Getting It Right: A Multidisciplinary Dialogue
Raymond J. Lanzafore, MD, MBA

Robot-Assisted Radical Prostatectomy: Has the Initial Promise Been Fulfilled?
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Laparoscopic Abdominal Access
Excerpt From Prevention and Management, 2nd Edition
Camran Nezhat, MD, Nanette LaShay, MD, John Morton, MD, Massimiliano Marziale, MD

The Interviewing Process
Making a Presentation, When You Present Yourself
Gustavo Stringel, MD

A publication of THE SOCIETY OF LAPAROENDOSCOPIC SURGEONS
Introducing the definitive, all-new technique guide to complications of minimally invasive surgery. The medical and legal communities continue to need up-to-date information on negotiating the learning curve of minimally invasive, image-guided surgery. *Prevention and Management of Laparoscopic Surgical Complications, 2nd Edition* comprehensively addresses specific complications of individual procedures as well as general issues and complications that arise in all applications of laparoscopic surgery.

A broader focus helps narrow the unknowns. *Prevention and Management*’s unique multispecialty approach opens the window to nuances and techniques otherwise missed when focus is restricted to an individual specialty. It provides a highly-efficient means of gathering the best information from the best minds working in laparoscopy today.

The online version of the first edition of *Prevention and Management of Laparoscopic Surgical Complications* is currently available free of charge at www.SLS.org. The full text including illustrations can also be viewed on PDAs and cell phones with Web access, through the RSS feed.

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ABOUT THIS COVER

The John F. Kennedy Library and Museum, where SLS will host an Evening with Faculty as a special event at the 15th International Congress and Endo Expo 2006 (see page 26), is dedicated to the 35th president of the United States. The Library and Museum opened in 1979 and is the architectural creation of Ieoh Ming Pei. Known by his initials, I. M. Pei is considered the last master of high modernist architecture and was selected by Jacqueline Kennedy to design the building.

This striking library and museum sits on a 9.5-acre park overlooking Boston Harbor in Columbia Point of Boston, Massachusetts, USA. Through 3 theaters, period settings, and 25 multimedia exhibits, museum patrons experience John F. Kennedy’s life, legacy, and leadership and see the events of the 1960s through his eyes and narrated in his voice.
SLS MISSION STATEMENT

The Society of Laparoendoscopic Surgeons (SLS) is a non-profit, multidisciplinary and multispecialty educational organization established to provide an open forum for surgeons and other health professionals interested in laparoscopic, endoscopic and minimally invasive surgery.

SLS endeavors to improve patient care and promote the highest standards of practice through education, training, and information distribution. SLS provides a forum for the introduction, discussion and dissemination of new and established ideas, techniques and therapies in minimal access surgery.

A fundamental goal of SLS is ensuring that its members have access to the newest ideas and approaches, as rapidly as possible. SLS makes information available from national and international experts through its publications, videos, conferences, and other electronic media.

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Submit articles, case studies, review articles, product reviews, news about minimally invasive surgery, and letters to the editor as an email message or attachment. Materials may also be submitted on 3 1/2 inch diskettes, zip disks, or CDs.

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All material should be prepared in accordance with the American Medical Association Manual of Style with references listed in citation-sequence format. Average article length is 1000 words.

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Modern medicine is concerned with empowering the patient, informed consent, applying leapfrog initiatives, IHI’s 100,000 Lives bundles, and practicing high-quality, evidence-based medicine, with 21st Century technology, against a backdrop of increasing scrutiny, increasing expenses, and declining reimbursement. Various constituencies tout pathways, clinical algorithms, physician report cards, and pay for performance as the vehicles to achieve improved outcomes and cost-effective, efficient health care.

The American consumer is increasingly more connected to the Internet and is being constantly barraged with a growing number of television and other presentations on health-related themes. Cable television channels air a wide variety of medical shows that demonstrate a diverse array of technology, science, and provide entertainment. High technology and high-risk procedures are presented as being state of the art and foolproof. More and more patients demand that their doctor perform specific procedures or prescribe specific therapies based on information from the Internet and other sources. Patient demands and preferences have a substantial impact on rising costs and increasing use of technology. Consumers demand “the best” and tend to equate high technology with high quality and least risk. These issues fuel the cost of care, particularly in reference to the need to acquire the technology, provide the appropriate care, and resolve complications regardless of whether they resulted from “operator” error or biological response.

My surgical career has seen the rise of arthroscopy, flexible endoscopy, laparoscopic cholecystectomy, minimally invasive surgery, and more recently, robotically assisted surgery. Each of these advances has improved patient care, bringing with it a new cadre of risks, costs, and complications. Each was embraced by the public, who then forced the medical community to seek training and begin to perform the new techniques, or lose substantial patient volumes.

The perception of the cost of these techniques is vastly different for each of the constituencies. The patient believes that no expense should be spared, particularly since most patients have some form of medical insurance or are able to qualify for Medicaid. Payers see increasing expenditures for more procedures. Hospitals see shifts in the cost of materials and changes in case mix and volume.

Learning and the acquisition of new skills are two pursuits that are highly satisfying irrespective of one's station in life. However, clinicians are finding it increasingly difficult to keep current with the staggering pace of advancing medical science and technology. There continues to be a trend toward increasing fragmentation of medical and scientific groups and economic and time constraints that prevent or limit one’s ability to attend meetings or participate in a diverse array of organizations. Those of us in surgery and other hands-on specialties need to understand the details of new technologies, and must acquire appropriate training and skill in their use. It is critical for us to understand the proper role and use of these technologies and techniques. We must be willing to critically evaluate their
applications and must also thoroughly understand their potential complications and effective methods to resolve them.

It is clear that advances in medicine are occurring across all of its disciplines. Much of the technology that readers of this publication use is also being used and developed by colleagues in other disciplines. Problem-solving techniques and developments in one specialty are often invaluable to those of us in other disciplines. However, knowledge of these advances and applications is often limited to narrow single-specialty societies, particularly if there is no vehicle whereby clinicians, academics, and scientists from different disciplines can come together to vet their ideas in a collaborative atmosphere. The Society of Laparoendoscopic Surgeons represents such an opportunity.

This year’s International Congress and Endo Expo will be held at the Westin Copley Place in Boston (September 6–9, 2006). Several learning opportunities and thought provoking sessions are planned. Cutting-edge developments in minimally invasive surgery will be presented. Sessions discussing innovations from the bench to the bedside; informatics and the laparoendoscopic surgeon; competency, metrics, and skills assessment; and numerous other topics will be discussed from the multidisciplinary perspective. Live telesurgery sessions, specialty breakout sessions, and preconference Master’s Classes will provide a custom palette for learning, dialogue, and debate.

SLS is truly a unique organization. We have accomplished much and have catalyzed multidisciplinary dialogue that has reaped numerous benefits for patients by advancing minimally invasive surgery and related disciplines. Our vision and mission are forward thinking and provide a basic framework for our direction. Yet, our organization is also a teenager, grappling with an increasingly complex future with a need to question and reevaluate the status quo. We are blessed with a large membership, capable leaders, an excellent central office staff, and a strong financial status. However, like the teenager, we must consider the opportunities and develop the strategies that will position us for the future. We must endeavor to understand minimally invasive surgery and the drivers of its application. Understanding is a critical component to any discussion of the risks, benefits, and opportunities inherent to minimally invasive surgery. It is only then that we can ask appropriate questions that will provide the evidence base for clinical applications and further research. It is only then that we can educate patients and payers about the value-added that minimally invasive technologies provide.

Curiosity and dialogue will expand knowledge and promote learning. The English essayist and critic Walter Pater (1839-1894) noted: “What we have to do is to be forever curiously testing new opinions and courting new impressions.” A collaborative, multidisciplinary dialogue is the key to getting it right for our patients.
Laparoscopy has been a tremendous advantage for patients as well as physicians over the past ten years. The new revolution however is even more exciting. It is one of robotics. Today we live in a digital age. Our music is digital, our data is digital. However, the interactions with our patients are still in analog. We look at x-rays that are obtained from conventional radiation sources, and we still have to reach out and physically examine our patients. With the invention of surgical robotics, this is changing. The new devices that are available today are to some extent fantastic as they allow us to perform surgeries across oceans while sitting comfortably in a recliner chair. Surgical systems such as the da Vinci Surgical System and the Zeus Surgical System are pioneers in surgical robotics, but these are only the tip of the iceberg. There are a number of companies that are looking to develop new robotic systems, and several companies are researching robotic endoscopes. Olympus is looking at developing active capsule endoscopy.

Our own area of interest is miniature robots and we have created a miniature prototype that is a wireless camera and device that allows us to insert a miniature robot into the abdominal cavity of a patient during a laparoscopy. The device is wirelessly driven through the abdominal cavity while at the same time sending video signals. We are now seeking FDA approval of this device for human use. So far it has been used successfully in the animal model. These and other technologies will revolutionize how we treat our patients and change medicine as radically as laparoscopy did more than ten years ago.

Notes
Dr. Oleynikov’s work with mini-robots has been reported on in the BBC news (http://news.bbc.co.uk; “Dextrous Mini-robots to Aid Ops”); New Scientist (www.newscientist.com; “Robot Set Loose to Film Your Insides”); and MedGadget (www.medgadget.com; “Tiny Robots for Remote Surgery”).
Articles have been published in IEEE Transactions on Robotics, Surgical Innovation, and Journal of Surgical Endoscopy.

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Robot-Assisted Radical Prostatectomy: Has the Initial Promise Been Fulfilled?

Thomas E. Ahlering, MD, Douglas W. Skarecky, BS

The development of a laparoscopic approach to radical prostatectomy has taken several years. Indeed after the initial report of 9 cases, by Schuesler, Clayman, and associates in 1997,1 2 to 3 years transpired before meaningful success was described by 2 groups in Paris.2,3 This is because laparoscopic radical prostatectomy (LRP) is considered the most difficult urological procedure to master due to technical and reconstructive requirements. Although LRP enjoyed sustained growth in Europe, the rather difficult “counterintuitive” nature of the technique retarded its acceptance in the United States.

In 2001, Menon and associates failed to establish a pure LRP program at the Henry Ford Hospital but subsequently fathered the first large-scale robot-assisted LRP program.4 This group demonstrated that the da Vinci robot (Intuitive Surgical, Inc, Sunnyvale, CA) could overcome the counterintuitive pitfalls of standard LRP surgery. Potential advantages offered by this technology include intuitive instrument handling, 3-D viewing and comfortable ergonomics, precise and facile camera positioning, plus “machine-like” precision with 7 degrees of freedom of the wristed instruments (Figures 1 and 2).

However, learning (and training) the technique of robotic (laparoscopic) prostatectomy (RLP) has a substantial learning curve. Several authors have reported that the “4-hour” learning curve is for 15 to 30 cases for experienced open surgeons as reported by Menon,4 Ahlering,5 and Wiklund6 (Figure 3). The “4-hour” learning curve for LRP has been reported to be 60 to 100 cases. Although the cost of the da Vinci robot (~$1.3 million) and per case expenses favor open and standard laparoscopic surgery, the rapid rise in interest and application of RLP leave little question of its growing acceptance by surgeons and patients. As an experienced open and robotic surgeon, there is no question that the ability to place the tip of the da Vinci 3-D camera between the rectum and prostate 1 cm to 2 cm from the apex and sharply dissect attachments is without parallel in open pelvic surgery. A potential drawback to robotics is the loss of tactile sensation. Some surgeons claim

![Image 1](image1.png)

Figure 1. The user-friendly da Vinci robotic console is shown at left, and an example of positioning of the robotic arms is shown at the right of the figure.

![Image 2](image2.png)

Figure 2. Placement of port sites for a 3-arm robotic surgery: L=robot’s left arm, R=robot’s right arm, =camera, Q=assistant’s left and right hand ports. Reprinted from Urology, Volume 63, Lee et al, Laparoscopic radical prostatectomy with a single assistant, Pages 1172-1175, Copyright 2004, with permission from Elsevier.
it is an important facet in determining points of extracapsular extension although data supporting the ability to feel a microscopic margin have not been demonstrated.

Factors important to both patients and surgeons include operative time, blood loss, transfusion rate, and length of hospital stay, among other things. RLP offers well-established benefits with regard to blood loss, transfusion rate, and length of stay. For example, blood loss was significantly reduced in LRP versus blood loss in open prostatectomy in 2 studies. In my own experience, complication rates have been reduced at least 50% (2% to 4% in RLP) compared with complication rates in my open experience (9%). In most published series, complication rates range from 8% to 20% versus 4% to 10% in RLP.

