April - June 2026

Sushrutha

Surgical Society of Bangalore ASICC Newsletter

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SSBASICC 2025: Office Bearers

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Dr. Sunil Kumar V

President Elect:
Dr Harish Gowda

Hon Secretary:
Dr. Vikram S Biligiri

Hon Jt Secretary:
Dr Satish O

Hon Treasurer:
Dr. Kapil Kishore S V

ASI EC Member:
Dr H V Shivram

Dr. Prem Kumar A
Past President

Dr. Sreekar Pai A
Past Secretary

Dr. Rajashekhar C Jaka
Chairman Elect KSCASI

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SSBASICC 2026: Executive Committee Members

DR MANJUNATH B D

DR SHASHIDHAR C NAIK

DR SHARATH A

DR OM PRAMOD RAJA

DR BHARATH B

DR SUDARSHAN S MURTHY

DR DEVAPRASHANTH M

DR ARUN DAVID

DR MAHESH PRABHU

DR SANTOSH KUMAR R

DR SAI HARISH M

DR SAHANA M

DR SANJANA GOPAL

DR NIRANJAN P

DR SAJEET NAYAR G

DR NISHANTH L

DR MANJUNATH K V

DR NATARAJ NAIDU R

DR BRIJESH BISWAS

DR RAGHAVENDRA BABU J

DR ANIL RAJ

DR RAVINDRA G

DR VISHNU KURPAD

DR HIMAGIRISH K RAO

DR SUNIL KUMAR ALUR

DR BALAKRISHNA SN

DR HEMANTH S GHALIGE

SPECIAL INVITEES

DR K L VENKATESH

DR SUNIL SUBHASH JOSHI

Manager
Mr. Glen

Assistant
Mr. Kumar

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Editorial Board Members

Advisory Panel

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SSBASICC Newsletter

Editorial Desk

Respected Surgeons,

Welcome to this latest edition of Surgeons of SSB. It is an absolute honor to address such a robust and resilient society. Though we have recently navigated through tumultuous and challenging times, our community has not only persevered but has emerged as a leading society in our field. This remarkable milestone is a direct testament to the vision and stellar leadership of our President, our Secretary, and the esteemed members of the Executive Committee, alongside the unwavering engagement of our active members.

This edition highlights the rich intellectual and clinical diversity of our collective expertise, featuring several key contributions:

Special Message: The Chairman of KSCASI has graciously penned her thoughts, providing valuable guidance and perspective for our journey forward.

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Editorial Desk

Clinical Insights: A vibrant young surgeon contributes a highly engaging and sophisticated surgical article, reflecting the exceptional talent of our rising generation.

Spotlight Interview: An exclusive and insightful interview with one of our very own celebrated surgeons, sharing firsthand professional wisdom.

Bringing an issue of this caliber to life requires immense coordination and dedication. This publication is entirely possible due to the tireless efforts of Nishanth and Niranjan, who have invested a great deal of time and hard work into assimilating and polishing these pieces.

We invite you to thoroughly enjoy these pages. Please do read, reflect, and share your valuable comments and feedback so we can continue to grow together.

Thanking you,

Dr. Sreekar Pai A.
Editor-in-Chief

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SSBASICC Newsletter

The President's Message

To the Distinguished Members of the Surgical Society of Bangalore, ASI City Chapter,

It is a privilege to connect with you again through Sushruta as we present our second newsletter issue for the 2026 tenure. Over the past months, our administration has remained steadfast in advancing academic excellence, literature-based clinical practice, and public health advocacy across Bengaluru.

Our accredited Monthly Clinical Meetings (MCMs), hands-on technological workshops, and community outreach programs continue to strengthen our society's core foundation. Building on this momentum, we are taking a monumental step forward in our organizational history.

Announcing SSBCON 2026: The 1st Annual Conference of SSB
I am proud to announce the inauguration of SSBCON 2026, the 1st Annual Conference of the Surgical Society of Bangalore, now established as our flagship annual event, along with the prestigious

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Prof. B. Hanumaiah memorial National CSEP. Designed as a comprehensive forum for high-impact scholarly exchange, SSBCON 2026 will integrate our society's most prestigious academic honors and competitions into a single landmark gathering:

- **Prestigious Orations:** Featuring the Prof. B. Hanumaiah Oration and the Prof. Authikesavulu Oration.

- **Competitive Excellence:** Hosting the Millennium Gold Medal Competition and the newly introduced Surgeons Innovation Award Competition to celebrate cutting-edge surgical solutions.

- **Scientific Deliberations:** A rich academic lineup including peer-reviewed paper presentations, interactive panel discussions, and debates addressing contemporary surgical challenges.

SSBCON 2026 represents a major step in fulfilling our collective responsibility to foster innovation, evidence-based surgery, and academic mentorship. Together with the Executive Committee, I invite every member, resident, and senior surgeon to participate actively in shaping this landmark event.

Thank you for your dedication to the fraternity and the communities we serve.

Vayam Sevamahe

Dr. Sunil Kumar V
President, SSBASICC

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SSBASICC Newsletter

The Honorary Secretary's Message

Respected Seniors, Dear Friends & My Esteemed Colleagues of SSBASICC

Warm greetings to each one of you from Team SSB 2026

Surgery is not merely a profession; it is a calling that demands courage, precision, continuous learning and, above all, compassion. Every patient who places their trust in our hands reminds us of the profound responsibility we carry as surgeons. The past few months have been a wonderful reflection of the spirit, unity and commitment of our surgical fraternity.

Through academic programmes, professional interactions, social initiatives and fellowship activities, SSBASICC–2026 has continued to create meaningful opportunities for learning, collaboration and engagement.

The Second E-Shushrutha Bulletin brings together glimpses of our activities and achievements, including Surgeons' Day celebrations, GIPA Talks, MID-IAGES 2026, SIMGLOBE activities, the Nandi Hills Trek and the Green Legacy Plantation Drive.

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Each initiative has added a distinct dimension to our association-academic excellence, professional development, camaraderie, wellness and social responsibility.

Among these, the Green Legacy Plantation Programme at Raj Gopal Reddy Estate, Sarjapur-Bagalur, holds a special place. With around 100 fruit-bearing saplings planted in the name of SSBASICC and KSCASI, the initiative beautifully demonstrated that our responsibility extends beyond the operating theatre-to our environment, our community and future generations.

The E-Shushrutha Bulletin is more than a newsletter. It is a platform where experience meets enthusiasm, senior wisdom guides young minds,and ideas are transformed into action. I encourage our young surgeons and postgraduate colleagues to actively participate, share their experiences, pursue research and bring innovative ideas to our fraternity.

As surgical science continues to evolve—from minimally invasive surgery and advanced critical care to robotics, artificial intelligence and other emerging technologies our commitment to learning and adapting must remain unwavering. Growth is not optional in surgery; it is our professional responsibility.

At the same time, our greatest strength remains our unity. Leadership is not merely about a position; it is about purpose. Service is not about recognition; it is about the positive impact we create.

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The Honorary Secretary's Message:

Let us continue to uphold the timeless values of excellence, ethics, empathy and service. May our hands remain skilled, our minds ever curious and our hearts compassionate.

"Wherever the art of Medicine is loved, there is also a love of Humanity."

Every incision carries responsibility. Every life we touch carries trust. Let us honour that trust through excellence, integrity and dedicated service.

I sincerely thank our President, senior members, Executive Committee, young surgeons, postgraduate colleagues and every member of SSBASICC for their valuable support and enthusiastic participation in all our initiatives.

Let us move forward together and continue to build a fraternity that stands as a beacon knowledge, integrity, fellowship and service. of Together, let us make the journey of SSBASICC–2026 meaningful, memorable and extraordinary. With warm regards and gratitude,

With warm regards,
Thanking you.
Dr. Vikram S Biligiri
Hon Secretary
SSBASICC 2026

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SSBASICC 2026: Monthly Clinical Meet

April - Command Hospital Airforce at CHAF, Blr.

Monthly Clinical Meeting hosted by Command Hopsital was held on 16th April at T G Jones Auditorium, Command hospital, Airforce.

There was a talk on "Vascular Surgery for General Surgeons - Insights and Evolution" by Dr. Brijesh K Biswas

This was followed by the poster and paper presentations.

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SSBASICC Newsletter

SSBASICC 2026: April MCM - WINNER POSTER

Dr.Silpa K, Command Hospital, Bangalore

The Twain Shall Never Meet - Case of TEF

INTRODUCTION & CASE REPORT

Oesophageal atresia with tracheo-oesophageal fistula (EA/TEF 1 in 2500–3000 births. A 22-year-old primigravida developed polyhydramnios and PPROM at 31 weeks. A 1120-g premature neonate was delivered by LSCS with respiratory distress, excessive salivation, and inability to pass an orogastric tube. Syndromic facies and right upper-limb phocomelia were noted.

INVESTIGATIONS:

Radiography showed the OG catheter terminating at T2. Echo revealed PDA and ASD. The radiological findings confirmed Type C EA/TEF with associated syndromic features.

MANAGEMENT: Right posterior thoracotomy revealed a distal fistula near the carina, high friable proximal pouch, high-riding azygos, and a wide gap precluding primary anastomosis. Cervical oesophagostomy and gastrostomy were performed. The infant subsequently received NICU care and gastrostomy feeds.

CONCLUSION: High-risk syndromic EA/TEF requires meticulous planning and a contingency strategy

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SSBASICC Newsletter

SSBASICC 2026: April MCM - WINNER PAPER

Dr Pradeep Kumar A , Command Hospital

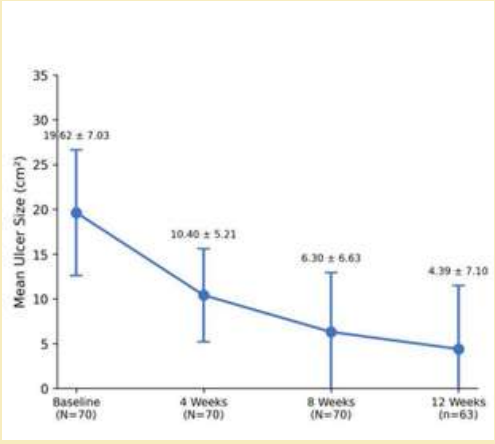
Outcome of Autologous Fat Grafting in Chronic Non-Healing Ulcers

INTRODUCTION: Chronic non-healing ulcers affect 1–2% of the global population and remain challenging to treat. Autologous fat grafting offers a regenerative approach.

