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Surgical Endoscopy, Gyn Laparoscopy, Endourology
San Francisco, California
September 5–8, 2007

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Information Retention and Skill Acquisition After CME Meetings

HARRITH M. HASSON, MD, HILLIARD JASON, MD, EdD

INFORMATION RETENTION

Recent brain research\(^1,^2\) and expanded research on the learning process\(^3,^4\) have substantially increased our understandings of how to improve any teaching we do.

Short-term human memory is seriously limited. A widely accepted generalization, based on a classic study\(^5\) is that short-term memory is limited to 7±2 discrete items and is subject to rapid degradation unless promptly reinforced. Under the right conditions, however, long-term memory can be fairly reliable. Moving information from short-term to long-term memory requires multiple repetitive acts of reinforcement. Several factors can enhance information retention:

1. A positive emotional context exists when information is first learned.
2. The new information builds on related, prior knowledge. Building on what one already knows is a critical requirement for meaningful learning.
3. Our brains are capable of an impressive, long-lasting visual pattern of recognition, if suitably reinforced, but this is separate from verbal learning.
4. Learners are helped to feel a genuine sense of “ownership” of whatever they need to learn. That is, they see the connection between what they are expected to learn and their personal and career goals (assuming that such a connection exists).
5. Learners are actively engaged in the process of learning. They are encouraged to:
   - a. raise questions and seek out information, not merely follow instructions.
   - b. take notes in classes, reflecting on, interpreting, and summarizing what they hear, not merely serving as stenographers.
   - c. review and reflect further on their notes and related information soon after their initial exposure, preferably within 24 hours.
   - d. thereafter, engage in repetitive acts of reconsideration, application, and reinforcement of the information they are seeking to learn.

IMPROVING INFORMATION RETENTION AFTER CME MEETINGS

Improving retention of information following a meeting is influenced and modulated by the quality of the learning experience at the meeting. SLS is pioneering an interactive format at the 2007 annual meeting, according to the principles outlined above. This new format will encourage a free exchange of information between presenters and participants, who will be encouraged to find a sense of ownership of the information and ideas being offered. For example, we will include town hall poster sessions and interactive round tables.

Engaging in repetitive acts of reinforcement of the information provided, and self-assessment after the meeting can be carried out using the Internet. Self-assessment, which can be done, in part, with multiple-choice questions, provides some guidance as to how much has been retained.\(^6\) The testing process in itself can be a reinforcer and can boost retention of...
LAPAROSCOPIC SKILL ACQUISITION USING SIMULATION-BASED LEARNING

The skills required to perform laparoscopic surgery include:

- The fundamental ability to operate on a 3D object from a 2D image using visuo-spatial translation and perception.
- Psychomotor hand-eye coordination using dominant and nondominant hands separately and together.\(^7\)

These abilities are based on inherent Basic Performance Resources (BPRs) that measure innate abilities.\(^8\) BPRs differ among various individuals and represent the operative-performance-limiting factor. With practice, the skills of an individual can improve to the limit of his/her ability (based on available BPRs) but not beyond it. Examples of pertinent BPRs include:

- Visual hand response speed
- Visual information processing speed
- Visual spatial short-term memory capacity
- Arm neuromotor channel capacity.

Fundamental abilities are manifested through basic skills, enabling skills and tasks comprising one or more basic skills to simulate procedures used in laparoscopic surgery. They are the building blocks for achieving technical proficiency in laparoscopic surgery using a simulated environment.\(^9\) Enabling skills and tasks include:

- Camera navigation
- Cannulation or threading
- Clip application
- Cutting
- Suturing and knot tying
- Application of energy sources

There is a difference between acquiring (basically expressing) laparoscopic abilities and acquiring enabling laparoscopic skills. Basic laparoscopic skills reflect innate abilities and generally require only brief instructions and mentoring. However, a more elaborate learning curve is needed to adapt to the peculiarities of the simulator interface. The length of that learning task reflects the abstract adaptive skills of the trainees as well as their technical abilities per se.\(^9\) On the other hand, enabling skills and tasks (especially suturing and knot tying) require detailed instructions and feedback from a mentor, without which proper learning may not be possible regardless of the innate ability of the trainee.\(^9\)

IMPROVING LAPAROSCOPIC SKILL ACQUISITION WITH SIMULATION-BASED TRAINING

Laparoscopic skills cannot be adequately learned in 1- or 2-day workshops. However, such workshops can serve to heighten the awareness and interest of participants and can provide them with a good start. However, the acquisition of skills to an expert level requires sustained, deliberate practice over many years.\(^11\)

Roger Kneebone\(^2\) studied the subject and made the following pertinent observations and recommendations:

1. An effective skill curriculum is critical to the success of the program.
2. Skills are best taught by a sympathetic mentor who initially provides the student with guidance and feedback, then with contingent instructions as needed and finally fades away when no longer needed.
3. Students need to take ownership of their learning experience and become self-mentors (through reflection and deliberate practice) after receiving the external guidance.
4. Repetitive deliberate practice of a skill moves it into long-term memory where it is embedded, integrated, retained, and easily recalled. In fact, core technical skills, once mastered, become automatically available when called upon.
5. Skills decay over time and need to be reinforced and consolidated with repetitive training.
with intent to achieve and sustain expert status.

6. Practicing simulated tasks over relatively small segments of time (distributed practice) is more effective than practicing them in one long intensive session (massed practice).

It should also be noted that training should be geared to achieving proficiency criteria without regard to number of training hours. Gifted trainees should be allowed to gravitate upward in the program. Periodic self-assessment using embedded simulation metrics are essential for providing evidence of change in manual skill aptitude with continued training over time. Objective assessment also keeps trainees engaged, challenged, and informed, and may provide them with an incentive to continue working toward reaching higher levels of proficiency.

Simulation-based training can benefit from Internet technology. Virtual-reality simulators can be linked worldwide through the Internet. Computer-based augmented reality simulators can pool their data to a central location for studies of performance and toward establishing nationwide (or worldwide) proficiency standards. Individual centers can share anonymous performance reports for comparative analysis and review.

CONCLUSION

New understandings about human learning and skill acquisition provide progressive societies such as SLS with unique opportunities for improving the educational impact of their meetings as well as offering their attendees possibilities for continued learning and assessment after the meeting using the Internet and simulation centers.

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5. Miller GA. The magical number seven, plus or minus two: some limits on our capacity for processing information. Psychol Rev. 1956;63:81-97.
**Impact of an Intensive Training Program on Laparoscopic Skills of Postgraduate Urologists**

*Peter D. Vlaovic, MD, Eric R. Sargent, MD, John R. Boker, MD, Federico A. Corica, MD, David S. Chou, MD, Corollos S. Abdelshehid, BS, Shannon M. White, BS, Leandro G. Sala, MD, Frank Chu, Todd Le, Ralph V. Clayman, MD, Elspeth M. McDougall, MD*

**INTRODUCTION**

The acquisition of laparoscopic skills requires a longer learning curve than that of open surgery. To help postgraduate urologists acquire laparoscopic surgical skills, an intensive 5-day mini-residency (M-R) program was created at the University of California Irvine through a grant from Yamanouchi Pharma America (now Astellas Pharma Inc.).

**PROGRAM DESIGN**

A maximum of 2 urologists are accepted per week into the M-R program. The trainee chooses one of the following training modules: (1) ureteroscopy and percutaneous renal access; (2) laparoscopic renal ablative (radical nephrectomy); (3) laparoscopic renal reconstructive (partial nephrectomy and pyeloplasty); (4) and robot-assisted prostatectomy. The course includes 2 hours to 3 hours of didactic lectures, daily practice on pelvic trainers and virtual reality simulators, 1 to 2 porcine laboratories per week, and observation of cases in the operating room.

Skills testing (ST) simulating open, laparoscopic, and robot-assisted laparoscopic surgery is performed and evaluated by an experienced observer on training days 1 and 5. The tasks include ring transfer (placing and removing rings from pegs), suture threading (threading a 3-0 Prolene suture through loops), cutting (cutting along designated curved lines), and suturing (continuous running of a suture around a foam hexagon) (Figure 1). Mini-residents undergo ST with open surgical instruments (forceps, needle driver, and scissors) sitting at a table (open ST), with laparoscopic instruments (graspers, needle drivers, and shears) on the pelvic trainer (laparoscopic ST), and with robotic instruments (needle drivers and scissors) on the da Vinci Surgical System (robotic ST). The participants’ performance is graded with a validated Objective Structured Assessment of Technical Skill (OSATS) scoring system. The total score is a product of the quantity score (ie, how much of the task is completed in the specified period of time) and the quality score (ie, how accurately the skill task is performed). The data were analyzed by using the paired sample t test and analysis of variance at a confidence level of $P<0.05$. 

**Figure 1.** The surgical skills tasks: 
A. Participant removes all 6 rings and then places them back on pegs within a 2-minute timeframe. 
B. Participant is given 2 minutes to thread a 2-0 Prolene suture through as many of the 11 loops as possible. 
C. Participant is given 2 minutes to cut along the inner curved line. 
D. Participant is given 3 minutes to run a 4-0 Vicryl suture on an RB-1 as close to the dots as possible.
RESULTS

Between July 2003 and June 2005, 101 urologists from 22 American states and 14 countries participated in the M-R experience. Mean participant age was 47 years (range, 31 to 70). Mean time from graduation from urology residency was 15 years (range, 1 to 42).