**ONCOLOGICAL CONTROL**

Oncologic outcomes, such as local recurrence or metastatic progression, are primarily driven by individual tumor characteristics like preoperative PSA levels and pathological Gleason score and stage. Obviously, radical prostatectomy cannot change these factors. The primary oncologic goal of radical prostatectomy regardless of approach is to avoid inadvertent entry into the prostate in low-risk patients (pT2 positive margins), and for patients with extracapsular extension the task is to resect soft tissue margins wide enough to prevent pT3 margins. An advantage of RLP is the visual capability afforded by minimal blood loss and intimate camera positioning adjacent to the prostatic capsule. Most experienced robotic centers report in pathologically organ-confined disease (pT2), margin rates ranging from 4.5% to 16%.

**QUALITY OF LIFE ISSUES**

**Continence**

Reporting of continence rates has been needlessly complicated. Continence should be defined as urinary control requiring no pads as determined on self-administered questionnaires. It is a definitive question and when coupled with the time following surgery to achieve pad-free status allows for Kaplan-Meier analysis (Figure 4). Several RP series have reported median time to pad-free status of approximately 35 days to 45 days and a 6-month pad-free status rate of 90%. Thanks to the innovative “single knot” urethrovesical anastomosis as described by van Velthoven, clinically evident bladder neck contractures in over 500 cases have been below 0.3% (personal data).
Potency

Like continence, the reporting of potency has a checkered track record. The use of validated questionnaires pre- and postoperatively (e.g., IIEF-5 International Index of Erectile Function) is essential to the acquisition of believable data, which can then be used to correlate postoperative erectile function with operative technique. There is no reason to believe that radical prostatectomy (regardless of approach) will make impotent men potent. Historically, the lack of use of validated questionnaires severely hinders evaluation or comparison of sexual function for RP.

In a review of an LRP series by Basilotte et al,47% to 86% of men who were “potent” preoperatively had erectile function adequate for intercourse at 1.5 years of follow-up with or without 5PDE inhibitors. El-Hakim and Tewari12 summarized the available series on postoperative sexual function in RP. In 4 centers reporting potency, 49.5% of patients had intercourse and 79% had return of erections, with or without 5PDE inhibitors at follow-up of less than 1 year. It is safe to state that definitive conclusions cannot currently be drawn.

Preservation of sexual function from a technical view has 2 components. It is critical to physically preserve the neurovascular bundle (NVB) and also limit thermal or other injury during dissection. RLP initiates the dissection at the prostatic vascular pedicles and proceeds antegrade to dissect the NVB to the apex. Generally, robotic and laparoscopic surgeons use some form of thermal energy to control the vascular pedicles. However, Ong and associates13 have definitively demonstrated in a laparoscopic dog model the critical need to avoid thermal energy in proximity to the NVB. Although the NVB was “preserved,” thermal injury resulted in a 95% loss of

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<table>
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<th>Surgeon Issues</th>
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<tr>
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**Table 1**

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<th>Surgeon and Patient Issues</th>
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<td>Mean surgical time (Average)</td>
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<tr>
<td>Estimated blood loss</td>
<td>100-200 mL</td>
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<td>Transfusions</td>
<td>0% to 1%</td>
</tr>
<tr>
<td>Conversions</td>
<td>0% to 1%</td>
</tr>
<tr>
<td>Complications</td>
<td>2% to 10%</td>
</tr>
<tr>
<td>Length of stay</td>
<td>1 to 2 Days</td>
</tr>
<tr>
<td>Return to work</td>
<td>2 to 4 weeks</td>
</tr>
</tbody>
</table>

**Oncological Results**

| Overall Margin Rates | 11% to 21% |
| pT2 | 4% to 10% |

**Patient Issues**

| Continence 0 pads at 6 months | 73% to 90% |
| Continence 0 pads at 12 months | 90% to 95% |
| Potency at 3 months | 40% |
| Potency at 9 months* | 71% |
| Potency at 18 months | 80% |

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*IIEF-5≥21, age<65.*

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Figure 5. Placement of a bulldog clamp on the neurovascular bundle. Reprinted from Urology, Volume 65, Ahlering et al., Feasibility study for robotic radical prostatectomy cautery-free neurovascular bundle preservation, Pages 994-997, Copyright 2005 with permission from Elsevier.

Figure 6. The interoperative placement of a bulldog clamp on the vascular pedicle. (SV=seminal vesical)
corporal pressures on the involved side. Gill and associates and Ahlering and associates recently described the feasibility of a cautery-free technique to preserve the NVB by using laparoscopic vascular “Bulldog” clamps (Figures 5 and 6). We have already experienced dramatic improvement over our previous technique using bipolar cautery to control the vascular pedicle; 43% vs. 8% of men (65 years and preoperative IIEF-5 of 22 to 25) have return of erectile function with the cautery-free technique at 3 months with or without 5PDE inhibitors. Menon et al. recently reported potency outcomes at 12 months at either 74% (conventional nerve sparing) and 97% with prostatic fascia preserved (veil of Aphrodite) for prepotent men (IIEF-5) >21 who underwent bilateral nerve sparing. Although the study did not control for bipolar cautery implicated by Ong et al., complete information regarding potency will require at least 2 years of follow-up.

CONCLUSION

In Kuhn’s classic description of science, robotic surgery is quickly progressing beyond the prenormative stage of nongeneralized methods and descriptions to a new consensus methodology. The impact of future technological advancements favors the robotic interface and perhaps a new surgical paradigm. Platforms are being explored for preoperative or real-time imaging, or both, of structures (ureters, arteries, nerves, prostatic capsule, and others) for immediate intraoperative feedback. Remote training or proctoring is another promising application. The future may already be evident. In 2001, 247 procedures were performed. In 2002, 2003, 2004, and 2005; 766, 2648, 8642, and 16,000 robotic procedures were performed, respectively. For 2006, the projection is 25,000 of an estimated 100,000 in the United States (personal communication from Intuitive Surgical Inc.).

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Thomas Ahlering, MD, is Professor and Chief of the Division of Urologic Oncology at the University of California, Irvine. Now in its fifth year of robot-assisted surgery, the UC, Irvine robotic-assisted laparoscopic prostatectomy experience is one of the oldest programs in the world. Dr Ahlering initiated the program and has performed minimally invasive robotic prostatectomies on more than 350 patients and is a recipient of Intuitive Surgical’s Pioneer of da Vinci Urology Surgery (2005).

Douglas Skarecky, BS, is a Staff Research Assistant in the Department of Urology at the University of California, Irvine, and has published more than a dozen articles on robotic prostatectomy with Dr. Ahlering.

References


(continued on page 10)

(continued from page 9) References: Robot-Assisted Radical Prostatectomy: Has the Initial Promise Been Fulfilled?

Minimally invasive surgeons, as proven by their existence, are an innovative lot. In 1806, Philip Bozini built an instrument that could be introduced in the human body to visualize the internal organs using a system of mirrors and candle light. Bozini called the instrument Lichtleiter or “light conductor.” He has been credited as the inventor of the first endoscope though it was never tested in humans. In his book, Bozini predicted the far reach of his innovation: “The use of the Lichtleiter is so universal that it will exert significant influence…on every field of medical science.” Bozini’s contemporaries, however, did not understand, and Bozini was reviewed by the medical faculty of Vienna and punished for his curiosity. Learn how to bring your invention to life at SLS’ 15th International Congress and Endo Expo 2006.

“I like to call it my ‘laparatus’”
PATIENT PREPARATION AND POSITION

The anesthesiology team and circulating nurses coordinate the patient’s transfer onto the operating table. The operative site is cleansed and shaved preoperatively. Operating tables must be designed to provide a 25-degree Trendelenburg position. After the induction of endotracheal anesthesia, an oral or nasogastric tube should be placed to deflate the stomach. Sequential compression devices are placed on the legs, which are then placed in padded stirrups to provide good support and proper position. Padding near the peroneal nerve is essential. To avoid nerve compression, no leg joint is extended more than 60 degrees for pelvic procedures. The buttocks must protrude a few centimeters from the edge of the table to allow uterine manipulation. The patient’s arms are placed at the side, padded with foam troughs, and secured by a sheet. This allows the surgeon and assistants to stand unencumbered next to the patient. The anesthesiologist should have easy access to the patient’s arm (Figure 1).

Once the patient is positioned, her abdomen, perineum, and vagina are prepared with a suitable bactericidal solution, and a Foley catheter is inserted. She is draped to expose the abdomen and perineum, and a pelvic examination is performed. Cystoscopy may be indicated for male or female patients and hysteroscopy may be indicated for female patients undergoing diagnostic and operative laparoscopy. After withdrawal of the hysteroscope, a uterine manipulator is inserted into the cervical os to manipulate the uterus and for chromopertubation. Rectal and vaginal probes can help separate the tissue planes of the cul-de-sac. The assistant can do a simultaneous rectal and vaginal examination for the same purposes. A sponge on a ring forceps is placed in the posterior fornix to outline the posterior cul-de-sac or anteriorly to identify the vesicouterine space. In patients who are suspected of having rectosigmoid endometriosis, a sigmoidoscopic examination is suggested. The rectum is insufflated to look for bubbles as they pass into the posterior cul-de-sac filled with irrigation fluid.1

PLACEMENT OF THE VERESS NEEDLE

Insertion of the Veress needle, the primary trocar, and the secondary trocars is an important aspect of diagnostic and operative laparoscopy. Serious complications and injuries can occur during these procedures. The following factors increase the risk of injury:

1. Previous abdominal and pelvic operations
2. Body weight (whether patient is very obese or very thin)
3. A large uterus and the presence of a large pelvic mass
4. Failure to deflate the stomach with an oral or nasogastric tube

Figure 1. This patient is in a dorsolithotomy position, but the thighs are not flexed so that the suprapubic trocars may be maneuvered.
The optimal location for the Veress needle and primary trocar is intraumbilical because the skin is attached to the fascial layer and anterior parietal peritoneum with no intervening subcutaneous fat or muscle. The transumbilical approach accounts for the shortest distance between the skin and the peritoneal cavity even in obese patients. When a patient is morbidly obese, or her umbilicus exhibits poor hygiene, or a suspicion exists of an umbilical hernia, initial placement can be above or below the umbilicus. These sites sometimes are modified. The primary trocar is inserted above the umbilicus even subxiphoid in patients who have an enlarged uterus caused by a uterine leiomyoma, pregnancy, or sometimes for para-aortic lymph node dissection.

Before the needle is inserted, a transverse or vertical cutaneous incision is made large enough to accommodate the primary trocar. A vertical umbilical incision provides better cosmetic results. When one is incising the umbilicus, a skin hook is used to grasp and evert the base of the umbilicus, raising it from the abdominal structures. If needed, and especially in the case of morbidly obese patients, a Kocher clamp can be used to grasp the fascia, lift up, and further increase the distance between the fascia and underlying abdominal structures.

One should check the patency of the Veress needle before it is inserted. Traditionally, the angle of insertion is approximately 45 degrees for an intraumbilical placement while the patient is horizontal; a premature Trendelenburg position alters the usual landmarks (Figure 3). Transumbilical placement with a 90-degree angle of insertion is recommended after proper training with this technique. Palpating the abdominal aorta and the sacral promontory is performed first. The patient is completely flat, and the operating table is all the way down to maximize the surgeon’s upper body control during insertion of the Veress needle. The Veress needle, held at the shaft, is directed toward the sacral promontory (Figure 4). The surgeon and assistant apply counter traction by grasping the skin and fat on each side of the umbilicus with a towel clamp. In obese patients, a 90-degree angle is necessary initially to enter the peritoneal cavity. In thin individuals, vital structures are closer to the abdominal wall, so the surgeon makes certain that the abdominal wall is elevated and only a small portion of the needle is inserted into the abdominal cavity. That is rarely more than 2 cm to 3 cm of the Veress needle or trocar. A prospective study involving 97 women undergoing operative laparoscopy showed that the position of the aortic bifurcation is more likely to be caudal to the umbilicus in the Trendelenburg position, compared with the supine position regardless of body mass index. Its presumed location can be misleading during Veress needle or primary trocar insertion. The physician must be careful to avoid major retroperitoneal vascular injury during this procedure.
VERIFICATION OF INTRAPERITONEAL LOCATION

Failure to achieve and maintain a suitable pneumoperitoneum predisposes the patient to complications.

“Hanging Drop” Method

Correct needle placement is verified by the “hanging drop” technique. A drop of saline is placed on the hub of the Veress needle after insertion through the abdominal wall. Lifting the abdominal wall establishes negative pressure within the abdomen, drawing the drop of fluid into the needle. Absence of this sign indicates improper placement of the Veress needle.

Additional methods of verifying proper placement of the Veress needle are summarized in Table 1.

PLACEMENT OF THE PRIMARY TROCAR

The sharp primary trocar is aimed toward the sacral promontory. Dull trocars require increased force during insertion, multiple insertions, and excessive instrument manipulation. The insertion of a disposable-shielded trocar in the presence of a pneumoperitoneum requires half the force needed for the insertion of a reusable sharp trocar. The disposable trocar shield does not completely prevent injury. Using these new devices can inflict injury because of the unexpected ease of their insertion. Numerous mesenteric, bowel, and vascular injuries have been reported with the use of disposable trocars.

