Urological Association of Uttar Pradesh

UAU Newsletter - November 2018

Website: www.uauonline.in
Email: office.uau@gmail.com

UAU Newsletter

MESSAGE FROM THE PRESIDENT

Dear Members,

Greetings,

What a stupendous performance by the Uttarakhand urological wing of UAU! Kudos to Dr. Sanjay Goel, Dr. Ankur Mittal & the rest of the team for putting up an excellent mid-term meeting at AIIMS, Rishikesh. The selection of topic (Female incontinence), the choice of faculty, the standard of academic discussion and above all, the hospitality made this conference a memorable one. As Dr Anil Elehence (One of the founders of UAU) said, it looked more like a north zone conference, Truly, they are ready for the annual UAU meet. Well done team Uttarakhand!

One other thing that stood out was the use of potted plants as mementoes. Carrying the theme forward, I suggest that at every meeting, we plant saplings at or near the venue to be looked after by the local urological society with regular posting of the growing sapling on whatsapp. A small drop in the ocean yet, a beginning.....

The recent attacks on centres run by urologists is of grave concern. With the gun culture gaining notorious popularity, it is time to go beyond lip service. UAU will partner with any practical approach to the solution. We invite suggestions from our members. Friends, let's face it - We are not bouncers or gun toting gangsters. Our profession makes us even more socially impotent. I am reminded of an Irish saying – 'It is better to be a coward for a little while than to be dead for the rest of your life.....Think about it.

Finally, UAU has been propagating the growth of high class urology and urologists in the so called 'B' towns. This is our contribution to the society at large and we are proud of it. So keep going lads & as the Duchess said to the Bishop - keep it up!!

Dr Ajit Saxena
President, UAU

MESSAGE FROM THE SECRETARY

Dear Colleagues,

Greetings from the new UAU team!!

The festival season is here and the weather has turned pleasant with the beginning of the autumn season. UAU continues to scale new heights and under the dynamic and vibrant guidance of Dr Ajit Saxena, our new president, the new team will leave no stone unturned to take UAU to unchartered territories and fulfil the expectations of our esteemed members. We are indebted to the outgoing UAU executive under the leadership of Prof U. S. Dwivedi and Dr Neeraj Kumar Agrawal for their outstanding contribution to the society and setting a very high benchmark to follow.

The annual conference at Varanasi was well attended and saw a very informative academic program provided under the guidance of Dr Neeraj Agrawal. We have a new session ahead of us and many new proposals are in pipeline for academic ventures. The suggestions from various members have been very positive and are likely to improve the content of our future meetings. Keeping in view the general sentiments, it has been decided to restrict the number of mid-term meetings/workshops due to a plethora of such activities at various levels.

We had a wonderful midterm meeting at A.I.I.M.S. Rishikesh under the guidance of Dr Sanjay Goyal and organized by young and dynamic Dr Ankur Mittal. The CME on female pelvic health included eminent faculty from all over the country and witnessed a comprehensive and enlightening interactive discussion on all aspects of female pelvic health. The academic activity was very well attended and greatly appreciated by the delegates.

We have now started working towards our next annual meeting, UAUCON-2019, at Allahabad. The dates have been finalized as 23rd and 24th Feb 2019. These dated have been chosen to make the conference coincide with the “Ardh-Kumbh”. Dr Dilip Chaurasia, the organizing secretary of UAUCON-2019, is making all efforts to make the meeting a memorable one besides offering the delegates a unique opportunity to experience the atmosphere at this mega event of Kumbh. I appeal to all the members to avail this opportunity and get registered for the conference at the earliest. We are also working hard to provide an informative and comprehensive scientific program for our attendees.

The UAU flag continues to fly high with the achievements of our esteemed members. A few of the notable achievements find mention in this newsletter. Our heartiest congratulations to all the distinguished members for keeping the banner of UAU high.

