FIAGES COURSE SYLLABUS

This 3 day FIAGES course comprises of

Lecture Module (9 AM – 4 30 PM),

Supervised endotrainer simulator training module (4 30 PM – 6 PM) **Live operative workshop (**9 AM – 1PM). We plan to cover all the important topics and teach various tricks of the trade that would aid all the trainees to learn the art and science of laparoscopy.

2) LECTURES TOPICS

Lectures schedule should be strictly followed.

DAY 01

Day 1 Pre Lunch	
9 AM - 9:15 AM	HISTORY
9:20 AM - 9:35 AM	VISION 2D / 3D
9:40 AM - 9:55 AM	INSTRUMENTS , ACCESSORIES
10:00 AM - 10:15 AM	STAY STERILE
10:20 AM - 10:35 AM	ENERGY SOURCES

COFFEE	
11:00 AM - 11:125AM	ERGONOMICS & HOW TO TRAIN FURTHER
11:20 AM - 11:35 AM	ENTRY INTO ABDOMEN

11:40 AM - 11:55 AM	KNOTS & SUTURES
12:00 AM - 12:15 PM	STANDARD LAP CHOLE
12:20 AM - 12:35 PM	DIFFICULT LAP CHOLE
12:40 PM – 12:55 PM	PHYSIOLOGY OF GA / REGIONAL ANESTHESIA
12-55PM -1-10 PM	INAUGURATION

Lunch

Day 1 - Post Lunch	
1:30 PM - 1:45 PM	BILIAPY INJURY - WHAT TO DO
1:50 PM - 2:05 PM	LAP CBD STONE MANAGEMENT
2:10 PM- 2:45 PM	COMPLICATIONS OF LC -PANEL
2:45 PM –3:00 PM	LAP APPENDECTOMY
3:05 PM -3:20 PM	LAP IN ACUTE ABDOMEN - Includes Gynae. No Appendix
3:25 PM - 3:40 PM	ENDO ANATOMIC VIEW - GROIN HERNIA
3:45 PM - 4:00 PM	TAPP
4:05 PM - 4:20 PM	TEP
4:30 PM - 6 PM	MEET+GREET PROFESSORS, 5-6 DELEGATES WITH 2 FACULTY

	TRAIN THE BRAIN WITH ENDOTRAIN-ER,

DAY 02

8AM to 9 Am- Meet the Professor

9 AM - 9:15 AM	MESH & TACKS - Single / Reuse for Hernia
9:20 AM - 9:35 AM	VENTRAL HERNIA - IPOM
9:40 AM - 9:55 AM	VENTRAL HERNIA - Beyond IPOM
10:00 AM - 10:15 AM	LAP HIATAL SURGERY
10:20 AM - 10:35 AM	LAP SPLENECTOMY / ADRENALECTOMY

COFFEE	
11:00 AM - 11:15 AM	PANCREAS / LIVER - CYSTS / STONES ABSCESSES
11:20 AM - 11:35 AM	LAP COLECTOMY BENIGN / MALIGNANT
11:40 AM - 11:55 AM	MIS IN PROCTOLOGY
12:00 AM -	INTRODUCTION TO MORBID OBESITY

12:15 PM	
12:20 AM - 12:55 PM	HERNIA SURGERY COMPLICATION - PANEL

Lunch

Day 2 - Post Lunch	
2:00 PM - 2:15 PM	NEWER HORIZONS IN MIS
2:20 PM - 2:35PM	ROBOTS IN SURGERY
2:40 PM - 2:55 PM	PRESENT WITH POWER VISION, POSTER
3:00 PM -3:15 PM	HOW TO WRITE FOR JOURNALS
3:20 PM - 3:35 PM	ENDOSCOPY FOR SURGEONS
3:40 PM - 3:55 PM	MEDICO LEGAL - PANEL
4:30 PM - 4:55 PM	MASTER VIDEO OF COMPLICATIONS AT LAPAROSCOPY

05.00 PM – 06.00 PM THEORY EXAMS FOR EXAM CATEGORY

4) ENDO TRAINER SESSION

Faculties must stay all time for this session and teach and evaluate the delegates.

Organizers should inform faculty beforehand.