A pneumoperitoneum reduces the proximity of the abdominal wall to the spine and the potential for damage to bowel and vessels. Whether a pneumoperitoneum is associated with a lower incidence of trocar-related injuries is unproved.

CONVENTIONAL TECHNIQUE

The direction of trocar insertion is 90 degrees to the abdominal wall plane toward the sacral

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<td>Loss of liver dullness early in insufflation</td>
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<tr>
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<tr>
<td>An unimpeded arc of rotation of the needle to detect anterior abdominal wall adhesions</td>
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<tr>
<td>Sound of air entering Veress needle with elevation of the abdominal wall</td>
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(Survey Results continued from page 12)

61% Instrument innovations
60% Adhesion prevention

Members from all specialties listed training as one of the five most important issues – at every end of the spectrum from residency to advanced techniques and learning to handle new equipment. Financial and insurance issues including cost containment and coding were also frequently listed.

Over 60% of members who completed the survey identified themselves as educators in the field of minimally invasive surgery. Most respondents indicated that they attend 2 or 3 medical meetings per year, think that the Multidisciplinary Plenary Sessions are the most important aspect of SLS’ International Congress, and find that SLS publications are their most valued member benefit.

In their spare seconds of the day, SLS members reported participating in a wide variety of activities. While hobbies ranged from gardening to flying, fishing to adventure racing, the ever-popular golf ranked number one.

“I’m not feeling very well. I need a doctor immediately. Ring the nearest golf course.”

Groucho Marx

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Figure 4. Note the anatomic location of the umbilicus and abdominal aorta in nonobese (A), overweight (B), and obese (C) patients.
promontory. Control of the laparoscopic trocar is essential as it penetrates each layer of the anterior abdominal wall. The trocar is inserted with the patient in a horizontal position because viscera tend to slide away from the advancing trocar. A premature Trendelenburg position does not prevent visceral injury even if significant adhesions are present. Altering the patient’s position affects the surgeon’s view of important landmarks, such as the sacral promontory and hollow of the sacrum. The major anatomic landmarks include the umbilicus located at the level of L3 and L4. The abdominal aorta bifurcates between L4 and L5.

In a program for laparoscopic sterilization, Soderstrom and Butler\textsuperscript{13} revealed that the complication rate was reduced 10-fold when a consistent operating format was used. Successful insertion depends on an adequate skin incision; trocars in good working condition (disposable trocars should be checked to be sure they are not locked); proper orientation of the trocar, sheath, and surgeon’s hand; and control over the instrument’s force and depth of insertion.

With all trocar insertions, the surgeon must hold the instrument properly with the patient supine position at the height of the surgeon’s waist or slightly below it. The trocar and its sleeve are held with the index finger extended to the level of the maximal planned penetration to prevent the sharp trocar tip from thrusting too deeply. The trocar is held in the palm of the dominant hand. It is rotated in a semicircular fashion with its long axis as controlled, firm downward pressure is applied (Figure 8). As the trocar is advanced, the operator senses when the fascia is traversed; the force is reduced as the trocar is advanced slowly to enter the peritoneum. Disposable pyramidal tip trocars are preferable. Flat dilating tip trocars leave a smaller fascial defect, but require more force pressure with less control. A disposable-shielded trocar has the advantage of a sharp instrument for each operation.

**Direct Insertion**

Trocar insertion without creating a pneumoperitoneum initially reduces the number of preliminary procedures, saving operative time and preventing potential complications. Direct insertion is a safe alternative to initially creating a pneumoperitoneum.\textsuperscript{14–21} Nezhat and associates\textsuperscript{14} compared the ease and safety of creating a pneumoperitoneum with those of direct insertion of either a reusable trocar or a disposable shielded trocar in 200 patients in a randomized, prospectively controlled study (Tables 2 and 3).

The direct trocar technique as described by Nezhat\textsuperscript{22} consists of placing the patient in the supine position with her legs in Direct OR stirrups after general anesthesia is induced. She is prepped and draped in the usual sterile fashion. A transurethral Foley catheter is placed for intraoperative bladder drainage. The stomach is decompressed with a nasogastric or orogastric tube. The operating table is lowered at or below...
the level of the surgeon's waist. After palpating the bifurcation of the aorta and sacral promontory, the umbilical skin is elevated with a skin hook and a 1-cm incision is made sharply with a scalpel. The anterior abdominal wall is then elevated by using 2 towel clamps placed on either side of the umbilicus. While elevating the anterior abdominal wall away from the underlying viscera, the surgeon holds a 10-mm trocar with his index finger positioned 3 cm away from the trocar tip to guard against sudden uncontrolled entry into the abdomen. The trocar is inserted at a 90-degree angle and advanced in a controlled fashion into the peritoneal cavity with a twisting semicircular motion. The laparoscope is then introduced, proper intraperitoneal placement ascertained, and pneumoperitoneum created with high-flow insufflation. The underlying structures are then carefully inspected for injury.

**Open Laparoscopy**

In 1971, Hasson introduced the concept of open laparoscopy to eliminate the risks associated with insertion of the Veress needle and trocar. This technique involves direct trocar insertion through a small skin incision without prior pneumoperitoneum. Specially designed equipment consists of a cannula and trumpet valve fitted with a cone-shaped sleeve. A blunt obturator protrudes 1 cm from the tip of the cannula. The cone sleeve seals the peritoneal and fascial gap.

A small transverse, curved, or vertical incision is made at the umbilicus. Two Allis clamps, a knife handle with a small blade, a straight scissors, a tissue forceps with teeth, a right-angle skin hook, 4 S-shaped retractors, a needle holder, 2 curved Kocher clamps, and 4 small curved hemostats are needed. As the incision is made, Allis clamps or a self-retaining retractor is used to provide adequate exposure. Once the fascia is cut, a 1-cm incision is made in the peritoneum. One suture of 0 polydioxanone (Ethicon) is passed through each peritoneal edge and fascia and tagged. The cannula carrying the blunt obturator is inserted through the opening into the peritoneal cavity. The obturator is withdrawn, and CO₂ is insufflated through the cannula, which is inserted as deeply as required to prevent leakage. The previously placed sutures are used to fix the trocar sleeve so that the laparoscope can move freely within the abdominal cavity. At the end of the procedure, the abdominal wall is closed, by using the previously placed sutures.

Open laparoscopy usually takes about 5 minutes to 10 minutes longer than closed laparoscopy performed by operators with comparable expertise. In more than 1000 consecutive operations done by Hasson, the frequency of minor wound infection was 0.6% and that of small bowel injury was 0.1%. In a review of the laparoscopic complications, the open techniques reduced the incidence of failed procedures, inappropriate gas insufflation, gas embolism, bladder and pelvic kidney punctures, major vessel injuries, and postoperative herniations.

In a survey conducted by Penfield, intestinal lacerations are the most serious complication of open laparoscopy, and most of those lacerations occurred during the early use of this technique. In 10,840 open laparoscopies attempted by 18 board certified obstetricians/gynecologists, 6 bowel lacerations were reported, 4 were recognized and repaired, and 2 were not suspected until several days postoperatively.

To reduce the risk of bowel laceration, the surgeon should use a focus spotlight, work with an experienced assistant, make a vertical incision to

| TABLE 3 |
|---|---|
| **Comparison of Reusable and Disposable Trocars** |
| | REUSABLE (n = 50) | DISPOSABLE (n = 50) |
| Complications | 3 | 0 |
| Two insertions required | 10 | 10 |
| Failed insertions | 4 | 2 |
facilitate exposure, grasp and elevate the fascia with small Kocher clamps, and cut between the clamps. A gynecologist who attempts open laparoscopy usually will find that the procedure is slow and cumbersome because of difficulty in exposing and identifying each layer of the abdominal wall.

ACCESSORY TROCARS

Additional cannulas are needed through which various instruments are inserted into the abdomen for manipulation and operative procedures. Placement sites depend on the patient’s anatomy, the contemplated procedure, and the surgeon’s preference. For diagnostic purposes, an incision generally is made 4 cm to 5 cm above the symphysis pubis in the midline. This area, delineated by the 2 umbilical ligaments and the bladder dome, is safe and usually avascular.

For operative laparoscopy, 2 accessory trocars (5 mm) are placed 4 cm to 5 cm above the symphysis pubis at the outer border of the rectus muscle, 2 cm to 3 cm lateral to the deep inferior epigastric vessels. These trocars are inserted under direct vision to lessen the risk of intraabdominal visceral, uterine, and vascular injury and to provide free access to the posterior cul-de-sac. Vascularization of the lower abdomen is provided by 2 vessels: the deep inferior epigastric originating from the external iliac artery and the superficial epigastric, a branch of the femoral artery. Transillumination helps identify the superficial vessels, but they are difficult to see in obese patients. The deep inferior epigastric vessels run lateral to the umbilical ligaments and are seen intraperitoneally and identified easily. These vessels pass the round ligament, proceed to the anterior abdominal wall, and are seen above the peritoneum. To avoid injuring these vessels, the trocar is inserted medial or lateral to the umbilical ligaments by viewing the underside of the abdomen wall laparoscopically (Figure 11). Despite these precautions, aberrant vascular branches occasionally are traumatized, and the operator must be able to manage this type of injury.

To reduce the chance of trauma to the abdominal structures, the proposed site for the secondary puncture is indented by applying abdominal pressure with the index finger and observing the peritoneal surface with the laparoscope. Next, mapping of the potential sites for accessory trocar placement is done by advancing the tip of an 18-gauge needle attached to a syringe transabdominally through the peritoneum, revealing the exact course and placement of the accessory trocar. This allows optimal placement. These maneuvers are important, particularly in a patient with evidence of abdominal wall adhesions, and help ensure safe access.

After the skin incision has been made, the trocar, held with the index finger extended on the sheath to control the depth of penetration, is inserted through the fat and fascia. Further advancement is controlled under laparoscopic view. The trocar is aimed toward the center of the abdomen and hollow of the sacrum. If it is aimed laterally, it can slide down the pelvic side wall without being seen through the laparoscope, resulting in injury to the iliac vessels. The accessory trocars are never inserted without laparoscopic observation of their indentation on the abdominal wall or before mapping the abdomen. When insertion of the trocars is viewed directly from the monitor,
the surgeon should be sure the camera has not been rotated so that it shows the wrong view of the pelvis. Other sites of entry include the midpoint between the symphysis pubis and the umbilicus and McBurney’s point.

Some accessory trocar sleeves are too long or too short to allow free access to the pelvic structures and tend to slip out of the peritoneal cavity. The presence of trap valves can interfere with efficient instrument exchange, prevent the introduction and removal of suture material, and prevent the removal of tissue. Several accessory trocar sleeves either screw in or have an umbrella to secure them to the abdominal wall. Radially expanding trocars may reduce laparoscopic complications, lessen a surgeon’s exposure to liability, and improve patient outcomes. 

Two hundred twelve women underwent various laparoscopic procedures involving the placement of 541 radially expanding access cannulas and no major complications occurred. One patient developed a postoperative mesenteric hematoma that was assumed to be secondary to a venous injury from the Veress needle. Despite the absence of fascial anchoring devices, only six (1%) cannulas slipped.

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References

(continued on page 18)
Computer Enhanced “Robotic” Surgery

William E. Kelley, Jr., MD

On July 12, 2000, the first computer-enhanced surgical system became FDA approved for abdominal and pelvic laparoscopic surgery in the United States. FDA approval followed in 2003 and 2004 for cardiac surgery, specifically for robot-assisted mitral valve replacement and robot-assisted CABG respectively.

Computer-enhanced surgery provides improved precision through motion scaling technology and electronic filtering. Wrist-tips at the end of the laparoscopic instruments provide 360-degree rotation and flexion within 2 cm of the instrument tips. These mechanical advantages offer the surgeon a precision of movement that cannot be duplicated with traditional laparoscopic or open instruments. In addition, a true 3-dimensional visual system gives the surgeon much more precision with the instrumentation. These mechanical and visual advantages allow most surgeons to be ambidextrous with dissecting and suturing techniques.

At the current stage of development, the computer-enhanced technology has been most useful for complex dissecting and suturing techniques, especially in small, poorly accessible locations. The flexibility of the instrumentation has greatly facilitated dissection and suturing for radical prostatectomy. The majority of centers that currently have robotic systems, many of which had had no previous experience with laparoscopic radical prostatectomy, are utilizing the robot for this technique. Gynecologic applications have thus far been limited to infertility surgery for tuboplasty and tubal reanastomosis.

