Sushrutavani

Adichunchanagiri Institute Of Medical Sciences
B G Nagara - 571448

2016

Department Of Surgery

From the HOD's desk ***Dr Shivakumar M***

My greetings to my colleagues and students.

With the divine blessings of Sri Sri Sri Dr Balagangadharanatha Mahaswamiji, Paramapujya Jagadguru Sri Sri Sri Nirmalanandanatha Mahaswamiji we are bringing out the first issue of newsletter of Department of Surgery "**Sushruthavani**" for the year 2016.

All of us, Surgeons seek to offer the best standard of care to our patients. As Surgeons, it is, imperative that we keep abreast of the constantly evolving changes in our specialty. Researching, critically analyzing and applying the current best evidence into the care patients is what evidence-based medicine is about.

I thank our principal Dr M G Shivaramu for his constant encouragement and support and our medical superintendent Dr T M Manohar who is a constant source of inspiration for all of us. Our motto as a faculty of a surgery is to train our postgraduates and send them as surgeons with a safe knife.
We are the team of 5 Professors, 2 Associate Professors, 6Assistant Professors and 12 Postgraduates with 3 Plastic surgeons, 3 Urologists and 1 Pediatric Surgeon running the show managing all the seven days out patient, 24x7 emergencies and trauma care, 5 units and 5 General surgery OT, 3 plastic surgery and 3 urology OT in a week.
I take this opportunity to thank the ancillary departments, Department of Anesthesia and Radiology without whose support it would not have been possible to run the show.

MOST COMMON CASE BUT IT'S RARE COMPLICATION AND OUR INNOVATIVE MANAGEMENT: Scrotal Enterocutaneous Fistula In Inguinal Hernia

Dr.Shivakumar M , Dr Thulasi Vasudevaiah, Dr Partha Pratim Bora,Dr Prashanth N Hudge

Introduction: Delayed presentation of inguinal hernia results in strangulation, incarceration, obstruction, and rarely fistula. In developing countries with limited resources, ignorance, financial constraints and lack of specialist medical knowledge, such complications associated with hernias are quite common and leads to increased morbidity and mortality. We report a case of scrotal enterocutaneous fistula, a rare complication of incarcerated inguinal hernia due to late presentation, neglect and lack of proper management.

Case report:

A 68 yrs old patient presented with inguino-scrotal swelling was initially reducible, but for the month before presentation it had been irreducible. A week prior to presentation, the patient developed abdominal pain and constipation for which he used self-medication. He then noticed sloughing of the skin on the right side of scrotum and faeco-purulent discharge from the wound. On examination, his right groin had a visible inguino scrotal swelling with tenderness and his right scrotum had a wound with faecal discharge.

Emergency exploratory laparotomy was performed. A Richter hernia of ileal loop with a 1 × 1 cm perforation about 60 cm from the ileocaecal junction was noted. There was no peritoneal contamination. Perforation was closed with primarily and re-enforced with tunica vaginalis patch. As the site of hernia was found to be faecally contaminated; a mesh repair would have been at high risk of infection. Therefore, Desarda repair technique was done. The scrotal wound was debrided and orchidectomy done. Daily dressing was done. After 48 h, the patient was started on oral feeds, which were well tolerated.

CONCLUSION:

Spontaneous faecal fistula in scortal region following rupture of strangulated Richter's hernia especially in adults is very rare and can occur even in absence of obstructive symptoms. In presentation of any groin swelling, there is need for an early accurate diagnosis followed by prompt treatment. The delay in its diagnosis and management may result in this rare complication of spontaneous faecal fistula. As our management first of its kind where perforation was re-inforced with tunica vaginalis patch and with a desarda repair of repair.

TICKING ABDOMINAL BOMB: PRIMARY VOLVULUS OF THE SMALL INTESTINE.

Dr.Shivakumar M, Dr Thulasi Vasudevaiah, Dr Ponnappa, Dr partha

Small bowel volvulus is an uncommon but important cause of small intestinal obstruction. It often results in ischemia or even infarction. Delay in diagnosis and surgical intervention increases morbidity and mortality rates. Based on cause, small bowel volvulus can be divided into primary and secondary type. There is no single specific diagnostic clinical sign or abnormality in laboratory or radiologic finding. In practice, the diagnosis can only be made by laparotomy. The failure to perform an exploratory laparotomy cannot be justified. Early diagnosis and early surgery are the keys for successful management of strangulation obstruction of the small bowel.