5) WORKSHOP

DAY 03

08.30 AM – 01.00 PM

1. STANDARD LAPCHOLE, STANDARD LAP APPENDIX, TAPP, TEP, SMALL DEFECT VENTRAL HERNIA

6) THEORY EXAMINATION

ASSESSMENT OF TRAINEES

- MCQ on Day 2 (Total 100 questions), TIME 1 hour

7) Assessment on endotrainer

Endotrainer Session :

Fellow must demonstrate 1. Extracorporeal knotting
2. Holding the needle and taking a bite.
3.Demonstrate C loop and knotting.

8) VIVA EXAMINATION

VIVA on Day 3

INTERVIEW: EXAMINATION/NON-EXAMINATION CATEGORY.

At least 1 of the following questions in Viva

- Critical View of Safety in GB
- Strasberg view
- Bleeding in Calots and how to control it
- Angle of Doom in Hernia

- Corona mortis
- Triangle of Pain
- Which suture to use in Hernia repair.

9) ANNOUNCEMENT OF RESULT

Result will be announced within 48 Hours and put on web site.

List of successful candidates to be sent to Hon Secretary and IAGES Annual Conference Organizers.

10) FAILED CANDIDATE

Candidates declared not successful will be able to appear in next FIAGES course without charges but they need to pay only registration fee only.

All FIAGES candidates should take up the examination. Only on successful completion of assessment he/she would be eligible for Fellowship of IAGES.

Certified members would receive the fellowship certificate during the FIAGES convocation at the IAGES annual conference.

If delegate is not able to attend in two consecutive national conferences, then the certificate will be mailed to the delegate.

APPENDIX

1) CRITERIA OF CANDIDATE- IAGES MEMBERSHIP IS MUST

Those who are not members may apply for membership online. See the website for more details. Number of years of experience in laparoscopic surgery should be 2 years and above (includes experience in laparoscopy as resident.). A certificate of experience has to be obtained from the

HOD of the hospital/Institution as a supportive document. Attach Xerox copies of MBBS, MS or DNB certificate and MCI registration certificate.

FIAGES: NON-EXAMINATION CATEGORY:

- Suitable for those candidates working as faculty in teaching institution and all surgeons with more than 10 year experience in doing laparoscopy.
- Already IAGES member or should be eligible to become IAGES members
- Apply with an additional letter to the convener of the course clearly stating the number of laparoscopies done In the last 10 years
- Would be eligible to receive the FIAGES fellowship on satisfactory completion of the FIAGES course and the informal interview. Decision of Examiner panel is final.

FIAGES: EXAMINATION CATEGORY

1. IAGES membership is a must.
2. Fellow should have experience certificate from HOD, Employer.
3. Fellow should present a duly certified Log Book .

   Minimum 25 Lap Chole
   Lap Appendix 10
   Diagnostic lap (Log book should post-operative complications and course.)

2) <u>Log Book</u>

No	Name	Age	Sex	Operation	Post Op Course	Infection	Bleeding	Others	Assisted/under supervision /Independent

Log Book Should be submitted at the time of Examination.

MEMBERS OF FIAGES BOARD

FIAGES BOARD

Special Invitee: Dr John Thanakumar (Chief Trustee)

Conveners
Dr. Achal Gupta

Dr. Meenakshi Sharma

FIAGES FACULTY

- All the EC members with interest and experience in laparoscopy.
- Other senior IAGES members with wide laparoscopic experience.

GUIDELINES FOR HOSTING FIAGES:

- The local organizing committee comprising of Chairman, Zonal Vice Presidentand secretary should express their interest in writing to Hon. Secretary and FIAGES convener and confirm suitable venue and date and get the MOU signed. The application and request for hosting FIAGES should come through Zonal Vice president only. Treasurer of IAGES will guide the organizing team regarding opening, maintenance and submission of the account for thecourse.

IAGES logo should be on the top of the brochure. The size of FIAGES font should be larger than the name of the local hospital.

- Venue should be ideally in the hospital setting with facility for Live laparoscopic surgery demonstration or transmission and enough space for endotrainer and simulator training (6-10 stations) and a 100 seated A/C lecture hall with A/V transmission facility
- It is expected that about 6 to 8 cases are demonstrated during live operative session on Day 3.

