repair of occult inguinal hernias during laparoscopic inguinal hernia repair: systematic review and Markov decision process

N H Dhanani et al. BJS Open. 2021.

BJS Open. 2021 Mar 5;5(2):zraa020.

doi: 10.1093/bjsopen/zraa020.

CONTRALATERAL HERNIA

DO YOU EXPLORE
AND REPAIR OCCULT
GROIN HERNIA ON
THE OTHER SIDE

Authors

N H Dhanani 1, O A Olavarria 1, S Wootton 2, M Petsalis 1, N B Lyons 1, T C Ko 1, L S Kao 1, M K Liang 1

Affiliations

1Department of Surgery, Lyndon B. Johnson General Hospital, McGovern Medical School at UTHealth, Houston, Texas, USA.

2Department of Pediatrics, Memorial Hermann Children's Hospital, McGovern Medical School at UTHealth, Houston, Texas, USA.

PMID: 33688950

DOI: 10.1093/bjsopen/zraa020



Background:

Contralateral clinically occult hernias are frequently noted at the time of laparoscopic unilateral inguinal hernia repair. There is no consensus on the role of contralateral exploration and repair. This systematic review assessed the safety and efficacy of operative repair of occult contralateral inguinal hernias found during unilateral repair.

Methods:

PubMed, Embase, and the Cochrane Central Register of Controlled Trials were searched from inception to February 2020. Adults diagnosed with a unilateral inguinal hernia undergoing laparoscopic repair were included. The primary outcome was the incidence of occult contralateral hernias. Summative outcomes of operative and expectant management were reported along with development of a Markov decision process.

Results:

Thirteen studies (1 randomized trial, 12 observational cohorts) with 5000 patients were included. The incidence of occult contralateral inguinal hernias was 14.6 (range 7.3–50.1) per cent. Among patients who underwent repair, 10.5 (4.3–17.0) per cent experienced a postoperative complication. Of patients managed expectantly, 29 per cent later required elective repair for symptoms. Mean follow-up was 36 (range 2–218) months. Using a Markov decision process, it was calculated that, for every 1000 patients undergoing unilateral inguinal hernia repair, contralateral exploration would identify 150 patients with an occult hernia. Repair would result in 15 patients developing a postoperative complication and 105 undergoing unnecessary repair. Alternatively, expectant management would result in 45 patients requiring subsequent repair.

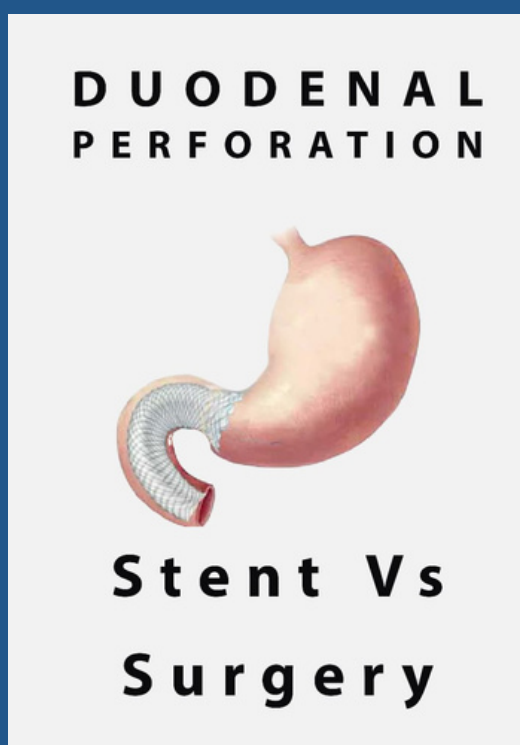
Conclusion:

Contralateral repair is not warranted in patients with occult hernias diagnosed at the time of elective hernia repair. The evidence is largely based on observational studies at high risk of bias.

