ASSOCIATION OF LAPAROSCOPIC SURGEONS OF GREAT BRITAIN AND IRELAND

AND

ASSOCIATION OF LAPAROSCOPIC THEATRE STAFF

Clinical Science Institute of the University College Hospital Galway and The Corrib Great Southern Hotel, Galway Thursday 17 and Friday 18 November 2005

FINAL PROGRAMME
WE ARE PLEASED TO WELCOME

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CONFERENCE SECRETARIAT

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GALWAY
COUNCIL 2005

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President Elect: Professor M J McMahon
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Honorary Treasurer: Mr D Menzies
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ASIT Representative: Mr Y M Kan
ALS Representative at AUGIS: Mr D Menzies
ALS Representative at EAES: Professor R W Motson
ALTS Representative: Ms C Clark

Local Organising Committee:
- Mr O McAnena
- Professor M Kerin
- Ms G Clarke

Thursday 17 and Friday 18 November 2005
Welcome to Galway. The ALS and ALTS are most grateful to our Irish colleagues for organising this Meeting which is full of interest for all. It is a particular pleasure to thank Oliver McAnena, Michael Kerin and Grace Clarke for all their hard work and effort on our behalf.

There is an excellent Trade Exhibition and I hope that everyone will attend the Drinks Reception at the Trade Exhibition in the Atlantic Suite of the Corrib Great Southern Hotel at 6.00 pm on Thursday; breakfast will also be provided in the Trade Exhibition area and coffee will be served there throughout the meeting. Later on Thursday evening I look forward to seeing as many of you as possible at our Annual Association Dinner, also in the Atlantic Suite.

The Live Surgery on Day One covers a wide and interesting spectrum and the surgery will be performed by very experienced Surgeons from both Dublin and Galway: the ALS is most grateful to them all.

Day Two entails a series of state of the art lectures with the overall theme of ‘Current Practice’ and what we should now be doing. In the afternoon there will be Abstracts submitted from our Members.

The Annual General Meeting takes place at lunchtime on the second day and it will be then that I demit from Office as President and install Professor Michael McMahon as my successor. It has been a great privilege and pleasure for me to be President of this Association for the past two and a half years; I have initiated a number of changes not only in terms of the name of our Association but also rationalising the Council to give wider representation to all regions of Great Britain and Ireland. I wish Michael McMahon all the success for his period of office.

I am sure that we shall have an extremely enjoyable Meeting and I look forward to seeing you all.

Professor Michael Bailey
President ALS
GENERAL INFORMATION

CONFERENCE VENUE

Thursday 17 November 2005
Clinical Science Institute
University College Hospital Galway
Newcastle Road, Galway, Ireland
Tel: 00353 (0) 91524222
Fax: 00353 (0) 91520316

Friday 18 November 2005
Corrib Great Southern Hotel
Dublin Road, Galway, Ireland
Tel: 00353 (0) 91755281
Fax: 00353 (0) 91751390

Emergency Contact Number:
Tel: 00 353 (0)91524 390
Fax: 00 353 (0)91494 509

ALS DRINKS RECEPTION AND ANNUAL DINNER

A champagne reception will be held in the Trade Exhibition area of the Atlantic Suite at the Corrib Great Southern Hotel at 6.00pm on Thursday 17 November 2005. This will be followed by the Annual Dinner also in the Atlantic Suite at 8.00pm at a cost of £50.00 per person. Dress code: Lounge Suit.

CLOAKROOM

The cloakroom on Thursday will be located in Room 340, 2nd Floor, Clinical Science Institute from 8.00am – 5.00pm. The cloakroom on Friday will be located opposite the Atlantic Suite from 8.00am – 5.00pm.

CURRENCY AND BANKS

Please be reminded that the currency used in Ireland is Euros.

DRESS CODE

Please be reminded that the dress code for the meeting is Lounge Suit.

LUNCH AND OTHER REFRESHMENTS

Thursday 17 November 2005
Lunch will be held on the 1st Floor, Clinical Science Institute between 12 noon and 3.00pm.

Friday 18 November 2005
Lunch will be held in the Trade Exhibition area of the Atlantic Suite at 12.30pm.

PARKING

Free parking is available at both the Clinical Science Institute and the Corrib Great Southern Hotel.

PASSPORT & VISA

All visitors are required to have a valid passport and non-EU nationals may require visas. Information on exact requirements should be obtained from your local Irish Embassy, Consulate or Tourist Office. Visit www.foreignaffairs.gov.ie for further visa information.

POSTER EXHIBITION

The Poster Exhibition will take place in the Renmore Suite on Friday 18 November 2005. Please ensure that your posters are displayed by 9.00am on the Friday morning. All posters will be judged on Friday lunchtime, and three winners will be announced at the end of the day.

TRADE EXHIBITION

A trade exhibition will be held in the Atlantic Suite of the Corrib Great Southern Hotel on Thursday 17 November 2005 from 6.00pm – 8.00pm and Friday 18 November 2005 from 8.00am – 4.00pm.
ALS AND ALTS PROGRAMME

DAY ONE 17th November 2005

08.30 COFFEE AND REGISTRATION

LIVE OPERATING

Moderators: Professor M E Bailey (President, ALS), Professor R W Motson (Colchester) and Professor N O’Higgins (President, RCSIre)

THEATRE 1

Case 1 Laparoscopic Hellers Cardiomyotomy
Mr P Broe (Dublin)

Case 2 Re-do Laparoscopic Nissen Fundoplication
Mr O McAnena (Galway)

Case 3 Colorectal Surgery
Ms A Brannigan (Dublin)

Case 4 Gastric Bypass Surgery
Mr J Geoghegan

THEATRE 2

Case 1 Non GI Minimally Invasive Parathyroidectomy
Mr D Quill (Galway)

Case 2 Colorectal Case
Mr J Hyland (Dublin)

Case 3 Sentinel Node Breast Surgery
Professor M Kerin (Galway)