The M-R open, laparoscopic, and robotic ST scores for all of the participants on the first and fifth days of the course are shown in Table 1. On both the first and final days, the open ST scores are significantly higher than the robotic ST scores (P<0.0005), which are significantly higher than the laparoscopic ST scores (P<0.0005). This was the case for all of the ST scores, including the overall score. No significant difference existed between the ST scores on the first and final day for any of the open skills tasks. However, the robotic ST scores were significantly higher on the final day compared with scores on the first day.

The participants’ performance according to the M-R training module was also examined. Laparoscopic ablative and reconstructive renal module participants demonstrated significant improvement in laparoscopic and robotic ring transfer, suture threading, cutting, and suturing on day 5 compared with day 1 (P<0.05) (Table 2). However, none of this group’s open ST changed significantly from day 1 to day 5. In the robot-assisted prostatectomy module participants, significant improvement occurred in the quantity score for the cutting task and the quality score for suturing (P<0.05) (Table 3).

Increasing participant age tended to inversely correlate with some ST scores. Participants older than 54 years of age scored lower on day 1 for the open ring transfer and suture threading than did individuals aged 44 to 53 years (P=0.03) and <43 years (P=0.03). Moreover, the urologists >54 years of age scored significantly lower on open suture threading on day 5 (P=0.01). For the robotic ST scores, the >54-year-old group scored lower on suture threading on day 1 (P=0.004) and day 5 (P=0.017) and on suturing on day 5 (P=0.006). For robotic ring transfer ST scores, surgeons <43 years scored significantly better than the older participants (P=0.0004). The rest

<table>
<thead>
<tr>
<th>Skill Task</th>
<th>Maximum Score</th>
<th>Open Skills</th>
<th>Robot-Assisted Skills</th>
<th>Laparoscopic Skills</th>
<th>P*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ring transfer</td>
<td>Day 1</td>
<td>46.1±4.7</td>
<td>46.8±3.7</td>
<td>0.15</td>
<td>38.2±11.2</td>
</tr>
<tr>
<td>Day 5</td>
<td>46.1±4.7</td>
<td>46.8±3.7</td>
<td>0.15</td>
<td>38.2±11.2</td>
<td>28.8±11.7</td>
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<td>Day 1</td>
<td>38.1±7.9</td>
<td>39.2±6.9</td>
<td>0.19</td>
<td>21.1±11.6</td>
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<tr>
<td>Day 5</td>
<td>38.1±7.9</td>
<td>39.2±6.9</td>
<td>0.19</td>
<td>21.1±11.6</td>
<td>2.5±6.8</td>
</tr>
<tr>
<td>Cutting</td>
<td>Day 1</td>
<td>67.8±6.4</td>
<td>68.1±6.9</td>
<td>0.76</td>
<td>22.4±10</td>
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<tr>
<td>Day 5</td>
<td>67.8±6.4</td>
<td>68.1±6.9</td>
<td>0.76</td>
<td>22.4±10</td>
<td>13.8±8.9</td>
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<td>Suturing</td>
<td>Day 1</td>
<td>48.2±11.1</td>
<td>40.3±10</td>
<td>0.10</td>
<td>14.5±8.3</td>
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<tr>
<td>Day 5</td>
<td>48.2±11.1</td>
<td>40.3±10</td>
<td>0.10</td>
<td>14.5±8.3</td>
<td>7.6±6.2</td>
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<td>Overall Score</td>
<td>Day 1</td>
<td>190.6±25</td>
<td>193.6±25</td>
<td>0.17</td>
<td>95±0.4</td>
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<tr>
<td>Day 5</td>
<td>190.6±25</td>
<td>193.6±25</td>
<td>0.17</td>
<td>95±0.4</td>
<td>52.5±20.3</td>
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</table>

*Open > Robot-assisted > Laparoscopic.

<table>
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<tr>
<th>Skill Task</th>
<th>Total Score</th>
<th>P</th>
<th>Quantity Score</th>
<th>P</th>
<th>Quality Score</th>
<th>P</th>
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<tbody>
<tr>
<td>Ring transfer</td>
<td>Open</td>
<td>46.1</td>
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<td>34.6</td>
<td>0.002</td>
<td>8.9</td>
<td>9.9</td>
<td>NS</td>
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<td>43.6</td>
<td>NS</td>
<td>10.9</td>
<td>11.6</td>
<td>NS</td>
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<tr>
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<td>39.1</td>
<td>NS</td>
<td>10.6</td>
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<td>7.1</td>
<td>NS</td>
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<td>68</td>
<td>NS</td>
<td>17.7</td>
<td>17.8</td>
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<tr>
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<td>7.9</td>
<td>NS</td>
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<td>27.5</td>
<td>NS</td>
<td>7.0</td>
<td>11.7</td>
<td>NS</td>
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<td>Open</td>
<td>38.3</td>
<td>40.3</td>
<td>NS</td>
<td>10.6</td>
<td>11.2</td>
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<td>11.4</td>
<td>0.009</td>
<td>3.2</td>
<td>4.0</td>
<td>NS</td>
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<tr>
<td>Robot-assisted</td>
<td>13.7</td>
<td>16.9</td>
<td>0.02</td>
<td>4.4</td>
<td>5.6</td>
<td>NS</td>
</tr>
</tbody>
</table>
of the open and robotic ST scores and none of the laparoscopic ST scores were significantly different between the various age groups (P>0.05) (Table 4).

Skill task scores of participants who graduated from urology residency less than 10 years earlier were compared with those who graduated more than 10 years earlier (Table 5). The more recent graduates had significantly higher scores for robotic suture threading on day 1 (P=0.01), open suture threading on day 5 (P=0.03), and laparoscopic cutting on day 5 (P=0.01). No other ST scores differed significantly between the 2 groups.

### DISCUSSION

The purpose of this study was to assess whether the course could develop participants' basic laparoscopic and robotic skills, such as general coordination of instruments (ie, ring transfer and suture threading), and surgically oriented skills, such as cutting and suturing. The results show that laparoscopic and robotic ST scores significantly improve over the 5-day course while open ST scores do not. It would be expected that open ST scores would not improve following the M-R course, as these types of skills are not formally addressed during the course. The observation that robotic ST scores are significantly higher than the laparoscopic ST scores at the beginning and the end of the course reflects the greater degree of complexity associated with performing pure laparoscopic skills. As other investigators have demonstrated, basic robotic skills are more easily developed than are laparoscopic skills. The robot facilitates the skill performance by providing an intuitive working format with more precise instrument movement, 3-dimensional visualization, and increased surgeon comfort at the master console. The counterintuitive, 2-dimensional working environment, long instruments fulcrumed at the abdominal wall, and magnification of the surgeon's natural tremor all compound to make laparoscopy a challenging surgical technique.

There appears to be some correlation between ST scores and age, particularly the robot-assisted ST scores. Surgeons older than 54 years of age may have poorer fine motor coordination of instruments when using the robot and may have more difficulty learning robot-assisted suturing. These surgeons may require a longer training program.
to reach the same proficiency level as their younger counterparts, although this study was not able to assess this. Conversely, age does not appear to influence laparoscopic ST scores, including suturing. Time since graduation appears to have a less significant impact on ST scores than age does.

CONCLUSIONS

Laparoscopic and robotic skills are difficult to acquire, especially for urologists who were not exposed to the technique during residency training. It appears that the 5-day intensive M-R course improves both laparoscopic and basic robotic skills and thus represents a new paradigm in postgraduate surgical education.

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References


Laparoscopy for Complex Problems in the Pediatric Patient, Including Access and Complications

Gustavo Stringel, MD

INTRODUCTION

Minimally invasive laparoscopic techniques have become the standard of care for many surgical procedures in the pediatric population. Laparoscopy in children is now well accepted and used even for complex problems. Some of the complex problems in pediatrics are unique to this specialty; the laparoscopic pediatric surgeon has to deal with a variety of patients, from the newborn who weighs only a few pounds to the adolescent who may weigh over 200 pounds.

COMPLICATIONS OF ACCESS

Access in pediatric laparoscopy can be accomplished in a manner similar to that of the adult patient. The placement of trocars can be done using a closed or an open technique. The closed technique involves use of the Veress needle and direct nonvisualized trocar insertion. This technique was common during the initial practice of laparoscopy but is now seldom used by pediatric surgeons. Most pediatric surgeons favor some modification of the open technique initially described by Hasson. I initially used the Veress needle technique for many cases. Although I did not have any serious complications related to access with this technique, I eventually changed to an open approach. I make a small incision below the umbilicus and grasp the root of the umbilicus with a Kocker clamp, pull the abdominal wall upward, make a small midline incision in the rectus fascia, and proceed to dissect with a mosquito clamp until entering the peritoneum; subsequently, I insert a blunt trocar. I adopted this technique several years ago. No visceral or vascular injuries have occurred with this technique with several hundred cases being performed. This technique is very useful in obese patients. We need to remember that in infants and small children the distance between the umbilicus and the xiphoid is larger than the distance between the umbilicus and the pubis; for this reason, the initial umbilical trocar should be directed toward the upper abdomen to avoid injuries.

