Sushruta

Newsletter of Surgical Society of Bangalore

Apr 2021

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

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Newsletter of Surgical Society of Bangalore

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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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Message from the President

Dear Members,

With the pandemic reaching its peak, the number of positive cases are building up, as well as the criticality of the patients and the number of deaths. The ray of hope is that majority are recovering. Stay safe and stay healthy. We have to move on to virtual platform for our monthly clinical meetings and CMEs for the time being.
Until the situation improves, we will continue with online meetings.

Dr. Venkatachala K
President SSBASICC 2021

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Online Monthly Clinical Meeting

SURGICAL SOCIETY OF BENGALURU ASICC (R)

[47 years] 1974 – 2021]

www.ssbasicc.org

DR VENKATACHALA K	DR SAMPATH KUMAR K	DR HARISHA N S	DR MANISH JOSHI	DR RAMESH B S
President	President Elect	Hon Secretary	Hon Jt.Secretary	Hon Treasurer
9845671017	9900515287	9535200453	8197910166	9845472444
drvenkat24@gmail.com	sampath17k@gmail.com	drharishans@gmail.com	docjoshi@gmail.com	rameshshamburao@yahoo.co.in

Dear Doctor, *13th May 2021*

You are invited for the 5th Online Monthly Scientific Meeting of the Year 2021.

DATE: - Wednesday 19th May 2021

HOSTS: - Private Surgeons of Bangalore & Corporate Hospitals

ONLINE: https://us02web.zoom.us/u/kbKYqRIF4o
Meeting ID: 820 3382 0597
Passcode : 106676
Please login at 4 -45 pm (All The PG's & Members of SSBASICC)

5-00 to 5-45 PM: -Enterocutaneous Fistula Interesting Case Capsule:-
BY DR. SHIVARAM, ASTER CMI HOSPITAL

E - POSTERS: 05:45 PM To 6-30PM (Private Surgeons of Bangalore)

1. Case Report Of Paraganglioma	Dr. Vishak,Bbh.
2. Case Report Of Ameloblastoma	Dr. Adarsh, Bbh.
3. Case Report Of Chordoma --	Dr. Pankaj/Rahul, Bbh.
4. Choledochal Cyst Our Experience	Dr. Arpith, Bbh.
5. HIPEC Our Experience	Dr. Ninu, Bbh.
6. An Unusual Presentation Of Intestinal Lymphoma	Dr. Susmitha Barama, Bmjh.
7. A Rare Case Of Omental Infarction	Dr. Sriram, St. Philomenas Hospital
8. Flexor Tendon Reconstruction –	Dr. Sameer, St. Philomenas Hospital
9. A Case Of Pseudopapillary Tumor Of Head Of The Pancreas	Dr. Anjali, St. Philomenas Hospital.

E- PAPERS: 6:30 PM TO 7:30 PM (Private Surgeons of Bangalore)

1. Comparative study of total extraperitoneal inguinal hernia mesh repair with or without tackers - **Dr. Pankaj, BBH.**
2. Comparision of GCS and CT brain findings in patients with traumatic brain injury – **Dr. Adarsh, BBH**
3. Comparative study between endovascular laser ablation and radiofrequency ablation for treatment of varicose veins of lower limbs – **Dr. Durga Prasad, BMJH**
4. Follow up on different methods of haemorrhoidectomy – **Dr. Monish Rajkumar, Sparsh Super speciality Hospital.**
5. Myotomy with Fundoplication: Is it a one stop solution for Achalasia – **Dr. Raghunath, Fortis Hospital, Bangalore.**
6. Is the E TEP RS new gold standard for medium sized,primary, and Midline Ventral Hernia Defects? An experience of 182 cases – **Dr. Saurabh Mishra / Dr. Gowtham,Apollo Hospital.**

7-30PM *ANNOUNCEMENTS*

Note: Inform and encourage your postgraduates to login online PG teaching program by 4:45pm

Dr. VENKATACHALA K
President

Dr. HARISHA N S
Hon Secretary

1st Floor, IMA House, Alur Venkata Rao Road, Bengaluru 560 018, Telefax 080 26705691 / Mob – 9243108442 ssbasicc1974@gmail.com

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Interview with Surgeon

First Paediatric Surgeon in Karnataka

Dr. B.V. RAMALINGA SETTY

M.B.B.S. (Mysore) F.R.C.S (Edin) F.R.C.S. (Glasg)

Hon. visiting Professor of Pediatric Surgery
Dr. B. R. Ambedkar Medical College
Bangalore.

Former President
Surgical Society of Bangalore
Bangalore Pediatric Society.
Beautify Levelle Road Associatin

Life Member
National Neonatalogy Forum
Indian Red Cross Society

Former Chairman
Karnataka State Chapter of Indian Association.
Pediatric Surgeons.
Bangalore Chapter of Indian Medical Association.
Academy of Medical Specialists.
Bangalore Chapter of Association of Surgeons of india.

Former Vice - President
Indian Medical Association _ Bangalore Branch.