For general surgery, the instrumentation has shown substantial advantage for laparoscopic Heller myotomy, with a significant reduction in the incidence of mucosal perforation. Other procedures that have been enhanced by this technology include laparoscopic esophagectomy, pancreatectomy, laparoscopic pyloroplasty when performed at the time of antireflux surgery, and suturing the posterior suture lines of Toupet fundoplication.

For vascular surgery, experience is now growing with robot-assisted laparoscopic aortofemoral bypass and laparoscopic aortic aneurysmectomy. In our center, we have experienced hospital stays of 2-5 days following aortofemoral bypass, with the patient returning to normal activities in one week.

Cardiac surgery is probably the most spectacular example of this enabling technology. Multiple centers in the United States and in Europe and Canada have performed mitral valve replacement, as well as CABG. Totally endoscopic coronary artery bypass is now being performed with as little as 2-day length of stay, with patients resuming their normal activities one week following surgery.

The greatest promise of computer-enhanced surgery lies in its future applications. Enhanced precision and flexibility and the ability to deliver highly functional instruments to small awkward locations will empower surgeons to develop new techniques that are not currently feasible with MIS techniques. Robotic surgery could very well stimulate a new evolution of surgery in the decade to follow, as the instrumentation evolves and more flexible platforms for instrument delivery are developed.
According to Webster’s Dictionary, a job interview is “a formal meeting in which one or more persons question, consult, or evaluate another person.” During our professional lives, we all are subjected to the interview process. It is important for the process to establish the reason for the interview. Is it for a professional purpose, or perhaps for personal, business, or other reasons? I will focus on the professional aspect of interviewing, mainly related to our careers in medicine. In this first article, I will limit the discussion to the interview process from the point of view of the candidate.

**GETTING THE INTERVIEW: Resume or Curriculum Vitae?**

The key to opening the door to any potential job opportunity is one’s resume or curriculum vitae (CV). The resume is generally preferred by business organizations, while the CV is more commonly used in medicine. At the same time, executive healthcare jobs often appreciate the value of the resume.

The CV is a long document that narrates the professional life of a person in significant detail, and it literally translates from Latin as “course of a life.” The CV describes almost all the most important events in the life of the person, including place of birth, marital status, family, education, past positions, qualifications, publications, presentations, awards, and social contributions.

The resume is a brief account of personal, educational, and professional qualifications and experience. It should be short and powerful, list one’s professional experiences in reverse chronological order going back 3 to 5 years, and generally not exceed a period of 10 years. The potential employer is more interested in the last few years of a job candidate’s life unless there were significant achievements in other periods that are relevant and worth highlighting. It is important to include words such as leadership, teamwork, motivation, management, creativity, experience, and career goals. The general guideline is that a resume should not exceed 3 pages.

The choice of resume or CV depends on the particular situation. Both formats are important and reflect one’s professional life, so these documents must be prepared well and with special care. There are professional agencies that can help to polish resumes or CVs, which are important not only for a job search but also for promotions and marketing. It is important to remember, however, that while these documents will open the door for a job seeker, resumes and CVs will not secure the job.

**FIRST CONTACT: The Phone Interview**

The telephone call is often the first interview, and a common procedure for recruiters to screen potential candidates. I, myself, dislike telephone interviews because I feel they can give the wrong impression of a candidate. The interviewer may be biased by the tone and quality of one’s voice, accent, and other variables. I do poorly in telephone interviews perhaps because I am self-conscious about my foreign accent.

The reason for the interview must be clear. It makes a difference if one is being interviewed for one’s technical skills, social skills, experience, management ability, etc. If a surgeon is being interviewed for his or her surgical skills, it is not
so important how the job candidate sounds on the telephone. If a telephone call about an interview comes at a bad time, one should not hesitate to tell the caller that another time, such as later in the day, would be a better time to talk. However, one must be mentally ready to be interviewed at any time when actively searching for a job.

INTERVIEWING IN PERSON

The job is generally won or lost during the interviewing process. Dress for the occasion! As a general rule, men should wear a conservative suit and tie, and women should wear a conservative dress or suit. I might add that every year during the interviewing season at hospitals and medical schools it is impressive to see all the young people in dark suits—despite the fact that after they are accepted into their programs, they are never again seen wearing suits.

It is advisable to prepare a number of questions pertinent to the job. Most recruiters recommend not talking about money during the first interview. Discussion of this matter should be reserved for the negotiation period. It is important to be on time for one’s interview. If the interviewers are late, do not be impatient. Be prepared for any type of interview.

There are 2 main types of interviews, the traditional interview and the behavioral interview. The traditional interview consists of general questions. Experts argue that this type of interview does not predict the future performance of the individual. The candidate can usually get away with telling the interviewer whatever he or she wants to hear, even if it does not reflect the candidate’s true feelings or experience. Examples of traditional questions and request for information may be: How do you describe yourself?; What are your professional goals?; How do you describe yourself in terms of your ability to be a team player?; Give me an example of your successful accomplishments; Tell me about the salary range you are looking for.

The behavioral interview is based on the following concepts: Situation or Task, Action (taken) and Results (achieved). It is often called the STAR (or SAR) technique. Some of the areas covered by behavioral interviews include decision making and problem solving, leadership, motivation, communication skills, interpersonal skills, organizational and social skills, and behavior in a stressful situation.

The behavioral interview is preferred by many organizations and most large organizations, as it has been said that the most accurate predictor of future performance is past performance in similar situations. During the behavioral interviewing, the interviewer tries to evaluate how the candidate will respond to a particular situation.

The kinds of questions and requests for information in the behavioral interview include: Describe a situation in which you were able to use persuasion to convince someone to see things your way; Give an example in which you were relatively quick to make a good decision; Give an example of a time when you went above and beyond the call of duty; and describe a recent unpopular decision you made and what the result was.

Examples of behavioral interviewing questions and techniques for preparation that can be found on many educational Web sites on the Internet.

It has been said that candidates who prepare well for behavioral interviews will also perform well during traditional interviews. Use of behavioral answers is well received even by inexperienced interviewers. Large organizations that invest time and resources preparing behavioral interviews attract the best candidates.

Interviews can also be categorized as structured or unstructured and be conducted in groups or on a one-to-one basis. The structured interview consists of predetermined questions. The unstructured interview is spontaneous and leaves the line of questioning to the interviewer’s discretion.
Group interviews can be conducted with a large or small group. The typical large interview is conducted by a search committee. I have been interviewed by large groups and have interviewed individuals as part of a large group. I find that large groups do not conduct effective interviews. There is little room for spontaneity or little time to ask any meaningful questions. In such groups, the local candidate has the advantage, because he or she knows the players and in many occasions may have political or social ties with some of the members of the group.

As a general rule, most physician interviews are casual and unstructured. The interviewer may ask all kinds of questions about one's skills, training, and experience. The advantage of interviewing physicians is that the medical boards that grant state medical licenses have generally conducted a thorough checking of the individual and credentials are not an issue, unless a particular red flag merits further investigation. At the same time, there are many questions that an interviewee is not allowed to ask. It is illegal to discriminate based on sex, race, national origin, marital status, sexual preference (in 16 states and the District of Columbia), religion, age, or disability. It is important to remember that while being interviewed, one is also interviewing the potential employer.

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Recommended Reading

JOURNAL WATCH: Surgical Products

Searching for the Safest Port. Ritsma R. August 2005:16-17 • Rich Ritsma briefly explains the process and dangers of trocar insertion before discussing several safer entry systems and techniques developed by Applied Medical, Ethicon Endo-Surgery, ConMed Corporation, Taut, Inc., and Patton Surgical.

JOURNAL WATCH: JSLS

Laparoscopic Splenectomy in Children. Qureshi FG et al. 2005;9:389-392 • This report suggests that laparoscopic splenectomy is a safe procedure in children resulting in shorter hospital stay which may translate into earlier return to full activity and a smaller burden on the child’s caretakers.
The ProMIS HALC, developed by Haptica and Ethicon Endo-Surgery, allows a surgeon to perform a complete Laparoscopic Hand-Assisted Sigmoid Colectomy on a totally simulated model and is the first simulator to integrate virtual reality with real haptics and real instruments. Surgeons are guided through the procedure step-by-step, and at the end are given feedback on their performance. Contact Haptica, www.Haptica.com

PARÉ Surgical offers a range of laparoscopic bags for the easy retrieval of tissue. Available in three sizes to suit a variety of applications, all products are easy to use with no special opening or closing devices required. The bags are made of a high performance fabric that is strong and tear resistant. Contact Paré Surgical, www.PareSurgical.com

Inlet Medical’s Carter-Thomason CloseSure System XL for trocar wound closure provides an easy method for preventing port-site herniation in obese patients. Elongated, larger instruments allow quick full-thickness closure and closure of multiple size defects. Additional uses include: ligating abdominal wall bleeders and tacking-up hernia mesh. Contact Inlet Medical, www.InletMedical.com

MEGADYNE has extended its MEGATip line with the J-Wire (#0605) electrode featuring a smaller profiled tip for dissection and coagulation in laparoscopic applications. The only electrode tips on the market with the patented, green E-Z Clean non-stick coating, MEGATips cut and coagulate at lower power settings, produce less thermal damage and eschar build up, and require fewer, easier cleanings. Contact MEGADYNE, www.Megadyne.com

The LAP-BAND System Adjustment Kit from Inamed Health puts everything needed to perform an adjustment in one kit and is the only kit that meets all FDA labeling requirements for LAP-BAND adjustments to support optimal weight loss. The kit is available for the 9.75 and 10 cm LAP-BAND systems and the LAP-BAND VG. Contact Inamed Health, www.Inamed.com

Teleflex Medical’s line of laparoscopic instruments offer precision and pattern variety to meet your needs. Their line of laparoscopic instruments is suited for all closed procedures. Optional extended lengths on select patterns are designed to help you keep pace with the growing surgical market. Contact Teleflex Medical, www.TeleflexMedical.com

Inlet Medical’s POPmesh, a soft monofilament polypropylene mesh that can be used for a variety of pelvic floor procedures, including cystocele, rectocele, and vault prolapse. Supple yet strong, POPmesh’s flexibility and low density enable optimal anatomical conformation. Contact Caldera Medical, www.CalderaMedical.com, 866-4-CALDERA

Encision’s Active Electrode Monitoring technology is designed to optimize patient safety during laparoscopic surgery and completely eliminates the risk of stray energy burns to patients. Now available is the new ergonomically designed handle, called eTouch. Encision offers a full line of AEM instruments. Contact Encision, www.Encision.com

Simbionix has developed a new simulation module for practicing complete laparoscopic incisional hernia repairs including simulation of adhesiolysis and reduction of the hernial content and mesh handling and fixation. The procedures are performed with realistic and accurate behavior of internal organs, tissue, and tools. The module simulates anatomical variation pathologies and complications. Contact Simbionix, www.Simbionix.com
CONGRESS FEATURES
Sept 6, 2006 Eight intensive half and full-day Master’s Classes
Sept 7, 2006 SLS Special Evening Event: Dinner With Faculty at the John F. Kennedy Library and Museum, featuring Thomas Fogarty, MD, a driving force in medical device development
Sept 7-8, 2006 Over 200 cutting edge scientific presentations including Laparoscopy Updates
Sept 7, 2006 Three new Multidisciplinary Plenary Sessions directed by those at the zenith of minimally invasive surgery: Innovations in Surgery and Medicine; From the Bench to the Bedside; Informatics for the Laparoscopic Surgeon; Competency Issues & Its Assessment Metrics
Sept 8, 2006 Watch the Masters perform surgery–LIVE–during two simultaneous telesurgeries
Sept 9, 2006 Be inspired by a vision of the future at the Breakfast and Future Technology Session directed by the brilliant Richard M. Satava, MD, featuring Kenneth Kamler, MD, presenting Medicine in the Extreme, Anthony Atala, MD, with the latest in Growing Organs, and David Hanson presenting Robots and Emotional Expression

ENDO EXPO 2006
Over 50 exhibitors will provide on-going presentations about not only the innovations of the year but also the latest ideas and technological developments to aid surgeons in the operating room

IMPORTANT DEADLINES
July 6, 2006 Registration deadline for $100 SLS member discount
August 7, 2006 Last day to receive discounted room rates at The Westin Copley Place

VISA INFORMATION
International attendees, please apply for your visa now.
If you need a written invitation, please visit www.SLS.org or email Conferences@SLS.org.
Additional visa information is available at www.unitedstatesvisas.gov
TUESDAY, SEPTEMBER 6, 2006
3:00 pm – 6:00 pm MASTER’S CLASSES REGISTRATION