TEA AND COFFEE WILL BE AVAILABLE THROUGHOUT THE DAY

12.00 to 15.00 LUNCH AVAILABLE FOR DELEGATES IN THE CANTEEN

17.00 CLOSE OF DAY ONE

18.00 DRINKS RECEPTION AND TRADE EXHIBITION IN THE ATLANTIC SUITE OF THE CORRIB GREAT SOUTHERN HOTEL

20.00 ANNUAL ASSOCIATION DINNER IN THE ATLANTIC SUITE OF THE CORRIB GREAT SOUTHERN HOTEL.
ALS PROGRAMME

DAY TWO

08:15  CONTINENTAL BREAKFAST IN THE TRADE EXHIBITION AREA

09:00  WELCOME: Professor M E Bailey and Mr O McAnena

09:10  KEY NOTE ADDRESS: CURRENT IRISH PERSPECTIVES
       Sponsored by Applied Medical
       Professor K Conlon (Professor of Surgery at Trinity College Dublin and former Professor of Surgery at Memorial – Sloan Kettering Centre, New York, USA)

09:40  LAPAROSCOPIC COLORECTAL SURGERY: WHERE ARE WE NOW? AN OVERVIEW
       Ms A Brannigan (Dublin)

10:00  BARIATRIC SURGERY: THE STRENGTHS AND WEAKNESSES OF CURRENT PROCEDURES
       Sponsored by Stryker
       Mr D Kerrigan (Liverpool)

10:20  LAPAROSCOPIC OESOPHAGO-GASTRIC RESECTION. AN APPRAISAL
       Professor G O’Sullivan (Cork)

10:45  COFFEE IN THE TRADE EXHIBITION AREA

11:15  LAPAROSCOPIC HEPATECTOMY
       Mr A Patel (London)

11:35  INNOVATIONS: WHATS NEW?
       Mr T Rockall (Guildford)

12:00  ANNUAL GENERAL MEETING

12:30  LUNCH IN THE TRADE EXHIBITION AREA

13:30  FREE PAPERS FROM SUBMITTED ABSTRACTS (10 PAPERS)
       Chairmen: Mr W D B Clements (Belfast) and Mr M Rhodes (Norwich)

       LAPAROSCOPIC COLORECTAL SURGERY – RESULTS FROM 150 CASES
       Scala A, Huang A, Rockall TA

       OUTCOME FOLLOWING LAPAROSCOPIC RECTAL RESECTION FOR CANCER: EXPERIENCE WITH 125 CONSECUTIVE CASES
       Parvaiz A, Lawes D, Gilani SNS, Austin R, Arulampalam THA

       LAPAROSCOPIC COLORECTAL RESECTIONS PERFORMED BY TWO NEWLY APPOINTED CONSULTANTS: EXPERIENCE WITH 118 CONSECUTIVE CASES
       Parvaiz A, Arulampalam THA, Austin RCT, Motson RW

       WHO SHOULD BE PERFORMING LAPAROSCOPIC CHOLECYSTECTOMIES?
       Andrews SN, Neary W, Irvin TT, Wajed SA

       RISK FACTORS ASSOCIATED WITH A POOR OUTCOME FOLLOWING LAPAROSCOPIC BILE DUCT EXPLORATION
       Noble H, Spratt MP, Norton SA, Thompson MH

       LAPAROSCOPIC DISMEMBERED PYELOPLASTY USING A 4 PORT TECHNIQUE IN A COMBINED APPROACH
       Nandi D, Francis D, Corr J, Menzies D

       LAPAROSCOPIC MESH REPAIR OF INCISIONAL HERNIA IS MORE COST EFFECTIVE THAN THE OPEN APPROACH
       Akhras F, Tutton MG, Sengupta N, Thomas S, Engledow A
ALS PROGRAMME (continued)

PROSPECTIVE STUDY OF PATIENT SATISFACTION AND OUTCOME OF DAY CASE LAPAROSCOPIC NISSEN FUNDOPICATION
Cheruvu CVN, Khan MA, Smith I, Hammond C, Nijjar RS

COMPARISON OF LAPAROSCOPIC BANDING AND LAPAROSCOPIC GASTRIC BYPASS PROCEDURES FOR THE TREATMENT OF MORBID OBESITY
Pring C, Ainslie W, Moore P, Sedman PC, Royston CMS, O’Boyle C

15:30 CLOSING REMARKS
PROFESSOR M E BAILEY, PRESIDENT OF ALS

15:45 TEA

ALS PROGRAMME

DAY TWO

18th November 2005

08:15 CONTINENTAL BREAKFAST IN THE TRADE EXHIBITION AREA

09:00 WELCOME
Ms C Clark (ALTS Chair)

09:15 DEVELOPING A LAPAROSCOPIC LIVE DONOR NEPHRECTOMY SERVICE
Mr C Earl Nurse Surgical Practitioner – Renal Surgery, MRI (Manchester)

10:00 LAPAROSCOPIC APPENDICECTOMY – IS IT BEST PRACTICE?
Mr S Baker, S.O.D.P (Derby)

10:30 COFFEE IN THE TRADE EXHIBITION AREA

10:45 BENEFITS OF A DEDICATED LAPAROSCOPIC THEATRE TEAM
Mr T Arulampalam, Consultant Surgeon (Colchester)

11:15 BENEFITS OF AN INTEGRATED LAPAROSCOPIC THEATRE
Ms J Hendricks, SCP in laparoscopic surgery (Colchester)

12:00 ALS ANNUAL GENERAL MEETING

12:30 LUNCH IN THE TRADE EXHIBITION AREA

13:30 LAPAROSCOPIC OESOPHAGO-GASTRECTOMY
Mr D Menzies, Consultant Surgeon (Colchester)

14:00 CASE STUDY OF LAPAROSCOPIC OESOPHAGECTOMY
Ms A Jones (Reading)

15:30 CLOSING REMARKS in the Atlantic Suite
PROFESSOR M E BAILEY, PRESIDENT OF THE ALS

15:45 TEA
Scientific Papers

13:30 - 15:30
Title: Laparoscopic colorectal surgery – results from 150 cases

Authors: Scala A MD, Huang A MS FRCS (Gen), Rockall TA MD FRCS (Gen)

Presenter: Mr Andy Huang

Institution: MATTU, Royal Surrey County Hospital, Guildford

Methods: A prospective database was established for all elective patients undergoing laparoscopic colorectal surgery under the care of one consultant surgeon. Patients underwent oral mechanical bowel preparation only if they required a total mesorectal excision and ileostomy. All other left sided resections received enemas only. All patients received prophylactic antithrombotic agents and broad spectrum antibiotics. Analgesia was given either via an epidural catheter or a patient-controlled delivery system. Medial to lateral dissection was performed for both right and left sided colonic mobilisations. Oral fluid intake was encouraged immediately after the procedure and diet was normally commenced on the first post-operative day. Patients were discharged when deemed medically fit. No specific enhanced recovery programme was applied.

