Editor's Perspectives – October 2012

The last two months have provided two very different amazing experiences. In July I operated for the charity “Operation Hernia” in Ecuador together with a Spanish and an American surgeon. Last month, although I failed to obtain a ticket, I experienced the “feel-good factor” that pervaded London during the recent Olympic Games.

Ecuador is a beautiful country which appears to be thriving despite worldwide economic hardship. Quito is a vibrant city with an exquisite old part which is now a National Heritage Site. The people were charming and welcoming, and where we were operating in the interior, most grateful. I led a team for “Operation Hernia”. We performed 86 operations in five days. Hard work, often in difficult circumstances, but enjoyable and fulfilling. I would recommend it to all surgeons — it is fun, cathartic and hopefully beneficial to those who cannot receive timely treatment. I followed my time on the mainland with a trip to the Galapagos islands I have longed to visit since reading Darwin’s works. I was not disappointed; exciting, fascinating and very different to all other places. Each island is different and the wildlife spectacular both on land and in the water. They should be a “must” for everyone.

The London scene was amazing in a completely different way. It was wonderful to experience the happiness and bonhomie in a capital not known for being friendly. A marvellous spirit of joie de vivre pervaded throughout the city. Everyone was smiling and even talked to each other on public transport!

This publication is full of fascinating articles from ten different countries. Firstly congratulations to Andy Petroianu our reviewer of the month for September and to Jim McCaul reviewer of the month for October. We depend on our reviewers especially those like Andy and Jim who have excelled in producing multiple good reviews in a timely fashion.

We start with a paper on the non-operative management of malarial splenic rupture by three surgeons from the USA and a microbiologist from Sudan. Two cases are presented and 60 cases found in the medical press are reviewed. The recommendations are urgent resuscitation and U/S if available to evaluate for blood in the peritoneal cavity. Non-operative management is possible in the stable patient. Next in the paper “Does endoscopic treatment for early oesophageal cancers give equivalent oncological outcomes compared to oesophagectomy?” the authors have found that Endoscopic Mucosal Resection should be the first line of treatment for T1a (mucosal) oesophageal cancers. T1b (submucosal) tumours, because of the higher rate of lymph node involvement precludes this approach unless the patient is unfit for major surgery. Another Best Evaluated Topic is the following one on laparoscopic mobilization of the oesophagus as part of a trans-thoracic oesophagectomy. It may have some benefits but there are no differences in mortality or morbidity. None of the papers reviewed contained a Randomized Control Study.

We follow with a review article on “stump appendicitis” — a late and potentially serious complication of appendicectomy. Next is another review on issues related to breast cancer management; a comprehensive review on how to approach various aspects of surgery for breast cancer. Another BET is the paper on surgical implants which reviewed 21 articles and found no difference in x-linked collagen in different implants. Another review from Saudi Arabia follows on the potential use of microRNAs as a biomarker in cancer and their role as gene regulators. The last contribution in this section is a neurosurgery topic … is 1 hole or 2 necessary to drain a chronic subdural haematoma. There appear to be no differences so one hole should suffice.

Moving onto our next section the first article is a clinical research retrospective study on the accuracy of FAST scans in blunt abdominal trauma from one of my ex Senior Registrars and his colleagues in London. They show that only 60% are accurate and therefore propose that these scans only help if positive for triaging those patients who need an urgent laparotomy but that negative scans do not exclude abdominal injury. Robotic assisted pancreatic-duodenectomy (20 cases) was compared to the open operation (67) in Hong Kong, China. It proved to be feasible, safe, with a reduced blood loss and shorter hospital stay but an increased operating time. The conversion rate was 5. Hartmann’s procedure has always been proposed as a safe operation in large bowel surgery. A retrospective study from the UK demonstrated an increased mortality in patients with increased CR-Possum scores, ASA grades and in patients >81 years. Also a delay in operation from the time of diagnosis contributed to a significant higher mortality.

We include experimental research on Thymoquinone on bacterial translocation and the use of intraperitoneal agents in promoting or reducing intestinal adhesions. Turning to clinical research we include a large number of articles. The ability of oncoplastic techniques in managing locall advanced breast cancers; the use of U/S in identifying the non-recurrent laryngeal nerve; one institution’s experience with SILS laparoscopic cholecystectomy and the use of pre-injury beta blockers on the heart rate in initial trauma resuscitation are all covered. Further breast studies are included with a paper on the Goldilocks mastectomy, which has a limited applicability and the sensitivity of needle core biopsies in phyllodes tumours are also of interest. The paper on the addition of a double sided posterior gastropey when performing a Nissen procedure seems excessive. I have often added a single suture to the right crus from the wrap which surely is sufficient, especially if the hiatal closure is good.
There are two further clinical papers I found of great interest. The first a study of 107 patients with acute mesenteric ischaemia; a difficult clinical problem. All were operated upon with a hospital mortality of 55.1%. The authors from Turkey point out the many negative predictive factors, but also the positive ones such as the use of TPN and CT angiography. They stress the need to decrease the time from diagnosis to surgery to improve survival. The last paper on the use of tension free vaginal mesh surgery for the treatment of pelvic organ prolapse is of great value with our ageing populations. This is a retrospective study from Japan on their first 50 cases by a single surgeon. There were few complications and it would appear to be better than conventional surgery.

We also publish two articles on safety and simulation for surgical training. Both come from the same institution in London, well known for leading in this field. The paper on ‘Building Global Capacity for Patient Safety....” details a single day course covering various aspects of patient safety. The programme was developed and conducted in Columbia and proved most efficacious. The article on “Simulators and the Simulation Environment: Getting the balance right....” shows that simulation is a means to gaining mastery within a complex clinical world in a safe environment. Its message, which I endorse, is that simulators should be used to augment rather than replace clinical learning in order to enhance the learning experience and ultimately patient care.

This issue is a truly international one with authors from ten different countries. It is also an issue for all involved with the practice of Surgery in General.

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