- Endotrainer and Simulator training stations should be arranged as per the guidelines of course convener.

Endotrainer & simulator should be made available in a large hall with at least 10 endotrainer& simulator station. All candidates should spend at least 1 hour with the endotrainer and simulator.

- Lecture modules should include all the topics given in the syllabus with time as mentioned. Each lecture should be of 15-18 minutes followed by 8-10 minutes of discussion and active participation by candidates is encouraged.
- MCQ assessment is done on Day 2 where 100 questions are given.
- Viva examination stations should consist of a viva voice examination and clinical skill assessment .

. Each Examiner has to fill a viva assessment for each candidate.

- Attendance on all 3 days is must to take up the Day 3 viva assessment
- Candidates can be given only certificate of participation on day 3 after filling and returning the feedback forms. Fellowship certificate will be issued only during the convocation at the annual conference.
- Travel allowances and local hospitality for faculty as per the guidelines

followed in FIAGES/FALS courses

•IAGES President, Hon. Secretary, and Zonal Vice President and course convener should be kept in the loop intimating all the arrangements and scheduling of scientific program for smooth and successful conduct of the course.

RECOMMENDED READING MATERIALS:

- IAGES Text book of Laparoscopic Surgery 4th Edition (Available online on Amazon and Google Books,)

FOLLOWING POINTS MUST BE INCLUDED IN THE LECTURES OF THE FACULTY

GENERAL INSTRUCTIONS :

1. 15 minute lecture
2. Evidence based medicine
3. Do not speak on ‘what I do’
4. STOP within 15 minutes
5. Brief answers only
6. Encourage as many questions as possible
7. Following are the points to cover in your lecture
8. Add more if you wish including edited video as yousee fit
9. Explain standard guidelines and steps of the procedure

10. Involve audience in discussion
11. Include the lecture guideline in your power point presentation

ENDOVISION SYSTEM

COMPONENTS OF ENDOVISION SYSTEM

- Camera including CCD – single chip, three chip, 3D, HD, 4K
- Light transmission cables (fibreoptic)
- Light source (Types and How to choose)
- Telescope
- Monitor – LCD, Medical grade monitors, LED, TFT
- Dynamics of transmission
- How to do your setup
- What is best today
- Describe an Insufflator – What is ideal
- Setting intra abdominal pressure – procedure specific and otherwise
- Flow rates – initial and during procedure

- Maintain the distension – leaks, suction, etc
- Ideal gas
- Troubleshooting in a flat abdomen

ENERGY SOURCES

ELECTROSURGERY NOT ELECTROCAUTERY

- Direct current (DC)
- Current does not enter patient's body
- Provides heated wire only
- Relatively high voltage current

MONOPOLAR SYSTEM

- Neutral return electrode attached to patient body
- The current flow from patient to return electrode
- Dissecting active electrode completes circuit

RETURN ‘ELECTRODE’ POSITIONING

- A well vascularised muscle mass

AVOID

- Vascular insufficiency
- Irregular body contours
- Bony prominences

CONSIDER

- Incision site / preparation area
- Patient position
- Other equipment on patient

BIPOLAR SYSTEMS

- Current flows between two electrodes at site of application
- Path confined to tissue grasped between forceps tips
- No patient return electrode needed

MASS SAFETY ISSUES

- Monopolar
- Power (Voltage)
- Insulation
- Return voltage
- Direct coupling
- Capacitative coupling
- Smoke

METAL CANNULA & SYSTEMS

- Capacitance cannot be entirely eliminated with an all plastic cannula system
- Inadvertant capacitator created
- Current dissipated through abdominal wall without injury

PLASTIC CANULA SYSTEMS

- Capacitance cannot be entirely eliminated with an all plastic system
- The patients conductive tissue can complete the capacitor
- Capacitance is reduced but is not eliminated.