Access to the abdomen should not be limited to the umbilicus. The surgeon should be familiar with access through other areas. This is especially important when dealing with patients with adhesions, previous surgery including umbilical hernia repair, and for procedures that do not require an umbilical approach. For example, I do not use the umbilical approach for splenectomy, because I do this procedure with the patient in the lateral decubitus position.

Complications of access, such as insufflation of the abdominal wall or falciform ligament, can be minor. Major complications involve damage to solid organs and intestinal and vascular injuries.

The inferior epigastric vessels can be injured, and they can bleed profusely or form a hematoma. Sometimes bleeding or hematoma formation is not evident until the trocar is removed. The problem can be avoided by visualizing the inferior epigastric vessels before placement of the trocar. The bleeding can be controlled by placing a suture or clip or by using a coagulation instrument like the Harmonic scalpel. A useful maneuver to control this bleeding temporarily is to place a Foley
catheter and inflate the balloon; traction in the catheter can tamponade the bleeding.

As a general rule, major vascular injuries require prompt conversion to an open procedure. Minor vascular injuries, enterotomies, and minor solid organ injury can be controlled laparoscopically.

Evisceration is usually obvious and can be readily repaired. The omentum is flimsy in small children, and it can be easily sutured to the port incision, sometimes including the intestine in the closure causing bowel obstruction. We generally make an effort to close all trocar sites in small children to avoid potential evisceration. Older children and adolescents do not need 5-mm trocar closure.

CHOLECYSTECTOMY

Gallbladder disease continues to increase in the pediatric population. This problem is seen more frequently and with more complicated presentations. I have done a significant number of laparoscopic cholecystectomies for acute cholecystitis. I have had no conversions, but the dissection can sometimes be tedious and difficult. I initially performed a significant number of intraoperative cholangiograms to identify the anatomy or to rule out choledocholithiasis. I now rely heavily on preoperative ERCP, because we are fortunate at our institution to have an excellent endoscopic team. After removal of the stones, a sphincterotomy is generally performed. The laparoscopic cholecystectomy can be done the next day. I unknowingly have left retained stones in the common bile duct after cholecystectomy in 3 cases. The stones were safely removed by ERCP.

In cases of difficult dissection or when unable to identify the anatomy, I prefer to use a Dome down or retrograde cholecystectomy rather than performing an intraoperative cholangiogram. The Dome down or retrograde cholecystectomy is generally easy to perform and facilitates the identification of the cystic duct, common bile duct, and vascular structures. On several occasions, the cystic duct was very large and needed division with the endoscopic stapler.

I exclusively use the Harmonic scalpel when performing cholecystectomy, thus avoiding the inherent complications of monopolar electrocautery.

APPENDECTOMY

I started performing appendectomies laparoscopically in 1993. Almost all cases of appendicitis can be managed with laparoscopy. The stable patient with an appendiceal abscess is generally managed with intravenous antibiotics with or without percutaneous drainage and interval appendectomy. The patient with perforated appendicitis, obese patients, and females benefit the most from the laparoscopic approach. Ironically, these very patients were excluded initially as candidates for the laparoscopic approach.

The patient with a small-bowel obstruction secondary to appendicitis can be a challenge because of the limited space inside the abdomen and because of the adhesions present. I have attended to several of these patients with a very low conversion rate. The converted cases occurred at the beginning of the learning curve. Conversion has not been necessary in the last few years. On some occasions, the child presented with small-bowel obstruction of an unclear cause, and diagnostic laparoscopy confirmed the cause as appendicitis. The most important goal is to create enough space inside the abdomen to work; this requires patience, careful dissection, and appropriate equipment; the Harmonic scalpel is very useful in this situation. I use 30-degree or 45-degree angled lenses to improve visualization inside the abdomen. When a perforation is found close to the cecum, I prefer to place the stapler across the lower part of the cecum. In case of perforated appendicitis, laparoscopy allows for a thorough suctioning of pus and debris and irrigation of all abdominal quadrants, which cannot be achieved with open appendectomy.
SPLENECTOMY

Splenectomy is performed for a variety of pediatric hematological disorders. The initial cases were done with the patient in the supine position with a 45-degree inclination. I currently prefer the right lateral decubitus position. This position allows for the spleen to be suspended in the left upper quadrant by the splenic ligaments.

In cases of a very large spleen, laparoscopic splenectomy can be challenging. Preoperative splenic artery embolization can be performed to decrease the size of the spleen. I converted cases in 2 patients with very large spleens that occupied almost the entire peritoneal cavity. In cases of thrombocytopenia, I prefer to raise the platelet count to above 50,000 with platelet transfusion.

Patients with sickle cell disease need a preoperative blood transfusion to elevate the hemoglobin above 10 g/dL. Appropriate intraoperative measures are necessary to prevent sickle cell crisis and acute chest syndrome.

A careful search for accessory spleens is always necessary to prevent a failure of the splenectomy; this is especially important in patients with idiopathic thrombocytopenic purpura (ITP). I had 2 failures of splenectomy in ITP patients because of accessory spleens. The accessory spleens were localized by nuclear medicine and CT scan and removed laparoscopically.

GASTROSTOMY AND NISSEN FUNDOPICATION

These procedures are very common in pediatric patients because of the large number of neurologically impaired children with gastroesophageal reflux and swallowing incoordination.

Nissen fundoplication is an ideal operation for laparoscopy. It can be challenging in patients with severe scoliosis or previous failed open or laparoscopic procedures. The presence of a previous gastrostomy, whether open, laparoscopic, or by percutaneous endoscopic technique is not a contraindication for laparoscopic Nissen. The laparoscopic Nissen fundoplication can be done without taking down the gastrostomy.

I converted 2 cases of fundoplication to the open method because of concrete-like adhesions and 3 cases of severe scoliosis with associated hepatomegaly.

GASTRIC AND INTESTINAL PERFORATIONS

Gastric and intestinal perforations can be repaired laparoscopically. Intestinal perforations are more commonly seen in abdominal trauma. They can be associated with seat belt injuries. I have repaired several small-bowel perforations secondary to trauma laparoscopically. Two patients with peptic ulcer perforations presented with acute abdomen; the perforations were diagnosed and repaired laparoscopically.

LAPAROSCOPY FOR ABDOMINAL TUMORS

Childhood intraabdominal tumors pose a diagnostic and technical challenge to the pediatric oncology team. The correct diagnosis and appropriate treatment are dependent on adequate tissue procurement for histologic, karyotypic, and molecular analyses. When these tumors are deemed unresectable by diagnostic imaging at diagnosis, a biopsy is done to obtain a sample of the tumor for histological analysis. Computerized tomography guided needle biopsies may not yield enough tissue for all studies. Laparoscopy now plays an important role in the management of these challenging tumors. Adequate tissue can be procured, and tumor resectability can be assessed.

Laparoscopy for pediatric intraabdominal tumors has been utilized for neuroblastoma.

In a series of 37 children with abdominal neuroblastoma, the length of hospitalization and the time to feeding, the initiation of chemotherapy, or both, was significantly shorter in the laparoscopic group, compared with the open surgery group. Operative time and estimated blood loss were similar.
Ovarian and adnexal lesions can be approached with laparoscopy in infants, children, and adolescents, with excellent results. As with other laparoscopic procedures, the operative time and length of stay are shorter, and the cosmetic results are superior to those of laparotomy. Children with mature teratomas can be treated with laparoscopy.

Laparotomy may be necessary to remove large tumors to avoid spillage. Tumor spillage may be a problem, especially in the case of Wilm's tumor. Perhaps an unresectable or bilateral Wilm's tumor may be better approached for biopsy through a small retroperitoneal incision. Laparoscopy can be used to determine the resectability and aid in the dissection of a large Wilm's tumor.

Laparoscopy is an important addition to the armamentarium against abdominal tumors in children. Biopsies are performed under direct vision, and adequate tumor tissue is procured for diagnostic and prognostic analyses. Dissection of the tumor is feasible and its resectability can be determined.

THE ROLE OF LAPAROSCOPY IN ABDOMINAL PAIN

Abdominal pain is one of the most common complaints in children. In most cases, the pain resolves with conservative treatment. Some children continue to have abdominal pain, and despite all investigations, no cause is found for the pain. These children are diagnosed as having chronic recurrent abdominal pain.

The cause of the pain is seldom found by clinical, laboratory, and imaging studies. It has been estimated that no organic cause for the pain is found in over 90% of children. The best approach in children with chronic recurrent abdominal pain includes a careful and detailed clinical history and physical examination and judiciously applied laboratory and imaging studies. Ultrasound has been recommended as one of the initial examinations because it is noninvasive and can exclude serious abdominal pathology. In a recent study of 57 children with recurrent abdominal pain, the findings of abdominal ultrasound were normal in 56 (98%). Three of these children subsequently had appendectomy because of persistent abdominal pain. The role of ultrasound continues to be that of reassurance to parents and treating physicians because it is useful in excluding important pathology amenable to ultrasound detection.

Computerized tomography continues to develop as a very important diagnostic tool in children with abdominal pain. The role of this more invasive and expensive investigation in the management of children with chronic recurrent abdominal pain remains to be evaluated.

Upper gastrointestinal endoscopy is important when ulcer disease or Helicobacter pylori is suspected as the cause of abdominal pain. Colonoscopy is useful in patients with suspected inflammatory bowel disease.

