Sushruta

Newsletter of Surgical Society of Bangalore

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

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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,

Professor B N Balakrishna Rao oration delivered by Dr. Anil D'Cruz was excellent. It was well attended and appreciated by all the members. Many congratulations to our senior surgeons, Dr. Joseph Antony and Dr. Srimurthy KR who were felicitated on this occasion.

The monthly clinical meetings will continue on a virtual platform as there is a fear of the third wave of the pandemic.

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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Best poster - BRAMC

Rare case of giant EGIST of wild variant

Dr. Bramhavar Shamburao Ramesh (Prof and H.O.D of Department of General Surgery),
Dr. Pushpa Satish Kumar (Associate professor), Dr. Hosni Mubarak Khan (Associate
professor), Dr. Veeksha V Shetty (Resident)

Dr B R Ambedkar Medical College and Hospital

Dr Veeksha

Abstract

Introduction

Gastrointestinal stromal tumors are uncommon when compared to all gastrointestinal neoplasms but are the most common mesenchymal tumors of the gastrointestinal tract.
The largest gastrointestinal stromal tumor ever recorded in literature weighed approximately18.5 kg and measured 42.0 cm × 31.0 cm × 23.0 cm. It accounts for about 3% of all gastrointestinal tumours and about 3-5% all sarcomas. EGIST constitute less than 5% of all GIST. The definitive treatment for these tumors is resection. About 85% of GISTs are reported to have activating mutation in KIT or PDGFRA, CD117 being a diagnostic marker. Small portion of GIST wild-type negative for both KIT and PDGFRA genes may harbour mutations of the BRAF gene and KRAS which are seen to involve mesentry or omentum.In the year 2000, the first patient was treated with the tyrosine kinase inhibitor imatinib and since then, gastrointestinal stromal tumors with high-risk features have been treated successfully with tyrosine kinase inhibitors.

Case report

We report 80year old female, known case of diabetes mellitus, on treatment, presented with complaints of distension of abdomen since 4 weeks, insidious in onset, gradually progressive in nature, associated with pain in Right iliac fossa. Associated with constipation, breathlessness on lying down occasionally, relieved on lying down on sides, weight loss about 5 kgs in 1.5 months and increased frequency of micturition.

On examination, a solid, mobile mass noted extending from right half of abdomen to involve almost whole of left half of abdomen. Mass mobile in horizontal direction. Per rectal examination was normal. Bilateral lower limb oedema was present.

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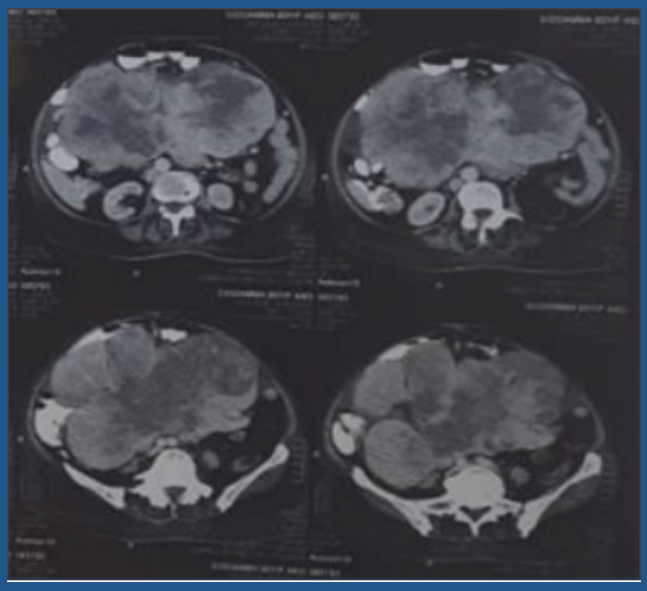
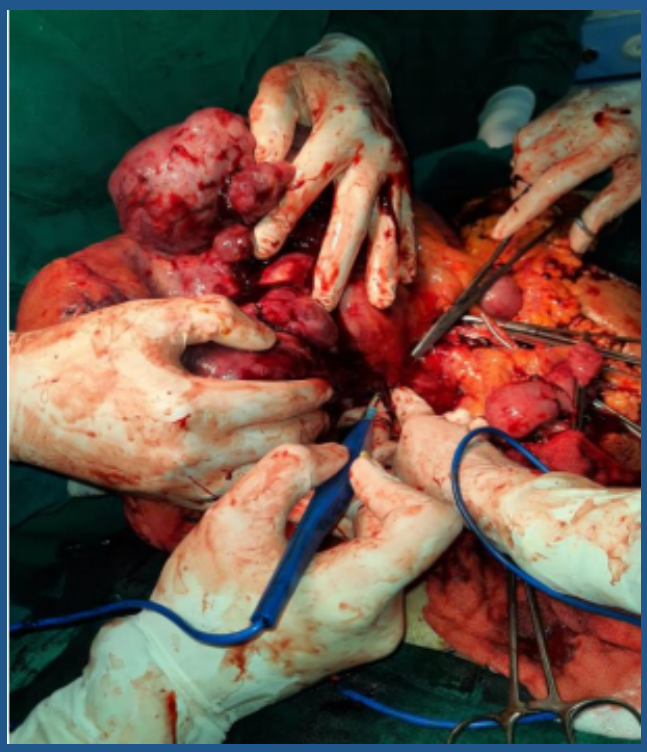
USG Abdo + Pelvis suggestive of a fairly lobular heterogenous lesion noted in peritoneal cavity about 37x20cm. Superiorly lesion extends to epigastrium, inferiorly to pelvic cavity and on either side to lumbar region with prominent internal vascularity. CECT Abdo + Pelvis showed findings similar to USG findings. Liver, spleen and pelvic structures normal. Thus features were suggestive of intraperitoneal neoplastic etiology



Intra operatively the tumor was noted to be arising from mesentery and ileum and caecum was noted to be stretched over the tumor. It weighed about 6kgs and measured 32 x 24 x 15 cm. The patient underwent exploratory laparotomy with R0 resection (ileal resection with caecum resection) with end jejunostomy since the patient was hemodynamically unstable. Post operative period was uneventful.



Histopathological report was suggestive of High Grade Mixed type Gastrointestinal stromal tumor with Immunohistochemistry being negative for CKIT, DOG1 and PDGFRA markers. Patient was being serially followed up for two months when she was planned to be started on second line of therapy- Sunitinib along with closure of stoma after Covid. But the above plan was not carried out as the patient passed away in her sleep at her residence.

