



globalnewsletter

BHATIA GLOBAL HOSPITAL & ENDOSURGERY INSTITUTE NEWSLETTER

VOL: 10 NO: 6

PRICE: Rs. 4/- PER COPY

JUNE, 2010



asicon2010

70th Annual Conference

Association of Surgeons of India

December 15 -20, 2010 Venue: **asicon City @ AIIMS Campus, New Delhi**

<p>Day 1: Wednesday, December 15, 2010</p> <p>asicon2010 Live Live Operative Workshop with a difference! Simultaneous Transmission to different halls. Basic Surgery Hall Upper G. I. Hall Urology Hall Hepato-Pancreatico-Biliary Hall Colorectal Hall</p>	<p>Day 2: Thursday, December 16, 2010</p> <p>asicon2010 CME Lectures by pioneers on contemporary issues Recent advances in surgery Master class for Post Graduates by eminent national faculty National Surgical Quiz A must for MS / DNBE Candidates & All practicing Surgeons</p>	<p>Day 3 - 6: Friday, December 17 - Monday, December 20, 2010</p> <p>Showcasing Indian Surgery! ASI Orations Guest Lectures Controversies in Surgery Panel discussions Videos, Symposium</p>	<p>Trade Exhibition</p> <p>asitech International Technology Show @ asicon2010 Open Surgery Instruments Laparoscopic Equipment & Instruments Sterilization Equipment Electronic Gadgets for Surgeons Hospital Information systems Latest Medical Books & Journals Hospital Security System Hospital Furniture, OT Equipment Integrated OTs</p>
<p>Trade Exhibition</p> <p>asitech First of its kind in India! Theme Hall: "Surgeon as an Entrepreneur" Setting up your hospital asitech tells you how "From Idea to Effect"</p>	<p>Day 1 - 6</p> <p>asicon2010 Specials Digital Technology & Surgeon Virtual Reality Hall, Video Hall Surgical Skills Learning Centre Basics of research methodology Basics of Biostatistics: that everyone must know Medicolegal Issues in Surgical Practice Know Your Tools Hall</p>	<p>Social Events : Day 1 - 6</p> <p>asicon2010 Social Events Welcome Dinner Dilli ki Ek Sham Apke Naam: An evening to remember! Multicuisine Food Court Special Area for Accompanying Persons & Children Delhi Darshan Guided Tours, Metro Rides</p>	

"An event you just cannot afford to miss"

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Online Registration Open

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Events

- Day 1: Wednesday, December 15 2010
asicon2010 Live
Live Operative Workshop with a difference !
- Day 2: Thursday, December 16 2010
asicon2010 CME
Lectures by pioneers on contemporary issues
Recent advances in surgery
Master class for Post Graduates by eminent national faculty
National Surgical Quiz
- Day 3 - 6: December 17 - 20, 2010
Showcasing Indian Surgery!
ASI Orations
Guest Lectures
Controversies in Surgery
Panel discussions
Videos, Symposium
- Day 1-6
asicon2010 Specials
Surgical Skills Learning Centre
Basics of Research Methodology
Basics of Biostatistics: that everyone must know
Medicolegal Issues in Surgical Practice
Know Your Tools Hall
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asicon2010 Social Events
Welcome Dinner
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Multicuisine Food Court
Special Area for Accompanying Persons & Children
Delhi Darshan Guided Tours, Metro Rides

He who works with his hands is a laborer. He who works with his hands and his head is a craftsman. He who works with his hands and his head and his heart is an artist. -St Fancis of Assisi

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OBSESITY

An Indian Perspective and Surgical Management

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It is ironic that in the so called "Third world" countries, where majority of the population lives below the poverty line, obesity is emerging as a major health problem. Obesity has reached epidemic proportions in India in the 21st century, with morbid obesity affecting 5% of the country's population. Almost 27% of the urban Indians are obese as was found in one epidemiological survey in Delhi. Not only is obesity restricted to the adult population, adolescents and children are also victims of this spreading epidemic. In one survey the prevalence of obesity in affluent schoolchildren is 6% and 22% of them were overweight. Along with the prevalence of obesity, other co morbidities including diabetes mellitus, hypertension, hyperlipidaemia are also on the rise in this group of population. This in turn also increases the risk of heart diseases, stroke and cancer.

WHO criteria for the Caucasian population:

BMI Status

Below 18.5	Underweight
18.5 – 24.9	Normal
25 – 29.9	Overweight
30 – 34.9	Obese
35 – 39.9	Severe Obesity
> 40	Morbid Obesity
> 50	Super morbid Obesity

Why BMI for western world does not apply to Indians

It has been seen that Asian Indians are at risk of developing obesity related co-morbidities at lower levels of body mass index (BMI) and waist circumference (WC) than their western counterparts. The reasons for this are

multifactorial. Lifestyle changes, increasing affluence and genetic predisposition are well known causes of obesity. Many socio cultural factors are also responsible for this trend. A diet rich in saturated fats are considered healthy rather than a balanced diet comprising of fruits and vegetables. Availability of cheap domestic labor also reduces physical activity in women who are homebound. Rapid urbanization resulted in consumption of more "fast food" and a sedentary lifestyle with no physical activity. Children and adolescents are also becoming victims of this growing epidemic.

