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Mama, let me see your face.....!!

By Rohinee Charles

A professor in a college ethics class presented his students with a problem. He said, "A man has syphilis and his wife has tuberculosis. They have four children: one has died; the second one is born deaf, the third one is blind and the fourth suffers from tuberculosis. The mother is pregnant again. What do you recommend?"

Now-a-days abortion has become a trend and a norm of life. If we don't want the unborn child, we go and get it aborted. Even the Government approves of it so that it can curtail the country's population. 'It is estimated that 40 to 60 million abortions take place during a year in the world. In India, it is estimated that about 6 million abortions take place every year, of which 2 million are spontaneous and 4 million are induced. Of the induced abortions, nearly 5 to 6 lakhs are legal and the rest are estimated to be illegal abortions' -Dr. M.C. Kapilashrami (NIHFW).

The question is how we define abortion. According to the Webster's Dictionary, it is the removal of an embryo or foetus from the uterus in order to end a pregnancy. In medical terms, abortion is the termination of pregnancy at any time before the foetus has attained the stage of viability. In other words, we could also say that it is a fashioned butchery of the modern life style.

There are many reasons for abortion. We sometimes abort because we are unwed mothers, or we did not plan to have a baby right then in our life or the doctor has told us that our unborn child is going to have some kind of congenital deformity. So what do we

do? Do we play 'God' and decide to abort or do we go on with the pregnancy? Does our conscience prick us?

"The greatest destroyer of peace is abortion.... And if we accept that a mother can kill even her own child, how can we tell other people not to kill one another? So, how do we persuade a woman not to have an abortion? Therefore, a mother who is thinking of abortion should be helped to love, that is, to give until it hurts her plans, or her free time, to respect the life of her child. The father of that child, whoever he is, must also give until it hurts. By abortion, the mother does not learn to love but kills even her own child to solve her problems." -Mother Teresa. Although an expectant mother undergoes pain while giving birth, yet there is joy on her face when she holds her new born in her loving arms. If it's an unwanted child, the parents should be encouraged to give for adoption rather than to abort. They should be made aware of reliable family planning methods.

As salt has the quality to preserve, it is used as a preservative. In the same way, we need to preserve our moral values. The world takes the broad path—the easy way out. But we need to take the narrow path. Of course, taking the narrow path is difficult but it preserves life. We can always make a difference. Doctors take the Hippocratic Oath, so why not preserve it and apply it in their profession. If we flow below the standards of the world, the world will punish us and if we flow above the standards of the world, the world will persecute us. Are we

ready to live an uncompromising life?

Let's come back to the question posed at the beginning- what would you recommend? Should the mother continue with her pregnancy? The students replied that the unborn child should be aborted. 'Fine', said the professor, 'you have just killed Beethoven.' Imagine how many Beethoven's we are killing!

Here is a beautiful song of an unborn child pleading his mother to let him live.

MAMA

Mama, I want to live. Mama, won't you let me live

Mama, let me see the daylight. Mama, let me see your face

I am a two month old baby in my mother's womb

And my life is just a beginning, a gift from up above

And they're planning to take my life won't you listen to my cry

Father God created us, in His likeness and image

Then how can you take a life that is not your own

He did trust you with a life so precious in His eyes

Then how can you turn your womb into a Killing Field

The blood of the slaughtered Innocents pleads out for justice

And God says I will hear their cry, take vengeance for their cause.

"I am the master of my soul, I am the captain of my fate." - Written by Nelson Mandela on the prison wall.

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Ten Steps of "Scarless" Single Incision Total Laparoscopic Hysterectomy

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Total hysterectomy has been shown to have more clinical benefits when performed with a laparoscopic approach in comparison to traditional open surgery. However, multiple puncture sites might increase trocar-associated complications, such as bleeding, hernias and wound infection and the cosmetic results are not always optimal. The umbilicus, an embryonic natural orifice, is an anatomical structure that may be used to perform advanced gynaecological procedures, further reducing the morbidity associated with classical laparoscopic surgery. Single incision laparoscopic surgery (SILS) is principally an extension of the multiport laparoscopic surgery with an aim to reduce the trauma of access to body cavities and thereby residual scarring to the patients and hence a new weapon in the armamentarium of surgeon especially minimal invasive surgeon.



Patient position

After the success of SILS appendectomy, SILS cholecystectomy and SILS hernia repair, we have now recently ventured into Single Incision Total Laparoscopic Hysterectomy (SITLH). The indications for SITLH are limited as of now, but as our experience and confidence increases, larger size uterus and patients with previous surgeries will

also be attempted. Advancing technology has launched articulating instruments and flexible camera tips in market which will facilitate in difficult cases.