Stent treatment or surgical closure for perforated duodenal ulcers: a prospective randomized study

Jorge Alberto Arroyo Vázquez et al. Surg Endosc. 2020.

Surg Endosc. 2020 Nov 30.
doi: 10.1007/s00464-020-08158-3. Online ahead of print.



Authors

Jorge Alberto Arroyo Vázquez 1 2, Kaveh Khodakaram 3, Maria Bergström 4 5, Per-Ola Park 4 5

Affiliations

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5University of Gothenburg, Sahlgrenska Academy, Gothenburg, Sweden.

PMID: 33258032

DOI: 10.1007/s00464-020-08158-3



Background:

Perforated peptic ulcer is a life-threatening condition. Traditional treatment is surgery. Esophageal perforations and anastomotic leakages can be treated with endoscopically placed covered stents and drainage. We have treated selected patients with a perforated duodenal ulcer with a partially covered stent. The aim of this study was to compare surgery with stent treatment for perforated duodenal ulcers in a multicenter randomized controlled trial.

Methods:

All patients presenting at the ER with abdominal pain, clinical signs of an upper G-I perforation, and free air on CT were approached for inclusion and randomized between surgical closure and stent treatment. Age, ASA score, operation time, complications, and hospital stay were recorded. Laparoscopy was performed in all patients to establish diagnosis. Surgical closure was performed using open or laparoscopic techniques. For stent treatment, a per-operative gastroscopy was performed and a partially covered stent was placed through the scope. Abdominal lavage was performed in all patients, and a drain was placed. All patients received antibiotics and intravenous PPI. Stents were endoscopically removed after 2-3 weeks. Complications were recorded and classified according to Clavien-Dindo (C-D).

Results:

43 patients were included, 28 had a verified perforated duodenal ulcer, 15 were randomized to surgery, and 13 to stent. Median age was 77.5 years (23-91) with no difference between groups. ASA score was unevenly distributed between the groups ($p = 0.069$). Operation time was significantly shorter in the stent group, 68 min (48-107) versus 92 min (68-154) ($p = 0.001$). Stents were removed after a median of 21 days (11-37 days) without complications. Six patients in the surgical group had a complication and seven patients in the stent group (C-D 2-5) (n.s.).

Conclusions:

Stent treatment together with laparoscopic lavage and drainage offers a safe alternative to traditional surgical closure in perforated duodenal ulcer. A larger sample size would be necessary to show non-inferiority regarding stent treatment.

Keywords:

Duodenal stent; Peptic ulcer perforation; Perforated duodenal ulcer.



'C S LESSONS' FOR INGUINAL HERNIA SURGERY :Dr C S Rajan

1. 10 Pre-operative Commandments for Inguinal Hernia (All Cs)

- 1) Correct Clinical Assessment, rule out the decoy hernia.
- 2) Confirm the need for surgical repair (? 'watchful waiting' is an option!)
- 3) Counsel on ALL available options of repair, Lap vs Open.
- 4) Choose the form of repair best suited for the patient. [NO SINGLE OPTION IS FIT FOR ALL]
- 5) Consent must be fully informed and to be taken by the operating surgeon
- 6) Certainty about your own strengths and weaknesses
- 7) Complete knowledge about all the prosthesis and fixation devices being used.
- 8) Confidence, with ability to handle one's own complications
- 9) Chronicled long term follow up for delayed complications and recurrence.
- 10) Careful documentation, that is simple and adequate, including follow up visits