Therefore the proposed cut-offs for defining overweight and obesity needs to be redefined for Asian Indians.

Surgical Management of obesity

Current International Guidelines: BMI above 35 kg/m² with co-morbidity, or BMI above 40 kg/m².

Consensus Statement for Asian Indians: BMI above 32.5kg/m² with co-morbidity, and BMI above 37.5 kg/m².



Which surgery

Options for Weight Loss Surgery:

- Restrictive Procedures: Adjustable Gastric Banding (LAGB) & Laparoscopic Sleeve Gastrectomy (LSG),
- Combined Procedures: Laparoscopic Roux-en-Y Gastric Bypass (LRYGBP), Malabsorptive Procedures: Bilio-pancreatic diversions (BPD),
- Experimental Procedures: ileal interposition and duodeno-jejunal bypass.

Laparoscopic surgical techniques have dramatically evolved over the last two decades and have created a worldwide revolution in the field of bariatric surgery. Laparoscopic techniques have progressively replaced the open approach to bariatric surgery.

LAPAROSCOPIC ADJUSTABLE GASTRIC BANDING (LAGB)

The procedure require banding of the upper stomach via placement of an adjustable silicone band to achieve a sensation of satiety with small meals. The method of LAGB placement has evolved into the pars flaccida technique. Principles of the pars flaccida technique include the creation of a very small proximal pouch (15ml), posterior dissection just below the crura above the reflection of the bursa omentalis, improved anterior suture fixation of the fundus and anterior gastric wall over the band, and complete deflation of the low pressure band at the time of placement. The port is attached to the tubing, excess tubing is passed into the peritoneal cavity, and the port is secured to the anterior rectus sheath with permanent sutures.

The restrictive procedures usually are simple, technically easier with low

complication rates. The lap band procedure may not be the best surgical option in certain patient subgroups, including super-obese patients, diabetics, patients with hiatal hernia or significant gastroesophageal reflux disease.



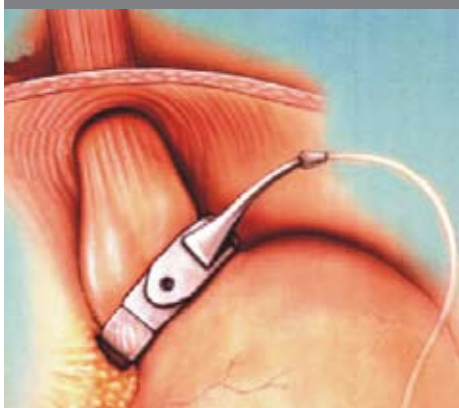
Gastric calibration balloon inside the stomach



Band being placed posterior to the stomach wall



Latest generation SAGB (Swedish Adjustable Gastric Band-precurved).



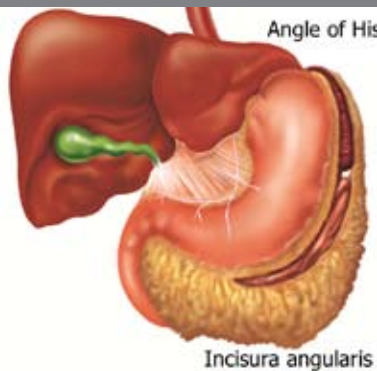
Band in position

LAPAROSCOPIC SLEEVE GASTRECTOMY (LSG)

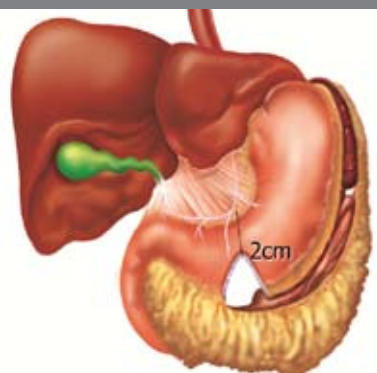
Bariatric surgery is technically difficult in super obese and should be cautiously applied in BMI greater than 60 kg/m², and high risk individuals. Laparoscopic Sleeve gastrectomy or a two staged procedure i.e. LSG + LRYGBP or LSG + BPD is an emerging option, as it reduces the risk and yet achieves satisfactory weight loss in super morbidly obese. In LSG greater curvature gastrectomy is done with starting point 6cm from pylorus, along a 32 Fr bougie to form a 60-80 cc gastric tube. No long term nutritional deficiency and dumping is there.