PROCEDURE

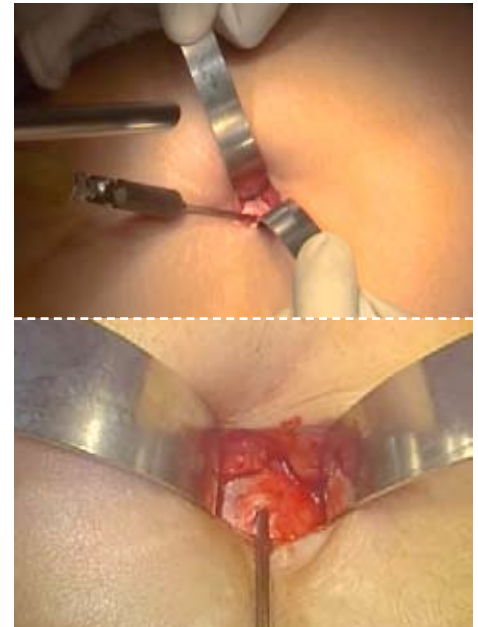
Step I. Abdominal wall access

We prefer to give a 11mm intraumbilical vertical skin incision (& not supra/infraumbilical or transverse incision). This incision utilizes the depth of umbilicus thus limiting the whole of incision intraumbilically. The laxity of umbilical skin further facilitates the space for trocar insertions. Subcutaneous tissue is separated and rectus sheath visualized. Veress needle is inserted in midline and pneumoperitoneum created upto 17mmHg.



Intraumbilical 11mm vertical incision

S shaped retractors are inserted on either side in the skin incision and a skin flap developed circumferentially using a gauze held on a long artery forceps. This technique of making the skin flap gives upto 2.5cm space in the same 11mm incision. The assistant focusses the camera on the incision for clear visualization of rectus sheath and the extra light also helps. First, optical 10mm port is inserted in midline. We prefer the 10mm transparent port instead of the reusable one.



S shaped retractors and veress needle inserted and seen with telescope

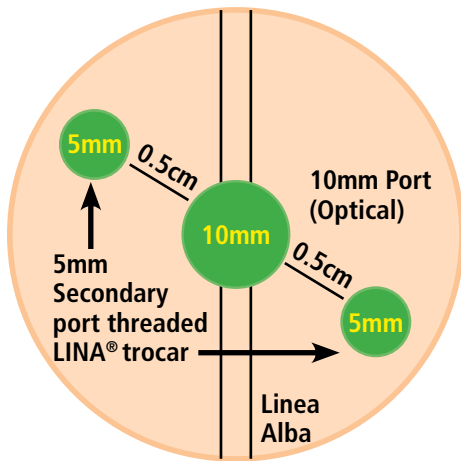


Transparent port preferred



Multiple fibroid uterus

Secondary ports are made on either side of the optical port, one little above while the other little below to avoid clashing of instruments. The ports are inserted in different directions with about 0.5cm distance in between the ports. We use the 5mm LINA® threaded trocars for secondary operating ports. Threading prevents slippage of the port. Long size ports are preferred. One 5mm trocar is threaded fully inside, while the other 5mm trocar only one thread is inserted. This keeps the handles of instruments at different levels to avoid clashing. To insert, the port is first slid into the skin flap (at about 45° angulation) and then at the proper position the port is made vertical and rectus sheath pierced. This creates more than 0.5cm space in between two ports.



Port positions

This technique, developed by us, obliterates the need of any special access port currently available in the market (like Covedien's SILS™ port, Gelpport or ASC Triport). These access ports are expensive and require atleast 2.5cm incision. Special articulating instruments (like Novare's Real Hand instruments) can be used but we have been able to perform SILS with our usual nonarticulating instruments.

After port insertion, the pneumoperitoneum is decreased to 15mm Hg.

Step II. Diagnostic Laparoscopy

After first port insertion, diagnostic laparoscopy of pelvis and upper abdomen is done. With reference to adhesions and mobility of uterus, if SILS is decided then further secondary trocars are placed in the same incision as described above.

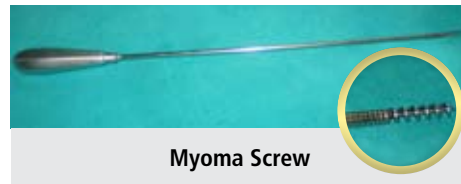


Ports in single intraumbilical incision

Step III. Uterine manipulation

Uterine manipulation can be done vaginally with a simple endometrial curette or laparoscopically using a myoma screw.

Myoma screw definitely helps in positioning the uterus. We like the myoma screw on a needle designed by Dr. Rakesh Sinha, BEAMS hospital, Mumbai (made by Creative Surgical®) for its sturdiness.



Myoma Screw

Step IV. Dessication of Attachments

The infundibulopelvic ligaments are dessicated using Harmonic ACE (if salphingo-oophorectomy is desired) or the upper pedicle consisting of tubes, round ligament and ovarian ligament is dessicated.



Telescope, grasper and Harmonic inserted through single incision at the umbilicus



Dessication of upper pedicle with Harmonic ACE

Step V. Pushing the Bladder down

Bladder is pushed down with sharp as well as blunt dissection (using rolled gauze piece).



"Cigar rolling technique of the gauze".