AIMS: To evaluate the effect of autologous fat grafting on wound size reduction and epithelialisation.

METHODOLOGY: A prospective single-centre observational study was conducted from 2024–2026. Seventy patients with chronic ulcers underwent topical nano-fat grafting. Wound dimensions and epithelialisation were assessed at 4, 8 and 12 weeks.

RESULTS: Mean wound area decreased from 19.62 to 10.40, 6.30 and 4.39 cm^2 at 4, 8 and 12 weeks, respectively ($p<0.001$). Complete healing increased progressively.



CONCLUSION: Topical nano-fat grafting is a promising, cost-effective treatment option.

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SSBASICC 2026: Monthly Clinical Meet

May - Private surgeons of Bengaluru at API Bhavana

Monthly Clinical Meeting hosted by Private Surgeons of Bengaluru and Corporate hospitals was held on 20th May at API Bhavana. There was a talk on “Lymph node biopsy - To do or not to do” by Dr. Sachin and on OSCE by Dr Challani.

This was followed by the poster and paper presentations.

This was the 5th monthly clinical meeting of the year and was well received with more than 145 members in attendance.

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SSBASICC 2026: May MCM – WINNER POSTER

Dr.Shravani E, Bangalore Baptist Hospital
Closing The Gap, Management of Congenital Diaphragmatic Hernia via Video-Assisted Thoracoscopic Surgery

INTRODUCTION & CASE REPORT

Congenital diaphragmatic hernia (CDH) is a condition characterised by herniation of abdominal viscera into the thoracic cavity, resulting in pulmonary hypoplasia.. Definitive surgical repair remains the cornerstone of treatment. A neonate was diagnosed antenatally with left-sided CDH on 32 and 34 week on antenatal ultrasonography. Following birth, the infant underwent prompt stabilisation in the NICU before being considered for thoracoscopic repair.

INVESTIGATIONS: Diagnosis and perioperative assessment included antenatal ultrasonography, serial chest radiographs

MANAGEMENT: Following haemodynamic stabilisation and reduction of pulmonary arterial pressure below systemic levels, thoracoscopic repair was performed using three 5-mm ports. The diaphragmatic defect was closed with interrupted Ethibond sutures

CONCLUSION: VATS is a safe and effective minimally invasive option for selected neonates with CDH

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SSBASICC 2026: May MCM - WINNER PAPER

Dr Abhisar Deswal , Baptist Hospital

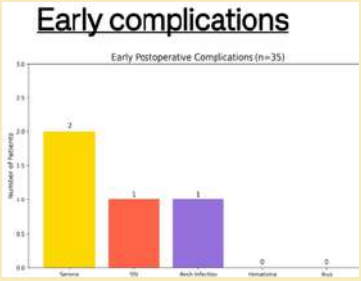
Early outcomes of eTEP-RS Ventral hernia Repair- An prospective observational study

INTRODUCTION: eTEP-RS repair is an evolving minimally invasive technique for ventral hernia repair, reproducing the principles of the open Rives–Stoppa repair while facilitating anatomical restoration with reduced surgical trauma.

AIMS: To evaluate the early postoperative outcomes and complications following eTEP-RS ventral hernia repair, - pain, ambulation, hospital stay, and surgical-site complications.

METHODOLOGY: A prospective observational study was conducted including 35 adults undergoing eTEP-RS repair. Operative characteristics, postoperative pain, recovery parameters, and complications were assessed

RESULTS: 26 patients (74.3%) were female, with a mean BMI of 29.88 kg/m². Mean operative duration was 195 minutes. VAS pain scores decreased from 6.2 on POD-0 to 3.1 on POD-1. Mean time to oral intake was 5.93 hours, and all patients ambulated by POD-1.. Complications included seroma, port-site infection, and mesh infection



CONCLUSION: eTEP-RS provides favourable early outcomes with effective abdominal wall reconstruction

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SSBASICC 2026: Monthly Clinical Meet
June - BRAMCH and VIMSRC at API Bhavana

Monthly Clinical Meeting hosted by Dr B R Ambedkar medical college and Vydehi Institute of medical sciences and Research center was held on 17th June at API Bhavana

This session was kickstarted by a talk on "Current scenario of Endocrine surgery in India and Advanced surgical technologies" by Dr. Ganesh Bhat & was followed by the poster and paper presentations.

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SSBASICC Newsletter

SSBASICC 2026: June MCM – WINNER POSTER

Dr. Janavi M R , BRAMC

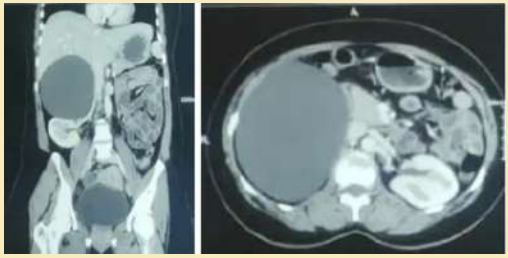
ENDOTHELIAL CYST PRESENTING AS AN ADRENAL INCIDENTALOMA : A RARE CASE REPORT

INTRODUCTION & CASE REPORT

Adrenal incidentalomas are clinically inapparent adrenal masses measuring >1 cm, detected during imaging for unrelated conditions. Adrenal endothelial cysts are exceptionally rare, with an incidence of approximately 0.06% in the general population. We report a 30-year-old woman presenting with abdominal pain and vomiting for two weeks. Clinical examination was unremarkable except for a previous lower segment caesarean section scar.

INVESTIGATIONS: USG & CT revealed a large cystic lesion in the hepatorenal region. Hormonal evaluation was normal

MANAGEMENT: The patient underwent diagnostic laparoscopy with right adrenalectomy. HPE confirmed a multiloculated endothelial cyst with calcifications and no evidence of atypia, with the remaining adrenal tissue appearing normal



CONCLUSION: Adrenal endothelial cysts are rare benign lesions that may mimic adrenal neoplasms

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SSBASICC Newsletter

SSBASICC 2026: June MCM – WINNER POSTER

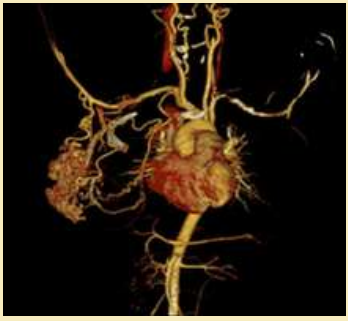
Dr Pavana M, VIMS

NOT A TUMOUR, BUT A TANGLE: A Rare Anterior Chest Wall Arteriovenous Malformation

INTRODUCTION & CASE REPORT
Chest wall AVMs are rare congenital high-flow vascular anomalies with diagnostic and therapeutic challenges. A 16-year-old female presented with a progressively enlarging right breast swelling present since birth, with recent rapid enlargement and spontaneous bleeding. Examination revealed a large pulsatile, compressible, bosselated mass involving the outer quadrants, with visible pulsations and palpable thrill.

INVESTIGATIONS: Doppler & CT angio demonstrated a high-flow AVM involving the breast & pectoral muscles. Multiple feeders noted from the internal mammary, axillary, lateral thoracic & intercostal arteries

MANAGEMENT: Following evaluation, staged embolisation was performed via transfemoral access. Residual feeders required repeat embolisation. Definitive surgical excision with a myocutaneous flap reconstruction was performed. Recovery was uneventful.



CONCLUSION: Complex chest wall AVMs require accurate vascular mapping and multidisciplinary planning

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SSBASICC 2026: June MCM - WINNER PAPER

Dr Lahari T R , BRAMC

One Incision, Two Objectives: Dual Purpose Pfannensteil Access for Combined Pelvic Surgery and Ventral Hernia Repair

INTRODUCTION: Concomitant pelvic and primary umbilical hernia may require separate approaches. This study evaluates the feasibility of utilising a Pfannenstiel incision as a single access route for pelvic surgery and ventral hernia repair

AIMS: To assess the feasibility and safety of combined pelvic surgery and ventral hernia repair through a single Pfannenstiel incision

METHODOLOGY: A prospective observational study was conducted. 60 pts underwent concomitant pelvic surgery and umbilical hernia repair through a single Pfannenstiel incision. Demographic, operative, postoperative, and patient-reported outcomes were assessed

RESULTS: Fibroid uterus was the commonest pelvic indication. All patients underwent retrorectus mesh hernioplasty with polypropylene mesh. Mean operative time was 75 ± 15 minutes and blood loss 37.5 ± 8.2 mL. Mean hospital stay was 3.2 ± 0.8 days. No major complications occurred. Cosmetic outcomes and patient satisfaction were favourable.

CONCLUSION: A single Pfannenstiel incision can safely and effectively provide access for selected concomitant pelvic surgery and ventral hernia repair. This approach offers adequate exposure & avoids additional abdominal incisions.

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Nandi Hills Trek-Healthy Surgeon: Healthy Nation Initiative

12th April - Nandi Hills

The Surgical Society of Bangalore organised a Nandi Hills trekking event as part of the Healthy Surgeon, Healthy Life initiative, encouraging surgeons to prioritise physical fitness and wellbeing The trek was spearheaded by Dr H. V. Shivaram, National Lead for **Healthy Surgeon - Healthy Nation**, and witnessed enthusiastic participation from more than 80 surgeons and members. Supported by Aster CMI Hospital and Trustwell Hospital, the event provided an opportunity for participants to reconnect with nature and promote camaraderie. The Nandi Hills trek was a successful blend of fitness, fellowship and fun, reinforcing the message that a healthy surgeon is better equipped to lead a healthy professional and personal life.

