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It's called MINDSET!

Dr. Sandeep Chopra

We are all born winners but are trained to loose. Right from childhood we are taught do's & don'ts as a part of civilized behavior. Reward and punishment form an integral part of growing up. Fear of failure gets incorporated in our personalities to an extent that majority of us tend to give up even before thinking of an attempt.

As my friend was passing by the elephants, he suddenly stopped, confused by the fact that these huge creatures were being held by only a rope tied to their legs. It was obvious that the elephants could, at anytime, break away from the ropes they were tied to but for some reason, they did not. My friend saw a trainer nearby and asked why these beautiful, magnificent animals just stood there and made no attempt to get away.

"Well", he said, "when they are very young and much smaller, we use the same size rope to tie them and at that age, it's enough to hold them. **As they grow up, they are conditioned to believe they cannot break away.** They believe the rope can still hold them, so they never try to break free." My friend was amazed. These animals could at any time break free from their bonds but because they believed they couldn't, they were stuck right where they were. **The powerful and gigantic creature has limited its present abilities by the limitations of its past.**

Like the elephants, how many of us go through life holding onto a belief that we cannot do something simply because we failed at it once before? How many of us refuse to attempt something new and challenging because of our so called MINDSET? We

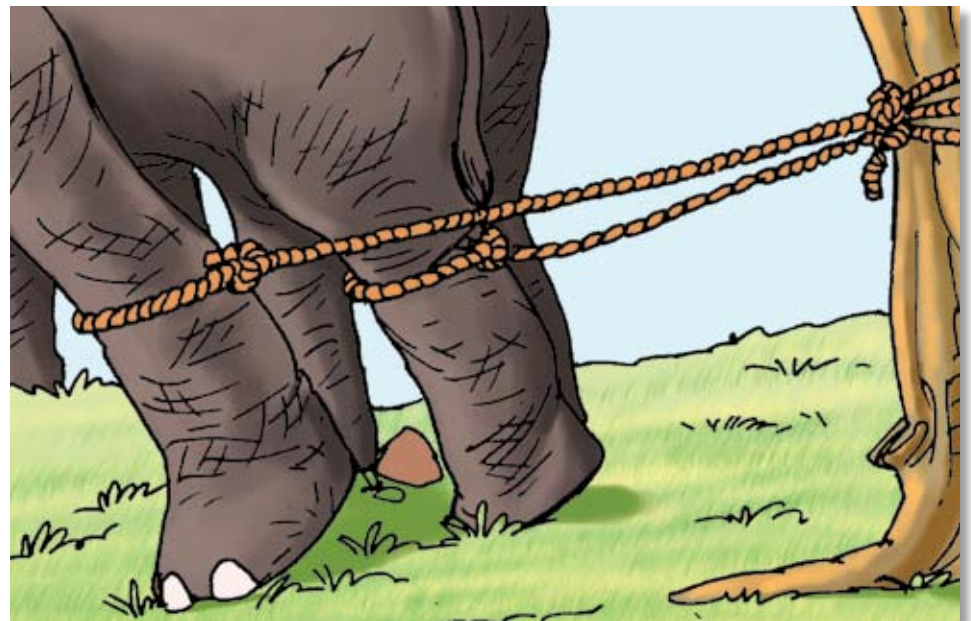
should CHOOSE not to accept the false boundaries and limitations created by the past.....**Our attempt may fail, but we should never fail to make an attempt...** Dale Carnegie said, "You can conquer almost any fear if you will make up your mind to do so. For remember, fear doesn't exist anywhere except in the mind." It is not because things are difficult that we do not dare, it is because we do not dare that things are difficult. Jan Ashford said "There is no such thing as can't, only won't. If you're qualified, all it takes is a burning desire to accomplish, to make a change. Go forward, go backward. Whatever it takes! But you can't blame other people or society in general. It all comes from your mind. When we do the impossible, we realize we are special people."

The greatest revolution of our generation is the discovery that human beings, by

changing the inner attitudes of their minds, can change the outer aspects of their lives. And there's no doubt that visualization is a proven success technique used by achievers in every field, from athletes to actors to astronauts. None other than golfing legend Jack Nicklaus is said to have always played a course in his mind before actually beginning a game. John Goddard, the number one goal achiever in the world, told that visualization was one of the main techniques he used to accomplish more than 550 major goals!