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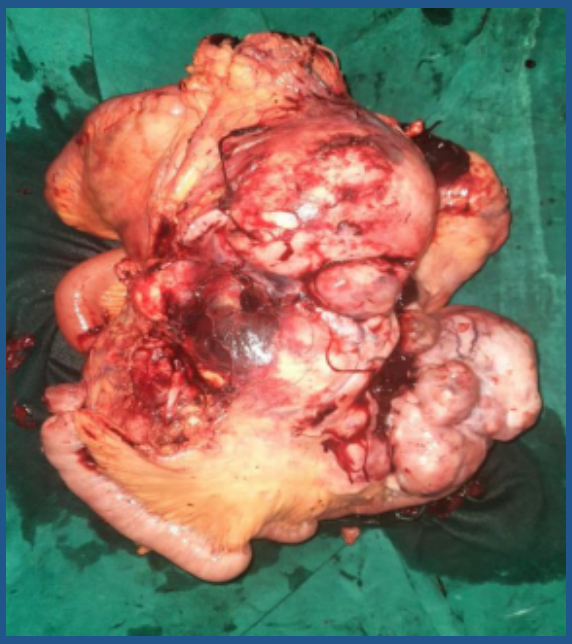
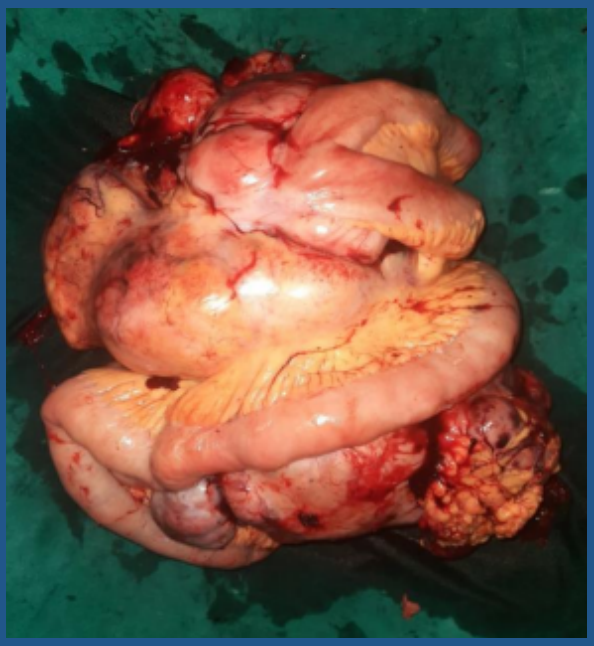
Resected specimen of tumor with excised specimen of ileum and cecum noted to be stretched over the tumor





References

-Nannini M, Urbini M, Astolfi A, et al. The progressive fragmentation of the KIT/PDGFRA wild-type (WT) gastrointestinal stromal tumors (GIST). J Transl Med 2017;15(1):113

-Pantaleo MA, Nannini M, Corless CL, et al. Quadruple wild-type (WT) GIST: defining the subset of GIST that lacks abnormalities of KIT, PDGFRA, SDH, or RAS signaling pathways. Cancer Med 2015;4(1):101–103.

-Boikos SA, Pappo AS, Killian JK, et al. Molecular subtypes of KIT/PDGFRA wild-type gastrointestinal stromal tumors: a report from the National Institutes of Health Gastrointestinal
Stromal Tumor Clinic. JAMA Oncol 2016;2(7):922–928.

-Joensuu H, Eriksson M, Sundby Hall K, et al. Adjuvant imatinib for high-risk GI stromal tumor:
analysis of a randomized trial. J Clin Oncol 2016;34(3):244–250.

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Best paper - BRAMC

Title: Surgical Treatment of Pilonidal Sinus in Gluteal Cleft: A Comparative Study of Outcome Between Excision Without Closure and Limberg Flap Technique.

Dr Sanyal Rana

ABSTRACT Background:

Pilonidal sinus is a chronic infection caused by penetration of a foreign body into the subcutaneous tissue in the post sacral intergluteal region. Incidence is reportedly 26 per 1000 population, affecting males four times as often as females and predominantly in young adults. Most reports have been limited to single surgical approach with only few randomised controlled trials available in current literature. Since most of the surgeries have their own series of complications, we are doing a comparative study of the two commonly done procedures.

Methods:

This is a prospective study of 60 patients from June 2019 to May 2021. Pain, time for wound healing, recurrence rate, cosmetic disfiguration, time taken to get back to work and overall outcome was analysed statistically.

Results:

Each Group was composed of 30 patients. The mean age at presentation for limberg flap group was 29.43 years and for Excision without closure was 27.27 years. 48.3% of our patients were drivers by occupation. Mean hospital stay and total time for wound healing was significantly more in excision without closure group. 11 patients out of 30 from excision without closure group had recurrence and this was statistically significant. Time to return to work was 11.4+/-4 days in limberg group and 10.5+/-7 days in excision without closure group. Post-operative pain was measured as per the visual analogue score and was found to be statistically significant on post op day 1 and 2 only. The cosmesis and the overall satisfaction was higher with the Limberg flap group. Our work was comparable with the meta-analysis and systematic review of Berthier et al and McCullem et al.

Conclusion:

A shorter hospital stay, early wound healing with shorter time off work and lower ratio of complications favours Flap placement. Lower pain perception and improved general health perception adds to the patient comfort and satisfaction.

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Best Paper – Vydehi MC

Study on The effect of hyperbaric oxygen therapy (HBOT) on Diabetic ulcers

Dr.Srivachan S S Post graduate
Under the guidance of Dr.Ramesh Reddy G. Professor &HOD
DEPARTMENT OF GENERAL SURGERY,
VYDEHI INSTITUTE OF MEDICAL SCIENCES AND RESEARCH CENTRE

Dr Srivachan

Abstract: Background and Aims:

Several treatment modalities and protocols for diabetic ulcers are available. However, little consensus exists on optimal treatment. In an endeavour to improve healing rates, HBOT is used.

The aim of this study was to compare current Standard Wound Care (SWC) vs. SWC with adjunct hyperbaric oxygen therapy (HBOT) in the treatment of Diabetic Foot Ulcers.

Patients and Methods:

Prospective,comparative study. Thirty patients with diabetic ulcers were included. These were divided into group A(SWC with adjunct HBOT) and group B(SWC only). Participants were followed 4 weeks and their ulcers were measured for their surface area and depth to assess any change in wound size.

Results:

Both groups demonstrated a significant improvement in wound reduction by the end of the trial.However, ulcer area ($p<0.001$) and depth ($p<0.001$) exhibited superior improvement in group A.

Conclusion :

SWC with Adjunctive HBOT seems to improve wound healing in Diabetic ulcers and merits further study.

Keywords:

Hyperbaric oxygen therapy, Diabetic ulcer, Standard wound care, HBOT.

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Best Poster - Vydehi MC

Spindle cell Ca of Penis

Dr SV Goutham

Abstract:

•Sarcomatoid carcinomas are Uncommon, High Grade, Biphasic tumors, which mainly consists of Anaplastic spindle cells.
•These are rare representing only 1% - 2% of all penile cancers1.

•Microscopic diagnosis of this is very challenging since it contains biphasic patterns of pleomorphic spindle cells along with components of squamous cell carcinoma

•This is considered as a variant of Squamous cell carcinoma or as a Metaplastic differentiation of the mesenchyme.

•The tumor has both lymphatic and hematogenous spread and is a very aggressive tumor and has a high mortality rate4.

•Risk factors include lack of Neonatal circumcision, Phimosis, HPV infection, Tobacco products, Penile L S & potentially Penile Trauma.

•Perineural invasion was recently found to be a strong predictor of lymph node metastasis1

•Patients with cancer of the penis, more than patients with other types of cancer, seem to delay seeking medical attention (embarrassment, guilt, fear, ignorance)7

•Differential Diagnosis include Leiomyosarcoma, malignant fibrous histiocytoma, Amelanotic Melanoma and LUPUS VULGARIS as in this case.

•Concomitant presentation of GUTB and Malignancy is a well-documented and an expected norm, which is seen in our case.