In the past, laparotomy through a limited right lower quadrant McBurney incision and appendectomy has been recommended in cases of chronic recurrent abdominal pain. This approach has provided good results for some investigators, with resolution of symptoms in the majority of patients, despite the fact that the appendix was histologically normal in most patients. This finding has led some authors to postulate a placebo effect of appendectomy. A careful, detailed clinical history and a physical examination remain the most valuable tools for managing children with chronic recurrent abdominal pain. The judicious use of imaging studies and laboratory investigations can contribute to eliminating some serious causes of the pain.
CONCLUSION

As we gain more experience and confidence with diagnostic laparoscopy, this procedure is becoming a powerful tool in the management of children. The early use of diagnostic laparoscopy may avoid unnecessary and expensive tests as well as prolonged hospitalization.

FROM THE 15TH SLS ANNUAL MEETING AND ENDO EXPO 2006, BOSTON, MASS, SEPTEMBER 6-9, 2006

General Session: Best of Laparoscopy Updates

ABDOMINAL AND PELVIC PAIN

PLEASE CHECK MY BLADDER BEFORE YOU REMOVE MY FEMALE ORGANS! IT IS NOT JUST ENDOMETRIOSIS: THE NEW INSIGHT FOR TREATING LOW ABDOMINAL AND PELVIC PAIN IN WOMEN.

PRESENTED BY MAURICE K. CHUNG, MD, RPH

Chronic pelvic pain can have many causes, including ailments occurring in the pelvic region, such as endometriosis, and in the bladder, for instance interstitial cystitis. Symptoms may be similar, and more than one condition may occur at the same time. Chronic pelvic pain, therefore, should be considered a multi-organ disease and treated accordingly.

BARIATRIC SURGERY

PRESENTED BY ALEX GANDSAS, MD

Obesity has increased dramatically as has the amount of money spent in treating major weight-related comorbidities. The cost of health care in morbidly obese patients has increased 5 times in the last 18 years. Although an increase has occurred in the number of patients requesting revisional surgery, few centers offer such surgery and few centers offer bariatric surgery in the ambulatory setting.

FERTILITY

ROLE OF DEEP INTRAMURAL FIBROIDS ON IN VITRO FERTILIZATION OUTCOME.

PRESENTED BY CHARLES H. KOH, MD

Deep intramural fibroids distort the uterine cavity during reproduction, and in most cases should be removed. However, removing fibroids is a surgical challenge. The laparoscopic approach is the best.

ROBOTIC SURGERY

COMPUTER ENHANCED “ROBOTIC” SURGERY.

PRESENTED BY WILLIAM E. KELLEY, JR, MD

The FDA approved the first computer-enhanced surgical system for abdominal and pelvic laparoscopic surgery in 2000. In 2003 and 2004 robot-assisted mitral valve replacement and robot-assisted CABG were approved. Computerized surgery provides enhanced precision, flexibility, and the ability to deliver highly functional instruments to small awkward locations. It is superior to MIS.
Imagine the following scenarios: making rounds and attending to a patient with a condition that you are not familiar with; writing a paper based on your recent research, or patient case; writing a review article to submit to JSLS, Journal of the Society of Laparoendoscopic Surgeons or another medical journal. In addition to using your computer, now imagine using your PDA or your cell phone as the tool for retrieving pertinent medical information in those situations! With the press of a few buttons, you can download the appropriate chapter of the first edition of Prevention and Management of Laparoendoscopic Surgical Complications, for example, or the “SLS Guide: Writing Effectively for MIS Journal Publication,” or other valuable information from the SLS website.

The mission of SLS is to “improve patient care and promote the highest standards of practice through education, training, and information distribution and to ensure that members have access to the newest ideas and approaches, as rapidly as possible.” Simply stated, SLS strives to make information available using the most convenient and practical means possible. They want to put information at your fingertips!

**How Is This Possible?**

This mission might seem like a tall order; however, SLS is succeeding at its mission and now even taking it a step further. The newly expanded and redesigned websites, www.SLS.org and www.LaparoscopyToday.com have features that will allow you to access MIS information anytime, anywhere. This is possible using an RSS feed. Once you have an RSS feed reader, also known as an aggregator, installed on your computer, PDA, or cell phone, you can use your device to access the SLS website and obtain information instantly.

**What Is an RSS Feed?**

There is some discussion as to what RSS stands for,
but the vote commonly goes to “Really Simple Syndication.” Essentially, it is a format for distributing content from sources on the web. RSS is particularly useful because it allows one to check for and retrieve the latest content available online from multiple information sources. The concept is based on syndicating information, much like newspapers have syndicated columns. The feed reader or aggregator software will grab the RSS feeds from your chosen websites and then display them on your computer or even manipulate them to be read on your cell phone or PDA.

How to Start Using Feeds

The first thing you need is an RSS feed reader or aggregator which can either be accessed using a browser or as a downloadable application. At your request, the aggregator searches your chosen sites and sends new information from those sites directly to your computer, PDA, or cell phone. Aggregators are available for free (NewsGator or NetNewsWire Lite for Mac are available at www.NewsGator.com) or for a small fee ($29.95 for NetNewsWire, the fully functional version of NewsGator for Mac, also available at www.NewsGator.com). To take advantage of RSS on your PDA, try Quick News for Palm OS (http://standalone.com/palmos/quick_news). At just $14.95, it’s a bargain.

The number of sites offering RSS is rapidly increasing, with websites such as those for the New York Times and the BBC as well as www.WebMD.com and www.MedicineNet.com offering the feature to keep viewers informed of the latest news. Sites offering RSS will typically show the RSS icon (Figure 1) or offer site viewers the option of subscribing to the site.

SLS uses RSS feeds to allow easier communication of MIS information from its website to physicians around the world who have access to computers and hand-held communication devices. Surgeons might also use RSS feeds within their institutions to share protocols, new procedures, news, or institutional policies with their colleagues.

Check Out These Other New Features on SLS’ Websites!

- New search engines powered by Google and IngentaConnect make gathering information from SLS’ publications easy. Search and download past issues of JSLS (Full text is available online 3 months after publication for free; new issues are available exclusively to members via password and login). A search of the SLS websites, powered by Google, is very effective for looking up the educational information available online. SLS prides itself on providing medical content from varied sources including journals, textbooks, conferences, forums and blogs.

- SLS Guide: Writing Effectively for MIS Journal Publication. This is a concise guide for both experienced writers and novices. It provides an overview of the steps to writing and preparing a submission worthy paper to MIS journals. Useful tips on how to present your information; preparing for writing; types of articles; outlining your paper; reviewing and editing your paper; how to prepare abstracts both structured and unstructured; and helpful references for more in-depth information are also available.

- MIS Discussion Forum. SLS is also starting a discussion page that provides a means of exchanging information and ideas. The current topic of discussion is hernias. Michael S. Kavic, MD, has submitted the article “Tension-free Repair Versus Watchful Waiting for Men with Asymptomatic or Minimally Symptomatic Inguinal Hernias: a Cost-effectiveness Analysis” by Stroupe KT, et al, published in the Journal of the American College of Surgery 2006;203(4):458-468 to stimulate discussion. One can log on, ask questions, provide feedback, and read others’ comments.

Figure 1. The RSS icon.
The 1st edition of Prevention and Management of Laparoendoscopic Surgical Complications—full text and illustrations—is now free online to both members and nonmembers of SLS. The first printing of this classic textbook was a complete sellout and has been translated into Chinese and Portuguese. With RSS feed reader installed on your PDA, cellphone, or computer you can access this textbook anywhere.

Prevention and Management of Laparoendoscopic Surgical Complications, 2nd Edition, which is a completely revised edition with 57 chapters and contributions from over 100 authors, is available for purchase through the website. This textbook is now being used in over 95% of MIS training programs. SLS members receive a discount when they purchase this text.

SLS Annual Meeting and Endo Expo proceedings are available online beginning with the 15th SLS Annual Meeting and Endo Expo 2006 held in Boston, Massachusetts, and will continue with the 16th SLS Annual Meeting and Endo Expo 2007 taking place in San Francisco, California, September 5-8, 2007. Information and proceedings for future meetings, including syllabi, will also be available online.

What more could you want from a society website? Well, there IS more! SLS’ publication Laparoscopy Today now has an online counterpart, LaparoscopyToday.com, with an innovative “category cloud” (Figure 2). The category cloud identifies the hottest topics based on popularity. Site visitors can download all previous issues of Laparoscopy Today which contain membership news, scientific articles, and important information about minimally invasive surgery.

True to its mission of promoting high practice standards through education, training, and distributing information, SLS is providing the most current research findings and educational material to minimally invasive surgeons worldwide through its newly updated Web sites. See for yourself at www.SLS.org and www.LaparoscopyToday.com.

Correspondence: Paul Alan Wetter, MD, 7330 SW 62nd Place, Ste 410, Miami, FL 33143. Telephone: 305 665 9959, Fax: 305 667 4123, E-mail: Paul@SLS.org

Paul Alan Wetter, MD, is Professor Emeritus, University of Miami School of Medicine; Chairman of the Society of Laparoendoscopic Surgeons, which he founded in 1990; Executive Editor of Laparoscopy Today; and Managing Editor of JSLS. He is the first gynecologist to bring endoscopic and microincision techniques for the treatment of tubal pregnancy, appendectomy, uterine fibroids, ovarian problems, and abnormal uterine bleeding to the State of Florida. He is also Florida’s first gynecologic surgeon to perform laparoscopic hysterectomy, laparoscopic appendectomy, and laparoscopic treatments for tubal pregnancy.