Former Honorary Pediatric Surgeon
St. Martha's Hospital - St John's Medical College.
Vani Vilas Children's Hospital - Bangalore Medical College

Life Member
Rotary Club of Bangalore
International Music & Arts Society

Dr Ramalinga Setty

Introduction:

Name : Dr.B.V.Ramalinga Setty.
Date of Birth : 30th August 1943
Place Of Birth : Davangere Karnataka
LMP : 1954 Bangalore Medical School
M.B.B.S : Mysore Medical College 1958
Lecturer in Anatomy : J.J.M. Medical College Dvanagere 1959

Departed to the united kingdom 1960.

Completed FRCS (EDIN) and FRCS (GLASGLOW) and worked as senior registrar in the Alder Hay Childrens hospital liverpool and at the Royal Victoria Infirmary Newcastle - upon-tyne.

Returned to india in 1967

was the first Pediatric surgeon in Karnataka.

joined as honorary pediatric surgeon at the St. Marthas hospital S. Johns medical college vanivillas hospital and bangalore medical college.

Started an exculsive pediatric surgical center on residency road in 1971.

Opened a multi speciality on Lavelle road in 1975.

Hon. visiting professor of pediatric surgery to the Dr. B.R. Ambedkar medical college Bangalore.

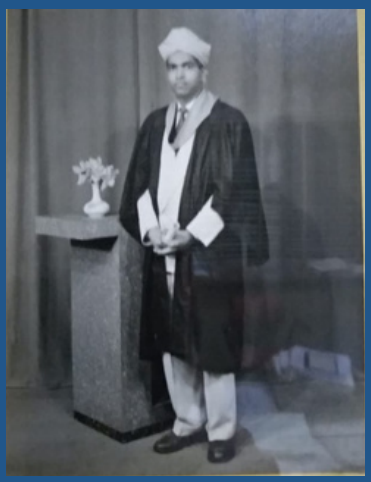
Has since retired leading a healthy life.

Acheivements:

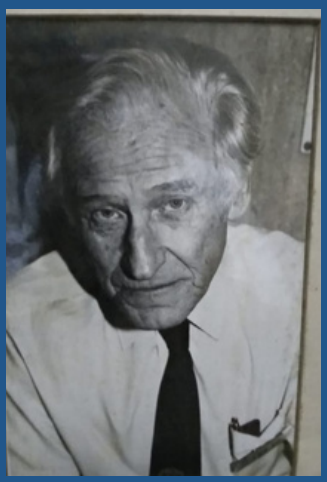
President : Surgical Society of Bangalore.
Bangalore pediatric society
Beautify lavelle road association

Chairman : Bangalore chapter of ASI bangalore
Bangalore chapter of IMA academy of medical specialists
Karnataka chapter of indian association of pediatric surgeons

Member : Rotary club of bangalore
National neonatology forum
Indian red cross society



MBBS convocation



His Chief Mentor :
Mr John Scott

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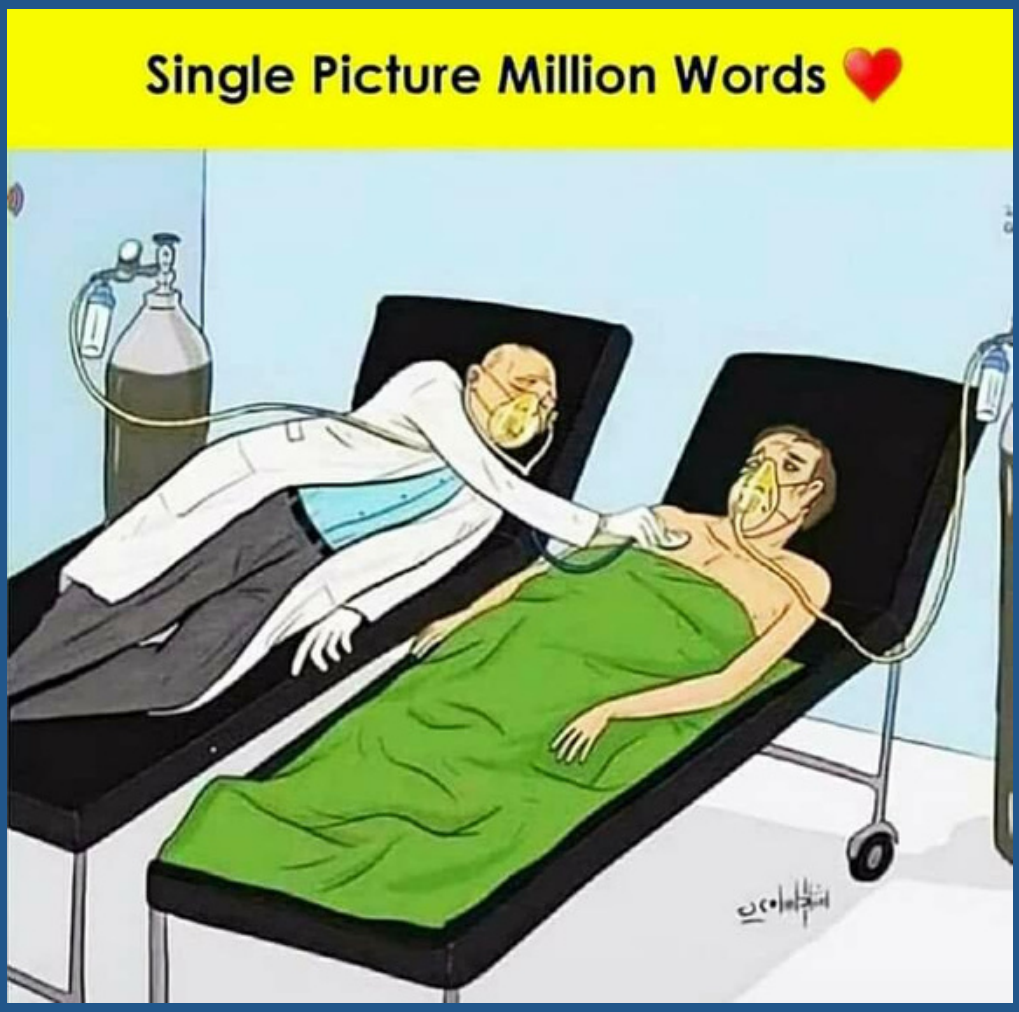
Mentors : MR. John Scott - livepool
Miss Farshall - liverpool
MR Harold Nixon - newcastle - upon-tyne
MR Peter Richham - newcasle-upon-tyne