WEDNESDAY, SEPTEMBER 6, 2006 • Pre-Congress Master’s Classes
7:00 am – 9:00 am MASTER’S CLASSES REGISTRATION / Complimentary Coffee & Bakery Items (Master’s Classes Attendees Only)
9:00 am – 4:30 pm CONCURRENT MASTER’S CLASSES (See page 25 for course descriptions)
12:00 pm – 6:00 pm CONGRESS REGISTRATION
5:00 pm – 6:30 pm OPENING CEREMONY WELCOME RECEPTION AND OPENING OF EXHIBIT HALL AND CYBER CAFE

THURSDAY, SEPTEMBER 7, 2006 • Day 1 International Congress and Endo Expo 2006
6:45 am – 7:00 am Moderator Briefing
6:30 am – 5:00 pm CONGRESS REGISTRATION
7:00 am – 7:30 am Complimentary Coffee and Bakery Items
7:00 am – 2:00 pm Exhibits open
7:30 am – 4:30 pm Poster Session
7:30 am – 8:30 am General Session Best of Laparoscopy Updates: Key Laparoscopy Updates highlighting the newest developments and future expectations of surgical and diagnostic procedures.
8:30 am – 12:45 pm Multidisciplinary Plenary Session (Gynecology, General Surgery, Urology) INNOVATIONS IN SURGERY AND MEDICINE: FROM THE BENCH TO THE BEDSIDE, INFORMATICS FOR THE LAPAROENDOSCOPIC SURGEON, COMPETENCY ISSUES AND ITS ASSESSMENT METRICS (See page 26 for description)
10:00 am – 10:30 am Coffe Break / Visit Exhibits
12:45 pm – 1:45 pm Complimentary Light Snacks and Refreshments Available in Exhibits Hall
1:00 pm – 1:30 pm POSTER PRESENTATIONS
1:45 pm – 5:00 pm CONCURRENT SCIENTIFIC SESSIONS Over 200 Scientific Presentations (See page 27 for preliminary listing)
2:00 pm – 4:00 pm Coffee Available
6:00 pm – 8:30 pm SPECIAL EVENT: SLS EVENING WITH FACULTY at the John F. Kennedy Library and Museum (See page 26 for more about this special event. Ticket required)

FRIDAY, SEPTEMBER 8, 2006 • Day 2 International Congress and Endo Expo 2006
6:30 am – 5:00 pm CONGRESS REGISTRATION
7:00 am – 7:30 am Complimentary Coffee and Bakery Items
7:00 am – 2:00 pm Exhibits Open
7:30 am – 4:30 pm Poster Session
7:30 am – 8:30 am AWARD WINNING SCIENTIFIC PAPERS AND VIDEOS PRESENTATIONS
8:30 am – 11:30 am LIVE TELESURGERIES Gynecology Reproductive Surgery at Columbia St. Mary’s Milwaukee Campus: Surgeons Charles H. Koh, MD and Grace M. Janik, MD; General Surgery Procedure at the University of Maryland Medical Center: Surgeon Adrian Park, MD
10:30 am – 10:45 am Refreshments Available in Exhibit Hall during Live TeleSurgeries Session
11:30 am – 12:30 pm Complimentary Light Snacks and Refreshments Available in Exhibits Hall
12:00 pm – 12:30 pm New Product Presentations by Exhibitors in Exhibit Hall
12:30 pm – 12:45 pm BEST POSTER AND RESIDENT AWARD-WINNING PAPER PRESENTATIONS
12:45 pm – 1:45 pm SPECIAL EVENT: EXCEL AWARD PRESENTATION AND LECTURE (Read more about the award and this year’s recipient, Richard M. Satava, MD, on page 29)
1:45 pm – 5:00 pm CONCURRENT SCIENTIFIC SESSIONS: Over 200 Scientific Presentations (See page 27 for preliminary listing)
2:00 pm – 4:00 pm Coffee Available

SATURDAY, SEPTEMBER 9, 2006 • Day 3 International Congress and Endo Expo 2006
7:00 am – 11:15 am CONGRESS REGISTRATION
7:30 am – 9:00 am SPECIAL EVENT: BREAKFAST WITH KEYNOTE SPEAKER – Medicine in the Extreme: Adventures of an Explorer in Extreme Environments (See page 30)
9:00 am – 10:30 am Future Technology Session BEYOND HUMAN LIMITATION: PERFORMANCE IN THE EXTREMES, ORGAN REGROWTH, AND EMOTIONAL ROBOTS (See page 30)
10:30 am – 10:45 am Closing Ceremony and Passing of the Presidential Gavel
10:45 am – 11:15 am SLS Business Meeting – All SLS Members are Encouraged to Attend
11:15 am – 3:00 pm SLS Committees Meetings
LAPAROSCOPY TODAY 25

#1 Master’s Class in the Prevention and Management of Laparoscopic and Endoscopic Surgical Complications

9:00am-12:00pm

FACULTY
Raymond J. Lanzafame, MD, MBA, Director
Carl J. Levinson, MD, Co-Director
Lawrence C. Biskin, MD
Ceana Nezhat, MD
Howard N. Winfield, MD

TOPICS
• Introduction and a Disastrous Case
• Detailed Anatomy of Selected Anatomic Sites, Based on Attendee Preconference Questionnaire
• Case Videos and Discussion
• Selected Video Cases/Disasters and Faculty Selected Highlights

#2 Master’s Class in Laparoscopic Treatment of Adhesions for the General Surgeon, Gynecologist, and Urologist Including Abdominal and Pelvic Pain

1:00pm-4:30pm

FACULTY
Harry Reich, MD, Director
Michael P. Diamond, MD, MBA, Director
James E. Carter, MD, PhD
Nicola Di Lorenzo, MD, PhD
Douglas E. Ott, MD, MBA

TOPICS
• Introduction and SCAR Study
• Why is the Surgical Treatment of Patients With Chronic Abdominal Pain From Intraabdominal Adhesions so Controversial?
• What Causes Adhesions? Do Adhesions Cause Pain?
• Abdominal and Pelvic Pain
• The Role of Laparoscopic Adhesiolysis and Adhesion Reduction Adjuvants in Gynecology and Infertility
• What About Acute Bowel Obstruction?
• Laparoscopic Entry Techniques After Multiple Laparotomies
• How Laparoscopy Affects the Peritoneum: Its Effect on Adhesion Formation and Methods of Reduction
• Laparoscopic Adhesiolysis-Surgical Plan and Techniques
• Deep Cul-de-Sac Dissection for Adhesions Involving Fibrotic Endometriosis, Including a Simple Technique to Repair Rectal Enterotomies
• Intraoperative Treatment of Bowel Injuries at the Time of Laparoscopy—Recognition, Repair, Resect, Hand-Assist, Open
• What’s Coming Next in Adhesiolsis and Adhesion Reduction Adjuvants

#3 Master’s Class in Laparoscopic Surgery for Complex Problems with Emphasis in Pediatrics & Pregnancy

9:00am-4:30pm

FACULTY
Gustavo Stringel, MD, Director
Robert K. Zurawin, MD, Co-Director
Craig Albanese, MD
Tommaso Falcone, MD
Raymond J. Lanzafame, MD, MBA

TOPICS
• Laparoscopy for Complex Problems in the Pediatric Patient, Including Access and Complications
• Advanced Laparoscopic Procedures in Newborns and Infants
• Laparoscopic Hernia Repair in Children, Including Inguinal Hernia, Umbilical Hernia, and Epigastric and Ventral Hernia
• Laparoscopy for Complex Problems in the Female Adolescent Patient
• Question and Answer with Pediatric Panel
• Laparoscopic Procedures in the Pregnant Patient. Physiological Considerations. Effect on the Mother and Fetus
• Laparoscopic General Surgery Procedures During Pregnancy, Including Laparoscopic Cholecystectomy, Appendectomy and Lysis of Adhesions
• Laparoscopy for Abdominal Tumors: in the Pediatric Patient; in Pediatric and Adolescent Gynecology; in Pregnancy
• The Role of Laparoscopy in Abdominal Pain; the Pediatric Surgeon; the Pediatric Gynecologist; the Pregnant Patient

#4 Master’s Class in Robotic Laparoscopic Surgery Jointly with the Minimally Invasive Robotic Surgery Association-MIRA

9:00am-4:30pm

FACULTY
Garth Ballintyne, MD, Director and President of MIRA
Santiago Horgan, MD, Co-Director
William E. Kelley, Jr., MD, Co-Director
Arnold Byer, MD
Ara Darzi, MD
Tommaso Falcone, MD
Marc Katz, MD
Jacques Marescaux, MD
Joseph Petelin, MD
Richard M. Satava, MD
Ash Tewari, MD

TOPICS
• Remote Preserve Robots
• Augmented Reality Surgery
• Telerobotic Bariatric Surgery
• Telerobotic Colorrectal Surgery
• Telerobotic Heller Myotomy & Esophagectomy
• MIRA Update
• Telerobotic Urolgy for Benign Disease
• Telerobotic Preprotectional Radical Prostatectomy
• Telerobotic Vascular Surgery
• Telerobotic Cardiac Surgery
• Telerobotic Gynecologic Surgery
• Remote Mobile Teleconferencing with a Robot Over the Internet
• The Future of Surgical Robotics

#5 Master’s Class in Gynecologic Endoscopic Surgery

9:00am-4:30pm

FACULTY
Farr Nezhat, MD, Director
Ceana Nezhat, Co-Director
Masaaki Andou, MD
Jacques Dequesne, MD
Tommaso Falcone, MD
Harth M. Hasson, MD
Wm. Leroy Heinrichs, MD, PhD
William E. Kelley, Jr., MD
Carran Nezhat, MD
Steven F. Patzer, MD
Danny Seidman, MD
Robert Zurawin, MD

TOPICS
• Safe Abdominal Entry Complications and Managements
• Laparoscopy and Infertility: Is There Any Role?
• Laparoscopic Treatment of Endometriosis in Failed IVF
• Laparoscopy and Hysterectomy: LAVH, TLH, or Supracervical
• Role of Endoscopy in Pelvic Floor Repair

#6 Master’s Class in Laparoscopic General Surgery Jointly with the Society of American Gastrointestinal Endoscopic Surgeons

9:00am-4:30pm

FACULTY
Michael S. Kavic, MD, Director
W. Peter Geis, MD, Co-Director
William E. Kelley, Jr., MD, Co-Director
Morris E. Franklin, Jr., MD
Santiago Horgan, MD
Raymond J. Lanzafame, MD, MBA
Joseph B. Petelin, MD
Phillip P. Shadduck, MD

TOPICS
• NOTES: Pipedream or Reality
• Laparoscopic Hernia Repair—The Right Prosthetic
• Endoscopic Options for GERD
• Complex and Recurrent Hiatal Hernia Repair
• Laparoscopic Management Achalasia
• Robotic Technology in the Laparoscopic Era
• Laparoscopic Adrenalectomy
• Laparoscopic Splenectomy
• Bariatrics—Laparoscopic Banding/Bypass
• Laparoscopic Options Benign Colon Disease
• Laparoscopic Options Malignant Colon Disease

CONGRESS EDUCATIONAL METHODS AND OBJECTIVES

The 15th International Congress and Endo Expo 2006 employs a variety of educational formats including topical general sessions, the presentation of scientific papers, open forums, posters, and original videos offered in small specialty-specific breakout sessions, and informal gatherings of participants and expert faculty.

The increasing complexity of minimally invasive diagnostics and therapy requires a continuous educational process. The exchange of knowledge and expertise among the physicians taking part in this congress contributes to the continuation of excellence in minimally invasive surgery.

Upon completion of the congress, participants will be able to:

• Increase comprehension of the basic and fundamental principles of laparoscopic, endoscopic, and minimally invasive techniques, enhancing the participant’s understanding of these techniques;
• Understand the recent advances in laparoscopic, endoscopic and minimally invasive techniques;
• Determine the appropriate use of laparoscopic, endoscopic and minimally invasive equipment as part of a treatment plan in the care of patients;
• Comprehend the developing technologies that will be available in the future to enhance the standard of patient care; and
• Acquire educational information within the physician’s specialty, which will enhance their professional development and patient care.