Amidst all the good deeds and cheers, the issue of membership and recruitment of new members remains a concern. Despite a large number of urologists being added in the region, the membership numbers are failing to keep pace with them. More active intervention is required from the members in different cities to achieve this objective. It was decided in the General Body Meeting at UAUCON-2018 in Varanasi to approach this issue with the help of nodal members in various cities. Efforts are being made in this direction and hopefully we will realize the fruits of these soon.

Wishing all the members a very Happy Dussehra and a bright and prosperous Deepawali

Dr Sameer Trivedi
Hon Secretary, UAU

Members' Achievements

- Prof K.M. Singh – Lifetime Achievement Award by Governor Shri Ram Naik
- Dr Vipul Tandon – Special Recognition award from Deputy Chief Minister Uttar Pradesh Government
- Dr Salil Tandon – Distinguished Alumni Award by Lucknow University
- Dr Diwakar Dalela was invited to demonstrate Oral Mucosal Graft Urethroplasty in Istanbul, Turkey
- Dr AK Sanwal was invited to present his innovative Nephrostomy Dilators and the technique of mini-PCNL in large renal calculi at the Asia Urology conference in Kyoto, Japan
- Prof Aneesh Srivastava – conducted instructional course on donor nephrectomy in SIU-2018, Seoul

Executive Council

President	– Dr Ajit Saxena, Noida
President Elect	– Dr Anil Jain, Kanpur
Secretary	– Dr Sameer Trivedi, Varanasi
Treasurer	– Dr Vijay Bora, Agra
Council Members	– Dr RK Sah, Varanasi
	– Dr Yash Agrawal, Muzaffarnagar
	– Dr Vimal Dassi, Ghaziabad
	– Dr PK Jindal, Varanasi
	– Dr Amit Deora, Noida

MID-TERM CME AT RISHIKESH

The department of Urology at AIIMS, Rishikesh organized a Mid-term CME under the aegis of Urological Association of Uttar Pradesh and Uttarakhand on 29th and 30th Sept,2018. The theme of the CME was “Female Pelvic Medicine and Reconstruction”. The CME was attended by over 200 delegates including many eminent Urologists and subject experts from across the country. The CME was inaugurated by Dean – AIIMS, Prof Surekha Kishore and addressed by Dr Ajit Saxena, President-UAU, Dr Sameer Trivedi, Secretary-UAU, Dr Sanjay Kumar Goyal, Organizing Chairman, and Dr Ankur Mittal, Organizing Secretary. The CME included video sessions, panel discussions, and lectures by eminent faculty addressing issues related to female pelvic health including pelvic organ prolapse, overactive bladder, female urethral stricture, stress urinary incontinence, vesico-vaginal fistula and pelvic floor dysfunction. The prominent speakers included Dr Nitin Kekre, Dr Amlesh Seth, Dr Sanjay Sinha, Dr Anil Elhence, Dr Ajit Saxena, Dr Sameer Trivedi, Dr Aparna Hegde, Dr Vivek Khandelwal, Dr Mayank Mohan Agrawal, Dr Shabbir Hussain among others.

UAU Newsletter

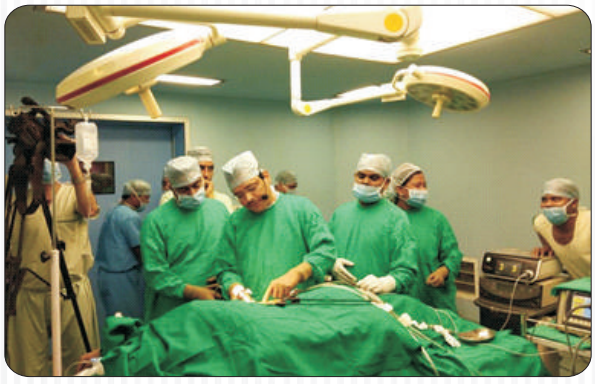
General Tips and tricks of learning Laparoscopic Urology

Dr Shashikant Mishra,
MS,DNB(Urol), MNAMS,Fellow(Endourol Inc.,USA)
Precision Urology Hospital, Lucknow.

