AUGIS Travelling Fellowships

Reports on the AUGIS Travelling Fellowships

Visit to Hospital Beaujon and Hospital Henri Mondor, Paris
Mr Mark Duxbury, Royal Infirmary of Edinburgh

My visit coincided with the worst Parisian winter weather of the last 30 years. Beaujon's austere fascade and dilapidated interior belie the premiere HPB unit within, which performs 120 liver transplants, 170 pancreatic resections and 250 liver resections annually.

Surgical attitudes at Beaujon are unapologetically traditional. Theatre was hushed with interns always first in attendance, prepping, draping and making the initial incision. Professor Belghiti's approach to liver surgery has clearly been influenced by his experiences in Japan. I was fortunate to join him for cases including a 'textbook Belghiti right hepatectomy' with 'hanging manoeuvre', a pancreaticoduodenectomy for IPMN, mesopancreatectomy, 2 atypical liver resections and 4 liver transplants.

Although the theatres were not aesthetically attractive, the team was first-class and all necessary technological adjuncts were available. Belghiti values intraoperative ultrasound highly, using contrast to give outstanding image clarity. All major liver resections conclude with intra-biliary injection of methylene blue to exclude bile leakage and no patient leaves theatre without a liver biopsy. Although Professor Belghiti honestly concedes this biopsy seldom affects patient management, it has provided the unit with a valuable biobank and a number of high-impact publications.

Rounding the 16-bed dedicated HPB ITU, I was struck by the number of transplants performed for acute-on-chronic alcohol-induced liver failure. While Professor Belghiti emphasised that this was unusual, the listing criteria applied to this patient group are evidently more lenient than in the UK.

'Staff' was initially held in English for my benefit, but naturally reverted to French to facilitate more passionate multidisciplinary discussion. A particularly notable feature of the 'Beaujon approach' was the frequency with which hepatic lesions were biopsied preoperatively, a policy I don't envisage gaining popularity in Edinburgh. For challenging resection candidates, I was interested to see first-hand the excellent outcomes Beaujon achieves in selected cases using their protocol of transarterial chemoembolisation followed by portal vein embolisation.

Parisian interns work a 0730-2000h six day week, with additional emergency and transplantation/retrieval on-call. Discussion of EWTD led to good-humoured snorts of derision. The level of camaraderie here is high. All surgical interns congregate for lunch in Beaujon's doctors' mess which is lined by some exceptional artwork, most of which would sadly not comply with current NHS standards of political correctness.

While laparoscopic HPB surgery has not been embraced at Beaujon, Hospital Henri Mondor, which formed the second leg of my visit, is a world-leader in this field. I received a warm welcome from Professor Cherqui's unit and enjoyed my time with Professor Alexis Laurent, Professor Claude Tayar and the team, assisting with a right hepatectomy (combined with sigmoid resection), participating in some emergency open liver surgery and observing some exciting robotic surgery. The Henri Mondor philosophy was similarly one of caffeine- and Marlborough-fuelled hard work and comradeship. I was particularly impressed by the high standard of data collection in the unit.

I would like to thank Professors Belghiti, Laurent, Tayar and Cherqui and their respective teams for their hospitality, as well as the AUGIS committee for allowing flexibility in scheduling a highly enjoyable fellowship.

Lunch at Hospital Beaujon

Belghiti spots the next patient going into theatre

Artwork, Doctors Mess, Beaujon

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AUGIS Visiting Fellowship to National Cancer Centre & Cancer Institute, Tokyo, Japan
Mr Yuk Man Kan, Peterborough District Hospital