Favorite Surgeries : Ramstedt operation
Recto - sigmoidectomy for hirschprungs disease
Repair of cleft lip and palate.

Reluctant Surgery : Tonsillectomy

Why i choose surgery : wanted to do surgery and pediatric surgery as a branch was not present in the state of karnataka

Message to young surgeons : Be honest hardwork choose your speciality early.



Trivia
courtesy : Dr Kalaivani V

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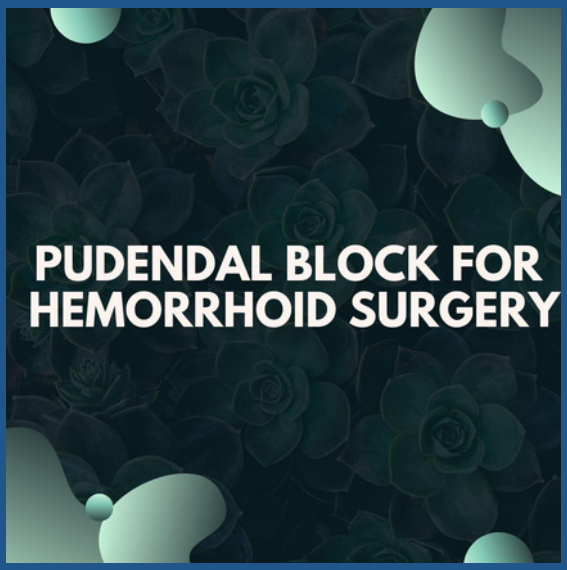
Pudendal Nerve Block In Hemorrhoid Surgery: A Systematic Review and Meta-analysis

Francesco Mongelli et al. Dis Colon Rectum. 2021.



Authors

Francesco Mongelli 1, Giorgio Treglia, Davide La Regina, Matteo Di Giuseppe, Jacopo Galafassi, Pietro E Majno-Hurst, Dimitrios Christoforidis

Affiliation

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PMID: 33591044
DOI: 10.1097/DCR.0000000000001985
Full text links
Cite

Background:

Postoperative pain represents an important issue in traditional hemorrhoidectomy. Optimal pain control is mandatory, in particular in a surgical day care setting.

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Objective:

The aim of this study was to investigate the use of pudendal nerve block in patients undergoing hemorrhoidectomy.

Data sources:

PubMed, Google Scholar, Cochrane Library and Web of Science databases were searched up to December 2020.

Study selection:

Randomized trials evaluating the pudendal nerve block effect in patients undergoing hemorrhoidectomy.

Interventions:

Hemorrhoidectomy under general or spinal anesthesia with or without pudendal nerve block.

Main outcome measures:

Opioid consumption, pain on the visual analogue scale, length of hospital stay and readmission rate were the main outcomes of interest and were plotted by using a random-effect model.

Results:

The literature search revealed 749 articles, of which 14 with were deemed eligible. A total of 1,214 patients was included, of whom 565 received the pudendal nerve block. After hemorrhoidectomy, patients in the pudendal nerve block group received opioids less frequently (relative risk 0.364, 95%CI 0.292;0.454, $p<0.001$) and in a lower cumulative dose (standardized mean difference -0.935, 95%CI -1.280;-0.591, $p<0.001$). Moreover, these patients

experienced less pain at 24 hours (standardized mean difference -1.862, 95%CI -2.495;-1.228, p<0.001), had a shorter length of hospital stay (standardized mean difference -0.742, 95%CI -1.145;-0.338, p<0.001) and a lower readmission rate (relative risk 0.239, 95%CI 0.062;0.916, p=0.037). Sensitivity analysis excluded the occurrence of publication bias on the primary endpoint and the overall evidence quality was judged "high".

Limitations:

Occurrence of publication bias among some secondary endpoints and heterogeneity are main limitations.

Conclusions:

This systematic review and meta-analysis shows significant advantages of the pudendal nerve block use. A reduction in opioid consumption, postoperative pain, complications and length of stay can be demonstrated. Despite limitations, pudendal nerve block in patients undergoing hemorrhoidectomy should be taken into account.