Ann Conti Morcos, MA, ELS, has been a medical writer/editor for 20 years. She is a member of the American Medical Writers Association, the Council of Science Editors, and is board certified by the Board of Editors in the Life Sciences. Her work has appeared in ADVANCE for Directors in Rehabilitation, ADVANCE for Nurse Practitioners, Annals of Internal Medicine, ASCO Daily News, Cardiology World News, CBS HealthWatch, Kids Health.org, Boy’s Life Magazine, and others. She is the Copy Editor for JSLS, Journal of the Society of Laparoendoscopic Surgeons and the English-language editor for the Brazilian Archives of Cardiology. She also edits manuscripts for the Heart Institute (InCor) of the University of Sao Paulo Medical School in Sao Paulo, Brazil.

Laparoscopic Approach for Retrieval of Retained Video Capsule Endoscopy. Dominguez EP et al. 2006;10:496-498 • The authors describe a safe laparoscopic retrieval of a capsule endoscopy retained in the terminal ileum secondary to scar tissue.
### EVENTS PRESENTED BY THE SOCIETY OF LAPAROENDOSCOPIC SURGEONS

**SEPTEMBER 2007**


3–7 NESA Days 2007—The Second Annual Scientific Meeting of the New European Surgical Academy. New European Surgical Academy. Istanbul, Turkey

5–7 17th World Congress of IASG. International Association of Surgeons & Gastroenterologists. Bucharest, Romania

5–8 16th SLS Annual Meeting and Endo Expo 2007. Hyatt Regency San Francisco. San Francisco, California, USA

5–8 16th Annual Congress of the ESGE. European Society for Gynaecological Endoscopy. Portorož, Slovenia


6–12 International Pediatric Surgical Week. in Buenos Aires

9–12 II World Congress of the World Federation of Associations of Pediatric Surgeons / VII Congress of the Federation of Pediatric Surgical Associations of the South Cone of America. WOFAPS/CIPESUR. Buenos Aires, Argentina

10–12 Current Techniques in the Treatment of Severe Endometriosis. IRCAD/EITS. Strasbourg, France


21–25 XX Asia & Oceania Congress of Obstetrics & Gynecology. Asia & Oceania Federation of Obstetrics & Gynecology. Tokyo, Japan

24–29 20th Annual Techniques in Advanced Robotic Gynecologic Surgery. Mayo Clinic College of Medicine/Mayo School of Continuing Medical Education. Lahaina, Maui, Hawaii, USA


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**SEPTEMBER 2007**

For more information about these and other upcoming events, visit www.Laparoscopy.org

**OCTOBER 2007**

4–7 Innovations & EBM in Urology. Athens, Greece

7–11 ACS 93rd Clinical Congress. American College of Surgeons. New Orleans, Louisiana, USA

12–17 The ACG Annual Scientific Meeting and Postgraduate Course. American College of Gastroenterology. Philadelphia, Pennsylvania, USA

20–22 APAGE Regional Meeting. Asia-Pacific Association of Gynecologic Endoscopy & Minimally Invasive Therapy. Xian, China

20–Nov 3 25th World Congress of Endourology and SWL. Endourological Society. Cancun, Mexico

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**OCTOBER 2007**

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**NOVEMBER 2007**

8–11 The 2nd Asia Pacific Congress on Controversies in Obstetrics, Gynecology & Infertility (COGI). Comtechmed Medical Conferences. Shanghai, China

15–17 Global Congress of Minimally Invasive Gynecology. AAGL 36th Annual Meeting. AAGL. Washington, DC, USA

17–18 Hand-assisted Laparoscopy–AUA Surgical Learning Center Course. American Urological Association (AUA). Houston, Texas, USA


**DECEMBER 2007**

8–10 9th International Workshop on Therapeutic Endoscopy. European Society of Gastrointestinal Endoscopy/ American Society for Gastrointestinal Endoscopy. Cairo, Egypt

**FEBRUARY 2008**

6–9 AsianAmerican MultiSpecialty Summit III Laparoscopy and Minimally Invasive Surgery. Hilton Hawaiian Village Beach Resort and Spa. Honolulu, Hawaii, USA

17–20 7th Annual Surgery of the Foregut Symposium & Endoscopy/Natural Orifice Surgery Workshop. Cleveland Clinic Florida. Coral Gables, Florida, USA

**FEBRUARY 2008**

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17–20 7th Annual Surgery of the Foregut Symposium & Endoscopy/Natural Orifice Surgery Workshop. Cleveland Clinic Florida. Coral Gables, Florida, USA
**Microline PENTAX** offers laparoscopic reusable instruments. The product portfolio comprises an assortment of disposable and reusable instruments for cutting, dissecting, grasping, cauterizing and ligating all laparoscopic surgical specialties: RenNew reusable handpiece with disposable tips; ML-10 reusable Clip Applier with disposable clip cartridges; and Visu-Loc 5mm disposable Clip Applier. Contact Microline PENTAX, [www.MicrolinePentax.com](http://www.MicrolinePentax.com)

The suction sheath of Pajunk’s suction / irrigation electrode can easily be retracted into the suction / irrigation tube. The tooth ring may be advanced to do this and may also be used to rotate the HF-electrode in all directions. All electrodes have a gold-plated HF-connection integrated into the handle for low transition resistance and to support conductivity. Contact Pajunk, [www.Pajunk.com](http://www.Pajunk.com)

The da Vinci S HD System by Intuitive Surgical virtually extends a surgeon’s eyes and hands into the surgical field for unparalleled visualization with a panoramic 16:9 ratio. The system, powered by state-of-the-art robotic technology with three-dimensional high definition vision allows a surgeon to perform precise surgery in complex procedures with improved clarity and detail of tissue planes and anatomy. Contact Intuitive Surgical, [www.IntuitiveSurgical.com](http://www.IntuitiveSurgical.com)

The 8666 Laparoscopic Transducer developed by B-K Medical is a versatile tool for laparoscopic ultrasound. It has a 4-way flexible head or can be utilized in rigid mode with the new No-Flex attachment, can be coupled with B-K’s integrated biopsy guide, and is compatible with Steris and Sterrad. Contact B-K Medical, [www.BKMed.com](http://www.BKMed.com)

With its LaparoscopyVR Surgical Simulation System, Immersion Medical is striving to perfect the practice of physicians. Designed after review of the Fundamentals of Laparoscopic Surgery endorsed by the Society of American Gastrointestinal Endoscopic Surgeons (SAGES), the LapVR surgical simulator with TouchSense technology includes Essential Skills, Laparoscopic Cholecystectomy, Ob-Gyn procedures and an Administration Module. Contact Immersion Medical, [www.IMMERSIONMEDICAL.com](http://www.IMMERSIONMEDICAL.com)

The GelPort laparoscopic system by Applied Medical combines the technology of the GelSeal cap with the enhanced circumferential retraction of the Alexis O wound retractor. The GelSeal cap enables unlimited hand and instrument exchanges without the loss of pneumoperitoneum, while the Alexis O wound retractor provides 360 degrees of atraumatic retraction and protection. Unique in its design, the GelPort system offers surgeons rapid set up with maximum control and versatility. Contact Applied Medical, [www.APPLIEDMED.COM](http://www.APPLIEDMED.COM)

Novare Surgical Systems’ RealHand instruments are High Dexterity (HD) instruments for minimally invasive surgery. These first full range of motion hand-held laparoscopic instruments mirror the surgeon’s hand movements at the instrument tip. RealHand offers 7 degrees of freedom of movement and tactile feedback to deliver dexterity and control. Contact Novare, [www.NovareSurgical.com](http://www.NovareSurgical.com)
WEBSURG.com has added a brand new section—Robotic Surgery. Approximately a hundred high quality videos optimized for portable media players and handheld devices are also now available for download for $6.95 per video.

SCIRUS.com, the search engine for scientific information only, allows users to search over 415 million science-specific web pages to pinpoint scientific scholarly, technical and medical data. The engine filters out everything but the science; so, when you search for REM, you’ll get articles on sleep not the rock group. Plus, users can select a range of subject areas; specify medium; find info in PDF and postscript files; and narrow searches by date, author, journal, or article. Visit the site to learn about additional features.

GOTBARIATRICJOBS.com Especially for those professionals seeking job placement in the area of bariatric surgery, this is the site of the only recruitment firm nationwide specializing in job placement for bariatric surgeons, nurses, program coordinators and support staff in the surgical weight loss field. Here you can read bariatric news, search job opportunities, submit your resume/CV, and sign up for job alerts.

RELEMED.com, for relevant medicine, was developed by researchers at the University of Virginia School of Medicine to provide medical professionals, researchers, and the general public with a more efficient and targeted way to search PubMed for the latest, most relevant medical literature to answer medical queries—not just the most recently published articles randomly containing the search terms.

LAPAROSCOPYTODAY.com, the online counterpart to Laparoscopy Today, features downloadable PDF and searchable text versions of Laparoscopy Today as well as the latest news from SLS. Use the innovative category cloud, Google powered search engine, or JSLS Journal search to find the information you need.

JOURNAL WATCH: JSLS
Laparoscopy in Transplantation. Krajewski E et al. 2006;10:426-431 • This report reviews the use of laparoscopic intervention in a variety of disease states following solid organ transplantation.