HEMOSTASIS

- H-f Electrocoagulation
- Ligasure
- Ultrasound scalpel
- Laser photocoagulation
- Application of clips
- Endoscopic knots
- Double suture ligation
- Vascular staples
- Biological tissue glue

ERGONOMICS

- Improved speed and accuracy
- Less physical and psychological discomfort for surgeon and team

IMPORTANT CONSIDERATION

- Central position of target
- Triangulation of camera and operating ports
- Port position

PORT POSITION

- Viewing axis
- Viewing axis to plane of target
- Target to laparoscopic distance
- Instrument to laparoscopic angle
- Instrument manipulation angle
- Instrument to target plane angle
- Intra – extracorporeal instrument length ratio
- Distal laparoscopic lensshould be parallel to plane of target
- Laparoscopic port placement differs with laparoscopic angle
- Practically, change to laparoscope with different angle to improve visibility instead of changing port position to accommodate laparoscope.

TARGET TO ENDOSCOPE DISTANCE

- Best performance between 75 to 125mm
- Less distance – Sword distance, excessive magnification, reduced field view

AZIMUTH ANGLE

- Axis of the instrument to the optical axis of the telescope
- 30 degree- ideal
- Both instruments should be at equal azimuth angles
- Wider angles increase execution time
- No difference in force or work done

MANIPULATION ANGLE

- Angle between the axis of two operating instruments
- 60 degree – ideal (45-60)
- Ideal force and better work done
- Narrow angle – less force but more sword fighting
- Wider angle – more execution time

ELEVATION ANGLE

- Angle between target plane and instrument
- 60 degree ideal (45-60)
- More elevation – less force
- Narrow angle – greater execution time

<u>IMAGE DISPLAY</u>

Position of display from surgeon

- 4 X Monitor size
- Best in front of the surgeon

SURGEONS EYE TO THE MONITOR ANGLE

- Minimum of 10 -25 degree below
- Best at surgeons hand level

SURGEON, TARGET AND MONITOR AXIS

- Straight line
- Monitor should be tilted – Gaze down view
-

ALLIGNMENT

Optimum Allignment

- Instrument viewed from above
- Best in front of the surgeon

Off axis allignment

- OK towards non dominant hand
- Dominant azimuth angle of 30

REVERSE ALLIGNMENT

- Reversing of camera by 180 degree
- Digi-video software

Intracorporeal – extracorporeal instrument length ratio

- =/> 1 smaller hand movements create larger instrument tip movements
- <1 degrades task performance

Operative table height

- Instrument handle between 0 and 10 cms below the elbow

TARGET POSITION

- Highest
- Mid air in case of bowel

Miscellaneous

- 2D V/s3D – 3D not > 3D systems
- Tactile feedback not optimal

ENTRY INTO ABDOMEN

FIRST STEP

- Aim
- Techniques (With pictures/Videos - Open/Closed
- Describe each techniques
- Advantages of each technique

ENTRY SITES

- Umbilicus
- Palmer's point
- Alternate sites

Precaution for each site

Confirmation tests for each entry

ADHERE TO MOST EXPERIENCED TECHNIQUE, BE FAMILIAR TO ALTERNATE TECHNIQUES

- Insufflation of peritoneal cavity
- Methodology and precautions during insufflations
- What to do if no free flow of CO2 inside
- Placement of first trocar – Blind/Direct/Optical
- Complications – Immediate/delayed
- Enumerate the different complications
- Vascular complications
- Various vessels likely to be injured
- Abdominal wall to aorta distance
- Insert pictures/videos

KNOTS AND SUTURES

- Why is it important?
- Why is it difficult?

Ergonomics of suturing

Angles in suturing

Types of knots – extracorporeal and intra-corporeal

Instruments required

Ideal sutures – Which why, how long

Length of suture – extracorporeal and intra-corporeal

Ideal Stitch

Stages of knotting

Ideal characteristics of a surgical knot

Sections of ligature material

Essentials in intra-corporeal knot tying

Needle holding

Correct wrapping techniques

Show small videos of techniques

STEPS OF ENDOSUTURING

- Introduction and retrieval of suture to the operative field
- Loading the needle to the needle driver
- Adjusting the needle direction
- Needle driving
- Advancing the thread
- Knot tying

TECHNIQUE OF ENDOSUTURING – STEP BY STEP

Slip knot

Extracorporeal knots – Importance and applications

Kinds of extracorporeal knots

Staplers in laparoscopy

STANDARD LAPAROSCOPIC CHOLECYSTECTOMY

- Laparoscopic anatomy of Gall bladder and biliary system
- Port placements – difference in different situations
- Dissection of Calot's triangle
- Strassberg critical view of safety
- When to convert?
- Managing cystic duct and cystic artery
- Bleeding from GB Bed
- Prevention of bleeding
- Prediction of bleeding
- Role of drain

