CONFERENCE REPORT

First Annual Conference of the Indian Association of Surgical Gastroenterology, Hyderabad, August 10 to 12, 1990

Hyderabad was the venue of the first conference of the Indian Association of Surgical Gastroenterology (the most recent section of the Association of Surgeons of India), formed in 1988 amidst loud and strong protests from the ranks of general surgeons. While the membership of the Section is only 250, the conference registered more than 600 delegates; I am sure a large number of surgeons came to attend the Diagnostic and Therapeutic Endoscopy Workshops organized simultaneously (medical gastroenterologists, beware, lest your scope be snatched).

The Continuing Medical Education (CME) programme covered broad areas in Surgical Gastroenterology. It got delayed by more than one hour because of the inaugural function. Can’t we do away with these inaugurations which are only meant to “please and honour” people? Dr Ravi Chandran, a young surgeon from Hyderabad, who had worked at Hammersmith Hospital, London, gave a clear and concise talk (a rare commodity in conferences) on liver transplant. Extrahepatic biliary atresia (where long-term successful results with Kasai’s portoenterostomy are only 30–35%), Budd-Chiari syndrome and hepatitis B virus disease (2 and 5 years survival with transplant being 50% and 20% respectively) are newer indications. Auto-transfusion and venovenous bypass reduce blood requirements which average 5–10 units, though an occasional patient may require many more units, making a rapid infuser essential. He also mentioned the viability of organs harvested from the same donor, cluster transplantation in one recipient use of one liver in two children, segmental transplantation and mother to child (left lobe) transplant.

The myth of flatulent dyspepsia being a symptom of gallsone disease must be done away with. There were divergent views about treatment of asymptomatic gallstones—while some felt such gall bladders should be removed in diabetes only, others suggested that all non-functioning gall bladders detected by oral cholecystography should be removed. Is there a role for prophylactic cholecystectomy in an area like North India where cancer of the gall bladder is “endemic”? An interesting statement was made (off the cuff, I suppose) that 20% of asymptomatic stones found incidentally at laparotomy become symptomatic within 2 years as opposed to only 2% of those found during investigations (this may mean that laparotomy for some other disease alters the natural history of asymptomatic stones).

Acalculous cholecystitis is important to recognize as it occurs more commonly in the elderly and critically ill patients and has a higher complication rate. Ultrasound scan is preferred to ultrasound for diagnosing acute cholecystitis—calculus or acalculous. While non-surgical measures (endoscopic papillotomy, basketing and nasobiliary drainage) have a role to play in the treatment of cholangitis and CBD stones in poor risk patients, it should be used with caution in the young as its long-term effects are not as yet known. Extracorporeal shock wave lithotripsy (ESWL) for gall stones is probably a mirage. In a series of 322 patients with gallstone disease, 22 were identified as suitable for ESWL—after excluding those who did not agree, dropped out or had complications, very few completed the treatment and only one dissolved. A surgeon from Bangkok presented his experience with ESWL in 20 selected patients with gallstones—only 4 had their stones dissolved; one patient at surgery was found to have a distended gall bladder filled with 150 ml blood.

Peroperative cholangiography (POC) was started in the US to protect surgeons against legal action for missing CBD stones; but routine POC started giving false positive results and resulted in negative CBD explorations. In patients with bilioenteric fistulae after cholecystectomy there is no need to rush in for surgery; the fistula may close and it does not have to be closed. Therefore, there should be a period of about 6 weeks between the injury and the attempt at repair or reconstruction. No stent need be used if an adequate anastomosis is obtained as is usually the case if the left hepatic duct is used.

In patients with cirrhosis secondary to biliary structure, the portal hypertension should be corrected first, although the GB Pant Hospital, Delhi group felt that this is not essential as this is not cirrhosis but merely fibrosis which is reversible. However, a warning that atrophy of one lobe of liver and hypertrophy of the other together result in rotation of the liver and alter the anatomical disposition of the ducts and veins in the porta.