• Anatomical Principals in Laparoscopy: How to Minimize Complications
• New Horizons in Myoma Managements
• Laparoscopy and Gynecological Malignancy: Where We Are and Where We Are Going
• Role of Simulation in Advanced Operative Endoscopy
• Robotics: Past, Present and Future
• Open Laparoscopy: The Original Technique. 29 Years of Experience.
• Evaluation and Management of Bowel Injuries
• My Experience in the Role of Laparoscopy in Japan
• Update in Hysteroscopy, Ablations and Sterilization Techniques
• Hands On Laboratory: New Instruments and Simulators

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### #7 Master’s Class in Bariatric Surgery: Reducing Hazards, Improving Outcomes

**FACULTY**
- Samer Mattar, MD, Director
- Alex Gandsas, MD, Co-Director
- Kelly Boyer, RD
- Daniel B. Jones, MD
- Stephanie Jones, MD
- Vivian Sanchez, MD
- Benjamin E. Schneider, MD
- Michael Schweitzer, MD
- Ashley Vernon, MD

**TOPICS**
- Incidence of postoperative complications
- Intraoperative Complications: How to Stay Out of Trouble
- Tips for Revisional Gastric Surgery
- Immediate Postoperative Complications: DVT/PE/Dehydration
- The Management of Postoperative Leaks
- Postoperative Gastrointestinal Bleeding
- Management of Small Bowel Obstruction
- Management of Stoma Complications
- Management of LapBand Complications
- Managing the Morbidly Obese Patient in the ICU
- Chronic Abdominal Pain in the Postoperative Patient
- Weight-Maintenance, Malnutrition, Regain
- Anesthesia Risk Reduction
- Systemic Approaches to Raising quality: The Betsy Lehman Report
- Strategies for Optimizing Long-term Follow up
- Medico-legal Implications Following Weight Loss Surgery

### #8 Master’s Class on How to Assess Competency in Laparoscopic Surgery, Includes Hands-On Laboratory

**FACULTY**
- Harith M. Hasson, MD, Director
- Richard M. Satava, MD, Co-Director
- Ara Darzi, MD
- Wm. LeRoy Heinrichs, MD, PhD
- Tadashi Matsuda, MD

**LABORATORY FACULTY**
- Randy Halluck, MD
- Dennis Klassen, MD
- Charles H. Koh, MD
- Mark L. Smith, MD, PhD
- Maria Terry, MD

**TOPICS**
- Assessing Cognitive and Technical Skills in Laparoscopic Surgery
- Technical Surgical Proficiency: Basic Laparoscopic Skills
- Virtual Reality Training in Laparoscopic Surgery
- Assessing Laparoscopic Surgical Performance by Reviewing Unedited Video Tapes-The Japanese Experience
- Presentation of Simulators
- Hands On Practice by Participants
- Summarization

### Innovations In Surgery and Medicine: From the Bench to the Bedside

**Thursday, September 7, 2006**
**3:00am-10:00am**

Physician innovators and researchers have made the world a better place. However these experts by nature lack the experience and the know how to bring an idea to reality. During this session, an international, renowned panel will address how to bring an idea to reality for the benefit of patients. To bring an idea to fruition involves research, patent protection, and business dimensions. This session will guide participants one step closer to bringing their dream of innovation to reality for the benefit of mankind.

**FACULTY AND PRESENTATIONS**
- Camran Nezhat, MD, Director
- Richard M. Satava, MD, Co-Director
- Thomas J. Fogarty, MD: *How to Start and Bring Your Idea of Surgical Instrument to Reality*
- Leslie Bottorff, Venture Capitalist: *Venture Side of Starting a Company and What to Look For in an Idea*
- Chris Mitchell, Attorney: *How to Start a Company Around Your Idea*

### Informatics for the Laparoendoscopic Surgeon

**Thursday, September 7, 2006**
**10:30am-11:30am**

Informatics is primarily concerned with the structure, creation, management, storage, retrieval, dissemination, and transfer of information. This session will provide physicians with introductory knowledge on biomedical informatics with focus on the current status of telemedicine, electronic medical records, and Internet resources, including medical search engines. Principles of designing a medical database for EMR will be elaborated on, and how to integrate this information into handheld devices will be discussed.

**FACULTY AND PRESENTATIONS**
- Gustavo Stringel, MD, Director: *General Informatic Session-Electronic Medical Records, CPOE, HIPAA Compliance, and Evidence Based Medicine*
- Alex Gandsas, MD, Co-Director: *Your Computer, the Internet and Your PDA(PalmPilot), Searching the Web and Finding Information*
- Paul Alan Wetter, MD: *Introduction-SLS Websites*

### Competency Issues & Its Assessment Metrics

**Thursday, September 7, 2006**
**11:30am-12:45pm**

Competency and the objective assessment of competency have been mandated by the Accreditation Council on Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS). The Residency Review Committee (RRC) has indicated that all training programs are required to have skills training with the focus of objectively assessing skills competence. This session will review the current approaches to competency and assessment in addition to giving guidance as to the correct definitions and metrics that can be used. There is already a next generation of skills training and methods that are being considered, including criterion-based training and intelligent tutoring, which will be introduced.

**FACULTY AND PRESENTATIONS**
- Richard M. Satava, MD, Director: *Competency, Proficiency and the Next Generation of Skills Training and Assessment Curricula Using Simulators*
- Harith M. Hasson, MD, Co-Director: *Technical Skill-A Component of Surgical Performance*
- Steve Dawson, MD: *A Scientific Basis for Measuring Surgical Skills Using Laparoscopic Simulation*
Laparoscopy Updates
Thursday, September 7, 2006

Presented by the SLS Special Interest Group Committees

Abdominal / Pelvic Pain / Adhesions, Maurice Chung, MD
Biliary Disease and Cholecystectomy, A. Elizabeth Martin, MD
Core Competencies, Gustavo Stringel
Endometriosis/Ovarian, Farr Nezhat, MD
Hernia, Lawrence Biskin, MD
Hysterectomy, Ceana Nezhat, MD
Office and Outpatient Laparoscopy, James F. Carter, MD
Pediatric Surgery, Harsh Grewal, MD
Pelvic Reconstructive Surgery / Stress Incontinence, Conrad Duncan, MD
Robotic Surgery, Ash Tewari, MD
Thoracic Surgery, Neil A. Christie, MD
Urology, Howard Winfield, MD

Concurrent Scientific Sessions Thursday, September 7, ‘06 & Friday, September 8, ’06

Over 200 Scientific Papers, Open Forum Presentations, Videos, and Posters will be presented by SLS members and colleagues from around the world. Preliminary Listing.

GENERAL SURGERY

Role of Subfascial Endoscopic Perforator Surgery (SEPS) by Harmonic Scalpel in Management of Chronic Venous Insufficiency of Lower Limbs, Narayan Agarwal MD
Transabdominal Laparoscopic Inguinal Hernia Repair: the Tricks We Have Learned, Which We Want to Propose and Discuss, Ferdinando Agresta MD
Penetrating Abdominal Trauma With no Signs of Peritoneal Penetration, Would a Diagnostic Laparoscopy Avoid a Laparotomy, Syed I Ahmed MD
Gastric Banding Without Fixation Suture, Housam A. Trabulsi MD
Laparoscopic Fundoplication: the Beneficial Effects of Preservation of Short Gastric Vessels, Muhammad Z Aslam MD
Laparoscopic versus Open Nissen Fundoplication in Infants After Neonatal Laparotomy, Katherine A Barsness MD
One Stage Laparoscopic Roux-en-Y Gastric Bypass Surgery is Safe and Effective in High-Risk Super Obese Patients, Eraz M Basseri MD
Laparoscopic Restorative Proctocolectomy: Is the Anastomosis Compromised?, Joel J Bauer MD
Hand-assisted Laparoscopic Surgery (HALS) in Colorectal Surgery. A Single Institution Experience, Anne-Marie Boller MD
Splenic-preserving Laparoscopic Distal Pancreatectomy, Natalie Bedin MD
Combined Surgical and Endoscopic Rescue of Severe Sepsis Post Bariatric Surgery, Gianluca Bonanomi MD
Follow-up and Early Referal Are Mandatory in Order to Avoid Late Diagnosis of Adjustable Gastric Banding Complications, Gianluca Bonanomi MD
Seldinger Technique for Band-to-Band Revisional Surgery, Catherine A Boulay MD
Adenomyomatosis and Cholesterolosis of the Gallbladder: Laparotomy Conversion During VLS Cholecystectomy, Case Report, De Werra Carlo MD
Endometriosis of the Cervix Mimicking Acute Appendicitis: a Case Report, Adel Chokki MD
Patient Recall and Comprehension After Laparoscopic Appendectomy, Benjamin L Clapp MD
Minimal Access Thyroidectomy Using an Endoscopic Transaxillary Approach, Titus D Duncan MD
Endoscopic Transaxillary Near Total Thyroidectomy: a Feasibility Study, Titus D Duncan MD
Initial Experience With the Use of the ON-Q Pain Pump During Laparoscopic Ventral Hernia Repair, Roger Ernest DO
Blood Loss in Colonic Surgery. Comparison Between Laparoscopic and Open Techniques, Greco Francesco MD
Wound Complication in Laparoscopic Roux-en-Y Gastric Bypass, Wesley F Francis MD
Laparoscopic Versus Open Appendectomy in Perforated Appendicitis, Yasuyuki Fukami MD
Laparoscopic Thoracic Duct Ligation, Mark O Gaon MD
Laparoscopic Splenectomy With Hand-Assisted Specimen Extraction in Massive Splenomegaly in Thalassemia Major, Nikolaos I Gatsoulis MD PhD
Videoaparoscopic Treatment of Parasplenicg Hemia, Roberta Gelmini MD
Laparoscopic Nissen With Mesh, George Kevin Gillian MD
Laparoscopic Excision of a Glucagonoma, Timothy E Goundrey MD
Bilateral Pulmonary Artery Thrombus After Laparoscopic Gastric Bypass: a Rare Occurrence, Ajay Goyal MD
Laparoscopic Retrieval of a Large Retained Fecalith After Laparoscopic Appendectomy, Bryan S Helsel MD
Mucocoele of the Appendix, Fernando A Herrera MD
Laparoscopic Cholecystectomy With Combined Method, Ryuichi Hotta MD
Assessment of Surgical Trainees for Technical Errors Enacted by Using Instrument Differently; Observational Clinical Human Reliability Analysis (OCHRA), Mubashar Hussain Dr Med
Objective Assessment of Surgical Trainees For Their Technical Errors by Observational Clinical Human Reliability Analysis, Mubashar Hussain Dr Med
Small Bowel Obstruction After Laparoscopic Roux-en-Y Gastric Bypass, Muhammad Jawad MD
The Impact of Laparoscopic Gastric Bypass Surgery on C-Reactive Protein Levels, Neel H Joshi MD
Conversion to laparoscopy?, Daniel S Kim MD
Thoracoscopic Resection of a Giant Thymolipoma, Daniel S Kim MD
Congenital Diaphragmatic Falciform Ligament Herniation: a Rare Case, Dan G Kolder MD
Randomized Clinical Trial of Three-Port vs Standard Four-Port Laparoscopic Cholecystectomy, Manoj Kumar MD
Gangrenous Cholecystitis: Laparoscopic Treatment, Sebastiano Lautignola MD
Polytetrafluoroethylene Patch Repair for Large Hiatal Hernia, Luis E. Lagana MD
Laparoscopic Colectomy for Benign and Malignant Diseases, Luis Enrique Lagana MD
The Impact of Routine Preoperative ERCP in Gallstone Pancreatitis, Jonathan A Larya MD
Selective, Versus Routine, Upper GI Series Leads to Equal Mortality and Reduced Hospital Stay in Laparoscopic Gastric Bypass Patients, Sophia D. Lee MD
Intracorporeal Stapled Billroth-I Gastroduodenostomy Using Hand-Access Device, Young-Joon Lee MD
Patient Satisfaction After Laparoscopic Cholecystectomy, Kiran M Lodha MD
Patients Paying for Bariatric Surgery Out of Pocket, Atul K Madan MD
Routine Histology of Gallbladder in Laparoscopic Era. Is There Any Justification?, Sajid Mahmud MD
Our Experience in TAPP Hernia Repair, Lombardi Marco MD
Long-term Results in Stapled Hemorrhoidectomy, Lombardi Marco MD
Laparoscopic Resection With Intraoperative Radiotherapy: a

SLS EVENING WITH FACULTY AT THE JOHN F. KENNEDY LIBRARY & MUSEUM

Join the SLS faculty, the driving force in minimally invasive surgery, and special guest speaker Thomas J. Fogarty, MD, a driving force in the development of medical devices, for dinner and a lecture at the John F. Kennedy (another driving force) Library and Museum, overlooking Boston Harbor. Thomas J. Fogarty, MD, developed his first medical device, the balloon embolectomy catheter, almost 50 years ago. At the time, it was unheard of to operate within an artery, but Fogarty’s balloon catheter was designed for just that and opened the way for endovascular therapy. It also was the first “less-invasive” medical technique used, resulting in less trauma to patients. Since then, Fogarty has helped launch many start-up medical device companies, including CTS, which makes devices for minimally invasive surgery. Fogarty is Clinical Professor of Surgery and Director of Research at Stanford University School of Medicine in California. Being in California, he has been exposed to winemaking, which he found intriguing, and now has his own winery. Because of wine’s well-documented health benefits, wine should be considered not so much as an adult beverage but as a health food according to Fogarty. Join us for this festive evening and hear about the latest from Dr Fogarty and what’s in store for SLS.
New Step in the Multimodal Treatment of Advanced Colorectal Cancer, Civello Ignazio Massimo Prof Dr Med