2. A Score (10 x 2) operative commandments for OPEN inguinal hernia MESH repair - All Ss

- 1) Skin incision to be transverse inguinal
- 2) Split external oblique muscle and external ring to enter the canal
- 3) Sharp, in situ dissection of cord, safe guard nerves, open cremasteric box, and identify sac.
- 4) Sac handling
 - i) Indirect sac: Isolate in the canal, preserving all other structures, divide sac, the proximal end ligated at deep ring (herniotomy), distal sac laid open.
 - ii) Direct sac: dissect free, invaginate through defect, plicate transversalis fascia over it.
- 5) Size of cremasteric bulk reduced, bring cord out of the canal;
- 6) Suture repair (Lytle's) of deep ring, if indicated.
- 7) Soft, large pore mesh prosthesis, 7.6 x 15 cm (3" x 6") chosen
- 8) Select non-absorbable monofilament suture for anchoring mesh (2/0 – 3/0)
- 9) Start fixation, on to rectus sheath, 2 cm medial to the pubic tubercle.
- 10) Slack (loose) running suture of the lower edge of the mesh, to the inguinal ligament, from pubic tubercle to deep inguinal ring.
- 11) Slit mesh to fish tail mesh over emerging cord at deep ring;
- 12) Slide (tuck) mesh and tails to lie under the external oblique muscle, lateral to deep ring.
- 13) See to it that the mesh has floppy placement - NOT stretched, flat, or snug.
- 14) Superiorly, fix the mesh to the conjoint tendon with 2 – 3 loose, mediolateral placed sutures.
- 15) Survey (check) for inadvertent nerve trapping by the sutures



- 16) Secure, confirm full haemostasis, replace the cord in the canal,
- 17) Shut (close) external oblique over the mesh, taking the suture through the edges of the tails of the mesh lateral to deep ring.
- 18) Subcuticular skin to complete the layered closure; no drain.
- 19) Sealing dressing, light
- 20) Scrotal tug on ipsilateral testis to restore anatomical position.

3) 10 commandments of Laparoscopic Inguinal Hernia repair – All ‘Ls’...!

(Modified from Edward Felix, MD: 2016 Annual Global Symposium on Robotic-Assisted and Minimally Invasive Hernia Repair)

- 1) Lower posterior abdominal wall, is focus of dissection across the midline to expose 3 potential hernia sacs. If you do not see the entire floor, you have NOT done a proper dissection.
- 2) iLiac vein to be seen[no need to expose it] to avoid missing a femoral sac.
- 3) Lipoma of cord to be sort for in tissue lateral to the vas deferens and gonadal vessels. It may be tiny but could be large once you start pulling it out.
- 4) Likewise, same area to prevent missing the tail of an indirect sac, that could lead to recurrence.
- 5) Laterally and inferior dissection far enough so that the peritoneum does not lift the mesh when it re- expands; it should be a big space (enough to fit a transplanted kidney!)
- 6) Lifting of mesh by enlarging bladder prevented by extension of the the mesh below the pubis, between the pubis and the bladder.
- 7) Large enough mesh to cover the three potential hernia sites and the pubis widely.
- 8) Leave no holes or gaps in peritoneal cover of mesh.
- 9) Let the inguinal hernia approach be the best fit for the patient; it could be the Open, TEP or TAPP
- 10) Limit one’s self to the principles of posterior hernia repair, through steps 1 to 9, whether you do a TAPP, TEP, E- TEP or even an R-TEP

4). Post- operative Complications Seen, and their Commended Solutions are (all in ‘C S’ terms)

(for BOTH, the open and the minimally invasive surgery options)

- 1) Common Seroma in wound / groin, best left alone to get absorbed
- 2) Congested Scrotum – transient pain and/or swelling, use scrotal support
- 3) Cut’s Sting - immediate post op pain, oral analgesics suffice