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Hand Rule of 5 for a Robust Gastric Conduit in Minimal Access Onco-Surgery

Jaganath Dixit1,2 & Anand Subash1 & Naveen Gowda1 & H. Deepak1 & Amanulla1

Introduction

Esophagectomy today has become an integral part of the curative treatment of locally advanced esophageal cancer. The surgical procedure is challenging, with a high postoperative complication rate and mortality rate among gastrointestinal interventions

[1]. Several different techniques for esophagectomy have been described in the past; in recent years, minimally invasive surgery and robotic-assisted thoracoscopic esophagectomy have taken precedence

[2]. Minimally invasive/robotic esophagectomy offers an innovative strategy for the management of resectable esophageal cancer. However, success of this intervention is well founded on the conduit design to restore continuity. Failure of the conduit can be potentially prevented by subtle technical modifications.

In this article, we discuss 5 important rules/tenets which could help create a robust and effective gastric conduit in minimal access surgery and to mitigate complications.

Rule 1

Numerous and persuasive explanations have been provided favoring a cervical anastomosis. Of the various modifications, creating a conduit along the greater curvature and a cervical anastomosis offer superior surgical and functional outcomes with a reduction in the incidence of fatal mediastinitis. The understanding of the vascularity to the conduit has led to optimization of the technique and better success rates. A less than optimal blood supply in the anastomotic site results in necrosis and leaks

With our current understanding, the gastric tube receives its vascularity entirely from its caudal end, through the right gastro-epiploic and right gastric artery veins. When making the cranial cut, an oblique cut directed from lesser curvature to greater curvature preserves additional vascularity to the anastomosis

(Fig. 1).
Some authors have suggested supercharging the cervical
end to reduce the risk of anastomotic site necrosis.

Rule 2

Iatrogenic squeezing, bruising, or kinking of the feeder vessels
or their tributaries can set the stage for ischemia and anastomotic dehiscence. Other factors compromising the adequacy
of the blood supply include damage to the left gastric and short
gastric arteries, anatomical variations, and vessel wall changes
[3].
When mobilizing the conduit from the abdomen, the diaphragmatic hiatus has to be widened to at least 5 cm to prevent
any pressure causing impairment of the vascular supply
(Fig. 2).

Rule 3

The gastric conduit is regarded as the workhorse for esophageal reconstruction, and the preferred choice among the senior
and younger surgeons alike. The incision placement and access are key determinants in creating a good conduit. Midline
incision is the preferred incision despite the complications
associated with it.
Minimal invasive technique is supported by better
magnification. This helps the surgeon several fold. We
recommend placing an incision in the midline 5 cm below the xiphisternum and 5 cm above the umbilicus in a
normal scaphoid abdomen. Following this, a wound protector can be used to gain better access and visualization (Fig. 2). Applying traditional self-retaining retractors
could injure the vascularity of the conduit and best
avoided. With a wound protector, adequate working
space is created to deliver the specimen and do a feeding
jejunostomy

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Fig. 1 Schematic diagram showing vascularity of stomach

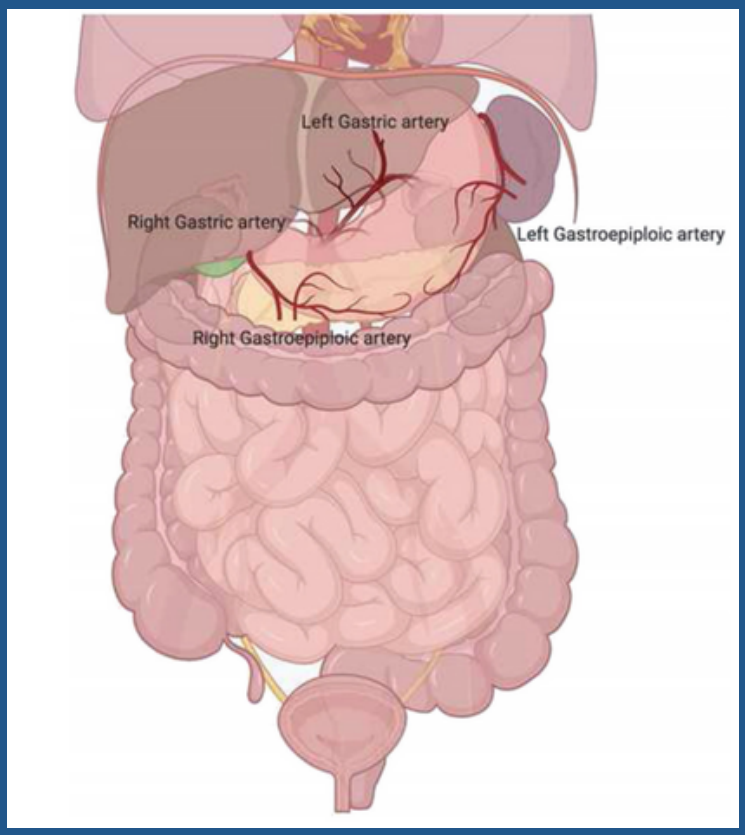

Fig. 2 Abdominal incision with the wound protector to increase working space and the harvested gastric conduit

Rule 4

The width of the conduit has been a widely debated point in esophageal surgery. Proponents of a wide conduit cite improved vascularity and strength at the anastomosis as the advantages. In our experience, we have noted that for best functional outcomes the conduit width should be no lesser than 4–5 cm (Fig. 2). A wide conduit can result in stasis and increase reflux, impairing quality of life.