Since the first description of Laparoscopic urology procedure (Nephrectomy) by Dr Clayman et al. in 1990, there have been significant strides and replacement of open urological procedures by laparoscopy. Unfortunately, the application of laparoscopic urology is not even among the caregivers. There are few urologists who do laparoscopic procedures regularly while the rest are still in the process of learning skills.

It is important for all the beginners to know all the steps and anatomy of the procedure well. There is a certain steep learning curve initially in all these procedures. Upper tract laparoscopy for kidney, adrenal and ureter is considered easy as compared to pelvic laparoscopy for bladder, lower ureter and prostate. Even for kidney, one can start with nephrectomy for non-functioning kidneys secondary to UPJO initially. As you ascend the learning curve, you can include cases with gradually increasing laparoscopic complexity such as radical nephrectomy, nephrectomy for stone disease, XGPN, pyeloplasty, partial nephrectomy and donor nephrectomy.

The main limitation of doing laparoscopic urological procedures is the 2D vision orientation of a 3D procedure, steep initial learning curve, complexities of surgical instruments and their usage, suturing skills and lack of adequate training centers. Laparoscopic urology surgery demands adequate training to facilitate smooth surgery and possibly avoid complications. Till date, there is no standardized structured training program globally to optimize adequate training. There are laparoscopic training fellowship programmes, at high volume centers recognized by urology societies such as Endourology society, USA, SIU etc. Given the opportunity, these fellowship programs hasten the skill acquisition process early in your academic carrier. However, even for practicing urologist, there are specialized and advanced courses that can initiate your laparoscopic learning process. I was fortunate to do Endourology society,Inc, USA laparoscopic fellowship at MPUH, Nadiad and even participate in advanced courses of IRCAD in Strasbourg, France. The ideal training scenario would include doing basic skills set in 20 hour dry lab involving pelvic trainers, basic and advanced skill set in wet lab using dead or live anaesthetized animal models, assisting experts in live situation and finally graduating from simple to complex live cases.



Some cheap alternative of initiating laparoscopy is to build your own caseload, participate in laparoscopic workshops, start laparoscopy under mentorship of an invited expert faculty (figure 1) and do the necessary skills acquisition on cheap inanimate models. If budget is an important limiting factor, there are simpler homemade pelvic trainers that one may consider using.

It is important to build a team and involve every member with important responsibilities. Dedicate specific people in your OR with laparoscopy. It is important for your team members to learn the nity grity of the procedure closely and master the nuances.

It is important for the surgeon to have the comfort of best possible instrument set to make the operation smooth. I would recommend, using lap set of a standard high definition camera system. It is recommended to invest in costly high definition camera that provides image quality of utmost clarity. Adult cases are best managed with 10 mm laparoscope. 5 mm laparoscope reduces the width of vision and is often used for pediatric cases. To keep a clear vision field, there are few tricks. Maintain a warm operating room temperature to minimize fogging, keep the insufflation tube away from laparoscope, have a covered flask of hot water for lens cleaning, piece of gauze for wiping the laparoscope tip when needed and controlled suction of any cautery smoke.

Common lap instruments include bowel forceps, maryland dissector, scissors, suction device and needle holder. My personal favorite lap instrument is hook. It is connected to mono polar cautery to facilitate hemostasis and dissection. It has a specific advantage of being able to do fine dissection with the angle of hook and dissection in narrow areas with the curved inner edge. The downside of this instrument is its narrow safety limit. It can be traumatic especially while pulling during dissection injuring near by organs and can also cause inadvertent thermal injury due to breakage of thermal insulating cover. Tissue sealants often used in market include harmonic energy, ligasure and Nseal. Most of the laparoscopy procedures are aided by tissue sealants. Invest in any of these, my personal preference is Ligasure that makes sealing advantageous in Cystectomies. In this procedure, sealing is secure for branches of internal iliac artery as well as vein. With the development in strong sealing harmonic devices such as Harmonic ace, this advantage is offset. The cost implications of the sealing devices for laparoscopy are also important. The ForceTriad™ generator offers enhanced monopolar and bipolar energy and LigaSure™ vessel sealing technology, all in one unit.