In an interesting talk on complicated problems in biliary surgery, delivered without slides, Dr V N Srikanth (in champion) advocated operating on clinical suspicion alone even though the investigations are inconclusive. He advocated a fundus first approach (known to unknown) for all cholecystectomies to avoid biliary tree injuries.

In a talk on Imaging in Gastroenterology a gastric ulcer or cancer was shown to be visualized on plain X-ray though I am sure a plain X-ray cannot be recommended for these conditions based on such anecdotal findings. In a talk on abdominal tuberculosis one would like the speakers to discuss how far to go to diagnose, the role of therapeutic trial and the role of antitubercular chemotherapy in radiologically demonstrated ileal strictures; but these very issues were scrupulously avoided.

The symposium on portal hypertension was better organised and conducted and most speakers did justice to their topics. While preprogrammed has an established role in prophylaxis, prophylactic endoscopic sclerotherapy (EST) remains controversial. EST should be the primary modality of treatment for acute bleeding varices; in patients who continue to bleed despite non-operative measures (EST and Sengstaken tube), stapler transaction of the esophagus is to be preferred. Attempts should not be made to increase hemoglobin beyond 70%, as it may induce bleeding. Cardiac output is invariably high in cirrhosis, warranting intensive
monitoring preferably with pulmonary artery wedge pressure recording. Child's status of a patient is not static and can be improved to have better results. For elective surgery in patients with non-shuntable veins, a limited Sugiura procedure with a feeding jejunostomy to take care of esophageal leak, which is not uncommon after esophageal transection in patients who have been on EST, was advocated. All non selective shunts (portacaval, lienorenal and mesocaval) become total shunts sooner or later and should not be expected to maintain any portal hepatic circulation. Recently, good results have been shown with the use of an 8 mm PTFE portacaval shunt. Warren's distal splenorenal shunt is a selective shunt and maintains the portal hepatic circulation but should not be used in patients with retrograde flow (clamp the portal vein—if the proximal pressure is higher than distal, there is retrograde flow).

The Professors could not be met as the CME programme on the first day continued till after 8.00 p.m, and on the second day most of the Professors had disappeared to dress for the banquet. Thus, both the Meet the Professor programmes were cancelled, as were many other scheduled talks/lectures, the CME open house session and even the valedictory function.

In the symposium on peptic ulcer, the use of colloidal bismuth or tinidazole in patients who have Helicobacter pylori to decrease relapses was emphasised; a commentator asked if repeated endoscopies especially using the same scope in a busy clinic are responsible for the spread of the organism. The role of omeprazole in refractory ulcer, and in those with esophagitis and Zollinger-Ellison syndrome, was highlighted. One of the senior surgeons was honest to admit (a rare one indeed) that he once perforated the duodenum while dilating a stented pylorus with the finger in association with highly selective vagotomy.

About 50 short papers from almost all parts of the country were presented in concurrent sessions; the host city contributed 15, justifying its claim to hold the inaugural conference of the Association. Surgeons seem to thrive on their colleagues' misadventures—there were many series of post-cholecytectomy strictures. Most papers were retrospective data analyses; more than a score were interesting case reports or surgical techniques which could best be presented as posters. Posters, unfortunately, continue to be considered as second-rate presentation despite many points in their favour.

The Vindhyas not only separate the North Indian culture and languages from those of the South but also seem to delineate the mainly Government based and small state private medical centres of the North versus the highly equipped and sophisticated private medical care set-ups in the South.

For a change, and a change for the better, while the scientific content was better than usual (though still not good), many grievances could be heard about organisation and arrangements—the reverse of what is usual in our conferences.

Sidelights

“How long do you give cyclosporin (after liver transplant)?” “Life long.” “Oh my god!”

“More investigations may give more information but information is not always knowledge, nor is knowledge always wisdom.”

“An alcoholic is one who drinks more than his doctor.”

“Biliary stricture surgery is like a marriage; everything is pink and rosy during the honeymoon, but the real test is after say 10—20 years.”

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