The best route of reconstruction after esophagectomy is the posterior mediastinum because it is the most physiologic and the shortest way and this was popularized by Akiyama.

A slack conduit can result in postoperative discomfort. We have noted that approximating the mediastinal pleura reduces this discomfort and further stabilizes the conduit, reducing tension at the anastomotic site.

Rule 5

Adequate conduit length is critical to have a tension-free cervical anastomosis to prevent anastomotic leaks. Suturing techniques can result in conduit shortening. We recommend use of multiple endostaplers. We use Linear Endostaplers blue cartridge (3.6-mm height with 1.5–1.75-mm thickness) or green cartridges (4.1-mm height with 2.0–3.25-mm thickness)

manufactured by Ethicon or alternately GIA-Tri Staple technology purple cartridge (3–3.5–4-mm height and 1.5–2.25-mm thickness) by Covidien. We avoid serosal suturing to prevent shortening of the conduit. It is best to use the 45 stapler cartridge above the pylorus along the lesser curvature to get better angulation and subsequently 60 stapler cartridge (Fig. 3) [4]. In our experience, a conduit of sufficient length often requires 4–5 such cartridges.

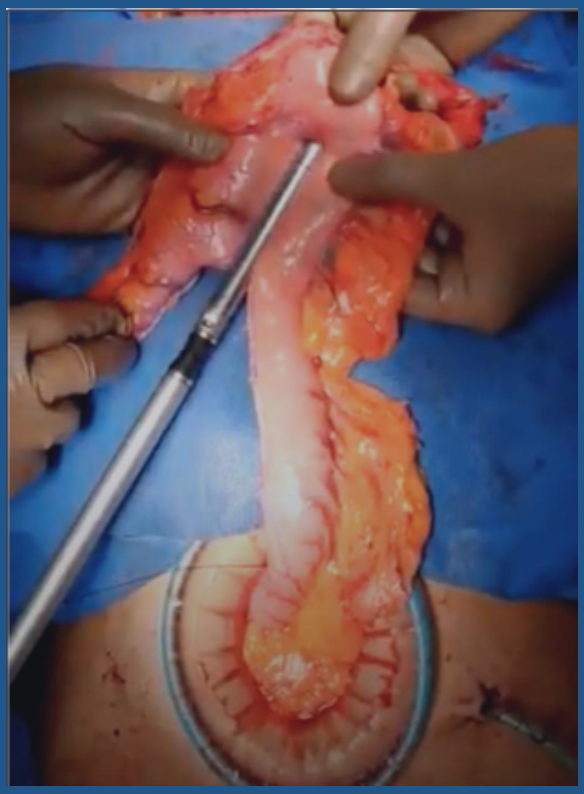

Fig. 3 Stapling above pylorus to prevent strictures

Discussion

Esophagectomy is most commonly performed for surgical procedure for esophageal cancer. Its other uncommon indications include benign conditions such as esophageal strictures, perforation, lye ingestion, Barrett esophagus, recurrent tracheoesophageal fistulas, and achalasia.

The transthoracic esophagectomies, such as the Ivor Lewis and McKeown techniques, are more popular followed by trans-hiatal esophagectomy. Different choices of conduit, i.e., the stomach, colon, and jejunum, have been used to maintain gastrointestinal continuity [5].

Despite improvements in surgical techniques and better case selection with optimization of performance status, esophagectomy still carries a significant risk of postoperative complications. The main complications encountered include anastomotic leaks, strictures, conduit ischemia, and necrosis. In 2015, the Esophageal Complications Consensus Group (ECCG) was convened and a consensus was reached upon to standardize all complications and adverse events occurring during in-hospital stay after esophagectomy (Table 1) [6]. Additionally, an endoscopic grading system was proposed to evaluate conduit necrosis (Fig. 4; Table 2) [7]

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Table 1

Esophageal Complications Consensus Group (ECCG) classification

Type	Diagnosis	Treatment
Type I: Conduit necrosis	focal	Identified endoscopically	Additional monitoring or non-surgical therapy
Type II: Conduit necrosis	focal	Identified endoscopically and not associated with free anastomotic or conduit leak	Surgical therapy not involving esophageal diversion
Type III: Conduit necrosis; extensive	Identified endoscopically	Treated with conduit resection with diversion

Table 2

Endoscopic classification system for the findings of gastric conduit ischemia and necrosis

Grades	Findings
Grade 1	Dusky bluish-color mucosa around the anastomosis covered with tenacious metallic-appearing mucous that cannot be easily washout
Grade 2	Partial disruption of the anastomosis with equivocal viability of the adjacent mucosa or the normal pink mucosa margins
Grade 3	Complete circumferential breakdown of the anastomosis with normal pink mucosa margins
Grade 4	Completely necrotic black mucosa throughout the gastric conduit with the anastomosis still intact

Upper abdominal viscera are supplied by the celiac axis. Performing a resection without trading off the blood supply is essential for safe esophageal reconstruction. Any vascular compromise at the celiac axis of gastro-epiploic artery impairs the viability of the gastric conduit [8]. In most cases, the conduit of choice remains the stomach and its blood supply is primarily from the right gastro-epiploic artery. Injury to the conduit during abdominal dissection or at the time of mobilizing through the thorax or neck can be damaging. Tension at the anastomosis or venous obstruction could hinder the healing at the anastomosis.