Results: Over a study period of 2 years, 165 patients were referred for elective colorectal surgery and 15 patients were excluded for laparoscopic procedure due to gross obesity (BMI > 35), large (> 10 cm) neoplastic/inflammatory masses or bowel obstruction. A total of 150 patients (92 females) underwent laparoscopic colorectal procedures (80 malignancies) and the median age was 67 years (IQR 52-75). The most common operations were anterior resection (n = 51), right hemicolectomy (n = 39) and left hemicolectomy (n = 12). The median operating time was 120 minutes (IQR 90-150) and 8 patients (5%) required conversion to open surgery. The median lymph node harvest in malignancies was 22 nodes (IQR 15-30) with routine fat clearance. There were no positive longitudinal or circumferential resection margins. There was 1 death and 18 complications (12%), including 3 anastomotic leaks, 2 haemorrhages, 5 prolonged ileus and 1 small bowel perforation. Four patients required re-operations due to post-operative complications. The overall median post-operative hospital stay was 4 days (IQR 3-6) and 11 patients (7%) were re-admitted within 30 days of hospital discharge.

Conclusions: Routine laparoscopic colorectal surgery is possible for most benign and malignant conditions, with low conversion and complication rates, as well as short hospital stay.
Title: **Outcome following laparoscopic rectal resection for cancer: Experience with 125 consecutive cases.**

Authors: Parvaiz A Mr, Lawes D Mr, Gilani SNS Dr, Austin R Mr, Arulampalam

Presenter: Mr Amjad Parvaiz

Institution: Colchester General Hospital, Essex UK, Colchester

Methods: A retrospective review of prospectively collected data for 125 consecutive laparoscopic rectal resections undertaken between 1994-2005. All tumours were located below the sacral promontory; surgery was either performed or closely supervised by one of three consultant surgeons. Analysis was made of conversion rates, median operative times, hospital stay and pathological staging.

Results: 125 patients (78 males) with mean age of 74 yrs (range 38-86) were included. AR was performed in 101 (81%) and APR in 24 (19%). Conversion to laparotomy was performed in 19 (15%) patients. Dukes A stage was identified in 21/125 (17%) of patients, B in 45/125 (36%), C in 56/125 (45%) and in three (2%) no residual tumour was seen following radiotherapy. Median operating time was 210 mins (range 120-428) and median hospital stay was 8 days (Range 6-37). Six (4%) patients died within 30 days of surgery, and 28(24%) had complication.

Conclusions: Laparoscopic rectal resection for cancer is both safe and feasible, short term outcome measures are comparable with published data for open rectal surgery.
Laparoscopic Colorectal Resections Performed by Two Newly Appointed Consultants: Experience with 118 consecutive cases

Authors Parvaiz A Mr, Arulampalam THA Mr, Austin RCT Mr, Motson RW Professor

Presenter A Parvaiz

Institution Colchester General Hospital, Essex UK, Colchester

Methods Patients requiring an elective colorectal resection under the care of two newly appointed consultants (RA and TA) underwent a laparoscopic procedure (non selective policy). The results were prospectively evaluated from February 2004 to Sep 2005. Analysis was made of type of surgery, conversion rates, median operating time, morbidity and 30 days mortality.

Results LCS was attempted in 118 patients (46 females) with median age of 73 yrs (range 34-85) during the study period. 32% (n=37/118) had Lap anterior resection, 14% (n=17/118) had lap APR, 25% (n=30/118) had lap sigmoid colectomy, 27% (n=32/118) had lap right hemicolecotomy and two patients had lap subtotal colectomy. The overall conversion rate was 21% (25/118). The conversion rates for colon and rectal resection was 17% (n=11/64) and 26% (n=14/54) respectively. Median operating time for colon and rectal resection was 170 and 240 mins respectively. Six (5%) patients died within 30 days of surgery, and 36(30%) had complications.

Conclusions LCS can be safely implemented by adequately trained and supported surgeons with no compromise in morbidity and mortality. A joint operating list appeared to be the single factor that influenced the ascent of the learning curve.
Title  Who should be performing laparoscopic cholecystectomies?

Authors  Andrews SN, Neary W, Irvin TT, Wajed SA

Presenter  Andrews SN

Institution  Royal Devon and Exeter NHS Foundation Trust, Exeter

Methods  A comprehensive retrospective analysis of all attempted laparoscopic cholecystectomies performed under eight different general surgical firms over a five-and-quarter year period at our institution was undertaken. Open conversion rate and incidence of operative complications were recorded.

Results  Between January 1999 and March 2004 (63 months), 1605 attempted laparoscopic cholecystectomies were performed under the care of eight general surgical firms. Only one firm declared a special interest in upper GI surgery, and performed an average of 104 procedures/year over this period. The median value for the other seven firms was 29.1 procedures/year (range 0.4 – 83.6). Conversion-to-open rate was significantly lower in the upper GI firm (1/30.3) as compared to non-upper GI firms (median 1/18.3; range 0–22.7) (p <0.05).

Five patients suffered a major bile duct injury, and one patient died as a consequence of visceral damage. None of these six major complications was from the upper GI firm, although this difference fell just outside statistical significance (p=0.078).

No relationship between volume of procedures and conversion or major complication rate was identified across the seven non-upper GI firms.