"As simple as it sounds, we all must try to be the best person we can: by making the best choices, by making the most of the talents we've been given."

Mary Lou Retton



If you really do put a small value upon yourself, rest assured that the world will not raise your price. - Anonymous

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Laparoscopic Total Pericystectomy for Hepatic Hydatid Cyst

Optimise: Combining Radicality with Minimal Access

Dr. Suviraj John, Dr. Neeta Sharma, Jhansi, Dr. Parveen Bhatia

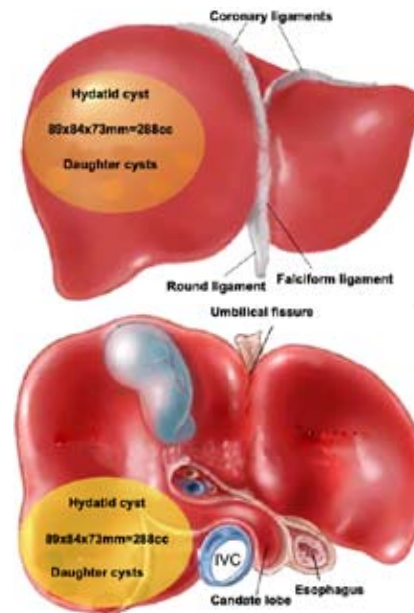
The classical approach to the curative management of hepatic hydatid cyst has been the radical surgical extirpation of the cyst in totality – namely total pericystectomy or resection of the related liver segment or lobe. However, this approach is technically more demanding and carries a significantly higher morbidity and mortality rate in comparison to more conservative approaches, such as endocystectomy and partial pericystectomy. Recognising this, most surgeons prefer the safer conservative alternative, combined with long-term disease surveillance. In turn, this calls for accepting a higher disease recurrence and biliary fistulisation rate and dealing with them on a need to treat basis.

With the introduction of laparoscopic approaches to the surgical management of hydatid hepatic disease, surgeons have experimented with implementing the minimal access approach to the full spectrum of operative options available. The more aggressive have reported success with approaches such as laparoscopic total pericystectomy as early as 1995^{1,2}. Subsequent experience has confirmed the success of such an approach in the hands of experienced surgical teams. Our team has been treating hepatic hydatid cysts with the minimal access approach for about a decade with the laparoscopic endocystectomy approach with benzimidazole chemotherapy combined with long-term disease surveillance as the treatment of choice with good long-term outcomes. We now report the successful outcome of a case of hepatic hydatid cyst where a more radical approach was employed.

CASE REPORT –

A 28 year old male patient was referred to us with a two year history of right upper

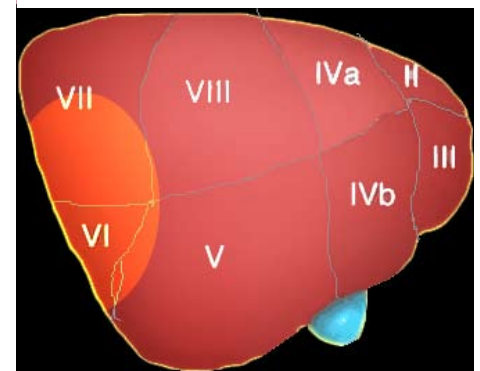
abdominal pain and swelling. He had twice undergone aspiration of the lesion before the current presentation.



On latest ultrasound investigation, he was found to have a large cystic lesion of the right lobe of the liver. Sonographic morphology of the lesion was one of a clear cystic collection with intra-cystic echoes. There was no gall bladder pathology noted and the biliary tree was normal on examination. The liver function tests were normal. A clinical diagnosis of hepatic hydatid disease had been made and the patient started on benzimidazole therapy before referral. With the presentation and sonographic characteristics suggestive of hepatic hydatidosis, the patient was planned for an operation of the same.

A diagnostic laparoscopy was carried out with the patient in the supine position with the head-end raised and right-side elevated. The surgeon and the camera assistant stood to the left of the patient with the second assistant to the right of the patient as in a laparoscopic

cholecystectomy. Carboperitoneum was created using the closed technique and the intra-abdominal pressure maintained at 15 mmHg. A 30° laparoscope as used through a 10 mm umbilical optical port. At laparoscopy, a large 'bulge' was noted in the postero-lateral aspect of the right hepatic lobe.