This could be due to varied factors including extrinsic compression. By adhering to hand rule of 5, a young surgeon can ensure good vascularity to the conduit, reduced the tension by creating a sufficiently long conduit, reduce the chances of shortening by avoiding serosal stitches and using at least 4–5 cartridges, and eliminate chances of extrinsic compression at the hiatus [3, 9].

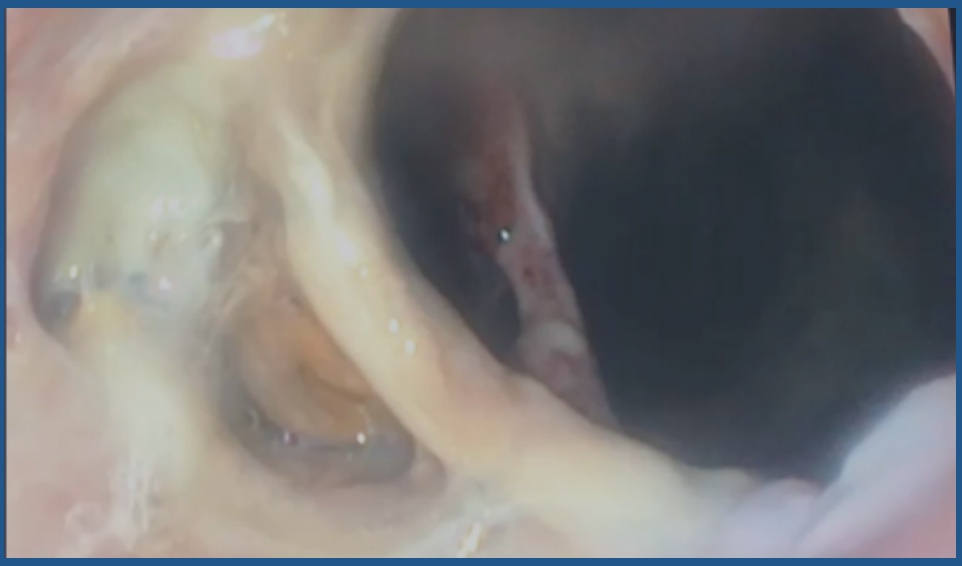
The benefit of perioperative pyloromyotomy or pyloroplasty in the context of gastric conduit for esophagectomy continues to be a matter of debate. Meta-analysis and systematic reviews have shown no added benefit of a pyloromyotomy or pyloroplasty. Our experience is no different and we do not routinely perform a pyloromyotomy [10].

Rarely, the surgeon would encounter scenarios such as previous gastro-jejunostomy, prior bariatric procedures, PEG tunes, corrosive injury/stricture, and prior radiation, where in the stomach vascularity has been violated and pervade with adhesions. In such situations, one has to look beyond the stomach for a conduit. Emphasis must be laid on endoscopic assessment of the stomach prior to the surgery. When found unsuitable, alternatives such as colon and jejunal interposition must be considered [11].

Despite best practices, assessment of the vitality of the conduit intraoperatively is challenging and not accurate as it relies on the subjective assessment of color and rate of bleeding at the cervical end. Newer technologies have now been developed and have made the assessment less subjective. The currently available techniques include Doppler flowmetry and spectrophotometry, fluorescence angiography, hydrogen clearance, transmucosal oxygen saturation measurement, light spectroscopy, intra-operative endoscopy, and indocyanine green fluorescence (ICG) [12].

All these tools and technologies are no substitute to proper tissue handing, being meticulous and understanding the factors that put the conduit at risk. These tools serve as an additional buffer to ensure creating a safe conduit.

Fig. 4 Gastric conduit necrosis visualized on endoscopy



Declarations

All authors have contributed towards the article.
The authors declare no competing interests.
Ethical clearance not required as this is a technical description.
Informed consent was obtained from the patients prior to surgery

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ಅಮ್ಮ

ವರುಷಕ್ಕೊಮ್ಮೆ ಆಚರಿಸುವರು ಅಮ್ಮಂದಿರ ದಿನ,
ನಿತ್ಯ ಸಂತಸದಲ್ಲಿ ಮರೆತೆ ಬಿಡುವೆವು ನಾವು ನಿನ್ನ,
ಅನುದಿನ ಅರಿಯದಾದೆವು ನಾವು ,
ಅಮ್ಮನಿಲ್ಲದೆ ಇಲ್ಲವೇ ಇಲ್ಲ ಈ ಜೀವನ .

ಈ ಜಗತ್ತಿಗೆ ನಮ್ಮನು ಪರಿಚಯಿಸಿದ್ದು ಅಮ್ಮ.
ನಾವು ಬೆಳೆದಂತೆ , ಜೀವನ ಕಳೆದಂತೆ ,
ಅಮ್ಮನ ಮರೆತು ನಾನೇ ಎಂದು
ಮರೆವ ಮಂಕು ತಿಮ್ಮ.