Conclusions  Over a five-year plus period, the outcome following laparoscopic cholecystectomy was significantly better when the procedure was performed by the specialist upper GI surgery firm as compared to the general surgical firms. There was no evidence to suggest that increasing patient volume in these firms improved surgical outcome.
Title RISK FACTORS ASSOCIATED WITH A POOR OUTCOME FOLLOWING LAPAROSCOPIC BILE DUCT EXPLORATION

Authors H Noble, MP Spratt, SA Norton, MH Thompson

Presenter H Noble

Institution Department of General Surgery, North Bristol NHS Trust, Bristol

Methods 436 patients underwent LCBDE between April 1994 and April 2005. 30 variables were identified as potential risk factors (Age, sex, presentation – colic, pancreatitis, jaundice, cholangitis or cholecystitis, previous failed ERCP, pre-operative CBD diameter, Hb, WCC, Plat, Urea, Creatinine, Bil, ALP, ALT, Alb, ASA, arrhythmia, hypertension, diabetes, ischaemic heart disease, respiratory disease, smoking, anti-platelet drugs, immunosuppressive drugs, b-blockers, weight and previous upper abdominal surgery). Data were collected prospectively and via a review of patient records. Complications, post-operative stay and conversion were the main outcome measures. Complications were graded using Clavien’s classification. Post-operative stay was defined as prolonged if greater than 3 days. Stepwise logistic regression was used to identify significant predictors.

Results The mean age was 57 years (range 18–91). 74% were female. There was one post-operative death. 17% of patients had a Clavien Grade II-V complication for which age was the only significant predictor (p<0.001, OR 1.034, CI 1.002-1.009 for every added year). If age was removed from the model then anti-platelet drugs (p=0.015, OR 2.478, CI 1.191-5.154) and serum urea (p=0.023, OR 1.169, CI 1.022-1.337) became significant predictors. Serum bilirubin was the only significant predictor for conversion (p<0.001, OR 1.006, CI 1.002-1.009 for every unit increase). Pre-operative bile duct diameter (p<0.001, OR 1.206, CI 1.129-1.288 for every mm), respiratory disease (p=0.026, OR 2.146, CI 1.094-4.208), anti-platelet drugs (p=0.025, OR 2.123, CI 1.1-4.098), immunosuppressive drugs (p=0.021, OR 12.653, CI 1.474-108.646) and previous upper abdominal surgery (p=0.011, OR 6.142, CI 1.514-24.918) were all associated with a prolonged postoperative stay. Previous failed ERCP was not associated with a poor outcome.

Conclusions Laparoscopic exploration of the bile duct is safe but age, co-morbidity and degree of jaundice increase the risk slightly: age is the dominant factor.
Laparoscopic Dismembered Pyeloplasty using a 4 port technique in a combined approach

Nandi D Mr, Francis D Mr, Corr J Mr, Menzies D Mr

D Nandi

Department of Laparoscopic Surgery, Colchester General Hospi,

Initially all patients have a cystoscopy & insertion of a 6F (26cm) Porges stent under Image Intensifier followed by catheterization. The patient is then placed in the lateral position. Through a transperitoneal approach the ureter is identified and followed cranially to the PUJ. The anterior and posterior surface of the renal pelvis is mobilised and the ureter is divided. The lateral aspect of the ureter is spatulated and the ureter with the stent is brought in front of any aberrant vessel. The redundant portion of the pelvis is then excised to match the ureter. Tension free anastomosis is carried out using a continuous technique with 4/0 vicryl over the 6F JJ stent. Robinson’s drain is placed via one of the 5 mm ports adjacent to the anastomosis. Catheter is removed 24 hrs later and drain at 24 - 48 hrs.

To date 8 patients have been operated on in this manner. Mean Hospital stay was 2.28 days (range 1-3). Three patients required intravenous morphine for post operative pain relief (1 day and 2 day requirement); the remaining 5 patients only oral analgesia was used. Anatomical variations were not a problem as one patient had a horseshoe kidney and in another patient a calculus was removed from the renal pelvis. There were no complications and all the patients were followed up post operatively at 6 weeks with an IVP followed by removal of the double J stent. The final outcome was measured comparing the pre and post operative MAG3 Lasix renogram at 3 months and no evidence of obstruction were noted in all the cases.

We recommend that laparoscopic pyeloplasty using a four port technique can be performed safely even in the presence of anatomical variations. The combined expertise of both a laparoscopic and urological surgeon is required, at least until the learning curve has been overcome.
Laparoscopic Mesh Repair of Incisional Hernia is More Cost Effective Than the Open Approach

Authors Akhras, F Dr, Tutton, M G, Mr, Sengupta, N Mr, Thomas, S Dr, Engledow AH Mr, Warren S J Mr

Presenter Dr Feras Akhras

Institution Chase Farm Hospital, Enfield

Methods The constant and variable costs of 30 consecutive patients who underwent laparoscopic mesh repair of a large (>4cm) VIH as a day-case were compared to 30 open cases, and to a published regional independently assessed average in-patient stay. Variable costs assessed were theatre time, in-hospital stay, and surgical equipment. Constants costs were in-patient and day-case admission, and anaesthetic costs.

Results The average laparoscopic VIH repair was 41 minutes compared to 69 minutes for the open repair. All laparoscopic VIH repairs were discharged the same day with a standard post-operative analgesic regimen. The average in-patient stay of open incisional hernia repairs was 3.5 days.

<table>
<thead>
<tr>
<th>Variable Costs</th>
<th>Open</th>
<th>Laparoscopic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theatre equipment</td>
<td>£200/Euro 294</td>
<td>£590/Euro 867</td>
</tr>
<tr>
<td>Theatre time required</td>
<td>(£69mins X £250/60mins)</td>
<td>(£41mins X 250/60mins)</td>
</tr>
<tr>
<td></td>
<td>£288/Euro 423</td>
<td>£171/Euro251</td>
</tr>
<tr>
<td>In-patient hospitalization</td>
<td>3.5 days X £293)</td>
<td>(0.5 days X £293)</td>
</tr>
<tr>
<td></td>
<td>£1025/Euro 1058</td>
<td>£147/Euro 217</td>
</tr>
<tr>
<td>TOTAL</td>
<td>£1514/Euro 2225</td>
<td>£908/Euro 1335</td>
</tr>
</tbody>
</table>

Conclusions Although the advantages of laparoscopic surgery have been well acknowledged, it is often felt to be more expensive than open surgery. This study demonstrated that when cost analysis is performed accurately, this is not the case, with day-case laparoscopic VIH repair being 60% the cost of a traditional open VIH repair in our institution.
Title: Prospective study of patient satisfaction and outcome of day case Laparoscopic Nissen fundoplication