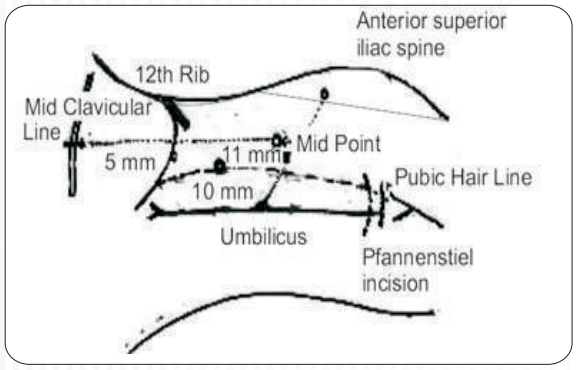
Hem-o-lok polymer clips (Teleflex Medical) clippings for the artery and vein is safe although endo GIA stapler are also used. There are certain cardinal rules for applying clips. See the knob before applying the clip, ensure an audible click after application and ensure circumferential dissection of tubular structure before clip application. Malfunctions of these have been described in past but can be avoided with careful application and recognition.

Establishing a safe and adequate access is key to success. Both Trans and Retro-peritoneal access have been defined and have distinct pros and cons. My personal preference is Trans-peritoneal approach. I feel that the specific advantages of trans-peritoneal approach is a wide surgical field, applicability to all urology procedures unlike Retro-approach that can be applied only to some specific procedures. It has been standardized now and more than 90% of practising laparoscopic surgeons prefer this access. There are three main options for initial port insertion; closed access using the verres needle, open hasson technique, or use of an optical port. I prefer, the closed verres access. The tactile feedback of the needle as it pierces the layers of abdominal wall gives fairly accurate entry. Certain safety steps include the absence of blood or gas at aspiration of syringe through the verres needle, low initial intra abdominal pressure and not so rapid rise of pressure while initial insufflation. The intra-abdominal pressure is kept at 20 mm Hg for initial port placement

and subsequently the working pneumo-peritnoneum pressures are kept at 15 mm Hg. The port tip designs have undergone gradual changes over the years in an attempt to decrease inadvertent organ injury while insertion. I prefer, Non bladed trocars that spread muscles and fascia instead of cutting allowing their anatomical approximation after withdrawal. It also obviates the need of port closure device. The entry systems currently in use are the re-usable metal trocars with central sharp cutting trocar and encasing cannula. The advantage of re-usability and versatility makes it a preferred cheaper entry system. The other disposable trocars work on Archimedes spin principle where the entry instrument comprises a threaded cannula only, that ends in a notched blunt tip.

No axial penetration force is applied, tissue parts radially and cannula pulls tissue up along its outside thread.

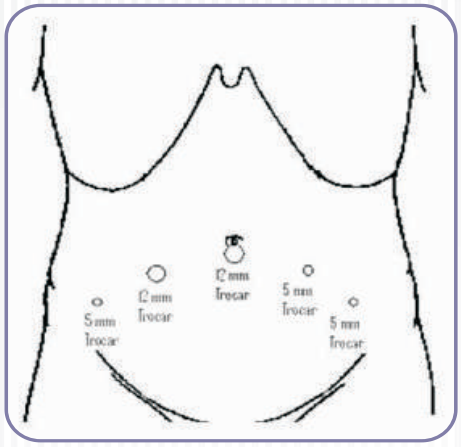
All patients undergo surgery in general anesthesia with close circuit and proper anesthesia ventilator. It is necessary to secure all pressure points and proper strapping of patient is required to provide complete immobility. Abdominal cavity is insufflated with carbon dioxide (CO_2) to a working pressure around 15 mm Hg. Higher pneumo-peritoneal pressures may lead to ET tube migration, hypercarbia, heamodynamic instability, subcutaneous emphysema, air embolism, hypothermia etc. The anaesthetist should be aware of these problems and take necessary steps to prevent them. The patient is placed in dead lateral flank position without kidney bridge in upper tract laparoscopy while in steep trendelenberg position with 30-45 degree tilt in pelvic laparoscopy. The pressure parts are adequately padded and belts applied to prevent patient fall.