An open gauze is rolled in a "cigar shaped" manner by the scrub nurse, and then the corners are cut sharply so that the loose threads of gauze don't fall into the peritoneal cavity. Rolled gauze, held on a grasper, is introduced into the peritoneal cavity through the 10mm optical port. The gauze should push on the cervix posteriorly and not on the bladder. It should be a "planar" push.



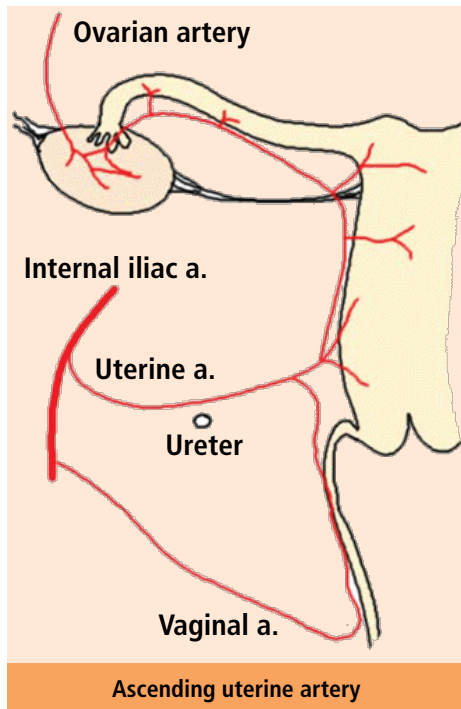
Bladder dissection with rolled gauze

To remove the gauze, edge of the gauze is held by grasper. The grasper holding the gauze along with the 5mm port is removed from the skin. As the grasper is catching the gauze, the gauze is pulled out of the abdominal tract.

Step VI. Uterine Vessels Dessication

"Kiss the uterus but from a safe distance" meaning one should not be very close to the

uterus. Too medial approach can damage the vascular supply of uterus while a too lateral approach can injure the ureter. While remaining parallel to the uterus, we take small but sure steps with Harmonic ACE.



After bladder dissection, uterine vessels become easily visible. We prefer to coagulate the uterine vessels first using bipolar and then desiccate with Harmonic ACE. With this approach, we hardly encounter any bleeding.

Step VII. Colpotomy

“Tampoons are enough rather than fancy cups”. A Tampoon made with gauze and held by sponge holding forceps is inserted into the posterior fornix. The posterior fornix is bulged out and uterosacrals made taut.

The uterus is anteverted at this point either by myoma screw in situ or by endometrial curette. Posterior colpotomy is done using monopolar hook. With that tampoon still in place to prevent gas leakage, another tampoon is inserted into the anterior fornix for anterior colpotomy in similar manner. Both the colpotomy incisions are reunited using monopolar or Harmonic ACE.

Pneumoperitoneum loss can be prevented by just placement of a single gauze or tampoon intravaginally and applying babcock forceps on the labia majora.



Tampoon in posterior fornix
Posterior colpotomy



Tampoon in anterior fornix
Anterior colpotomy

Step VIII. Delivery of uterus

Either vaginally or by morcellation



Specimen

In larger uterus, morcellation may be required. It has not yet been done in single incision laparoscopic surgery. But with the emerging and advancing technology, any day a 5mm morcellator will be launched, solving this problem also. But till then if need arises, we can change the 10mm port to 12mm port and morcellation can be guided by 5mm telescope (cystoscope with hysteroscopic sheath).

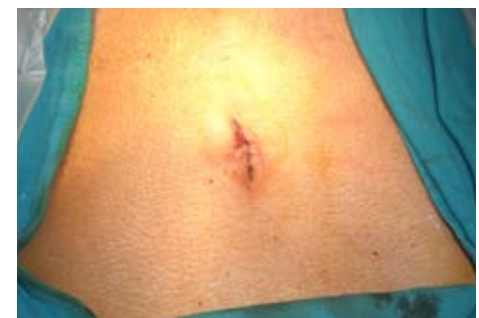
Step IX. Colpotomy closure

Can be done vaginally or laparoscopically. Either way, we believe in using delayed absorbable (vicryl no 1-0) continuous suturing.

Step X. Single Incision closure

After check laparoscopy to ensure hemostasis, ureter and bladder integrity, the secondary ports are removed. The 10mm port is slid off the peritoneal cavity under vision so that all the gas comes out (the scope remains in and the canula is pulled out).

After deflating the abdomen properly, the incision is closed. With S retractors in place the edges of the rectus sheath of the 10mm port is held by long artery forceps and sutured together using vicryl no-1 (prevents any chance of herniation) Subcuticular sutures using monocryl no 3.0 are applied on the skin. The incision falls back into the depth of umbilicus. Thus making it a “Scarless” surgery.



Scarless surgery

Our technique is very cost effective because custom made access ports and specially designed articulating instruments are not used. Other than these ports being expensive, they also require a 2.5cm incision. While with our technique we give the usual 11mm incision.

SILS is the next big step in laparoscopic surgery worldwide. It offers a huge cosmetic advantage and also enables much quicker recovery for the patient compared to conventional lap surgery. For the patient it is extremely appealing to be offered surgery through a single small cut, than through multiple incisions.