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Tree Sapling Plantation Drive
19th April at Chikadammarapalaya, Bagalur

Around 100 fruit-bearing saplings were planted in the name of SSBASICC & KSCASI. It was heartening to witness the enthusiastic participation of all our friend's & members. The event was inaugurated with a pooja followed by sapling plantation by Dr Sunil Kumar V, Dr Vikram S Biligiri, Dr K L Venkatesh, Dr Prem Kumar, Dr Venkatachala K, Dr Ravindra G, Dr Ameet Kumar, Dr Brijesh K Biswas, Dr Manjunath B D, Dr Sunil Kumar Alur, Dr Hemanth Ghalige and other members.

The programme was well organized with excellent hospitality, and was appreciated by all attendees. It truly reflected a meaningful green initiative

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Public Awareness Programme
30th April - 4th May at GIPA, Bengaluru

This public Awareness program was conducted in collaboration with Gokhale Institute of Public Affairs.

A comprehensive *Public Awareness Lecture Series.* These sessions were designed to disseminate evidence-based medical knowledge and promote preventative health strategies within the community.

It was a 5 day event where we had members of SSB interacting with the general public through presentations and an intriguing Q and A session.

Each day different subtopics were covered. The event was well appreciated and was also telecasted live on the GIPA website

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Dr Sunil Kumar and Dr H R Ravishankar spoke about First Aid and Trauma management

Dr Vishnu Kurupad and Dr Nataraj Naidu spoke about Cancer prevention

Dr H V Shiram and Dr Sunil Kumar spoke on Healthy lifestyle and Obesity

Dr Prem Kumar and Dr Nishanth Lakshmikantha spoke on Hernia and Common Urinary problems

Dr Harish Gowda and Dr Vikram S Biligiri spoke about common perianal conditions and its management

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SIMGLOBE – Global Simulation Summit
5th – 7th June at BMCRI, Bengaluru

SimGlobe 2026: Bridging Borders and Building Surgical Excellence

The inaugural *SimGlobe 2026*, a landmark global simulation summit, was held at Bangalore Medical College and Research Institute (BMCRI) from June 5th to June 7th, 2026. Bringing together luminaries and faculty from across all continents, the summit served as a premier international platform to advance healthcare simulation.

The event featured a rich academic agenda, including keynote addresses, panel discussions, debates, and 14 pre- and post-conference workshops. A key highlight was the active partnership of the *Surgical Society of Bangalore (SSB)* in organizing state-of-the-art laparoscopic and robotic simulation workshops. Delegates engaged in interactive discussions with simulator platforms and gained hands-on experience to refine their technical skills.

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Dr. Sunil Kumar V, President of SSB, delivered an invited guest lecture titled *"Will Algorithms Replace Our Faculty?", which drew significant appreciation from delegates for its methodical analysis of AI's evolving role in surgical pedagogy. The summit marked a pivotal step forward in simulation-based medical education.

"The strongest medical education simulation scenarios translate abstract concepts into decisions with consequences. In realistic but forgiving spaces, students make mistakes, reflect in structured debriefs, and return to the bedside more prepared."

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NSGE Update - 2026
12th and 13th June - BMCRI

The 23rd National Surgical Gastroenterology Update® 2026, a Single Theme Live Workshop cum CME, was successfully conducted on 12th and 13th June 2026 at the Dr Basavarajendra Alumni Auditorium, BMCRI, Bengaluru. Centred on "Proctology: Piles, Fissure, Fistulae, Prolapse, etc. – Evidence, Expertise & Excellence," the conference brought together national and local experts for academic exchange and practical learning.

The inaugural ceremony and Surgeon's Day celebrations were held on 12th June, with Chief Guests Dr Maruthu Pandian (President ASI), Dr Vijay Oza (Frmr President PGMEB & Frmr Chairman MARB, NMC) along with office-bearers of the Association of Surgeons of India, KSC-ASI, SSBASICC & NSGE Update.

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A major highlight was the live operative workshop, featuring contemporary procedures for haemorrhoids, complex fistula-in-ano, pilonidal disease, rectal prolapse and obstructed defaecation syndrome. Live demonstrations from multiple centres - IGOT, Bengaluru, GEM Hospital, Coimbatore & Healing Hands, Pune - offered insights into surgical decision-making and technique. The programme also included live transmission of colonoscopic interventions related to proctology from AIG, Hyderabad, which was highly appreciated.

Organised under the auspices of RGUHS, IGOT, KSC-ASI and MERT, and in association with SSBASICC. With 60 invited faculty & 280 registered delegates, the conference successfully integrated evidence, expertise and hands-on learning. The organisers received appreciation from delegates and faculty for the academic quality, thoughtful planning and professional execution of the programme.

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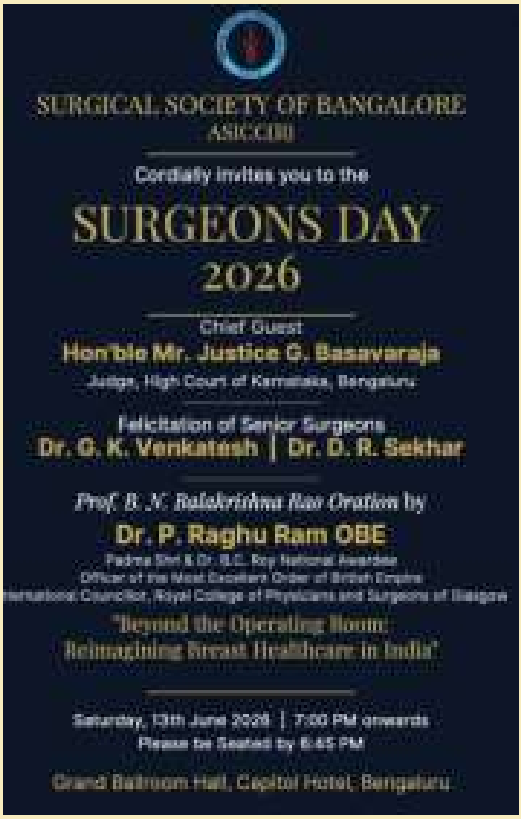
Surgeons Day Celebration 2026
13th June at the Capitol Hotel, Bengaluru

The Surgical Society of Bangalore ASICC(R) celebrated its annual Surgeons Day on June 13, 2026, at the Capitol Hotel, Bengaluru. The event serves as a flagship annual convention to honor pioneering senior surgeons, facilitate high-level scientific discourse, and foster community integration among medical professionals across the region.



The ceremony hosted over 200 active members and featured the prestigious 26th Prof. B. N. Balakrishna Rao Memorial Oration delivered by Dr. P. Raghu Ram OBE.

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Surgeons Day Celebration 2026
13th June at the Capitol Hotel, Bengaluru

The event commenced with academic and state protocols:

The master of ceremonies duties were conducted by Dr. Sahana M. and Dr. Brijesh Kanti Biswas.

The formal inauguration was solemnized by the lighting of the traditional lamp by

the Chief Guest - Hon'ble Mr. Justice G. Basavaraja and the dignitaries on the dias

Dr. Sunil Kumar V. delivered the introductory address, outlining the society's key milestones and responsibilities within the contemporary healthcare and scape.

A core objective of Surgeons Day is the recognition of lifelong service to medical science.

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Surgeons Day Celebration 2026
13th June at the Capitol Hotel, Bengaluru

Dr. G. K. Venkatesh was felicitated by the Office bearers of SSB for his contributions to surgical practice.

Dr. D. R. Sekhar was felicitated by the Office bearers of SSB for his contributions to surgical practice.

Hon'ble Mr. Justice G. Basavaraja addressed the assembly, highlighting the interface between law, medical ethics, and societal expectations.

He commended the surgical community for maintaining high clinical standards and stressed the legal frameworks that safeguard equitable healthcare delivery.

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Surgeons Day Celebration 2026
13th June at the Capitol Hotel, Bengaluru

Dr. P. Raghu Ram presented a literature-backed framework focusing on a paradigm shift from purely reactive surgical intervention to proactive public health management.

The convention formally concluded with a Vote of Thanks delivered by Hon. Secretary Dr. Vikram S. Biligiri, followed by the rendering of the National Anthem.

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MID IAGES Conference

26th - 28th June at Royal orchid resort, Bangalore

Organised by IAGES in association with the Surgical Society of Bangalore and KSCASI, the programme combined scientific discussions with extensive hands-on learning and contemporary surgical perspectives. The conference featured live operative workshops across three days, alongside sessions covering Upper GI, colorectal and proctology, HPB surgery, hernia and abdominal wall reconstruction, bariatric and metabolic surgery, and laparoscopic surgery. Master video sessions showcased advanced procedures

The programme also explored the future of surgery through dedicated sessions on robotics, artificial intelligence, simulation and advanced MIS training, culminating in discussions on AI in healthcare.

With panel discussions, quizzes, viva voce sessions and an MCQ examination complementing the scientific sessions, MID IAGES 2026 successfully blended knowledge, technology and practical surgical expertise, reinforcing its commitment to advancing minimally invasive surgery.

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Exclusive Interview

Dr. H. V. Shivaram

A Life in Surgery & Beyond

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Introduction

Dr H. V. Shivaram is one of Karnataka's most respected gastrointestinal and bariatric surgeons. With a career spanning over four decades, his journey encompasses military service, pioneering work in laparoscopic and pancreatic surgery, academic leadership, surgical education, and professional service at both state and national levels.

Born into a family rooted in Vedic scholarship and agriculture, Dr Shivaram's rise from a small village in the Malenadu region of Karnataka to becoming a nationally recognised surgeon reflects an enduring commitment to discipline, excellence and lifelong learning.

In this interview, Dr Shivaram reflects on his professional journey, achievements, mentors, personal interests and advice for the next generation of surgeons.

