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EDITORIAL

DETERMINATION

**Do what you believe in and believe in what you do.
All else is a waste of energy and time.** —
Nisargadatta

In 1883, a creative engineer named John Roebling was inspired by an idea to build a spectacular bridge connecting New York with the Long Island. However, bridge building experts throughout the world thought that this was an impossible feat and told Roebling to forget the idea. It just could not be done. It was not practical. It had never been done before. Roebling could not ignore the vision he had in his mind of this bridge. He thought about it all the time and he knew deep in his heart that it could be done. He just had to share the dream with someone else. After much discussion and persuasion, he managed to convince his son Washington, an up-coming engineer, that the bridge in fact could be built. Working together for the first time, the father and son developed concepts of how it could be accomplished and how the obstacles could be overcome. With great excitement and inspiration, and the headiness of a wild challenge before them, they hired their crew and began to build their dream bridge.

The project started well, but when it was only a few months underway a tragic accident on the site took the life of John Roebling. Washington was injured and left with a certain amount of brain damage, which resulted in him not being able to walk or talk or even move.

"We told them so."

"Crazy men and their crazy dreams."

"It's foolish to chase wild visions."

Everyone had a negative comment to make and felt that the project should be scrapped since the Roeblings were the only ones who knew how the bridge could be built. In spite of his handicap, Washington was never discouraged and still had a burning desire to complete the bridge and his mind was still as sharp as ever. He tried to inspire and pass on his enthusiasm to some of his friends, but they were too daunted by the task.

All he could do was move one finger and he decided to make the best use of it. By moving this, he slowly developed a code of communication with his wife. He touched his wife's arm with that finger, indicating to her that he wanted her to call the engineers again. Then he used the same method of tapping her arm to tell the engineers what to do. It seemed foolish but the project was under way again.

For 13 years, Washington tapped out his instructions with his finger on his wife's arm, until the bridge was finally completed. Today, the spectacular **Brooklyn Bridge** stands in all its glory as a tribute to the triumph of one man's indomitable spirit and his determination not to be defeated by circumstances. It is also a tribute to the engineers and their team work, and to their faith in a man who was considered mad by half the world.

Perhaps this is one of the best examples of a never-say-die attitude that overcomes a terrible physical handicap and achieves an impossible goal. Often when we face obstacles in our day-to-day life, our hurdles seem very small in comparison to what many others have to face. The Brooklyn Bridge shows us that dreams that seem impossible can be realised with determination and persistence, no matter what the odds are.

Even the most distant dream can be realized with determination and persistence.

It is my pleasure to share with you that Global Hospital is racing ahead on global highways. Our hospital figures in the list of 34 hospitals from India who have been chosen by National health services (NHS) U.K. for treatment & operations for foreign patients (www.nhsfamilychoice.co.uk). The hospital has taken a giant leap by providing state of the art technology with a dedicated patient sensitive team.

We are proud of our achievements, but we are more proud of association with you.

R.S. Bhatia Sanchit

Opportunity dances with those, who are already on the dance floor.



ARTICLE

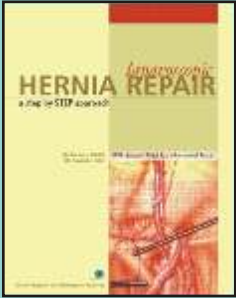
Complications of Laparoscopic Cholecystectomy

Dr. Parveen Bhatia
Medical Director,
Laparoscopic Surgeon

Dr. Bharat Bhasin
Surgical Associate

AUG '04

Vol. 4 No. 08



Laparoscopic Hernia Repair
(a step by STEP approach)

Forewords by

Dr. J. Barry Mckernan
Dr. Adarsh Chaudhary

Contents

200 pages with 16 chapters,
300 coloured photographs &
diagrams)

Authors

Dr. Parveen Bhatia
Dr. Suviraj J John



The eBook

CD on
Laparoscopic Hernia Repair
(a step by STEP approach)

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Besides all other complications associated with access and pneumoperitoneum, the most common complications associated with the procedure itself are **bleeding, duct injuries, and intestinal perforation** along with other less common ones.

Bile duct injuries

Sixteen percent of patients with major common bile duct injuries have findings of acute cholecystitis and 58% of these major injuries are "easy" gallbladders. Barry Salky

Mechanism of injury

Misidentification of anatomy appears to be the most common cause of laparoscopic bile duct injury. The most common scenario, initially described by surgeons at Duke University as the **"classic" Injury**, occurred in 63% of their patients. The "classic" injury occurs due to mistaking the CBD for the cystic duct which is clipped and divided. Further retraction of the gallbladder then leads to a second higher injury with division of the common hepatic duct as it approaches the bifurcation. This second ductal injury is often described in the operative note as being a 'second cystic duct' or "an accessory duct." This injury is particularly devastating as complete transaction of the biliary tree virtually removes any possibility of non-operative management by either endoscopic or transhepatic technique and mandates biliary-enteric drainage.