Case report:

35 years of old male patient comes with history of acute pain abdomen with vomiting showed distension with fever since 2 days. On examination tachycardia and febrile, per-abdomen examination showed distention with guarding and rigidity with absent bowel sounds, on Per-Rectal examination empty rectum. Haematalogical investigation showed elevated total leucocytes count with elevated bilirubin level. On Ultrasound Abdomen coffee bean sign s/o volvulus with sign of strangulation. On emergency laparotomy was done and showed ileal volvulus was found with gangrene of ileal volvulated segement due to distal band at terminal ileum. Resection of gangrene segment with anastamosis of small bowel was done. Patient post-operative period was uneventful.

In conclusion:

This is rare but serious complication resulting in a small bowel obstruction which required prompt surgical intervention. A high level of clinical awareness can ensure low mortality rates. Particularly for general surgeons, small bowel volvulus should always be in differential diagnosis in the patients with a history of previous surgery involving especially intestines. In our case as patient has no previous history of surgery, has no clear predisposing factors and no specific signs and symptoms, nor clear diagnostic imaging or laboratory parameters. • Diagnosis is that of exclusion of the common causes of acute abdomen in the particular environment. Surgeons should always consider it in patients with features of acute abdominal pain due to upper intestinal obstruction and advice immediate laparotomy, the length of time between reporting of the symptoms and timing of operation is important.

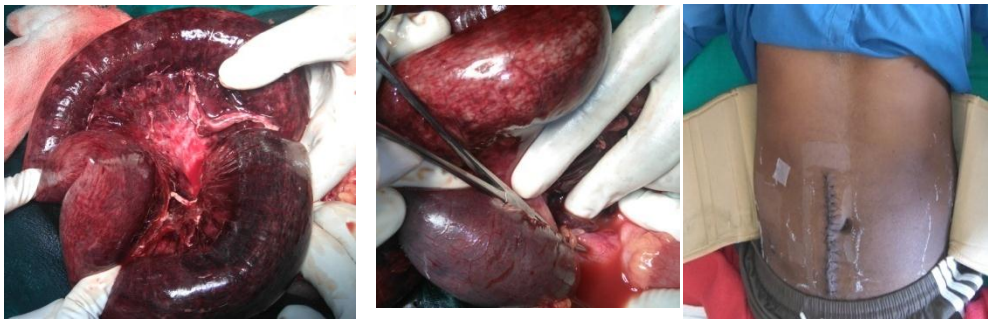


Figure: showing ileal volvulus and post-operative wound.

UNINVITED GUEST IN A LANDZERT MANSION: A Rare Case Landzert's Hernia (Internal Hernia)

Dr Geeta Avadhani, Dr Arun Kumar Shirshetty Dr Subba Rao

A 39 years old male patient presented to emergency department with a history of pain abdomen, acute in onset, located in left lateral region of the abdomen and also had history of vomiting two episodes, the vomitus contained food particles only. On examination vitals were normal, per abdomen examination revealed no significant abnormality except for mild tenderness in the left lumbar area. Elective laparotomy and proceed was planned. Per operative finding was a crowded bowel loops in left paraduodenal area through an abnormal defect in the mesentery and the entry point of the sac had mesenteric vessels. Post operatively patient recovered well and was discharged on post-op day 10.

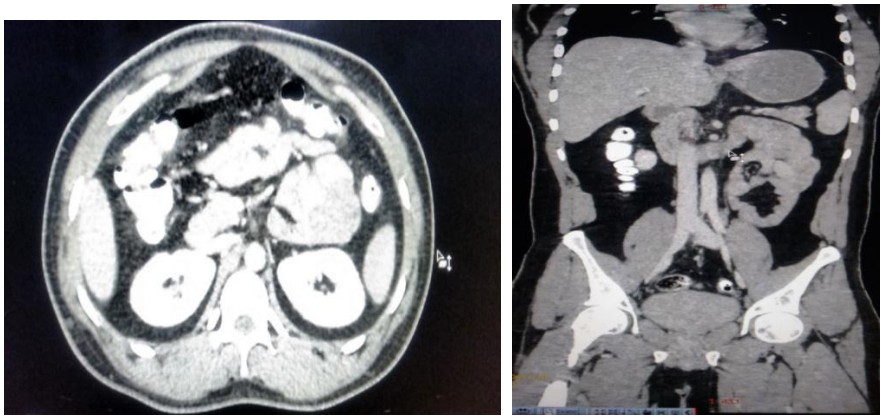
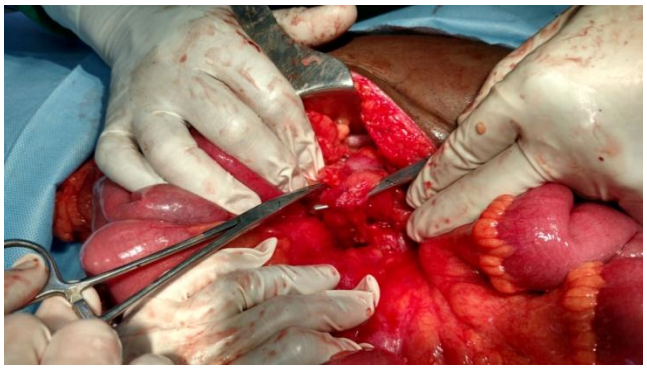