No other lesions were noted in the abdomen. Further ports were added: 10 mm port at the epigastrium, below the costal margin, 5 mm subcostal port in the anterior axillary line and an 11 mm port an inch above the anterior iliac spine in the right mid-axillary line. Lysis of hepatoparietal fibrinous adhesions with Harmonic Scalpel™ revealed a large white domed cystic lesion with a well-formed pericyst. The most prominent area of the lesion was surrounded adequately with rolling gauze piece soaked in hypertonic saline (3%).



The lesion was then carefully penetrated in a controlled manner with the Palanivelu Hydatid System (PHS) introduced through the 11 mm right mid-axillary port. The cyst contents were aspirated under vision.



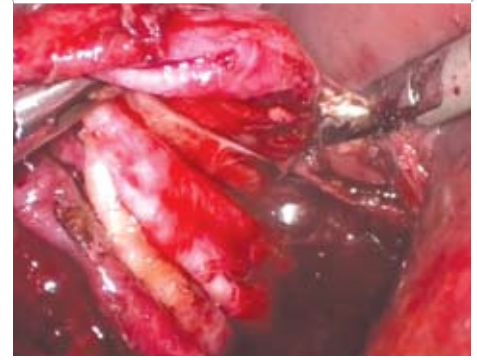
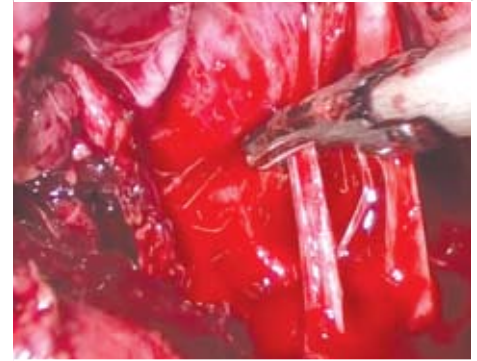
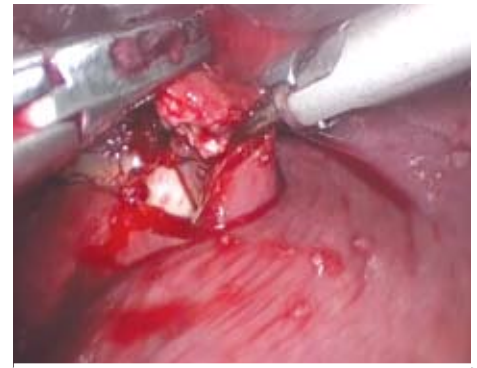
The cyst cavity was then examined for residual contents and any biliary leak. Having confirmed the absence of the above, the cavity was filled with hypertonic saline

and given a contact period of 10 minutes for scolical effect, at the end of which the cavity was reaspirated.

At the end of the endo and ecto-cystectomy, it was noted that the pericyst had a significant proportion of it superficial and in addition, was very discrete in relation to the surrounding healthy liver. A clear hypo-vascular plane was then progressively developed between the pericyst and the liver utilizing sharp and blunt dissection (by suction-irrigation cannula).



Haemostasis was enabled with the Harmonic Scalpel™. No large hepatic vasculature was encountered during dissection. A bile radicle entering the pericyst that was endo-clipped and then transected. The dissection was then continued in the hypo-vascular plane leading to a complete pericystectomy.



The excised pericyst was extracted using an endobag through the enlarged mid-axillary port site.



A no. 24 Fr. drain tube was left in the cavity after haemostasis was secured and the port sites were closed in layers.



The patient recovered rapidly in the post-operative period with the drain tube being removed on the 3rd post-operative day. It had drained about 200, 50 and 20 ml of sero-sanguinous fluid on the first, second and third post-operative days respectively. There was no bile-tingeing of the drained fluid. The patient was discharged on the 4th post-operative day, ambulant and on normal diet. Histopathological examination of the cyst confirmed hydatid pathology.



We conclude that whenever possible in the case of a surgically treatable hepatic hydatid cyst, the approach that assures the patient with the best disease free outcome, associated with an acceptable risk profile must be employed. We advise, that in the case of a hydatid hepatic cyst where the pericyst is well-formed and is easily separable from the surrounding liver, a laparoscopic total pericystectomy must be attempted in the hands of an experienced laparoscopic surgeon with due care given to vasculo-biliary connections. **The new mantra to Optimise = Radicalise + Minimise!**

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Pericystectomy for Hepatic Hydatid Cyst



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