DIFFICULT LAP CHOLECYSTECTOMY

- Introduction
- When to call Lap chole difficult?
- When to convert?
- Partial cholecystectomy/subtotal/subtotal fenestrated cholecystectomy
- Complications and how to treat them
- How to prevent bile duct injury

PHYSIOLOGY OF GA/REGIONAL ANAESTHESIA

- Gas for insufflations
- Why is CO_2 ideal?
- Advantages/Disadvantages
- Positioning of the patient
- How various positions affect anaesthesia

EFFECT OF PNEUMOPERITONEUM

- Altered physiology
- Cardiovascular effects
- Hemodynamic changes
- Respiratory effects
- Splanchnic effects
- Neurological effects

ANAESTHESIA IN LAPAROSCOPY

PERIOPERATIVE MANAGEMENT

- Airway and anaesthesia
- Ventilation
- Monitoring
- Analgesia
- Gas embolism – symptoms and treatment

PREOPERATIVE EVALUATION

- Cardiac and pulmonary status
- Other factors

POSTOPERATIVE MANAGEMENT

- Pain
- Shoulder tip pain

REGIONAL ANAESTHESIA

- Feasibilty
- Safety

BILIARY INJURY – WHAT TO DO?

INCIDENCE OF CBD INJURY

- CBD injury after open cholecystectomy – 0.2%
- CBD injury after laparoscopic cholecystectomy – 0.1 to 0.5%

CBD INJURY

1. 30 degree
2. Fundal traction
3. Infudibular traction
4. Rouviers sulcus
5. Cystic LN
6. Elephant sign
7. Wave the flag
8. Strasberg view

MANAGEMENT OF CBD INJURY

Immediate(intraoperative diagnosis)

- Class I or II Injury – primary repair over T tube
- Class III or IV injury
    1. Hepaticojejunostomy or
    2. Control CBD with clip, drain, antibiotics, transfer

Delayed (Postoperative diagnosis)

- Bile leak
    1. <300ml per day
    2. Resolves in 5-7 days
    3. Percutaneous catheter

4. Settles down

Major leak : 1. >300ml per day

2.Fails to resolve

3. Do ERCP

Delayed post operative diagnosis – CBD injury.

LAPAROSCOPIC CBD STONE MANAGEMENT

ANATOMY, INCIDENCE AND SAFETY OF LAP IN CBD STONE INJURY

- CBD stone in 10% young, 25% in ages >65 years
- CBD stones during IOC or US of CBD

SAFETY IN LAPAROSCOPIC CBD EXPLORATION

- Safe and effective Lap CBD exploration
- One stage for CBD stone and GB removal
- Cheaper, less days in hospital

TRANSCYSTIC APPROACH (TCBDE) – INDICATIONS

- <9 stones
- Stones distal to cystic duct – CBD exploration
- Stones < 6mm

LAP CBD EXPLORATION

- Multiple stones >9
- Stone diameter > 6mm
- Intrahepatic stones
- Cystic duct <4mm
- Distal or posterior cystic duct entrance
- Surgeon with lap suturing skills

COMPLICATIONS OF ERCP AND CBD EXPLORATION

- Incomplete clearance
- Pancreatitis
- Bile leak
- Stricture

INDICATIONS – LAPAROSCOPIC CHOLEDOCHODUODENOSTOMY

- In selected CBD obstruction – chronic pancreatitis, stricture
- Mandatory CBD > 1.5cm

LAPAROSCOPIC ROUX EN Y CHOLEDOCHOJEJUNOSTOMY

- CBD < 1.5cm
- To eliminate tension on anastomosis
- To divert food stream
- To prevent stump syndrome and cholangitis
- In inoperable cancer where >6 month expectancy

TECHNIQUE

VIDEO

LAPAROSCOPIC APPENDICECTOMY

- Pre operative preparations
- History
- Physical examination
- Laboratory and radiological investigation
- Role/need of CT