Other less common mechanisms of injury include a **"tenting injury"** in which the CBD is pulled laterally at the time of occlusion of the cystic duct and caught in the clip, thermal injuries due to injudicious use of cautery or laser, excessive application of clips to control bleeding in the area of the triangle of Calot and finally injuries to an aberrant or low-inserting right hepatic duct.

How to prevent ?

1. Lateral retraction of the infundibulum

In 1991 Hunter noted that Bile duct injuries with

laparoscopic cholecystectomy appeared to be more common in the U.S. (0.5 to 2.7%) than in Europe (0.33%)

He observed that American teaching stressed cephalic (towards the Right shoulder) traction on the infundibulum of the gallbladder, tenting the CBD and risking its misidentification. The cystic duct normally emerges at acute angle to the CBD and this angle actually narrows when the fundus is retracted towards the shoulder. From the perspective of the telescope, the distal Common Bile Duct appears continuous with the cystic duct and can easily be mistakenly identified as a long cystic duct. European instruction stresses the lateral retraction depicted in Figure 2 Such retraction places the cystic duct at right angles to the CBD, reducing the likelihood of misidentification.

2. Meticulous dissection

Arguably the most important step in preventing CBD injury. No clip should be placed on, and no incision should be made in, any structure until the transition between cystic duct and gallbladder infundibulum is clearly visualized.. Safe dissection absolutely requires that the cystic duct must be seen widening into the gallbladder before one can certify accurate anatomic identification.

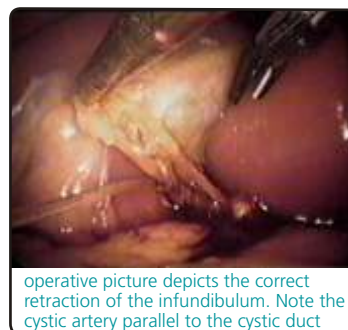
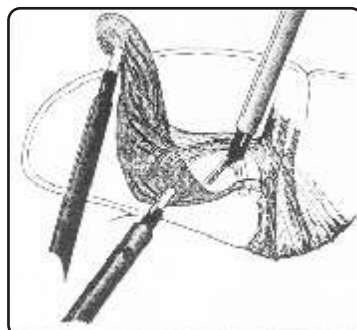
3. Know the indications for intraoperative cholangiogram (IOC)

If the patient is morbidly obese, has a significant prior history of disease or surgery in their abdomen, or if the surgical field is difficult to see due to the patient's anatomy or internal bleeding, the surgeon can always attempt an IOC.

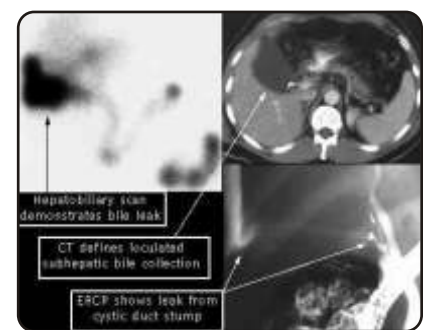
The Australian study reported that the risk of bile duct injury was decreased by half if IOC was performed during lap. or open cholecystectomy. As case complexity increased (e.g., severe inflammation around the gall bladder), obtaining an IOC decreased the risk of bile duct injury by eight-fold!..

Management of Bile Duct Injury

While the early recognition is important to prevent



operative picture depicts the correct retraction of the infundibulum. Note the cystic artery parallel to the cystic duct



ARTICLE (contd.)

infection and excessive scarring, immediate repair of the Common Bile Duct is associated with unacceptably high failure and it often compounds the initial injury.

1. Intraoperative: Management of bile duct injury depends upon surgeon experience. Roux-en-Y hepaticojejunostomy to the proximal common hepatic duct or to the bifurcation of the right and left hepatic duct is necessary.

2. Postoperative: Pain, fever, abdominal distention, and abnormal liver function tests are signs of bile leakage into the peritoneal cavity. **Definition and drainage of the biliary tree** requires an experienced interventional radiology team that can perform complex biliary tree manipulation. Percutaneous transhepatic cholangiography and percutaneous biliary drainage can delineate any biliary defect, and will divert the bile away from the area by allowing it to drain. The best diagnostic modality to demonstrate this bile leak is a Pipida (P-isopropylacetanilide-iminodiacetic acid) Scintigram (99% accuracy). These leaks are best managed by the placement of a common bile duct stent via ERC. via gravity into a bile bag. **Control of bile peritonitis** often means creating drainage for a biloma in the region of the biliary defect. **Reconstruction of the biliary tree** usually means construction of a hepaticojejunostomy in an elective setting. A wait of 4-6 weeks allows most peritonitis to settle, improving the likelihood of a good repair.