Port position for Upper tract Urology

Port position for Upper tract Urology: we follow the port position as described by Gill et al (figure 2). Essentials of this port positioning is that the minimum distance between the ports is 4 finger width apart to avoid clashing of the instruments, the camera port is positioned so as to face directly at the hilum of kidney, the main dissection port is 10 mm to facilitate passage of Hemolock clips, and the rest non dominant hand port for retraction and additional assistant port for retraction are 5 mm. An initial 1-cm incision for introduction of the veress needle and 10-mm camera port is placed midway between the umbilicus and the superior iliac crest just lateral to the rectus muscle. A second 5/10-mm port is placed at the subcoastal line in the perpendicular line starting from the first port and intersecting the coastal cartilage. The second and third trocar can be either a 5- or 10-mm depending on the side and the dominant hand of the operating surgeon. The camera port 10 mm is inserted at the junction of upper one third and lower two third at the lateral border of rectus belly. The camera port thus inserted lies at the level of pelvis.

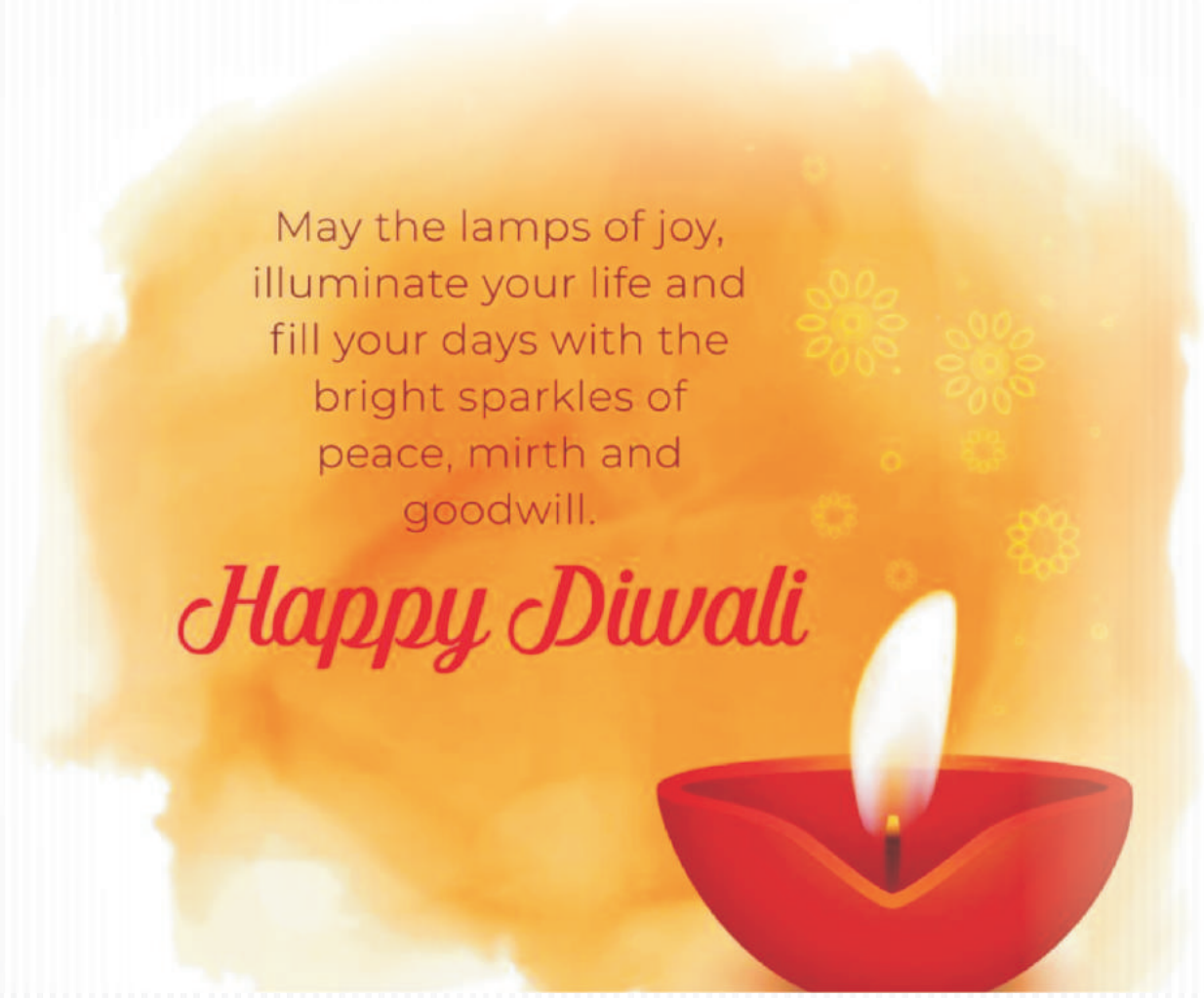
Port position for Lower tract Urology (figure 3): The first 10/12 mm camera trocar is placed just above or below the umbilicus for bladder or prostate surgery, respectively. After a pneumoperitoneum is established, one 10/12mm working port is placed 6 cm away from the umbilicus under a 30° laparoscopic camera, along the line from the anterior spine of the iliac crest to the umbilicus. One 5-mm assistant port was placed 4-cm above the right anterior spine of the iliac crest.