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Interview with surgeon : Dr H K Nagaraj

DR.H.K.NAGARAJ

NAME : DR.H.K.NAGARAJ
DATE OF BIRTH : 21-07-1954
AGE : 66 YEARS
QUALIFICATION : 1. MBBS (1977) Bangalore Medical College, Bangalore, Karnataka.
2. M.S. (GENERAL SURGERY) (1980) Bangalore Medical College Bangalore, Karnataka.
3. M.Ch (Urology) (1987) Kasturba Medical College,Manipal, Karnataka.
4. FICS (1989)RESIDENTIAL ADDRESS : # 29, 3rd cross, 1st main, Dollars Colony, RMV 2nd stage, BANGALORE-560 094.
TEL: 080-2351 9242 Mbl: 0 93412 23797
Email: nagarajharohally@hotmail.com

CURRENT POSITION : Working as Professor & Head of Urology, Unit -1, at M.S.Ramaiah Medical College

PLACE OF BIRTH & EARLY EDUCATION

Born in Bangalore Rural District. My early education is in Bangalore Rural District close to my native place in a Government school.

My M.B.B.S., & M.S. (General Surgery) is from Bangalore Medical College. I did my M.Ch., in Urology from K.M.C. Manipal.

MY MENTORS ARE

Prof. C.Vittal
Prof. N.A. Narayanaswamy
Prof.P.Vegugopal

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MY FAVOURITE SURGERIES

Laparascopic & Robot Assisted Radical Prostatectomy, VVF Repair, Pediatric Pyeloplasty etc.,

WHAT SURGERY YOU ARE RELUCTANT TO DO

Extrophy bladder

WHAT WOULD YOU DO DIFFERENT IF YOU GET A CHANCE TO RELIVE P.G.LIFE

Nothing different.

PERSONAL

-Playing Shuttle badminton
-Farming

FAVORITE BOOKS

-S.L.Byrappa's Stories
-Ramayan & Mahabharat

FAVORITE PLACE TO TRAVEL

- Nill

FAVORITE QUOTES

Quality is never an accident. It is always the result of an intelligent effort.
The first wealth is health.
Good manners are made up of petty sacrifices.

MY REGRETS

Always Heparinise before clamping any vessel. Clotting can occur in vessels.

ANYWAY YOU TACKLE STRESS

Watch surgical videos of others.

KEY TO SUCCESS.

Be honest & sincere to your patient. Hard work and update the new techniques.

ANY MESSAGE TO YOUNG SURGEONS.

Don't go after money. Work with passion and master the surgical skills. Money will follow.
We should remain as a student for ever. keep watching how others do.

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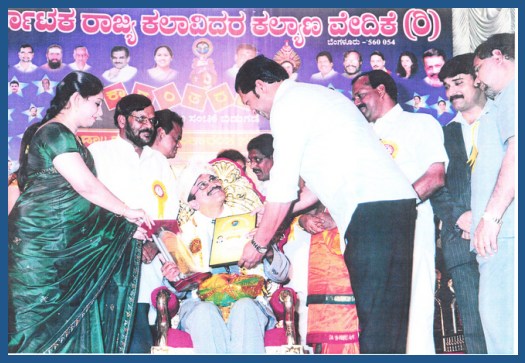

DISSERTATION FOR M.S.: (GENERAL SURGERY):

Study of 100 cases of Acute appendicitis – Etiopathology and clinical presentation. In this study, Acute appendicitis was seen in 80% of vegetarians in contrary to the belief that it is commonly seen in non-vegetarians. The time of presentation was before midnight in 60% of cases as compared to early morning presentation. Whip worms seen in the lumen of the appendix in 20% of cases.

RESEARCH WORK PPERFORMED DURING M.Ch.(UROLOGY) TRAINING PROGRAMME

1.Assessment of Residual renal function in grossly hydronephrotic kidneys which were non – visualized in an I.V.U.
2.Measurement of risk index in Renal Stone formers.
3.Sequelae of modern antituberculosis drugs.
4.Value of Routine Urodynamic evaluation in suspected BPH.

SCIENTIFIC PAPERS PUBLISHED

1.Urethral Hemangioma – Treatment by injection of Sclerosant St.John's Journal of Medicine, 1: 2, May 1988.
2.Urethral Injury – unusual case – Indian Journal of Urology, 1: 51, 1986.
3.Management of post ARV Neurogenic bladder – Indian Journal of Urology.
4.Percutaneous Nephrostomy in Nonvisualised Hydronephrotic kidney – submitted for publication.
5.Promise to Chemotherapy in Seminoma – Submitted of publication
6.Nephroblastoma – A rare histopathological variant – submitted for publication.
7.Ureteroscopic management of Uretero – Vaginal and Ureter- Uterine fistulae – Indian Journal of Urology, November 1995.
8.Endoscopic railroading of rupture of posterior Urethra.
9.Congenital giant hydroureter presenting as abdominal mass in an infant
Cent Eur J Urol 2013; 66: 383-384
10.Dislodged Dormia Basket, UROLOGY 81: e1-e2, 2013.
11.Early Laparascopic repair for supratrigonal vesico-vaginal fistulae
Int.Urogynecology.J(2007) 18:759-762

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GUEST LECTURES DELIVERED

1.Management of male fertility disorders – Indian Medical Association, Bangalore.
2.Retention of Urine – Update for family physicians at St.John's Medical College,Bangalore.
3.Urinary diversion - IMA building, Bangalore.
4.Management of Stress Urinary incontinence in females.
5.Management of Urethral Strictures.
6.Dr.Guru Basamma endowment lecture – Management of Ureteric injuries April 1995.
7.Presented guest Lecture at International Uro-Gynec workshop in October 2006 at Bangalore.
8.Invited as Faculty for international Uro-Oncology workshop 3rd to 5th November 2006 at Mumbai.
9.Invited to conduct Laparoscopic Urology workshop -2007 at Guahati Medical College, Assam.
10.Management Male fertility disorders- Devaraj Urs Medical College, Kolar. Karnataka 2014.
11.Laparascopic Management of Urological Injuries in OBG Practice- West Zone International Gyenec Surgeons Cornference, at Sholapur. Maharastra, 25/08/2014.
12.S.S.Narasanagi Oration for the year-2015. Karnataka State Chapter, Association of Surgeons of India.(15/02/2015 at Mysore)
13.Conducted Advanced Laparascopic Urology Workshop at Jaslok Hospital, Mumbai in Dec 2014.
14.Valve Bladder Syndrome at Gangtok, Oct, 2018.
15.Uro- gynaec workshop 8th January, 2019
16.Guest lecture on Varicocele in All India Uro & gynaec conference.

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AWARDS

1.Gold Medallist in ENT competition Exam.
2.Best scientific paper award at annual conference of U.S.I. Delhi, 1983.
3.Best scientific paper award at annual conference of Kerala Urological Association, Manipal, 1985.
4. Best Scientific paper award at Bangalore surgical Society Meeting, 1988.
5.Organizing Secretary – 29th Annual Conference Urological society of India 1996, Bangalore.
6.Best paper award by International College of Surgeons October 1990.
7.Gold Medal for the outstanding research in Urology – by the Bangalore Rotary international in 1997.
8.Gold medal for the outstanding scientific paper in Urology – by the Bangalore Rotary international in 1998.
9.Invited for the teaching program at Rose Medical center, Denver, USA in 1996
10.Arya Bhata award 2003.
11.Kannada Rajyothsava Award 2007.
12.Outstanding Social Service in Medical by Red Cross, Karnataka, 2008.
13.Scroll of Honor by Surgical Society of Bangalore 27/06/2008.
14.Doctor's day 2008 award by IMA, Bangalore branch.
15.Teacher Par Excellence – Dr.M.G.R.University, Chennai. 2013.
16.Delivered Several guest Lectures.
17.Nada Prabhu Kempegowda Award (Medical) - 2016.

