SELF-LEARNING OF LAPAROSCOPIC SURGERY

Dear Editor,

The first laparoscopic cholecystectomy by P. Mauret in 1987 [1] took the world by storm. A number of teaching and training programmes have been suggested [2]. But in our country, there is no recognised certification or privilege granting hospital committees, and certification and credentials given by unrecognized training courses are not true reflection of competence.

Keeping this in mind, a team of surgeons of Indira Gandhi Medical College, Shimla started self-learning of laparoscopic surgery in August 1993. The team first learnt to produce pneumoperitoneum and diagnostic laparoscopy by conventional laparocater used in family planning programme and later on learnt laparoscopic punch biopsy. Then we modified open cholecystectomy to gain experience in technique of remote controlled movements and 2-dimensional interpretation of 3-dimensional structures.

The technique we followed was: Surgeon should stand on the left side of the patient. Incision should be standard right subcostal incision. Gall bladder fundus is held with sponge holder and is pushed towards the diaphragm to expose the hilum. Hartman's pouch is held by another sponge holder. To achieve a 2-dimensional image effect, surgeon's one eye is kept closed by an eye shield. To avoid tactile sensations, surgeon's hands should not enter the peritoneal cavity. Robert's artery forceps are used for dissecting the adhesions, cystic duct and artery mimicking the movements during laparoscopic cholecystectomy. The right angle forceps creates the space for ligacips. After applying the ligacips, the cystic duct and artery were divided. The dissection of gall bladder was done with the help of a diathermy hook. Then open cholecystectomy with one eye closed was done with long laparoscopic instruments.

Then rotation among surgeons was done so that all learnt the technique and new learner surgeons entered the training cycle as trained surgeons left. After gaining this experience laparoscopic cholecystectomy was tried and different surgeons of our team were able to perform it

successfully. A total number of 100 laparoscopic cholecystectomies were performed by different surgeons between August 1994 to December 1996, after learning to perform laparoscopic cholecystectomy by the above technique.

Perhaps, the major hurdles to overcome in laparoscopic surgery are to develop hand-eye coordination using a 2-dimensional video image and manipulation of instruments under laparoscopic control. For these reasons, a number of simulators in laparoscopic workshops using inanimate objects and trainers has been suggested. But these are costly, cumbersome [3] and lack the real steps of laparoscopic surgery like creation of pneumoperitoneum, actual anatomy of hepatobiliary system and feel of human tissue.

We feel that our technique of self-learning of laparoscopic surgery can help the aspiring surgeon to practise laparoscopic surgery. However, it cannot replace the time honoured process of observation, assistance and finally to operate assisted by an experienced surgeon. And one should not hesitate to convert the laparoscopic cholecystectomy to open method in case of difficulty.

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ENDOSCOPIC TRAINING: IT IS NOT TABOO FOR SURGEONS!

Dear Editor,

From the time endoscopes were described as "expensive pieces of illuminated spaghetti", flexible endoscopes have come a long way [1]. Endoscopic facilities are widely available even in our country, the high cost of initial investment notwithstanding. The ever growing popularity of endoscopy is due to many reasons: It gives a direct visual impression of the lesion to the clinician; anaesthesia is rarely, if at all, required; and recovery from the proce-

dures is therefore very rapid - there are no incisions to heal. It is cost effective in the long run when compared to many other modalities of investigation and treatment. Tissue diagnosis is possible in most instances, even from such narrow tubes like the lacrimal or salivary ducts [2]. Most importantly, therapeutic procedures are being done increasingly all over the world. From injecting sclerosants to extraction of bile duct stones and relieving luminal obstruction (by dilatation, stenting and laser ablation of