ಈ ಜಗತ್ತಿಗೆ ಭಗವಂತನ ಅಧ್ಭುತ ಕೊಡುಗೆ ಅಮ್ಮ.
ಎಲ್ಲೆಡೆ ತಾನಿರಲಾರೆನೆಂದು ಪ್ರತಿ ಜೀವಿಗೂ ತಾ ನೀಡಿದನು ಅಮ್ಮ.

ಅಮ್ಮನಿಲ್ಲದ ಜೀವನ ಒಮ್ಮೆ ನೆನೆಸಿನೋಡಿ.....
ಮನೆಯೂ ಖಾಲಿ, ಮನವು ಖಾಲಿ...
ಇದುವೆ ಜೀವನ ಜೋಕಾಲಿ.
ಇದ್ದಾಗ ಅಮ್ಮನ ಮರೆಯದಿರು,
ಕಾಲಾನಂತರ ತಾಯಿಯೇ ದೇವರು ಎನ್ನದಿರು !!!!

ತಾಯಿಯೇ ಪ್ರತ್ಯಕ್ಷದೈವ ,
ನಿನ್ನಿಂದಲೇ ಈ ಜೀವ , ನಿನ್ನ ನಲ್ಮೆಯು ಮರೆಸುವುದು ಎಲ್ಲ ನೋವ !!
ವರುಷದ ಅನುದಿನವು ನಿನ್ನದೇ ದಿನ .....
ನೀನಿಲ್ಲದೆ ಇಲ್ಲ ನಮ್ಮ
ದೈನಂದಿನ .....
ಅಮ್ಮ ಐ ಲವ್ ಯು....ಅಮ್ಮ

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Courtesy :Dr Ramesh B S

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Research Topic -1 Journal Club

Dr K Lakshman

A Journal club (JC) is an essential part of surgical training. It is considered a conventional teaching tool, along with Lectures, Bedside Clinics, Subject seminars etc,. A JC is basically designed to teach critical appraisal of scientific papers. In this era of evidence based practice, we should be equipped to search for and evaluate current evidence regarding various aspects of our practice. JC deserves to be taken seriously by teachers, students and practicing surgeons alike.

How should a JC be conducted?

Teaching institutions involve ALL teachers and students in a JC. Non-teaching institutions can form their own JC groups consisting of like minded surgeons wanting to have academic discussions. The JC usually has a presenter who does background work consisting of choosing a suitable article and preparing a presentation. In teaching institutions the presenter is a student and he is guided by a mentor who is a teacher in the department.

The choice of the paper to be discussed is based on the following:

- It should be recent - preferably within 2 years.
- Topic must be clinically relevant.
- It is preferable to have an original paper. While review articles can be critiqued, the primary goal of JC is to help us learn about the good and the not so good points of a study design in an original article. The presenter sends a copy of the paper chosen for the JC a week in advance to all the members of the JC, requesting them to prepare their critique and make some notes to facilitate discussion during the JC.

With the help of the mentor, the student prepares a presentation summarising the contents of the paper in question. The slides are prepared giving the gist of the various sections of the paper like the aims and methods, results and discussion and conclusions. The presenter prepares his own critique. After each section, the members of the JC are invited to give their critique before the presenter puts up his/her critique. This critique/discussion is the crux of the JC.

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How does one critique a paper?

The ethos behind a critique is to look at both good and the not so good points in the paper.
Some simple questions are asked and answered by carefully reading the paper. These questions are:

- Is the topic relevant? Is the research question important? Is it a recent paper? Is the impact factor of the journal good?
- How good is the study design? Is the study design appropriate for the research question? Are the numbers adequate? Are all confounding factors accounted for?
- How good is the collection of data? Are all data points adequately populated? Is there good blinding of the observer?
- Are proper statistical tools applied? Is the presentation of data properly done?
- In the discussion, are other papers on the subject adequately studied and represented? Are differences in the findings among papers adequately explained? Are limitations in the study acknowledged?
- Are the conclusions based on robust data from the study?

Concluding discussion

The JC ends with a concluding discussion based on answers to all the above questions. In particular the group concludes about the 1. Scientific veracity of the paper, 2. Whether the methods used and the conclusions drawn are applicable to the local milieu and 3. Whether, based on the conclusions, we need to change our practice to keep pace with the current evidence.

Further reading: How to critique a paper?

https://u.pcloud.link/publink/show?code=XZr8IjkZT2Y57Orn0xh93TaYC0qbDyAFbyHX

How to prepare for a JC?

https://u.pcloud.link/publink/show?code=XZYjGWXZb5LUqH7b9WfMIg3LqI7n4XF7DLc7

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Case report: Congenital absence of cystic duct

Dr H V Shivaram
Aster CMI Hospital

Congenital anomalies of extrahepatic biliary tree are not uncommon and if it is not recognized during cholecystectomy, it will have grave consequences including bile duct injury and need for reconstructive surgery.

46-year lady with no comorbidities was evaluated for gallbladder calculi and was scheduled for elective laparoscopic cholecystectomy. Ultrasound had shown medium sized multiple gallbladder calculi and liver function test was normal.

During the surgery, it was noted that the gallbladder is distended and there are no signs of recurrent cholecystitis or adhesions. Entry into the Calot's triangle was not possible. Cystic artery was clipped after identifying it. Further dissection was carried out. It took some time to dissect and see the critical view of safety.