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ACADEMIC ACTIVITY

1.Training Undergraduates and post graduates (M.S.General Surgery) since 1982.
2.Examiner for postgraduates and DNB in Urology, Karnataka West Bengal, Pondichery, Assam, Tamil Nadu.
3.Popularising Laparoscopy work in urology & Conducted Laparascopic Urological Operative Workshops all over India since 2006.
4.Paper setter for M.Ch., Urology, West Bengal, Assam, Orissa, Maharashtra, Pondicherry,
5.Teacher for M.Ch., (Urology) Post Graduates since 1996
6.Guide and Co Guide for Post Graduates desertations since 2000.
7.Governing Council Member of Urological Society of India, 2003-2006.
8.Running M.Ch., (Urology) Post Graduates Course at M.S.Ramaiah Medical College, since 2009.
9.Head of the Department of Urology from Oct 1989 till July 2011 at M.S.Ramaiah Medical College, Bangalore.
10.President South Zone Urological Society of India 2003.
11.Executive Committee Member of Urological Society of India (3 years).
12.Convener of Laparascopic Urology Sub Speciality for USI.
13.Conducted Annual Conference of Urological Society of India, in 2006.
14.Conducted continued urological education programmes at several institutions.
15.Internal Examiner for M.Ch., Urology B.L.D.E. Medical College, Bijapur, 2014 and M.S.Ramaiah Medical College, Bangalore-54.
16.Conducted Workshop at Gowahati Medical College on 12/07/2014 in Lap Urology.
17.Attended SZ-Usicon-2014 at Kochin and presented on Partial Nephrectomy.
18.Gandhi Medical College, Secunderabad-2015.
19.External Examiner – Andhra Medical College, Vishakhapatnam, A.P. on 24/07/2015.
20.Conducted Continued Urological Education (AUA Sponsered) for Urological Society of India.
21.Faculty for Mock Exams (USI Sponsored) for Urology Post Graduates since several years.

MAJOR OPERATIONS PERFORMED PER YEAR

1.Anatrophic Nephrolithotomy -22 cases.
2.Renal Autotransplantation - 12 cases
3.Renal Transplantation - 52 cases
4.Percutaneous Nephrolithotomy - 250 cases
5.Ileal Replacement of Ureter - 10 cases
6.Radical Cystectomy with Rectal pouch - 12 cases
7.Transurethral resection of prostate and bladder tumors - 48 cases
8.Ureteropyeloscopic basketing of calculus - 200 cases
9.Laparascopic Urological Surgeries - 300 cases.
10.Urethroplasty - 150 cases
11.Hypospadiasis repair - 48 cases

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FIELD OF INTEREST

1.Male fertility Disorders
2.Semen Bank
3.Renal Transplant
4.Percutaneous Nephrolithotomy
5.E.S.W.L.
6.Lasers in Urology.
7.Laparascopic Urology.
8.ROBOT Assisted Urology Surgeries

Clinical trials in urology:

1.Benign Prostatic Hyperplasia -Phase III 2004
2. Erectile dysfunctin -Phase III 2005
3. Overactive bladder -Phase III 2006

Social Services:

1.Member of Karnataka Red Cross since 1980.
2.Served the Karnataka Red Cross for 4 years are executive committee member.
3.Chairman Health Committee, Karnataka Red Cross, for 15 years.
4.Conducted several health camps all over the state.
5.Conducted cataract surgery camps with own money.
6.First in the country to start a Mobile stone blasting (Lithotripsy) service to rural masses from 1995. The mobile Van goes to several rural areas in the state like Hassan, Chickamagalur, Gulbarga, Raichur, Bellary, Kolar etc.,
7.Running a charity Lithotripsy center at Hudson circle, Bangalore since 1995.
8.Participated in media health awareness programs.

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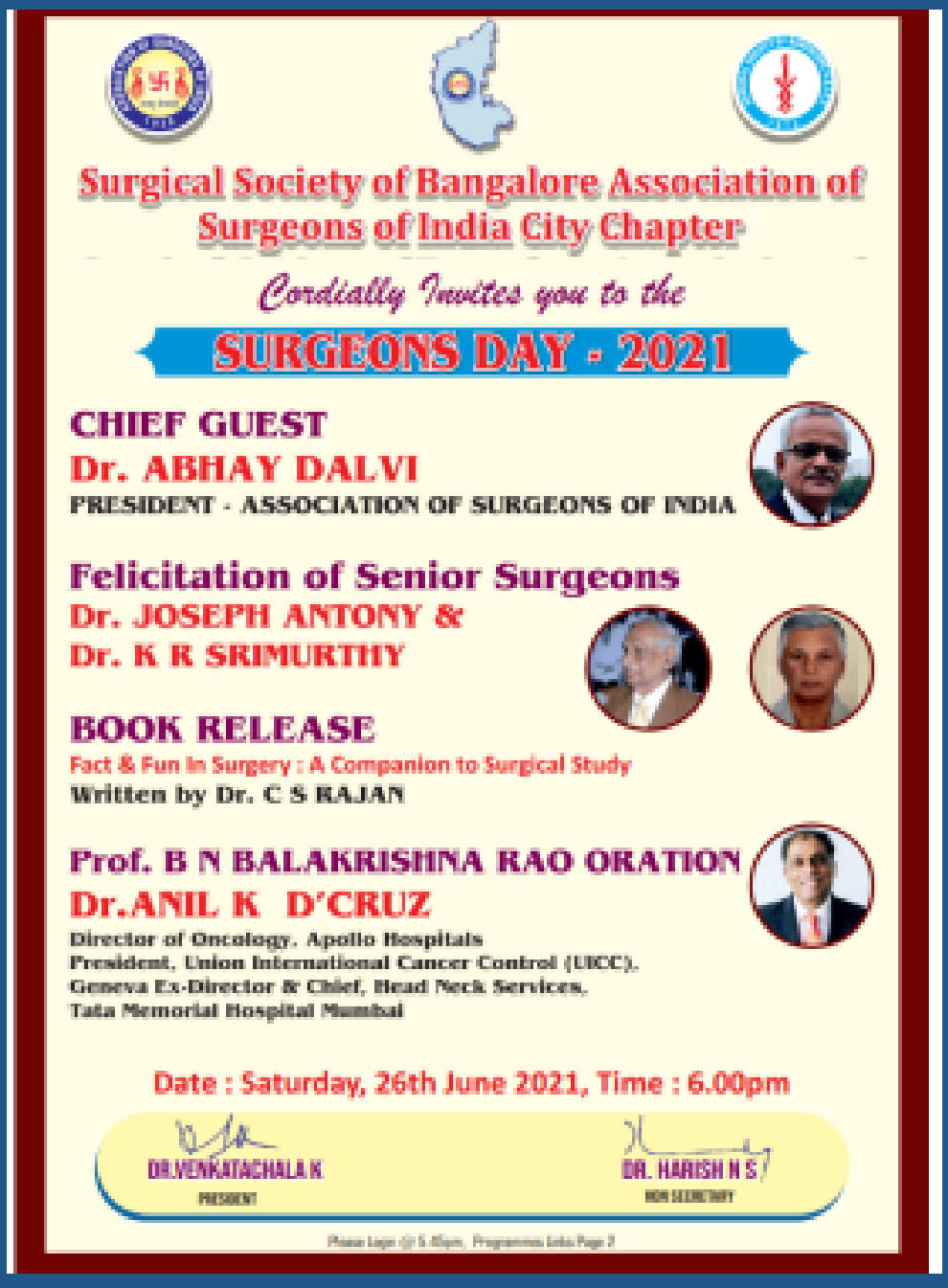