Port position for Lower tract Urology

I prefer using 10/12 mm disposable port (ENDOPATH®, Ethicon) for the dominant right hand dissection port while all rest re-usable metal ports. This improves operative ergonomics while maintaining cost efficiency. 10 mm disposable port allows you to use the 5/10 mm instruments without need of port reducers. All laparoscopic reconstructive procedures require acquaintance with intra corporeal suturing. It is pertinent to learn these skills in a skills lab before doing in a live case. The availability of special modifications of suture material like barbed suture (V-loc) has eased the suturing learning curve. My preference of suture material in pyeloplasty is 4-0 vicryl, partial nephrectomy 2-0 vicryl on CT-1 needle 15 cm length, DVC complex 0-vicryl on CT-1 needle, urethro-vesical anastomosis 2-0 monocryl on UR-6 needle or 3-0 V-Loc 17 mm needle, Bladder and vagina 2-0 V-Loc sutures.

Specimen retrieval bags are also important adjuncts that help reduce the retrieval scars. They are available in 10/15 mm sizes according to the size of the mass to be retrieved. Use appropriate size laparoscopic port for inserting retrieval bag. The downside of retrieval bag is cost economics. Cheap retrieval bags (Nadiad bag) are commercially available in India that reduces the cost while maintaining the efficiency.



UAUCON 2019

6th Annual Conference of
Urological Association of UP/UK

23th & 24th February 2019 at Prayagraj

Please block your dates & be a part of The Scientific Kumbh

Dr. Dilip Chaurasia
Organizing Secretary
UAUCON 2019
Prayagraj (Allahabad)

Secretary Address:

Dr Sameer Trivedi
Hon. Secretary UAU
M.S.,M.Ch.(Urology), D.N.B.(Urology),
Head - Deptt. of Urology,
Institute of Medical Sciences,
Banaras Hindu University,
Varanasi (UP) - 221005

Email: drsameertrivedi@gmail.com
Mobile: +91 98398 61656

Disclaimer


UROLOGICAL ASSOCIATION OF UTTAR PRADESH
UAU