PROBLEMS OF DIAGNOSIS

- Stump appendicitis
- Recurrent appendicitis
- Appendicitis in children and elderly
- Appendicitis in pregnancy
- Counselling
- Risk and benefits
- Conversion
- Technique
- Positioning
- Trocar placement
- Procedure – Role of Diagnostic laparoscopy
- Base first technique
- Retrograde appendicectomy
- When to convert?
- Intraoperative complication complications and treatment

PROBLEMS ENCOUNTERED DURING SURGERY

- Normal appendix is found
- Appendix cannot be found
- Appendicular tumour is found
- Appendicular abscess is found
- Need of caecostomy/ right hemicolectomy

Advantages

Disadvantages

Post-operative complications and treatment

SPECIAL CONDITIONS

- Mass lesion
- Pregnancy
- Gynecological conditions

LAPAROSCOPY IN ACUTE ABDOMEN - Includes Gynae. No Appendix

- History
- Introduction
- Indications and contraindications
- Various procedures : Overview
- Current evidence

ENDO ANATOMIC VIEW - GROIN HERNIA

- Introduction
- Endoview in TAPP and TEP
- Identification of landmarks
- Triangle of Doom, Triangle of pain
- Extent of dissection
- Identification of plane of dissection
- Tricks and Tips

LAPAROSCOPIC TRANSABDOMINAL PREPERITONEAL INGUINAL HERNIA REPAIR

- Indication and patient selection
- Ideal patient for beginners
- Counselling
- Patient position and operative room set up
- Essential instruments
- Port placements
- Access to TAPP
- Importance to correct plane and identification of landmarks
- Boundaries of dissection
- Importance to create enough space
- Dissection of cord and cord structures
- How to tackle large direct/indirect sacs
- Reduce peritoneal sac completely
- Do not make nerves bare
- Check for lipoma of the cord
- Mesh deployment and fixation
- Where to tack?
- How to avoid recurrence
- Closure of peritoneal defect
- Postoperative complication
- Current evidence of comparison between TAPP V/S TEP

TEP - TOTAL EXTRAPERITOEAL REPAIR OF INGUINAL HERNIA

- Preperitoneal space first described by Ger
- History – first described by Dulucq

Patient selection
Ideal patient for beginners
Counseling
Anatomy relevant to TEP – Already included in anatomy lecture
Patient position and operative room set up
Essential instruments
Access to TEP – Extraperitoneal Space
Importance to correct plane and identification of landmarks
Port positions
Steps of dissection
Boundaries of dissection
Importance to create enough space

- Dissection of cord and cord structures
- How to tackle large direct/indirect sacs
- Reduce peritoneal sac completely
- Do not make nerves bare
- Check for lipoma of the cord
- Mesh deployment and fixation
- Where to tack?
- How to avoid recurrence
- Complications and how to avoid them

MESHES AND TACKS

- History
- Various meshes – Intraperitoneal V/S Onlay-Extraperitoneal
- Their Advantages and disadvantages
- Various tacks – reusable/disposable/absorbable/non-absorbable : Their advantages and disadvantages
- Future meshes and newer fixation devices
- How to choose
- Complications and how to avoid them

VENTRAL HERNIA – IPOM

- Introduction
- Indications and patient selection
- Position and instruments
- Abdominal access and trocar placements
- Sac dissection
- Choice of Mesh/overlap and fixation

POSTOPERATIVE COMPLICATIONS

- Pain
- Seroma
- Postoperative ileus
- Enterotomies
- Current evidence of status of IPOM and its future

LAPAROSCOPIC VENTRAL HERNIA REPAIR - BEYOND IPOM

- Introduction
- Various techniques like IPOM+, eTEP, SCOLA etc.
- Indications and patient selection
- Position and instruments
- Abdominal access and trocar placements
- Sac dissection
- Choice of Mesh/overlap and fixation
- Complications
- The Future

LAPAROSCOPIC HIATAL SURGERY

Fundoplication – Reflux esophagitis
Paraoesophageal hernia
Hellerscardiomyotomy – achalasia cardia

INDICATIONS OF FUNDOPLICTION

- History
- Endoscopic criteria
- 24 hour pH
- Manometry to choose type

Counselling before the ffundplication

- Need to try medical measures
- Choosing psychologically fit patients
- Explanation of post surgery gas bloat
- Explanation of small meals after surgery
- Explanation of post op medication if indicated
- Alternate measures to surgery