Authors: CVN.Cheruvu, MA.Khan, I.Smith, C.Hammond, RS.Nijjar

Presenter: CVN.CHERUVU

Institution: University Hospital North Staffordshire, Stoke on Trent

Methods: Patients with symptomatic GORD who failed medical therapy or who preferred to avoid long term medication were considered for surgery. Preoperatively all patients were assessed with an upper gastro-intestinal endoscopy, 24 hour pH studies and oesophageal manometry. Well-motivated ASA grade 1 or 2 patients, living within close proximity to the hospital and with a full-time carer for three days were offered day case LARS. Patients with Para-oesophageal hernias, previous LARS and those not suitable for day case surgery were excluded. All patients received a modified anaesthetic regime to minimise post-operative pain, nausea and vomiting and had a Nissen-Rosetti fundoplication performed by a single surgeon. Patients were discharged home with information leaflets after review by the operating surgeon. Follow up for post-operative pain, nausea and dysphagia was performed by telephone interview using visual analogue scores (0-10) on the night of discharge and day 3, 5 and 7 after operation, by an independent nurse observer. Further symptomatic assessment using the modified Visick symptom score (MVSS) for heartburn, dysphagia and gas bloat and patient satisfaction was completed in outpatient clinic at 2, 6 and 12 months.

Results: Twenty-five patients were studied prospectively between July 2004 and September 2005, with a median age of 46 years (range 28-60 years). The median operating time was 80 minutes (range 35-120 minutes) and there were no conversions. Peri-operative morbidity was 4% - one patient developed a port site infection day 3 after surgery. All patients were discharged home on the day of surgery with a median post-operative stay of 6.8 hours (range 5-8.5 hours). There were no re-admissions but one patient re-attended hospital for upper abdominal distension following an erroneous prescription of effervescent analgesia. Mean post-operative visual analogue scores (0-10) for pain, nausea and dysphagia on the evening after surgery, three days and seven days after surgery were 5.2, 2.0, 3.0 respectively, 3.6, 0.9, 1.9 respectively and 2.5, 0.2, 1.3 respectively. All patients considered the information given at discharge good or adequate and the mean global satisfaction score seven days after surgery was 9.8/10. Ninety six percent of patients were glad they had the procedure as a day case with only one patient expressing a wish to stay in hospital overnight.

The MVSS for heartburn, dysphagia and gas bloat, assessed in outpatient clinic at a mean follow up of 5.6 months (1-13 months) was excellent or good (grade 1 and 2) in 96%, 100% and 100% respectively with one patient with grade 3 reflux. 96% of patients were satisfied with the clinical outcome and would recommend the procedure to a friend.

Conclusions: Our prospective study shows that with appropriate pre-operative counselling and peri-operative care, day case LARS can be performed safely with low morbidity, high patient satisfaction and excellent clinical outcomes.
Title  COMPARISON OF LAPAROSCOPIC BANDING AND LAPAROSCOPIC GASTRIC BYPASS PROCEDURES FOR THE TREATMENT OF MORBID OBESITY

Authors  Pring C, Ainslie W, Moore P, Sedman PC, Royston CMS, O’Boyle

Presenter  Chris Pring

Institution  Hull and East Yorkshire Hospitals, Hull

Methods  A retrospective study was performed of 223 patients undergoing laparoscopic bariatric surgical procedures

Results  Between May 1998 and Aug 2005, 62, 78, and 94 patients respectively underwent GBP, LB, LSB. The median age of the patients was 39(22-57) years. The median percentage excess weight loss at 90 days was 34%, 28% and 23% (p<0.05) and at 365 days it was 54%, 46% and 36% (p<0.05) respectively. Eleven patients (5%) underwent conversion from banding to gastric bypass during follow-up. 30% of LSB, 15% of LB and 6% of GBP patients underwent re-operation for complications or other post operative problems. Thirty percent of re-operative procedures in the banding groups were as a result of band related problems and 60% were as a consequence of problems related to the subcutaneous reservoir or the tubing. The 3 re-operations in the GBP group were for early (2) and late (1) anastomotic leakage

Conclusions  Laparoscopic banding procedures are effective at obtaining clinically significant weight loss in morbidly obese patients, albeit with a high incidence of reoperations. The GBP surgery offers better excess weight loss with a reduced reoperation rate
Title Laparoscopic surgery for upper gastrointestinal malignancy – an emerging alternative to open surgery.

Authors Wright, C. Mr; Wong, C. Dr; Francis, D. Mr; Menzies, D. Mr.

Presenter Mr Chris Wright

Institution Colchester General Hospital, Department of Laparoscopic and, Colchester

Methods Patients undergoing elective laparoscopic gastric or oesophageal resection (LRS and LRO respectively) were prospectively evaluated. All had previously undergone staging laparoscopy and neo-adjuvant chemotherapy. A standardised audit form was completed after each procedure and included demographic and surgical details, including lengths of operation and ITU stay, predicted morbidity and mortality (using the POSSUM II scale), actual morbidity and mortality, and total stay.

Results In the study period 30 patients underwent LRO (24 males; 6 females). Mean age was 65 years (range 55-77). One patient was converted to open because of difficult anatomy. Median operating time was 300 mins (range 240-360), and mean ITU stay was 4.5 days (range 2-22). Mean predicted morbidity and mortality were 57% and 16% respectively, and compare with mean actual morbidity and mortality of 38% and 13.3% respectively. Morbidity and mortality rates were significantly lower than predicted.

16 patients underwent LRS in the same period (12 males; 4 females). Mean age was 76 years (range 68-88). Median operating time was 210 minutes (range 120-290), with mean ITU stay of 2.5 days (range 0-17). Mean predicted morbidity and mortality rates were 68% and 20% respectively, compared with actual morbidity and mortality rates which were 18% and 12.5%. Again both morbidity and mortality rates were significantly lower than predicted.

Conclusions Laparoscopic gastric and oesophageal resection can both be routinely undertaken with no compromise in operating times or mortality. Morbidity and mortality rates for patients undergoing both operations are lower than predicted.
Posters

1. LAPAROSCOPIC VERSUS OPEN APPENDICECTOMY: AN AUDIT IN A DISTRICT GENERAL HOSPITAL
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LAPAROSCOPIC VERSUS OPEN APPENDICECTOMY: AN AUDIT IN A DISTRICT GENERAL HOSPITAL

Authors
Malde D.J. Mr, Bryson A. Dr, Adelekan M. Mr, Curran F.J.M.