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Awards

- Bangalore University Gold Medal for MS (General Surgery), 1992
- Sainya Seva Medal from the Government of India and Armed Forces, 1988
- Rotary International Gold Medal for Best Young Surgeon
- Mahadevan's Award from the Association of Surgeons of India (Karnataka Chapter)
- Doctor of the Year Award, Family Physicians Association of India, 2013
- Vidyaranya Best Video Award, ASI Karnataka Chapter
- ASI Award of Honour (Website Initiative), 2019
- ASI Outstanding Member of the Year Award, 2023
- Eminent Doctors South Award (India Today), 2023
- Lifetime Achievement Award and Civic Honour at my native village, 2023
- Distinguished Alumni Award, Mysore Medical College and Research Institute, 2024
- MMCRI Centenary Oration Award, 2024
- Karnataka Anatomists Award of Honour, 2024
- Best Doctor South Award (Outlook), 2024
- ASI Award of Honour for the National Surgeons Day Initiative, 2025

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Posts and positions held

- Medical Officer in the Army Medical Corps (1983–1988)
- Surgical Residency (1988–1991)
- Resident Surgeon at St Philomena's Hospital, Bengaluru (1992–1995)
- Consultant Surgeon at St Philomena's Hospital, Bengaluru (1996–2002)
- Visiting Consultant and Head, Surgical Unit III at St Philomena's Hospital, Bengaluru (2002–2016)
- Visiting Consultant at Mallya and Lakeside Hospitals (2000–2008)
- Visiting Consultant at Sri Sathya Sai General Hospital (1996–2000)
- Consultant Surgeon at Columbia Asia Referral Hospital, Yeshwanthpur (2008–2016)
- Chief of Minimal Access GI Surgery and Bariatric & Metabolic Surgery at Aster CMI Hospital, Bengaluru (2016–2025)
- Visiting consultant at Aster RV Hospital (2025–Present)

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Posts and positions held

- Executive Committee Member, Karnataka State Chapter, ASI (2013–2015)
- Honorary Secretary, Karnataka State Chapter, ASI (2015–2017)
- President, Surgical Society of Bengaluru and ASI City Chapter (2014)
- Secretary, Surgical Society of Bengaluru and ASI City Chapter (2012)
- Executive Committee Member, Surgical Society of Bengaluru (2011)
- Executive Committee Member, Obesity Surgery Society of India (2018–2020)
- Executive Council Member, OSSI (2020–2022)
- National Executive Committee Member, Association of Surgeons of India (2019– 2021)
- National Executive Board Member, ASI (2025–2027)
- Secretary, ASI Website Committee (2019–2020)
- Chairman, ASI Webinar Committee (2019–2020)
- Organising Co-Chairman, KSCASICON 2020
- Organising Chairman, OSSICON 2022
- President and Chairman, ASI Karnataka Chapter (2023–2024)

Orations

- Dr H. S. Bhat Memorial Oration (KSCASI State Conference, 2019)
- Prof. M. Authikesavulu Memorial Oration (Surgical Society of Bengaluru, 2018) .
- Prof. Balakrishna Rao Memorial Oration (Association of Surgeons of India, 2023) .
- Mysore Medical College Centenary Oration (2024)

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Sir, could you tell us about your personal background?

I was born on 25 June 1958 in Honnagundi, a village near the sacred town of Sringeri, home to the southern Sharada Peetham established by Adi Shankaracharya.

I come from a family of Vedic scholars with an agricultural background. From childhood I was taught discipline, Gita and Veda mantras at home. Primary education was in Kannada medium Government school

In 1988, I married Dr K. S. Jayashree, an anaesthetist. We have two daughters and are blessed with two grandchildren

Could you describe your educational journey and professional development?

I completed my primary and middle school education at the Government Higher Primary School, Basarikatte, followed by high school at Sree Sadguru High School, Basarikatte.

I studied in Kannada medium till 10th standard. My pre-university education was at Bhandarkars Arts and Science College, Kundapura. Thereafter I pursued MBBS at Mysore Medical College and MS in General Surgery at Bangalore Medical College.

My military service taught me discipline, resilience and commitment. The challenging conditions of service along the border areas strengthened my character and shaped my outlook towards life and medicine.

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Following postgraduate training, I joined St Philomena's Hospital as a Resident Surgeon in 1992.

Through dedication and perseverance, I became the first resident surgeon in the institution's history to be promoted directly to the position of Consultant Surgeon.

Over the years, I developed a special interest in gastrointestinal and pancreatic surgery. To further refine my skills, I trained at G. B. Pant Hospital, New Delhi, and PVS Memorial Hospital, Kochi.

Subsequently, I undertook observerships at Southampton University Hospital and North Manchester General Hospital in the United Kingdom, Memorial Sloan Kettering Cancer Center in New York, USA, and Heidelberg University Hospital in Germany.

I was among the early adopters of laparoscopic surgery in Karnataka during the 1990s.

My growing interest in pancreatic surgery resulted in increased referrals for complex pancreatic disorders.

To date, I have performed surgeries for a broad spectrum of pancreatic diseases, including 132 Whipple's pancreaticoduodenectomy procedures. Our team was also the first in Karnataka to perform laparoscopic Whipple's surgery.

In 2004, I partnered with Prof. Dr Nandakumar Jairam to establish Sapthagiri Centre for Specialty Surgery, which subsequently evolved into a highly successful group surgical practice.

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I underwent specialised training in bariatric and metabolic surgery and established one of the earliest dedicated bariatric surgery units in Bengaluru. At Columbia Asia Hospital, our team treated patients from India as well as from the USA, Nigeria, Oman, Iraq and Mauritius.

At Aster CMI Hospital, we started advanced minimally invasive and robotic surgery. We established DNB Surgery, FNB Minimal Access Surgery and FMBS training programmes,

The additional responsibilities of Principal, Professor and Director of Academic Affairs enhanced my administrative capabilities and provided valuable leadership experience. In 2025, I transitioned my practice to Aster RV Hospital, closer to my home in Jayanagar, enabling me to pursue both professional and personal interests with greater balance.

What are your activities outside surgery?

Travel

I greatly enjoy travelling, interacting with local communities and understanding different civilisations and cultures. To date, I have visited 36 countries and travelled extensively throughout India.

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Trekking

Trekking allows me to reconnect with nature, remain physically fit and challenge my personal limits.

Significant expeditions have included:

- Everest Base Camp
- Mount Kilimanjaro
- Kailash Parikrama
- Lares Trek
- Alpine treks

Reading

I enjoy reading novels, biographies and books on history.

Writing

I regularly write travelogues and blogs. My writings may be accessed through my travel blog

Blog: HV Shivaram Travel Blog

Cooking

I Enjoy cooking vegetarian dish

Health and Fitness

I practise yoga daily, undertake regular brisk walking and maintain a healthy, protein-rich diet.

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Who have been your mentors?

I have been fortunate to learn from many exceptional surgeons and teachers.

Among those who have had a profound influence on my professional life are:

- Prof S Kantha
- Prof. C. Vittal
- Prof. K. V. Ashok Kumar
- Dr M. G. Bhat
- Dr Nandakumar Jairam
- Dr H. Ramesh
- Prof. Robert Rutledge
- Prof. Markus Büchler
- Prof Adarsh Choudhary

Interestingly, I often feel that my students have been my greatest mentors, constantly inspiring me to learn and grow.

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If you could relive your postgraduate years, what would you change?

My postgraduate training was extremely demanding. Surgical trainees often performed responsibilities extending well beyond clinical education.

Continuous duties lasting three or four days without meaningful rest were not uncommon. I believe surgical trainees should be treated with respect, entrusted with responsibility and regarded as partners in both learning and patient care.

They should receive strong mentorship and be encouraged to question, analyse and think independently. Even after their course completion, they need to be mentored till they establish independent practice.

Can you share a bit more about your interest in social service and giving back to society?

I strongly believe that a doctor's responsibility extends beyond the operating theatre. Medicine has given me opportunities, education, and a meaningful career, and I have always felt a deep obligation to give back to society, particularly to those who are less privileged.

My commitment to social service stems from my own upbringing. I come from a modest rural background and studied in government schools and government medical institutions. The opportunities provided by these institutions shaped my life and career. I therefore consider it both a privilege and a responsibility to contribute towards the welfare of society,

especially in the areas of healthcare and education.

Service to the Nation

My earliest contribution to public service was through the Indian Army. From 1983 to 1988, I served in the Army Medical Corps with the rank of Captain and was posted in several challenging locations, including the difficult terrain of the Poonch and Rajouri sectors along the Indo–Pakistan border. This period of service earned me the **Sainya Seva Medal** and instilled in me a lifelong commitment to discipline, service and leadership.

Charitable Medical Service

For twenty-five years, I served at St Philomena's Hospital, Bengaluru, a charitable institution where I provided free consultations and surgical care to patients admitted to the general wards and those from economically disadvantaged backgrounds.

In addition to patient care, I actively participated in the teaching and training of DNB students and surgical residents.

I also devoted ten years of voluntary service to **Sri Sathya Sai Hospital, Whitefield**, where I conducted weekly free outpatient clinics and performed free surgeries under the inspiration and guidance of the late Sri Sathya Sai Baba. This experience reinforced my belief that quality healthcare should be accessible to all sections of society.

Disaster Relief and Humanitarian Work

In 2001, following the devastating earthquake in Kutch, Gujarat, I participated in relief efforts organised through the Sadhu Vaswani Mission. Under difficult circumstances, we provided free medical and surgical services to earthquake victims,

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performing emergency procedures that helped save both limbs and lives.

Surgical Camps and Public Health Initiatives

Over the years, I have actively participated in numerous free surgical camps organised by the Association of Surgeons of India, Karnataka State Chapter, and the Bengaluru City Branch, providing surgical treatment to patients who otherwise had limited access to specialised care.

Philanthropy and Educational Support

A major focus of my philanthropic efforts has been supporting government educational institutions and economically disadvantaged students.