Gastric surgery for malignancy in the Far East and the world literature is dominated by the Japanese experience and none more so than data from units in Tokyo. I was fortunate enough to be given the opportunity to visit two of these units, spending one week in the National Cancer Centre (NCC) with Dr Hitoshi Katai and a second week at the Cancer Institute where Dr Takeshi Sano had recently moved too. The population of Tokyo is around 12 million with a national screening programme of endoscopy for gastric cancer for everyone over the age of 40. However, uptake of this by the general population is only 15% but the detection of gastric cancer and its early stage of presentation is much higher than the UK. The reason behind this is two folds – firstly the incidence is over four times that of the UK and secondly there is a general awareness by the Japanese public of this type cancer especially with their emperor requiring a gastrectomy for gastric cancer. The early detection arises from the fact that anyone presenting to their medical practitioner with any mild abdominal discomfort for whatever reason apparently seems to automatically be referred for an endoscopy and hence the early detection as oppose to the advance cancers that we are faced with in the UK. The incidence of H Pylori infection in the Japanese population is around 80% which is decreasing

Cancer Institute

and this coincide with a reported reduction in the incidence of gastric cancer in Japan.

The Division of Gastric Surgery at the two hospitals were dedicated to pure gastric resections undertaking 2-3 resections cases daily and all cases involved a D2 resections. The NCC was essentially government funded whilst the Cancer Institute was a privately run organisation. Each and every day began with a daily wound dressing round where every patient's dressings were regimentally removed, inspected and replaced by the surgical team. With this degree of care they had a 3% wound infection rate and no MRSA infection. Surgical grand round was held on the Tuesday morning and the cases would be presented by the surgical resident/fellow with all the imaging and notes held within the hospital computer system. All diagnostic or therapeutic endoscopy were performed by the medical endoscopist and never by the surgeons. The identification and staging of early lesions was made on endoscopy alone simply by the fact that the endoscopist were so use to identifying these lesions on a daily basis and they rarely require the need for advance endoscopic imaging such as Narrow Band Imaging and other modalities to confirm early disease. Other investigation that was used was a barium meal as part of the work-up for surgery. The demonstration of

Dr Sano

surgical anatomy was truly astounding with clearance of all nodal tissues for a D2 resection with surgical precision but this is off course in patients whose BMI rarely extended beyond 25. They rarely encounter the huge omentums and bleeding fatty tissues that we commonly see in the UK. Throughout the 2 weeks, there were two theatres running daily for gastric resection but they were aware that there is an acute shortage of anaesthetic staff as this is due to the fact that it is no longer perceived as a desirable specialty for the medical graduates as pay is relatively poor for all hospital specialty. Despite this, the numbers undertaken still continues with expansion into laparoscopic resection for T1 lesions and pylorus sparing gastrectomies for cancers 3-4cm proximal to the pylorus. Patient stay averaged 9-11 days with a complication rate of around 20% of which 10% was pancreatic fistula.

The two centres also has a very active therapeutic endoscopy unit undertaking Endoscopic Submucosal Resection (ESD) where lesions of varying size are removed. Witnessing this is similar to seeing the surgical resection with the advance endoscopic technique quite astounding. The procedures were performed under anaesthetic and the endoscopist had the patience and technical expertise to continue this endoscopic procedure in some cases as long as 2-3 hours long.

A visit to these centres, cannot go without visiting the sites of Tokyo. It is a very interesting place with a very large underground/train system which is even more complicated than the London underground. People are extremely helpful even if they can't converse in English with you. The sites included one of the largest fresh fish market in Japan (waking up at 5am to see the freshly caught tuna loaded of the boats by the NCC in a fish market full of people is impressive), replica Eiffel tower, bullet train, Ginza (entertainment district), Royal Palace and gardens, Bond street equivalent, electronic city for all your gadgets and many many more.

Throughout my whole stay I was always made so welcomed. I am extremely grateful to Dr Sano for his time and for arranging my two weeks at the two institutes. I would also like to thank AUGIS for the fellowship where the experience and time was invaluable.