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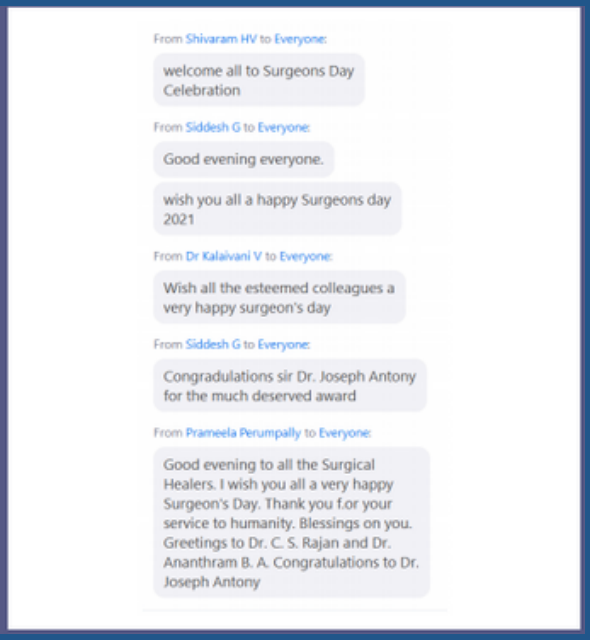

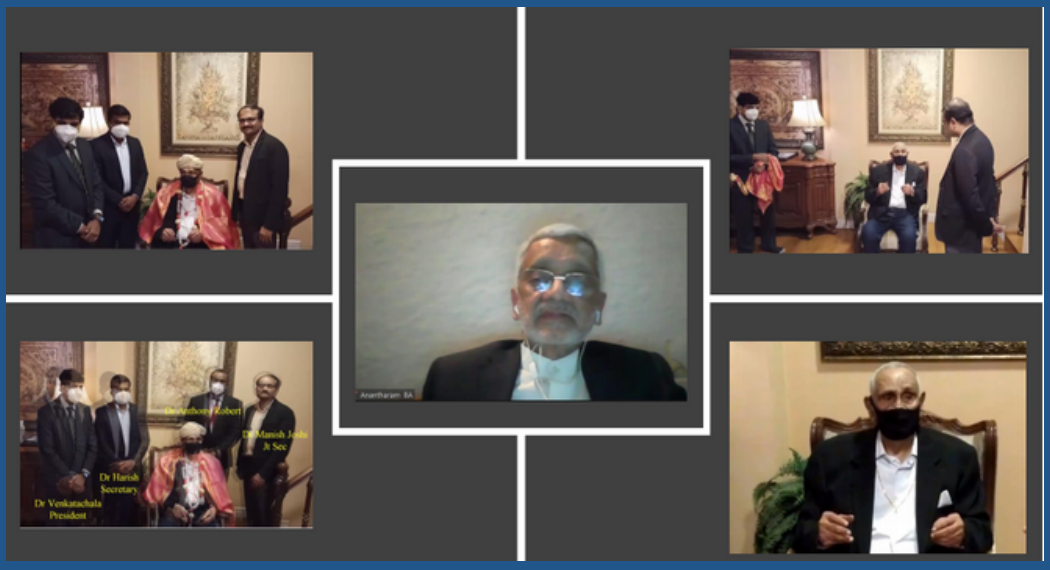

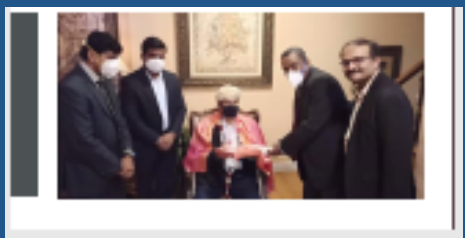

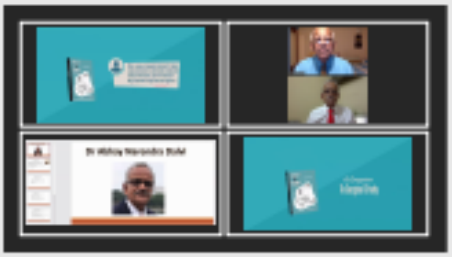

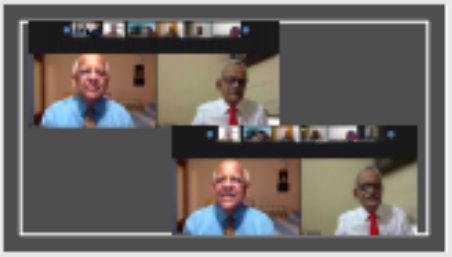

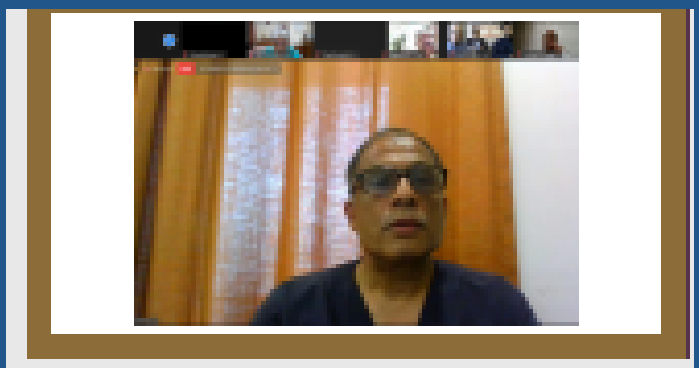

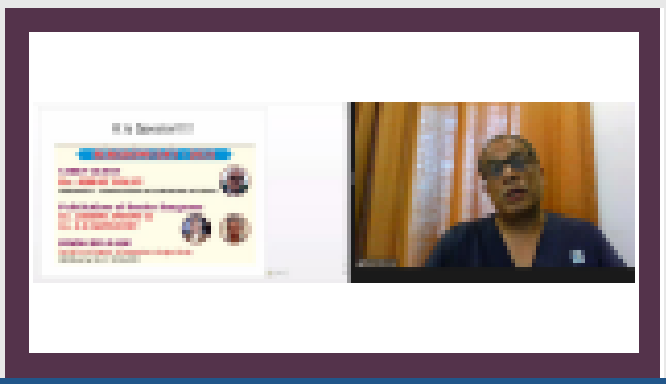

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Upcoming events – CME : Ethics in Surgery – Panel Discussion July 24th, 2021 [x]

Zoom link: Click here ID: 541 050 0137 PC: 957151
YouTube link: Click here

Dr Venkatachala
President

Dr Harish
Secretary

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The fine-tuning of practical examination - How to avoid failure

Dr.U Vasudeva Rao - MS, FRCS(Engl), FRCS(Glasg), FAIS, FICS Consultant Surgeon - Manipal Hospital - Bangalore Formerly HOD, Academic Coordinator Member Medical Advisory Board Dean KU-MEMG PG PROGRAM Adjunct Professor Manipal Academy of Higher Education Inspector and Appraiser National Board of Examinations International Advisor for RCPS Glasgow UK Examiner for MRCS & FRCS Royal Colleges UK Member Board of Studies SDM University - Dharwad

INTRODUCTION

Assessment of a trainee is an essential component of any learning process globally and dates back to many centuries. There are many different ways by which it is done and the most common format is either a written Q & A paper with or without a practical assessment. There is also a method of internal assessment that happens throughout the course of the study and in some instances, this is also taken into consideration during the final evaluation. Clinical case presentation is unique for medical college students as they are expected to deal with human beings (as patients) after their graduation. During the undergraduate training, the examination covers broad specialities of medicine but postgraduate training is more focussed on a particular speciality over a shorter duration. The aim of this brief discussion is to highlight the complexities involved in the assessment of a surgical trainee and offer few tips for the candidate for the preparation for the examination and how to face the examiners. Few issues concerning the examiners will also be discussed

GETTING TRAINED - HOW?