Fig.1: Computed tomographic scan showing incarcerated loops of small bowel in the left paraduodenal area. And enhanced Computed Tomographic picture demonstrates a cluster of small



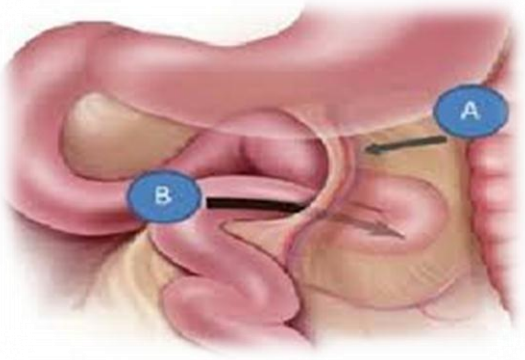


Fig.3: Hernial orifice seen intra operatively.

Paraduodenal hernias are the most common type of internal hernias. Left paraduodenal hernia is a rare congenital anomaly arising from an error of rotation of the midgut. They can be asymptomatic, can cause abdominal pain or may present with acute intestinal obstruction. .CECT scan is the most specific imaging technique to come to a diagnosis preoperatively. It is important to consider the diagnosis of internal hernias in the differential diagnosis for a young patient with recurrent small bowel obstruction with no past history of any surgical intervention. Future complications can be prevented by timely surgical intervention.

LAPAROSCOPY ASSISTED ORCHIDOPEXY FOR UNDESCENDED TESTIS: PROCEDURE DONE AT OUR HOSPITAL: BETTER OR BITTER?

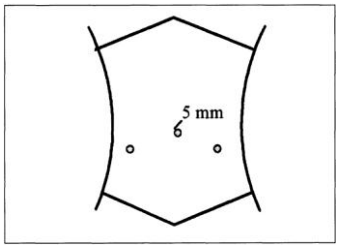
Dr Abinash Hazarika, Dr Karan

The management of impalpable testis remains controversial. Localization of the site of the impalpable testes helps the surgeon plan the operation most suited for each patient. Ultrasonography, computed tomography, testicular angiography and magnetic resonance imaging (MRI) have all been used with varying success for this purpose. This is usually followed by surgical exploration through either an inguinal or an abdominal approach. The aim is to relocate or remove the testis.

Laparoscopic procedure: Accessory ports, each 5 mm in diameter, were inserted in both the right and left upper quadrants. A 10 mm port was used to close a patent processus. vaginalis if this was present. The Gubernaculum was identified, divided and used for traction on the testis.

The spermatic cord was carefully mobilized. Through a small scrotal incision, a curved hemostat was guided into the peritoneal cavity medial to the inferior epigastric vessels. The gubernaculum was grasped and pulled through the "new" inguinal ring into the scrotum. The testis was placed in a subcutaneous pouch taking care to avoid twisting the spermatic cord. small inguinal incision was done to complete the procedure. Wounds were closed by subcuticular 4/0 absorbable sutures.

OUR VERDICT IT'S BETTER: Laparoscopy for the impalpable undescended testis offers a simultaneous diagnostic and therapeutic tool. It obviates the need for invasive and/or expensive diagnostic imaging and saves the patient an extensive surgical procedure with equally good results. It is particularly valuable in bilateral cases. We recommend laparoscopic orchidopexy as the treatment of choice for the impalpable undescended testis.



Sites of ports.

MIRIZZI SYNDROME-RARE CAUSE OF MAJOR BILIARY COMPLICATIONS: CASE REPORT

Dr Abinash Hazarika, Dr.Chandan.K.R, Dr K Santhosh Kumar,

INTRODUCTION

Impaction of unique large or multiple small gallstones between neck of gallbladder and confluence of cystic duct and common hepatic duct results pathologic changes in normal bile flow and local and systematic complications. The process of inflammation, wall ischemia and external compression lead to erosion of the involved tissues and duct structure of common hepatic duct or cholecystocholedochal fistula formation. Despite modern advances in imaging diagnoses, Mirizzi syndrome presents challenge surgery treatment situation caused by presentation of rare anatomical variation of cystic duct and total change of normal anatomy

after long standing inflammation. Good surgical knowledge for diagnosis and reconstruction is needed.