NCCI

AUGIS Travelling Fellowships

Reports on the AUGIS Travelling Fellowships

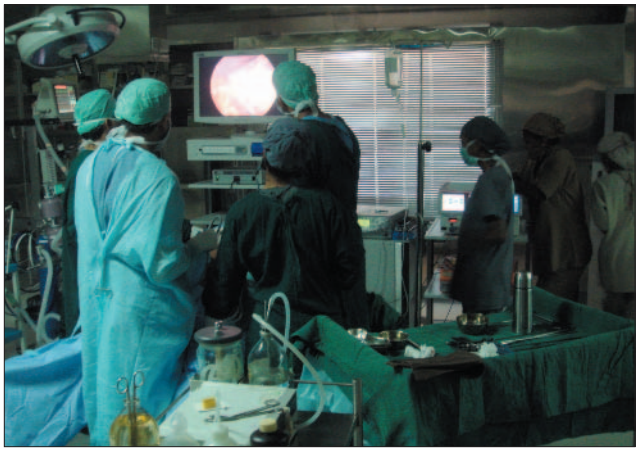
Visit to India and USA
Mr Stewart Duncan, Chesterfield Royal Hospital, Chesterfield

A Trip of Contrasting Experiences

Leaving seasonal UK temperatures of 7-8 °C in late March, I arrived in Coimbatore with daytime temperatures in excess of 35 °C. I was very grateful then, to be in the air conditioned theatre suite of GEM Hospital early the following morning. GEM Hospital (figure 1) was founded in 1991 by Dr C Palanivelu and is a 200-beded private hospital managing a range of surgical and medical gastro-intestinal conditions.

Dr Palanivelu, the Chief, heads 3 surgical teams, with each team individually led by a senior surgeon (which would probably compare most accurately to the old senior registrar grade in the UK). The teams "rotate" through clinic, operating and ward work days so that a patient with for example, symptomatic gallstones, seen in the clinic is frequently operated on the following day by the same team and discharged from the ward the day after that. The referral pattern of patients to the clinic is in many ways similar to that in the UK. Patients may be referred by family physicians or they may receive referrals from other clinics but crucially and in a very different manner to the UK system, patients may also present themselves to the hospital, with the reputation of the Institution largely responsible for these self-referrals. With the influence of cultural differences, the fee-paying nature of the patients and the importance of reputation, it is not unusual for a patient presenting with suspicious upper or lower gastro-intestinal symptoms to undergo diagnostic tests, cross-sectional imaging and any medical consultations required before definitive operative intervention all within the space of 4-5 days.

GEM Hospital, Coimbatore



One of six operating theatres at GEM Hospital, Coimbatore

Operations are carried out 6 days a week, with the case mix and the operating surgeon decided by the Chief depending on ability, experience and training needs. The vast majority of cases are approached laparoscopically, in both elective and emergency situations. There are 6 dedicated theatres (figure 2); all with high definition imaging systems and the harmonic scalpel is used in all cases requiring tissue dissection. They perform approximately 50 oesophageal resections a year and have adopted a minimally invasive approach. The procedure begins with thoracoscopic mobilisation of the oesophagus with the patient in the prone position. The patient is then turned supine, allowing laparoscopic gastric mobilisation, lymphadenectomy, pyloroplasty and formation of the gastric conduit, with a cervical anastomosis. Dr Palanivelu has also performed laparoscopic transhiatal resections.

The range of surgical procedures performed during my visit was extensive considering the usual practices of a single surgeon in the UK. Including upper gastro-intestinal resections for malignancy, other procedures included pancreatic resections, extended cholecystectomy, bariatric procedures (sleeve gastrectomy and duodenal switch), a range of colorectal operations and even some gynaecological procedures.