Is a Appropriate That Laparoscopy-assisted Gastrectomy With Extended Lymph Node Dissection is Performed in Advanced Gastric Cancer? Young-Joon Moon MD

Laparoscopic Preperitoneal Inguinal Hernia Repair Using Preformed Polyester Mesh Without Fixation-4 Year Study, John E Morrison MD

Role of Diagnostic Laparoscopy in Penetrating Abdominal Stab Wounds, Albert Mousa MD

Pathophysiology of Parietal and Visceral Peritoneal Tissue Acidosis During CO2 Pneumoperitoneum, Ospan A Mynbaev MD PhD

Pathophysiology of Peritoneal Tissue Acidosis During Laparoscopic Surgery, Ospan A Mynbaev MD PhD

Role and Value of the Predictive Factors of Common Bilary Duct Lithiasis in Preparation to the Laparoscopic Cholecystectomy, Vincenzo Neri MD

Significance of Laparoscopic Live Donor Nephrectomy: Lessons Learned from 128 Cases, Andreas Paul Prof Dr Med

A Synthetic Cynoacrylate Tissue Sealant Impairs Tissue Integration of Macroporous Mesh in Experimental Hernia Repair, Alexander H Petter-Puchner MD

Equine Cross Linked Collagen Implants for Experimental Incisinal Hernia Repair, Alexander H Petter-Puchner MD

Mesh Fixation With Fibrin Sealant in Transabdominal Preperitoneal Mesh Repair: Recurrence and Impact on Quality of Life Evaluated in a Prospective Manner, Alexander H Petter-Puchner MD

Videothoracic Neurophysiomecnothy, Igor Poliansky Prof Dr Med

Laparoscopic Ladd’s Procedure in an Adult Male with Symptomatic Malrotation, Emil I Popa MD

A Pilot Study Evaluating a Novel Magnetic Gasless Laparoscopy Device in Porcine Laparoscopic Liver Resections, Adam Howard Power MD

Initial Experience With the Use of the On-Q Pain Pump During Laparoscopic Inguinal Hernia Repair, Anuj Prashar DO

Chronic Pain After Laparoscopic Repair of Ventral and Incisinal Hernia, Srđan Rakic MD PhD

Laparoscopic Appendectomy in Patients With a Body Mass Index of 25 or Greater, Robert L Ricca MD

Transgastric Surgery: Current Indications and Future Implications, Kurt E Roberts MD

Laparoscopic-assisted, Transgastric Endoscopy: Current Indications and Future Implications, Roberts E. Roberts MD

Difficulty of Laparoscopic Heller Myotomy Is Not Determined by Preoperative Therapy and Neither Difficulty of Myotomy nor Preoperative Therapy Determine Long-term Outcome, Alexander Rosemurgy MD

K-ras Mutation as Prognostic Factor in Procedure of the Colorectal Cancer-Laparoscopic vs Laparatomeric Approach, Lukas Sakra MD

Autologous Skin Grafting With Bioabsorbable Sental for Widespread Endoscopic Mucosal Resection of the Esophagus, Tadasu Sakurai MD

Assessing Decision Making in Laparoscopic Surgery, Sudip K Sarker MD PhD

Chronic Inguinal Pain After Laparoscopic Inguinal Hernia Repair: the Role of Tack and Mesh Removal, Jeffrey D Sedlack MD

A Ten Year Single Surgeon Experience With Laparoscopic Appendectomy, Jeffrey D Sedlack MD

Laparoscopic Approach in Acute Cholecystitis, Dragos Stojanovic MD PhD

Intussusception as a Complication Following Roux en Y Gastric Bypass, Renee E Thompson MD

Gastroscopy and Esophagoscopy in Preparation to the Laparoscopic Cholecystectomy, Tadashi Sakurai MD

Social History of Patients Undergoing Laparoscopic Bariatric Surgery, David S Tichansky MD

Major Bile Duct Injuries After Laparoscopic Cholecystectomy: a Tertiary Center Experience, Juergen Trekmann MD

Laparoscopic Treatment of Rectal Cancer: Tips, Tricks, and Limits, Paolo Uziyol MD

Trocar Port Site IncCISIONAL Hernias After Laparoscopic Surgery, Ali Uzunoyku Prof Dr Med

Hernia Recurrence in Right Subcostal Incisions After Laparoscopic Repair, Eelco Wassenaar MD

Laparoscopic Repair of Umbilical Hernia: One Hundred Fifty-four Consecutive Procedures, Eelco Wassenaar MD

The Aesthetic Inguinal Herniorrhaphy: a Single Umbilical Incision Technique, James A Westervelt MD

Gynecology

Ruptured Non-Communicating Hem-uterus Presenting With Acute Pelvic Pain, Mark Howard Amols MD

Biopsy of Sentinel Lymph Node Improves Staging of Early Cervical Cancer, Anne-Sophie Bats MD

Analyzing Tension Free Vaginal Tape-Otoburator (TVT-O) Suburethral Sling Procedures With Integrated Definition (IDETF) Modeling Language and Performance Audits of Intravideo, James E. Bauer MD

Embryoscopy in Recurrent Pregnancy Loss, Howard J A Carp Prof Dr Med

Day Surgery Laparoscopic Subtotal Hysterectomy: a Multicentered Study With 250 Patients, Stefanos Chandakas MD PhD

The Safety of Helica Thermal CaOagulator in the Treatment of Endometriosis: a Series of 500 Patients, Stefanos Chandakas MD PhD

Pelvic Peritonitis After Laparoscopic Supra Cervical Hysterectomy, Leroy Charles MD

Reactiveion Haemorrhage in Gynaecological Surgery, Mark Erian MD

Intraoperative Sentinel Node Detection Using Techneum-99m Sulfur Colloid Predicts Nodal Metastases in Patients With Early-Stage Cervical Cancer, Amanda Nickles Fader MD

Myositis Revisited, Herbert A Gildard MD

Minimally Invasive Outpatient Treatment for Boveland (Fecal) Incontinence: a New Procedure for the Gynecologist, Stephen A Grochmal MD

The Identification of Bowel Incontinence in Gynecologic Practice: a Multicenter Investigation of a New Questionnaire, Stephen A Grochmal MD

Moving Forward With Breast Endoscopy: From Diagnostic to Interventional Ductoscopy, Volker R. Jacobs MD PhD

Laparoscopic Treatment of Infiltrated Endometriosis, Francesco La Grotta MD

Influence of Surgical Access on Outcome of Early Borderline Ovarian Tumors, Fabrice R Lecuru MD PhD

Diagnostic Hysterectomy Findings During Follow-Up of Women With HP/PCO, Fabrice R Lecuru MD PhD

Effect of Carbon Dioxide Pneumoperitoneum During Laparoscopic Surgery on Morphology of Peritoneum, Yan Liu MD

The Anatomic Relationship of the Umbilicus to Retropitoneal Major Vessels, Yan Liu MD

Complications of Hysterectomy, Sadok Mohamed Dr Med

Ectopic Pregnancy, Sadok Mohamed Dr Med

Breast Cancer, Sadok Mohamed Dr Med

CISH Hysterectomy 15 Year Perspective, John E Morrison MD

A Comparative Study of Hysterectomy Sterilization Performed In-office Versus a Hospital Operating Room, Mark Nichols MD

Usefulness of Minihysteroscopic Bipolar Coagulation for Bleeding Control After Removal of Transvaginally Prolated Myoma on QPO Basis, Sum-Tack Oh MD PhD

The Usefulness of Minihysteroscopic Bipolar Coagulation of Bleeding Point, Sum-Tack Oh MD PhD

Second Look Laparoscopy for Severe Endometriosis: Does Reoperation Within One Year of Initial Surgery Improve Patients Pain?, Hilda Elena Rodriguez MD

Laparoscopic Hysterectomy with Retropitoneal Dissection and Uterine Artery Occlusion, Jay P Shah MD

Da Vinci Assisted Laparoscopic Sacrocolpopexy, Amir Shariati MD

Laparoscopic Tubal Anastomosis, Jonathan Y Song MD

Laparoscopic Approach to the Large Leiomyoma, Jonathan Y Song MD

Pregnant Woman With Dermal Cyst Developing in an Accessory Ovary Located in the Left Infundibulopelvic Ligament, Hidenori Takashi MD

Primary Omental Ectopic Pregnancy: A Case Report, Hidenori Takashi MD

Laparoscopic Findings in Serious Surface Papillary Carcinoma-A Case Report, Takashi Yamada MD PhD

Laparoscopic Appendectomies Performed by Gynecologists in Women With Pelvic Pain, Parves S Vahora MD

Fertilescopy: Review of a 1500 Cases Continuous Series, Antoine A Waterlot MD

Laparoscopic Resection of Retropitoneal Cyst, Tomone Yano MD

Urology

Techniques for Laparoscopic Localization of Intraluminal ureteral Pathology, Ronnny Abaza MD

Da Vinci-assisted vs Pure Laparoscopic Aortorenal Bypass in an Acute Porcine Model, Ronnny Abaza MD

Robotic-assisted Pyeloplasty With Synchronous Removal of Renal Calculi in the Adult Patient: Technical Modifications, Fatih Atug MD

Robotic Pyeloplasty in Children, Fatih Atug MD

Transurethral Excision of the Distal Ureter and Retropitoneone-scopic Radical Nephroureterectomy With Three Ports in Modified Lhithotomy Position. Yildirim Bayrakt MD

Comparison of Healing After Cystotomy and Repair With Fibrin Glue and Sutured Closure in the Porcine Model, James F Borin MD

Robotic Partial Ureterectomy for Upper Ureteral Tumor: a Conservative Approach, Erik P Castle MD

Standardized Evaluation of Complications of Robotic Radical Prostatectomy, Erik P Castle MD

Positive Surgical Margins in Robotic Radical Prostatectomies: Impact of Learning Curve on Oncologic Outcomes, Erik P Castle MD

Laparoscopic En Bloc Resection of Locally Advanced Renal Cell Carcinoma and Overlying Right Color: a Multidisciplinary Approach, Erik P Castle MD

Laparoscopic Nephrolithotomy: a Minimally Invasive Treatment Option, Erik P Castle MD

Robotic-assisted Radical Cystoprostatectomy With Extended Bilateral Pelvic Lymphadenectomy and Orthotopic Neobladder, Erik P Castle MD

Initial Experience With Robotic-assisted Radical Cystectomy in 17 Cases, Erik P Castle MD

High Power (80 W) Potassium-Titanyl-Phosphate (KTP) Laser Photoselective Vaporization Prostatectomy (PVP) for Sympto- matic Benign Prostatic Hyperplasia (BPH), Daniel J Culkin MD

Laparoscopic-assisted Lysis of Fibrotic Capsule Around Penile Prosthesis Reservoir and Placement of Artificial Urinary Sphincter, Brian H Eisner MD

Incidence of Urothelial Carcinoma Recurrence Following Hand-assisted Laparoscopic Nephroureterectomy With Cystoscopic en Bloc Excision of the Distal Ureter and Bladder Cuff, Arthur E Eletz MD

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LAPAROSCOPY TODAY

28
Laparoscopic Donor Nephrectomy: a Review of the Last 220 Cases, Christopher Ip MD

Pediatric Laparoscopic Pyeloplasty, Po N Lam MD

Percutaneous Cystolithotomy of Large Urinary Diversion Calculi Using a Combination of Laparoscopic and Endourologic Techniques, Po N Lam MD

Video of Complications During Laparoscopic Nephrectomy and Adrenalectomy, Michael C Lipke MD

Open Adrenalectomy: Has Laparoscopy Made It Obsolete?, Michael C Lipke MD

Laparoscopic Donor Nephrectomy in the Presence of a Circumferential Renal Vein, Gregory G Lovallo MD

Conversion From Open to Robotic-assisted Radical Prostatectomy is Associated With a Reduction of Positive Surgical Margins Amongst Private Practice Based Urologists, Ralph R Madeb MD

Tips and Tricks to Facilitate Renal Parenchymal Suturing During Laparoscopic Partial Nephrectomy, Elspeth M McDougall MD

Laparoscopic Adrenalectomy for Benign And Malignant Adrenal Lesions Using a Novel Vessel-Sealing System: a Combined Experience, Ravi Munver MD

The Learning Curve for Robotic-assisted Laparoscopic Radical Prostatectomy: a Multinstitutional Experience of Laparoscopic and Oncologic Trained Urologists, Ravi Munver MD

Robotic Radical Prostatectomy: Histopathologic and Short Term Biochemical Recurrence Data at One Year, Vipul R Patel MD

Laparoscopic Inguinal Hernia Repair During Laparoscopic Radical Prostatectomy, David M Rodin MD

Asymptomatic Unilateral Urolithiasis in Living Donor Transplant Kidneys, Chandru P Sundaram MD