Case report:

50yr old male patient presented with jaundice fever, upper right abdominal pain, predominantly in right sub costal region, nausea and vomiting for last 24 hours.

Abdominal US reveal a 17 mm stone incorporated in Harmann's pouch, pericholecystitis.

Intra-operativelly there was a inflamed gallbladder, pericholecystitis, intensive fibrosis and edematous of hepatoduodenal ligament. After bimanual palpation, stone was found in neck of gallbladder. . Antegrade mobilization of gallbladder helped to find impacted stone and mobilized the cystic duct to CHD. No fistula or bile leaks were discovered. Proximally to inflamed part of CHD was placed T-drain, with Long Branch to be "stent" and prevent structure and decompress biliary tree. Follow-up and control cholangiography confirmed complete recovery.

Conclusion:

Mirizzi syndrome is rare pathological condition that cannot diagnose during physical examination. It requires imaging study. Management is to determine the type and best surgical procedure at time of laparotomy. In Type I case, simple cholecystectomy is method of choice. If CHD wall inflammatory changes are found, T-tube placement is recommended to avoid disruption, leaks and stricture. Type II-IV patients require complex management. Total isolation of inflamed segment with Roux-en-Y hepaticojejunostomy may have the best long-term outcome.

TODAY'S NEW SURGEONS: Are You Prepared Beyond Gadgets, Cameras and Robots? -SKEPTICAL SCALPEL

By Dr.Shivakumar M, HOD, Dept of surgery

"I know whom I'd call if I ever needed a surgeon," a friend said to me after watching the surgeon breeze through what we thought would be a particularly challenging case.

One day I finally gathered the courage to ask my mentor, great surgeon and my teacher for his "secret." I half-expected him to laugh at my question or decline to respond because the real answer was that he was simply born with such gifts, like an Olympic-level athlete or Sachin Tendulkar of surgical field

Instead, he answered without hesitation. "It's doing the operations over and over and over again," he said. He described the hundreds of operations he had participated in during his residency and the final years of training when he felt as if he were "living, breathing and eating surgery. I could have done these operations with my eyes closed," he said grinning.

I thought of his words often over the next few years as I tried to hone my own surgical skills.

Today's residency programme limited all in-hospital work including any elective "moonlighting" jobs to 80 hours per week, mandated the number of hours "free of duty" after different "duty periods" and even specified the timing of "strategic napping" in no uncertain terms

With limits set on their time at the hospital, young surgeons-in-training had fewer opportunities to care for patients or scrub in on operations. While previous generations of trainees had the luxury of participating in at least one operation a day, new trainees had only enough time to be involved in two or maybe three operations each week.

Adding to the challenge, surgery itself was changing, and the number of skills that surgeons now needed to acquire was expanding as never before. The discovery of new medications like anti-ulcer agents rendered once standard operations less common, but not entirely obsolete; so surgeons still had to know how to perform all the operations without getting to practice them as often. Huge advances in minimally invasive and robotic surgery allowed surgeons to remove inflamed gallbladders and deadly tumors with fiber optic telescopes, miniature pliers and robotic tools through incisions small enough to be covered afterward with Band-aids. But they still needed to know how to wield the scalpel and operate the "old way" in case of complications.

"It's hard to compensate for real-world experiences," When you take a whole year's worth of in-hospital experiences out of training, you can't be surprised that the 'product' is not the same,"

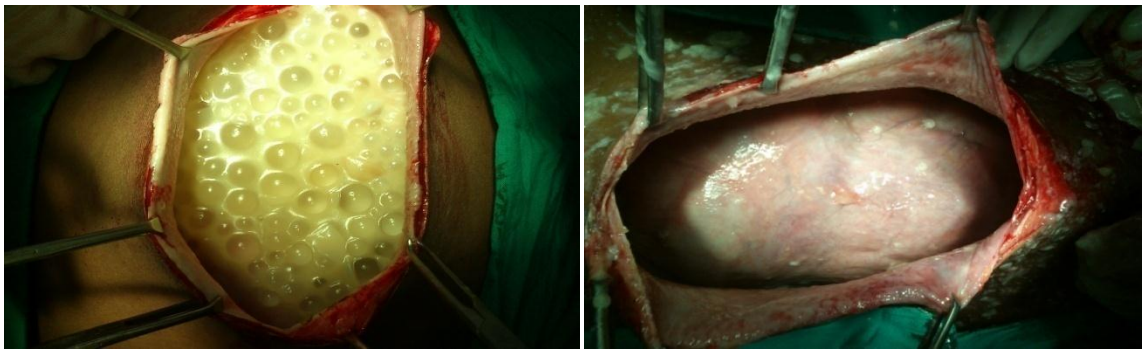
"Things needed to change, "but not recognizing the potential long-term effects was dangerous. Even issues that seem completely obvious and one-sided can sometimes have significant consequences."