NISSEN FUNDOPLICATION

- Table setup with patient position
- Team position
- Trocar sites
- Steps of operation
- Divide short gastric / or not
- Mobilize last 5cm of oesophagus
- Adequacy of wrap by shoe shine maneuver
- 3 sutures
- Loose floppy flap 1-2 cm

Intraoperative complication

- Perforation
- Bleed
- Pneumothorax

Postoperative complications

- Dysphagia
- Slipped Nissen
- Gas bloat
- Recurrence of GERD

ACHALASIA CARDIA

History of Dysphagia

Tests required

1. Swallow
2. Endoscopy
3. Manometry

Indications:

1. Failed dilatations
2. Young age – less than 40
3. Patient preference for surgery

Alternate measures

- Endoscopic dilatations
- BOTOX
- POEMS

HELLER'S CARDIOMYOTOMY

- Table setup with patient position
- Team position
- Trocar sites
- Steps of operation
- Extent of myotomy in chest and in stomach
- Identification of mucosa at surgery
- Width of myotomy

Safety test of mucosal integrity

- Intraoperative endoscopy for air insufflations
- Dye test with methylene blue
- Intraoperative manometry to predict accuracy

Discuss additional measures suchas partial fundoplication –Dor , Toupet

COMPLICATIONS

- Mucosal injury
- Persistent Dysphagia
- Injury to spleen

LAPAROSCOPIC SPLENECTOMY

1. NON TRAUMATIC INDICATIONS - Hematologic, Neoplastic, benign pathology

2. TRAUMATIC INDICATIONS

- Approaches – advantages/disadvantages
- Port placements
- Position of patient
- Prevention of bleeding
- Post operative complications – bleeding etc.
- Current status with level of evidence

Variations of conventional Lap Splenectomy

- Needlescopic surgery
- Single port surgery
- Hand assisted lap Splenectomy (HALS)
- Robotic splenectomy

LAPAROSCOPIC ADRENALECTOMY

NON TRAUMATIC INDICATIONS –

Hematologic, Neoplastic, benign pathology

TRAUMATIC INDICATIONS

- Indications
- Approaches – advantages/disadvantages
- Port placements
- Position of patient
- Prevention of bleeding
- Post operative complications – bleeding etc.
- Current status with level of evidence

Variations of conventional Lap Adrenalectomy

- Hand assisted lap Adrenalectomy (HALS)
- Robotic Adrenalectomy

PANCREAS / LIVER - CYSTS / STONES ABSCESSES

Brief introduction and overview about various laparoscopic procedures like:

- Pseudocyst pancreas – Cystogastrostomy, Cystojejunostomy
- Liver cyst and abscess – Laparoscopic Hydatid cyst excision/ Large symptomatic simple cysts
- Pancreatic tumours etc.- Whipple's , Distal pancreatectomy
- Chronic pancreatitis – Laparoscopic pancreatico-jujenustomy
- Pancreatic abscess – VARD
- Complications of laparoscopic liver and pancreatic surgery

LAP COLORECTAL SURGERY

- History
- Introduction
- Indications (Benign and Malignant)
- Port placements for various colectomies
- Steps of procedure -medial to lateral/lateral to medial advantage-disadvantage
- Troubleshooting
- Anastomosis–extracorporeal - intracorporal
- Complications and how to avoid them
- Current evidence

MIS IN PROCTOLOGY

1. Piles
2. Partial prolapse
3. Fistula
4. Large polypectomy
5. Cancer

PILES

- Technique of stapling of piles
- Various staplers in market and cost effectiveness
- Indications and Contraindications
- Complications

PARTIAL PROLAPSE

- Stapled transrectal resection of the rectum STARR

FISTULA IN ANO

MAFT VS VAFT

- Indication and contraindication
- Method of doing
- Variations of doing

- Complications

Glue therapy for fistula : When to use and how?

What glue?