Complications in 252 Laparoscopic Donor Nephrectomies, Chandru P Sundaram MD

Laparoscopic Management of Renal Cell Carcinoma With Complete Renal Vein Tumor Thrombus, Raju Thomas MD

The Large Adrenal Tumor: Laparoscopic Adrenalectomy Technique, Raju Thomas MD

Laparoscopic Donor Nephrectomy in the Setting of Multiple Vessels or Anomalous Vasculature, Ilya A Volfson MD

Effect of Vascular Clamping on Partial Nephrectomies, Melissa M Walls MD

High Power (80 W) Potassium-Titanyl-Phosphate (KTP) Laser Photoselective Vapoporation Prostatectomy (PVP) for Large Volume Benign Prostatic Hyperplasia (BPH), Carson Wong MD

High Power (80 W) Potassium-Titanyl-Phosphate (KTP) Laser Photoselective Vapoporation Prostatectomy (PVP) for Refractory Urinary Retention Secondary to Benign Prostatic Hyperplasia (BPH), Carson Wong MD

MULTISPECIALTY

Comparison of Effects of Pethidine (IM) and of Diclofenac (Suppository) for Relief of Pain After Laminecetomy, Masouneh Ahmad MD

Intravesical Jump Start Therapy Using a Therapeutic Cocktail for the Treatment of Interstitial Cystitis, Jeffrey R Dell MD

Short-Term Impact of a Laparoscopic Mini-Residency Experience on Postgraduate Urologists Practice Patterns, Elspeth M McDougall MD

Construct Validity Testing of the Lapmentor™ Laparoscopic Surgical Simulator, Elspeth M McDougall MD

Developing a Laparoscopic Skills Curriculum Using Virtual Reality Simulation, Kurt E Roberts MD

Minilaparoscopy-assisted Natural Orifice Surgery, Daniel A Tsin MD

Laparoscopic Pelvic Lymph Node Dissection and Radical Prostatectomy by a Transperitoneal or an Extrapelvic Method: Impact of Different Types of Previous Inguinal Hernia Repair, Ramakrishna Venkatesh MD

SPECIAL EVENT

Friday, Sept. 8, 2006 / 12:45pm-1:45pm

Excel Award Recipient: Richard M. Satava, MD, presents The Impossible Futures of Surgery

Established in 1991, the Excel Award has been presented to 21 surgeons deemed by the SLS Advisory Board to have made outstanding contributions to laparoscopy, endoscopy, and minimally invasive surgery. These outstanding surgeons are from various specialties and of various nationalities. The 2006 recipient of this prestigious award, Richard M. Satava, MD, FACS, has long been active in SLS and numerous other societies, is a past president and member of the SLS Board of Trustees, and is a regular presenter at the SLS annual meeting. Dr Satava is Professor of Surgery at the University of Washington Medical Center, Program Manager of Advanced Biomedical Technology at the Defense Advanced Research Projects Agency (DARPA), and Special Assistant in Advanced Surgical Technologies at the US Army Medical Research and Materiel Command in Ft. Detrick, Maryland. He served on the White House Office of Science and Technology Policy (OSTP) committee on Health, Food and Safety. Dr Satava’s brilliant career has included 23 years of military surgery during which he has been an active flight surgeon, an Army astronaut candidate, MASH surgeon for the Grenada Invasion, and a hospital commander during Desert Storm—all the while continuing clinical surgical practice.

Active in surgical education and research, Dr Satava has contributed to more than 200 publications in diverse areas of advanced surgical technology, including Surgery in the Space Environment, Video and 3-D imaging, Telepresence Surgery, Virtual Reality Surgical Simulation, and Objective Assessment of Surgical Competence and Training. He also sits on the editorial boards of numerous surgical and scientific journals, is a past president of SAGES, and is on the Board of Governors of the NBME.

While striving to practice the complete discipline of surgery, Dr Satava is aggressively pursuing the leading edge of advanced technologies to formulate the architecture for the next generation of Medicine.
DESTINATION: BOSTON, MASSACHUSETTS

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Please be sure to mention you are attending the SLS Congress in Boston, Massachusetts.

For those attending the conference who require special assistance (accessibility, dietary, etc.), please contact SLS no later than August 7, 2006 with special requests.

EXHIBIT HALL EVENTS

WELCOME RECEPTION: Kick off the congress at an informal reception open to all registrants in the Exhibit Hall. Meet old and new friends, and get a preliminary look at the technical exhibits.

SLS CYBER CAFÉ: While away, stay in touch. Check your E-mail, surf the Net, participate in an educational program, or go wireless at the SLS WiFi station. Educational programs will be scheduled throughout the day.

SLS INNOVATIONS OF THE YEAR: Come see what and how many innovative devices have been developed over the past year. The SLS Innovations of the Year will be recognized at the 15th International Congress and Endo Expo 2006. It is not necessary for a company to exhibit or advertise to be eligible for this recognition. SLS encourages all commercial entities to enter their most innovative product for consideration. Contact SLS for details: Tel 305.665.9959, Toll free 1.800.446.2659, Fax 305.667.4123, Conferences@SLS.org

NEW PRODUCT PRESENTATIONS BY EXHIBITORS: SLS invites all exhibitors to share information about new products, technology, and developments during the New Product Presentation Session. Exhibitors who submit new product information will be allowed a one-minute presentation during the mid-day break, Friday, September 8, 2006. Note: each exhibitor will be allowed to present only one product that must have been developed within the past year. Contact SLS for details:
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TOP GUN: IT’S HIGH NOON—ARE YOU READY FOR A SHOOT OUT? It doesn’t matter whether you’re right-handed or left-handed. In this shoot out, you use your nondominant hand. See who’s fastest on the draw-or stitch-in this entertaining, but challenging, training exercise in minimally invasive surgical procedures. Congratulations to last year’s winner, Roderick Brown, MD. See if you will take home the trophy this year and be named the “fastest draw” in SLS’ 2006 Top Gun Laparoscopy Shoot Out!

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SPECIAL EVENT: BREAKFAST AND FUTURE TECHNOLOGY SESSION

BEYOND HUMAN LIMITATION: PERFORMANCE IN THE EXTREMES, ORGAN REGROWTH, AND EMOTIONAL ROBOTS

Saturday, September 9, 2006
7:30am-10:30am

Richard M. Satava, MD, Director
Keynote Speaker Kenneth Kamler, MD, presents Medicine in the Extreme: Adventures of an Explorer in Extreme Environments
Anthony Atala, MD, presents Regenerative Medicine: New Approaches in Healthcare for the 21st Century
David Hanson presents Robots and Emotional Expression

The Future Technology Session offers a look at what science fiction has actually become fact. The keynote speaker, Kenneth Kamler, MD, will show his experience in the most extreme of environments, with truly unbelievable accomplishments in the most unlikely places—the Amazon jungle, miles under the sea and at the top of Mt. Everest. This will give a personal insight into his accomplishments, which he has documented in his award-winning book, Surviving the Extremes. He will be available for a book signing after the session.

Professor Anthony Atala will update us on the latest of human organs he has grown with tissue engineering and stem cells. His success in clinical trials has made the fiction of replacing synthetically grown organs a reality.

Professor David Hanson will take us to the world of robots where their facial expressions are indistinguishable from human emotion. The future of robots in which they look and react like humans is one step closer. David Hanson’s work earned him (and his Einstein robotic face) personal praise from President Bush and a place on the cover of a number of magazines and journals.

Keynote Speaker, Kenneth Kamler, has been on Mt. Everest twice at the request of NASA, helping to test space-age remote medical monitoring equipment.

Old friends, Paul Alan Wetter and Liselotte Mettler, meet new technology at Endo Expo 2005

Top Gun host, James C. Rosser, Jr., and the 2005 Top Gun winners

Top Gun winners
JUNE 2006

1-3 Advanced Videoscopic Surgery Training Course. University of California. San Francisco, California, USA

7-10 ISMICS 9th Annual Scientific Meeting. International Society for Minimally Invasive Cardiothoracic Surgery. San Francisco, California, USA

7-11 3rd International Hernia Congress. American Hernia Society and European Hernia Society. Boston, Massachusetts, USA

9-10 Advanced laparoscopic and Robotic Urologic Surgery. Washington University. St. Louis, Missouri, USA

21-26 World Congress on Gynecologic Laparoscopy. Croatian Medical Association; Croatian Medical Chamber; Croatian Society for Obstetrics and Gynecology; Croatian Society for Urogynecology; Academy of Medical Science of Croatia; and Ministry of Health of Republic Croatia in affiliation with AAGL. Dubrovnik, Croatia

AUGUST 2006

17-20 World Congress of Endourology. The Endourological Society. Cleveland, Ohio, USA

21-25 Gamma Knife Radiosurgery Training Series. Cleveland Clinic. Cleveland, Ohio, USA

30–SEPT 1 International Conference, Advances and Controversies in Laser Medicine and Surgery. Barcelona, Spain, USA

SEPTEMBER 2006


13-16 10th World Congress of Endoscopic Surgery Incorporating the 14th International Congress of EAES. European Association for Endoscopic Surgery. Berlin, Germany

OCTOBER 2006

8–12 ACS Clinical Congress. American College of Surgeons. Chicago, Illinois, USA

9–10 Endourology and Urologic Laparoscopy. University of Minnesota. Minneapolis, Minnesota, USA


31–Nov 2 2nd Congress of the Iranian Endourology and Urolaparoscopy Society. Urology/Nephrology Research Center. Tehran, Iran

Error Reduction Through Team Leadership: Applying Aviation’s CRM Model in the OR. Healy GB et al. 2006;91(2):10-15 • Crew resource management training originated in 1979 when the research presented at a NASA workshop (which was the outgrowth of research into causes of air transport accidents) showed that systems broke down and problems occurred because of failures in communication/team interaction and cognitive skills. The authors explain CRM, how it is relevant to the operating room, and how to cultivate an environment in which the team can function utilizing its principles. Not only does CRM training appear to be improving patient outcomes, it may also improve employee’s satisfaction with work.

NOVEMBER 2006


12–16 28th Congress of the Societe Internationale d’Urologie. Cape Town, South Africa

17–19 Advanced laparoscopy. American Urological Association. Baltimore, Maryland, USA
LAPAROSCOPY.org Online Now! The First Edition of SLS’ Complications Textbook. Full text of the first edition of SLS’ textbook Prevention and Management of Laparoendoscopic Surgical Complications is now freely available online. A representation of the multidisciplinary philosophy of SLS, this sellout book covers general surgery, gynecological surgery, and urological surgery, as well as techniques and equipment. Though an updated second edition has recently been published, the first edition remains a rich source of information that has been made easy to search and reference by its presence on the Web. Busy practitioners can even subscribe to the site’s RSS feed for easy download to computers and PDAs. Link to the book from the SLS website, www.Laparoscopy.org.

The SLS website also provides detailed information about the updated second edition of Prevention and Management of Laparoendoscopic Surgical Complications. Visit www.Laparoscopy.org to read a review of the second edition, browse its table of contents, and take the opportunity to add this comprehensive, multidisciplinary reference to your library.

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WEBSURG.com The World Electronic Book of Surgery’s latest additions include 2 chapters on Laparoscopic Radical Prostatectomy and 7 laparoscopy videos covering adrenal tumor resection, treatment of a hydatid cysts of the liver and lung, Heller myotomy, segmentectomy for hepatocellular carcinoma in cirrhosis, delayed Bochdalek diaphragmatic hernia, and imperforate anus.

ROYLANTZ.com Roy Lantz has published the short article “Make Great Patient Care Contagious.” In this piece, the author discusses the organizational attitude and values that are required for good patient care and how these attitudes and values can be spread throughout your office. Available at http://www.roylantz.com/article-contagious.shtml

JOURNAL WATCH: JSLS

Video Consent: a Pilot Study of Informed Consent in Laparoscopic Urology and Its Impact on Patient Satisfaction. Sahai A et al. 2006;10:21-25 • The authors report a new protocol in which patients are invited to watch a video of the operation they might be undergoing in addition to the normal consent process. Sahai et al utilized self-constructed, patient-directed questionnaires as well as the Client Satisfaction Questionnaire to evaluate the protocol. Patients reported high satisfaction scores.

JOURNAL WATCH: J Reprod Med

Surgery for Vaginal Prolapse. Francis SL et al. 2006;51:75-82 • Through this review, the author aims to assist readers in choosing the appropriate surgical method to correct vaginal apical prolapse based on objective data. The following approaches are reviewed: Moschowitz and Halban Caldoscopy, Abdominal Sacral Colpopexy, Laparoscopic Sacral Colpopexy; Uterosacral Suspension, McCall Caldoscopy, Uterosacral Suspension/Modified McCall, Sacropinous Suspension, Copocleisis, and Intravaginal Slingplasty.

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