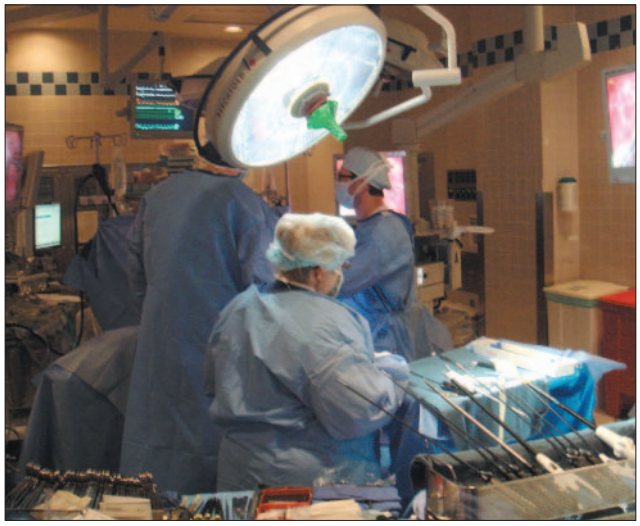
In stark contrast to the working practices at GEM hospital in Coimbatore, I spent four weeks observing the work of Dr J Luketich, at the University of Pittsburgh Medical Centre (UPMC). Dr Luketich is the Director of the Heart, Lung and Esophageal Surgery Institute (HLESI) and Chief of Thoracic

Reports on the AUGIS Travelling Fellowships

Surgery at UPMC. Although UPMC itself is comprised of a number of sites in and around Pittsburgh, the majority of the oesophago-gastric surgery is carried out at Presbyterian hospital (figure 3) close to the University and the Medical School.

UPMC has an excellent reputation for training with stiff competition for the residency program. There are also a number of fellows who come from all over the world to work with Dr Luketich, usually for a period of 1 year. Dr Luketich was routinely present in the operating room on Mondays, Wednesdays and Fridays and this is when all major oesophago-gastric cases are carried out. There were usually three rooms working concurrently, with Dr Luketich moving from room to room carrying out the more complicated steps of individual procedures. Up until 2005, he utilised a 3-stage approach to resection, but now prefers a two-stage procedure with a stapled, intra-thoracic anastomosis. The procedure begins with laparoscopic gastric mobilisation and formation of the conduit. Thoracoscopic mobilisation of the oesophagus, lymph node dissection, resection and restoration of continuity is carried out with the patient on their left side. The procedure is performed without epidural analgesia, but local anaesthetic is infiltrated into the intercostal spaces under direct vision prior to the end of the procedure. The majority of patients are extubated in the operating room and spend a single night in the surgical ICU. As long as there are no post-operative complications, the aim is to

UPMC Presbyterian hospital, the emergency room entrance is adjacent to the main hospital entrance



OR 16 at Presbyterian hospital

discharge patients home on the 5th or 6th post-operative day. Using this approach Dr Luketich and his team have reduced the anastomotic leak rate requiring surgical intervention to 2%.

The management of simple and complex situations attributable to gastro-oesophageal reflux disease also forms a significant component of the work undertaken in the unit. The initial procedure of choice is a Nissen-type fundoplication, with the liberal use of the Collis gastroplasty for the shortened oesophagus. An aggressive surgical policy is adopted for those with on-going or recurrent symptoms and re-do fundoplication, oesophago-jejunostomy or even oesophago-gastrectomy are all utilised depending on the situation. I was able to observe all of these situations during my visit and was fortunate to attend a course designed specifically to address and discuss the role of surgery in the management of complex benign oesophageal disorders.

The increasing use of minimally invasive techniques in the surgical management of oesophago-gastric malignancy in the UK has led to UK trainees and Consultants seeking practical and observational experience in various parts of the world. A significant number of those have been supported financially by the AUGIS fellowship awards. I am very grateful to count myself in this group and I am indebted to AUGIS and Drs Palanivelu and Luketich for enabling me to complete this trip.

