Health and Social Welfare are high on the Agenda of politicians in the United Kingdom and the USA at the moment. Surgery has been at the forefront in both countries. But whatever change is introduced, it is patient care and safe surgical practice that must remain at the core of our profession. In the UK the basic tenets of the Health and Social Care Bill are commissioning led by healthcare professionals based on quality, greater patient involvement, less bureaucracy, limited use of any qualified provider, integration between secondary and social care, and all care to be provided free of charge at the point of delivery (a core principle enshrined in the National Health Service since its foundation). In the USA, the President’s Health Bill concentrates more on how to pay for the ever increasing costs of healthcare. The introduction, to a majority of the population, to be privately insured by law, is a step too far in many voters’ beliefs.

My own position is that no country in the world can afford all treatments to all patients free. When Beveridge drew up his plans for a National Health Service introduced by Aneurin Bevin in 1948, what could be offered to patients is a small proportion of what can be offered today. Joint replacements, transplants, robotic surgery, minimal access surgery and sophisticated imaging, are just a few of the modern procedures and investigations used in the 21st century. Therefore, it makes sense that non-urgent, and often not completely necessary, operations and investigations might need to be funded elsewhere. I think that all countries should have a public-private partnership with funding by Government and insurance companies together. All those who are unable to afford it, or the very young or elderly, must have their care covered by their Government. But the working population should have insurance to cover them for those procedures not deemed absolutely necessary, for example, operations that border on aesthetic plastic surgery. Some countries in Europe are taking this route already, which relieves the Government of the total bill for healthcare. Rationing and prioritisation always have and always will be evident in day-to-day practice.

We do not include any specific papers on this topic but some of our invited editorials touch on what is and what could be done in surgery. In this, our tenth year, we are pleased to publish these editorials, together with reviews and, as always, articles on research and clinical matters.

The first editorial concentrates on General Surgery – present and future. This is a subject I have waxed lyrical about for some time, and it is timely, as for the first time since 1974 in the United Kingdom a new surgical speciality has been launched – Vascular Surgery. This paper from Spain states that sub-specialisation within General Surgery has led to a decrease in General Surgery as a speciality in the last few decades. They comment that laparoscopy did rejuvenate General Surgery at the end of the last Century, and NOTES may further rejuvenate it in the future. However, laparoscopy is now performed within all the sub-specialities of General Surgery as no doubt NOTES will be if it becomes an accepted form of surgery. Also, these techniques are expensive, especially in third world countries who do not have the wherewithal to perform them in most centres. It is much more important that surgical procedures are performed efficiently and safely. The authors comment that in the USA there has been a decrease by 23% in applications for General Surgery residency programmes. I believe General Surgery will continue, as it is needed in rural areas, even the first world, and it is certainly needed in the third world. We will have to think of new training programmes to embrace General Surgery as well as its subspecialty offshoots.

I found the second article that we publish in this edition a rather strange one entitled “Minimal Access Maximal Success: a myth or a reality”. The article comes from Kashmir when it is possible that minimal access surgery is not practised widely. Minimal Access Surgery is a reality and has given huge benefits to thousands of patients. The learning curve, which occurred during the early introduction of these techniques in the late 1980s, should no longer be a factor as we should all have excellent virtual and real training. I would strongly recommend the third invited editorial on “Colorectal Surgery Current Practice & Future Developments”, which is written by Surgeons from Scotland. The paper concentrates on laparoscopic and robotic colorectal surgery for cancer, failing to mention the role of neo-adjuvant chemo-radiation. They then discuss the management of acute diverticulitis in full, and state there is no place for elective resection as taught in the past, following one or two episodes. Also, in patients who are admitted as emergencies who have no previous history of acute diverticulitis. They state that emergency surgery should be used only if aggressive non-operative management fails, or there is generalised peritonitis, or the patient is haemodynamically unstable. They strongly recommend CT guided drainage and possibly laparoscopic lavage and drainage. They also add that if patients have severe faecal peritonitis, septic shock, haemodynamic instability, or are on chronic steroid therapy, then surgery is indicated. They say that there is a decrease in incidence of performing a Hartman’s operation with patients either being fit enough for a primary anastomosis, or just needing lavage and drainage. They move on to discuss stapled haemorrhoidectomy, and mention haemorrhoid arterial ligation (HALO and THD) as alternatives to conventional haemorrhoidectomy. Next they discuss pelvic floor disorders and laparoscopic rectopexy for rectal prolapse. They also discuss the place of sacral nerve
stimulation for faecal incontinence, and end by stating that the way forward may be NOTES and SOLE (sealed orifice laparoscopic or endoscopic surgery).