JOURNAL WATCH: Outpatient Surgery
Managing Post-Op Pain in Pediatrics. Stanfield L. June 2007:49-52 • Stanfield points out that most healthcare providers tend to undertreat pediatric patients for pain. Contrary to the simple thought that smaller bodies require smaller amounts of medication, milligram-per-kilogram children actually have higher analgesic requirements due to their speedy metabolisms. The author also discusses the pre-op sedation, pre-medicating to while the patient is still anesthetized, PACU portions, communicating with children and their guardians, and PONV.

JOURNAL WATCH: Obstet Gynecol
The Effect of Acute Sleep Deprivation and Alcohol Consumption on Simulated Laparoscopic Surgery [abstract]. Rotas M et al. 2007;109(4 suppl):9S • Using a laparoscopic simulator, performance of 30 participants was assessed based on tracking, location and coordination, and object positioning in three groups: rested overnight, after alcohol, and after 24-hour call. The authors found that performance after 24-hour call was equivalent or worse after a 24-hour call than after alcohol consumption.

JOURNAL WATCH: JSLS
Minilaparoscopy-Assisted Natural Orifice Surgery. Tsin DA et al. 2007;11:24-29 • The authors conclude that minilaparoscopic-assisted natural orifice surgery may serve as a bridge until natural orifice surgery becomes standard care.
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 Laparoendoscopic Surgical Complications, 2nd Edition comprehensively addresses specific complications of individual procedures as well as general issues and complications that arise in all applications of laparoendoscopic 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 Laparoendoscopic 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.

Order this indispensable reference guide at www.sls.org
ENDO EXPO 2007
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 5, 2007 Registration deadline for $100 SLS member discount
August 3, 2007 Last day to receive discounted room rates at the Hyatt Regency San Francisco

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

READ MORE ON THE FOLLOWING PAGES

CONFERENCE FEATURES
Sept 5, 2007 Six intensive half and full-day Master’s Classes plus the Simulation Laboratory
Sept 6, 2007 SLS Special Evening Event: Food Among the Flowers With Faculty at the Conservatory of Flowers, North America’s oldest existing public conservatory
Sept 6–7, 2007 Over 200 cutting edge scientific presentations including Laparoscopy Updates
Sept 6–7, 2007 Four new Multidisciplinary Plenary Sessions directed by those at the zenith of minimally invasive surgery: Improving Practice Performance and Quality; How to Bring a New Surgical Idea to the Bedside; New Directions in Simulation Training and Credentialing; Next Generation New Technologies for the Laparoendoscopic Surgeon
Sept 7, 2007 Watch the Masters perform surgery—LIVE—during three simultaneous telesurgeries
Sept 8, 2007 Be inspired by a vision of the future at the Breakfast and Future Technology Session directed by the brilliant Richard M. Satava, MD, featuring John Kenagy, MD, presenting Adaptive Innovation; Timothy Broderick, MD, presenting NEEMO Mission; and Joseph Bruner, MD, with the latest in Fetal Surgery
**TUESDAY, SEPTEMBER 4, 2007**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:00 pm – 6:00 pm</td>
<td>MASTER’S CLASSES REGISTRATION</td>
</tr>
</tbody>
</table>

**WEDNESDAY, SEPTEMBER 5, 2007 • Pre-Conference Master’s Classes**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
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</thead>
<tbody>
<tr>
<td>7:00 am – 9:00 am</td>
<td>MASTER’S CLASSES REGISTRATION / Complimentary Coffee &amp; Bakery Items (Master’s Classes Attendees Only)</td>
</tr>
<tr>
<td>9:00 am – 4:30 pm</td>
<td>CONCURRENT MASTER’S CLASSES (See page 25 for course agenda)</td>
</tr>
<tr>
<td>2:30 pm – 3:00 pm</td>
<td>Refreshment Break</td>
</tr>
<tr>
<td>5:00 pm – 6:30 pm</td>
<td>OPENING CEREMONY Presidential Address, Honorary Chair Presentations, and Award Winning Scientific Papers and Videos Presentations</td>
</tr>
<tr>
<td>6:00 pm – 8:30 pm</td>
<td>SPECIAL EVENT: WELCOME RECEPTION / OPENING OF EXHIBITS AND CYBER CAFE</td>
</tr>
</tbody>
</table>

**THURSDAY, SEPTEMBER 6, 2007 • Day 1 Annual Meeting and Endo Expo 2007**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
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</thead>
<tbody>
<tr>
<td>6:30 am – 5:00 pm</td>
<td>CONFERENCE REGISTRATION</td>
</tr>
<tr>
<td>7:00 am – 7:30 am</td>
<td>Complimentary Coffee and Bakery Items</td>
</tr>
<tr>
<td>7:00 am – 2:00 pm</td>
<td>Exhibits open</td>
</tr>
<tr>
<td>7:30 am – 4:30 pm</td>
<td>Poster Townhall</td>
</tr>
<tr>
<td>7:30 am – 8:30 am</td>
<td>General Session: Best of Laparoscopy Updates: Key Laparoscopy Updates highlighting the newest developments and future expectations of surgical and diagnostic procedures.</td>
</tr>
<tr>
<td>8:30 am – 9:30 am</td>
<td>Multidisciplinary Plenary Session (Gynecology, General Surgery, Urology)</td>
</tr>
<tr>
<td>9:30 am – 10:00 am</td>
<td>IMPROVING PRACTICE PERFORMANCE AND QUALITY (See page 27 for description)</td>
</tr>
<tr>
<td>10:00 am – 11:00 am</td>
<td>Multidisciplinary Plenary Session (Gynecology, General Surgery, Urology)</td>
</tr>
<tr>
<td>11:00 am – 12:00 pm</td>
<td>HOW TO BRING A NEW SURGICAL IDEA TO THE BEDSIDE</td>
</tr>
<tr>
<td>12:00 pm – 12:30 pm</td>
<td>Multidisciplinary Plenary Session (Gynecology, General Surgery, Urology)</td>
</tr>
<tr>
<td>12:30 pm – 1:45 pm</td>
<td>NEW DIRECTIONS IN SIMULATION TRAINING AND CREDENTIALING</td>
</tr>
<tr>
<td>1:45 pm – 5:30 pm</td>
<td>CONCURRENT SCIENTIFIC SESSIONS: Over 200 Scientific Presentations (See page 28 for preliminary listing)</td>
</tr>
<tr>
<td>2:00 pm – 4:00 pm</td>
<td>Complimentary Coffee Available in Designated Areas</td>
</tr>
<tr>
<td>6:00 pm – 8:30 pm</td>
<td>SPECIAL EVENT: SLS EVENING WITH FACULTY Food Among the Flowers at the Conservatory of Flowers (See page 30 for more about this special event. Ticket required)</td>
</tr>
</tbody>
</table>

**FRIDAY, SEPTEMBER 7, 2007 • Day 2 Annual Meeting and Endo Expo 2007**

<table>
<thead>
<tr>
<th>Time</th>
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<tr>
<td>6:30 am – 5:00 pm</td>
<td>CONFERENCE REGISTRATION</td>
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<tr>
<td>7:00 am – 7:30 am</td>
<td>Complimentary Coffee and Bakery Items</td>
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<tr>
<td>7:00 am – 2:00 pm</td>
<td>Exhibits Open</td>
</tr>
<tr>
<td>7:30 am – 4:30 pm</td>
<td>Poster Townhall</td>
</tr>
<tr>
<td>7:30 am – 8:30 am</td>
<td>Multidisciplinary Plenary Session (Gynecology, General Surgery, Urology)</td>
</tr>
<tr>
<td>8:30 am – 11:30 am</td>
<td>NEXT GENERATION NEW TECHNOLOGIES FOR THE LAPAROENDOSCOPIC SURGEON</td>
</tr>
<tr>
<td>11:30 am – 12:30 pm</td>
<td>CONCURRENT SCIENTIFIC SESSIONS: Over 200 Scientific Presentations (See page 28 for preliminary listing)</td>
</tr>
<tr>
<td>12:00 pm – 12:45 pm</td>
<td>New Product Presentations by Exhibitors in Exhibit Hall</td>
</tr>
<tr>
<td>12:45 pm – 1:45 pm</td>
<td>BEST POSTER AND RESIDENT AWARD-WINNING PAPER PRESENTATIONS</td>
</tr>
<tr>
<td>1:45 pm – 5:30 pm</td>
<td>CONCURRENT SCIENTIFIC SESSIONS: Over 200 Scientific Presentations (See page 28 for preliminary listing)</td>
</tr>
<tr>
<td>2:00 pm – 4:00 pm</td>
<td>Complimentary Coffee Available in Designated Areas</td>
</tr>
</tbody>
</table>

**SATURDAY, SEPTEMBER 8, 2007 • Day 3 Annual Meeting and Endo Expo 2007**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>7:00 am – 11:15 am</td>
<td>CONFERENCE REGISTRATION</td>
</tr>
<tr>
<td>7:30 am – 9:00 am</td>
<td>SPECIAL EVENT: BREAKFAST WITH KEYNOTE SPEAKER (See page 31 for more about this special event.)</td>
</tr>
<tr>
<td>9:00 am – 10:30 am</td>
<td>Future Technology Session: THE EDGE OF INNOVATION IN SURGERY, SPACE AND BUSINESS</td>
</tr>
<tr>
<td>10:30 am – 10:45 am</td>
<td>Closing Ceremony and Passing of the Presidential Gavel</td>
</tr>
<tr>
<td>10:45 am – 11:15 am</td>
<td>SLS Business Meeting – All SLS Members are Encouraged to Attend</td>
</tr>
<tr>
<td>11:15 am – 3:00 pm</td>
<td>SLS Committees Meetings</td>
</tr>
</tbody>
</table>
#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
Qeena Nazhat, MD
Howard Winfield, MD

AGENDA
- Introduction/Disastrous Case
- Detailed Anatomy of Selected Anatomical Sites Based on Audience Preconference Questionnaire
- Case videos and Discussions
- Selected Video Cases/Disasters/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, Co-Director
Maurice K. Chung, MD
Douglas E. Ott, MD, MBA
Joseph Petelin, MD

AGENDA
- Introduction and SCAR Study
- Why is the Surgical Treatment of Patients with Chronic Abdominal Pain from Intraabdominal Adhesions so Controversial?