- 4) Curtain Sepsis – mesh Infection / rejection, both are dreaded, with high morbidity, will ultimately need mesh explant
- 5) Continued Soreness – inguinodynia, delaying recovery, affecting Quality of Life scores, will need counselling and physiotherapy. Can try local Cortico-Steroid injections at specific pain trigger points in that groin. May need to Consider Surgery again to explant mesh.
- 6) Circulation Subtraction to gonad –Ischemic orchitis, (infarction leading to atrophy) with orchalgia, is also unpleasant, and may need surgical exploration / orchidectomy
- 7) Coital Sensitivity – Dysejaculatory syndromes in a few, settle with counselling and time
- 8) Crying Symphysis denotes pain due to osteitis pubis, also needs counselling, and analgesics
- 9) Chronic Sinus
 - a) In Open surgery : located over scar – due to a Contrite Suture of a bulky polypropylene knot, explore under LA and remove Causative Strand/s of polypropylene
 - b) In Minimally Invasive surgery – has more Challenging Sources of origin
 - i) Curtain Sepsis : as part of No 4 above
 - ii) Cursed Suppurations of non-caseating granulomatous infections of abdominal wall
- 10) Comes Second time, the unwelcome recurrence...!
 - = PCut & Suture (Anterior) repair recurrence – repair by Closed Solution (MIS) approach
 - = Closed Solution (MIS) repair recurrence – repair by Cut & Suture (Anterior) approach

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Trivia : courtesy Dr Rajshekar Halkud [x]



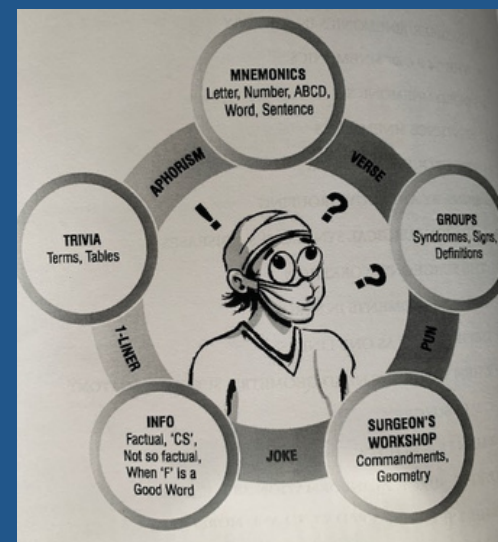
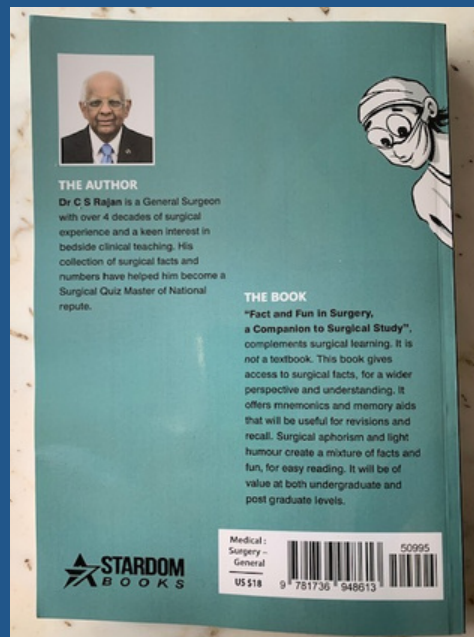
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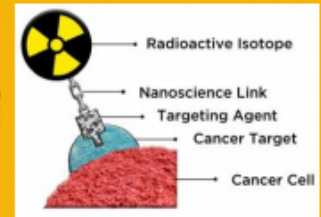
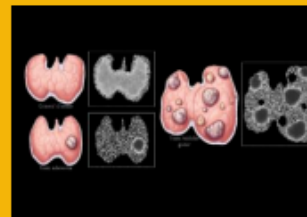
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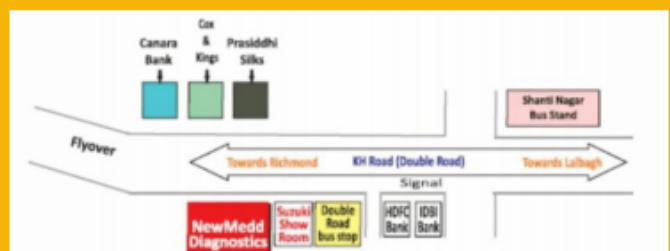
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