Reports on the AUGIS Travelling Fellowships

AUGIS Travelling Fellowship for Diploma course at 'Centre Hepatobiliaire' Paul Brousse Hospital Paris

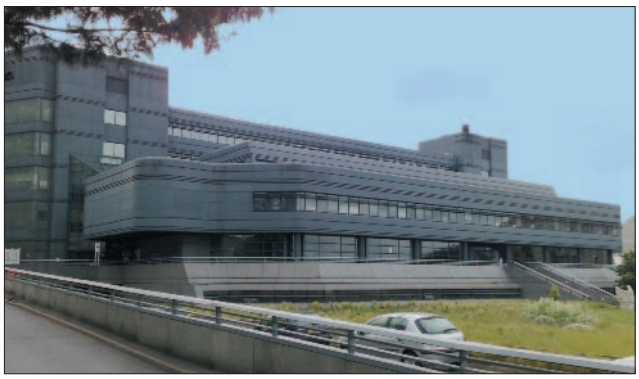
Mr Vivek Upasani, St. James's University Hospital, Leeds

The Hepatobiliary Centre at Paul Brousse Hospital, Paris is a leading European centre for liver transplantation and one of the biggest centres for liver cancer, biliary tract and pancreas surgery. It was established by Professor Henri Bismuth in 1970's. It has 71 beds, 15 ICU beds and 5 operating theatres dedicated to HPB and transplant and performs around 200 liver resections and 130 liver transplants each year.

The institute conducts the 'European University Diploma: HPB cancers' course in partnership with University of Barcelona, Brussels, Torino and Stockholm along with University of Paris. It aims to promote the multidisciplinary approach to HPB cancer management and includes the latest advances in this field. The sessions include presentations on the latest scientific data and discussions on the evidence in literature. It is organised by Prof Rene Adam and his team, and is aimed at senior HPB trainees and junior consultants. It is well attended by HPB trainees and consultants across the European continent. Although the course is held in Paris, the sessions are in English!

The course consists of a series of 3 sessions of one week each followed by an exam at the end. We had a great opportunity to meet and discuss with expert faculty like Prof H Bismuth, R Adam, G Poston, L Capussotti, D Cherqui, J Figueras, PA Clavien, JF Gigot, JR Delpero, D Elias, D Azoulay, M Ducreux and others during the interactive scientific sessions.

The first session covered generalities on HPB cancers and included wide range of topics from prevention to latest treatment modalities like gene therapy and liver transplantation. The highlights included the increasing use of contrast enhanced ultrasound for liver metastases, portal vein embolisation, role of laparoscopic surgery, video presentations on laparoscopic liver resections, Surgery for Klatskin tumours and debate on the controversial role of liver transplantation in biliary tract cancers.



'Centre Hepatobiliaire' - Paul Brousse Hospital, Paris

Eiffel

The second session included topics like liver metastases from colorectal cancer and new oncosurgical strategies, role of chemotherapy and surgery, timing of treatment, results of 'rescue' surgery, resectability of liver metastases (The Oncosurge model), two stage liver resection and 'extreme' liver surgery. The latest data on LiverMetSurvey was also presented.

The key topics of the third session were liver metastases from non-colorectal cancer, rationale for surgery, cancer of the pancreas, prognostic factors of pancreatic resection, neoadjuvant and adjuvant treatments. This final session concluded with the examination which I successfully passed.
I had a great opportunity to meet and exchange views with HPB community from different parts of Europe, learn about different health systems and training programmes. It was a good chance for cultural exchange and making new friends.

Besides all the academics, evenings in Paris were a real joy! Eiffel at night, Seine cruise and shopping at the capital of fashion were the exciting highlights. Daily commute from the hotel to the Paul Brousse Hospital by metro and tram gave me a true flavour of Parisian life.

I thank Prof Rene Adam and his team for their excellent organisation. I am extremely grateful to Mr G Poston for supporting me for this fellowship. I would like to thank AUGIS and my consultants at University Hospital Aintree for their support.

This diploma course has given me a new insight into the management of HPB cancers and has helped me to update my knowledge in this field. I thoroughly enjoyed this inspiring course.

Mr Vivek Upasani