Lillemoie of John Hopkins cautioned that " Bile duct injuries may have a less satisfactory outcome because of both the more complex nature of the injuries and the frequent association with significant inflammation and fibrosis secondary to the bile leakage. Furthermore operations performed before referral to a tertiary biliary tract surgical center may lead to a poorer outcome" Long term results are far from being satisfactory. Perhaps the longest follow-up available after the management of major bile duct transections in the laparoscopic cholecystectomy era is reported by Bergman et al from the Netherlands in which patients sustaining major bile duct injury were reconstructed with a Roux-en-Y hepaticojejunostomy. At a median follow-up of 25 months, 33% of the patients required subsequent transhepatic balloon dilatation or reconstruction with a secondary hepaticojejunostomy.

BLEEDING COMPLICATIONS

The most common bleeding problems relate to improper insufflation techniques (iliac or aortic injury), poor selection of abdominal wall puncture sites (epigastric vessel injury), failure to visualize the trocar sites upon withdrawal of the laparoscopic sleeves at completion of the procedure, unfamiliarity with the vascular anatomy of the procedure being performed, inadequate laparoscopic training in the use of hemostatic techniques available, and undiagnosed coagulopathy . Bleeding can occur during the dissection – from the abdominal wall, from the liver bed or from hemostatic clips coming off after the surgery.

It can usually be controlled endoscopically; if bleeding cannot be controlled, the procedure will be terminated and the abdomen opened to gain direct control.

The bleeding and duct-injury rates with the open procedure are reported at about 0.4%, whereas they run almost 1 % with the laparoscopic procedure.

Non-biliary complications can be equally devastating, but have received less attention in literature. They occur as frequently as biliary injuries, and can be life-threatening and difficult to manage.

Perforation

Perforation of the bowel during laparoscopy can occur either by puncturing the bowel with the trocars used to enter the abdomen or by the dissecting instruments used during the procedure. Patients with a perforation require an emergency operation(s) to repair the injury. The commonest is duodenal perforation during dissection of the Calot's triangle.

Dropped gallstones

There has been a considerable increase in the number of perforations of the gallbladder (10%-32%), resulting in intraperitoneal gallstone spillage. This spillage has caused an increase in the incidence of lost gallstones (0.2t - 20%) Recently, Läufer et al published a review of lost gallstones including many macroabscesses in different localizations, granulomas, fistulas, bowel obstruction, choledocholithiasis and choledochorrhea, and migration of stones into the femoral canal, pelvis, and ovary. Previously, there had been reports about the elimination of biliary stones through the urinary tract as a late complication.

Is laparoscopic cholecystectomy safe in cirrhotic patients?

Laparoscopic cholecystectomy can be performed safely in selected patients with cirrhosis(Child's A & B patients) with some technical modifications to avoid varices in placing the ports site This remains a relative contraindication to the procedure and certainly should be avoided in patients with Child C cirrhosis and its associated complication.

Reference

- Deziel DJ. Complications of laparoscopic cholecystectomy: a national survey of 4,292 hospitals and an analysis of 77,604 cases. *Am J Surg* 1993;165:9-14.
- Mathisen O, Soreide O, Bergan A. Laparoscopic cholecystectomy: bile duct and vascular injuries. Management and outcome. *Scand J Gastroenterol* 2002;37:476-81.
- Bacha EA, Steiber AC, Galloway JR, Hunter JG. Non-biliary complication of laparoscopic cholecystectomy. *Lancet* 1994;344:896-7.
- Thompson JE Jr, Bock R, Lowe DK, Moody WE III. Vena cava injuries during laparoscopic cholecystectomy. *Surg Laparosc Endosc* 1996;6:221-3.
- Hunter JG. Avoidance of bile duct injury during laparoscopic cholecystectomy. *Am J Surg* 1991;162:71-76.



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MRP

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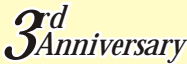
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announces...



LAPAROSCOPIC WEEK
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Live Workshops & CME

1. **Focus on "Hysterectomy"** 19th Nov
November 19, 2004 (Friday)
2. **Focus on "Endo Hernia 2004"** 20th Nov
November 20, 2004 (Saturday)
3. **Focus on "Urinary Stones"** 21st Nov
November 21, 2004 (Sunday)

	Registration for each event		Spot
	Before 01-11-2004	After 01-11-2004	
Residents	250/-	500/-	1000/-
Consultants	500/-	1000/-	1500/-

Registration for all events

Residents	700/-	1200/-	2500/-
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or Call Mr. Amit Mattoo; *Event Manager, Global Digital Services*
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HIGHLIGHTS of 08-08-2004 CME



Dr. Nalin Nag, Consultant Apollo Hospital delivering an excellent talk on "HIV & the Surgeon".



Dr. Sunil Sharma, Assistant Professor and Bariatric Laparoscopic Surgeon, University of Pittsburg, Pittsburg, USA, sharing his experience on "Past, present, and future of Obesity Surgery".



Dr. Arvind Kumar, Professor Surgery, AIIMS telling about the forthcoming Conference on Health Insurance on Oct. 16-17, 2004 at Indis Habitat Centre.



Dr. Shakti Kumar Gupta, Additional Professor, Hospital Administration, AIIMS speaking on "Health Insurance in India".

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