Our final invited editorial is on “Pancreas Cancer Treatment: A Surgeon’s Perspective ‘Today’,” from Italy. This article traces the history of successful pancreatic surgery, dating it from John Howard in 1968. They point out that mortality is now as low as 2%–3% in high output centres. The anxiety is that morbidity remains high at 30%–40% with the incidence of pancreatic fistula unchanged in the last decade. Recent trials show that early removal of drains result in a decreased rate of fistula formation, compared to leaving drains longer. They also point out that of a third of patients who undergo pancreatic-duodenectomy, there is a high incidence of early local recurrence. Resection margin involvement (R1) is a key prognostic factor, but the R1 rate reported varies greatly (20%–75%). They feel this is the fault of the pathologist, not the surgeon, and suggest a new method of examining the surgical specimen. They finish by stating that neo-adjuvant treatment is the most promising therapeutic modality if we are to improve long term results.

Turning to our reviews, the first entitled “Current knowledge on pancreaticobiliary reflux in normal pancreaticobiliary junction” comes from Chile and introduces fascinating possibilities. The proliferative changes of biliary epithelium, hyperplasia, and cancer seem to be related to reflux, and this may be associated with gallbladder cancer and possible gallstone formation. If the consequences of pancreaticobiliary reflux can be supported by level one research, this would constitute a major breakthrough in understanding and eventually in treating gallbladder disease.

Our next review looks at “Enteral vs total parenteral nutrition following major upper gastrointestinal surgery”, and comes from Scotland. This review points out that randomised control trials show that enteral feeding leads to a decrease in hospital stay, a decrease in incidence of severe or infectious complications, a decrease in severity of complications and a decrease in cost. They conclude that this is the best form of post-operative feeding.

This is followed by a review of the role of diagnostic laparoscopy as an additional staging procedure in patients with radiologically staged resectable oesophago-gastric junctional tumours. This is a best evidence topic review and they conclude that laparoscopic staging does detect previously occult peritoneal metastases, as well as liver metastases, and involved lymph nodes, which can lead to a change in management in more than 10% of patients. However, one has to recognise there is a morbidity to this procedure and PET scanning may be superior in the future.

The last review questions whether ligation of the thoracic duct during oesophagectomy decreases the incidence of post-operative chylothorax. There are conflicting results from retrospective studies but the conclusion they have drawn from reviewing all the prospective randomised trials is that this is an effective measure to decrease the incidence of post-operative chylothorax.

Turning to our clinical and research papers, we start with an article on Sliding Inguinal Hernias from Spain, in which prospectively they studied 464 patients with inguinal hernias. Only 16 were diagnosed as sliding (3.4%) with 62.5% having sigmoid colon, whilst bladder, appendix and caecum affected 12.5% respectively. In their series there was only one recurrence.

The next paper is on “The Future of Trauma Care in a developing country: Interest of medical students and interns”, which comes from Nigeria. In a survey, they show that 80% of their students and young doctors showed interest in pursuing post-graduate specialisation, with surgery being the most popular. Interestingly, 35% selected related trauma specialities. The reason for this, they state, were good role models, being male, and being single. They end by stating the need to make training programmes and surgery less stressful, and lifestyle issues need to be made more favourable.

Our penultimate article is a randomised controlled trial from Pakistan on “Post-operative port-site pain after gallbladder retrieval from either the Epigastric or Umbilical ports”. They randomised 120 patients and found that the pain as assessed by a visual analogue scale was much lower in the 60 patients who had the gallbladder extracted via the umbilicus.

Finally, our last paper addresses The Utility of CT Angiography in planning Perineal Flap Reconstruction, and is from the United Kingdom. The authors comment that following radical excision of pelvic tumours, perineal closure can be difficult and often there is a need for flap reconstruction. CT angiography was shown to be useful in aiding pre-operative planning and in operative reconstructive choice, as well as outcome. There were only six cases and the deep inferior epigastric artery was visualised in all of them. In one case, narrowing was noted so a flap based on this artery was not used. I personally found this edition of our Journal compelling, and we are indebted to all the authors, especially to the four who were invited to produce editorials and reviews. If the Journal is to be as successful as it has been in its first decade, we need more articles and reviews of this calibre.