Some notable contributions include

- Donating ₹20.65 lakh for the complete renovation of the century-old Anatomy Dissection Hall Complex at Mysore Medical College and Research Institute during its centenary year in 2024.
- Contributing more than ₹8 lakh towards the renovation of the Government Primary and Middle School at Basarikatte, Chikkamagaluru District.
- Donating ₹2.25 lakh in 2008 towards the construction of a classroom at Sri Sadguru High School, Chikkamagaluru District,
- Donating ₹1 lakh to the Chitradurga Doctors Association to support academic activities and medical service initiatives
- Contributing ₹3 lakh towards the construction of a classroom at Sewa Sangama Vidya Kendra,

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A Personal Philosophy of Giving

The primary focus of my social and philanthropic activities has been to support quality education and healthcare for economically weaker sections of society, particularly through government-run institutions.

Having personally benefited from education in government schools and medical colleges, I remain profoundly grateful for the opportunities I received. My motivation has always been simple: to give back to society and help create opportunities for future generations, just as others helped create opportunities for me.

What are your favourite foods, places and books?

Favourite Foods - Traditional Malenadu cuisine, including: • Kadabu, Patrode, Menthya Halva & Millet-based preparations

Favourite Destinations

Within India - Himalayan Mountain range, Uttarakhand, Himachal Pradesh & North-Eastern states

Internationally - Iceland, Scandinavian countries & New Zealand

Favourite Books

Novels by Dr S. L. Bhyrappa, Travel literature & Inspiring autobiographies

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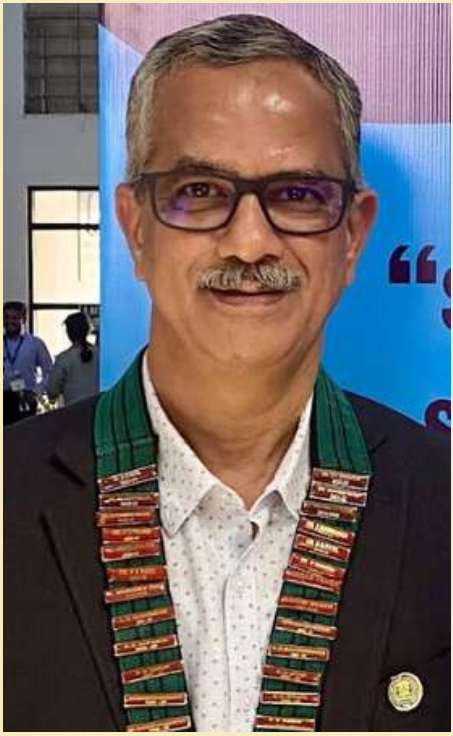
What do you consider the key to your success?

The principles that have guided me throughout my life are

- Discipline
- Hard work
- Continuous learning
- Relentless pursuit of excellence
- Refusal to accept mediocrity



What advice would you offer to young surgeons?

Work hard to gain experience and mastery of your craft. Do not become preoccupied with financial rewards; if you devote yourself fully to patient care and professional excellence, success will naturally follow.

Never stop learning. Surgery is a lifelong educational journey. Operate with skill. Lead with humility. Teach generously. Serve selflessly

Beyond the operating theatre, remain engaged with professional organisations, society and contemporary platforms of communication. Ultimately, the true measure of a surgeon is not the number of operations performed, but the lives influenced, the students trained and the legacy left behind.

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A ‘C S’ on Team RCB of 2026

RCB’s Classic Success in 2026 was by a Team of Cricketers Symbiotic of

Captain **S**mart Rajat Patedar, a **C**olossal **S**ix hitter
RCB’s **C**onstant & **S**taunch Virat Kohli, the **C**elebrity **S**tar, **C**haser **S**upreme, always **C**harged up & **S**mart
Charismatic & **S**pirited Phil Salt
Curly haired & **S**wift Jacob Bethel
Charming **S**troke maker, Devdutt Paddikal, **C**arefree & **S**tylish
Catcher & **S**tumper Jitesh Sharma
Cow corner **S**pecialist Tim David, **C**lean **S**triker over, & **C**ommitted **S**liding fielder at
Calypso **S**miles of Romario Shepherd, with bat &/or ball
Cunning & **S**treet smart Krunal Pandya, so full of **C**ommon **S**ense

Author

Dr C S Rajan

Classy **S**eamer Bhuvneshwar Kumar, **C**apable & **S**easoned **C**ub **S**mart Suyash Sharma, the **C**lever **S**pinner
Charging **S**ydneysider Josh Hazelwood, the **C**onsistent **S**peedster
Chosen **S**ubstitute pacer Rashik Dhar

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Comfy **S**ub Venkatesh Iyer, the **C**onfident & **S**washbuckling batter
Commencing **S**eason swing bowler, Jacob Duffy

The team was **C**oached to **S**upremacy
by the **C**harismatic and **S**easoned Andy Flower.
Helped by the **C**alculative & **S**pry Dinesh Kartik, all **C**heer & **S**miles
Always under the **C**ool & **S**harp eye of Manager Mo Bobbat.
At the **C**hinaswamy **S**tadium, in Bengaluru.

The trio helped to **C**oalesce and **S**tick together a Team
Of **C**ricketing **S**oldiers focused on the **C**hallenges **S**pecific
To win the Tata IPL **C**up **S**pecial,
For the **C**onsecutive **S**econd time.

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Enhanced-View Totally Extraperitoneal (Etep) Repair: A Paradigm Shift In Minimally Invasive Hernia Surgery

Author

Dr Bharath Basavaraju
EC SSB

The Beginning: Enhanced view and Jorge Daes

The story of eTEP has a humble beginning from the operating rooms of Clinica Bautista in Barranquilla, Colombia, where Dr Jorge Daes a laparoscopic surgeon described in a landmark 2012 paper[1] in Surgical Endoscopy, was elegantly simple in concept though demanding in execution.

By shifting the camera port more cranially and entering the retrorectus space first rather than working directly in the confined preperitoneal Retzius space, by doing this the surgeon could develop a dramatically better-illuminated and large working field and was framed enhanced-view totally extraperitoneal approach: eTEP.

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Why Retromuscular repair Matters?

The shared anatomical logic across hernia types is precisely what gives eTEP its intellectual coherence. Extraperitoneal dissection, mesh in a physiologically sound plane, peritoneal integrity preserved: these principles apply with adaptation to inguinal, umbilical, epigastric, and incisional defects alike.

A 2025 comprehensive narrative review in BJS Open (Henriksen et al[4].) — produced by eight international abdominal wall surgery experts — positions eTEP as offering direct retromuscular space access, reduced intra-abdominal complication risk, and the capacity for larger mesh deployment with reduced fixation requirements.

The Expanding Evidence Base

A 2023 midterm analysis in the Journal of Minimal Access Surgery (Mishra et al[5].) reviewed 150 consecutive cases, encompassing incisional, primary, and recurrent ventral hernias demonstrating that eTEP RS is reproducible across hernia types, and that adding a transversus abdominis release (TAR) for larger defects.

The literature shows shorter hospital stays, reduced postoperative pain, and the avoidance of intraperitoneal mesh complications such as adhesion formation and visceral erosion. As IPOM rates have fallen globally over the past decade in response to these concerns.

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The robotic iteration (r-eTEP) has added a further dimension. A 2025 systematic review found that robotic eTEP was associated with a median hospital stay of two days versus three days for laparoscopic eTEP, reflecting the ergonomic advantages of robotic platforms in a confined retroperitoneal space. For centres with robotic capability, r-eTEP is increasingly favoured. For those without, the laparoscopic approach remains well-supported — a 2024 BJS report across two non-robotic departments confirmed excellent postoperative outcomes, affirming that the technique's benefits are not contingent on robotics.

The Learning Curve: An Honest Appraisal

eTEP demands serious investment.

The technique requires detailed knowledge of extraperitoneal anatomy its natural divisions, neurovascular structures, and the orientation shifts that occur as the surgeon crosses from one retrorectus space to the other.

Daes himself, in his 2023[2] Cirugía Española review, emphasised that formal training which ideally includes fresh cadaveric practice under an experienced mentor is very much essential before independent practice.

The learning curve for eTEP in ventral repair is generally cited at 20–30 cases before operative times and complication rates stabilise. For inguinal eTEP, the challenges are different that includes port placement, angle of dissection,

and anatomical landmarks differ from TEP in ways that require deliberate re-learning even for experienced endoscopic surgeons. The technique should be approached as a new procedure, not a minor variation on what came before.

The complications specific to eTEP are internal hernia from posterior rectus sheath dehiscence, linea alba injury during crossover, large haematomas from the retromuscular space even though rare but real, and are best avoided through familiarity with the technique's particular failure modes rather than extrapolation from TEP experience.

Where eTEP Stands Today

eTEP has become one of the most actively discussed techniques in abdominal wall surgery

It is performed worldwide and has been adapted for robotic platforms, extended to lumbar and parastomal hernias, and combined with component separation for complex reconstructions.

For inguinal hernias, eTEP occupies a specific and valuable niche: complex cases where conventional TEP's spatial constraints are limiting recurrent hernias, large inguinoscrotal defects, post-pelvic-surgery patients, bilateral repairs requiring generous bilateral dissection.

For ventral hernias, its role is broader and still expanding: primary, incisional, and recurrent defects of small to medium size, with or without diastasis recti, with or without component separation. The 2025 BJS Open comprehensive review reflects the current

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eTEP is among the most promising minimally invasive approaches for ventral hernia, applicable across a defined anatomical envelope, extendable with posterior component separation, and appropriate for surgeons willing to invest in the requisite training and volume.

eTEP in India: Building a community

In India, the propagation of eTEP has been championed by two organisations working in concert: the Abdominal Wall Reconstruction Surgical Collaborative (AWRSC) and the Hernia Society of India (HSI), through a sustained national programme of live operative workshops, observerships, and registry-based research.