Though the learning process and the content is the same for any professional course, there is wide variation in the way this is achieved. In other words, there are different categories of learners 1 The trainee is very focused right from the beginning and gets on with the task at hand straight away. He is serious, sincere and determined not just to pass the examination but to come out with distinction. He or she is seen in the library most of the time and doesn't get involved in
extracurricular activities or social gatherings. They are frontbenchers in the class and stand very attentively during the clinics. The majority in this group ultimately achieve what they set out to achieve and very few fail in fulfilling their dreams.

2 The trainee is focused but doesn't jump into the business of reading and learning immediately. He will take some time in orienting himself to the new environment but gradually picks up the pace. He or she is popular outside the classroom taking an active part in sports and cultural activities. He may struggle a bit towards the end but finally manages to catch up and utilizes all learning tools at his disposal to get favourable results. The majority of trainees belong to this group

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3 The trainee is simply not interested. It may be that the trainee was forced to take up the course much to his or her dislike and just want to see through the period of training not really focussed on getting good results. Few among these may call it a day and drop off but few others decide to stay on and somehow obtain the degree and may resort to means other than studying to achieve the goal. With proper counselling, some of them may change their mind before it is too late. Irrespective of variation in the process of learning these trainees undergo, the method of assessment is the same for everyone and the outcome may come as a surprise to a few. A well-trained candidate who has put his best efforts may find himself in rough weather and end up getting the wrong end of the stick while a candidate who was average in his preparation may do better than expected

THE EVENT CALLED EXAMINATION!!

As mentioned earlier assessment of a surgical trainee involves a written component and a practical part. We will not discuss preparation for the theory but focus on the practical part which consists of clinical case presentation and viva examination. Viva Voce (medieval Latin) or examination by word of mouth or orally (by the living voice) dates back to pre-medieval times Aristotle in 350 BC defended robust oral arguments from which much philosophical and logic emanated. Even in Indian history, Sushruta gave a description of how a trainee should look and behave and was tested for his professionalism. The oral arguments were a favourite pastime of Indian kings in their durbar. While it is known that there is no single examination technique that adequately assesses surgical skills, oral examination is still very popular and widely used in medical colleges worldwide. The aim of oral examination is to assess the candidate’s cognitive knowledge psychomotor skills and best attitude for a good outcome in the chosen speciality (1)

ADVANTAGES

It is best suited to small candidate numbers. It tests the depth of knowledge and his understanding of the topic. It is also very flexible. The candidate has to formulate the answer there and then and has very little room for re-ordering once the question is answered. For the examiner, very little effort is required as he needs to just jot down a few topics from the syllabus on the morning of the event. In fact, some seasonal examiners may not even see the need for this exercise and start asking questions in a random fashion. For many, it is gratifying to their ego who at times enjoy the session at the expense of the candidate.

DRAWBACKS

Viva-voce rates least among other examination methods on any scale of objectivity. To begin with, there isn't a uniform pattern of conducting it except for the duration. (15 to 20 minutes) Most often there are two examiners conducting the examination but there is no clearly defined role for each of them. Both can ask questions and evaluate the answer independently. Within the given period of time usually not more than 4 to 5 questions can be asked and the candidate’s performance is extrapolated to mean or average performance. It is not unusual for a candidate to get stuck while answering a particular question.

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The examiner then has a choice of moving on to the next question but much to the discomfort of the candidate sometimes the examiner insists on getting the answer. The candidate may finally get it right but loses precious time in the process. There is no uniformity in questioning. This non-uniform random and unwieldy format may sometimes seem like comparing apples to oranges. Most examiners are happy and satisfied if the candidate answers correctly and without any prompting. There are some who instead of appreciating his knowledge start asking more difficult questions just to show the candidate in a poor light. This battle of wits between the candidate and the examiner may go either way and can result in an unpleasant situation. The scoring of marks is done at the end and not on the spot. This may lead to the examiner comparing the candidate's performance with the previous one (shifting the reference point) Ideally the scoring should be done independently immediately after the oral session and should be confidential. But many a time score is altered in an attempt to reach a consensus with the fellow examiner

EXAMINER ISSUES

Whenever there is an interaction between two individuals human factors come into play and this happens in viva examination as well. A number of biases are operational which are not apparent immediately but may contribute to the final outcome. In our student days, it was not uncommon to see exam going students spending their precious time before the examination trying to find out who their examiner is, especially the one coming from outside. (external) They go to any extent to find out and even try to influence the examiner indirectly. There are instances where examiners have succumbed to pressures from a variety of sources and for a number of reasons. I will not dwell more on this as most of it is hearsay and unconfirmed and the subject is sensitive
in nature. But it is a fact that the examiner may exhibit personal prejudice towards a particular candidate for many reasons. There may be gender bias, racial and or ethnic or regional considerations. From the point of the candidate, it is difficult to predict in what way these factors affect the outcome. Strictly speaking, they should not, but in reality candidates, performance is overruled by the extraneous factors It is also a well-known fact that the examiner's mood on a particular day influences the outcome. If he has to travel a long distance and arrives late at night before and is put up in shabby accommodation and the breakfast was bad he may exhibit unfair intolerance even if minor errors occur thereby giving an unfair judgement. On the other hand, if the examiners have time to relax and refresh from their work and travel and are offered good hospitality by the host institution his outlook would be positive and he will be in a better frame of mind to listen and decide in a fair manner. If there are too many candidates, fatigue sets in towards the end and the examiner tend to be in a hurry especially, if he has to catch a flight or train on the same day. This may again affect the final outcome with candidates during the final session bearing the brunt.

Examiners are categorised as good, fair, tough etc by the candidates but most of these assessments have no real basis. A candidate who sails through without much difficulty may find the examiners as good or fair whereas the one who doesn't make it in spite of what he thought of as good performance may put the blame on the tough examiner.

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Of course, it is unrealistic to expect all examiners to be the same in their approach and attitude. Here comes the importance of training to become an examiner or being an observer for the first few examinations before becoming one and the presence of an independent observer who oversees the whole examination process

HOW TO PREPARE & FACE THE EXAMINER?