Presenter
Deep J. Malde

Institution
Stepping Hill Hospital, Wythenshawe

Methods
All adult appendicectomies in the year 2004 were reviewed (n= 178). Variables compared included operating time, negative appendicectomy rate, equipment cost, post operative pain, wound infection and intra-abdominal collections, length of post operative inpatient stay and time taken to return to routine activities.

Results
Fifty-four (30.3%) LA and 124 (69.7%) OA were performed. There was no statistically significant difference in post operative intra abdominal collection and readmission rates, but the decrease in wound infection and post operative pain with LA were significant (p<0.05, chi squared test). Mean operating time was greater with OA (45.3 min.) than LA (39.5 min.). Mean post operative inpatient stay showed patients going home a day earlier after LA; whilst return to routine activities following discharge was earlier with LA (mean 20.7 days) than OA (mean 28.4 days). The equipment cost of LA was an average of £195.80 more per procedure compared to OA.

Conclusions
The benefit of LA over OA in operating time, post operative pain, wound infection, hospital discharge and return to daily routine outweigh the more expensive equipment costs and lead us to conclude that LA is the procedure of choice for our institution.
Title: **Laparoscopic subtotal cholecystectomy is a safe, effective technique that avoids laparotomy during difficult cholecystectomy.**

Authors: Lawes D, Phillips J, Cook A, Arulampalam T, Motson R.

Presenter: Lawes D

Institution: Department of Surgery, Colchester District General Hospital, Colchester

Methods: 1,917 emergency and elective cholecystectomies performed at Colchester DGH between September 2001 and December 2005 were retrospectively reviewed. The notes of patients who underwent a subtotal cholecystectomy were reviewed. This procedure, performed when the cystic duct cannot be identified safely, consists of resecting the anterior wall of the gallbladder, removing all stones and placing a large drain into Hartman’s pouch without formal closure of the cystic duct.

Results: Subtotal cholecystectomy was performed in 26 cases, 13 during emergency and 13 elective procedures. The median age of patients was 68 years (range 36-86), with 15 females and 11 males. Indications were severe fibrosis in 16 cases, inflammatory mass/empyema in 8 and inability to safely identify the cystic duct in 2. The median post-operative inpatient stay was 5 days (range 2-26). Four patients underwent post-operative ERCP for persistent biliary leak and 1 for retained CBD stone. One patient (ASA grade IV, presenting with biliary peritonitis) died 2 days post operatively and 5 developed complications, 1 required a laparotomy for subphrenic abscess, 1 required a subsequent completion laparoscopic cholecystectomy for recurrent pain, 1 developed post-operative pneumonia and 2 developed port site hernias.

Conclusions: Laparoscopic subtotal cholecystectomy is a safe alternative to laparotomy during difficult cholecystectomy in either the elective or emergency setting with patients seldom requiring further surgical intervention.
CORRECTABLE CAUSES OF RECURRENT REFLUX, DYSPHAGIA AND VOMITING AFTER ANTI-REFLUX SURGERY.

Mr H Dowson, Mr V Patel, Mr AJ Botha

Henry Dowson

Guy’s & St Thomas’s Hospital, Guildford

All patients requiring revision anti-reflux operations since 2001 were reviewed with regard to the type of previous surgery, recurrent symptoms, intra-operative anatomical diagnosis, and revision surgical procedure performed. A telephone interview and notes review were conducted to assess symptom improvement and patient satisfaction.

Thirteen patients had 17 (1-3 per patient) previous anti-reflux operations: 5 laparoscopic and 8 open Nissen fundoplications, 3 antrectomies with Roux-en-y bypass, and 1 gastrojejunostomy. The causes of recurrent symptoms were reflux in 6, dysphagia in 3, vomiting in 3 and gas bloat in 1. The revision procedures performed were 9 Nissen fundoplications, 1 anterior partial wrap, 1 posterior partial wrap and 3 open gastric resectional procedures. 9 out of 13 revision operations were done laparoscopically with 2 conversions, and 3 were emergencies. Six anatomical abnormalities were found relating to the fundoplication (wrap undone, slipped, tight, low, telescoping cardia, anterior slippage of hernia sac), 2 relating to the hiatus (recurrent hernia, hiatal stenosis), and 3 relating to the distal stomach/small bowel (pyloric dysfunction, gastro-jejunal dysfunction, short Roux loop). There were no mortalities and no significant complications. Twelve patients had resolution/improvement of their presenting symptoms.

We identified eleven surgically correctable causes of recurrent reflux, dysphagia and vomiting after anti-reflux operations. Increased awareness among surgeons and prevention of these anatomical abnormalities may further improve the outcome of primary anti-reflux surgery.
Title  LAPAROSCOPIC GEOMETRICAL REPAIR OF VENTRAL HERNIA, HOW I DO IT.

Authors  Dr. Vishwanath Golash

Presenter  Dr. Vishwanath Golash

Institution  Sultan Qaboos Hospital, Salalah

Methods  The technique involves suturing the GoreTex Dual mesh plus biomaterial in a tension free manner around the hernial defect. The mesh was fixed with sutures circumferentially in two circles. Tackers and staplers were not used. The hernial sac is not dissected and left behind. This saves the difficult dissection, blood loss and large incision of conventional open repair. The size of hernial defect and the site of sutures are accurately marked on the skin and on the mesh with the help of full protractors, compass and ruler. The protractors have helped us in standardizing the placement interval of the sutures. The markings on the skin are the mirror image of the markings on the mesh which makes the orientation and positioning easy even for a very large mesh.

Results  Over a period of 58 months we have repaired 112 ventral hernias including the most difficult recurrent ones using same technique. There were no recurrences. Four cases were converted to open. There was no mesh or wound infection and minimal wound pain.