Dr Ramana Balasubramaniam stands at the foundation of this effort a member of the original 2017 eTEP pilot group and founder of the AWR Surgeons Community, which has directly trained over 25,000 surgeons worldwide. Dr Pramod Shinde and Dr Rahul Mahadar have been instrumental as faculty and researchers, contributing original publications on eTEP through both platforms.

Dr Sarfaraz Baig, President-elect of HSI and a prolific surgical educator from Kolkata and Dr Ganesh Shenoy From Bangalore has through his renowned observership programme introduced hundreds of Indian surgeons to live eTEP for both inguinal and ventral hernia repair. Together, they have ensured that eTEP is not merely known in India, but practised, taught, and advanced here.

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The Visual Stethoscope: A New Era in Surgical Practice

Author

Dr Naaz Jahan Shaikh , Chairman KSCASI

Ultrasonography (US) has been an important diagnostic imaging modality since the development of the B-mode scanner in the early 1950s.[1] Over the decades, it has evolved from a bulky, cumbersome device into the sleek, high-resolution machines available today.

The advent of handheld transducers capable of displaying images on mobile phones has further revolutionised ultrasound's use, making it readily accessible at the point of care. This accessibility not only enhances diagnostic capabilities but also empowers healthcare professionals to make more informed decisions in real-time. As technology continues to advance, we can expect even greater integration of ultrasound into everyday clinical practice ultimately improving patient outcomes. Often described as an "extended stethoscope" or a "visual stethoscope", it has become a natural extension of the clinical examination.

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In its early years, surgeons were among the first clinicians to embrace and perform ultrasound. However, as surgical practice became increasingly complex, with newer technologies & procedures, ultrasound gradually moved out of the surgeon's routine skill set. Today, obtaining a USG often involves transporting the patient to the radiology department and waiting for the study to be performed and reported.

While this process may be acceptable in stable clinical situations, it becomes a significant limitation in the setting of trauma or in a deteriorating postoperative patient, where every minute is critical. In such circumstances, rapid bedside ultrasound can provide immediate diagnostic information, expedite clinical decision-making, and potentially improve patient outcomes.

Time is often the most valuable commodity in these situations, and point-of-care ultrasound (POCUS) [2] has changed this math. By bringing diagnostic imaging directly to the bedside, we are eliminating the "Diagnostic gap". Whether it is a FAST/E-FAST exam in trauma, a guided vascular access or assessing a pleural effusion in the ICU, POCUS allows us to make high-stakes decisions in minutes rather than hours.

A faster triage in trauma where we can see the hemorrhage, cardiac and lung status in a few minutes, assessing post-operative collections, monitoring ileus, fluid status and organ perfusion, making a decision on when to put a needle in the abscess cavity, guiding the biopsy needle and so on, the opportunities become endless.

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The point-of-care US of the abdomen does not replace radiologist-performed abdominal US, but is rather used as an extension to the physical examination of the acute patient. The US is therefore relevant to most surgeons because it allows to quickly assess patients' anatomical and physiological characteristics. However, the deep structures and lesions acoustically shadowed by bone or air are difficult to visualize with US, which can limit the use of US of the abdomen compared to CT.

In contrast, the superficial structures of the head & neck are optimal for US, providing images with higher resolution of lymph nodes, thyroid, and the salivary glands than CT. [3] The US is therefore the first-line imaging modality for patients referred with neck masses and is essential in TNM staging of thyroid cancer.

The portable high-resolution US machines have made office-based US possible, and head & neck surgeons are increasingly performing US in their out-patient clinics.

It can be used in the preoperative planning to characterize neck lesions in detail and explore their anatomic relation to adjoining structures in real time.

The US is also recommended as guidance for fine-needle aspiration in the diagnostic work-up of neck masses. A surgeon-performed US can save the patient from an additional appointment at a radiology department. Intraoperative ultrasound has its special usage, and it once again implies that a surgeon knows how to perform ultrasound examination.

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In contrast to the surgeon-performed US in the emergency setting, the office-based US may increasingly replace the radiologist-performed US. It is quite simple and often quicker to diagnose acute appendicitis, acute calculous cholecystitis, liver abscess, and acute pancreatitis.

The beauty of it is that a surgeon can perform ultrasound in the same patients, repeatedly, when the situation demands, at no added cost. However, US is a very user-dependent image modality, and the competence of the operator is needed in order to ensure high diagnostic accuracy.
Having recognized the growing role of surgeon-performed ultrasonography, let us understand how accurate the surgeons are in comparison with their radiology colleagues.

In a review article published in the International Journal of Surgery, there was moderately good evidence for the routine use of ultrasound by surgeons at the bedside for gallbladder, thyroid, parathyroid, DVT scanning and trauma scanning

1. The ultrasound performed by the surgeon was reliable in both ruling out gallstones as a cause of RUQ pain and also allowing appropriate triage to either inpatient or outpatient management. Adequate evidence therefore exists for the routine use of bedside ultrasound in the detection of biliary pathology

2. Similarly, detection and accurate measurement of AAA (Abdominal Aortic Aneurysm) at the bedside is feasible and has good evidence for its use

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3. Ultrasound was accurate in determining the type of hernia (direct vs. indirect) with an 85% success rate and an overall accuracy by surgeons of 92% in finding a hernia, even in patients with no palpable bulge. Clearly, hernia ultrasound has the potential to be highly useful for surgical practice; however, a well-designed trial needs to be carried out.

4. There is extensive evidence regarding the use of surgeon-performed ultrasound in thyroid disease. Diagnostic thyroid ultrasound is important in the outpatient setting to differentiate benign pathology from malignant, triage of patients, and surveillance for benign lesion

5. Ultrasound performed by breast surgeons as part of the initial workup, especially in “one-stop" breast clinics, has been part of routine clinical care in the UK for over a decade and in many parts of the world. In a study conducted by Whitehouse et al, surgeons performed ultrasound had a sensitivity of 98.3% and specificity of 91.7%, demonstrating that surgeon-performed USG had high accuracy in differentiating benign from malignant disease.

6. A study evaluating the use of bedside USG in the ER in detection of appendicitis in patients presenting with a clinical suspicion of appendicitis found a sensitivity of 65% and specificity of 90%.[5] The greatest advantage is that a repeat examination may be done as required. Routine use in clinical practice will help a surgeon differentiate a catarrhal from a suppurative appendicitis and thus change the management.

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Since we do not have structured training with certification, it is important to understand how competence can be developed, assessed, and maintained in both emergency and office-based settings. US is a dynamic examination that differs from other stationary imaging modalities because the operator needs to combine both technical skills and image interpretation skills during the examination. We all know that the US is user-dependent. Technical skills are needed to operate the US equipment and optimize the image according to the need of the situation. Probe handling and proper maneuvering is an important skill that will help in getting an optimum image

Coming to the image interpretation skills, a basic knowledge of anatomy and its cross sections at various angles is of prime importance. A black and white image with various shades of grey need to be understood based on the tissue density, fluid, air, bone etc. which determine the display in a grey scale. In addition, knowledge of artefacts is essential, which helps in an accurate diagnosis.

All this needs structured training. The uptake of bedside ultrasonography in the UK has been less enthusiastic due to perceived issues with training, competence and medico-legal issues. The Royal College of Radiologists has issued guidelines for the training in the medical and surgical specialties in ultrasound. Yet, there has been a patchy response towards bedside ultrasonography by surgeons

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The College of Emergency Medicine and the Royal College of Obstetrics and Gynecology have embraced diagnostic ultrasound, with curricula, educational programs and credentialing available for trainees in these specialties. In India, there is a major problem of possessing a USG (Ultrasonography) machine due to the PCPNDT Act. Nevertheless it is not as difficult as it is thought of. Surgeons may utilize ultrasound in their practice upon demonstrating necessity, provided they comply with the rules and regulations established by this act. Incorporation of ultrasound as an extension of clinical examination will impart an additional examination skill. According to the SAGES GUIDELINES for institutions granting ultrasound privileges to surgeons, the surgical training should include ultrasound training in their curriculum. For those who did not have this facility, a structured training program must be made available.

The growing recognition of USG as an extension of the clinical examination has sparked enthusiasm among surgeons nationwide. Those with experience in surgeon-performed ultrasound can play a pivotal role in guiding and training others. With several structured courses now available, the pathway to acquiring these skills is clearer than ever. Change may not happen overnight, but our readiness to adapt will determine how quickly ultrasound becomes an integral part of everyday clinical/surgical practice. The future belongs to surgeons who combine clinical acumen with point-of-care imaging to deliver safer, faster, and more effective patient care.