This is not an easy question to answer Can there be a standardised process of learning for the trainee and uniform teaching methods for the trainer? There is no written rule as to what a first-year trainee should do or a final year exam going student should be doing. I will give a narrative of how I prepared myself to face the examination at the end of my course. During our trainee days in the ’70s, we had limited resources to study other than clinics, classes and libraries. For some of us buying a textbook was an expensive affair and most of the reading was in the library and books borrowed from others. The number of trainees was not as many as one sees nowadays but there was some system in place. First-year trainees were asked to concentrate on ward work, second-year residents were allowed in the operating theatre but as an observer, unless there was a shortage of hands. Final year trainees used to get the opportunity to scrub and assist and at times even allowed to perform a few procedures under supervision. During the teaching program, first-year residents are asked to present topics mainly on surgical anatomy & pathology whereas a second-year postgraduate used to present on clinical features and investigation and the final year student had to cover all aspects including management. There used to be some hesitation by first-year residents to present cases which is understandable. Generally, he was given a short case and the discussion used to be mainly on history taking and elicitation of clinical signs. During the second year, fine-tuning our skill in presentations by different professors used to happen and once you are in the final year you get busy not only in clinical work but also in preparing and attending the teaching programs. We had what was popularly called a Saturday clinic where not only the head of the department but other unit heads used to be present and our presentation skills were really put to test. The HOD used to sit on a high chair and pass cryptic comments on the style, content and discussion of each case. Even the language and grammar had to be perfect. Frequent interaction among colleagues and healthy competition to test the knowledge and skill also helped.

I used to make a lot of notes particularly on some tough topics which are difficult to understand and memorize. In fact, I always suggest to all my trainees to keep a notebook in their coat pocket and make short notes at the end of each day about the cases seen in the ward, operations performed, and cases presented. This exercise will reduce the burden during the final preparation. Though the primary objective of every trainee is to pass the examination and obtain the coveted degree, it is also equally important to learn the actual art and science of surgery. In real life that is what matters. It is known that a skilled surgeon need not be a good teacher and all good teachers need not have a good pair of hands. We had a senior surgeon who was very good in his operative work but was not very popular as a teacher. By and large, most of the senior faculty are good in their own way. Some are exceptionally good and students flock whenever they teach or take clinics.

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Attending clinics by your own faculty doesn't quite give the exposure of external examiners who play a vital role in deciding the fate of a postgraduate. While one can have a measure of his own professor it is difficult to predict the behaviour of someone from another college or university. Of course, we get some prior information as to who that person is and how tough or easy he is. Attending the annual teaching program conducted by other institutions helps in this respect. I was lucky to be in the first batch of postgraduates to attend the annual CSEP conducted by the Surgical Society of Bangalore way back in 1978.

Some of the teachers are quite good but very often it is difficult to get them to teach. The HOD when I joined was also the principal of the college and was always busy with administrative work but we went on requesting him to take clinics. He relented finally and that two-hour session is remembered by many of us even now. Similarly, a unit head was excellent in his operative surgery classes but was always busy with private practice. One of us used to wait outside the nursing home early in the morning and make sure that he comes to the hospital after the operating session to take a class for us on operative surgery! Of course, he was very obliging and once you attended his lecture which used to be more of an interactive session there was no need to read operative surgery . There are many such examples where you try and get the best out of your teachers no matter what it takes. There is no place for spoon-feeding in postgraduate training. You have to fend for yourself if you want to succeed Another avenue for learning is to make use of visiting faculty whenever the opportunity comes along. We came to know that a well-known professor who was the co-author of a textbook of surgery, was visiting our campus to be with his son who was heading the urology department. Though his visit was kept as a secret we came to know and pleaded with him to take clinics for us. He finally relented. The clinics started at 8 am and ended at 6 pm with one hour of lunch and a toilet break. The master had covered almost all topics from head to toe. We didn't touch the book nor visited the library for one week!

Case presentation is an art by itself. You need not only the knowledge and the requisite skill to take history and elicit physical findings but also present your findings in a systematic way loud and clear using good language which is easily understood. In the long case, it is better to divide your time beforehand so that you don't end up in a hurry. First 10 to 15 minutes for history taking, next 15 minutes to examine and last 10 minutes for review. You must develop the habit of presenting the case to yourself as if you are an examiner. Gaining the confidence of the patient goes a long way in your effort to elicit the clinical findings properly. Some of these patients have been to the examination hall many times and they themselves help if you approach them in a friendly manner. There was this lady who was operated on for papillary carcinoma thyroid many times. Our professor used to send a postcard every week before the examination and she used to promptly come. Being a seasoned patient with a long history of repeated operations she was a tough case to present for many students. When our turn came a clever batch mate of mine somehow got her address and sent her card just two days before the due date saying that the examination got postponed!

She didn't show up and we all heaved a sigh of relief. It is not uncommon for the examiner, especially the host, to give subtle hints so that you get back to the right track. For this reason, it is useful to make eye contact with the examiners while presenting. One of my short cases was inguinal lymphadenopathy; it was a proven case of Hodgkin's disease. When I was asked for the diagnosis I gave it as Hodgkins The internal examiner stared at me for a second and I immediately knew what he was hinting at. I then very tactfully said that it could very well be tuberculosis since it is more common than Hodgkins. The external examiner was pleased

Another rather wasteful exercise according to me is to find out about the cases the previous day and see if the expert who allots the case can be of some help. A trainee was told that he will get a hydrocele as a short case and he was all prepared to examine and present. Unfortunately, the patient also had a small direct inguinal hernia which was completely missed by the candidate. It is not uncommon for an external examiner to reject a few of the cases and replace them with newer ones and this happens shortly before the exam is due!

The best approach is to go with an open mind and follow the rules of the game. It is important to understand that the examiner may not be fully impressed if a correct diagnosis is given but the relevant signs were not elicited or interpreted. One of our professors taught us that one must try to come to anatomical diagnosis - From where the lesion is arising from and if at all possible give a pathological diagnosis. As said by a wise man, if anatomy is wrong, pathology won't be right either. Another pitfall is to offer differential diagnosis sometimes without being prompted to do so. There can't be a differential diagnosis for inguinal hernia if all the clinical signs are described correctly. If a mass in the right side of the abdomen appears to be arising from the liver and there are enough clinical signs to say so, giving a differential diagnosis of lesion arising either from the right kidney or from ascending colon is asking for trouble. Even if the examiner prods you must defend yourself rather than agreeing with him. He will be happy that you agreed with him but may not give pass marks. Quite often the organ or the system is apparent the moment you see the patient - peripheral arterial disease, varicose veins, breast lump etc but on a few occasions, the anatomical origin may be difficult - neck swelling, vague abdominal mass. And on a few other occasions, it may be difficult to make out the pathology though anatomy is fairly clear. You have to have the presence of mind to work out all these permutations and combinations and make up your mind before you face the examiner. Of course, you need not be rigid and be prepared to be flexible during the course of your presentation and discussion.

The discussion during the case presentation may vary depending on the nature of the particular case. If there is a straightforward case of peripheral arterial disease with gangrene of toes and if you present all the relevant clinical findings, the discussion will be on causative factors and perhaps on investigations. If for example, the patient is around 60 years with a history of diabetes it is likely that the aetiology is atherosclerosis. On the other hand, if he is a male aged 40 with a history of smoking, the diagnosis is likely to be TAO. But in some other situations, the discussion may focus mainly on arriving at a proper diagnosis - whether a given lump is benign or malignant or inflammatory, congenital or acquired its anatomical origin etc

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Self-confidence is one of the virtues required while facing the examiner but overconfidence can be risky. Sometimes in your eagerness to impress, you not only rattle out the history and findings but give a diagnosis and even mention what investigations to carry out to confirm. While you may be totally on the right track this doest give any space for the examiner to continue the Q&A and in the bargain, he may suddenly take you off track by asking totally irrelevant questions. The option here is to stop and start as if you are at a traffic signal. Present your findings and wait for the question to be asked. You then guide the examiner the way you want. Issues like dress code, appearance, tools to take etc are described elsewhere but the important thing is to have good sleep the previous night and have a good breakfast. Whatever said and done clinical and viva is a stressful affair and there will be a rush of adrenalin and a rise in the steroid level which brings the glucose level down. This will adversely affect the thought process and decision making.

