Editorial

Perspectives on the issue of the IJS 6-3

Having just returned from a Royal Society of Medicine Section of Surgery meeting held in Cape Town, South Africa, I was privileged to be able to visit the Christian Barnard Museum at Groote Schuur Hospital. This reminded me that it is only just over 30 years since the first heart transplant was performed. I was just qualified and it was a truly momentous moment in surgical history. Of course, there have been many such moments throughout the ages but transplantation had only just taken off, and the thought of replacing the heart was certainly beyond my expectation, and I am sure most trainee surgeons at that time.

The enormous amount of laboratory work that led up to this operation, and also the strength of character and compassion to perform it, came over strongly. The world is a much smaller place now, and of course communication is so much faster. It was interesting that it took some time before the world were aware that Mr Washansky had received the heart of a young girl tragically killed in a road traffic accident. Nothing stands still in surgery, whether it be research, techniques, training or management of the surgical patient.

This edition of our Journal certainly addresses many of these problems. The training of young surgeons to perform complex oesophago-gastric surgery within the current climate of changes to medical training and reduced hours is difficult. The paper from Rohatti and his colleagues demonstrates that even complex surgery cases can all be used for training purposes. A large number of patients (270) underwent primary oesophagectomy under a single Consultant, of which only 15 (6%) were performed solely by that Consultant. They have shown that trainees under supervision can competently perform an oesophagectomy without compromising patient care. This is an important paper, which hopefully other surgeons at that time.

The paper from Martinique on Laparoscopic Cholecystectomy in Sickle Cell disease patients was fascinating as most reports on laparoscopic procedures show advantages. In their 136 patients the laparoscopic group had more complications related to sickle cell disease due to the acute chest syndrome.

A number of articles are concerned with technique and one on 99m Tc-MIBI guided surgery for the detection of abnormal parathyroid glands and for recurrent sites of secondary hyperparathyroidism was impressive and compared much more favourably than pre-operative ultrasound examination or CT scanning. Anything that makes this type of surgery easier should be applauded. Whilst on technique, the question many pancreatic surgeons have asked is whether pre-operative duct stenting prevents pancreatic fistula after surgery and this has been addressed by a Japanese unit from Tokyo. They reviewed 18 patients but found no obvious difference and have suggested further investigations should be undertaken. It would seem that every conference I attend discusses Endo-Vascular Aneurysm Repair (EVAR). We publish an excellent paper from England which covers not only the indications, anatomical suitability, criteria for eligibility, advantages and complications, but also covers the problems of endoleaks. They conclude that EVAR is an exciting but demanding technology, which holds great promise, and we will have to await further trials.

The idea of covering a colonic anastomosis with polypropylene mesh is probably not one that comes to most surgeons’ minds. Most of us were brought up with the idea that if adhesions occurred they brought in vascularity, which may in fact aid colonic anastomosis and astomotic healing, and the idea of covering the anastomosis must seem odd.

The authors of the paper from Istanbul performed a trial in rabbits, performing a segmental colonic resection and doing the anastomosis in a single layer. In one group a polypropylene mesh as long as the circumference of the anastomosis surrounded the suture line. The animals were sacrificed at 10 days and they showed no difference in peritoneal adhesions. The authors pointed out what is probably already known, but it is important to emphasise the place of sentinel lymph node biopsy in this disease.
Visceral artery aneurysms are uncommon but have a potential for rupture. The paper on splenic artery aneurysms, which are the most common and associated with a high mortality rate when they rupture, is addressed by Obstetricians and Gynaecologists from Addenbrooke’s Hospital, Cambridge. The mortality in pregnant women, who rupture their splenic artery aneurysm, is exceptionally high at 75% with a fetal mortality of 95%. The authors point out that prompt management of these aneurysms, especially in the pregnant woman, is of prime importance.

Moving from Cambridge to Oxford, Mr Stavros Gourgiotis and his colleagues paper on damage control surgery in the abdomen: an approach for the management of severely injured patients, has important messages, especially with respect to the triad of hypothermia, acidosis and coagulopathy. They enumerate the principles of damage control and these measures have led to improved survival. Morbidity remains high but as they point out, is acceptable in the light of improved survival. The paper should be read by everyone involved with trauma and note taken of the five critical decision making stages of damage control.

Post-surgical adhesions often affect the quality of life of millions of our patients worldwide. I can still remember different approaches to prevent or reduce the incidence of peritoneal adhesions taking place in our own laboratories under the auspices of Professor Harold Ellis when I was a student and trainee. The whole problem of adhesions is addressed by the Turkish group who point out the usual methods to try and lessen their formation, such as improving surgical techniques, optimising laparoscopy conditions and using agents that provide a physical barrier to adhesion formation. Certainly, this is not the last article to be written on this subject.

The ethical question as to whether organ donors should be paid is addressed by the team from King’s College Hospital, London. There are huge ethical questions about this subject and as the authors have pointed out, the number of patients requiring an organ transplant is increasing year on year. However, it would seem to go against the grain of most doctors and surgeons to condone sale of organs. It may well put undue pressure on to those least likely to comprehend the problems that could ensure. However, it is a brave article and obviously a subject that should be debated further. I am sure it will bring many comments over the next few months.

The French surgeons paper on the surgical treatment of renal cell carcinoma with right atrial thrombus is a beautifully illustrated article, which shows that cardio-pulmonary bypass can be used in this situation. The operative techniques are well described and as the authors point out, the inferior vena cava often has tumour thrombus from renal cell carcinoma (in 4–10% of cases). The fact they were able to do the technique with no other hypothermia extracorporeal circulatory bypass nor cardioplegic cardiac arrest is commendable. Morbidity related to aortic cross-clamping was avoided and it would appear the complete resection of the tumour was always performed without tumour or air embolism and minimal blood loss. Although this technique might only be performed in a limited number of cancer centres, it is important for us all to know that it is possible and that our patients should not be denied this treatment.

The review on staphylococcus aureus in orthopaedic and cardiac surgical sites is a comprehensive one and vital in these days of increasing MRSA infection. The French group from Lyon used a Medline literature search and found that staphylococcus aureus represented the most common pathogen amounting to 20% of all surgical site infections. Sadly, they do not tell us how to avoid these infections.

Surgical management is not just technique and the paper on the effect of intraoperative fluid optimization on renal function in patients undergoing emergency abdominal surgery is an excellent randomized pilot study, but sadly showed no real benefit in replacing the identified fluid deficit. It is certainly an area for further trials. Whilst discussing trials, the last paper I wish to mention is that entitled “The Weakest Link”. This showed that the Consort check-list adherence was poor with an average score of 11.1/22 and no publication achieving full compliance. The authors suggest that the authors of the articles have a poor understanding and what elements are essential to convey to readers in their published reports and what action should be taken. The authors give possible solutions and the idea of trials being registered at the outset is important, though not new.

The Journal should instruct authors to stipulate that if they are reporting a randomized control trial, they should use the Consort check-list. They feel the most effective strategy for improvement would be to cultivate a culture where every contributing individual would recognise the importance of a scrupulous and conscientious attention to detail. They duck, however, the question as to whether editors should publish these trials if the Consort statement principles are not adhered to or followed.

Once again we have produced a superb cross-section of surgical problems, their management in terms of pre-operative approach and surgical techniques. Ethics, training and trials also are given space as we believe these subjects are of prime importance to working surgeons across the world.

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