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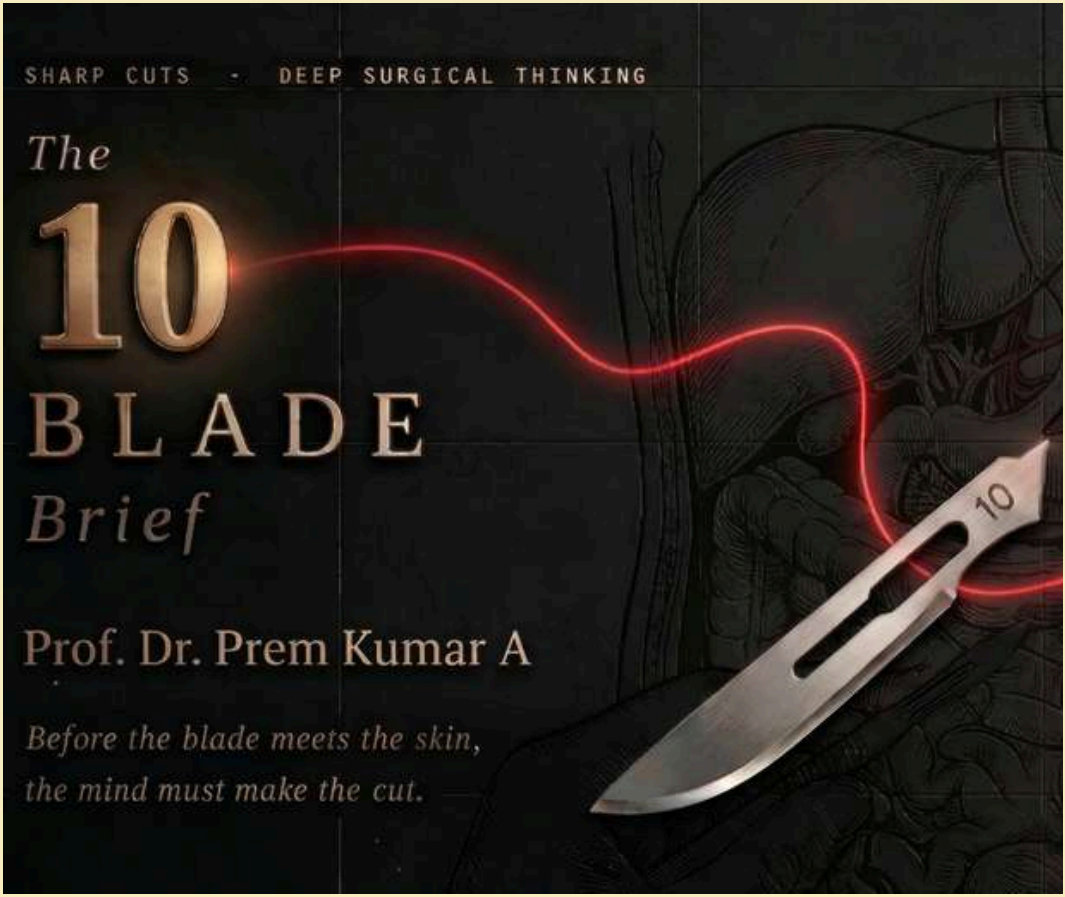
The 10-Blade Brief
Sharp Cuts. Deep Surgical Thinking



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The 10-Blade Brief

Sharp Cuts. Deep Surgical Thinking

EVIDENCE & JUDGEMENT - Innovation Without Illusion. Between Skepticism and Adoption: The Psychology of Surgical Innovation

Why the best surgeons are neither sceptics nor enthusiasts — but disciplined evaluators of evidence.

For trainees — and for those who train them

AUTHOR
DR. PREM KUMAR A
PROFESSOR & HOU
DEPT. OF SURGERY, BMCRI

I recently sat on a conference panel where the real event was not the panel at all. Outside the venue, parked with the confidence of a touring rock band, was a mobile demonstration unit for a new robotic platform. Delegates were invited to step inside, sit at the console and experience the future.

Watching the reactions — first from the stage and later from the queue outside was a masterclass in surgical psychology

A young surgeon was visibly captivated by the articulated instruments, immersive three-dimensional view and sheer futurity of the

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We are here to perform precise interventions—on assumptions, on patterns, on the way we see the world.
Here, the clinical meets the creative.
The technical meets the philosophical.

The two ways surgeons can fail a patient

There are two ways a surgeon can fail a patient when confronted with a new technology, although surgical culture tends to discuss only one.

1. The error of adopting too late

History is full of innovations initially treated as eccentric, unnecessary or even dangerous. Laparoscopic cholecystectomy is the familiar example. A surgeon who rejected it indefinitely because the open operation was familiar was not necessarily being conservative; once the evidence and expertise matured, continued refusal could deprive patients of smaller incisions, shorter recovery and reduced morbidity.

2. The error of adopting too early

The opposite error is equally important. Minimally invasive radical hysterectomy for early cervical cancer was attractive for all the reasons minimally invasive surgery is attractive: smaller wounds, less immediate morbidity and technical elegance. Yet later randomised evidence showed inferior oncological outcomes compared with open surgery. An appealing surrogate story had outrun a hard clinical endpoint.
Neither error is primarily a failure of dexterity. It is a failure of judgement about evidence — a competence that receives far less formal attention

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in surgical training than anatomy, technique or operative decision-making

Medicine advances because somebody refuses to accept the present. Medicine protects patients because somebody refuses to accept the future too quickly.

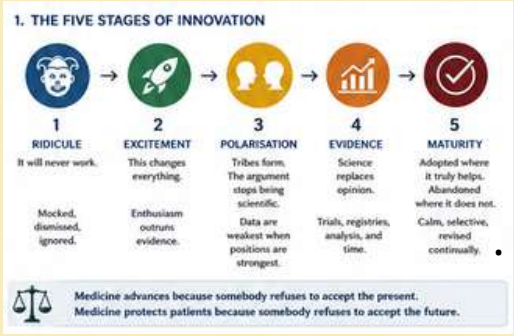
The disciplined adopter

The surgeon's obligation is therefore not to become an early adopter or a late adopter as an identity. It is to become a disciplined adopter: someone whose position on a technology is proportional to the strength of the evidence, whose enthusiasm is bounded by uncertainty, and whose opinion changes when the evidence changes.

This sounds obvious, but it is surprisingly difficult. Surgeons inherit attitudes from mentors, departments, conference networks, institutional investments, industry exposure and temperament. Once a technique becomes part of professional identity, changing one's mind can feel less like updating a scientific opinion and more like surrendering expertise.

The scalpel is calibrated. Judgement usually is not.

The five-stage life cycle of surgical innovation



Many important innovations seem to travel through a recognisable psychological and scientific arc. The stages are not universal laws, but they are useful because they tell us

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where enthusiasm, evidence and identity may be out of alignment.

Stage 1 — Ridicule

"It will never work." Hand hygiene, early laparoscopy and enhanced recovery all encountered versions of this response. Novel ideas often threaten established expertise before they threaten established evidence.

Stage 2 — Excitement

"This changes everything." Manufacturers, innovators, conferences, social media and early adopters create momentum. Evidence may still consist mainly of feasibility studies, case series, expert-centre results and surrogate outcomes.

Stage 3 — Polarisation

The debate becomes tribal. Enthusiasts interpret scepticism as ignorance; sceptics interpret enthusiasm as marketing. Ironically, positions often become most confident precisely when the evidence is least mature.

Stage 4 — Evidence

Registries, comparative cohorts, randomised trials, meta-analyses, learning-curve studies and economic evaluations begin to replace narrative with measurement.

Stage 5 — Maturity

The technology finally discovers its proper indication. Mature innovation rarely means "for everyone." It means knowing for which patient, procedure, surgeon and health system the technology adds sufficient value.

The period of maximum enthusiasm is often the period of minimum evidence.

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Why scepticism is necessary — and why it can become dangerous?

Surgical scepticism deserves respect. Operating on human beings creates an appropriate reluctance to experiment casually.

Long-term outcomes may be unknown; learning curves are real; costs have opportunity costs; and evidence generated in expert centres or sponsored environments may not generalise.

But scepticism ceases to be scientific when it becomes immune to evidence. A useful test is simple: what evidence would change my mind? If the answer is "nothing," the position is no longer scepticism. It is preference wearing scepticism's coat.

Biases that can trap the sceptic

- Status quo bias — current practice feels safe partly because its harms are familiar.
- Sunk cost of mastery — decades spent perfecting a technique can make the technique feel like an achievement to defend rather than a method to test.
- Survivorship reasoning — "my results are excellent" is incomplete without a denominator, audit and comparator.
- Comfort in caution — patient safety can be a legitimate reason to delay adoption, but it can also become a respectable language for avoiding a learning curve.

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Biases that can trap the adopter

- Novelty bias — newer is assumed to mean better.
- The technology halo — sophistication, articulation, screens and automation create an aesthetic of superiority before superiority is demonstrated.
- Prestige and authority — exceptional results from a master surgeon or pioneering centre may not be reproducible elsewhere.
- Fear of being left behind — professional anxiety can masquerade as clinical urgency.
- The surrogate trap — less blood loss, smaller incisions, faster docking or improved ergonomics may matter, but they are not automatically equivalent to survival, recurrence, function or quality of life.

Industry is part of this ecosystem, but it should not be caricatured as the villain. Much genuine surgical innovation would not exist without commercial engineering and investment. The distinction is simpler: a company is an advocate for its technology, not the final adjudicator of its clinical value.

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From personality-driven adoption to protocol-driven adoption

Every department contains innovators, early adopters, a majority that waits for clearer signals, and colleagues who change only after a technology has become standard. The leadership problem is not to eliminate this. A healthy unit needs several of them. The leadership problem is whether adoption occurs through a protocol or through the personality of the most influential surgeon.

A department that never moves early will never build capability and may eventually become obsolete. But a department that converts the enthusiasm of its leader directly into institutional policy exposes many patients to an unmeasured experiment. Responsible leadership creates a controlled bridge between innovation and routine practice.

Five questions every new technology must answer

Before a technology earns routine use, it should be able to survive five deceptively simple questions:

1. Is it safe?
2. Is it better — compared with the best current alternative properly performed, rather than with a weak comparator?
3. For whom — which patient, pathology, disease stage and clinical context?

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4. At what cost — not only money, but theatre time, consumables, training and organisational complexity?
5. Can average surgeons reproduce the result in average hospitals?

The fifth question is often decisive. A technique that works beautifully only in the hands of its inventor is an achievement; it is not yet a system-level clinical advance.

Robotics, asked properly

Robotic surgery is an ideal contemporary test case because the debate is often framed too crudely.

The question "Is robotics better?" is not difficult; it is incomplete.
For which operation, in which patient, in the hands of which surgeon, in which institution, at what cost, compared with what alternative?

What robotics can genuinely offer

·Articulation and dexterity in confined spaces.
·Tremor filtration and a stable three-dimensional view.
·Technical advantages in selected deep pelvic and complex reconstructive procedures.
·Improved surgeon ergonomics, which may matter over a long operating career.

What robotics genuinely costs

·Capital and consumable expenditure and, depending on the platform, supply-chain dependence.
·Set-up, docking, training and credentialing requirements.
·A real learning curve borne by real patients.
·A benefit profile that varies by operation: compelling in some settings, marginal or equivalent to high-quality laparoscopy in others.