Whatever appeared to be cystic duct was wide and, in such cases, CBD could be easily mistaken for cystic duct. Opinion of another two surgical colleagues was taken. Some more medial dissection was carried out as suggested by them. Cystic duct was nowhere to be found. Gallbladder neck was directly joining the common hepatic duct without cystic duct.

To be sure that it is not a case of Mirizzi syndrome the gallbladder was opened at the neck and the gallbladder CHD junction was identified. There was no impacted stone. Clear Golden yellow bile was seen. The other options in such cases are: subtotal cholecystectomy, conversion to open cholecystectomy, operative cholangiography, or use ICG fluorescence imaging.

This is a case of rare congenital anomaly of absent cystic duct. Only few such cases are reported in world literature. To prevent the narrowing of the bile duct a linear stapler was used to transect the gallbladder at the neck doing a stapler choledochoplasty. Tube drain was kept at the gallbladder bed and was removed after 48 hours. She had an uneventful recovery. Post-operative MRCP after 1 month showed normal bile duct.

Video link: https://youtu.be/G7WQIZtD4sQ

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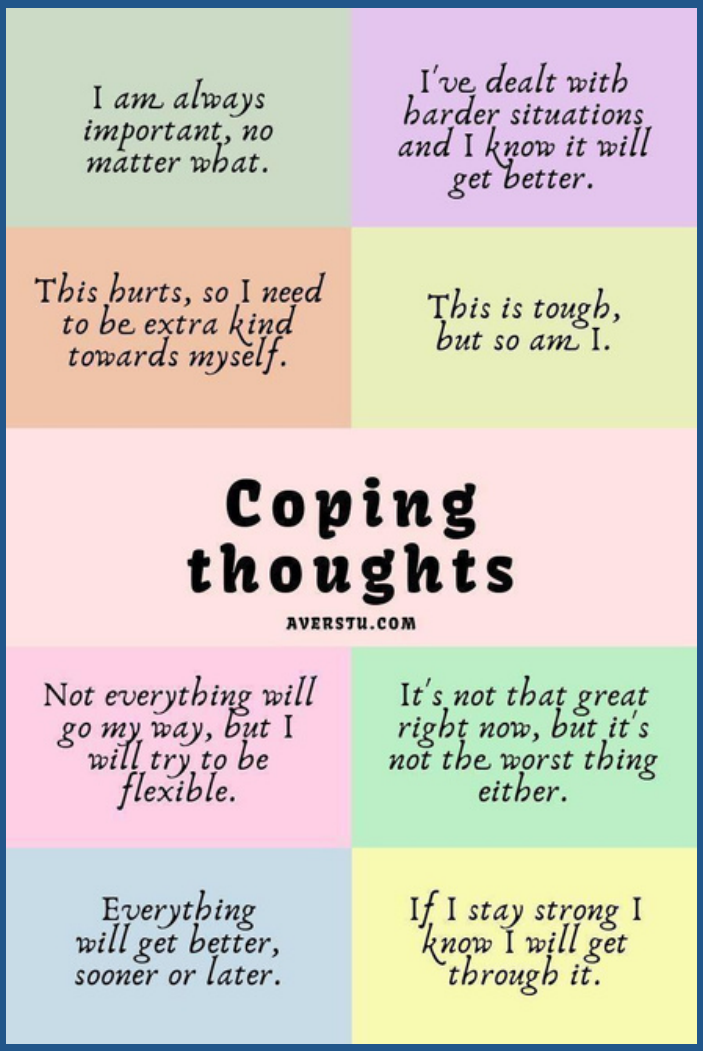

Trivia [x]

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"HAS TECHNOLOGY OVERULED THE CLINICAL SKILLS"

21st century medical Health care system Revolutionized by Advancement in Diagnostic as well as therapetic technology.

Artificial intelligence,Virtualreality, Augmented Reality ,Healthcare trackers Genome Sequencing, Nanotechnology , Robotics ,3D printing are some of the Advances in Health care .

Are we becoming Servants to these masters technology? Is our clinical skills are Vanishing? Are we loosing the humanistic medicine?

History taking and physical examination are the vital part of our Diagnosis , which amount to 60-70% of clinical Diagnosis .

Technology should support the clinical Diagnosis.

Because of the Overuse of technology, clinicians are relying more on diagnostic tests rather than the clinical skills.
This amounts to missed diagnosis and/or over diagnosis of the Diseases .

The Mastery of clinical skills is Important to the tranformation of a Doctor into a Competent health professional.

Today there is a paradox that, clinicians are using Diagnostic tests more than clinical skills.

This leads to attrition of Art and science of Clinical Examination and Clinicians are loosing cognitive thinking about the Diseases.

We Need to retrain our medical education system so that doctors listen to and talk with the patients and develop good communication with the patients which will Help clinicians to treat patients rather than just treating the diseases.

It's the need of the era to restructure the medical Education which Imparts human values , communication skills and Induces critical thinking and Analytical reasoning about the diseases.

This is required so that we can bridge the gap between hospital based medicine and community based medicine with that we can achieve holistic medicine.

Courtesy : Dr Harisha

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