Will the next generation of surgeons be able to embrace fully the promise of old traditional evidence based surgery?? The debate continues over whether surgical training is in need of reform or revolution. Restoring the confidence of patients, surgeons, and trainees in the excellence of our education system is of utmost importance.

SURGIQUIZ: Can you guess?

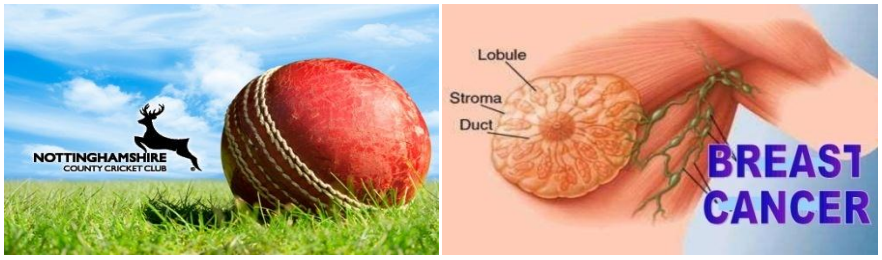
For your answers contact DR.PONNNAPPA Assistant Professor of surgery and get your prize?

1) *Guess this: it's a gift of dog?*

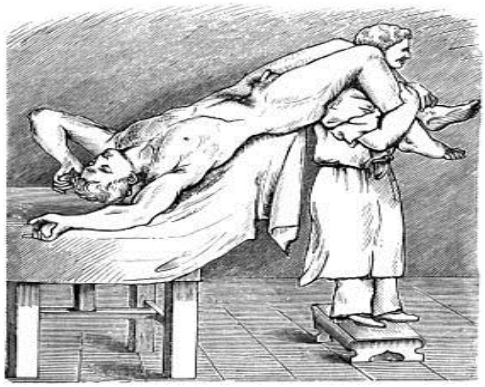


2) *It will comes out once before life and usually goes back before birth?*
   - *What is it?*

3) *Can you relate these two pictures?*

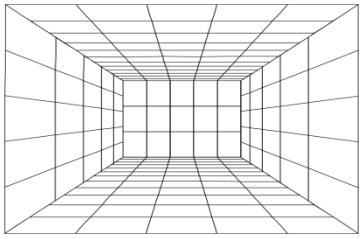


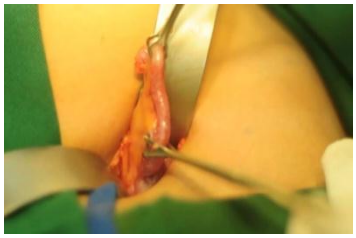
4) *Can you guess this surgeon?*



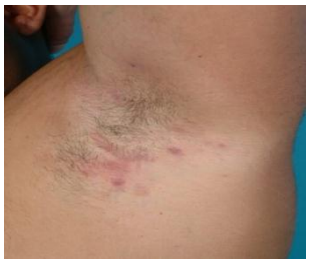
5) *Can you guess the human organ?*

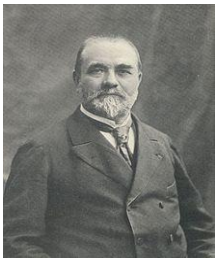
6) *Guess the incision?*





7) *Can you diagnose the cancer?*





8) *Can you guess the sign and diagnoses?*


9) *Guess this triad?*



EVENTS IN DEPARTMENT:

- Dr. Shivakumar.M was felicitated in JSS medical college, Mysore by 1991-92 batch reunion occasions as "BEST TEACHER"

- Dr.Shivakumar M chaired a session in conference held in Hassan Medical College, 27th April, 2016.
- Dr.Shivakumar M – chaired a session in state conference 13th February , KSCASICON 2016 Shivamogga Institute of Medical Sciences, Shivamogga