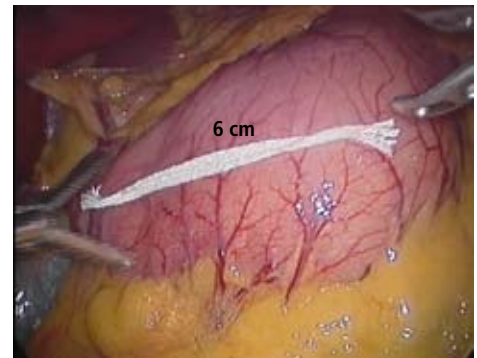
6 cm proximal to pylorus, vertical branch of nerve of Latarjet seen



Gastrolysis done upto Angle of His



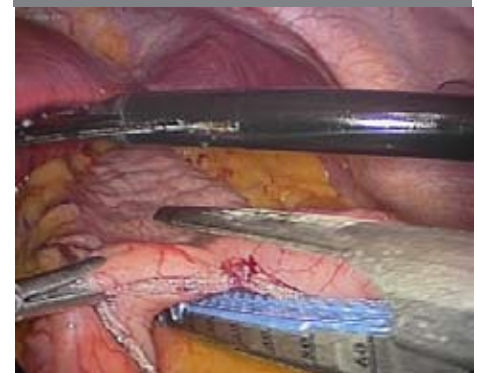
1st stapling done 2cm away from lesser curvature



Gastrolysis started 6 cm proximal to pylorus



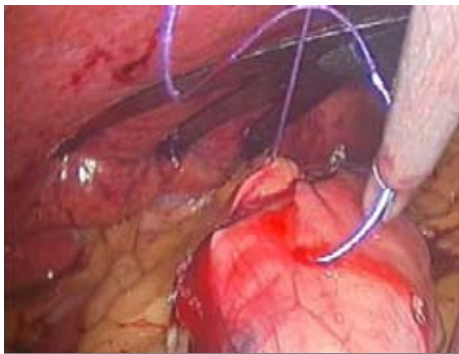
Gastrolysis of greater curvature and opening of the lesser sac



Echlone 60 blue staples fired upto angle of His

Advantages of Laparoscopic Sleeve Gastrectomy

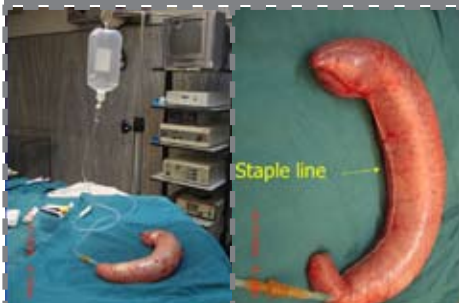
- Stomach volume is reduced, but it tends to function normally so most food items can be consumed in small amounts.
- Removes the portion of the stomach that produces the hormone that stimulates hunger (Ghrelin).
- No dumping syndrome because the pylorus is preserved.
- Minimizes the chance of an ulcer occurrence.
- By avoiding the intestinal bypass, the chance of intestinal obstruction



Suturing for Staple line reinforcement



Intraoperative Endoscopy and Air leak test



'Extracorporeal' leak test done with normal saline additionally.



Sleeve Gastrectomy

(blockage), anemia, osteoporosis, protein deficiency and vitamin deficiency are significantly reduced.

- Very effective as a first stage procedure for high BMI patients (BMI >55 kg/m²).

LAPAROSCOPIC ROUX-EN-Y GASTRIC BYPASS (LRYGBP)

Roux-EN-Y Gastric Bypass is constructed using a small 15 to 20mL gastric pouch and a Roux-en-Y gastrojejunostomy. This procedure creates malabsorption by bypassing the distal stomach, proximal duodenum, and a variable length of the jejunum depending on the length of the Roux limb. A Roux limb length between 50 and 100cm appears to be preferred by most surgeons with similar results.



The Roux limb is measured 150cm distally starting from jejunal division



Jejuno jejunostomy done at 150cm of alimentary limb

The data suggest the superior weight loss benefits in RYGBP patients without the long-

RNI NO.: DELENG/2001/6114
REGD. NO.: DL(W) 10/2076/2009-11
LICENSED TO POST WITHOUT
PRE-PAYMENT: U(W)-38/2009-11
 Posted on 21st / 22nd of every month



For proximal gastric pouch creation lesser omentum incised



Creation of Roux-en-Y gastro jejunostomy with linear stapler and suturing

term sequelae of band erosion, reflux and vomiting. Most of the nutrient and vitamin deficiencies caused by the gastric bypass (iron deficiency anemia and vitamin B12 deficiency) were correctable with vitamin supplementation. In addition, the altered anatomy reliably produces altered gut absorption leading to symptoms of dumping syndrome in response to high-calorie sweets intake. This likely remains an important difference from pure gastric restriction and explains some of the greater weight loss. Laparoscopic Roux-en-Y gastric bypass in most clinical series have demonstrated excess weight loss (EWL averaging between 65 - 85%).