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This is precision adoption. We already accept that a drug is not simply "better" in the abstract; its value depends on indication, patient, comparator, benefit, toxicity and cost. Surgical technology deserves the same intellectual discipline.

The asymmetry: omission versus commission

Surgical culture often punishes the two errors unequally. Commission — adopting a new technique and causing a visible complication — is dramatic, auditable and potentially litigated. Omission — failing to offer an innovation that later proves beneficial — is often invisible. The patient may never know that a better alternative existed.

That asymmetry can make institutional conservatism feel safer than it really is.

Ethical evaluation must count both harms: the harm of exposing patients too early and the harm of withholding benefit too long. Otherwise, what appears to be ethics may simply be professional risk management.

A seven-question adoption protocol

The five questions above interrogate the technology. The next seven interrogate the decision: should this unit, in this system, for this population, adopt it now?

01 What is the evidence, and at what level?

Registry, cohort, randomised trial, systematic review or meta-analysis — name the level explicitly.

02 What is the magnitude of benefit?

Do not stop at statistical significance. Ask how large the effect actually is.

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03 Is the benefit meaningful to the patient?

A technically elegant difference is not automatically a patient-important difference.

04 Is the endpoint hard or surrogate?

Prioritise survival, recurrence, function, complications and quality of life over convenient proxies when the clinical question demands it.

05 Can our team deliver it safely?

Define proctoring, credentialing, minimum case volume, conversion strategy, complication rescue and audit.

06 Is it economically sustainable here?

Value is local. A technology affordable in one health system may displace essential care in another.

07 What is the opportunity cost?

A robot or a functioning ICU? A platform upgrade or additional nurses, staplers, imaging, simulation and audit infrastructure?

Question seven is especially important in resource-constrained systems. Every rupee has an alternative use, and the alternative use also has a patient attached to it.

What surgical training should add

If evidence judgement is an everyday surgical competence, it should be taught deliberately. Trainees should learn not only how to perform a new operation, but how to interrogate the claims surrounding it. Journal clubs should ask about effect size, external validity, learning curves, conflicts of interest, patient-important outcomes &

opportunity cost. Simulation should be paired with credentialing. Early adoption should be paired with prospective audit.

A mature training programme should also make changing one's mind intellectually respectable. Updating practice after better evidence is not inconsistency; it is what scientific professionalism looks like.

A practical framework for the next innovation

When the next device, platform, or operative technique arrives, a surgeon can use a simple sequence: separate the claim from the mechanism; distinguish feasibility from effectiveness; distinguish surrogate from patient-important outcomes; examine who generated the evidence; ask whether results are transferable; define the learning curve; calculate local cost and opportunity cost; adopt in a controlled, auditable pathway; and decide in advance what evidence would trigger expansion, restriction or abandonment.

Innovation should enter the operating theatre through a protocol, not through excitement alone.

Closing

Progress in surgery does not come from believing every new technology, nor from rejecting every innovation. It comes from asking better questions than enthusiasm, fear, prestige or marketing have prepared answers for. The finest surgeons are neither permanent sceptics nor permanent enthusiasts. They are curious enough to examine everything seriously and disciplined enough to be

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convinced only in proportion to the evidence. They hold two humilities at once: that today's standard practice may look primitive in twenty years, and that today's exciting innovation may become something we later regret.

Both surgeons outside that demonstration bus will eventually be right about something and wrong about something else. Neither knows which yet.

What settles the argument is not seniority, novelty, confidence or the beauty of the machine. It is evidence — usually arriving after the conference lights are switched off and the demonstration bus has moved to the next city.

Curiosity without scepticism is marketing. Scepticism without curiosity is decline. The craft is in holding both.

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ಅಭಿವ್ಯಕ್ತಿ ಸ್ವಾತಂತ್ರ್ಯ

ಮೂಳೆಯಿಲ್ಲದ ನಾಲಿಗೆ
ಹೊರಳಾಡಿದೆ ಎಲ್ಲೆ ಇಲ್ಲದೆ!

ನಿರಂಕುಶ ನಾಲಿಗೆಗೆ
ನಿಯಮಗಳ ಪರಿಮಿತಿ ಇಲ್ಲವೆ?

ನಯವಿನಯವಿಲ್ಲದ ನಾಲಿಗೆಯಿಂದ
ನವನಿರ್ಮಾಣದ ಕನಸು ನನಸಾದಿತೆ?

ನಂಬಿಕೆ ಇಲ್ಲದ ನಾಲಿಗೆ
ಅನೀತಿಯ ಗೂಡಲ್ಲವೆ!

ಕ್ರಾಂತಿ ನಾಲಿಗೆಯ ಗುಲಾಮ ಅಲ್ಲ
ಕ್ರಾಂತಿ ಹದ್ದು ಮೀರಿದ ಮಾತಿನಿಂದಲ್ಲ

ನಾಲಿಗೆ ನುಡಿದಿದ್ದೆಲ್ಲ
ಅಭಿವ್ಯಕ್ತಿ ಸ್ವಾತಂತ್ರ್ಯವಲ್ಲ

ಸ್ವಾರ್ಥಿಗಳ ರಾಜಕೀಯದಾಟದಲ್ಲಿ
ನಲುಗಿದೆ ಅಭಿವ್ಯಕ್ತಿ ಸ್ವಾತಂತ್ರ್ಯ

ಮುದುಡಿದೆ ಸತ್ಯದ ಕ್ರಾಂತಿ
ನಿರ್ಜೀವವಾಗಿದೆ ಕ್ರಾಂತಿಯೋಗಿಗಳ ತಪಸ್ಸು

ಡಾ. ಅನುಪಮಾ ಪೂಜಾರ್
ಪ್ರಾಧ್ಯಾಪಕರು ಮತ್ತು
ಶಸ್ತ್ರಚಿಕಿತ್ಸಕರು SIMSRC

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“Beyond costume lies transformation. Inspired by the magnificence of Yakshagana, this artwork is not a portrait of a performer, but of the sacred moment when ornament, ritual, and imagination dissolve the human into the timeless

Dr Srinivas Yadav
Senior resident, SIMS RC

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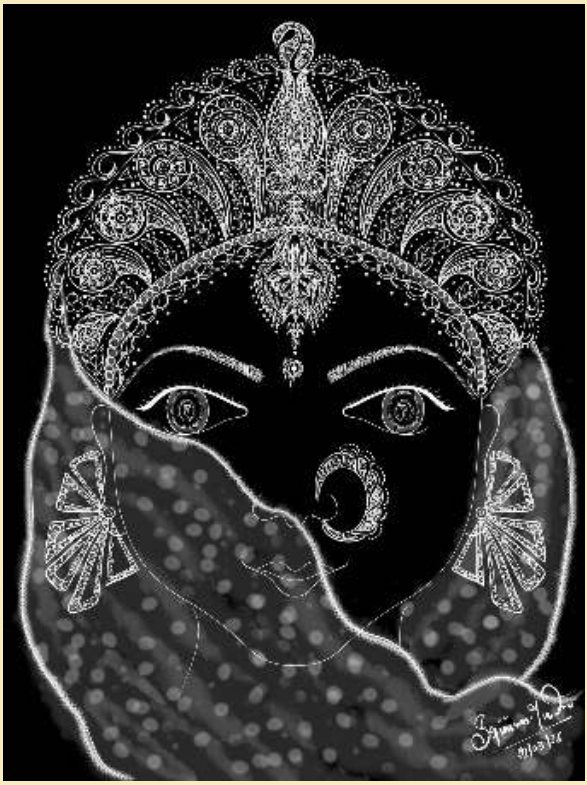

The Veiled Empress”

A face emerges from darkness, revealing only what is essential— the eyes, the ornaments, and the soul. The intricate crown, woven with delicate mandala-like patterns, symbolizes wisdom, heritage, and timeless beauty. Every line is intentional, echoing the craftsmanship of traditional Indian art while embracing a modern minimalist aesthetic.

Dr Srinivas Yadav
Senior resident, SIMS RC

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ANNOUNCEMENTS

Upcoming events

Monthly clinical meeting

August - St Johns Medical College

September - Bangalore medical college

April - June 2026

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ANNOUNCEMENTS

Extraordinary General Body Meeting

MEMORANDUM

Dear Member,

11th August 2026

The Extraordinary General Body Meeting of our Society is planned at API Bhavana on 19th Wednesday August 2026 at 8-00PM at API Bhavana.
(Combined with the Monthly Clinical Meeting & Followed by fellowship & Dinner)

Date: 19th (Wednesday) August 2026

Time : 8-00 pm (After paper presentations)

Venue: API Bhavana Hall – Vasantha Nagar - Bangalore – 560 052

AGENDA

1. To discuss the proposal for submission/application for grant of land for a proposed "SSB Bhavan" (Surgical Society of Bangalore Building/Convention Centre)
2. Proposal for Land Acquisition – by Dr Rajshekhar Jaka – Chairman Elect KSCASI.
3. Discussion on API Bhavan (First Floor)
4. Legal & Financial Structure & Liability.
5. PAN Card Issue.
6. Trust formation
7. Approval of initial application payment for proposed land acquisition near Devanahalli for SSB Bhavan.

Please Note: -

All the SSBASICC members are welcome!

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SSBCON - 21st & 22nd November 2026

Dear Esteemed Seniors & Colleagues,

The Executive Committee of SSBASICC cordially invites you to the 1st Edition of SSB CON 2026—our flagship annual conference celebrating 53 Years of Surgical Excellence & Fraternal Camaraderie.

Programme highlights

* Invited Keynote Lectures by Eminent Faculty
* High-Definition Surgical Video Demonstrations
* Surgeons' Innovation Awards 2026
* Prof. B. Hanumaiah Oration
* M. Authikesavulu Oration
* Oral Paper & Poster Competitions (for PG Residents & Young Surgeons)

Send your News, Articles, Case Reports, Classifieds, Awards and Acheivements etc. to

"sushruthassb@gmail.com"