Finally, if you have not prepared well, consider giving the exam a miss and appear at a later date. There are some who decide to appear just to see what it is like. This attitude is not good to adopt. It is like playing as an opener in a test match without net practice. There are good chances that you will get out without scoring and you may find yourself as the twelfth man cooling the bench for the next match!

WHAT IS THE SCENE TODAY

There has been a sea change in the field of medical education. The number of trainees has increased tremendously. When I visited a medical college to give a guest lecture I thought I was in an undergraduate class! There were no less than 40 postgraduates (I was told 10 were absent) Sadly there hasn't been much increase in the clinical material and staffing at some institutions is not adequate. For the trainee, there are a number of options other than attending classes and clinics. He has access to E-Learning whereby, sitting in front of the computer he can train himself as to how to present a case and how an operation is performed by watching Youtube. There are a number of books specially designed to help students prepare themselves for the examination. In spite of all these advances, case presentation and other learning tools like journal club, topic presentation still has its place and it is for the trainee to utilize these in addition to other resources.

The curriculum and the system of assessment have undergone remarkable changes in the west, keeping in mind the recent advances and societal requirements. Sadly, the pace of reforms has been painfully slow in our country. The course content and curriculum was revised to some extent but the examination and assessment have remained the same. The National Board of Examination which was set up as an alternative to those who could not get into the university because of the limited number of seats available came up with its own system of training and the method of assessment which to some extent is comparable to what is practised in the west. Hopefully, further reforms take place and a more objective assessment will be introduced for the benefit of the trainee.

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Few salient features which are part of these reforms seen in the west are - Introduction of MCQ in all formats of theory examination and replacement of viva and clinical examination by what is popularly known as OSCE (Objective Structured Clinical Examination) In England as per the present system the surgical trainee has to appear for MRCS which is considered as entry-level examination and after completion of a period of training as stipulated by the Royal Colleges, have to appear for exit examination in a chosen speciality of surgery - General surgery Trauma & Orthopedics, urology, neurosurgery etc Though not recognised the MS or DNB examination of our country is considered as entry examination by the educational authorities in the UK.

HOW TO BE A GOOD AND FAIR EXAMINER

The conventional or traditional system which is still practised at many universities and medical colleges involves clinical case presentation followed by viva examination. The clinics are held during the morning session and viva in the afternoon. The candidate is given one long case (45mintes 100 marks) and two short cases(15 minutes each 50 marks each) There are four stations for the viva (25marks each)

Generally, there are two examiners at each station - one internal and an external. Both can ask questions and both give marks. Sometimes the initial questioning is started by one examiner and suddenly his colleague takes over for a few minutes. This I feel is not the correct way to conduct a viva examination. If one examiner asks the question only he should complete the whole part of the question and only he should decide on the marks for that particular question. Even better, if one examiner does the questioning and the other gives the marks, they reverse the role for the next set of candidates.

As far as I know, there is no definite pattern in questioning. For example, in operative surgery, viva one candidate may be asked about hernia and the next one appendicectomy and the third breast lump. This is what is often referred to as comparing apples to oranges. Ideally, there should be a fixed set of questions that are the same for all candidates in the particular batch. In other words, if it is decided to ask about hernia all candidates should be asked about hernia. Then it becomes easy to compare the answers from different candidates marking will also be uniform. It is also preferable if there is general agreement on the type of response or reply given by the candidate - Minimum level of knowledge required to pass. This is the process followed in the MRCS exam where the questions are pre-determined and decided and even the answers are given to the examiners as reference.

The third issue is the level of competence expected from each candidate. It is unrealistic for the examiner to expect the candidate to know everything about everything. The idea should be to assess broadly the knowledge and skill which is required to safely start his surgical career and not to become an expert from day one.

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Since we do not have the system of entry-level and exit level evaluation the first-year trainee is considered as a resident and the final year is considered as registrar who is allowed to take decisions independently if the occasion arises. The examiner should put himself in the candidate's shoe than the other way round. A biased examiner may go soft on some while suddenly changing his stance and becoming strict for a few others. The questions should focus on the current practice rather than historical events. During my time most common X Rays used to be plain X-Ray, barium meal or enema or chest X-Ray with air under the diaphragm. None of these tests has any relevance these days. Ultrasound has become as common as XRay and it can diagnose quite a number of clinical conditions with a fair degree of accuracy.

Some of the examiners stick to the traditional conservative way of approaching the patient's surgical condition, while the new breed of examiners are more radical in their thinking and use modern investigations wherever necessary to confirm the diagnosis and explore all therapeutic options in the management. To give an example from my own experience is a patient with the peripheral arterial disease with gangrene of a toe. An old-timer may conclude that the aetiology is TAO if the patient gives a history of smoking and decides that no further investigation other than Duplex scan is necessary and the only treatment other than toe amputation is sympathectomy, whereas his younger colleague may decide to investigate more thoroughly in the form of an angiogram and consider the option of arterial bypass to salvage the foot. There are a number of such examples especially in areas of super speciality like vascular surgery, oncology etc. Examiners still insist on doing tourniquet tests for varicose veins while in practice no one does this and the patient is sent for a Duplex scan which is now available at most places. It is important to realise that one examiner's opinion on a particular candidate need not decide his ultimate fate. There are opportunities for the candidate to make up for his average performance in one section, in other areas though it is limited. Broadly speaking a candidate is assessed as pass, borderline and fail. In the OSCE system, a candidate can make up for other stations if he doesn't do well in one or two. But he should keep his composure and remain cool throughout

Finally as mentioned in the beginning there is no foolproof system of assessment of a trainee and the examiner should make the best use of the existing pattern and give his judgement in a fair and unbiased manner. As my professor often used to comment - How can I let loose - you chaps to society, if you are not competent enough to know when to use the knife and when not!

In conclusion, practical examination is a two-way process. Both candidate and the examiner should engage themselves in deciding the outcome. The candidate must try and display his knowledge and skill within the given period of time in such a way that the examiner won't have to scratch his head while giving marks. On the part of the examiner, he should create a friendly and cordial atmosphere and not frighten the candidate even if he doesn't get the right answers for all the questions The impression about the performance of the candidate in his section should be neutral for the candidate so that he can go on to next section with the same level of confidence.

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I am sure many universities are in the process of changing the present system and bringing about the much-needed reforms and the time has come for us to implement these changes so that the quality of assessment matches international standards and remains uniform. After all, it is our responsibility to make sure that well-trained surgeons serve the community practising safe surgery and no one will find fault with any examiner if he discharges his or her duty keeping this principle in mind.

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On the occasion of doctors day I have penned my feelings to write a poem I feel many of the doctors feel the same

Wishing a very happy doctors day to all

:_ವೈದ್ಯೋ ನಾರಾಯಣ ಹರಿ_

ವೈದ್ಯನಾಗುವುದು ಎಂದರೆ ಸುಲಭದ ಮಾತಲ್ಲ ,
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ಅರ್ಧ ಬದುಕು ಕಲಿಯಲು ಸವೆಸಲೇಬೇಕು .

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ವೈದ್ಯೋ ನಾರಾಯಣ ಹರಿ !!..

ಡಾ|| ಬಿ.ಎಸ್. RAMESH.

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