Transanal Endoscopic Micro Surgery (TEMS)

Indications : Polyp, excision, Biopsy, In-situ tumours

How to do

Limitations of doing the procedure

When not to do TEMS

INTRODUCTION TO MORBID OBESITY

- Definitions
- Introduction
- Problem in INDIA
- Patient selection
- Various proceduresincluding endoscopic procedures
- Indications and contraindications
- How to choose
- Complications and how to avoid them
- The future

PANEL DISCUSSION SHOULD DISCUSS: (Inguinal)

1. Anatomy of ANGLE OF DOOM
2. Anatomy of ANGLE OF PAIN by chairperson to revise quickly prior to starting.
3. Extent or boundaries of dissection medial, lateral, posterior and superior.
4. What to do if bladder is opened.
5. What to do if inferior epigastric artery is damaged.
6. What to do if contents of hernia are too difficult to reduce?
7. What to do with peritoneal multiple holes?
8. Where do you staple (or suture why) your mesh? - how many staples, absorbable / non absorbable both for staples and sutures.
9. What to do if bleeding from angle of doom?? - mild and also severe?
10. How to determine size the prolene mesh for the defect? How to adjust mesh for large direct or large indirect hernia?
11. How to close peritoneum over mesh....What type of abs/nonabs suture ...cont/interrupted..OR staples.
12. What if you don't find direct or indirect sac?
13. Does lipoma of cord require tmt? What is it?
14. Any other complications for hernia can be tackled.
15. This talk is to include newer promising aspects in laparoscopy over the past 5 years to so speaker to cover what method and how it is done. We have given some guidelines on what are the possible newer versionswhich may improve results.

NEWER HORIZONS IN MIS

ROBOTS IN SURGERY

- Introduction
- History
- Various robots available
- Procedure where robotic surgery is used
- Current Status of various procedures done by Robots
- Operation Room setup
- Advantages/Disadvantages
- The future of robotic surgery

PRESENT WITH POWER VISION, POSTER

- Why present
- Introduction to various hardware and software
- How to choose
- Video recording
- How to make a PowerPoint presentation/video
- Various formats to be used in video presentation and their advantages
- Troubleshooting (what to do when a video is not working)
- Telepresence and Google glass
- Future Techniques

HOW TO WRITE FOR JOURNALS

- Conflict of interest
- Purpose
- History
- Introduction
- Why write?
- Priorities
- Key elements of publishing
- Ethical issues
- Plagiarism
- Style and language
- Structure of a paper
- Components of a paper
- Author listing
- Title
- Abstract

ENDOSCOPY FOR SURGEONS

- History
- Surgeon as endoscopist – why and how?
- Indications
- Procedures to be learnt like upper GI endoscopy (gastroduodenoscopy), lower GI endoscopy (Sigmoidoscopy, Colonoscopy)
- Therapeutic Endoscopy like ERCP, polypectomy, dilatations etc.
- Complications and how to avoid them
- The future
- Legal Aspects

PROPOSED NEW LECTURES FOR FIAGES COURSE

NEWER ACCESS
Single incision laparoscopy

Devices for single port access – types
Instruments for single site laparoscopy
Flexible scopes
SPIDER surgical system with rigid and flexible ports

NEWER INTRAOPERATIVE IMAGING

- Intraoperative ultrasound
- Intraoperative cholangiogram
- Intraoperative -scopy for small bowel enteroscopy
- Narrow band imaging – significance
- Intraoperative indocyanine dye for imaging cystic duct and CBD in GB
- Intraoperative MRI in laparoscopy in liver receptions
  (Imaging sequences for MR guided laparoscopic liver resection in 1.0T high field open MRI.

NEWER INTRAOPERATIVE HEMOSTASIS

- Intraoperative CUSA for liver, spleen, kidney dissections
- Argon coagulator – caution on IAP
- Newer agents like glue, snow for diffuse surfaces
- Buttress for prevention of stapled edges – what material, how?

INTRAOPERATIVE ANASTOMOSIS

- Staplers color
- Went house blue, green, white,, gold black, pink staplers
- When buttress (copilot, repeat surgery, steroids, post transplant)
- Wound protector for cancer surgery

NEWER INTEGRITY OF VASCULARITY IN THE BOWEL MARGINS AT LAPAROSCOPY

- Indocyaninegreen enhanced fluorescing bowel perfusion in anastomosis
- Near infra red perfusion angiography in colorectal surgery.

ENHANCED RECOVERY AFTER SURGERY (ERAS)

Meaning and methods