#3 Master's Class: Hands-On Course on Laparoscopic Suturing in the "Vertical Zone"

8:00am-4:30pm

FACULTY
Charles H. Koh, MD, Director
Randy Haluck, MD, Co-Director
Jeremy M. Carver, SA
David M. Boruta, II, MD
Keith Issacson, MD

AGENDA
- Introduction, Orientation and Description of Lab Process
- Lecture: Ergonomics, Theory, Construct Validity of the Vertical Zone Technique
- Pretest: Intracorporeal Knot Tying
- LAB 1: Drills, Intracorporeal Suturing with ‘Smiley’ needle technique
- Lecture: Expert Knotting, Continuous Suturing, Cinch Knot
- Applications in surgery including Managing Complications by Suturing
- LAB II: Expert Knotting, Continuous, Cinch Knot
- Posttest: Intracorporeal Knot Tying

SPECIAL EVENT
Friday, Sept. 7, 2007 / 12:45pm-1:45pm
Recipient: Elspeth M. McDougall, MD, presents The Future of Surgery in Education

Established in 1991, the Excel Award has been presented to 22 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 various nationalities.

Elspeth M. McDougall, MD, the 2007 recipient of this prestigious award, is internationally recognized for her laboratory and clinical research in urologic laparoscopic surgery and for teaching courses on fundamental and advanced endourological and laparoscopic techniques. She completed her medical training at the University of California, Irvine, Department of Urology faculty in 2002 to continue her clinical and research work in minimally invasive urologic surgery and assist in the development of a minimally invasive surgery education center. She is a Fellow of the Royal College of Surgeons of Canada (Urology) and certified with the American Board of Urology. Dr McDougall has published more than 132 peer-reviewed journal articles and numerous book chapters. She is the co-editor of two textbooks on laparoscopic surgery.

EXCEL AWARD PRESENTATION AND LECTURE

Dr McDougall was chairperson for the Ad Hoc Surgical Simulation Committee and a member of the Laparoscopic Training Committee of the American Urological Association. She is on the editorial boards of the Journal of Endourology and the Journal of the Society of Laparoendoscopic Surgeons. She is Past President of the Society of Laparoendoscopic Surgeons and is a member of the Surgical Simulation Committee of this society. She is a member of the World Congress of Endourology’s Scientific Meeting Advisory Committee. She was recently elected to the prestigious American Association of Genitourinary Surgeons.

Dr McDougall is Director of the Yamanouchi Center for Urological Education at UIQ and developed the ongoing, five-day mini-residency training program in minimally invasive urologic surgery for post-graduate urologists.

REGISTER AT www.SLS.ORG
Master's Class | Wed, Sept 5, ’07

## Master’s Class

### Hands-On Gynecologic Endoscopic Surgery Jointly with the American Association of Gynecologic Laparoscopists (AAGL)*

8:00am-4:30pm

**FACULTY**

Farr Nezhat, MD, Director
Ceana Nezhat, MD, Co-Director
Andrew Brill, MD
Michael Diamond, MD
Tommaso Falcone, MD
Wm. Leroy Heinrichs, MD, PhD
William E. Kelley, Jr, MD
Timothy B. McKinney, MD, PhD
Harry Reich, MD
Howard Winfield, MD
Robert Zurawin, MD

### AGENDA

- Safe Abdominal Entry Complications and Management
- Laparoscopy and Infertility: Is There Any Role?
- Role of Simulation in Advanced Operative Endoscopy
- Laparoscopy and Gynecological Malignancy: Where We Are and Where We Are Going
- Role of Laparoscopy in Hysterectomy: LAVH, TLH or Supracervical?
- Adhesion Prevention, Current and Upcoming Agents
- Update in Hysterectomy, Ablations and Sterilization Techniques
- How Can We Progress to Perform More and More Minimally Access Surgeries? Are Robots the Answer?
- Update in Energy Sources and Electrosurgery
- Pelvic Reconstructive Surgery and Prolapse: How to Match the Two Correctly
- Evaluation and Management of Bowel Injuries
- New Horizons in Myoma Management
- Urologic Complications and Management
- Hands-On Laboratory: New Instruments

---

**#3–5** Master’s Class Simulation Practice Center

Open 8:00am-4:30pm

**FACULTY**

Jose Benito Abraham, MD
Geoffrey Box, MD
Shoma Datta, MD
Randy Haluck, MD
Rudina Kazarinova, MD
Madeleine Lemuye, MD
Ali Mahdavi, MD
Jaime Ozampo, MD
Naghmeh S. Saberi, MD
Mark L. Smith, MD, PhD
Maria Terry, MD
James Watson, MD

**INVITED SIMULATOR COMPANIES**

- Hapticia
- Immersion Medical
- Surgical Science
- Medical Education Technologies, Inc.
- Mimic Technologies
- National Biocomputation Center – Stanford – SUMMIT
- Simbionix
- Surgical Science
- Varif Technologies

Participants of Master’s Classes #3, #4, #5 and #6 will have the opportunity to practice their laparoscopic skills in the Simulation Laboratory. Time has been allotted in these classes to rotate participants through the Simulation Laboratory to provide hands-on experience with the simulation systems. Participants of Master’s Class #3: Hands-On Course on Laparoscopic Suturing in the “Vertical Zone” will be the first time that the value of a postgraduate course involving laparoscopic skills is measured with detailed objective means.

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**#8** Master’s Class

### In Laparoscopic General Surgery Jointly with the Society of Gastrointestinal Endoscopic Surgeons (SAGES)*

9:00am-4:30pm

**FACULTY**

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

### AGENDA

- NOTES: Progress to Date
- Prosthetics for Hernia Repair—Choosing the Right Material and Techniques
- Endoscopic Treatment for Thyroid Disease
- Hiatal Hernia and GERD Management
- Achalasia—Best Options
- Robotics: What’s Hot, What’s Not
- Bariatric Surgery—Bypass or Band
- Laparoscopic Solid Organ Surgery—New Vistas
- Biliary Tract Surgery—The Tough Issues
- Laparoscopic Cholecystectomy—Part I
- Laparoscopic Cholecystectomy—Part II

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**CONFERENCE EDUCATIONAL METHODS AND OBJECTIVES**

The 16th SLS Annual Meeting and Endo Expo 2007 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 conference contributes to the continuation of excellence in minimally invasive surgery.

Upon completion of the conference, 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.

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 conference contributes to the continuation of excellence in minimally invasive surgery.

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- 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.

The amount of skill improvement experienced by tested participants as a result of this Master’s Class. This will be the first time that the value of a postgraduate course involving laparoscopic skills is measured with detailed objective means.

Certificates of Participation and Certificates of Performance will be given to participants who complete the laboratory exercises.
Improving Practice Performance and Quality

Thursday, September 6, 2007
8:30am-9:30am

Healthcare has seen a growing emphasis on Quality, Safety, and Performance in recent years. There have been efforts by healthcare groups like the AMA and The Institute of Medicine to define quality in health care as, “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes that are consistent with current professional knowledge.” The delivery of high quality care has been centered on health outcomes and the expectations of patients and other customers of healthcare.

Quality, Safety and Performance are an integral part of the new culture of healthcare. Traditionally the blame has been placed on the individual for the lack of quality and safety that cause errors. The new culture of safety analyzes systems that are conducive to poor quality; system failures are identified as opportunities to improve safety and quality.

Pay for Performance systems link compensation to measures of work quality or goals. At the present time, Medicare pays providers for services delivered, regardless of the quality of care. Medicare has various Pay for Performance ("P4P") initiatives in offices, clinics and hospitals, seeking to improve quality and avoid unnecessary health care costs. The Centers for Medicare and Medicaid Services (CMS) have several demonstration projects underway offering compensation for improvements.

There is no question that Pay for Performance is here to stay. At the present time the government, health insurance companies and other private organizations are actively developing Pay for Performance models. It is important for surgeons to learn and understand this system and its possible impact on their practices.

The new changes in healthcare have created financial pressures on hospitals. Previously lucrative surgical services are now facing financial challenges. The costs of materials and services continue to increase while the reimbursement for services has remained the same or in many cases has decreased. Many institutions have resorted to increasing their volume of patients, while others have tried to increase the number of lucrative cases. The institutions that have survived have implemented effective changes through improved processes to increase their efficiency and lower their costs.