Conclusions  This approach is suitable for all types of ventral hernia. It is a safe and cost effective. The hospital stay is shorter and patients return to work early.
An Audit of Laparoscopic Nissen Fundoplication

Authors
CES Crampton, LJ Horgan, SEA Attwood

Presenter
CES Crampton

Institution
North Tyneside General Hospital, North Shields

Methods
All patients undergoing Laparoscopic Nissen Fundoplication at North Tyneside General Hospital (January 2001- March 2005) were identified from the theatre records (89 patients). Any patients undergoing additional procedures at the same time were excluded. The patient notes were obtained, and four pieces of information gathered and stored in a confidential way.

The 4 criteria were audited were:

- Length of surgery
- Intra operative complication rate
- Conversion to open surgery
- Post operative length of stay

Results
Mean length of operation fell from 113 minutes in 2001 to 58.3 minutes in 2005. All patients stayed overnight in 2001-2002. Day case surgery started in 2003, and rates increased from 14% in 2003 to 80% in 2005. The mean length of stay decreased from 50 hours in 2001 to 10.8 hours in 2005.

Conclusions
The standards identified in America were met and surpassed by the surgical team. The mean length of stay could be shortened further by more day case surgery in the future.
Title  
Does open surgery still have a role in elective splenectomy?

Authors  
Boddy AP, Mahon D, Rhodes M

Presenter  
AP Boddy

Institution  
Department of Surgery, Norfolk and Norwich University Hospit, Norwich

Methods  
Between September 1995 and April 2005, 95 elective splenectomies were performed by a single surgeon. Operative data was collected prospectively.

Results  
Comparing the operations that took place prior to 2001 (n=47) with those after 2000 (n=48) for all sizes of spleen, there were significant reductions in conversion rate, operative time and hospital stay in the later group. When laparoscopic splenectomy (n=11) was compared to open splenectomy (n=18) for cases of splenomegaly, open surgery resulted in a significantly shorter operative time with a lower operative blood loss and no significant difference in hospital stay.

Conclusions  
Although laparoscopic splenectomy is the treatment of choice for the majority of patients requiring elective splenectomy, the procedure for patients with significant splenomegaly requires caution and common sense. We have found that performing an open splenectomy in these patients significantly reduces operative time and blood loss without increasing morbidity or hospital stay.
Title: The Role of Laparoscopic Loop Colostomy

Authors: Beirne CLJ, Cooke F, Khan MF, Regan MC

Presenter: CLJ Beirne

Institution: University College Hospital, Galway, Ireland.

Methods: A retrospective review was performed of patients who had a laparoscopic loop colostomy between December 2002 and May 2005.

Results: 11 patients (7 male, 4 female) with a mean age of 58 years underwent laparoscopic stoma formation. There were no conversions. Colostomy was indicated due to primary rectal or anal neoplasm, mainly prior to neoadjuvant therapy (n=7), complex fistulæ formation (n=2), rectal extension of prostate carcinoma (n=1), and faecal incontinence in a patient with Fredrich’s ataxia (n=1). Mean duration of surgery was 46.1 min (range 30-70 min). There were no intra-operative or post-operative complications. Mean time to return of bowel function was 2.2 days (range 2-3 days). Inpatient stay ranged from 3 to 15 days. Discharge from hospital was delayed due to oncological assessment and palliative care. Four patients have subsequently died due to disease progression. During the follow-up period to date there has been no reported stoma prolapse or other peri-stomal problems.

Conclusions: From our experience laparoscopic loop colostomy is a safe and effective minimally invasive technique when faecal diversion is required for palliative measures or prior to further curative intervention at a later date.
**Title**  
Comparison of the learning curve for laparoscopic Trans-Abdominal Pre-Peritoneal (TAPP) hernia repair for trainee hernia surgeons and a consultant

**Authors**  
Burgess A, Eyers PS, Welbourn R

**Presenter**  
Adele Burgess

**Institution**  
Taunton and Somerset Hospital,

**Methods**  
Prospective study of trans-abdominal pre-peritoneal (TAPP) inguinal hernia repair by one consultant and trainees. The technique used a 10mm umbilical and right and left 5mm ports, a 15 x 10cm prolene mesh for each hernia and a 2/0 continuous peritoneal suture. The outcomes measured were: operative time, complications, recurrence rate, and confidence to perform unassisted.

**Results**  
Four hundred and fifty one TAPP repairs (303 patients, 155 unilateral, 148 bilateral, 71 recurrences in all) were carried out between May 02-Aug 05. The mean time taken by consultant (222 patients) was 45’, 37’ and 30’ for unilateral, and 71’, 59’ and 45’ for bilateral repair in the first, second and third group of 74 patients (both p<0.05, t-test).

Eleven trainees did part or all of 81 operations (median 6, range 1-21), 73 of these on a dedicated day case list introduced in Jan 04. Trainees were median SpR year 2 (range SpR 2-SpR year 6 or above). Overall, the mean time taken by trainees was 56’ for unilateral and 69’ for bilateral repair.

There were 2 major (0.7%) and 7 minor (2.3%) operative complications, and two recurrences (0.7%) (all consultant operated). There was 1 major post-operative complication (0.3%, consultant operated) and 28 minor post-operative complications (9.6%, no difference between consultant and trainees).

Only 2 trainees became confident to perform TAPP unassisted (both year 6 or above).

**Conclusions**  
Trainee surgeons took longer to do TAPP repair but the complication rate was comparable to the consultant. More senior trainees learn the technique quicker and a dedicated theatre list facilitates training.
Title: Does the use of acid suppression medication indicate failure of Nissen fundoplication to control reflux?

Authors: Osborne A, Welbourn R

Presenter: Alan Osborne

Institution: Taunton and Somerset Hospital

Methods: Anonymous postal questionnaire study of consecutive patients undergoing laparoscopic Nissen fundoplication (LNF) by one consultant. Structured questions using modified Visick and DeMeester scores for post-operative symptoms were used, together with questions about use of ASM or abdominal pain. LNF was performed using 5 ports. The crura were repaired, the hiatus was fully mobilised and a 2cm long, 360 degree wrap fashioned without a bougie.

Results: Seventy-seven patients underwent LNF between April 99 and June 05. Fifty six of 70 contactable patients (80%) returned questionnaires. At median follow up of 23 months (range 2–57) 43 (78%) were Visick 1 or 2 and 44 (79%) had DeMeester heartburn scores of 0 or 1. Twenty-seven (48%) had bloating and 16 (28%) problems belching. Twelve (21%) were taking regular ASM and had mean Visick scores of 2.64 compared to 1.72 if not on ASM. ‘General stomach pain’ was much commoner in patients on ASM compared to those not on ASM (7/12 vs. 8/41, chi squared p=0.007), but there was no difference between groups in ‘pain below ribcage’.

Conclusions: LNF was effective at controlling reflux but a proportion restart ASM, strongly associated with abdominal pains not due to reflux.
Title  
Small Bowel Obstruction - a complication of Laparoscopic TAPP Right Inguinal hernia repair

Authors  
Abraham A Mr, Deans GT Mr

Presenter  
A Abraham

Institution  
Stepping Hill Hospital, Stockport

Methods  
A retrospective audit of all laparoscopic TAPP inguinal hernia repairs performed by a single surgeon in the last ten years was performed. Case notes of patients identified as having post-operative small bowel obstruction were reviewed to assess common factors that caused this complication.

Results  
A total of 1423 patients undergoing TAPP procedure were reviewed and 6 cases of post-operative small bowel obstruction were identified (4 in patients undergoing unilateral hernia, 2 in bilateral hernias). The mean time from operation to diagnosis of obstruction was 5 days (range 2-10). All but one patient had been discharged from hospital and were readmitted as an emergency. All presented with abdominal distention following the hernia surgery, which failed to resolve spontaneously. All patients required reoperation (by laparoscopy (2), mini-laparotomy (2) and lower midline laparotomy (2)). There was a mean delay from readmission to reoperation of two days. Two patients required small bowel resection due to bowel ischaemia. In all cases the offending repair was on the right side. The mechanism was identical in all cases in that the peritoneal suture had slipped at the medial end of the peritoneal incision, allowing a knuckle of small bowel to protrude through the peritoneal defect into the pre-peritoneal space and come in close contact with the mesh with varying degrees of inflammation. No port site hernias were noted. Following re-operation, there was no mesh infection and no recurrent hernias or small bowel obstruction.

Conclusions  
Small bowel obstruction is a rare but serious complication of sutured TAPP repair. All cases require re-operation, which should not be delayed. All cases occur on the right side since on the left the sigmoid colon reinforces the peritoneal closure making it more difficult for the small bowel to fall into the pre peritoneal space.
Title: **Short Stay (23 hours) Surgery: Implications for Laparoscopic Surgery**

**Authors:** Balakrishnan S, Singhal T, Grandy-Smith S, El-Hasani S.

**Presenter:** Mr. Santosh Balakrishnan

**Institution:** The Princess Royal University Hospital, Bromley

**Methods:**
Our NHS trust opened a Treatment centre in November 2003. The centre provides full independent theatres with facilities for theatre list management, pre-assessment and recovery. In addition there is a provision for overnight stay with adequate nursing care and medical cover with an on site surgical doctor. Criteria for selection of patients and operations suitable for this centre were outlined and care protocols were established.

**Results:**
The facility of overnight short stay made it possible to provide a wide range of laparoscopic treatment procedures without occupying acute surgical beds. This facility made it possible to utilise afternoon and early evening lists for procedures where the patient could not have been sent home the same evening due to inadequate recovery time. We have performed a variety of basic and advanced laparoscopic procedures like cholecystectomy, bilateral groin hernia repair, Nissen’s fundoplication and appendicectomy with minimal morbidity and no mortality. There has been a significant decline in waiting times for most routine general surgical operations especially those for day or short stay surgery.

**Conclusions:**
Short stay surgery and centres providing for the same could be the solution to better management of surgical waiting lists and prompt and safe surgical service provision. Laparoscopic surgery has made a number of procedures suitable for this method of service delivery.
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Stryker Endoscopy is a technology leader in the operating room. Our innovative products help to give surgeons more control and better outcomes – whilst making surgery easier and more efficient for medical professionals and hospital administrators.

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Surgisis(r) Gold™ Hernia Repair Graft supports the surgical site while the body’s natural healing process replaces the graft with new host tissue. It has been used extensively for laparoscopic and open incisional hernia repair.

The Nathanson Liver Retractors will be demonstrated to the few people still unfamiliar with this popular device.

A kit for laparoscopic common bile duct exploration will be exhibited for the first time in Europe, along with a new laparoscopic common duct stent.

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Tyco Healthcare, incorporating Auto Suture™, Valleylab™ and Syneture™, is proud to be an ALSGBI Corporate Partner for 2005. Tyco is as committed to supporting and providing educational opportunities for surgeons, nurses and healthcare professionals throughout the world as we are to the highest standards of innovation and production of world class products. We look forward to meeting you at stand no. 2 and showing you how our products can assist you in providing the highest standards of patient care.
## Exhibitors

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ANNUAL GENERAL MEETING

The Annual General Meeting of the Association of Laparoscopic Surgeons of Great Britain and Ireland will be held on Friday 18th November 2005 at 12 noon in the Atlantic Suite.

AGENDA

1. Apologies for absence

2. Minutes of Annual General Meeting, Liverpool, Friday 26th November 2004

3. Honorary Secretary’s Report – Mr M Thompson

4. Honorary Treasurer’s Report – Mr D Menzies

(a) Membership Fees

5. Director of Education – Mr R H Kennedy

6. Election of Professor M McMahon as President

7. Any other Business

Date and place of ASGBI Spring Meeting, 3rd to 5th May 2006, Edinburgh.
MEMBERSHIP APPLICATION FORM

I wish to apply for membership for the Association of Laparoscopic Surgeons of Great Britain and Ireland and the Association of Laparoscopic Theatre Staff.

NAME (please print): __________________________________________________________

Proposed by (name of Consultant): ____________________________________________

Telephone number of Consultant: _____________________________________________

MY PREFERRED MAILING ADDRESS IS

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*Full member with extended membership to the European Association of Endoscopic Surgery (EAES) and the journal Surgical Endoscopy.
Please fill in the whole form using a ball point pen and send to:

The Association of Surgeons of GB & Ireland, at The Royal College of Surgeons of England, 35 – 43 Lincoln's Inn Fields, London WC2A 3PE

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