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

FACULTY AND PRESENTATIONS
Camran Nezhat, MD, Director
Thomas Fogarty, MD: Bringing Your Surgical Idea to Reality – What Gets in the Way?
Mike Henson: Invention to Commercialization... and Beyond
John Savarese, MD: How to Bring a New Surgical Idea to the Bedside

New Directions in Simulation Training and Credentialing

Thursday, September 6, 2007
11:00am-12:00pm

The American College of Surgeons (ACS) has taken a bold new step in surgical education by agreeing to become a certifying body for new training centers, referred to as ACS Accredited Educational Institutes. This new model will help to ensure the quality of education as well as help to standardize training methodologies, which should serve as an inspiration for other major societies (such as Urology, OB/Gyn, Cardiothoracic, etc.) to follow. This session will summarize the role of the centers, the application process (and the dos and don'ts of applying) and the new consortium of training centers which will begin the process of standardization of training.

FACULTY AND PRESENTATIONS
Harrith M. Hasson, MD, Director
Richard M. Satava, MD, Co-Director
Ajit Sachdeva, MD: The ACS Accredited Educational Institutions—The Beginning of the Revolution of Certification of Training Centers
Mika Sinanan, MD: Applying for Certification—Do's and Don'ts
Richard M. Satava, MD: The Consortium of ACS Accredited Educational Institutes—One Solution to Standardization
Virtual Reality Laparoscopic Simulator with Tactile Feedback: Does It Improve Performance?, Dan Eisenberg MD
Laparoscopic Repair of Recurrent Incisional Hernia in Cardio-Transplant Patients, Dan Eisenberg MD
Thymoma: Minimally Invasive Transsthoracic Approach, Brian C. Fallon MD
Laparoscopic Colon Surgery: The New Gold Standard, Michael E. Rognilo MD
An Uncommon Situation of Massive Haematomenes—A Really Strange Situation, José M.M. Ferreira-Coelho Prof Dr Med
Percutaneous Computer Tomography-Guided Radio Frequency Ablation of Liver Tumors: Case Report and Review of the Literature, Jacques P. Fontaine MD
The Fixation of Hotul Meshes with Rfbir Sealant in an Experimental Model in Pigs, Pene H. Fontaivey MD
Laparoscopic-Assisted Colonic Polyectomy: Long Term Results, Morris E. Franklin MD
The Use of Small Porcine Bovell Submucoosa Mesh in the Treatment of Gastroesophageal Reflux: Long Term Results at the Texas Endosurgery Institute, Morris E. Franklin MD
Laparoscopic Biliary Bypass Procedures: Review of the First 14 Years, Morris E. Franklin MD
Olipless Laparoscopic Cholecystectomy, Roberta Giminini MD
Robotic Nissen Fundoplication: An Excellent Training Procedure, Monika Hagen MD MBA
Impressions of Inexperienced Individuals and Laparoscopic Surgeons in Their First Use of the da Vinci Surgical System, Monika Hagen MD MBA
Robotic Swenson Pull-Through for Hirschsprung’s Disease in Infants, Andre Hebra MD
Applying Ultrasonic Long Sourns Reduces Operation Time in Transection Endoscopic Microsurgery, Pleun EA Hermens MD
Robot Assisted Laparoscopic Distal Gastricomy with D2 Lymph Node Dissection, Woon Jin Hyung MD PhD
The Effects of Different Surgical Approaches on Systemic Inflammatory Response After Gastrectomy, Woon Jin Hyung MD PhD
Unusual Mechanisms of Failure After Antireflux Surgery: Report of Two Cases, Atif Iqbal MD
Development of Breast Ductoscopy and its Future Perspective, Voker H. Jacoby MD PhD
Laparoscopic Spleen Sparring Distal Pancreatectomy, Uthaih P. Koksalova MD
Jejunocolonicstrictures with Gastric Remnant Perforation After Laparoscopic Roux-en-Y Gastric Bypass, John S. Koppman MD
Anastomotic Leses Following Laparoscopic Gastric Bypass, John S. Koppman MD
Laparoscopic Gastric Bypass for Mobility Obesity: Prospective Study with Two Gastric-Jejunum Anastomosis Techniques, Jose L. Leyba MD
Early Experiences with Laparoscopic-Assisted Colectomy for Colon Cancer, Richard C. Liu MD
Bowel Injuries During Laparoscopic Surgery: Benenden Experience, Kiran M. Lodha MD
Our Experience in Laparoscopic Ventral and incisional Hernia Repair, Marco Lombardi Prof Dr Med
Sentinel Node Biopsy (SNB) and Extracapsular Extension of the Surgical Treatment of Breast Cancer, Sinisa Maksimovic MD PhD
Laparoscopic Cholecystectomy: Our Experiences After 2000 Patients, Sinisa Maksimovic MD PhD
Laparoscopic vs. Open Colectomy for Non-Metastatic Colorectal Cancer: A Prospective Study of Long Term Survival, Muhammad S. Mirza MD
Robotic-Assisted Colorectal Surgery: Initial Experience, Philippe Moret Prof Dr Med
Harmomic Scalpel Use in Thorascopy and Pulmonary Resection, John Morrison MD
Building a Laparoscopic Colorectal Mentoring Program at a Community Hospital: A 5-Year Experience, Prashant S. Navaran MD
Technique for the Salvage of Infected Mesh Prosthesis without Re-Operation or Mesh Removal: A Case Report, Prashant S. Navaran MD
Total Laparoscopic Esophage-Gastrectomy, Salvador A. Navarete MD
Validation of the Magnetic Resonance Cholangiography (MRC) Before the Videolaparoscoholecystectomy (VLC) in the Patients with Mild Acute Biliary Pancreatitis, Vincenzo Neri MD
Laparoscopic Total Colectomy and ileorectal Anastomosis for Colon Cancer, Joseph W. Nuno-Mensah MD
Laparoscopic Repair of Spiegel’s Hernia, Francisco A. Obregon MD
All Laparoscopic Grasper are Known Crushing Systems: Is This a Product Design Defect and Product Liability?, Douglas E. Or MD MBA
Laparoscopic Adrenalectomy Via Lateral Transperitoneal Approach (1997-2006), Maciej Otto Prof Dr Med
A Novel Technique for Radio Frequency Ablation of Hepatic Dome Neoplasms Using Iothragen Hydrothorax, Francesco Palazzo MD
Laparoscopic Resection of Ovar-Web-Pendu Lesion, John Park MD
The Beginning Experiences in Treatment of Ventral Hernias with Composite Mesh, Veroljub Pejic MD
Therapeutic Evaluation of Laparoscopic Hemiplasty for Inguinal Hernia in Elderly Male, Harajg Peng MD
Rfbir Sealant for Fixation of IPTF Meshes in Experimental IPFO Repair—Impact on Adhesion Formation and Reduction of Perforating Rolution Devices, Alexander H. Pettet-Pucher MD
The Assessment of the Quality of Life in Laparoscopic Hernia Repair—Suggestions for the Development of Standards Within the SLS, Alexander H. Pettet-Pucher MD
Mihiaplasty for GERD Treatment, Juan G. Quiróz MD
Laparoscopic Splenectomy Following Embolization for Blunt Trauma, Kenneth-Joe Ransom MD
Transaxillary Endoscopic Paraachydoctomy: Our Initial Series, Qammar N. Reeshid MD
Near Total Thyroidectomy Using a Transaxillary Endoscopic Approach, Qammar N. Reeshid MD
Metastasis of Recurrence After Laparoscopic Repair of Paraesophageal Hernia, Munir A. Retnow PRS
A Novel Technique in Diagnosing a Leak in the Lap Band System, Kurt E. Roberts MD
The Effect of Videogame “Warm-up” on Performance of Laparoscopic Surgery Tasks, James C. Rosser, Jr., MD
Ureteral Clipping During Laparoscopic Donor Nephrectomy Improves Operative Field Visibility and Does Not Affect Recipient Outcome, Karen S. Sajadi MD
Laparoscopic Surgery for Colorectal Carcinoma: Costs and Benefits in the Europe Region, Lukas Silava MD PhD
Early Post-Operative Results Comparing Restrictive Procedures in the Massively Super Obese, David L. Schumacher MD
Minimally Invasive Repair of Congential Diaphragmatic Hernias: A Review of Our Experience, Soheil R. Shah MD
Laparoscopic vs. Laparotomy Approach for Colorectal Carcinoma, Jiri Siller MD, PhD
Laparoscopic Adrenalectomy: Transperitoneal or Retroperitoneal Approach, Gintaras Simutis MD PhD
Laparoscopic Transabdominal Hernia Repair for Incarcerated Gruin Hernias, Ul Seiravari Dr Med
Laparoscopic Hernia Repair, Martin Sausewind MD
A Laparoscopic Approach to the Surgical Management of Gastrointestinal Trata: Follow-up, Vincenzo Tosto MD
Unusual Delayed Complication Following Laparoscopic Adjustable Gastric Banding, Michael B. Tempel MD
Laparoscopic Hernia Repair: A Two Port Technique, Katarina Theodoropoulou MD
Major Bile Duct Injuries After Laparoscopic Cholecystectomy: Factors That Influence the Results of Treatment, Konstantinos George Tsilis Prof Dr Med
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